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Veterans' stories of substance use, recovery, and moral injury : an exploratory study

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Veteran's Stories of
Substance Use/Misuse,
Recovery, and Moral
Injury: An Explorative
Study

ABSTRACT

This explorative/descriptive study investigates veterans'
stories of substance use/misuse, recovery, and moral injury. 12
male veterans participated in semi-structured interviews and
answered questions about how their motivations for substance
use/misuse and recovery changed prior to, during, and after
their military service. Participants were also asked if they
experienced moral injury while in the military, and if this
precipitated or motivated substance use/misuse. The purpose of
this study was to determine how the military impacts a veteran's
substance use/misuse and recovery. Qualitative research on moral
injury is minimal, and this study aimed to address that gap in
the literature. The study found that a majority of participants
increased their substance use/misuse during and after military
service, and that a majority of combat veterans experienced
moral injury, noting that their substance use/misuse was
motivated by their moral injury experiences. Implications for
social work policy, practice, and future research are discussed.

VETERANS' STORIES OF SUBSTANCE USE, RECOVERY, AND MORAL INJURY:

AN EXPLORATIVE STUDY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

INTRODUCTION

Research has suggested that military personnel experience rates of substance use disorders (SUDs) that are higher than that of the civilian population, and these numbers have increased throughout the 1900's and 2000's alongside the evolving nature of warfare. According to the National Institute on Drug Abuse (2013), tobacco use, alcohol use, including binging, and prescription drug misuse, particularly of opioids, was not only more common among military service members, but also on the rise at that time.

Illicit drug use is lower in the military population compared to civilians, which is attributed to the military's strict zero tolerance policies in regards to drug use, enforced by random drug testing. This has not been the case with tobacco and alcohol, which are more socially acceptable, as well as prevalent staples of military culture, and to opioids, which are prescribed by physicians to assist those who experience pain return to active duty and/or combat as soon as possible in order for them to continue their role in the war effort (National Institute on Drug Abuse, 2013).

Multiple studies corroborate the findings that service members who have had multiple deployments and were exposed to combat stressors are at greater risk of developing substance use disorders than those who did not (National Institute on Drug Abuse, 2013; Institute of Medicine, 2012). Between 2004 and 2006, 7.1% of US veterans met criteria for a SUD (SAMHSA, para. 5, 2017). More recent data is needed to determine if this has increased, decreased, or stayed the same.

While many studies have determined that veterans use/misuse substances to self-medicate the challenges that they experienced due to combat exposure and multiple deployments, there is a paucity of studies where researchers have specifically asked veterans about what motivated them to use/misuse substances (Jacobson, et al., 2008; Seal et al., 2011; Burnett-Zeigler et al., 2011; Jakupcak et al., 2010). The purpose of this study is to fill that gap in the literature by giving voice to veterans by providing them a platform to share their own personal experiences and motivating factors for substance use/misuse, as well as recovery. There is also a lack of research that explores veterans' motivating factors and sustaining factors for recovery from substance use and misuse, and this study aims to fill that gap in the literature as well. Lastly, there is also little research concerning the relationship between veterans' substance use/misuse and experiences of moral injury, and if such

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experiences motivated their substance use/misuse or not. This study explores this question by prioritizing veterans' anecdotes about any possible relationships that may or may not exist between the two phenomena.

This exploratory and descriptive study investigates veterans' stories about their experiences with substance use/misuse and recovery prior to, during, and following their time as US military service members. I conducted semi-structured interviews with 12 participants to obtain the data. My research was driven by the following research questions: What are motivating factors for veterans' substance use/misuse and recovery? I asked the following sub-questions of my participants: Did your military experience(s) motivate you to use/misuse substance(s)? What motivated you to change your relationship with your substance(s) of choice and pursue a lifestyle of recovery? What were your recovery goals, and what helped you to sustain those goals?

Moral injury, a concept with a long history, has only become a topic of increasing interest primarily within the psychology and psychiatry fields within the last five years (Haight, Sugrue, Calhoun, & Black, 2016, p. 190). My second research question was: Does moral injury play a role in either precipitating in substance use/misuse or causing a veteran's

substance misuse to grow worse? I asked participants if they experienced moral injury during their time in the military, and if so, if they would like to elaborate on those experiences. I asked if their experience(s) motivated them to use/misuse substances, if applicable.

The theoretical frame that guides this research is narrative theory, which prioritizes participant experiences and conceptualizations over the medical and mental health research and theories that guide substance use, misuse, recovery, and formal addiction treatment in order to obtain new insights about veteran's lived experiences. In the process of interviewing veterans, it became clear that the stigma that veterans experience, especially combat veterans, is not only pervasive but seemingly immovable, challenging to hold, to carry, and to disrupt. As the post-traumatic stress narrative dominates and crowds out the stories of post-traumatic growth and transformation, the image of veterans as "damaged" holds currency in our culture, which promotes and perpetuates ignorance among civilians about the veteran's perspective and trajectories. The veteran may be left feeling disembodied, misunderstood by, and understandably resentful of civilians at large, most of whom oppose our wars from a convenient, privileged distance. This disconnect is one that war journalist David Wood described in his most recent book *What Have We Done:*

The Moral Injury of our Longest Wars (2016) as "one of ignorance and perhaps suspicion, hostility, and guilt" (p. 270). After reading Nancy Sherman's *Afterwar* (2015), which chronicles the stories of military personnel who have experienced moral injury, I have heeded her lesson about how these very emotions convey a communal need for us to listen to and talk to one another, especially for civilians to listen to our veterans, and to talk with them about the war and their homecoming experiences:

> There is a lesson here for all of us as we share the current homecomings. We are a part of the homecoming--we are implicated in their wars. They may feel guilt toward themselves and resentment at commanders for betrayals, but also, more than we are willing to acknowledge, they feel resentment toward us for our indifference toward their wars and afterwars, and for not even having to bear the burden of a war tax for over a decade of war. Reactive emotions, like resentment or trust, presume some kind of community-- or at least are invocations to reinvoke one or convoke one anew. Guilt is a call to self, resentment to another. They are a part of the reintegration of a self and a community after war. (2015, p. 20)

It is not easy to do this, to talk about war and its impact. But it is all the more challenging and impossible to have constructive and meaningful dialogues without shaking the

firm foundation of the disconnect, for when conversational interchanges across the military-civilian divide do not occur and veterans continue to feel safe talking only to other veterans, and when civilians feel comfortably complacent talking only to other civilians, we embrace the status quo, and we prevent forward movement in combating stigma. As a civilian researcher, this study represents my journey of entering and interrogating the military-civilian disconnect with my utmost humility and circumspection. I cannot thank the veterans enough who were willing to be vulnerable enough to enter into this disconnect with me.

Hopefully, this study's findings will benefit both the federal VA and non-federal behavioral health systems, which are primarily concerned with optimizing positive outcomes for those undergoing treatment for recovery from substance use/misuse and co-occurring trauma and mental health diagnoses among their patients. In particular, it aims to benefit those working directly with veterans, as it provides insights into what motivated veterans to use/misuse substances in the first place—which can be overlooked in the field itself, and in research—and what motivated them to change their use/misuse. Though every individual's recovery differs, clinicians and other mental health professionals reading this study may develop new sensitivities into what has helped veterans maintain their

recovery from substance misuse. Ideally this research will

inform treatment initiatives for substance misuse and recovery

to improve upon those initiatives by accounting for the needs of

veterans.

My study focuses on veterans' motivating factors for substance use/misuse and recovery, and will explore whether their military experiences and/or possible experiences of moral injury motivated their substance use, if at all. Prior to an investigation of the existing literature on these research questions—because of the controversial debates surrounding the etiology and treatment of addiction—I will first summarize how conceptualizations of addiction have evolved since the early twentieth century, and illuminate how the current dominating discourse of "addiction as a chronic brain disease" in research and popular culture is more likely to fuel stigma and keep the narratives of freedom from addiction from being lived and celebrated.

Defining Addiction

Neuroscientist and professor Marc Lewis provided a quick summary of the debates around defining addition in his book *The Biology of Desire: Why Addiction is not a Disease* (2015), and noted the lack of consensus (p. 1). He argued that the myriad conceptions can all fit under one or more of the following three categories: addiction as disease (medical); addiction as choice

(cognitive); and addiction as self-medication (developmental) (p. 1-4). There is overlap, and as is often the case with semantics, no "right" conception; individuals may ascribe to more than one category at once, or none, and form their own beliefs— but ultimately the disease model has prevailed as the dominant model in the US.[1]

Neurobiological discoveries of addiction are significant contributions. They are not the problem, but research on brains changed by addiction that are lauded as proof of (addiction as) disease[2] due to the changes has become problematic, as this keeps stigma alive, even though there have been countless individuals who had problems with substances and overcame them. Does that mean they are still diseased for life? The disease model can breed complacency instead of hope, a negative self-image instead of someone who has the chance to start anew. While there are people who find this ascription reassuring, others do not see themselves as diseased and reject formal treatment or AA philosophies that instruct them that it is this way—they may understandably feel alienated and disempowered by such a stigmatizing label. But because the disease model is more commonly accepted than disputed (though it is disputed by Gabor

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[1] It is worth exploring if and how non-western and non-medicalized cultures understand addiction.

Mate (2008), Stanton Peele (2000), and various others), research funding and support for this model takes priority over conducting research using other lenses with which to view and help treat addiction. Even in the field of neurobiology, the focus could be less stigmatizing and more hopeful. For instance, in *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, published by the US Department of Health and Human Services (2016), it is reassuring that such a disease model-friendly organization recommended future research on recovery's neurological correlates:

> Developing a better understanding of the recovery process, and the neurological mechanisms that enable people to maintain changes in their substance use behavior and promote resilience to relapse, will inform the development of additional effective treatment and recovery support interventions. (2-25)

Canadian physician Gabor Mate's charge *In the Realm of Hungry Ghosts* (2008) is that "a multilevel exploration is necessary because it's impossible to understand addiction fully from any one perspective, no matter how accurate…addiction has biological, chemical, neurological, psychological, medical, emotional, social, political, economic and spiritual underpinnings…" (p. 138). This seems to complement a clinician's

training to embrace the biopsychosocial-spiritual approach to assessment. With these two points in mind, it seems most comprehensive, then, to view the three conceptualizations of addiction outlined by Lewis as lenses rather than as incompatible definitions for the same thing.

At any rate, the dominance of the disease model is illustrated through the following definitions of addiction, which are provided by some of the leaders of addiction treatment and program research: the *Surgeon General's Report* defined addictions as "chronic illnesses characterized by clinically significant impairments in health, social function, and voluntary control over substance use" (p. 2-1). When searching for a definition of addiction on Google, the American Society of Addiction Medicine (ASAM, 2017, para. 1) is the first "hit." The organization's broad definition begins with: "Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry." The next hit, (aside from dictionary.com and merriamwebster.com), is from The National Institute on Drug Abuse (NIDA, 2016, para. 1). The site defined addiction as "a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences." Addiction is diagnosed in the behavioral health field using the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (*DSM-IV,* 2013). The American Psychiatric Association

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(APA) revised the *DSM-IV* language of *substance dependence* –what

we conceive of as addiction—to be clinically indicated as a

substance use disorder, and is further clarified as either mild,

moderate, or severe.

How we got here: Moral Deficit evolves into the Disease Model

During the first half of the twentieth century, people

struggling with addiction were believed to be bereft of morality

and goodness, and could not be helped, but rather doomed to a

life without reprieve from the cravings of their substance(s) of

choice; the spotlight at this time was on alcohol though not

limited to it, and such views of addiction as a moral deficit

seemed to reflect Christian influence on social norms. While

this view had historical roots prior to this timeframe, it

seemed to define this moment. The Prohibition movement and the

"do-good" early 1900s sentiment asserted that abstinence for

everyone was best. At that time, the gradual medicalization of

social work and psychology was slowly gaining traction alongside

the advent of Alcoholics Anonymous (AA). While medical

professionals began to view addiction as a type of illness or

malady to be cured, in the circles of AA addiction was conceived

of as a spiritual malady that could be overcome by accepting

one's powerlessness over it through surrender to a higher power;

AA also heralded the notion that those struggling with

alcoholism could benefit from support, and recover from alcoholism in lieu of being cast aside by society as hopeless drunks (Lewis, 2015, pp. 12-13).

In the 1950s, the disease model was ascribed to by Narcotics Anonymous (NA), and by the Hazelden Center's newly emerging "Minnesota Model," which mixed twelve-step principles with residential treatment (Lewis, 2015, pp. 13-14). Addiction was more authoritatively medicalized by biostatistician and physiologist E. M. Jellinek in his book, *The Disease Concept of Alcoholism* (1960). In 1967, the American Medical Association first defined addiction as an illness (p. 14). Lewis mentioned how "the twelve-step literature maintains that the disease of addiction is built into one's character," and both AA and the medical disease model have asserted that addiction will be a lifelong disorder that one can cure only with abstinence (p. 15). For some people, drinking in moderation is possible, and illustrative of recovery. New discoveries in the neurobiology of addiction in the 1990s, also deemed "the decade of the brain," further supported the disease model of addiction and led to advancements in our understanding of how addiction works (p. 17).

Addiction Today

It may come as a surprise that the majority of people who use substances do not become addicted; rather, in the US, 10 to 20% of people who use drugs, depending on the substance, become addicted (Hart, 2017). While many people believe that one can become addicted to substances rather quickly, neuroscientist Carl Hart (2017) attributed this assumption—one of many about substance use—to discourses of the "war on drugs" that tend to perpetuate misinformation about the perils of use and negative stereotypes that vilify the users and substances, and leave little room for explorations of the social causes of addiction.

