

The Impact of the Psychological Sequela of Trauma on Veterans Seeking Higher Education

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Abstract

Despite evidence that mental health burden is associated with lower academic success and non-completion in college students, and the high incidence of combat-related trauma exposure in returning veterans, few studies exist regarding the intersection of these issues in student veterans. This paper presents findings from a study on the mental health burden of student veterans attending rural community colleges in the southern United States. Based on qualitative research, the findings illustrate how the psychological sequela of combat-related trauma exposure impact classroom integration and academic achievement. The findings highlight the need for supportive services to integrate student veterans into campus communities and link them to mental healthcare resources, potentially improving academic success.

Keywords: Academic success, student veterans, mental health, trauma exposure

The post-9/11 GI Bill (Office of Public and Intergovernmental Affairs [OPIA], 2014) provides more than \$20 billion in educational benefits to veterans and their beneficiaries. This federal policy has the potential to improve returning veterans' economic futures via increased employment opportunities and long term earning potential. However, veterans returning from overseas combat (e.g., recently terminated military campaigns in the Middle East), often struggle with trauma-related psychological distress that can affect daily life and academic performance. Prior research has shown mental health burden is associated with lower academic achievement and a greater risk of non-completion of college (Hunt, Eisenberg, & Kilbourne, 2010; Kessler, Foster, Saunders, & Stang, 1995). Few studies have addressed the interplay of veteran combat experiences, mental health, and experiences in educational settings.

Many of the intense and disorganizing feelings associated with psychological trauma are experienced immediately following the event (James & Gilliland, 2012); however, individuals can experience long-lasting (i.e., longer than one month) psychological effects including depression, anxiety, and post-traumatic stress disorder (PTSD) (American Psychiatric Association, 2013; Foa, Hembree, & Rothbaum, 2007). Returning veterans with psychological trauma may experience intrusive symptoms (e.g., recurrent or involuntary memories, distressing dream/sleep disturbance, dissociative reactions or flashbacks, negative alterations in mood), may persistently avoid triggering events, and may also suffer a delayed autonomic hyperarousal response to current stimuli unrelated to previous combat (e.g., feelings of isolation or re-experiencing trauma in situations that pose no serious threat) (James & Gilliland, 2012). While each per-

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son's response to a traumatic event is unique, traumatic exposure, and particularly multiple exposures, increases the likelihood of developing symptoms that interfere with day-to-day life (Foa et al., 2007).

Recent work indicates that combat exposure and lingering PTSD symptoms contribute to veterans' feelings of alienation on campus (Elliott, Gonzalez, & Larsen, 2011). Student veterans may have difficulty relating to others, perceiving student peers as immature and/or their comments as disrespectful (DiRamio, Ackerman, & Mitchell, 2008). Veterans' extended gap between high school and college (e.g., several years compared to recent graduation from high school for civilian freshman) (Steele, Salcedo, & Coley, 2010), older average age, and deployment experiences further differentiate them, and may create additional challenges for classroom integration (Astin, 2011; Olsen, Badger, & McCuddy, 2014). As a result, student veterans may struggle to find a sense of belonging, leading to feelings of isolation (Whiteman, Barry, Mroczek, & Macdermid Wadsworth, 2013). Furthermore, student veterans often have physical and mental injuries, deployment- and combat-related stress, and family/relationship disruption after deployments, which can make it challenging to concentrate and learn (Steele et al., 2010) and may negatively affect academic performance.

Because many student veterans returning from the wars in Iraq and Afghanistan exit military service with signs and symptoms of mental health disorders (e.g., PTSD), understanding the impact of psychological trauma on classroom performance and integration is critical (Rudd, Goulding, & Bryan, 2011). To date, we know very little about: (1) the mental health burden of veterans attending rural community colleges, (2) their experiences in obtaining higher education, and (3) the effect of trauma on their educational experiences. In this article, we seek to fill the gap in the literature by examining the effects of psychological sequela of trauma on the mental health and experiences of rural veterans seeking higher education.

