

2012

A theoretical approach to understanding alcohol misuse in military personnel returning home from Operation Iraqi (OIF) and Operation Enduring Freedom (OEF)

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Patrice Kenyatta Boyce
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understanding alcohol misuse in
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and Operation Enduring Freedom
(OEF)

Abstract

This theoretical thesis explores the misuse of alcohol in military personnel who are returning home from the current conflicts in Iraq and Afghanistan. The study focuses on what occurs to these soldiers upon their return home, as they try to manage their experiences of combat while continuing to fulfill their duties as soldiers, sailors, Marines, airman, and guardians. The comorbidity of posttraumatic stress disorder (PTSD) which sometimes result from traumatic memories and experiences of the Middle East, and the misuse of alcohol which some returning soldiers use as an acceptable tool for numbing symptoms of PTSD are explored in this thesis, the vicious cycle of PTSD and alcohol misuse are examined through the use of systems theory and the theories of PTSD which help to explain the role that systemic pressures to uphold military values has upon the actions and choices of the military personnel under discussion.

**A THEORETICAL APPROACH TO UNDERSTANDING ALCOHOL MISUSE IN
MILITARY PERSONNEL RETURNING HOME FROM OPERATION IRAQI (OIF)
AND OPERATION ENDURING FREEDOM (OEF)**

A veteran of OIF developed this thesis to fulfill requirements for the degree of Master of Social Work.

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2012

Acknowledgements

My thesis is dedicated to every serviceman and servicewoman who has served in the military. To those who are currently serving, have served in the past, and to those who will serve in the future, I offer my thanks to you. To all those military personnel who are coping with the traumatic events of war, I extend the warm hand of a fellow comrade who knows what you are going through. To all those soldiers, Marines, sailors, guardians and airman who have died in battle, may your families continue to be comforted with the knowledge that you died while preserving their freedoms.

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Chapter One

Introduction

Since the terrifying events of 9/11, our men and women in uniform have answered Congress's call. Our nation was faced with the decision to defend its borders against the unknown. To restore hope and security in the American people and those of our allies, our President declared war. President George W. Bush appealed to the concerns of all of us with the following response aired on March 19, 2003:

My fellow citizens, at this hour, American and coalition forces are in the early stages of military operations to disarm Iraq, to free its people, and to defend the world from grave danger. On my orders, coalition forces have begun striking selected targets of military importance to undermine Saddam Hussein's ability to wage war....The enemies you confront will come to know your skill and bravery. The people you liberate will witness the honorable and decent spirit of the American military. In this conflict, America faces an enemy who has no regard for conventions of war or rules of morality....Our nation enters this conflict reluctantly -- yet, our purpose is sure. The people of the United States and our friends and allies will not live at the mercy of an outlaw regime that threatens the peace with weapons of mass murder. We will meet that threat now, with our Army, Air Force, Navy, Coast Guard and Marines, so that we do not have to meet

it later with armies of fire fighters and police and doctors on the streets of our cities. My fellow citizens, the dangers to our country and the world will be overcome. We will pass through this time of peril and carry on the work of peace. We will defend our freedom. We will bring freedom to others and we will prevail. May God bless our country and all who defend her. (“Operation Iraqi Freedom, 2003”)

The call to serve, mentioned by our President, has ended in the deployment of over 2 million of our men and women in uniform to places in Iraq and Afghanistan (Tan, 2009). These places expose our military personnel to many of the effects of combat that include fighting, killing, and seeing dead bodies during their deployments (Kim, Bliese, Wilk, Hoge, McGurk, & Thomas, 2010). As our military personnel return home from the conflicts in Iraq and Afghanistan, they reenter the military system ready to train in order to deploy again if needed.

Our military system requires that its members be focused on being physically and mentally ready for combat. Thus, our active duty personnel will have to continue to be able to answer that call in order to maintain their jobs within the system, even with repeated deployments (Brown, Bray & Hartzell, 2010). The results of these many deployments have caused military personnel to utilize quick coping mechanisms, according to the National Center for Posttraumatic Stress Disorder website (NCPTSD), to deal with the traumatic events of war and in order to be physically and mentally ready to deploy again if ordered (“PTSD and Problems, 2007”).

The impact of combat on all military personnel returning home from both Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) wars have made the front covers of magazines, newspapers and several news specials (Alvarez, 2008). The old system of handing out whiskey and cigarettes to help military personnel deal with the stress of battle has evolved into a system that penalizes any military personnel who is drinking on duty (Wilson, 1993). Research now supports the deadly effects of prolonged alcohol misuse, and the military concurs with these new findings (Maraldi, Harris, Newman, Kritchevsky, Pahor, Koster, & Volpato, 2009).

Allison-Aipa, Ritter, Sikes, & Ball (2010) studied military personnel who recently returned home from a tour in Iraq and Afghanistan. They found that 11-17% of all OIF and OEF military personnel were at risk of misusing alcohol within 3-4 months of returning home from combat duty. The purpose of this theoretical thesis is to explore two of the reasons OIF and OEF active duty personnel may be misusing alcohol after returning home from war: the conditions that they experienced overseas, and the military system's encouraging or hindering of soldiers from receiving mental health services.

The DSM-IV-TR's description for PTSD will be applied to analyze the impact the experience of war has on OIF and OEF military personnel viewpoints toward seeking help (APA, 2000). This diagnosis will be applied to the OIF and OEF population to assess how traumatic memories that reexperienced by military personnel are later numbed through the misuse of alcohol. Systems theory will be applied to the phenomenon to further explore whether the military system and the stigma associated

with seeking help within the military contributes to military personnel who have experienced combat exposure to self medicate with alcohol instead of seeking mental health services.

This study will contribute to the literature that will help social workers better understand the impact that war has on those who return home. Awareness of some of the pernicious effects of military personnel's deployment and the role of the military in helping or hindering the process of military personnel receiving proper care after a deployment will, hopefully, help social workers better understand some of the reasons why some soldiers misuse alcohol and aid in the development of social work interventions for this population.

How social workers can intervene on behalf of military personnel will become apparent after the study has been completed. A better understanding of what goes on overseas and how the military system both fosters drinking as a quicker remedy versus seeking mental health, due to stigma, will become apparent after the study has been done.

Chapter Two

Methodology

Throughout this thesis, I have attempted to incorporate the voices of the men and women in uniform who have served in OIF and OEF, their experience while overseas, and the various forms of combat (fighting, killing, and bearing witness to death, and depravity among them) that military personnel have endured while serving in the Middle East. Many of these service men and women who are exposed to combat later develop PTSD from serving overseas, and some of these OIF and OEF military personnel choose to misuse alcohol as an acceptable way of coping with their symptoms of PTSD within the military system.