Despite the controversial space we find ourselves in concerning (mis)information about addiction, 10-20% of individuals is still quite large. According to the latest research on the prevalence of substance use in the US outlined in the *Surgeon General's Report* (2016), in 2015, 20.8 million people, or 7.8% of the US population, met the diagnostic criteria for a substance use disorder (p. 1-7). Furthermore, "in 2015, 66.7 million people in the US reported binge drinking in the past month and 27.1 million people were current users of illicit drugs or misused prescription drugs" (p. 1-1). Thousands lose their lives abusing substances or battling addiction annually:

Alcohol misuse contributes to 88,000 deaths in the US each

year; 1 in 10 deaths among working adults are due to

alcohol misuse. In addition, in 2014 there were 47,055 drug

overdose deaths including 28,647 people who died from a

drug overdose involving some type of opioid, including

prescription pain relievers and heroin—more than in any

previous year on record. (p. 1-1)

In addition to loss of life, the economic consequences of

substance misuse and substance use disorders are astounding,

costing more than $400 billion annually when taking into account

"crime, health, and lost productivity" expenses for both alcohol

and drug use disorders (p. 1-2). While these sobering statistics

are enough to manifest a dark cloud of hopelessness in combating

addiction, the last three decades demonstrated continuing

progress in the development of successful treatment initiatives

that have led many individuals to lead lives of recovery through

moderation or abstinence.

Despite commonly heard assertions from some of those using

alcohol and other drugs, and observers alike, that recovery is a

hopeless feat, *The Surgeon General's Report* (2016) noted that

recovery *is* possible, and that "well-supported scientific

evidence shows that substance use disorders can be effectively

treated, with recurrence rates no higher than those for other

chronic illnesses such as diabetes, asthma, and hypertension"

(p. 4-2). But a minority seek treatment: of the 20.8 million in

the US in 2015 who met criteria for a substance use disorder,

only 2.2 million of those individuals received any type of

treatment (p. 1-7). In other words, only 1 in 10 individuals who

could have used treatment received it (p. 4-8). According to

Results from the 2015 National Survey on Drug Use and Health

(2016) conducted by the Center for Behavioral Health Statistics

and Quality, the government's lead agency for behavioral health

statistics, many individuals who did not seek treatment have not

been informed that they may have a substance use disorder, or do

not believe that they do; those who were aware provided the

following reasons for not seeking treatment (in order from most

to least common): individuals were not ready to stop using; they

did not have health coverage or could not afford treatment; they

believed it may have a negative impact on their job or cause

neighbors or community members to have a negative opinion of

them and their efforts; they were unaware of where to go for

treatment, or did not have access to a program that had the type

of treatment they desired; they did not have adequate

transportation, the programs were too far away, or they felt

that the hours were inconvenient (p. 4-9). While these responses

reflect not only the ambivalence that defines active addiction,

many of them implicitly reflect the harmful and overarching

societal stigma that serves as a barrier for those armed with motivation in the battle over their addictions. It is not only reflected in the individual's concern of judgment from authority figures and community members, but also within the financial disparities and lack of access to services for the less privileged that define our healthcare system's reign over the disenfranchised.

Stigma

Stigma is a set of negative beliefs that society holds about a person or a group of people, often due to their "real or perceived health status" (Villa, n.d.). These beliefs are often based on assumptions rather than facts, and can marginalize and separate individuals from being accepted and from receiving the treatment benefits that they deserve (Villa, n.d.). Individuals are *more likely* to stigmatize those enduring drug addictions than those with mental illness, according to a 2014 study entitled "Stigma, Discrimination, Treatment Effectiveness and Policy Support: Comparing Public Views about Drug Addiction with Mental Illness" conducted by the Johns Hopkins Bloomberg School of Public Health (Barry, McGinty, Pescosolido, & Goldman, 2014). It is also common for those enduring addiction to experience internalized stigma.

Although the commonly-held perception that addiction is a moral weakness rather than a treatable condition predominated the addiction discourse in the first half of the twentieth century, the disease model breeds its own stigma. The researchers concluded that this may be due in part to negative media portrayals of addicted individuals, the "illegality" of drug use, and certain "socially unacceptable behavior" such as crime associated with use. Consequently, this harmful worldview translates into a lack of support for adequate drug treatment and rehabilitation service policies, particularly when compared with mental illness treatment and services. The researchers surveyed 709 individuals about insurance parity, increased government spending for treatment, increased spending on programs to subsidize housing costs, and government spending on job support programs. While participants favored these policies for the treatment of mental illness, they did not for substance abuse treatment (Barry, McGinty, Pescosolido, & Goldman, 2014). The authors of the study suggested that with more public education about the treatability of addiction, stigma may be reduced as it was with HIV (Barry, McGinty, Pescosolido, & Goldman, 2014).

Due to stigma's prevalence in mass culture, it is more common for addiction discourses and research to focus on the negatives rather than embrace the positives: for example, the

notion that there are multiple pathways of recovery that assist

individuals reach their recovery goals. The *Surgeon General's*

Report (2016) indicated that

> Remission from substance use disorders—the reduction of key
>
> symptoms below the diagnostic threshold—is more common than
>
> most people realize. "Supported" scientific evidence
>
> indicates that approximately 50% of adults who once met
>
> diagnostic criteria for a substance use disorder—or about
>
> 25 million people—are currently in stable remission (1 year
>
> or longer). Even so, remission from a substance use
>
> disorder can take several years and multiple episodes of
>
> treatment, RSS [recovery support services], and/or mutual
>
> aid. (p. 2)

This might lead one to draw three conclusions: (a) more

psychoeducation about recovery and its attainability could

benefit society's outlook and those battling with addiction;

(b) recovery narratives must be celebrated and gain more

visibility in public discourse, and not be confined to the

church basements of 12-step support groups, or the like; and

(c) the scarcity of empirical research on recovery and

recovery narratives perpetuates stigma. Researchers should

not only look to the experts on this (i.e., those in

recovery) and conduct more qualitative studies, they should

also explore the neurobiological components of recovery, not just addiction, a recommendation of *The Surgeon General's Report*. Ideally this perspective would contribute to the cultural shift of destigmatizing addiction; it may also inspire others to commit to recovery.

In my study design involving veterans who have reportedly experienced addiction and recovery, my aim is to be sympathetic to the above conclusions, and emphasize the importance on veterans' unique recovery narratives. This focus prioritizes the importance of people's lived experiences, empowers the research participants by allowing them to share with the audience what they believe to be most salient for them about the research topic, and enables the audience to note the ways in which their experiences have evolved over time (Elliott, 2005, p. 6). While narrative has numerous definitions, in Using Narrative in Social Research (2005), Elliott shared a helpful and broad definition coined by professors Lewish and Sandra Hinchman (1997):

> Narrative (stories) in the human sciences should be
> defined provisionally as discourses with a clear
> sequential order that connect events in a meaningful way
> for a definite audience and thus offer insights about
> the world and/or people's experiences of it. (p. 3)

From the lens of narrative research, recovery narratives are the subjugated knowledge that is overshadowed by the disease model, which trivializes the importance of personal experience; these narratives may provide new insights into the growing edges of addiction treatment. Conceptualizations of addiction are continually evolving, but the stigma underlying addiction as a moral deficit has never seemed to shift. In fact, it still flourishes today, just under a newer guise: the disease model.

Following this outline of the evolving conceptions of addiction that bring us to the contemporary moment, I will provide a brief overview of the US military, and then explore veterans' history with using substances, their motivating factors for use, and recovery through a review of the relevant literature.

Overview of the US Armed Forces

In 2015, the most current statistic available, 18.8 million veterans lived in the US, and over 3.5 million served in the military (US Census Bureau, 2016). The military is divided into Active Duty and Reserve service members, and then differentiated further by those who are enlisted or officers. The Active Duty branches include the Department of Defense's (DoD): Army, Navy, Marine Corps, and Air Force, and the Department of Homeland

Security's (DHS) Coast Guard, while the Reserve components include the DoD's Army National Guard, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard, Air Force Reserve, and the DHS' Coast Guard Reserve. In 2015, there were 1,301,443 Active Duty members, 39,090 Active Duty Coast Guard members, 1,101,353 DoD Ready Reserve and DHS Coast Guard Reserve members, 216,370 Retired Reserve members, 9,899 Standby Reserve members, and 865,019 DoD Appropriated and Non-Appropriated Funds civilian personnel. The rate of racial and ethnic minorities and women service members continues to increase. In 2015, 15.5% of Active Duty force members and 19% of the Reserve and Guard (Selected Reserve) members were women. 31.3% of the Active Duty force members and 26% of the Selected Reserve identified as a racial minority (i.e., Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Multi-racial, or Other/Unknown) (DoD, 2015).

Stigma and the Military-Civilian Disconnect

In my research, it became clear that US veterans experience a distinct stigma of their own that distinguishes them from society's civilians. This is often aggravated by the *civilian-military disconnect*, or the lack of communication between military personnel, veterans, and civilians. Veterans often feel alienated and misunderstood by civilians when they return from

combat deployments. Military personnel and veterans also experience stigma perpetrated by other fellow service members or authority figures concerning seeking mental health for Post-Traumatic Stress Disorder (PTSD) or other disorders, and/or substance misuse treatment, as it is perceived as a personal weakness to need treatment. So when a veteran is using substances or struggling with addiction, a double layer of stigma may be endured that may therefore be even more challenging to navigate and respond to constructively and to dismantle in the larger societal context. These are just some of the reasons why a veteran may forego treatment for mental health disorders and decide to self-treat with substances instead.

The military-civilian disconnect appears to be so pervasive that it is challenging to cross for both civilians, military personnel, and veterans. For a civilian, crossing this divide would mean confronting the realities of war and our role in them. For service members, it means confronting their own feelings about the war that they feel may be misunderstood and judged harshly by civilians. Civilians and service members operate in different moral worlds – the civilian shares a worldview with other civilians in which the very nature of war and killing is immoral, while military personnel share a worldview that their role in the war is moral, and without this reassurance, the worth of their actions is questioned by them.

It is important for them to feel that what they have participated in was worth it, for if they did not feel this way, their identity, values, and principles come into question. Many veterans experience this crisis of meaning upon returning home regardless of if they felt that their engagement in wars was with or without moral purpose.

Studies suggest that stigma is one of many barriers for veterans seeking mental health treatment. In a study conducted by *The New England Journal of Medicine* (2004), Hoge et al. provided anonymous surveys to infantry combat veterans from the Army and the Marine Corps who served in Iraq (2,530) and Afghanistan (3,7671) either before their deployments or three to four months after their return from Iraq or Afghanistan. The results demonstrated that veterans who were in Iraq experienced more exposure to combat than those who served in Afghanistan, and, for those who met criteria for PTSD, major depression and generalized anxiety disorder diagnoses were higher for those after duty in Iraq (15.6 - 17.1%) than for those who were in Afghanistan, (11.2%) or before deploying to Iraq (9.3%). Those in Iraq had higher rates of PTSD, which was linked with more exposure to combat. Notably, only 23-40% of veterans with mental disorders sought medical care, so a large percentage of veterans in the sample did not seek treatment. The individuals who sought treatment were twice as likely as those who did not have a

mental disorder to express reservations about stigma and barriers to seeking mental health treatment, and in particular, were concerned about how their peers and authority figures would perceive them if they did (Hoge et al., 2014). While one limitation of this study was related to selection bias, as many recruited individuals were unable to participate due to needing to work on their operational units, the sample size was still large enough to generalize the data using the veterans who were able to participate. Those who were wounded or removed from their units due to misconduct were not eligible to participate, so the researchers noted that the findings are therefore conservative based on these two aspects of the study's selection criteria (Hoge et al., 2014).

A study conducted by Cornish, Thys, Vogel, & Wade (2014) aimed to better understand post-deployment difficulties and help-seeking barriers to treatment and psychotherapy among combat veterans. The sample comprised of 30 participants, including both men and women who engaged in one of six focus groups. In the focus group on barriers to help-seeking, findings fell into the following two categorical trends: stigma (internalized self-stigma, and stigma from others), and concerns about the therapeutic relationship (worries about lack of confidentiality, actual and anticipated dissatisfaction from mental health services, belief that they would not be able to

relate to the therapist and that he/she would not be able to relate to the veteran, lack of knowledge about available services, concerns about time and cost, reluctance to speak with a stranger, and difficulty trusting the therapeutic process) (Cornish, Thys, Vogel, & Wade, 2014).

The following section is a synthesis of studies that explore a veteran's motivations for substance use and recovery, and how their military experience(s), including the possibility of experiencing moral injury, may or may not have impacted these factors. I paid special attention to those theorists and researchers who highlighted PTSD and moral injury in relation to substance use and recovery, noting significant findings, limitations, and gaps in the literature that underscore the need for further research. Each wartime era has a complex history of its own; all are worth exploring, though not within the scope of this review. I focus on the most recent studies on the topic of veterans and substance use, a majority of which employ quantitative design methods and highlight the experiences of veterans who served in Iraq and Afghanistan.

Substance Use in the US Military: History and Policies

Substance use and misuse is prevalent among US service members and veterans, and has a long history. The one comprehensive report that reviews trends of substance use in the

military was conducted by the Institute of Medicine using a quantitative methodology (2012). In terms of alcohol use, heavy drinking has historically been known as an acceptable aspect of military culture that is often ritualized and marks promotions. Citing various studies, the authors identified motivating factors for use, including recreation, rewarding hard work, easing interpersonal tensions, and promoting social connectedness and camaraderie among military personnel (p. 29). The authors argued that reduced prices and availability of alcohol at military bases may contribute to increased use. In addition to these reasons, binge drinking may be used to cope with traumatic and stressful experiences of wartime, as a handful of studies have demonstrated that heavy drinking and alcohol-related issues are associated with military deployments and combat exposure in the wars of Iraq and Afghanistan (Institute of Medicine, 2012, p. 29).