Methods

Estimates indicate that over 5,500 veterans have used the post-9/11 GI bill to obtain higher education in the state of Arkansas (U. S. Department of Veterans Affairs, 2010). Many of these veterans attend two-year community colleges and four-year universities close to their homes, often in rural, underserved areas of the

state (Field, 2008). This student population is often understudied. To better understand the unique needs of veterans attending two-year community colleges, we conducted a Department of Defense-funded study on the mental health burden and treatment-seeking behaviors of veterans attending community colleges in rural areas of Arkansas. A total of 11 community colleges from diverse rural regions throughout Arkansas, including colleges in the medically underserved Mississippi Delta Region and Ozark Mountains, participated in the study (Health Resources and Services Administration, 2015).

The first phase of the study (from January to April 2012) was marked by quantitative data collection; the second phase (from March 2012 to December 2014) by qualitative data collection. In this paper, we focus on the qualitative findings but merge mental health screening and military background data obtained from the quantitative study to better explain our qualitative findings. As described below, veterans were eligible to participate in the qualitative phase of the research if they screened positive for PTSD, depression, and/or anxiety—screening tools were embedded within a web-based survey—and agreed to participate in follow-up research.

Study Design

We conducted a large-scale quantitative survey using a web-based format, followed by in-depth qualitative interviews. Because prior research has primarily focused on students attending four-year institutions (Eisenberg, Hunt, & Speer, 2013), quantitative data were collected to better understand the prevalence of mental health conditions among student veterans attending two-year community colleges and to their assess treatment-seeking behaviors. In-depth qualitative interviews were conducted with a selected subset of participants to elicit student veterans' experiences with mental health issues to provide a more granular picture of the links between mental health and life stressors as well as their effect on day-to-day student life. Focus group discussions were conducted to deepen understanding of the findings via in-depth interviews and additionally to elicit suggestions for ideal ways to screen student veterans and link them to healthcare services.

Recruitment and Sampling

The web-based survey used in the first phase of the research was used to recruit participants for the

qualitative phase of the study. The registrar's office of each community college was contacted to obtain a list of students registered for the 2012 spring semester, and all students using the Post-9/11 GI bill were preliminarily classified as veterans. (Veteran status was later confirmed by self-report.) We sought to contact 100% of veterans using the Post-9/11 GI bill at each community colleges (n=928), and sent a letter in the mail with an unsolicited \$20 incentive inviting veterans to participate in a web-based survey. The survey link was included in the initial letter, followed by four reminder emails sent to veterans' registered email addresses. (All veterans irrespective of their decision to participate in the research received the \$20 incentive, survey link, and email reminders.) Participants were informed of the purpose of the study and their responses were confidential; all participants provided online informed consent. The study received full ethical approval from the University of Arkansas for Medical Sciences Institutional Review Board (IRB).

Data Collection

Mental health screening and military background data. Mental health screening tools used in the Healthy Minds Study (on which this study was modelled) were used to assess current probable mental health burden (Eisenberg et al., 2013; Eisenberg, Hunt, Speer, & Zivin, 2011). Participants' current mental health status was assessed using validated screening instruments for depression, PHQ-9 (Kroenke, Spitzer, & Williams, 2001); general anxiety disorder (GAD), GAD-7 (Löwe et al., 2008); and PTSD, PC-PTSD (Prins et al., 2004).

As part of the web-based survey, participants were asked if they had ever served in the United States (U.S.) Armed Forces, military Reserves, or National Guard and, if so, whether they were currently in Reserve Officers' Training Corps (ROTC), military Reserves, or the National Guard. Additionally, the survey asked whether participants were on active duty or had been on active duty during the prior 12 months or in the past but not during the prior 12 months. Participants with a history of military service were asked if they had been deployed (either within or outside the continental U.S.). Those participants with deployment experiences were asked a series of questions about their experiences during deployment to understand if or how often they had: (1) gone on combat patrols or other dangerous duties; (2) been under enemy fire; (3) been surrounded by the enemy; (4) had soldiers in

their units who were killed, wounded, or missing; (5) fired rounds at the enemy; (6) seen someone hit by incoming or outgoing rounds; or (7) been in danger of injury or death.