The emotions and fears experienced by two military soldiers after returning home from such dangerous conflicts of war were illustrated through the use of their stories and experiences of their deployment(s) (Gutman & Lutz, 2010; Alvarez, 2008). The impact that combat exposure has on military personnel's ability to regulate their behavior and affect while being in a system that can stigmatize mental health services through its traditions and values of personal courage and duty, and those implications for alcohol misuse, were explored by incorporating the findings of various researchers (Kim et al., 2010; "PTSD and Problems, 2007"; Jacobson et al., 2008; Brown et al., 2010; Allison et al., 2010; Maguen et al., 2010; & Nunnink et al., 2010) who have also studied OIF and OEF personnel upon their return home from combat.

Systems theory was included to show how the military systems' traditions and values can sometimes cause military personnel to choose self-medicating mechanisms (alcohol) as a more acceptable way of dealing with symptoms of PTSD rather than receiving mental health services, due to stigma-related feelings and their concern that they are presenting as weak and lazy to military leaders. The traditional values of the military: honor, selfless service, integrity, personal courage and respect, are all values that can impede the client system of soldiers, Marines, sailors, guardians and airman who are returning home from combat and experiencing symptoms of PTSD from seeking mental health services. These values, along with the use of the systems theory terms such as the "target" and "client system" were included in the systems chapter to show the reader how the military's embodiment of such values and traditions could encourage some military personnel to misuse alcohol instead of seeking mental health services for their symptoms of PTSD.

The concept of PTSD and its prevalence in those military personnel who are returning home from the wars in Iraq and Afghanistan was also explored. To show how the images and memories of combat continue to follow military personnel as they reintegrate into their lives at home. The various symptoms of PTSD, including flashbacks, startle responses, hyperarousal, and the use of numbing and avoidance tools are, all responses to the various forms of combat exposure that military personnel have experienced while overseas (fighting, artillery, improvised explosive devices, killing, and bearing witness to depravity). The chapter on PTSD discusses how once military

personnel are diagnosed with PTSD, alcohol misuse can seem to them an appropriate way to cope with their symptoms of PTSD.

The phenomenon of alcohol misuse among military personnel who are returning home from the current conflicts in Iraq and Afghanistan were explored in this chapter through the use of various findings from many researchers who have studied OIF and OEF personnel. How drinking alcohol helps military personnel to fulfill their daily military duties, and its comorbidity with PTSD were also explored in this section. I also reviewed several research studies, including those from the Veterans Affairs (VA). VA officials are also interested in the phenomenon of PTSD and alcohol misuse in returning military personnel. The functional relationship between symptoms of PTSD and the misuse of alcohol as an acceptable way of numbing the pains of war in a system that regards strength, duty, and courage as coveted values versus those values that seeking mental health services might cause one to appear as weak, vulnerable, and cowardly were also included in this chapter.

The value of service, which is shared by both social workers and military personnel, was explored in the discussion chapter. Included is a call for social workers to serve military personnel as they return home from the Middle East after having experienced the aftermaths of combat. I conclude the study with a brief discussion on our obligation, according to the National Association of Social Workers (NASW), to serve vulnerable populations, such as OIF and OEF military personnel after they return home

from war, and assert that this is an act of service and duty for all social workers to undertake (NASW, 2006).

Chapter Three

The Phenomenon: Alcohol Misuse

Gutman & Lutz (2010) interviewed Demond Mullins, a soldier who served in Iraq, who recounted his experience while being overseas. Mullins begins by first mentioning the twenty-five military personnel who had been killed within the eleven months of his deployment. He then proceeds to describe the environment of Iraq as being hostile and overwhelming. He said the following about the fallen:

Most of the people were blown up. And because they were blown up, and the way that they were blown up –the way that the bombs are placed—there’s really nothing that you can do about it, you know? You’re just a target, and if your number’s up then your number’s up, you know? There were no straightforward kills. There were no ‘Oh, my buddy got shot and he died.’ It was, ‘Ten people got blown up today because they couldn’t see the bomb under the road and they just rolled right over it.’ The most frustrating thing about it, and I carry that frustration with me now, was just the powerlessness that you feel. (p. 33)

The above story recounts the feelings and emotions experienced by one military personnel while serving overseas. But According to the *Marine Corps Times*, as of October 2009, over 2 million military personnel have deployed in support of OEF, which began in October of 2001, and OIF, which began in March of 2003. Of this number 793,000 have deployed more than once (Tan, 2009). As active duty (AD) personnel continue to return home from the wars in Iraq and Afghanistan, they face another war on

the home front. The war fought on the battlefield continues to intrude upon the lives of those military personnel who have experienced combat exposure while serving in support of Operation Iraqi (OIF) - and Enduring Freedom (OEF).

The severity of combat experienced by OIF and OEF personnel can impact their ability to function in their individual lives after the war is over. A recent study assessed the relationship between combat exposure and alcohol misuse among military personnel returning home from OIF (Kim et al., 2010). According to the article, AD personnel reported experiencing the following forms of combat exposure while deployed: fighting, killing, dealing with the uncertainty of one's life, death/injury of others, mayhem, and witnessing oppression (Kim et al., 2010). According to Kim and colleagues (2010), combat exposure becomes embedded within the memories of our women and men in uniform, and alcohol misuse is often a response to traumatic memories which come from the various forms of combat exposure (killing, fighting, death/injury of others, etc.) that they experienced while being deployed. According to the National Center for Posttraumatic Stress Disorder (NCPTSD), which distributes information on research, and education on topics related to trauma and PTSD, military personnel misuse alcohol as a way to cope with what they have experienced while serving in the Middle East ("PTSD and Problems, 2007").

Kim et al., (2010) surveyed a sample of 1080 OIF and OEF personnel who had recently returned home from their deployment. Their findings show that 25% of their

sample screen positive for alcohol misuse¹ which was related to the fighting, death, dealing with uncertainty, injury, and the mayhem experienced while in combat. For the purposes of this thesis, the term alcohol misuse will be defined using the DSM-IV-TR definition for alcohol abuse.

Kim et al., (2010) & Maguen, Lucenko, Reger, Gahn, Litz, Seal, Knight, and Marmar (2010) studied the misuse of alcohol in military personnel with different combat experiences. Both studies surveyed military personnel who had returned from a deployment within the past six months and looked at various forms of combat exposure experienced by military personnel. Kim et al., (2010) asked military personnel returning home from both OIF and OEF about their experiences of exposure in fighting, killing, and death. The combat exposures of these military personnel were compared with their alcohol misuse. In a survey administered prior to this study, the researchers found that 37% of those soldiers who had been exposed to combat tested positive for alcohol misuse and 25% of the same sample screened positive for alcohol misuse 3-4 months after their deployment (Kim et al., 2010).