As with alcohol, it is also common for service members on US bases and on deployments overseas to use illicit drugs such as cocaine, marijuana, and heroin. The authors attributed this to those drugs' ability to "reduce pain, lessen fatigue, and to help in coping with boredom or panic that accompany battle" (Institute of Medicine, 2012, p. 29). Heroin and opium became widely used during the Vietnam War in the late 1960s and early

1970s, and it was so common that "almost 43% of those who served in Vietnam used these drugs at least once, and half of those who used were thought to be dependent on them at some time" (p. 29). The authors cited a study by Robins et al. (1975), which found that the motivating factor for use was aiding personnel in coping with war stressors (p. 29). Notably, a majority of military personnel ended their heroin use upon discharge and reintegration into civilian society (Golub & Bennett, para. 17-19, 2013). This finding is often used by scholars to attest to the extent to which stressful environmental factors may motivate use, and when such stressors are no longer present, substance misuse may subside. Lewis (2015) mentioned the famous Rat Park studies and the Vietnam Readjustment Study to illustrate this:

> The powerful attraction to addictive drugs and activities is a response to some degree of psychological suffering, including social isolation and recurring negative emotions. The "Rat Park" studies show that even rats will voluntarily withdraw from narcotics when their environments become more livable, as did most Vietnam vets when they got back from the war. (p. 168-169)

Due to the extent that prescription drugs were heavily prescribed to assist individuals in returning to combat as soon as possible, misuse of prescription drugs in the military actually had higher rates than that of the civilian population

(Institute of Medicine, 2012, p. 29). This was especially the case with opiates to relieve chronic pain, and one study conducted by Bray, Olmsted, and Williams (2012) found that those who held a prescription for pain medications were three times more likely to misuse opiates compared to those who did not have a prescription (p. 30). A study conducted by Golub and Bennett (2013) using respondent-driven sampling among OEF/OIF military personnel found that prescription opioid misuse was most commonly a result of them being prescribed these medications during deployments, but that most from this sample did not misuse their prescriptions (para. 17-19). However, a study conducted in 2007 using secondary data analysis of VA longitudinal administrative data found that in 2002 veterans who were male, younger adult, and individuals with more days' supply of prescription opioids were more likely to develop opioid abuse and dependence (Edlund, Steffick, Hudson, Harris, & Sullivan, 2007, p. 355). This study focused on veterans who use VA care only, while the 2013 Golub and Bennett study likely had a mix of veterans who did or did not utilize VA services exclusively, based on its method. It appears that the 2007 study may be more reliable based on sample size and method, but it is also possible that the more recent study's findings may reflect advances in prescription opioid management and prevention efforts, although that cannot be ascertained.

Cigarette, cigar smoking and the use of chewing tobacco is also widespread in the military, and likely a matter of culture and lifestyle. This became the norm as the result of the War Department including cigarettes in K-rations and C-rations during World Wars I and II (Institute of Medicine, 2012, p. 30). The DoD introduced its antismoking campaign in 1986 that focused on education of the negative impact of tobacco use on health, and restricted smoking behaviors on base to designated smoking areas only, and offered smoking cessation programs to those who were motivated to quit. Despite a decreased rate of smoking by 2008 compared to previous years, smoking still remains a public health concern within the military (Institute of Medicine, 2012, p. 31-32; 38).

The DoD initiated policy directives aimed at prevention and decreasing drug and alcohol abuse in the 1970s, which utilized education, law enforcement techniques, and returning service members to their positions following treatment (Institute of Medicine, 2012, p. 30-31). The early 1980s heralded an era of zero tolerance policies surrounding illicit drug use in the context of the war on drugs, and DoD increased drug testing along with requiring drug users to participate in mandatory treatment programs for alcohol and drug use that—if not adequately participated in or attended—would result in discharge (Institute of Medicine, 2012, p. 31). In the Army, this is known

as the Army Substance Abuse Program (ASAP).[3] The policies remain
strict as the consequences of use on health and military
performance have become clearer with more psychoeducation
campaigns and research on deleterious effects of use.

In terms of the military's active duty component, the DoD
conducted 10 cross-sectional surveys of Health-Related Behaviors
among Military Personnel (HRB) from 1980-2008 that analyzed
substance use within the past month; these surveys had large
enough sample sizes to be generalizable to the active duty
component during this timeframe. These surveys provide a glimpse
of use in the active duty component of the military. Of note is
that heavy alcohol use and binge drinking is the largest
substance misuse problem within the military, particularly among
younger personnel. The researchers found that binge drinking
increased from 35% in 1998 to 47% in 2008. Heavy alcohol use
declined from 21% in 1980 to 17% in 1988, was stable with some
changes from 1988 to 1998 with an average around 15%, increased
to 18% in 2002, increased to 19% in 2005, and to 20% in 2008
(Institute of Medicine, 2012, p. 62). This increase appears to
at least partially reflect the engagement in the Iraq and
Afghanistan wars. When compared to civilians, active duty

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[3] For more information on ASAP policies, see
http://www.armystudyguide.com/study-guide-online/online-study-guide.php?cat=2

personnel, aged 18-35, were more likely to engage in heavy drinking. Compared to a Selected Reserve component survey from 2007, after adjusting analyses of the active duty surveys to do so, heavy drinking rates for Reservists were significantly lower than the active duty component at 16.7% for heavy drinking and 40.4% for binge drinking within the past month for the reservists, although the data showed that alcohol use disorders had been increasing for the reserve component as well (Institute of Medicine, 2012, p. 62-63).

In terms of illicit drug use among active duty personnel, including marijuana, cocaine, crack, hallucinogens, (PCP, LSD, MDMA), heroin, methamphetamine, inhalants, and GHB/GBL, findings illustrated a decline in use from 28% in 1980 to 3% in 2008. Nonmedical use of prescription-type amphetamines/stimulants, tranquilizers/muscle relaxers, barbiturates/sedatives, or pain relievers almost tripled from 2005-2008 from 4% to 11%. It is revealing that 10% of the misuse of prescription drugs in 2008 was of pain medications or opioids. Compared to the civilian population, service members aged 18-25 and 26-35 were less likely to use illicit drugs, and those aged 36-45 and 46-64 were more likely to use illicit drugs – in particular misuse of prescription drugs (p. 43). There may be underreporting in this data set due to strict policies on drug use in the military and

participants' possible concerns about job security, even though the surveys were anonymous. More studies such as this – conducted by both government and non-government organizations for comparison – need to be conducted to determine more current use of alcohol and drugs in the military. Longitudinal studies would also be helpful in determining how alcohol and drug use changes throughout the lifespan, and in particular to compare how use changes prior to, during, and following military discharge. It is also not possible with these data to determine how many of the individuals who used illicit drugs and alcohol had a substance use disorder or not, as data account for all use within the past 30 days. Data are limited among the Reserve component for illicit drug use, but suggest that drug and alcohol treatment in the military is more successful with drugs compared to alcohol, which may be at least partially related to alcohol's pervasiveness within military culture, where it is socially acceptable.

Risk and Protective Factors among Service Members and Veterans

There is a paucity of studies that explore the reasons why some veterans may be more likely to develop a substance use disorder than others, and more studies should be conducted to determine predictors for substance use disorder development among veterans. A study review examined 114 peer-reviewed

longitudinal studies and a handful of cross-sectional studies published prior to 2010 that assessed protective and risk factors for young adult "substance use outcomes" between the ages of 18 and 26 (Stone, Becker, Huber, & Catalano, 2012). This age range was used because the authors identified this as the period when substance use issues reach their point of prevalence (p. 747). A subsequent review corroborates Stone, et al.'s findings that "the majority of those who meet criteria for a substance use disorder in their lifetime started using substances during adolescence and met the criteria by age 20 to 25" (*The Surgeon General's Report,* 2016, p. 1-16). Stone et al. used the term "substance use outcomes" broadly in order to determine various outcomes of heavy use, problematic use, or dependence, and that term does not correspond to *DSM-5* delineations of substance use disorders, as the article was published in 2012. The study's authors noted that though there are a few longitudinal studies that assess associations between military status and substance use outcomes, one cross-sectional study and one longitudinal study reviewed found mixed results. The cross-sectional study conducted in 1991 by Bray, Marsden, and Peterson found that "young adults entering the military may have higher rates of heavy drinking and cigarette use compared to civilian young adults," (p. 771) although the researchers could not determine conclusively whether this may have been a

result of bias in the selection of participants, or was an outcome of their military involvement. Another longitudinal study conducted in 1999 by Bachman et al. found that men entering the military were more likely to increase cigarette use compared to those entering college, and more likely to increase alcohol consumption compared to working or unemployed men. The reverse held true for illegal drug use when comparing men entering college and entering the military, which is likely due to the military's punitive response to drug use in the military (p. 771). This study noted the great utility in conducting longitudinal studies on predictors for substance use over an extended period; however, they are expensive and difficult to conduct, although the authors provided suggestions to allay these problems.

Because it is clear that certain risk and protective factors may predispose an individual to use or not use respectively, it would be interesting to determine whether certain military personnel, upon entering the military, are more likely to possess more risk factors than protective factors going into an occupation where use is widespread and a lifestyle choice. Certainly each individual carries their own set of risk and protective factors.

The Surgeon General's Report (2016) cited the Stone, et al.
review (2012), noting that one community-level risk factor for
substance use disorders is "easy access to inexpensive alcohol
and other substances," which corresponds to the ease of
obtaining alcohol in some military settings (p. 1-15). *The
Surgeon General's Report* (2016) identified three caregiver and
family-level risk factors: "low parental monitoring, a family
history of substance use or mental disorders, and high levels of
family conflict or violence" (1-15). Individual level risk
factors identified in the report include "current mental
disorders, low involvement in school, a history of abuse and
neglect, and a history of substance use during adolescence" (p.
1-15). Community-level protective factors include

> higher cost for alcohol and other drugs, regulating the
> number and concentration of retailers selling various
> substances; preventing illegal alcohol and other drug sales
> by enforcing existing laws and holding retailers
> accountable for harms caused by illegal sales; availability
> of healthy recreational and social activities; and other
> population-level policies and their enforcement. (p. 1-15)

Caregiver and family-level protective factors include "support
and regular monitoring by parents" (p. 1-15). Finally,
individual level protective factors include "involvement in

school, engagement in healthy recreational and social activities, and good coping skills" (p. 1-15).

According to an article published in 2009 by Gary L. Anderson, military and Junior Reserve Officers Training Corps (JROTC) recruiters often "target low income students who often have fewer post-high school options or who see the military as a way out of depressed rural communities" (p. 267). It is also not uncommon for recruiters who must reach quotas to "fail to provide students with truthful information and a balanced view of risks and opportunities" (p. 267). The author mentioned that such troubling recruitment practices may be more prominent when there is a higher need for service members, for example, during the mid-2000s when there was an increased need for troops for the war in Iraq. And yet, when considering the risk and protective factors for substance use/misuse with a recruitment focus on underprivileged students, it is worthwhile to consider whether service members tend overall to be more at risk for developing a substance use disorder than the general population, and who then enter an environment in which substance use, particularly alcohol, is socially acceptable, and, due to the stressful nature of the job, are more likely to use alcohol and drugs as a way to reduce anxiety (and to a larger extent if engaged in combat).

OEF/OIF Veterans, Substance Use, and PTSD

A majority of recent studies on veterans and substance use focus on combat veterans returning from the combat operations in Iraq and Afghanistan, the relationship between substance use disorders and PTSD, and the effectiveness of treatment outcomes for these often co-occurring disorders (Brancu, Straits-Troster, and Kudler (2011); Seal et al. (2011); Jacobson, et al., (2008); Burnett-Zeigler et al., (2011); Jakupcak et al., (2010). These studies also found relationships between self-medication and PTSD. Most of them employed quantitative designs and many relied on secondary data from the VA. Those that utilized qualitative methods and inquired about veterans' own experiences and preferences pertaining to substance use and treatment have been uncommon. More studies should be conducted that focus on non-combat veteran's motivating factors with substance use, and compare their experiences with those of combat veterans to determine the similarities and differences among them concerning substance use and recovery prevalence, motivating factors, and recovery. There are also many veterans who deployed to combat theater, held supportive or administrative roles, and did not engage in combat. Studies must make this differentiation, and

focus on how their experiences with substance use differ from those engaged in combat.

There is a high incidence of comorbidity between PTSD and substance use disorders among combat veterans. One study conducted by Brancu, Straits-Troster, and Kudler (2011) reported that according to VA data, almost 22% of OEF/OIF veterans with PTSD also had a SUD (SAMHSA, para. 5, 2012). A 2011 study conducted by Seal et al. found that out of 456,502 Iraq and Afghanistan veterans who were first-time users of VA healthcare between October 15, 2001 and September 30, 2009 (and who received care through January 1, 2010,) over 11% were diagnosed with alcohol use disorder, a drug use disorder, or both. Fifty-five to seventy-five percent of those individuals also had co-occurring PTSD or depression diagnoses; furthermore, alcohol and/or drug use diagnoses were 3-4.5 times more likely to occur in veterans with PTSD or depression. The study also found that male gender, those who were 25 years of age or older, those who were never married or divorced, and those who experienced greater combat exposure (those who were enlisted military and not officers, and those in the Army or Marines as opposed to other branches), were associated with increased rates of alcohol and drug use disorders (Seal et al, 2011). This study reviewed secondary VA data only, so it is only generalizable to veterans

who were seeking treatment through the VA. There are a large proportion of veterans who seek treatment outside of the VA, or do not seek treatment at all who were not represented in this sample; however, this study was the first of its kind to determine the prevalence and predictors of substance use disorders in a large, representative sample of veterans seeking treatment at the VA for the first time (Seal et al, 2011, p. 99). More studies should seek to find similar data among veterans who seek treatment outside of the VA.

Returning Home

The Institute of Medicine's "Returning Home from Iraq and Afghanistan: Preliminary Assessment of Readjustment needs of Veterans, Service Members and their Families" (2010) documents some of the unique characteristics of these "war on terror"-era wars that may increase the likelihood that a service member or veteran may experience heightened stress levels and self-medicate. In our current post 9/11 conflicts, there is a smaller number of active duty service members present than in previous wars, and 40% (as of 2009) engaged in more than one tour of duty, many of those serving more than 2 tours; each of these transitions (to and from the conflict theater) and the planning associated with those transitions can cause stress on the service member and their family (p. 25). Also, the duration and

nature of the wars has required longer tours and shorter periods of time at home in between tours than the DoD initially mandated: for active duty personnel, 2 years at home in between deployments, and he/she could not be deployed for longer than 12 months; for Reservists, 5 years at home between deployments, and he/she could also not be deployed for more than 12 months. These policies were not heeded, and veterans experienced less "dwell time" in between deployments. These wars have also relied more on higher numbers of the National Guard and Reserve component than past wars (p. 26).