Of the 928 veterans sampled, 30.7% (n=211) completed the web-based survey. The socio-demographic characteristics, mental health burden, and treatment seeking behaviors of this cohort are reported elsewhere (Fortney et al., 2016). For the qualitative study, we focused on 87 of the 211 veterans who completed the survey and screened positive for depression, GAD, and/or PTSD, and also agreed to be contacted for future research. We contacted 100% of these 87 participants, and a total of 23 veterans were recruited and agreed to participate in the qualitative research (see Tables 1 and 2 for a quantitative description of all 87 veterans eligible to participate in the qualitative study). We did not find any significant differences between the 23 veterans who participated in the qualitative research and those who declined to participate or who were not reachable (see Tables 1 and 2).

Qualitative interviews. We engaged participants in a qualitative, in-depth interview regarding mental health burden, treatment-seeking behaviors, and ideal models of screening and linkage to care. A semi-structured interview guide with open-ended questions was used to elicit information about participants': (1) military experience; (2) transition from military to civilian life and college; (3) day-to-day stressors and emotional and psychological health; (4) support systems; (5) help-seeking behaviors; (6) perceived need for treatment; and (7) preferred models of screening and linkage to care. The interview guide was developed with input from a student veteran research assistant and tested with a rural student veteran to ensure trustworthiness and validity. Interviews, which lasted between 45 minutes and two hours, were held in a private location at each participant's respective campus.

Subsequent focus group discussions were held with 10 student veterans (6 men and 4 women) who participated in an in-depth interview. During the focus group discussions, an overview of the findings on mental health burden, treatment seeking, and barriers to care was presented to the veterans. Participants discussed the findings' relationship to their own experiences. In addition, participants were presented with initial recommendations for screening and linkage-to-care programs and provided an opportunity to elaborate on these ideas and discuss their perceived value. Participants in both the qualitative interviews

and focus groups received \$50 for their participation in the study.

Data Analysis

We merged data from quantitative and qualitative phases of the research, providing a more complete understanding of the mental health burden among student veterans and its effect on their day-to-day life (Creswell, Klassen, Plano Clark, & Smith, 2011). The quantitative survey data were used to generate descriptive statistics, including frequencies on socio-demographics, socio-economics, military service, and current mental health conditions among the 23 veterans who participated in the qualitative study. The qualitative interview data provide in-depth insight into the effects of psychological sequela of trauma during military service on veterans' day-to-day life and student experience.

Qualitative interviews were recorded and transcribed, then imported into MAXQDA, a qualitative data analysis software program (VERBI Software, 2012). In the first phase of analysis, structural codes (i.e., codes derived from the interview guide) were applied to the text. The second (AMC) and last (GMC) authors developed a detailed codebook and independently coded the same text to assess inter-coder agreement (MacQueen, McLellan, Kay, & Milstein, 1998). The coders met to reconcile disagreement and to revise the codes until an inter-coder reliability of 0.80, considered an acceptable percent of agreement between coders, was reached (Bernard, 2002). In the second phase of coding, the first (JM) and second author (AMC) used an inductive approach, engaging in line-by-line reading of the text, to identify emergent themes (Ryan & Bernard, 2003). Once themes were identified, the first (JM) and second (AMC) authors defined their dimensions and discussed the relationships among themes, their dimensions, and the data (Strauss & Corbin, 1990).