Maguen et al., (2010) studied the impact of direct and indirect killing on military personnel's mental health using a post-deployment assessment. The sample consisted of 2,797 U.S. Army soldiers who had just completed a tour in Iraq. Soldiers were asked if

¹The DSM-IV-TR defines alcohol abuse as determined by an individual meeting at least one of the following criteria's within a 12 month period: 1) not being able to fulfill major obligations due to substance abuse,; 2) operating a vehicle or participating in other dangerous activities while using substances; 3) legal problems associated with alcohol consumption; and 4) continuous use of substances after interpersonal relationships begin to fail (APA, 2000).

they had killed someone or if they felt someone was killed due to their actions. If they had seen dead bodies of either civilians, or other military personnel, and whether or not they had witnessed someone else being killed were all assessed during the survey. The results revealed that 16% of the sample had reported being injured, 77% had seen dead bodies, 56% reported seeing someone killed, and 40% reported actually killing in combat. The authors conclude that the various combat exposures placed military personnel at risk for developing symptoms of PTSD and alcohol abuse, mental health/anger difficulties, and psychosocial functioning in intimate relationships.

All military personnel who have deployed in support of either OIF or OEF face the depravities of war: fighting, death, and killing. These different forms of combat exposure can cause intrusive thoughts, flashbacks, and startle responses which are associated with PTSD (Allison et al., 2010). Within this diagnosis is a list of criteria(s) that can be experienced by military personnel who have deployed in support of the wars in OIF or OEF. Under Criteria (A), the military personnel must meet both in order to receive the diagnosis of PTSD: (1) the military personnel has to have witnessed or experienced an event that either threatened their life or another; (2) the military personnel's response, to the event, has to be one of fright or dreadfulness. For Criteria (B), the military personnel only needs to meet one of the following for more than 1 month: (1) persistent thoughts and images of the traumatic event; (2) persistent dreams of the actual event; (3) persistent flashbacks and reliving of the event; (4) mental distress associated with internal or environmental stimuli that remind the military personnel of the

event; (5) bodily reactions to an inside or outside event that resembles the traumatic experience. Under Criteria (C), the military personnel must meet at least three of the following for more than 1 month: (1) an overall avoidance of any conversations or emotions associated with the event; (2) an avoidance of activities and places that remind the military personnel of the traumatic event; (3) not being able to remember different facets of the trauma; (5) feelings of aloofness and separation from others; (6) limited affect; (7) a sense of hopelessness about one's future. Criteria (D), two or more of the following for more than 1 month: (1) insomnia; (2) petulance or feelings of anger; (3) not being able to focus; (4) caution; (5) overstated response to events. The latter criteria's must impact the military personnel's overall functioning in a daily life domain (APA, 2000).

PTSD often co-occurs with alcohol misuse. According to The National Center for Posttraumatic Stress Disorder, military personnel who experience trauma, and therefore are diagnosed with this disorder, are more likely to develop drinking problems than those without PTSD ("PTSD and Problems, 2007"). The likelihood that military personnel will develop a drinking problem increases as it co-occurs with their traumatic experiences. Close to a third of those who experienced combat in both OIF and OEF report alcohol misuse ("PTSD and Problems, 2007"). In order to cope with the effects of war and the transition to their civilian life, some military personnel misuse alcohol as a numbing mechanism for readiness. According to findings from Allison et al., (2010), 11% to 17% of OIF and OEF personnel are at risk of misusing alcohol within 3-4 months of returning

home from combat duty. Another study followed OIF and OEF personnel for a five year period to survey their alcohol consumption at three outcome measurements: baseline, follow-up and new onset (Jacobson et al., 2008). The researchers surveyed each military personnel, first during 2001-2003, which they termed as baseline, and the second survey was administered during 2004-2006, which was termed as follow-up/new onset. The results showed that those military personnel who had been exposed to the fighting and killing rated higher in all three outcome measures of alcohol misuse at baseline 57.6%, follow-up 56.0%, and new onset 26.6%.

Alcohol Misuse among Different Groups

The United States military is comprised of soldiers, sailors, guardians, airman and Marines. Among these are various members who represent different socio-economic and demographic backgrounds. Whether the military personnel is enlisted or an officer, in an intimate relationship or not, and whether he or she has been exposed to combat while deployed to Iraq and Afghanistan, as well as educational background, age, income levels, and ethnicity are all predictors of their predisposition for alcohol misuse (Jacobson et al., 2008; Maguen et al., 2010 & Kim et al., 2010).

Various researchers have examined the demographic data of military personnel who misuse alcohol after returning home from the wars in Iraq and Afghanistan (Brown, Bray, & Hartzell, 2010; Kim et al., 2010; Jacobson, Ryan, Hooper, Smith, Amoroso, Boyko & Bell, 2008 & Maguen et al., 2010). Using this data, researchers determined that the following demographics were predictors of alcohol misuse: Being born after 1980;

not earning a college degree; being a male active duty soldier; being single; having been exposed to fighting and killing; being a current smoker; being white and; being a member of the Marine Corps (Jacobson et al., 2008 & Maguen et al., 2010).

With the evolving presence of women in the military (14.3%), and their increasing participation in combat-supportive roles alongside their male comrades, Brown et al., 2010; Nunnink, Goldwaser, Heppner, Pittman, Nievergelt, & Baker, (2010), found that combat exposure while deployed have influenced women's alcohol misuse, and increased exposure to trauma and risks of developing PTSD within their study. In a sample of all female military personnel who had deployed to either Iraq or Afghanistan, Nunnink et al., (2010) reported that 31% of those women who had deployed screened positive for PTSD.

Nunnink et al., (2010) studied military females in more depth. In their study of 36 females, the majority identified themselves as moderate drinkers before entering the military. However, after their daily interaction with their male counterparts, 47% of those women who had deployed screened positive for high-risk drinking (Nunnink et al., 2010 & Brown et al., 2010).

Alcohol misuse has huge implications for readiness for deployment to Iraq and Afghanistan for both men and women in the military. According to Brown et al., (2010), binge drinking and heavy drinking increased from 15.4% in 1998 to 18.1% in 2002 for both genders. These rates also have significant implications for the military system. Some of these implications are related to being passed over for promotion because of drinking,

receiving lower performance ratings because of drinking, losing one week or more from duty because of alcohol-related illnesses, and receiving Uniform Code of Military Justice (UCMJ) punishment because of drinking (Brown et al., 2010). Losses in daily productivity, driving under the influence, alcohol dependence, increased illness and risky behaviors, and overall health practices are just a few examples of the impacts of alcohol misuse on military personnel who have deployed in support of OIF and OEF (Brown et al., 2010; Nunnink et al., 2010 & APA, 2000). Alcohol misuse within the ranks of our military has also resulted in the Department of Defense (DoD) investing millions of dollars on productivity loss and treatment programs to ensure that military personnel are fit-for-duty and able to deploy if needed (Brown et al., 2010), and the military has implemented various protective and mediating factors to ensure troop readiness and mental health through the Veterans Administration (VA) and the DoD programs (Brown et al., 2010).