According to The Substance Abuse and Mental Health Services Administration's Treatment Improvement Protocol (TIP) 57 on Trauma-informed Care in Behavioral Health Services (2014), military service members who experience multiple deployments are more likely to experience traumatic stress reactions, which are also referred to as combat stress reactions (CSR), which may or may not lead to PTSD. Those being deployed or redeployed may experience these reactions as well (p. 39).

Veterans who have experienced more than one deployment are more likely to have diagnoses of depression, anxiety, or acute stress – 27% of those who were deployed three or four times receive such diagnoses compared to 12% who were deployed once (Institute of Medicine, 2010, p. 29). Additionally, as indicated

by data collected in 2009, about 10-20% of OEF/OIF veterans have endured mild traumatic brain injury (TBI) (p. 29). Other stressors that combat military personnel experience in particular, may include but are not limited to the following: "working while being physically exhausted, exposure to gunfire, seeing or knowing someone who has been injured or killed, traveling in areas known for roadside bombs and rockets, extended hypervigilance, [and] fear of being struck by an improvised explosive device" (SAMHSA, 2014, p. 39).

According to SAMHSA's TIP 57 on trauma-informed care, "treatment outcomes for clients with PTSD and a substance use disorder are worse than for clients with other co-occurring disorders or who only abuse substances (Brown, Reed, & Kahler, 2003)" (2014, p. 89). The National Center for PTSD (2017) authors also suggested this, noting that individuals who have comorbid PTSD and SUD have "poorer treatment outcomes, more additional [sic] psychiatric problems, and more functional problems across multiple domains, including medical, legal, financial, and social, than those with just one disorder" (para. 5). Due to the difficulty of treating co-morbid PTSD and SUDs, it is understandable that much of the research conducted on this is concerned with improving treatment outcomes. SAMHSA's TIP 57 (2014) noted the challenges that abound in treatment:

PTSD can limit progress in substance abuse recovery,

increase the potential for relapse, and complicate a

client's ability to achieve success in various life areas.

Each disorder can mask or hide the symptoms of the other,

and both need to be assessed and treated if the individual

is to have a fully recovery. (p. 87-88)

Furthermore, some PTSD symptoms are aggravated with abstinence for some individuals, so if one is successful at reducing or greatly moderating substance use, the PTSD oftentimes remains unresolved and perhaps un-medicated, and symptoms may be amplified. The National Center for PTSD (2017), in concordance with VA policies, stated that Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) are the best treatments for PTSD, and should be offered to veterans experiencing comorbidity. Evidence-based treatments such as cognitive behavioral therapy (CBT), other evidence-based treatments for substance use disorders, and psychopharmacology should be provided to those experiencing substance use disorders, according to their policies. While more research is being conducted on the best practices for treatment for comorbid PTSD and SUDs, and a number of specialty programs are available through VAs across the nation, the National Center for PTSD (2017) stated that:

There is no single ideal type of program for the treatment

of co-occurring PTSD and SUD. Rather, best practice

suggests a "no wrong door policy" where Veterans are

welcome to participate in treatment for PTSD and SUD

regardless of the type of program through which they access

treatment (e.g., primary care, behavioral health

interdisciplinary program, or specialty PTSD or SUD) or the

level of care through which they receive treatment (e.g.,

outpatient, intensive outpatient, or residential). (para.

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Moral Injury

Moral injury is an evolving concept. While it is perhaps as

old as human existence, and can be experienced in both military

and non-military contexts, the term's inception as a

psychological concept gained traction when it was coined by

researchers who studied combat veterans and PTSD in the 1990s.

Jonathan Shay, a staff psychiatrist at the Boston's VA medical

center, wrote *Achilles in Vietnam: Combat Trauma and the Undoing

of Character* (1994), in which he discussed Vietnam War era

veterans and PTSD in comparison to the *Iliad,* Achilles' wartime

experiences, and the timeless parallels between them. He

recognized a phenomenon occurring among Vietnam veterans that

was quite distinct from PTSD, though similar to Achilles' loss

of moral meaning portrayed by Homer in the *Iliad*, which involved

a crisis of meaning precipitated by an existential conflict of right and wrong. The term moral injury was coined by Shay as "part of any combat trauma that leads to lifelong psychological injury" (Wood, 2016, p. 19). He further defined it as "a betrayal of what's right by a person in legitimate authority in a high stakes situation" (Haight, Sugrue, Calhoun, & Black, 2016, p. 192). This is now considered just one of the ways in which moral injury could manifest within an individual, although Shay uncovered its psychological significance, and spearheaded later studies on moral injury.

From 1994 – 2017, the study of moral injury continued to evolve with one of the most important moments occurring in 2009. Litz et al.'s groundbreaking study *Moral Injury and moral repair in war veterans: a preliminary model and intervention strategy* (2009) was the first to provide a thorough and coherent definition including characteristic features, and also proposed intervention techniques for veterans suffering from moral injury. Litz et al's (2009) definition of moral injury is "the lasting psychological, biological, spiritual, behavioral, and social impact of perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations" (p. 697). In comparison to other more broad definitions of moral injury that are used in the literature or in books or popular culture, Litz et al.'s (2009) definition is

more complete because it distinguishes between three different types of moral injury. The following quote on the operational nature of the definition demonstrates (a) the anticipated initiation of a burgeoning moral injury field of study and; b) the importance of its conceptualization, and for future studies that build upon this foundation: "Our working definitional structure should serve as a guide in item selection, emphasizing content validity, and as a means of fostering construct validation" (p. 705). Their definition remains the most comprehensive in the field, although interestingly it has not gained currency in mainstream society. If people have heard of moral injury, they often associate it with soldiers who have killed individuals during war, often civilians; however, that is only one type of moral injury, and moral injury can be experienced by anyone, not just soldiers. But due to the nature of war, it appears to be much more common in the "high stakes" scenarios that combat veteran's experience.

Even though Litz et al. (2009) conceptualized moral injury within the context of those engaged in combat, the researchers' grounded conceptualization of moral injury provided a framework that is applicable across contexts. It is cited by subsequent researchers who are currently exploring moral injury within a range of civilian contexts and in systematic reviews (see reviewed studies in Haight, Sugrue, Calhoun, & Black, 2016).

Since moral injury had not been systematically studied, Litz' review focused primarily on just one of the three types of moral injury, that of perpetrating an act that goes against one's moral code. The researchers reviewed studies that explored the psychological impact of killing and committing atrocities (p. 697). Litz' et al declared this as one of the study's limitations, and made the recommendation that research on other characterizations of moral injury—such as those that are witnessed, learned about, or failed to prevent—should be conducted to augment empirical research. The authors also recommended interdisciplinary approaches, the creation of reliable and valid instruments to assess moral injury, and randomized controlled trials of interventions that target moral injury. Furthermore, they argued for the implementation of future studies that aim to determine the prevalence of moral injury, and possible military contextual predictors.

It is critical to highlight how PTSD researchers became interested in moral injury as they were critiquing and responding to what they perceived as shortcomings of PTSD diagnoses. According to Haight, Sugrue, Calhoun, and Black (2016), "Psychiatrists providing services to Vietnam combat veterans have argued that many are suffering from a type of persistent distress that is not captured by the DSM diagnosis of

PTSD (Gray et al., 2012; Shay, 2014), or resolved by interventions for PTSD (Gray et al., 2012; Litz et al., 2009; Nieuwsma et al., 2015) (p. 191).

The following study illustrates that the same may be true for post 9/11 era veterans as well. Steenkamp, Litz, Hogue, and Marmar (2015) aimed to determine the treatment outcomes and symptom improvements in veterans and military personnel with military-related PTSD who engaged in cognitive processing therapy (CPT) and prolonged exposure (PE) in both individual and group settings. The researchers found that these therapies were the most frequently studied, and are considered by the VA to be the gold standard psychotherapy treatments for military-related PTSD. CPT and PE were selected by the VA in 2008 for nationwide utilization (p. 489; 493). These two treatments were mainly tested on female sexual assault survivors, and neither were considered empirically effective among veterans and active duty personnel initially (p. 493). The researchers reviewed 36 randomized clinical trials (RCTs) of veterans and service members who engaged in these treatments. They compared the results to civilians who also engaged in these therapies for trauma, and also compared the results of these treatments with what they call "non-trauma" focused psychotherapies, which included a variety of alternative modalities such as acupuncture, mindfulness, healing touch therapy, memory

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specificity training, and more. While 49-70% of participants saw improvement in PTSD symptoms for CPT and PE, "the mean posttreatment scores remained at or above clinical criteria for PTSD," and about two-thirds of participants retained their PTSD diagnosis following CPT or PE treatment (p. 489). When compared to non-trauma focused psychotherapies, similar results in symptom improvement were found, which is why the researchers concluded that "CPT and PE were marginally superior compared with non-trauma-focused psychotherapy comparison conditions" (p. 497; 489). One-fourth of participants in the clinical trials dropped out during treatment which the authors reported, was "broadly comparable" to dropout rates of civilians engaging in these therapies as well (p. 497).

The researchers cite that "the extended, repeated, and intense nature of deployment trauma and the fact that service members are exposed not only to life threats but to traumatic losses and morally compromising experiences that may require different treatment approaches" may be some of the reasons why PTSD treatment outcomes are lower than hoped for among the military population (p. 497). This may be why more positive PTSD outcomes are higher for civilians than veterans. The researchers, who are partial to moral injury and may be biased toward its existence, are implying that moral injury may be part of the reason why PTSD treatments are not as effective as they

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could be. In other words, the PTSD diagnosis could be inaccurate; the treatment does not really address what is troubling the person; the person's distress is not fear-based; or, the individual is experiencing both a fear-based and a morally compromised distress simultaneously. If one did experience moral injury, this would be left unaddressed in CPT and PE treatments, which are focused on retelling a traumatic event over and over again until it loses its emotionally triggering nature, and the individual ascribes new meanings and understandings to the traumatic memory. The findings suggest that more research could be conducted with the goal of improving current PTSD treatments to gain increased positive treatment outcomes. Researchers could interview veterans who experienced unsuccessful CPT or PE treatment outcomes and inquire about what factor(s) may have contributed to this. Researchers should also continue to evaluate other treatments that contribute to increased quality of life among veterans with PTSD. Of course, the interplay of SUDs with PTSD cannot be overlooked and remains a challenging clinical obstacle.

Haight, Sugrue, Calhoun, and Black's (2016) excellent scoping study reviewed the research on moral injury to date. They defined a scoping study as "a type of systematic review and knowledge synthesis useful when considering complex, emerging areas of research" (2016, p. 190) which "map key concepts, types

of evidence, and gaps in the literature" (p. 192). The researchers found that within the last five years there has been increased interest in moral injury in the psychology and psychiatry fields, though social work has paid surprisingly little attention to studying the concept (Haight, Sugrue, Calhoun, & Black, 2016, p. 190).

The scoping study was concerned with determining directions for social work research on moral injury after assessing the extent of studies currently available, as it is a relatively new empirical concept (Haight, Sugrue, Calhoun, & Black, 2016, p. 190). The study identified 59 studies about moral injury that spanned various fields of research, and included some dissertations. Inclusion criteria for the review were "published, peer-reviewed journal articles related to moral injury, as determined by key words, titles, and abstracts" (p. 192). Of the studies, 54% were published in psychology or psychiatry journals, while 7% were in social work journals. The study's authors noted that currently the field of social work has only paid "little attention" to moral injury (p. 198). Thirty-two of the studies (54%) were conceptual with no empirical data, while 29 (46%) were empirical; of those, 17 were qualitative, nine were quantitative, and one used mixed methods. In the empirical studies, there was an overemphasis on military samples—85% or 23 of the studies had only veterans in their

samples. Fifteen percent of the empirical studies involved non-military populations. It was clear that moral injury is relevant in civilian samples, particularly those in "high stakes contexts," and the researchers recommended that future studies should be done on social work clients in "the high stakes contexts of child welfare, criminal justice, substance abuse and other mental health treatment" (p. 198). They also noted the extent to which social workers themselves may experience moral injury as they navigate the mental health system and experience "morally injurious behaviors of others and of systems" (p. 199). The researchers recommended that it is important to augment the empirical literature on moral injury since a majority of the studies are conceptual (p. 198). Because most of the empirical studies used cross-sectional and qualitative methods, the authors noted that it is important to conduct longitudinal studies on moral injury, especially research that attempts to illustrate how an individual's experience of moral injury may change over time, and particularly how therapeutic interventions may impact individuals experiencing moral injury. Quantitative studies will be crucial in obtaining statistics about the prevalence of moral injury. Frankfurt and Frazier (2016) noted that in response to Litz et al.'s 2009 study request to create moral injury measures for assessment purposes, two were created

- the Moral Injury Events Scale (MIES) and the Moral Injury

Questionnaire- Military Version (MIQ-M) (p. 320).

    Another important finding for future research of moral

injury is determining the extent to which moral injury may vary

depending on the sociocultural context, and whether it is

"widespread or specific to particular groups" (p. 198). This

point is underscored by the fact that moral frameworks are

culturally bound, and because a majority of moral injury

research has been conducted in the US in the context of its

military personnel.

    Litz et al. (2009) explain how moral injury can become

psychologically distressing for an individual, and found that

the answer lies in difficulty with the reconciling process of

the moral violation, or:

> the inability to contextualize or justify personal actions
>
> or the actions of others and the unsuccessful accommodation
>
> of these potentially morally challenging experiences into
>
> pre-existing moral schemas, resulting in concomitant
>
> emotional responses (e.g., shame and guilt) and
>
> dysfunctional behaviors (e.g. withdrawal). (p. 705)

In their working conceptual model of moral injury, the

researchers concluded that an individual gains an awareness that

there is a "discrepancy" between his or her morals and the

experience that violated them: the dissonance that arises causes psychological turmoil, and depending on how one navigates this determines the severity of the potential dysfunction and debilitation that can result (p. 700). The model notes that if one experiences remorse about behaviors, guilt arises; if one blames themselves, shame arises. There are also variant attributions that can be given to the moral injury, which in analysis seem not to be limited to the following: a *global attribution*, which means that the event is not dependent on the context; *internal*, that the event is perceived as a character flaw; or *stable*, meaning that the experience of being "tainted" is one that is "enduring" (p. 700). The researchers noted that if the individual withdraws as a result of the moral injury, they are subsequently "thwarted from corrective and repairing experience (that otherwise would temper and counter attributions and foster *self-forgiveness*) with peers, leaders, significant others, faith communities (if applicable), and the culture at large" (p. 700). Protective factors for experiencing moral injury include self-esteem, forgiving social supports, and the belief in a just world, while risk factors include neuroticism or negative affectivity, and shame-proneness (p. 700-701). Unfortunately, the need for the individual to reconcile that which cannot be easily reconciled into one's moral schema results in a re-experiencing of the moral violation, which can

"weaken and destabilize self-esteem and tarnish relational expectations (e.g., by reducing worthiness or increasing expectations of censure)" (p. 701).