Results

Table 1 shows socio-demographic and mental health characteristics for the 23 student veterans involved in the qualitative phase of the larger mixed-methods study. These veterans were mostly married White men between ages 23 to 30 in their second year of college. Nearly 70% had been on active duty in the past, with 17% on active duty at the time of the study. Eighty-three percent screened pos-

itive for depression, 65.2% for GAD, and 56.5% for PTSD. Nearly a quarter (21.7%) expressed suicide ideation in the two weeks prior to the survey.

Table 2 details the military experiences of the 23 student veterans shared during the qualitative research. Nearly three-fourths (69.6%) had been deployed, 69% had been under enemy fire, and 56% had been surrounded by enemy fire and had seen someone hit by rounds. Over a third (34.5%) reported danger of injury or death, with a quarter indicating between 4 and 12 separate exposures.

The Transition from Military to Civilian Life

Many of the student veterans in our study deployed to support the conflicts in Iraq and Afghanistan and were involved in combat patrols. Such experiences do not always fade with the passing of time, and can leave enduring psychological scars. Student veterans described hypervigilance and intense reactions to everyday sights and sounds as well as having a "short temper" and anger outbursts upon return from deployment and reintegration into civilian life. The transition from a highly structured environment where roles are clear and institutionally enforced to a less structured environment where roles are unclear and not always enforced caused disorientation.

During interviews, veterans discussed their difficulties transitioning out of the military, pursuing civilian education, reintegrating with family, and coping with the lingering psychological effects of trauma. In the following section we describe veterans' transitional experiences, particularly in regard to student life, highlighting the effects of social distance, the stress of multiple competing demands, and re-experiences of trauma on integration into the classroom and achieving academic success.

Social distance. Many struggled to relate with the civilian world and their student peers. A young man in the focus group discussion said, "we're very well trained, very disciplined individuals and very motivated." Referring to a previous comment made by another man in the focus group, he said, "like one of the other guys was saying, we're not kids. We're not 18-, 19-year-old kids; we're disciplined, organized, intelligent individuals."

Others expressed a sense of disconnection from their peers related to their older age and prior military and deployment experiences: "Being the oldest guy in class, that makes it a little hard, too, because everybody looks at you and calls you the old man."

Student veterans also talked about frustrating interactions with civilian “kids,” who they often described as immature. During one of the focus group discussions, one veteran candidly discussed this irritation:

That’s the thing I had problems with the first probably year or two I was in. I got so irritated being with civilians and immature kids and stuff. It about drove me insane because I just wanted to go into class [and] sit down.

The social distance veterans felt from other students’ immaturity was compounded by perceived stigma attached to having served in military combat. The veterans’ perceptions were often exacerbated due to civilians’ inappropriate questions and assumptions about service members. Multiple veterans brought up the peer insensitivity in asking about war experiences, particularly questions inadvertently reinforcing veterans’ feelings of isolation or “difference.” One veteran explained:

A lot of the kids here, when they ask you about the military or if you’ve been to war, one of the first questions that everybody always asks is, “Did you kill anybody?” That’s a question that’ll piss off a Veteran quicker than anybody.

Veterans in our focus group stated their belief that many university students are treated like children. They were often taken aback at the way students were coddled in the classroom:

I had a similar issue where people just didn’t understand that I’m not a kid. I just want to get in and sit down and learn and take it seriously and do what I need to do and get out. I hate to say it, but they’d really pander to the college kids and treat them like they’re kids. I was like, ‘I’m a grown adult. I’ve been in the military and I don’t feel like I should be treated like a kid.’”

Stress of competing demands and expectations. Many struggled to successfully juggle the demands and expectations of marriage and parenthood, employment, and education. Despite receiving assistance from the Post-9/11 GI Bill, which pays for tuition, books, and a housing allowance throughout the academic year, participants struggled to pay bills, including childcare, as well as their everyday expenses.