Learning how to cope with the traumatic memories of combat and avoiding/preventing the misuse of alcohol is important not only for the military but for the military personnel. As AD personnel continue to choose manufactured methods of self-medication to increase positive emotions and numb the pain of war, they become, according to Allen (2005), at risk for further trauma. Allen (2005) discusses the vicious cycle of alcohol misuse and PTSD on victims. Although military personnel become intoxicated with alcohol to cope with combat, this behavior can become dangerous due to the impaired judgment, blunted awareness, decreased capacity to protect oneself, and

increased chances of experiencing another traumatic event that it causes. As van der Kolk & McFarkane (1996) suggest, PTSD affects person's ability to understand the impact that trauma has had on his or her capacity to problem solve and to deal with new information.

Chapter Four

Posttraumatic Stress Disorder

In 2008, the Center for Military Health Policy Research used the 17-item PTSD Checklist (PCL) to assess the rate of PTSD in military personnel who have deployed in support of the wars in Iraq and Afghanistan. Of the 1,938 sample of military personnel who were screened, 13.8 % screened positive for the disorder (Tanielian & Jaycox, 2008).

Military personnel who are diagnosed with PTSD not only have to live with the trauma that occurred during their deployment, but with the continued reexperience of the traumatic event through daily flashbacks, intrusive thoughts, startle responses and nightmares (Allen, 2001). As their symptoms manifest, our men and women in uniform may try new coping skills to adapt to their trauma symptoms; some of these skills may be adaptive and others, such as alcohol misuse, may be maladaptive. As military personnel continue to grapple with what they think are “effective” ways to cope with the mental traumas of war, the co-occurrence of PTSD and alcohol misuse could increase in OIF and OEF personnel (Allen, 2001).

The chapter will briefly give a historical background on PTSD and how it has been diagnosed since its introduction in the Diagnostic Statistical Manual of Mental Disorder (DSM-III) in 1980 (APA, 1980). The case of Mr. Klecker will be used in this chapter as one example of how PTSD and alcohol misuse can co-occur in military

personnel who are returning home from the current conflicts in OIF and OEF. Finally, research on the comorbidity of alcohol misuse and PTSD will be discussed.

Lasiuk & Hegadoren (2006) in their article titled “Posttraumatic Stress Disorder Part I: Historical Development of the Concept” identified four reasons why this diagnosis was significant to society. First, the diagnosis of PTSD named a horrific life event and allowed a framework for us to study its effects; second, the diagnosis stipulated that an external event, not internal weakness, was the cause for this disorder; third, the diagnosis validated and legitimized the experiences of individuals and; lastly, the diagnosis helped to contextualize the way healthcare professionals classify individuals who are survivors of trauma. The concept of PTSD has evolved from a disorder given to individuals based on an inherent defect like traumatic neurosis to a diagnosis that is based solely on external stimuli’s or factors, such as being exposed to deadly combat. Having to identify a stressor as the cause of the disorder lessens the stigma associated with having the label of PTSD, because it allowed people, including military personnel, who are diagnosed with PTSD to be given the diagnosis based solely on an identified stressor and not something that can be attributed to the self (APA, 2000).

The American Psychiatric Association included PTSD as a diagnosis in the third edition of its DSM-III classification for clinical-related mental disorders (Trimble, 1985 & APA, 1980). In the current DSM-IV-TR, the diagnosis of PTSD is given to those individuals who have experienced a catastrophic event that is considered to be unlike any normal human experience (i.e., fighting in combat versus getting a divorce), where an

individual, whether soldier or civilian, indicates that the stressor experienced has caused them to fear actual or perceived death or injury to themselves (APA, 1980 & APA, 2000).

As mentioned in the phenomenon chapter, to be diagnosed with PTSD, individuals have to meet certain requirements: “A,” there must be an identified stressor where one’s life was threatened; “B,” intrusive recollection of the experience that evokes fear and terror. “C,” the use of avoidant and numbing techniques to prevent being exposed to similar stimuli; “D,” symptoms of hyper-arousal and insomnia; “E,” is the duration of symptoms, which in the DSM- III, was listed as six months, which was later decreased to one month, where it remains in the DSM-IV-TR. When clinicians diagnose individuals with PTSD, they must specify whether it is acute (less than 3 months), chronic (3 months or more), and whether the onset of the diagnosis is 6 months after the stressor, which is labeled as “delayed onset” (Trimble, 1985 & APA, 2000). If the individual meets the minimum requirements as established by our current DSM-IV-TR, he/she will be diagnosed with PTSD by a healthcare professional.

Posttraumatic stress symptoms can last from days to decades. Similar to other mental illnesses, symptoms and impaired performance may fluctuate from occurring chronically to acutely. Not all military personnel who have been diagnosed with PTSD will experience all its symptoms.

Also, not all military personnel who have deployed in support of the current conflicts in Iraq and Afghanistan and, who might be experiencing symptoms of PTSD, will be diagnosed with the disorder. And of those military personnel who have been

diagnosed with this disorder, not all will misuse alcohol. In one study conducted by Allison and colleagues (2010), only 11-17% of military personnel who have been diagnosed with PTSD misused alcohol.

Case of Mr. Klecker

The impact that war has on our military personnel's ability to function in society after returning home from the conflicts in Iraq and Afghanistan can sometimes be attributed to the symptoms of PTSD: the flashbacks, intrusive thoughts and startle responses that are associated with the disorder can cause some military personnel to misuse alcohol as a way to cope with the fighting, killing and seeing dead bodies, which can occur during their deployment in the Middle East (APA, 2000).

The following account relays the actual experiences of a Marine who served in OIF and struggled with reintegrating into society after his deployment:

Most nights when Anthony Klecker, a former Marine, finally slept, he found himself back on the battlefields of Iraq. He would awake in a panic, and struggle futilely to return to sleep. Days were scarcely better. Car alarms shattered his nerves. Flashbacks came unexpectedly, at the whiff of certain cleaning chemicals. Bar fights seemed unavoidable; he nearly attacked a man for not washing his hands in the bathroom. Desperate for sleep and relief, Mr. Klecker, 30, drank heavily. One morning, his parents found him in the driveway slumped over the wheel of his car, the door wide open, wipers scraping back and forth. Another time, they found him curled in a fetal position in his closet. His eight months at

war had profoundly damaged his psyche. Mr. Klecker has since been diagnosed with severe PTSD. “I imprisoned myself in my own mind.” (Alvarez, 2008)

This story, published in the New York Times on July 8, 2008, tells the story of an OIF Marine who served as a gunner in the streets of Baghdad, Iraq (Alvarez, 2008). The story of Mr. Klecker is just one example of how PTSD can co-occur with alcohol misuse as a way for some military personnel to numb the pain of combat exposure (Allison et al., 2010; Kim et al., 2010; PTSD & Problems, 2007; Jacobson et al., 2008 & Brown et al., 2010).