The researchers posited that moral repair is achieved through the two following routes: "(a) psychological- and emotional-processing of the memory of the moral transgression, its meaning and significance, and the implication for the service member, and (b) exposure to corrective life experience" (p. 701).

The researchers noted that they are piloting a modified CBT approach to address moral injury and summarize its elements:

1. A strong working alliance and trusting and caring relationship.

2. Preparation and education about moral injury and its impact, as well as a collaborative plan for promoting change.

3. A hot-cognitive (e.g., Greenberg & Safran, 1989; Edwards, 1990), exposure-based processing (emotion-focused disclosure) of events surrounding the moral injury.

4. A subsequent careful, directive, and formative examination of the implication of the experience for the person in terms of key self- and other schemas.

5. An imaginal dialogue with a *benevolent* moral authority (e.g., parent, grandparent, coach, clergy) about what happened and how it impacts the patient now and their plans for the future or a fellow service member who feels unredeemable about something they did (or failed to do) and how it impacts his or her current and future plans.

6. Fostering reparation and self-forgiveness.

7. Fostering reconnection with various communities (e.g., faith, family).

8. An assessment of goals and values moving forward (p. 702).

More recently, Litz, Lebowitz, Gray, & Nash, (2016) further standardized a therapeutic model called *Adaptive Disclosure,* which "consists of eight 90-minute weekly sessions" originally developed for active duty service members on bases and veterans (p. 8). At the onset of therapy, the service member or veteran chooses whether what is distressing them is conceived as a life-threatening event, a traumatic loss, or a moral injury. (p. 8). The creators of the approach define it as

a hybrid of existing CBT strategies, specifically, a form of exposure therapy (imaginal emotional processing of a seminal event) that also incorporates some techniques used in other cognitive-based treatments (e.g., CPT), as well as

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techniques drawn from other traditions (e.g., Gestalt, psychodynamic therapy, mindfulness). (p. 8)

Litz et al. (2009) compellingly argue that the characteristics of the current post-9/11 wars discussed earlier in the review "may be creating an additional risk for exposure to morally questionable or ethically ambiguous situations" (p. 697). Journalist David Wood, author of *What Have we Done: The Moral Injury of Our Longest Wars* (2016), provided his audience with some historical context of recognizing moral injury:

The US involvement is Vietnam was a watershed in our understanding of war trauma, and even though it took almost a decade for the mental health field to officially recognize PTSD, tens of thousands of combat veterans eventually found some relief through psychotherapy. But because several of the indicators of PTSD—anxiety, depression, anger, isolation, insomnia, self-medication—are shared with moral injury, it took time for therapists and researchers to unbraid the two. (p. 19)

Litz et al. (2009) stressed that they do not believe that moral injury should become a diagnosis, but rather that research must explore and address the topic because "service members and veterans can suffer long-term scars that are not well captured by the current conceptualizations of PTSD or other adjustment difficulties" (p. 696). They also stressed the importance of

promoting dialogue and empirical research on moral injury in

light of the "clinical care vacuum and need (especially in the

Department of Defense)" that overemphasis on PTSD has left

unexplored (p. 696).

Wood (2016) also noted another interesting finding that

underscores the need for further study on moral injury related

to how suicides among military personnel may shed light on the

use of a PTSD diagnosis to adequately address non-fear based

trauma:

> The accumulating evidence of war trauma made it more and
>
> more difficult to cling to the notion that most veterans
>
> experiencing psychological problems simply had PTSD.
>
> Researchers studying psychological autopsy data following
>
> military suicides, for instance, found that the majority of
>
> completed suicides did not meet criteria for a *DSM-IV*
>
> disorder, or PTSD, at the time of suicide. Shira Maguen,
>
> the research and clinical psychologist at the VA in San
>
> Francisco, had published much peer-reviewed clinical
>
> research on the effects of combat, especially of killing.
>
> In her work she found PTSD to be an important but minor
>
> part of war trauma. "While the predominant view is that the
>
> majority of war zone traumas involve a fear-based reaction
>
> to life-threatening situations, there is accumulating

evidence that trauma types are far more diverse, involving

a much wider range of emotions at the time of the trauma,

and varying post-trauma reactions in the aftermath," she

wrote in 2013. (p. 91-92)

Studies on Substance Use/Misuse and Moral Injury

Because numerous studies have found that veterans enduring

posttraumatic stress self-medicate their symptoms with drugs

and/or alcohol, it would be worthwhile to investigate whether

veterans who experience moral injury also self-medicate the

lasting negative self-states that accompany it. If explored and

compared, would the findings point to the possibility that some,

or a majority of veterans who are abusing alcohol and other

drugs, were actually self-medicating features more accurately

resulting from moral injury rather than PTSD? Or might veterans

self-medicate both PTSD *and* moral injury? How commonly do PTSD

and experiences of moral injury overlap with one another? If a

survey with a large, representative sample size queried veterans

with the open-ended question: "Why do you self-medicate with

alcohol and/or drugs?", might their responses look more like

PTSD? Moral injury? Both? Neither?

To return to the question of whether veterans use/misuse

substances to self-medicate the effects of moral injury,

Frankfurt and Frazier (2016) discovered five studies that found

a relationship between moral injury and substance misuse in their review of research on moral injury (Currier, J. M., Holland, J. M., Jones, H. W., & Sheu, S., 2014; Killgore et al., 2008; Maguen, et al., 2011; Wilk et al., 2010; Yager, T., Laufer, R., & Gallops, M., 1984). Maguen, et al. found that after controlling for prior alcohol abuse and combat exposure among Gulf War veterans, killing was associated with postdeployment alcohol abuse; Killgore et al., made the same finding among OIF soldiers (2008). Among Vietnam veterans, both perpetrating and witnessing atrocities was associated with a higher risk of postdeployment substance abuse. This association was identified in the later study of OIF soldiers conducted by Wilk et al., (2010). The reviewers noted that "the direction of the relation is unclear" and also varies with individuals, suggesting varying patterns of substance abuse following moral injuries (Frankfurt and Frazier, p. 322). While the varying relationship(s) between moral injury and substance use/misuse must be further studied, it is notable that in Litz et al.'s (2009) conceptualization of moral injury, abuse of substances is a common maladaptive coping mechanism: they noted its "chronic collateral manifestations" include "*self-harming behaviors,* such as poor self-care, alcohol and drug abuse, severe recklessness, and parasuicidal behavior, *self-handicapping behaviors,* such as retreating in the face of success or good feelings, and

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demoralization, which may entail confusion, bewilderment, futility, hopelessness, and self-loathing (p. 701).

Conclusion

This literature review provided a grounding of addiction's evolving conceptualizations and stigma's hold over possible advances in improved treatment and recovery outcomes. It summarized substance abuse/misuse in the US armed forces and policies for prevention of SUDs. It highlighted the high incidence of comorbidity of PTSD and SUDs among combat veterans. More research must be conducted on substance use/misuse and noncombat veterans. This review also addressed moral injury as an evolving concept, and one that deserves continued attention and research among military personnel and veterans. More research should be conducted that explores the relationship between substance use/misuse and moral injury among veterans, as well as prevalence and treatment options. In the following chapter, I present the study's methodological design.

CHAPTER III

METHODOLOGY

This qualitative study explores motivating factors for substance use and recovery among the veteran population. I employed interviews with open-ended questions to provide veterans an avenue for sharing their unique experiences with substance use and recovery, allowing them to go more in-depth about their individual motivating factors for use in lieu of more generalized quantitative information. Because there is a lack of research investigating veterans' personal responses about how military involvement may or may not have been a factor in their relationship with alcohol and/or drugs, this study aims to fill this gap in the literature. There is also a lack of qualitative studies that embrace the personal recovery narratives of veterans; therefore, this study aims to give voice to veterans who have transcended addiction at a juncture where societal stigma of addiction is at times so pronounced – as well as a lack of knowledge about addiction – that many people believe that recovery is an impossible feat to attain. This chapter presents the methods used in this study to learn more about veterans and their relationship with substances, and

includes the study design, sample selection, data collection, and data analysis procedures.

Study Design

This exploratory descriptive study utilized semi-structured 60-90 minute interviews with veterans. Participants were eligible to be interviewed for the study if they met the following inclusion criteria: he/she is a US veteran, is 18 years of age or older, and considers him or herself to be in recovery from a relationship with substance(s) that was addictive in nature.

Addiction, as defined by the American Society of Addiction Medicine (2016), is a chronic brain disease that includes excessive use of a substance or substances at higher frequencies than the person intended, an inability to control use, and continued use despite physical and psychological problems associated with it. The veteran must consider him/herself to be presently seeking a healthy lifestyle of recovery. A required timespan of abstinence is not a requirement of the study, however the veteran-participant has decided to alter his or her relationship with the substance(s), noticing that it was interfering with daily functioning in a way that they wished to change, thereby moderating use or becoming abstinent from one or more substances. Onset of addiction could have occurred before, during, or after his or her military career, and I explored how

the veteran's military experience influenced his/her relationship with the substance(s), if at all. While recovery is subjective, the Substance Abuse and Mental Health Services Administration broadly defines it as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (2017, para. 2). I was interested in how veterans conceptualize their recovery process, and what helped sustain their recovery goals. An exclusion criterion included any veterans who were actively using their primary substance of choice. While this was not initially a criterion, I excluded one person who expressed an interest in participating but appeared to be exhibiting symptoms of mania. Initially I recruited combat veterans from the wars in Iraq and Afghanistan and drafted the study information and flyers to reflect this during the recruitment process. However, because this strategy did not yield any participants, I expanded the inclusion criteria and revised the two research study flyers to include any US veterans in order to obtain the desired sample size of at least 12 veterans within the timeframe allotted. Following this revision, there was an increased interest in participation.

Participant recruitment was conducted through various pathways of convenience sampling: I personally corresponded by word of mouth, emails, (Appendix B) and flyers (Appendix C) to

personal and professional contacts within the mental health field in the local area, veteran's support organizations and administrators, peace activists and advocacy organizations, the local veteran's homeless shelter, and friends and acquaintances who were veterans or mutual friends who may know of veterans interested in participating. I also contacted the administrators of local veteran student centers at two community colleges in the local area.

I asked my professional and personal contacts to share my flyer about the study with their contacts and acquaintances. Veterans began calling or emailing me concerning participation in the study. I screened participants before meeting with them to ensure that they were not in early recovery of 1-3 months, or had relapsed within the last month to minimize risk. I asked the following two screening questions: "When was the last time you used your substance of choice?" and "I will be asking you questions about your substance use and recovery, and I would not want this to impact your recovery goals or well-being. Do you feel that you are able to participate without jeopardizing your recovery?"

I provided participants with the informed consent (Appendix E) in person or via email. The informed consent included information about the research question and purpose, a

description of the study procedures, risks and benefits of participation, confidentiality, the right to refuse or withdraw from the study, and the right to ask questions and report concerns about the study to the Smith College School for Social Work Humans Subjects Committee. The consent explained that the veteran's participation would be kept confidential, and that all identifying information about the veteran would not be included in the study, but instead changed by referring to participants as Participant A, B, etc. The veterans were also made aware that all research materials including recordings, transcriptions, data analyses and consents would be stored in a secure location at the researcher's home for three years according to federal regulations and then destroyed. Electronic documentation would be password protected on the researcher's computer until deleted after the three-year period as well. Because some of the questions that I planned to ask could be emotionally challenging or triggering, the informed consent also explains that to prevent harm due to this risk of participating that a resource of mental health services would be provided to the veterans. For those veterans who did not reside in the local area, I provided them with a list local mental health resources from their respective locations.

Five interviews were conducted in a private room at the local homeless shelter. Two interviews were conducted at my home

because participants were known to me through mutual acquaintances, and one interview was conducted at the participant's home for the same reason. One interview was conducted at the office of an employee of a local VA. Three interviews were conducted via Skype. I sent these veterans the informed consent via email and received a returned copy of the signed consent via email prior to the interviews. For all other interviews, the consent was provided to the veterans before the interview and returned at the time of the interview or via email. All veterans were asked to keep a copy of the consent for their records. Prior to the in-person interviews, veterans were asked if they would like food or non-alcoholic beverages to be provided, which I provided.

Sample Selection

A nonprobability convenience sample of 12 male veterans ranging from 29-65 years of age were interviewed. A majority of participants identified as Caucasian, while one-third identified as ethnic minorities (African-American, Hispanic, and Cuban/Asian). (See Appendix A). They represented Vietnam-era and post 9/11-era wartime, including Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom (Iraq), while other veterans were serving during peacetime or wartime at military bases in the US. They occupied three branches of the military

including the Army, the Marine Corps, and the Navy, and had varying military occupational specialties (MOS). Although I attempted to recruit female veterans from a homeless shelter in the local area, I did not receive any interest from them in participating. This may have been due to the protectiveness of the administrator of the women's shelter who may have influenced the veterans not to contact me. Because I relied on convenience sampling and yielded a small sample size of 12 participants, the study's findings are not generalizable to the US veteran population; rather, the study's purpose is intended to highlight moments of resilience and challenge among veterans on their journeys of addiction and recovery, as well as to inspire future research.