Throughout the semester, participants worked full-time, part-time, and/or odd jobs to “get by.” For some, competing demands necessitated dropping or discontinuing classes. One single male veteran, who worked full-time and had an 18-hour course load, discussed the challenges with juggling both:

I had to drop some classes because I was taking way more classes and work[ed] full time. Just before I started that semester, work offered me a fulltime position, which I took because I needed the money. . . . I thought I could handle and it just became more or less I couldn’t, there wasn’t enough time in the day to finish all my work.

Some struggled to find purpose and meaning in their new role as students, which many described as less meaningful than military service. Veterans also associated being students with an inability to adequately provide for their families or to do enough to meaningfully contribute to society: “[Being a student] makes me feel like I’m not providing for my family and it makes me feel like I’m just a drain on society.” Veterans discussed how these demands coupled with drastic changes in their financial situation, which tended to shift from having enough money to pay bills and enjoy leisure time activities to barely having enough money to get by, created stress, loneliness, and, in some cases, depression. One veteran discussed the frequent negative emotional effects of staying home to study while his wife went to work:

There’s five or six times a month where I’ll have a little pity party sitting at the house. The wife will come home and I’m just over there at my desk feeling sorry for myself. I’ll be in a bad mood all afternoon, walking around mumbling, crying to myself.

In this case, the demands of education involved long hours of studying alone, which was isolating and contributed to depression symptoms. This veteran, similar to other participants, used alcohol to cope with loneliness, depression, and traumatic memories. He explained:

I’ll just start cracking a beer to go watch a movie. The next thing you know I’m looking at my buddies on the wall – their pictures, feeling sorry about that; feeling sorry that I can’t find a job;

feeling sorry because this bill's behind or am I going to have enough money to go do this with the family. And then before you know it, the nights up and I'm stumbling to bed drunk.

Existing mental health problems, such as depression, GAD, or PTSD, exacerbated veterans' symptoms, increasing challenges to academic success (e.g., difficulty attending classes regularly or meeting educational expectations [e.g., passing or high grades]). One woman veteran with a history of depression explained:

I saw the warning signs [of depression]; I ignored them. I had been thinking that the depression and stress and all that, was coming from, 'Well if I make better grades then I won't have that [depression]...I'm a little depressed and that's why I'm not even in class this semester.

Re-experiencing trauma. Events or situations on campus that triggered memories related to combat further complicated the ability of veterans to integrate into the classroom and achieve academic success. These memories, in turn, induced heightened levels of stress and, in some cases, caused veterans to re-experience and re-live the trauma of combat.

Some participants described the effect of crowded situations as distressing, shaping not only their campus experience but how they navigated daily life at school. For these participants, and other student veterans like them, situations reminding them of combat both produced anxiety and resulted in hypervigilance, increasing their distress. In this excerpt, a woman who screened positive for PTSD described situations on campus that invoked her anxiety:

It was just the registration portion of it, like being in those little offices...They would have...that front desk...that woman was helping all the students in there. And it's 30 students standing there in that little space waiting for her. That's how it was in almost every office you went into.

In some instances, specific events or experiences on campus triggered disturbing memories, as described by a participant in the following excerpt:

Well, for instance, the other day I came and there was a kid that we thought seized out downstairs...

and I had him in my arms, trying to keep him from hitting his head and stuff. And when I was sitting there holding him the same way I was holding this guy that got shot in Iraq, and the guy died, I was sitting there thinking, "Oh my God. Is this guy gonna die too?"

These experiences reinforce the psychological distance between students with combat experience and their peers, further disrupting classroom integration.

Other veterans struggled with intrusive thoughts and memories related to traumatic experiences that interfered with their ability to focus and concentrate during class and therefore negatively affected their academic performance. In the following excerpt, a veteran explicitly describes the negative effect of combat-related trauma and re-experiencing trauma in the classroom:

Veteran: Yeah, just thinking back to the things you've been through, like the things that happened . . . Some of the classes what they discussed would bring up (trails off).