Comorbidity

Several researchers have published findings supporting the comorbidity of PTSD and substance abuse disorders in military personnel returning home from the current conflicts in Iraq and Afghanistan. Hoge and colleagues’ (2004) article about combat duty in the Middle East and its relationship to mental health, discussed various forms of combat exposure experienced by army and Marines while deployed. The authors reported that 95% of all Marines and 89% of all army soldiers who deployed to Iraq, and the 58% of all army soldiers serving in Afghanistan experienced an ambush during their deployment. Some other forms of combat exposure that the authors reported military personnel facing were incoming artillery, rocket, or mortar (92%, 86%, respectively), and seeing dead corpses (94%, 95%, and 39%, respectively) (Hoge et al., 2004 & Bernhardt, 2009). These findings are just a few examples not only of the different forms of combat exposure but the significant percentages of military personnel who are affected by it.

Also in this study were findings revealing that 17% of military personnel returning from OIF and 11% returning from OEF had met the criteria for the diagnosis of PTSD 3-4 months after their deployment?

Studies of alcohol usage among post-deployment military personnel have varied, but uniformly troubling findings. Hoge and colleagues' (2004) findings also reported that 24% of returning Iraq and Afghanistan personnel agreed on consuming "more alcohol than they meant to"; 21% of Iraq and 18% of Afghanistan soldiers felt they needed to decrease their drinking behaviors.

Milliken, Auchterlonie, & Hoge (2007) reported that 12% of military personnel returning home from OIF and OEF agreed to misusing alcohol. In a study compiled by Jacobson et al. (2008) on Reserve and National Guard personnel who had deployed to the Middle East, the researchers showed that the sample were more likely to experience "new onset" of heavy weekly drinking, binge drinking, and alcohol-related problems (9%, 53%, and 15%, respectively) compared with "new onset" rates for nondeployed personnel (6%, 26.6% and 4.8%, respectively).

In a review of the literature on the comorbidity of substance use disorder (SUD) and PTSD; Jacobson, Southwick, & Kosten (2001) deem SUD and PTSD as functionally relating to one another. The authors further state how symptoms of PTSD precede SUD that help individuals to numb PTSD symptoms. As individuals afflicted by PTSD become dependent on substances, and as they attempt to recover from these substances, according to the authors, the physiologic arousal resulting from withdrawal of alcohol and/or other

substances may increase symptoms of PTSD, due to the substance being used as a numbing mechanism for symptoms of PTSD, which may cause individuals to relapse. Furthermore, the authors' postulate how vicious this functional cycle can be for those individuals who are currently operating from within its domain.

The research on comorbidity rates of substance use and PTSD support their conclusions. Of those soldiers presenting to primary care at a Memphis Veterans Affairs Medical Center (VAMC) McDevitt-Murphy, Williams, Bracken, Fields, Monahan, & Murphy (2010) found that 15.9% of OIF and OEF veterans screened positive for both PTSD and hazardous drinking based on the PTSD Checklist, military version (PCL-M) and the Alcohol Use Disorders Identification Test (AUDIT). Another study conducted on military personnel administered in a VA system located in San Diego found the comorbidity of alcohol abuse and PTSD to be slightly higher in newly registered OIF and OEF patients. The authors reported that 17.4% of military personnel were coping with the comorbidity of PTSD and alcohol abuse (Baker, Heppner, Afari, Nunnink, Kilmer, Simmons, Harder, & Bosse (2009). Jakupcak, Tull, McDermott, Kaysen, Hunt, & Simpson (2010) studied the relationship between PTSD symptoms and alcohol abuse in Iraq and Afghanistan war veterans seeking mental health services at a Seattle Deployment Health Clinic. The results of this one study revealed that 28% of the sample screened positive for alcohol misuse and 37.3% for PTSD. Finally, in a study compiled by Kofoed, Friedman, & Peck (1993), estimates of the percentages of veterans seeking PTSD treatment, who also have some history of substance abuse, are between 60 to 80%.

As these two disorders continue to occur simultaneously researchers and healthcare professionals will have to learn how to treat both of these issues at the same time.

It is adaptive for people, including our military personnel, to have strong reactions to traumatic events. It helps our bodies to respond to the threat if it comes again. Unfortunately individuals with PTSD continue to react when the stimuli no longer is present. As the symptoms of PTSD manifest themselves in military personnel, some soldiers may choose to misuse alcohol to numb the traumatic memories of their deployments. In order for OIF and OEF personnel to learn how to cope with the co-occurrence of PTSD and alcohol misuse, the military system will have to allow these soldiers access to mental health when needed. Without this partnership between the military and mental health professionals, soldiers will not learn effective ways to cope with the aftermaths of war and the misuse of alcohol will not change in the military.

Chapter Five

Systems Theory

General systems theory (GST) was first introduced by a biologist, Ludwig von Bertalanffy, in 1937 (Held, 2000). Bertalanffy was very interested in the relationships between living organisms and their environments. He believed that instead of reducing an organism to the properties of its component parts, that the relationship between these parts should be the focus of study. To better understand these relationships, Bertalanffy developed systems theory. The following is a summary of Bertalanffy's definition of a system:

Any entity maintained by the mutual interaction of its parts, from atom to cosmos, and including such mundane examples as telephone, postal and rapid transit systems. A Bertalanffian system can be physical like a television set, biological like a cocker spaniel, psychological like a personality, sociological like a labor union, or symbolic, like a set of laws. (Wells, 1998, p. 90)

The example above, was developed between 1930 and 1940 by Bertalanffy helps to explain his idea of how a system's parts are dependent and reliant on one another to function as a whole. However, around 1949, Bertalanffy re-defined a system as "a set of elements standing in interrelation among themselves and with the environment" (Bertalanffy, 1969, p. 252). With this definition, Bertalanffy integrates the environment

into his explanation of systems theory. Many disciplines would adopt the theory and use it to describe their own various systems in interaction with one another.

In applying the ideas of systems theory to this study, two types of systems will be discussed in this chapter: the target system, consisting of the military structure and its emphasis on values, which can prevent military personnel from seeking mental health services due to a fear of being stigmatized and; the client system, which, for the purposes of this study, will be all military personnel who have served in support of the wars in Iraq and Afghanistan. I will use these two terms to examine how each system perpetuates alcohol misuse (Kirst-Ashman & Hull, 2001). This chapter will also provide some insight into the mental illness stigma that exists in our current military culture.

Target System

The target system is that organization or community that needs to change to fit the needs or fill the gaps of the client system. For the purposes of this study, the target system is the military system and its values that can perpetuate alcohol misuse and stigma associated with receiving mental health services (Kirst-Ashman et al., 2001).