Recruitment and Data Collection

Prior to contacting any veterans to participate in the study, I obtained written approval from the Smith College School for Social Work Human Subject Review board concerning the study's design, parameters, and recruitment process. I prepared an interview guide (Appendix F) consisting of 12 open-ended questions, designed to explore the research question in more detail. They covered a wide range of topics, including the veteran's demographics (age, race/ethnicity, socioeconomic status, education), upbringing, initiation into the military and

military experience, substance use history prior to, during, and after the military, motivating factors for use, whether experiences of moral injury influenced use, and finally, recovery. The veterans were told that the interviews would take 60-90 minutes, and seven were within that timeframe. However, some veterans were more talkative and open to sharing more details than others, and five of the interviews went over 90 minutes. I was cognizant of the time, and told the veterans about the time, and the veterans who went over the time limit were aware of this and consented to it. The average interview lasted about one hour and fifteen minutes, while the longest interview lasted four hours, as the veteran was more forth-coming and wished to share more details.

Data Analysis

Participant interviews were recorded with an audio voice recorder, and I transcribed the interviews into password protected Microsoft Word documents. I created a separate password protected word document, which included a template of the interview questions, and began compiling the participant's responses for each question together for the purpose of comparison. Next, the responses were further analyzed to detect emerging themes, patterns, and variations among them. I highlighted particularly poignant direct quotes from

participants that were considered for use in the Findings

Chapter.

CHAPTER IV

FINDINGS

This chapter presents the findings of a qualitative analysis of veterans and their personal narratives of substance use, misuse, and recovery. The content, derived from open-ended interviews, is analyzed and divided into four parts: (a) An overview of the participant's demographics, motivating factors for joining the military, and military occupation; (b) the veteran's substance(s) of choice, frequency, motivating factors for use, and how use and motivating factors changed prior to, during, and after the veteran's military experience, as well as their experiences with reintegrating to the civilian context; (c) whether veterans felt that they experienced moral injury while in the military, and if their substance use was or was not related to such experience(s); (d) the veteran's recovery goals and understanding of what recovery means to them, and what pathways of recovery helped to sustain their recovery goals. Several overarching themes, trends, and anomalies emerged from the content analysis, which are discussed. Embedded within the findings are quotes from the veterans that are not only illustrative of the trends, but give voice to their unique lived experiences.

A. Demographic Data

The following demographic data were collected: age, race/ethnicity, socioeconomic status, education, and employment status (Table 1, Appendix A). All participants identified as males. Participants ranged from 29-65 years of age. One participant was 29, six were in their thirties, one participant was 43, one was 54, one was 58, one was 63 and one was 65. Two-thirds of the participants (n = 8, 67%), identified as Caucasian or "white." One-third of the sample identified as ethnic minorities: two identified as African-American, one as Hispanic, and one as "Asian and Hispanic," or multiracial. Though a majority of participants are Caucasian, the sample includes diversity that reflects the national population distribution. Over half of the participants (n = 8, 67%) identified themselves as of one or more European ethnicities (English, Irish, Scottish, Polish, Portuguese, German, Italian, and Spanish). Four identified themselves as non-European (Korean/Cuban, Hispanic, and Jamaican), while Participant G identified himself as both European and non-European (French, Portuguese, and Jamaican). In terms of socioeconomic status, fully half of the participants (n = 6, 50%) identified themselves as poor, working class or middle-working class, and four as middle (three) or upper-middle class (one). Three-quarters of the participants pursued post-HS educations (n = 9, 75%). One-third are currently

college students. (n = 3, 25%). Eight were employed, while four were unemployed.

What motivated you to join the military?

While everyone has their own story for joining the military that is unique to their circumstances, it is interesting to get a sense of why the veterans in my sample decided to join the military, to note how this decision aligned or did not align with their expectations, and how it impacted their lives and identities over time. Participant responses varied. Some prevalent motivating factors included: embracing and upholding the family tradition of joining the service; the desire for an alternative route, or escape from, continuing their education; escape from an unappealing hometown or city; boredom, and a desire to experience adventure, or to embark on "something new."

There was one major outlier in responses, as this question did not apply to Participant G: in 1970, at the age of 18, he was drafted and deployed to Vietnam, which he described as a "traumatic experience" that he attempted to avoid by being in college: "I'm thinking, not only going to school will I get away from the draft, but I will have fun."
This was just one way of avoiding the draft and possibly being granted deferment, though many of the men who were given this opportunity came from wealthy backgrounds (Valentine 2016). It is unknown as to why Participant G was not exempt from receiving

a letter instructing him to go to the induction center and begin the process of joining the military, though not uncommon during the draft. The draft ended in 1973, and the US has since had a volunteer military.

Family Tradition

Nine participants had at least one family member who served in the military, and six of those participants' fathers served. Two participants did not mention whether they had family members in the military. Of the nine participants who did have family in the military, six noted that this was a motivating factor for them to join, and some mentioned their fathers in more detail than others.

Participant B responded:

> So that was the last time I saw my father, I was about 5. I was such a daddy's boy. He was like my hero, just a good dude. And all I had left of him was just medals. Medals of his time in service and I didn't even know what the hell they were...I kinda figured out what they were and I just kinda always wanted to be in the military at that point 'cause I would see him come back in uniform sometimes. And I'm like this is it, so at 5-years-old I knew I was going into the military.

Participant J responded:

When I was growing up in a small, dry town, the only bars

in town were the VFW and the American Legion. You got the

old guys sitting on park benches reminiscing. It was very

patriotic until Vietnam. Vietnam was when everybody started

protesting. It was a really fucked up war. But I was too

young to understand that. All I wanted to do was join the

military like my uncles, father, and brothers. By the time

I got in, all I wanted to do was to make rank and get my

Honorable Discharge...I definitely wanted to go.

It appeared that it was not only important for some of these

participants to be like their fathers and follow in their

footsteps, but some also felt compelled to join the service

because of their commitment to the nation. Participant J noted:

I wanted to fight for my country. I was very patriotic.

Cultural Influences

Family influence, particularly of fathers being in the

service, as well as popular culture, were motivating factors for

many of the participants for joining the military. Participant C

described what he called "the cult of the warrior" as a big

influence on him.

I had an obsession with violence – martial arts, and the

whole cult of the warrior—that had me hooked from a very

early age, and my dad actually tried to push me away from

that, 'you don't want to join the military it's a bad

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life,' but at the same time what says more to a kid, telling them, or serving as a role model that the kid idolizes and telling war stories that are way more interesting than your friend's Dad's stories? Stories made him my role model and inspired me to want to be a part of what he was talking about and have types of experiences in life that were being glamorized or idealized in both the stories of my dad and his friends and other military family members.

Participant C defined the cult of the warrior:

Warrior culture is what I'm talking about-militarism militarism or military adventurism in popular culture and just the cult of the warrior – it's an archetype...I played a lot of violent video games and violent fantasy and wanted to fill that archetypal role in our society and the only way to do that in our society is to become a cop or a soldier, and I didn't like cops even back then.

Boredom/Seeking Adventure

Participant F, who joined the military after college and working for a couple of years, mentioned that he had a number of relatives who served in the military, though this "family tradition" did not motivate him to join; rather, he shared that he desired to embark on a new path and challenge himself, feeling bored with his job in finance at the time:

Mainly I was bored, I really was. I wanted to do something

bigger with my life. It was a good job I had but at the end

of the day I was just putting numbers into a spreadsheet

for the Board of Directors and I was just bored. That was

it. You know, I kinda remember thinking to myself I don't

want to be bored and never having done anything with my

life and never having adventure or proving myself or

testing myself. It was adventure with testing myself and

going out and doing something exciting...to make me really

live. I wanted to do something that was going to make me

really live.

Participant L responded: "To try something new."

Participant K shared: "I wanted geographic change."

Joining the military: An Alternative to Continuing Education

It is well-known that many individuals join the military

because it is one way that they would be able to afford their

education with GI benefits received following military service.

While no one mentioned this as a motivating factor for joining,

it is notable that a majority of the participants made the

decision to join the military leading up to or right after high

school graduation. Some participants saw joining the military as

an alternative to continuing education, and some felt that

because they did not do well in school that they did not have

any other sufficient alternatives.

Participant A had a difficult experience with high school, which

he attributed to the way in which he, an African-American, was

moved from an urban school setting to a suburban, white-

dominated school setting in an integration effort. He felt

alienated and misunderstood by the mostly white staff, and he

eventually transferred to Job Corps.

> I just graduated Job Corps I had no idea what I was going
>
> to do with myself...I never would have thought of joining
>
> the military in a million yrs. Nine-Eleven happened right
>
> when I was done with school, so I was like, this is crazy,
>
> I want nothing to do with that...I was young and just
>
> trying to make something work – I had no idea why I did
>
> it... I just knew it was something drastic, I knew I needed
>
> a drastic change at that time, assessing my situation,
>
> like, okay, I can go back and stay with [my girlfriend's]
>
> family but I don't want to do that, as I stated my mom
>
> taught us to be really autonomous, so it's either sell
>
> drugs which I had never done, which unfortunately is
>
> something that black men figure out, so I'm either going to
>
> do this, 'cause I'm not going to work doing fast food, or
>
> join the military. 'cause I had been exposed to it (selling
>
> drugs), my brothers did it, so I knew it couldn't be that
>
> bad, and I'm smarter than them so I could be more
>
> successful at it. I think when you're 16 and you lose your

family support you don't really have a lot of options, like who is going to take care of you? It's that or this. I was so ambivalent and naïve about my decision.

Participant C described his negative school experience as one motivating factor for joining the military as well:

Another thing that affected me was being told by guidance counselors and teachers – you have to go to college, and I hated school, I hated everything about it, I didn't want to continue after high school. I've always thought negatively of the education system and always thought experiential learning is probably more for me, and more for everyone, but I thought of the military as a way out of going to a college that I didn't want to be at.

Participant D shared:

I joined the army because the town did not have a good school system in my opinion, they don't teach evolution because it's controversial. In hindsight it was probably because I just didn't care about the things I was learning, I didn't like the school I went to...I didn't know what kind of jobs they would have for a high school graduate in [a small town], not very good ones, they [military] offered to let you see the world, one part of the world, so really I needed something to do and I knew it wasn't going to be college 'cause if I did, I'd fail.

Participant J responded:

> I got kicked out of school the second time. Public high
> school. I got kicked out for non-compliance, I would skip a
> lot and didn't do my homework. So when I got kicked out the
> second time...I said I'm just going to join the Marines.

Direction/Discipline

Three participants shared narratives that illustrated
regular use of drugs and alcohol prior to entering the military
as interfering with their functioning in a way that was related
to their motivation to join the military. Participant J noted
that he had been drinking regularly during high school as an
escape from his "shitty childhood." Participant H noted that he
was drinking alcohol and using drugs regularly prior to entering
the military, and also endured the loss of his mother to a
terminal illness.
He shared:

> After high school I flopped around for a couple of years
> after I graduated, I was doing construction. If you're
> working in that field it is not uncommon for people to
> bring other drugs to work, like cocaine started peeking out
> a little bit for me then, I didn't have any direction; my
> mom – her sickness was a long drawn out process and it was
> just years and years of drawn out suffering, and after she

passed away I just felt like if I didn't make some changes I was probably going to die, so uh my little brother, he was four years younger than me and already decided to join the military, so I started thinking about that and it seemed like a good idea at the time.

Participant L, who was drinking daily in high school and using drugs, said that he did not do well in school and shared that his father said to the recruiter, "'I can't do nothing with him, maybe you guys can.'"

Branch of military/Military Occupational Specialty (MOS)

Of the five branches of the military, the Army, Marine Corps, and the Navy were represented within the sample, with no participants from the Coast Guard or Air Force. Six participants were in the Army, five were in the Marine Corps, and one was in the Navy. Participant E, who was in the Army, is currently in the National Guard. Seven participants were deployed overseas and engaged in combat, and five participants were employed on US bases performing various duties and operations. Participant G was deployed to Vietnam. Participants H, I, J, K, and L were not deployed. There were a wide range of MOS' represented within the sample. (Table 1, Appendix A).

B. Motivations for Substance Use/Misuse

Various studies cite the prevalence of self-medication of combat stressors as a factor for substance use among the veteran

population (Jacobson, et al., 2008; Seal et al., 2011; Burnett-Zeigler et al., 2011; Jakupcak et al., 2010). Such studies note the high co-morbidity rates of PTSD and substance use disorders, and rely on secondary data from veterans' VA care to determine these statistics. However, I have not found studies that directly ask veterans about their motivations for substance use/misuse. Since a majority of these studies focused on combat veterans, less is known about motivating factors for non-combat veterans. I aimed to determine if and how one's military experience(s) changed their initial motivations for use. Participant responses varied. Motivations for use prior to entering the military were primarily for social/recreational reasons and for emotional regulation of negative self-states. One common factor among the responses was that a majority of participants began to use substances significantly more between deployments and following discharge than they were prior to joining the armed forces and during their military experiences.

Before the Military:

In terms of motivations for use prior to entering the military, the participants noted one or more of the following themes: (a) social/recreational: they drank and/or used substances as a social enhancer that allowed them to relax and feel more comfortable communicating with others, or to reduce anxiety in social situations; (b) some participants reported

engaging in substance use more often at social events or parties on the weekends, as this was common in adolescence; (c) for self-medication purposes related to managing family dysfunction and neglect, or to relieve negative self-states described as depression, anxiety, inadequacy, and insecurity. Eight participants reported drinking and/or using drugs for social and recreational reasons. Participants E, H, and J (3) reported drinking for self-medication reasons. Participant G shared that he drank and used drugs for both social/recreational, and self-medication reasons. Two participants reported that they never tried either drugs or alcohol prior to entering the military, or only tried them once or twice. While nine participants would engage in social or recreational use, which for some participants included periods of binge drinking, four (participants H, J, K, and L) were drinking or using drugs three-four times weekly or daily prior to entering the military. A majority of the participants reported that they would drink or use drugs when they were able to obtain these substances, or when it was available to them, as they were under the legal drinking age, and/or illegal substances such as marijuana, heroin, hallucinogens (mushrooms, LSD, mescaline, PCP), and cocaine were not always easy to obtain.

Participant H captured the motivation of social enhancement:

As far as growing up and stuff, yeah it seemed like a normal thing to do. I just remember having this feeling in my stomach of inadequacy, anxiety, and stress, and when I would drink that would subside and I would feel good, I would feel ok. I could interact with people and feel comfortable and not be carrying around that burden with me.