Interviewer: Would bring up those memories?

Veteran: Yeah, and so I would find myself sometimes zoned off in deep thought about other things that I had been going through versus what we're talking about in class.

For others, thoughts and memories of traumatic events occurred at night, disrupting their sleep patterns and making it difficult to attend classes. One male combat veteran explained:

One thing that really made it hard on me [going to school] was a lot of mornings I would wake up and still be tired because I have these real bad dreams during the night. Trying to make it into class after being up just about all night was just very hard.

These student veterans brought lived experiences of the psychological sequela of trauma with them to the classroom, and the residual effects shaped both classroom integration and academic performance.

Discussion

The data described in this article reflect the difficulties veterans experienced trying to integrate into the classroom at community colleges in rural areas of the American South. The experiences of our participants might not be entirely representative of what other veterans experience in other contexts (e.g., in more urban settings in the Northeast). Additionally, these qualitative findings from the lived experience of veterans are meaning-centered, context dependent, and difficult to generalize. Despite these limitations, our study is among the first to fill in the gaps regarding the mental health burden faced by veterans at the community college level.

By studying 11 community colleges from diverse rural regions throughout Arkansas, the findings from our study indicate veterans who screened positive for depression, GAD, or PTSD struggle with mental health concerns, especially psychological trauma related to combat exposure. These findings reveal some underlying reasons returning veterans might be unable to connect with peers and experience feelings of isolation while transitioning from military service to a campus environment. Our study highlights the need for more data on the range of experiences of veterans seeking out secondary education using the Post-9/11 GI Bill in a variety of educational settings (e.g., Universities, community colleges, vocational schools, etc.) to provide appropriate support in each context. This is important as the number of degree-seeking veterans is expected to grow (Widome et al., 2011).

In our study, we found that the majority of veterans had deployed and reported being in danger of injury or death. Many student veterans also had to deal with the effects of trauma exposure while adapting to an environment where they felt isolated and out of place. As veterans' narratives evidence, war-related trauma and related impairments (e.g., traumatic brain injury can hinder returning veterans' academic performance (Ellison et al., 2012; Smee, Buenrostro, Garrick, Sreenivasan, & Weinberger, 2013).

Similar to participants in other studies regarding veterans' re-integration, participants in our study conveyed the difficulty they faced during the transition from the highly structured military profession to a campus setting with peers from whom they felt disconnected, due to differences in life experiences, age, and stage in life (Astin, 2011). Bonar & Domenici (2011) referred to the integration process as a type

of culture shock that requires "attainment of a new set of cultural competencies and awareness" (p. 208). Not surprisingly, some felt as if the behaviors that had once made them successful were now devalued and isolated them from their peers.

Practical Implications

Our findings have practical implications for college and university disability providers, administrators, and educators. As veterans increasingly transition from the battlefield to the classroom, colleges and universities must be able to address the unique needs of this student population (Zinger & Cohen, 2010). Existing tools may help to facilitate veterans' transition and minimize adverse classroom experiences. The National Center for PTSD and Veterans Administration (VA) recently created a "VA Campus Toolkit Handout" that offers tips on how higher education can respond to common issues returning student veterans face (e.g., distraction, provocative class material, challenges sitting quietly because of hyperactivity, sleepiness because of troubled sleep or reoccurring nightmares, or challenges adjusting to classroom rules and expectations including unstructured setting, group activities, open-ended assignments). The VA toolkit provides administrators and educators with easy-to-implement practices to address these common issues, including the use of "trigger warnings," which alert students to potentially unsettling or upsetting images, text, or discussions that could evoke traumatic memories or experiences. Additionally, the toolkit encourages administrators and educators to consider the following: (1) campus culture, especially politicized statements, can negatively affect veterans' experiences, (2) veterans are often older, non-traditional students with multiple responsibilities, and (3) veterans appreciate being treated with respect.