For military personnel to function as a part of the system they have to follow the oaths, regulations and values the system has put into place; those who are a part of the military have to abide by the various parts of its system in order to both navigate and survive within it (Brown et al., 2010).

Value System

The following is the oath of enlistment that is taken prior to joining the United States Armed Forces:

I, _____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; and that I will obey the orders of the President of the United States and the orders of the officers appointed over me, according to regulations and the Uniform Code of Military Justice. So help me God. (“Army Values, n.d.”)

This oath becomes an agreement between the military personnel and their branch of service. It serves as a form of interface “a contact point between various systems, including individuals and organizations, where interaction and communication may take place” (Kirst-Ashman & Hull, p. 132). The oath of enlistment is an example of the contract that exists between the military personnel and their branch of service.

There are also values that military personnel embody in their service to their country. The United States Army adheres to the values of loyalty, bearing true faith to your country, the army and your fellow soldiers; duty, fulfilling your responsibilities; respect, treating people the way they should be treated; honor, being able to embody the army values; selfless service, putting the needs of others in front of your own; integrity, doing what is morally and legally right and; personal courage, facing moral and physical fear with courage (“The Army Values, n.d.”).

The stated values of the United States Navy and Marine Corps are similar honor, to conduct oneself in the highest moral and ethical manner; courage, the ability to face fear and overcome it and; commitment, the ability to respect all people regardless of their differences, and to fulfill all obligations that come with wearing the uniform (“The Values That Define a Marine, n.d.” & “The United States Navy, 2009”).

The first core value of the United States Air Force include: integrity, to control all the appetites and elements of one’s personality; courage, doing what is right even when the consequences are high; honesty, “our work must be our bond”; responsibility, to fulfill our obligations; accountability, not to shift blame to another person for our mistakes; justice, we are rewarded or punished based on our actions; openness, feedback is necessary in order to track how we are doing while serving; self-respect, behave in a manner that will not bring shame to ourselves or the institution that we represent; and humility, being humbled by the task of serving our Nation (“Our Values, 2009”).

Lastly, the values of the United States Coast Guard are honor, being loyal and accountable to the public faith; respect, working as a team with a diverse work force and; devotion to duty, serving our country with pride (“The United States Coast Guard, 2011”).

All these values and/or ethos are what the military system expects of its members. But at times, military personnel embody these values at the risk of their own mental health. These values are personified by the military personnel through their allegiance to

their country and expected to be demonstrated through their fulfillment of their daily obligations as a servant of the armed forces.

When military personnel are unable to fulfill these obligations, and thus exhibit these values because they are unable to resume their job due to trauma or sickness, the military system has to find another soldier to “pick up the slack” or stand in the place of the mentally unready soldier (Westphal, 2007). This makes the military system less efficient at working to accomplish its mission to protect and serve the country. The responsibility to find another soldier who not only accomplishes their mission but the mission of the comrade, who is seeking mental health attention, falls on military leaders. The system requires, in these instances, that the leader documents and explains why an individual soldier is absent due to mental illness, and the soldier has to attest to not being mentally stable enough to accomplish his or her mission.

All military personnel have other leaders whose main mission is to ensure that they are adhering to the values and mission being set out by those in power. These “higher ups” receive their orders from others to ensure that the overall mission of the military is being accomplished. And since 2003, the mission has been to retain military personnel who can deploy and to discharge those who cannot (Kim et al., 2010; Wright, Cabrera & McGurk, 2009; Green-Shortridge, Britt & Andrew, 2007; Gutman & Lutz, 2010 & Sherman, 2010). Because a mental illness diagnoses puts the military personnel at risk for not being able to deploy again, there is an incentive for military personnel to not present as having a mental illnesses that is related to a previous deployment overseas.

Furthermore, if the soldier is told that he or she is not fit to deploy, and thus not capable of completing the mission, they become susceptible to being discharged from the military. As will be discussed later, this systemic pressure can cause some military personnel to misuse alcohol in an attempt to both numb and mask the effects of their mental illness in order to prevent being discharged from their branch of service.

Westphal (2007) gives one example of how issues of mental illness are dealt with when sailors seek help. The author cites one of the responses from a fleet leader who discusses the importance of a sailor being physically and mentally ready to complete his/her mission:

Sailors need to be able to do their job 100% when they return from any type of medical services. In response to manpower losses, the leaders must use their power and authority to increase the productivity of remaining crew members. Given the burden of manpower losses and demands on leaders' productivity, leaders have an incentive for keeping the number of sailors needing mental health treatment to a minimum. (p. 1140)

In other words, there is systemic pressure on fleet leaders to ensure that sailors who are seeking mental health services are kept to a minimum. Such system-required procedures stigmatize the personnel who is thus deemed unfit to serve. As fleet leaders try to keep the numbers of sailors seeking mental health services low, some soldiers may seek to avoid the stigmatization by misusing alcohol as a way to cope (Kim et al., 2010;

Westphal, 2007; Calhoun, Elter, Jones, Kudler, & Straits-Troster, 2008; Brown et al., 2010; Maguen et al., 2010 & Jacobson et al., 2010).

Because of stigmatization, in other words, military personnel are reluctant to be diagnosed with any mental illnesses. For the purposes of this study, stigma is defined using the definition for public and self-stigma developed by Greene-Shortridge et al., (2007). Public stigma, or in this case, military stigma, is the reaction of the military toward military personnel with mental illness. Military personnel will self-stigmatize when the military hierarchy depicts military personnel with mental illness negatively. This negative depiction of soldiers who are struggling to cope with the effects of war can shape how a soldier deals with mental illness. For instance, as will be discussed below, military personnel who believe that seeking help for mental illness will have negative consequences for his or her military career, may self-medicate with alcohol, a behavior which is not stigmatized (Brown et al., 2010; Kim et al., 2010; Jacobson et al., 2008 & Maguen et al., 2010).

Client System

“I was trying to be the tough marine I was trained to be—not to talk about problems, not to cry.” –Anthony Klecker

The current military system is set up to ensure readiness and deployment at the risk of the mental health of its personnel. In President Bush’s 2001 speech given at the start of the war in Iraq, he was not only speaking to the American people, but to our

military personnel when he said, “We will meet that threat now, with our Army, Air Force, Navy, Coast Guard and Marines” (“Operation Iraqi Freedom,” 2003).