Participant J responded:

Once I found it, alcohol was an escape from my shitty childhood. Escape motivated my drinking and smoking prior to the military. Mom was never there for me, I raised myself. Say, for instance, when I joined the football team at school. I tried to get family members to come and nobody would ever show...Instead of going to practice, I went down the road to get high.

Participant K and G both noted that they enjoyed drinking, smoking, and drug experimentation not only for the social aspect, but also because they found it fun and enjoyable.

Participant G shared:

I think most people start with those things 'cause they think it's fun, it's going to enhance something...'cause you look at your friend, he's high or he's on some substance and he's just enjoying himself, so I think the

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factor is...I want to do that so I can feel like them, because somehow you feel like your personality is not enough for you to enjoy – you can't enjoy the natural things like you really want to.

Participant K elaborated:

It was euphoric. It was not that I needed it, I wasn't an insecure guy, I wasn't a fast loud mouth guy, I was brought up proper, [with] manners and respect, but...when I started experimenting with it and stuff, it was fun, it was exciting, it was bad and it was dangerous but it gave you a little something.

During the Military

When asked about how their frequency of use changed upon entering the military, three participants (E, K and L) reported that their use stayed about the same as it did prior to entering the military, while nine participants (A, B, C, D, F, G, H, I, and J) reported increases in alcohol and/or drug use. When I asked those participants with increased use if their motivation for use also changed, a handful of them commented on how they were entering a military culture in which using substances, especially alcohol, was a norm that went unquestioned. When a participant commented on "the culture of the military" being a factor related to their substance use, they were always

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referring to alcohol, not drugs as "part of the culture," even though alcohol and drugs both do exist within this microcosm. This illustrates the pervasive extent of alcohol use in the military as not merely a "socially acceptable" cultural aspect, but also as a norm that is expected to be fulfilled. While not everyone wished to fulfill this role, it appeared that pressure to fill this role was more present when someone was of a lower rank. When asked about if social pressure to drink was present, Participant F, a Marine Corps Captain, shared:

> No it wasn't. Certainly alcohol was glamorized, most of us drank. There were guys that didn't drink and no one cared. We had Mormons. We didn't care. Some drank, some didn't. We probably respected them more for not being an idiot...Maybe with the enlisted guys, the younger guys, but certainly with the officers and older enlisted guys you kinda just did what you did. We all drank.

Participant A, an Army veteran, who noted that he "didn't even like drinking," shared an anecdote about how his initiation into the military when he was 18 involved a night of heavy drinking influenced by his peers.

> Off the bat like literally my first day at the duty station was the first day I was ever drunk in my life, like when you first get to where you are going to stay, and pretty much where you're going to be working...I was enlisted for

4 years – first year relegated to training and remaining three years were in Hawaii 'cause that's where my base was – day 1 was an initiation, not anything formal though, and I was introduced to people in my platoon and they were drinking Hypnotic and Hennessey, mixing them together and calling it the incredible hulk, and they're like, "oh, here's the new guy, we gotta get him a drink." They're like, "you don't drink? You're a pussy." So I went, drank, they're like, "we're going to the club," and I kept falling over, and I was like, what is going on? And you can imagine the rest.

Participant B, a Marine, who reported that he did not like drinking prior to the military shared that he began drinking regularly on bases that he was stationed at when he was not deployed:

I drank a shit ton. Like a shit ton. Beers and tequila. Tequila was my number 1 go to...Our biggest ones we would drink was called prairie fires. Tequila and Tobasco sauce as a shot. We would just get lit. You know to the point that I'd wake up sometimes and have blood all over my pants and was not sure what the hell happened. (Researcher clarified if the blood implied he had gotten into physical fights with the other Marines, and he said yes).

When asked if he felt pressured to drink, Participant B shared:

> I don't know if it was pressure. But it's definitely the
> culture. The culture in the Marine Corps was, you know,
> have the muscles. Being physically fit. Being tough. Being
> just a muscle bound person. That was all the marines wanted
> to do. And definitely partying. But then drinking was a big
> part. And I don't want to necessarily say that there was
> peer pressure, no, but you wanted to. No one pressured you.
> But you didn't want to be the odd guy out either. You
> didn't want to be that marine that couldn't be on the same
> level as the other guys.

Participant H, who was in the Marines Corps and stationed in the
US from 2000-2004, shared that he would smoke marijuana daily,
use cocaine, and drink about 2-4 times a week prior to joining
the military. While he shared that he stopped using drugs due to
the regular drug tests, he noted an increase in his drinking
upon entering:

> It removed drugs from the equation, I was able to get away
> from that when I joined 'cause they did drug tests so I
> took a step back from all that stuff, which was something I
> needed to do at that point in time, but I think part of the
> problem was it's such a huge drinking culture- it's people
> from all over the country who end up in the
> barracks...they're like 19, 20-years-old, a lot of them

it's their first time away from home, and there's just a
lot of drinking that goes on, it's nonstop...It taught me
how to drink and how to be a functional alcoholic as well.

Participant H reported that the weekends were "a blur" for
him, noting that they were reserved for heavier use. Nine other
participants also noted that they would drink more heavily, or
use more drugs on the weekends when they were not scheduled to
be working.

Five participants, a mix of combat and noncombat veterans,
shared that they were motivated to use substances due to
boredom. While some specifically mentioned the "boring" nature
of their work, others shared variations of this, such as there
being "nothing to do" during downtime, and wishing to enhance
the "monotony of the day to day." Participant D explained his
motivation for use while living at a US military base:

Being with friends, there's nothing else to do. Just
hanging out with my friends, like you work all week and
they control your whole life and they let you off for two
days and you do whatever you want to. On military bases
there isn't much to do: you go to the mall, unless you have
kids or a family, you play video games, you go drink.
Participant responses varied among those who were engaged in
combat in terms of preference for use when deployed.

Participants A-G are combat veterans. All of them shared an increase in use upon entering the military, except for Participant E, who noted that his use was similarly heavy in the military as it was prior to him entering. Participant E, like Participant B, D, and F, reported that they chose not to use alcohol or drugs when deployed. Participant D explained why he chose not to use during his deployments:

> I didn't feel the need to, I just kind of shut it off when deployed; it is not a good way to be in a combat area. Without the social element, I didn't feel compelled or obligated to drink very much at all.

Participant A, a truck driver in the Army, shared how he first tried prescription drugs while deployed in Iraq:

> We started taking Xanax every day, and also mixing this with cough medicine, codeine, and Ambien, and just driving cars, during the day...it became regular, like at first I was opposed to it, like I had never used any prescription meds in my life, so it was a bit absurd to even talk about doing it, but peer pressure, seeing your peers do it, and literally my peers were snorting them and crushing them – the Xanax - they would just crush the pills and snort them – and eventually I would try it – I have snorted it...but I didn't continue to do it that way.

When asked what his motivations for use were at this time, he responded:

> I think the monotony of the day-to-day, just being under so much constant duress and stress, working 7 days a week, caught me off guard - we get no days off, like we really just don't get a break. You push the human body to the limit in a combat environment, and if you just have poor supervision which is what we had, he was a great leader, but he was just pushing us so much because he was trying to make himself look good as a leader, but he was a very flawed person. That culture motivated my use, you are going to meet very few service members who enlist in the military and don't end up acquiring some type of substance use addiction because of the culture itself, I mean this is something that is being passed on from generation to generation; it's almost like a tradition, this is something you hear on your inception: people are like, "here's alcohol, drink." How else do you cope with that stressful ass environment? It's stressful.

Participant A also tried a variety of drugs while in Afghanistan, and like Participant C, noted that he began using substances while deployed for stress management purposes, among other reasons.

Participant G, who was in the Army in Vietnam, noted that prior to the military he would use marijuana, cocaine, and heroin about twice a week. He reported that he began snorting heroin in Vietnam every other day, and would also use marijuana regularly as well, though not as frequently as heroin. Participant G shared that while his use increased, his motivation for use did not; rather, use of heroin and marijuana was very common, as it was very available. He shared: "It was very covert in the military, and I didn't realize how common it was until I was in Vietnam."

Participant I, who was stationed in the US as a field medic and later a mental health specialist, shared how his motivation for drinking shifted from social prior to entering the military to stress management:

> If you were in the barracks you had nothing to do. You are stuck there for a while and plus everybody else was drinking. Everybody else drank all the time. So I started out drinking slow and not a real lot, but once I started drinking and was then hit with a lot of emotional crap, I started drinking more and more and more.

Cough Medicine Misuse

While Participants A shared that he experimented with cough medicine by mixing it with other drugs while deployed in Iraq,

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Participant D also mentioned it. He reported using it once while deployed, sharing that it "wasn't a great experience;" however, he said that it was commonly used by himself and other soldiers while on US bases. Most over-the-counter cough medicines include the cough suppressant dextromethorphan, or DXM, which is used recreationally due to its dissociative effects if taken in large quantities. Participant D provided an explanation as to why he believes that it is commonly used:

> We did cough medicine pretty habitually which is not great. It produces symptoms of megalomania. The reason we used cough medicine is not only do you get super high, they don't test for it, because we weren't being tested, and on military bases they sell an off-brand of the drug for $2 a box. It would be sold out all the time because all the soldiers were using it. It was a known problem. The army had to confront this problem because there were soldiers in Korea going ape shit, things like that. I don't think they ever did anything about it, to be honest. It was a store brand essentially; since it was federal land there were no state controls of it.

Between Deployments

The three participants who had multiple deployments were C, D and E. All reported increases in drinking between deployments. Participant D mentioned the celebratory nature of returning from

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a deployment. Participant C mentioned the desire to "cut loose" and to live life to the fullest in case he did not return from his second upcoming deployment. Participant E reported that he drank more during this time due to his desire and ability to do so. Participant D shared what motivated him and his buddies to drink in between their first and second deployment:

It wasn't a lot of partying but when we did do it we are going to get trashed-a bunch of young men who just deployed together want to get as drunk as possible. The anthropology answer is it has a lot to do with masculinity, we weren't processing what was happening to us. My unit had the most combat casualties of any Special Forces unit on active duty, so we had a lot of funerals, lots of guys in our unit first year and second year. My friend who was in my section, he died temporarily of a small pox related thing with his brain, he got medically retired because of it...we actually knew when we came back that we were deploying again really soon, so we had a six month window essentially to get really drunk. Afghanistan is an Islamic republic-you can't really drink there, you can get alcohol, but how much fun can it be? You're not going out, there's no women, there's a bunch of men in a dirty hut in a desert, and so there was a lot of partying [prior to deploying a second time].

Participants A, C, D, and F mentioned the prevalence of steroid abuse among their peers while deployed.

After the Military; "Reintegration"

I asked participants about their experiences returning home. I also asked if their substance use/misuse changed upon coming home, and if their motivation for that use changed. Participant responses revealed that this transition was not without hardship and a variety of challenges. Such challenges often motivated veterans to self-medicate, or to use/misuse substances as a way to address or quell the unpleasant emotions, situations, and setbacks they found themselves in. Emerging themes include feeling disconnected from society and friends and relatives, difficulty maintaining close relationships, obtaining work, and enduring lasting mood changes or tolerating debilitating emotional states, including depression, anger, rage, lack of motivation, anxiety, and resentment toward the military. Many of the participants also expressed that the disconnected feeling that they had upon returning home was also related to the palpable loss of camaraderie and deep connections that they had with their military buddies. Eight participants reported sleep problems upon returning from their military service, and used substances to help them sleep. Seven of those were combat veterans, and one was a noncombat veteran. All participants described how over time they came to recognize that

their use/misuse was interfering with their functioning, and that they felt they needed to make changes by moderating their use or becoming abstinent to lead healthier lives realigned with their values.

The term that is often used to define veterans returning home, whether from US bases or abroad, is reintegration. Participant D captured the complexities of reintegration: "I'm not even sure if I've fully reintegrated yet; I'm not sure if you ever really fully integrate."
This participant had an emotional reaction to this question while he was also intrigued by it, and shared that it is something that he considers in his own research among veterans. He continued:

> The fact that people ask me these kinds of questions you always have that marker [of being a veteran], right, but I guess the license plates and things, you know, that's part of my research, why are veterans killing themselves? It's because we don't feel like we identify with people around us anymore.

While asking this question, I recognized my positionality as a civilian attempting to investigate the military-civilian disconnect. I responded:

> "Yes, it does seem like the question itself might be a little alienating to you?"

Participant D responded:

Yeah, it is alienating, and it's very hard, it's like, what
is the answer to that, what do we need? Do we need a
ritual? It's not "thank you for your service," my gosh, I
could write a whole thesis about how it's not thank you for
your service. The transition, I don't know, it's just,
that's a great question, I'm not sure I have a full answer
for you. Most of my school I've followed a pretty clear
line of show up to every class, do all the work, answer all
the questions, read all the reading. It kind of goes back
to that thank you for your service thing, the fact that a
majority of people you are going to meet are going to say
that and it's nothing like that, you don't know if I was an
administration guy or in the band or if I chopped
somebody's head off, and actually these kinds of
conversations are probably better for reintegration where
you actually ask the people from start to finish, not just,
did you kill somebody? Have you ever been blown up? You
know? Things like that. You're not around your buddies
anymore, you're with your civilian friends and all they've
been doing is going to college or working a job. The things
I would have been doing if I wasn't in the military. And
things just aren't that interesting, to be honest. It's
kind of like that quote in Fight Club where he says, "The

volume gets turned down on everything...it's like taking a really good drug and then having to come down essentially." You had purpose and you had meaning, and a lot of veterans struggle with finding meaning afterwards, so a lot of my last few years I have been working at purpose and meaning, so reintegration has been a lot of that; it's been a lot of kind of a disconnect because you can't really tell everyone about everything, which is what you want to do, but you can't. It's just translation, like, do I draw them a picture? Do I write an ethnography like I'm trying to do? This might be the anthropologist in me: you never have the full answer, you can't tell everybody everything, sometimes you can tell people more than others.