It is important that college and university service disability providers recognize that although veterans may struggle with symptoms of depression, GAD, or PTSD, this study suggests many do not seek mental healthcare services. In part, this was because many veterans attend community colleges where limited resources are available to support student mental health (particularly the unique mental health needs of veterans). Unlike four-year institutions, many community colleges serve low-income students and offer low-cost tuition, reducing funds for student services, including health and mental healthcare services (Kahlenberg, 2015).

All college and university students face multiple barriers to accessing mental healthcare services (Eisenberg, Golberstein, & Gollust, 2007). Student veterans in rural contexts arguably face additional barriers based on military enculturation and conservative gender role expectations that constrain ability to seek formal mental healthcare (Abraham, Cheney, & Curran, 2016). Student veterans may struggle to seek assistance from mental health professionals due to military specific stigma around mental health and help-seeking (e.g., “only the weak seek care;” Hoge et al., 2004). Our previous findings indicated that student veterans were more likely to recognize the need for treatment, compared to civilian students, but also perceived more public stigma which can negatively influence treatment seeking (Fortney et al., 2016). Student veterans can access VA mental healthcare services, including community-based outpatient clinics designed to serve veterans in rural areas. Therefore, college and university disability service providers need to be aware of local VA services and resources so they can refer veterans appropriately.

Conclusion

For student veterans already facing the difficult task of reintegration, managing the symptoms of psychological trauma may impede both their ability to successfully use existing educational tools and to interact with other students (Smee et al., 2013). While Post-9/11 GI Bill benefits are intended to invest in the veteran and their community, veterans struggling with the aftermath of trauma exposure may find any potential returns diminished. As seen among the veterans in our study, sleep disturbance, hypervigilance, irritable/aggressive behavior, and problems concentrating were the most recognizable mental health symptoms. Trauma-related stressors and comorbid disorders can create challenging barriers for student veterans to overcome, reducing the effectiveness of current programs. Linkage-to-care interventions, such as peer-led supportive services, have been found to be especially effective among student veteran populations and have the potential to connect veterans to needed resources as well as offer veterans a sense of community, potentially increasing retention rates and helping to ensure academic success (Olsen et al., 2014). Veteran-led peer programs may be appropriate and feasible in rural settings where there is limited access to campus and community mental healthcare services (Cheney et al., 2016).

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Table 1

Student Veterans' Demographic Characteristics

Variable	Veteran participants (N=23)	Veteran sample pool	<i>p</i> ^a
	N(%)	N(%)	
Age			
18-22	1 (4.35)	4 (6.25)	0.9346
23-30	12 (52.17)	29 (45.31)	
31-40	6 (26.09)	20 (31.25)	
41+	4 (17.39)	11 (17.19)	
Male	15 (68.18)	49 (76.56)	0.4370
Race			
White	13 (56.52)	48 (75.00)	0.1982
Black	5 (21.74)	10 (15.63)	
Other ^a	5 (21.74)	6 (9.38)	
Married	13 (56.52)	33 (51.56)	0.6828
Years attending community college			
1	7 (30.43)	19 (29.69)	0.5622
2	14 (60.87)	33 (51.56)	
3	1 (4.35)	10 (15.63)	
4+	1 (4.35)	2 (3.13)	
Lives off campus	22 (95.65)	31 (48.44)	0.0876
Current financial situation			
It is a financial struggle	16 (69.57)	31 (48.44)	0.0876
It is tight, but doing fine	7 (30.43)	24 (37.50)	
Finances not a problem	0 (0.00)	9 (14.06)	
Mental Health			
PHQ-9	19 (82.61)	49 (76.56)	0.5472
GAD-7	15 (65.22)	34 (54.84)	0.3896
PC-PTSD	13 (56.52)	39 (61.90)	0.6513
Thoughts and behaviors			
Suicide ideation	10 (43.48)	25 (39.68)	0.7511
Acute suicide ideation	5 (21.74)	18 (29.51)	0.4764

Note. ^a Comparisons made using Chi-square *t*-tests.