Deployments

How do we meet the call to serve? It has been done through the continual deployment of our men and women in uniform to places in Iraq and Afghanistan where seeing fighting, killing, death and poverty all around them can occur daily during their deployment (Kim et al., 2010; Felker, Hawkins, Dobie, Gutierrez & McFall, 2008; & Maguen et al., 2010). According to the *Marine Corps Times*, as of October 2009, over 2 million military personnel have deployed in support of OEF, which began in October of 2001, and OIF, which began in March of 2003 (Tan, 2009). All military personnel who have deployed in support of the wars in Iraq and Afghanistan are expected to “function at their highest possible capacity” (Bray, Pemberton, Lane, Hourani, Mattiko & Babeu, p. 390). After military personnel return home from the conflicts in Iraq and Afghanistan, they are faced with the past events of what occurred during their time in the Middle East. As the traumatic memories of war unfold in the military personnel’s mind, they may seek mental health services but also quickly learn the implications of seeking these services for their aspirations to stay enlisted in the armed forces (Westphal, 2007; Sherman, 2010; & Gutman, 2010). Some military personnel can quickly learn that by misusing alcohol as a way to numb the pain of their deployment will not only help them to appear ready to redeploy, but will prevent them from being ostracized or possibly discharged for seeking mental health services (Greene-Shortridge, 2007). But as Bray (2010) discusses, the use

of excessive drinking and illicit drug use can impact military personnel's ability to perform their duties proficiently, and if a soldier is unable to perform the task that they have been trained to execute while overseas, this can impact their current enlistment and possibly cause them to be discharged from the armed forces. The use of alcohol as a way to mask the effects of mental illness does not, ultimately, solve the issue.

Warrior Training

To combat the notion of not being physically or mentally fit for an upcoming tour of duty overseas, military personnel are trained to defeat the current enemy through daily combat drills and training classes. And although this training can be helpful for soldiers, in addition to the fear of stigma and its consequences, the idea of possible death and armed combat could be just one of the reasons soldiers choose to misuse alcohol as a way to cope and prepare for a deployment in the Middle East (Tick, 2005).

Atkinson (2004), a military historian, uncovers the preparation of one of these units, the 101st Airborne Division, a unit known within the military culture as the Screaming Eagles. This division is a part of the United States Army and was preparing for their deployment to Baghdad, Iraq.

Alcohol Misuse

As the priority of military personnel is continually focused on the mission first and self last, some military personnel will find other recreational ways to release the emotions and feelings that are associated with the uncertainty, daily responsibilities, and

the pressures that come with being a servant in the United States Armed Forces (Brown et al., 2010; Kim et al., 2010; Jacobson et al., 2008 & Maguen et al., 2010).

When military personnel are forced to handle their pain without mental health care, soldiers may choose to self-medicate with alcohol in order to manage symptoms. A study conducted by Calhoun et al. (2008) revealed that “military personnel have higher rates of heavy drinking (defined as consuming 5 or more drinks on the same occasion at least once a week in the past 30 days) than civilians, which is 16% versus 12.9% (p. 1686). This information was taken from an article that surveyed a representative sample of soldiers who had recently returned home from one of the wars in the Middle East. Although this is just one article, with the higher rates of risky drinking that were found in this study for soldiers returning home from the conflicts in OIF and OEF, there is a possibility that the percentages are due in part to the military and self stigma that occur in the military system in relation to receiving mental health services.

Although the system of the military has evolved from being a dictatorship to more of a democracy there is much more that needs to be done to address some of the systemic pressures that our men and women are currently facing while serving their country. The system needs to continue its progress towards allowing military personnel to deal with their traumas from war without soldiers fearing being stigmatized by their comrades or worst being dishonorably discharged from the armed forces which could prevent military personnel from being able to secure employment in the civilian world and therefore not be able provide for oneself or their families.

Chapter Six

Discussion

Dear Clinical Providers:

Thank you for helping us. You may not understand our behaviors, but neither do we. Without you who knows where any of us would be? (Johnson, 2010, p. 182)

This chapter will provide a brief recap of all the sections that have been presented in this thesis. It will include an analysis of how PTSD, the military system, and alcohol misuse impact those who have served in OIF and OEF; how the misuse of alcohol can be seen, by some military personnel, as a safe and accepted way of coping with the traumas of war in a subculture that values individual strengths over weaknesses; implications for social work practice and engaging military personnel with co-occurring alcohol misuse and PTSD. Finally, this author will address the strengths and weaknesses of having a veteran of OIF write this thesis.

Recap/Analysis

The Phenomenon: Alcohol Misuse

The phenomenon of alcohol misuse among military personnel after their deployments to the Iraq and Afghanistan wars has been discussed throughout this thesis. A case example from the New York Times regarding Anthony Klecker, a Marine who served in OIF, who misused alcohol as a way to numb his symptoms of war, was included to show how one Marine chose to misuse alcohol as a coping mechanism to deal with symptoms of PTSD (Alvarez, 2008).

Research findings in relation to “heavy drinking,” “new onset drinking” and other different forms of alcohol misuse were also included to show how PTSD and alcohol misuse can co-occur in military personnel who have seen combat in Iraq and Afghanistan (Kim et al., 2010; “PTSD and Problems, 2007”; Jacobson et al., 2008; Brown et al., 2010; Allison et al., 2010; Maguen et al., 2010; Nunnink et al., 2010; McDevitt-Murphy et al., 2010; Baker et al., 2009; Jakupcak et al., 2010 & Jacobson et al., 2001). Information related to alcohol misuse after combat was taken from the NCPTSD and the VA websites to document the military’s awareness of the predicaments that military personnel face who are living with co-occurring symptoms of PTSD and alcohol misuse (“PTSD and Problems, 2007” & Bray et al., 2010).

Posttraumatic Stress Disorder

The different forms of combat, which included fighting, exposure to death, artillery, rocket launchers and the uncertainty of war, were discussed in the PTSD chapter to give the reader a better understanding of what military personnel are enduring while serving in the Middle East (APA, 2000).

In the case example of Demond Mullins a soldier’s experiences of the war was portrayed. Mr. Mullins’ recounting of his experiences while serving in the Middle East: how quickly his comrades were killed during their deployment and his sense of powerlessness over not having control of a rocket launcher flying in the air and landing on a nearby building that housed his buddies, was used to help the reader see the fear, powerlessness and uncertainty that can accompany war (Gutman & Lutz, 2010).

Mr. Mullins' experiences along with those of the countless other military personnel who have participated in research has advanced a growing body of knowledge about the comorbidity of PTSD symptoms and alcohol misuse occurring in military personnel post the wars in Iraq and Afghanistan (Kim et al., 2010; "PTSD and Problems, 2007"; Jacobson et al., 2008; Brown et al., 2010; Allison et al., 2010; Maguen et al., 2010; Nunnink et al., 2010 & Alvarez, 2008).

Systems Theory

The military system can perpetuate soldiers' misuse of alcohol by stigmatizing mental health services (Brown et al., 2010; Westphal, 2007; Kim et al., 2010; Wright et al., 2009; Green-Shortridge et al., 2007 & Sherman, 2010). The previous chapters included a discussion of the barriers to mental health care in the systems chapter along with various research findings that detail the gaps in mental health services, and how these gaps can perpetuate the misuse of alcohol in military personnel who are afraid of being stigmatized due to their inability to adhere to military traditions which include negative views on receiving mental health services (Green-Shortridge, 2007; Westphal, 2007; Warner et al., 2008 & Calhoun et al., 2008).

