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Case Study

Veteran Adrenaline Dependence and Intergenerational Impact: Extending Case-Oriented Findings Through Family Systems and Occupational Outcomes

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ABSTRACT

Parental posttraumatic stress disorder (PTSD) and depression are associated with impaired parenting and elevated child internalizing and externalizing symptoms. Veterans may also experience withdrawal-like dysphoria following the loss of high-arousal environments, consistent with a behavioral addiction framework for adrenaline dependence. The author's quantitative thesis study of 147 veterans demonstrated that those employed in high-risk occupations (e.g., law enforcement, firefighting) reported lower depression severity compared with peers in low-risk jobs or unemployment, although statistical significance was strongest for elevated depression in low-risk roles. This article extends those findings into family systems, synthesizing case reports and empirical studies on parental PTSD/depression, intergenerational transmission and children's perspectives. A conceptual model is proposed in which adrenaline withdrawal amplifies parental psychopathology, undermining parenting and heightening child vulnerability. Clinical implications include routine screening for adrenaline withdrawal among veteran parents and the integration of safe, prosocial arousal outlets into trauma-informed, family-centered care.

Keywords: Veterans; Adrenaline Withdrawal; PTSD; Depression; Parenting; Child Development; Family Systems; Intergenerational

Introduction

Military service calibrates individuals to chronic high-arousal states. Following separation, some veteran's report anhedonia, irritability and craving for intensity, paralleling withdrawal symptoms described in extreme-sport populations[1]. In a quantitative study of 147 veterans, Jackson-Campos[2] found that participants in high-risk civilian jobs (e.g., firefighting, law enforcement) reported lower depressive symptom severity compared with peers in low-risk jobs or unemployment. However, statistical significance was strongest for higher depression in low-risk occupations, suggesting that absence of arousal may exacerbate withdrawal-related dysphoria.

While the thesis focused on occupational outcomes, research underscores that PTSD, depression and withdrawal-like symptoms reverberate through family systems. Parental psychopathology disrupts parenting and directly affects children's wellbeing[3-5]. This article integrates family-oriented research with occupational findings to propose an intergenerational model of veteran adrenaline withdrawal.

Case-Oriented and Family Systems Research

Research shows that parental depression predicts both internalizing and externalizing symptoms in children[4,5]. Creech and Misca[3] reviewed studies demonstrating that PTSD in military parents is associated with diminished warmth,

heightened irritability and inconsistent parenting behaviors. Senecal, Lopez Adorno, LaFleur and McNamara[6] documented an autoethnographic account of a veteran's marital strain and difficulty reconnecting with children, underscoring attachment ruptures and withdrawal. Wang, Liu, Merrin, Keller and Yoon[7] found that PTSD reduced veterans' capacity for mentalization, which in turn predicted harsher parenting. Pre-military trauma exacerbated these risks. May, Van Hooff, Doherty and Carter[8] interviewed youth aged 9-17, who described parental volatility and unpredictability, highlighting children's direct awareness of parental psychopathology. Family-centered programs such as Families Over Coming Under Stress (FOCUS) demonstrate improvements in both parental functioning and child adjustment when family stress is addressed[9,10].

Adrenaline withdrawal and behavioral addiction frameworks

Research on extreme sports and addiction provides a parallel lens. Rock climbers deprived of climbing reported craving and dysphoria akin to withdrawal[1]. Among veterans, Serfioti, Hunt and colleagues[11] found that structured motorsport participation restored motivation and social connectedness. Together with Jackson-Campos'[2] thesis findings, these studies suggest that safe, structured arousal outlets may serve as protective buffers against withdrawal-related depression.

Integrative conceptual model

The proposed model links:

- Military service → calibration to high-arousal states.
- Transition to civilian life → withdrawal-like dysphoria (adrenaline dependence).
- Psychopathology → PTSD and depression amplify irritability and withdrawal.
- Parenting disruptions → diminished warmth, harsh or inconsistent practices.
- Child outcomes → elevated internalizing/externalizing symptoms.
- Buffers → safe, prosocial arousal outlets improve parental affect regulation and family functioning.

Implications for VA and military leadership

The findings have important implications for both the Department of Veterans Affairs (VA) and military leadership in shaping prevention and support initiatives. Veterans' mental health cannot be addressed solely through individual-focused treatment; it requires a systemic, family-centered approach.

Expand family-centered programming

- Programs such as FOCUS demonstrate measurable improvements in family functioning and child adjustment[9,10]. Scaling these programs across bases and VA clinics would ensure broader access.
- Incorporating family psychoeducation on PTSD, depression and adrenaline withdrawal could reduce stigma and promote early recognition of risk factors.

Integrate safe arousal outlets

- Military leaders and VA providers should recognize the role of adrenaline withdrawal in post-service adjustment. Partnerships with community organizations (e.g., motorsport, adventure therapy, structured physical training) can provide safe outlets for veterans to regulate arousal.
- Embedding these programs within reintegration services could buffer withdrawal-related depression and improve family stability.

Enhance transition planning

- Separation and retirement programs should assess veterans not only for employment readiness but also for psychological and physiological adjustment to reduced adrenaline exposure.
- Providing resources for veterans and families to explore high-engagement careers or structured recreation could mitigate risks of depression and relational strain.

Policy and advocacy

- VA disability evaluations could consider adrenaline withdrawal as a contributing factor to depression and PTSD-related impairments, warranting recognition within benefits determinations.
- Military leadership should advocate for research funding focused on family systems, intergenerational transmission of trauma and adrenaline withdrawal as a behavioral addiction framework.

Strengthen family support services

- Child development specialists, family therapists and school-based mental health liaisons should be integrated into VA and military health systems to directly support children of veterans.
- Military leaders can ensure that command climates promote family wellbeing by supporting policies that prioritize parenting leave, spousal mental health and child support services.

Clinical Implications

Clinicians working with veteran families should:

- Screen for adrenaline dependence/withdrawal as part of PTSD and depression assessments.
- Support occupational fit discussions to mitigate withdrawal symptoms.
- Offer family-centered, trauma-informed programs (e.g., FOCUS).
- Monitor child functioning in coordination with pediatric providers.

Future Research Directions

Future research should:

- Conduct longitudinal studies tracing adrenaline withdrawal and parenting outcomes over time.
- Incorporate children's perspectives via mixed-methods designs.
- Explore neurobiological mechanisms (e.g., HPA axis dysregulation, FKBP5 methylation)[12-14].
- Evaluate structured arousal interventions (e.g., motorsport, adventure therapy) through controlled trials.
- Examine cumulative effects of pre-military trauma on veteran-parent functioning.
- Compare occupational and family-level interventions to determine optimal strategies for resilience.

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