Table 2

Student Veterans' Military Background

Variable	Level	Veteran participants (<i>n</i> =23)		Veteran sample pool (<i>n</i> =64)		<i>p</i> ^b
		Number of times	Military service ^a	Veteran sample pool (<i>n</i> =64)		
Deployed, <i>N</i> (%)			16 (69.57)	47 (73.44)		0.7216
Served in U.S. military, <i>N</i> (%)	Currently in military Reserves or National Guard		3 (13.04)	12 (18.75)		0.2978
	Now on active duty		4 (17.39)	4 (6.25)		
	On active duty past 12 months, not now		0 (0)	4 (4.69)		
	On active duty in past, but not past 12 months		16 (69.57)	45 (70.31)		
Went on combat patrol, <i>N</i> (%) ^b	No		2 (12.50)	10 (21.28)		0.7751
	Yes	1-3 times	3 (18.75)	4 (8.51)		
		4-12 times	3 (18.75)	7 (14.89)		
		13-50 times	3 (18.75)	10 (21.28)		
		51+ times	5 (31.25)	16 (34.04)		
Were under enemy fire, <i>N</i> (%)	Never		5 (31.25)	13 (27.66)		0.9434
	Yes	<1 month	3 (18.75)	7 (14.89)		
		1-3 months	2 (12.50)	5 (10.64)		
		4-6 months	3 (18.75)	8 (17.02)		
		7 months or more	3 (18.75)	14 (29.79)		
Were surrounded by enemy, <i>N</i> (%)	No		7 (43.75)	31 (65.96)		0.3022
	Yes	1-2 times	5 (31.25)	5 (10.64)		
		3-12 times	2 (12.50)	7 (14.89)		
		13-25 times	1 (6.25)	1 (2.13)		
		26+ times	1 (6.25)	3 (6.38)		
Percentage of killed, wounded, or missing soldiers, <i>N</i> (%)	None		6 (37.50)	17 (36.17)		

Table 2, continued

Variable	Level	Veteran participants (<i>n</i> =23)		Veteran sample pool (<i>n</i> =64)		<i>p</i> ^b
		Number of times	Military service ^a	Veteran sample pool (<i>n</i> =64)		
How often did you fire rounds at the enemy? <i>N</i> (%)	Some	1-25%	9 (56.25)	28 (59.57)	0.9380	
		26-50%	1 (6.25)	2 (4.26)		
		51-75%	0 (0.00)	0 (0.00)		
		76% or more	0 (0.00)	0 (0.00)		
	Never	8 (50.00)	30 (63.83)			
How often did you see someone hit by rounds? <i>N</i> (%)	Yes	1-3 times	1 (6.25)	4 (8.51)	0.1418	
		4-12 times	3 (18.75)	8 (17.02)		
		13-50 times	4 (25.00)	2 (4.26)		
		51+ times	0 (0.00)	3 (6.38)		
	Never	7 (43.75)	26 (55.32)			
How often were you in danger of being injured or killed, <i>N</i> (%)	Yes	1-3 times	1 (6.25)	11 (23.40)	0.1859	
		4-12 times	5 (31.25)	5 (10.64)		
		13-50 times	2 (12.50)	4 (8.51)		
		51+ times	1 (6.25)	1 (2.13)		
	Never	6 (37.50)	15 (32.61)			
How often were you in danger of being injured or killed, <i>N</i> (%)	Yes	1-3 times	2 (12.50)	12 (26.09)	0.6638	
		4-12 times	4 (25.00)	4 (25.00)		
		13-50 times	2 (12.50)	7 (15.22)		
		51+ times	2 (12.50)	2 (4.35)		

Note. ^a Military service provides frequency and percentage for those answered "Yes" or "Some" to the questions.

^b Comparisons made using Chi-square t-tests.