Examples taken from fleet leaders in the Navy were used to show the reader how the military, sometimes, puts the mission before the mental health of its personnel (Tan, 2009; Bray et al., 2010; "Operation Iraqi Freedom, 2003;" Atkinson, 2004 & Tick, 2005). The dilemma of choosing mental health over mission is also discussed in the systems chapter as the values of each military branch, and the oaths taken at enlistment,

are related to the President's call for military personnel to serve in the Middle East. This call was heard by our Army soldiers, Airforce airman, Navy sailors, Marine Corps Marines, and our Coast Guard guardians ("The Army Values, n.d.;" "The Values That Define a Marine, n.d.;" "The United States Navy, 2009;" "Our Values, 2009;" "The United States Coast Guard, 2011"&; "Operation Iraqi Freedom, 2003") . These values, traditions, and service obligations can be the cause for the stigma and therefore some military personnel misuse alcohol and avoid seeking mental services while serving in the armed forces.

Synthesis

As of October 2009, more than 2 million men and women have deployed in support of the wars in Iraq and Afghanistan, with 793,00 of them deploying more than once (Tan, 2009).

Of those military personnel who have deployed between March of 2003 and October of 2011: 6,276 of our military personnel have paid the ultimate sacrifice of war by dying on the battlefields of Iraq and Afghanistan ("Honor the Fallen, 2011").

The purpose of this study is to provide the reader with information on the impact of war and the aftermath on those who serve in the military. These men and women have taken the oaths and values of the military system, and had to find "appropriate" and "acceptable" ways to cope with symptoms of PTSD without having to tarnish their identities as untouchable warriors. As military personnel become attached to the identity of duty, loyalty, honor and personal courage, the meaning of these values unfold as

soldiers choose to misuse alcohol and/or other substances over seeking mental health services for PTSD.

By using alcohol as a quick and temporary numbing and self-medicating tool for symptoms of PTSD, military personnel are attempting to “honor” the values and oaths of the military system. Alcohol, although dangerous to the health of anyone who misuses it, becomes a safer choice because the military system does not stigmatize its use as much as it does the use of mental health services (Brown et al., 2010 & Westphal, 2007).

Strengths/Weaknesses

How can anyone with lived experience produce a work that is without bias? Yes, I have served in Iraq for 12 months, and yes, I have seen combat and have witnessed the vicious cycle that PTSD and alcohol misuse can have on some military personnel who are returning home from war. I personally feel that my experience and insights into what actually occurs in those who have served in OIF and OEF is a strength. I also feel the inclusion of various military personnel stories and researcher knowledge has strengthened and deepened my “expert knowledge.”

The weaknesses of this thesis can easily be the same as my strengths. The mere fact that I had a hypothesis of what was causing alcohol misuse in military personnel returning home from Iraq and Afghanistan, which was war, prevented me from investigating other causes for the misuse of alcohol: such as depression, childhood traumas, rape, acute stress and various other ailments that military personnel could have encountered prior to serving in Iraq or Afghanistan, or even previous to their commitment

to serving their country. All of these factors could have caused people to misuse alcohol, but these factors were not included because the author felt they were not the cause for the misuse of alcohol in returning OIF and OEF personnel.

Implications for Social Work Practice

As our nation continues to utilize its all-volunteer military to defend against threats abroad, social workers will not only need to be aware of the different forms of combat that are occurring in the Middle East, but we will also need to be prepared to work with military personnel upon their return from war.

As our men and women reintegrate into their various home environments, social workers must be familiar with the posttraumatic symptoms that can accompany war: nightmares, flashbacks, hyperarousal, and avoidant behaviors. These issues make assimilating into their neighborhoods, homes, jobs, families and other spheres of their life even more difficult for the returning veterans who have been exposed to combat. As symptoms of posttraumatic stress disorder are activated through environmental stimuli that trigger reactive and hyperarousal responses to events that remind military personnel of war, social workers will be called upon to address the comorbidity of PTSD simultaneously while addressing the misuse of alcohol.

One therapeutic model that addresses both the symptoms of PTSD and substance abuse is the *Seeking Safety* framework, which focuses on helping individuals attain safety from PTSD and substance abuse. The key principles of the Seeking Safety framework are: “(1) Safety as the main goal of helping clients to attain safety in their relationships,

thinking, behavior, and emotions; (2) Integrated treatment as we tackle both PTSD and substance abuse simultaneously; (3) A focus on principles that help to counteract the loss of principles in both PTSD and substance abuse; (4) Focusing on four content areas: cognitive, behavioral, interpersonal and case management while in therapy, and (5) Being mindful of the clinical processes of transference, countertransference, self-care, and other issues. The Seeking Safety model is currently the most studied framework, with 6 pilot trials, 4 controlled and/or randomized trials, 2 multi-site trials and 1 dissemination study according to the NCPTSD. Although other methods are being used to treat the co-occurrence of PTSD and substance abuse such as: the Concurrent Treatment of PTSD and Cocaine Dependence (1 pilot study); Substance Dependence PTSD Therapy (1 pilot study); Collaborative Care (1 controlled trial); Video Intervention (1 pilot study); Transcend (1 pilot study); Women's Integrated Treatment (1 pilot study); CBT for PTSD in Addiction Programs (1 pilot study) & Trauma Recovery & Empowerment Model (TREM) (1 controlled trial), the military has chosen to use the Seeking Safety model instead of the other frameworks listed above due to the multiple scientific testing showing positive outcomes in trauma-related symptoms and reduction in substance misuse in military personnel (Najavits, 2002; Kim et al., 2010; "PTSD and Problems, 2007"; Jacobson et al., 2008; Brown et al., 2010; Allison et al., 2010; Maguen et al., 2010 & Nunnink et al., 2010).

There is much that needs to be done within the military system in order for the phenomenon of postwar to decrease. The military system will need to assess its values,

beliefs, and oaths to determine if these traditions bring about the misuse of alcohol in returning OIF and OEF military personnel. The stigma attached to receiving mental health services, a stigma created as a result of the embodiment of military traditions, will also need to become a priority for assessment by those who hold the power within the military system.

I would like to end this thesis by emphasizing the National Association of Social Workers (NASW) value of *Service* and the principle behind it: “Social workers’ primary goal is to help people in need and to address social problems” (Code of Ethics, 2006, p. 5). My hope is that social workers will continue to intervene on behalf of military personnel who are returning home from the current conflicts of Iraq and Afghanistan with presenting issues of PTSD and alcohol misuse.

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