An excellent journal article published in *Traumatology* entitled "The Combat veteran paradox: paradoxes and dilemmas encountered with reintegrating combat veterans and the agencies that support them" (2015) described the various paradoxes that combat veterans experience upon returning from combat and/or being discharged from the military. The authors argued for the importance of counseling combat veterans and providing them with transitional support at such critical junctures, regardless of the presence or absence of mental health diagnoses. The authors noted:

Helping combat veterans understand how their views and

assumptions of the world may change after combat is

important. At no time are these interventions more

essential than when a combat veteran returns home from

deployment or when the combat veteran leaves the military.

These transition points are especially critical because it

is here where combat veterans renew existing relationships,

as well as form new ones (Castro, Kintzle, & Hassan, 2014).

(Castro, Kintzle, & Hassan, p. 299-300)

Ironically and paradoxically, two combat veteran

participants in the study shared that although they received

transitional support information regarding benefits and

assistance with returning home, the combat veterans were not as

present as they could be due to anticipating going home.

I was speaking with Participant B about mental health

treatment that he received after returning home. He shared:

I didn't actually even know we get five years of enhanced

health care at no cost to us until I ran into a captain who

was like, dude, you got to go to the VA. *(They didn't tell

you when you were discharging?)* I'm not gonna say that they

didn't, I just probably didn't hear it. *(And you probably

weren't the only one?)* Yeah, I'm sure we just were all in

'let's go home mode.'

Participant A shared an anecdote about his experience with the
transition from military to civilian life:

> The discharge process was cumbersome and unintuitive. I had
> no idea what these people were talking about, I was just
> concerned with my wellbeing, and what was I gunna do next.
> I couldn't even concentrate so I had no idea what benefits
> I was entitled to and what they were, I had no idea what
> the GI bill was, I just knew that I paid for it at the
> beginning of the year. I didn't know anything about
> college....I was getting out and it was like starting all
> over again.

Some combat veteran participants shared that they felt
anger and rage upon their return from the military. When asked
about any major challenges that he had readjusting to being
back, participant E responded:

> I was just really angry, a really angry person. I would
> have a lot of malice, hate. I would want to hurt people. I
> was very judgmental and critical. *(Why do you think?)* I
> guess it was kind of the way I interpreted the way I was
> being treated. Doing things wrong, and then eventually
> getting the hang of it. That judgment and criticism, for me
> at the time [during my military experience] was necessary
> because I was in life-threatening situations, but it
> carried over into non-threatening situations, but it didn't

just carry over, it bled over into getting the right change

at the gas station, paying for a candy bar, or bringing my

gun everywhere I go, stuff like that, and just constantly

measuring people, and wanting to go back to the violence

that I had become accustomed to. (*Did you feel disrespected*

by folks, coming back?) Yeah, yeah, I felt disrespected by

some people, and I felt like I was a victim, I felt like I

was at a disadvantage. *(Why did you feel victimized? Did it*

have something to do with your military experience?) I felt

like I was a victim because I knew my thinking wasn't

normal and I thought it was because of the military, which

may or may not be true, but it was what I was blaming. So I

thought I was at a disadvantage.

Participant F also described feeling rage and anger in

relation to feeling guilty and disappointment in himself due to

his experiences of moral injury, which is mentioned in the Moral

Injury section. Participant C also mentioned feeling an

underlying aggressiveness upon returning home, which he

associated with difficulty maintaining a romantic relationship.

Because the VA prescribed him Adderall at one point upon his

return to help him with concentration and focus, he shared that

he felt this contributed to his aggressiveness and the demise of

his relationship:

You can't be on it for that long, especially when you

have alcohol combined [with it] and you have an addictive

personality. Anyways, if you're on the Adderall for too

long you're gonna get angry, apathetic, competitive, more

nerdy and robot-like. That's what I've experienced and I've

seen it happen to other people. [With] other people,

they've been taking it for years and you'd never know. [My]

hypercompetitive and aggressive, confrontational,

vindictive, or apathetic type of behaviors started to

surface and my relationship fell apart, about a year and a

half relationship, and it just ended with me falling apart

and telling her to go cause I was getting to the point

where I thought I was going to be violent. We would get

into arguments, and she had some emotional problems too and

she provoked me and whatnot, but I was totally out of

control. She told me to fuck off one time and I started

getting into the habit of taking a couch pillow and

throwing it at her when we'd get into arguments. I threw a

lighter at her after that, and then I thought about that

later. I was like, "Oh I'm moving up the chain of objects

from non-harmful to potentially harmful." She provoked me

again and I totally I went off. I went ballistic and I

smashed a chair, and I was like, wait a minute. I'm

throwing small objects at my girlfriend and smashing chairs

on the ground. How much more time before I start smashing chairs at my girlfriend? I can't do this. But I can't leave. I was like, "I'm so sorry." It was hard cause I loved her. But we were horrible, and I was on a self-destructive mission, and I was losing my mind and she was just in love with me and didn't want me to go, and she called me an asshole and started a big fight the next day. And I had to tell her, "Look. I don't love you, I do not love you anymore. You need to go." I had to tell her that 'cause that was the only thing to get it through her head to fucking drop me and go on with her life. I loved her. I just knew that I had to leave 'cause I was going to hurt her or myself. I saw it as a bad trend and I aborted. I aborted hard. *(That's a really sad story because it sounds like you did really love her. Why do you think there was so much anger?)* Activism- feeling total fucking futile and observing myself falling apart and not being able to be a productive activist. Watching me melt down and the Adderall and alcohol mixed. Yeah, that was really hard telling [her] that I didn't love her when I actually did, and I wanted to stay. But I knew it was the wrong thing to stay, and I was out of control.

While describing his reintegration process and what was challenging for him about it, Participant B articulated how and

why he felt disconnected from others, as well as how this interfered with his relationships, and how drinking alcohol made him feel comfortably "normal":

When I came back I was just a wreck. I didn't want to be touched. I didn't want to talk to anybody. I didn't want sex. I didn't want anything. I just wanted to be left alone; I wanted to sit in my hole and stay there and watch TV. I think there was a part of me that wanted to be normal too, you know what I mean? *(And you didn't feel normal when you came back?)* No, not at all. I just felt so disconnected from everything and everyone around me. And I went by myself to Iraq, which is called an Individual Augmentee. They didn't take my whole unit, they just took me. And then we connected with like 26 other guys that had the same thing, and then we went to Iraq. Those who came back, we all disbursed, so I didn't come back to a unit that deployed before, you know, so I had no support. I didn't have guys that were like, "Hey man, I'm feeling the same way," or "Hey, let's go get a drink, I'm feeling the same way," or whatever. It was guys who had never deployed [on base] and most of my friends who were never in the military. So I tried to open up to them, and it would be just like talking to a wall, you know? I literally was trying to pour my heart out, what was going on with me, and

then I'd get, "So what should I do with this girl?"...In my head I'd be like, literally I've screamed out for help. And I couldn't talk to anyone, either. I wasn't confident at all. I started drinking more and more and more. *(And you said that was a couple months after you came back?)* Yeah, about 3 months after I came back. I started drinking more, more, more, and I felt like I had my confidence back. *(And what would you be drinking at that time?)* I'd drink about 10 beers and 10 shots. *(In a day?)* In a night, yeah. And at that point like, I was good. I didn't even feel drunk. I felt normal...I felt like I could talk to anybody...I just kinda forgot that there was even an Iraq. I felt like that never happened. I just felt confident. I felt like I could be fun and free and just me again, and that was a great feeling. And so I wanted to reproduce that every day, and I started to reproduce it every day. *(So you got to the point where you were drinking every day that much?)* Mhm.

To the question, "What do you think motivated you to start drinking so much at that time when you came back?," Participant B responded:

It was the feeling that I got. *(More connected, you said, more like you could talk to people.)* Right, exactly. *(Feeling normal sort of.)* Right, exactly...That's what I've always said: feeling normal, you know? Not feeling like I

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just got back from deployment...I came back and that was really isolating, so when I started drinking like that I started to hang out with my friends again. So really just living life. And when I didn't drink, I wasn't living. I was just sitting at home on the couch. *(I know that it's very common for a lot of folks to feel that way when they come back, and there's this big disconnection and reintegration feels weird, feels foreign. What do you feel like it was about the deployment that you didn't want to feel? You said you didn't want to feel like you just got back from it.)* Every day at least for me—I can't speak for everyone—but I know for me and I'm pretty sure it's for a lot of people over there, you wake up every day thinking, is this going to be the last day? Am I going to die today? You get mortared and rocketed I don't know how many times. I mean it was scary. I was supposed to be at a gym one day. I went to the gym between 2 and 4 o'clock everyday because we worked 12-hour days and you could take 2 hours for fitness. I mean who wouldn't take 2 hours, right?...This one day, [Names the exact day and year] it was a Sunday. I was supposed to be in the gym just like I did every day, just like I did every Sunday, and then a friend of mine who was a Marine, she ended up talking me out of the gym. I told her I'm not gonna go to the gym tomorrow. And then

Sunday came around. And I was like, wait a second. If I
don't go to the gym I don't get to shower and then I have
to work 12 hours. I'll just go...and then I told her "I got
to go get my gym bag," and she was like, "No, you said you
weren't gonna go." So I was like, "Fine, then I won't go."
And that day a rocket landed in the gym and killed my boss
and killed another Colonel and blew up like 18 other
people. It was eerie man; I should have been there. I was
like God's get out of jail free card. That's what I'm
saying, that feeling every day, you never know. That was
the feeling—fear every day, adrenaline every day. You know
I had a rocket fly over my head, like from where your head
is to that ceiling [gestures to the space in between my
head and the ceiling]. -And then at the point when you're
that close, that's it. I knew I was dead. I'm way too
close. I can see the rockets flying over my head and that
I'm dead. That's what I thought. A weird thing happened.
There was no head on the rocket. The head is what explodes
which then explodes the tube and the tube is what kills
people. Which that's what I would have died from, no doubt
about it. But the head wasn't on it. So I can't tell you
where the head went. People think it separated while it was
coming in the air. Like maybe the head took off, which
never happens. The tube came down and slid across the

ground and hit a wall, and I was like, again? Fuck man,

this is my second get out of jail free card.

Participant B shared that what he described as morally injurious

to him did not motivate him to drink. I clarified with him about

this:

(So not moral injury but for you just coming back, just

kind of reintegrating in a way?) Yeah, reintegrating, sure,

sure. I think the gym thing kind of messed me up too. Cause

for an hour or two people were looking for me. 'Cause they

knew that I was always in the gym...I was just off post

doing something and I heard the bomb hit. But the bombs hit

all the time. I didn't know it hit our base, though. I

didn't know it hit the gym...I finally get back on base and

they're like, "Where the fuck have you been? We thought you

died." I'm like, "What the fuck are you talking

about?"...Then I saw a guy, a gunny in the Marine Corps. He

looked like a ghost; he had dust all over him and he just

looked at me like he was he was dead. I felt like I was

dead and he was. I don't know, I felt like we were in hell

for a second. And he just looked at me and was like, "You

weren't in the gym today. You weren't in the gym," and I'm

like, "No I wasn't in the gym." He was in the gym, though.

(So the moments where like you said, just knowing that your

life is on the line at all times and those moments that

really affected you.) That moment specifically because

everybody who went to the gym, the 2 to 4. We didn't plan

it. None of us were friends. We just happened to go to the

gym at 2-4...it was the same people. Can I get a spot? Are

you done with that? You didn't have to talk to understand

that these were your peeps. Like I said, my boss died, my

major who had three kids, one on the way, a wife who was an

attorney. You start to think like, why not me? It shoulda

been me, like fucking I only got 1 kid, my relationship is

not going well. Like why take a guy whose got a lot of shit

going for him?

Participant B did not specifically mention the term *Survivor's*
Guilt here, but this seems to define what he experienced
following the rocket attack on the gym. Participant D shared a
similar response to the question of what motivated him to drink
more heavily and frequently upon returning home. The responses
were similar in that both participants mentioned similar
motivations for drinking alcohol upon returning, and also
expressed guilt due to surviving:

Alcohol helped me sleep and it was also helping me not sit

around the house and be bored. It was a good social conduit

to meet people and try to find that new camaraderie. I

think a lot of what it is, is a loss of deep camaraderie-

no one is going to be as close as your army friends are, so

that's what you do, you're in college, you drink beer, you talk to girls, hang out with your friends, so it was a conducive environment. I didn't have mental health counseling at the time. I didn't consider myself to have PTSD, I knew something was wrong, but I didn't consider myself to be diagnosable. Actually I knew what I was experiencing at the time was survivor's guilt. But that's not lumped into PTSD. Like I just felt bad 'cause I didn't die, you know? And that was the main emotion that I was experiencing.

Participant I described his difficulties with getting a job and feeling displaced, and he reported drinking more at this time:

I was still going to college in the military. I was going part-time and taking college courses here or there. They have colleges on the base. When you are in, you can get a waiver by command because you are doing good to go ahead and take college courses and the Army would pay for part of it. I had about 120 credit hours when I got out. I thought I was going to have a semester or last semester left to get my bachelor's, but only 75 transferred over. It really pissed me off. Also I couldn't really find a job with what I did in the military. I was overqualified and underqualified at the same time....I did work as a social worker doing therapy and

all that other stuff. When I got out I couldn't do that because I didn't have a degree, so it kind of left me out of place. Nobody really respected what I did, no one really understood what I did, and no one cared. *(So when you got back you were really underappreciated by society especially when trying to get a job?)* Definitely, I was definitely out of place. I was drinking a lot then too. *(Tell me about the duration and frequency of drinking when you got out. How did it shift?)* I started hanging out with my friends and we were drinking a lot more. About 30 beers a day. That was their normal functioning. *(How much did you drink a day, roughly, around this time when you got out?)* Maybe I would drink two or three days a week. It was mainly on the weekends but then it just crept up. I hung out with the same people that were drinking a lot more and I started drinking. Everything just started snowballing together 'til I was drinking just about every day. *(How much would you drink a day?)* When I started moderating I was drinking about a 12-pack of Kilian's and a pint of whiskey a day. That was a normal day and that's not on binge weekends. *(The day you were discharged, how long did it take for you to start drinking daily?)* About a half year. *(So you were hanging out with those people and worked up to it.)* Yeah, I was getting straight A's in college. *(So there was a functional part.)* Oh yeah, and I was still

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working, too. *(There was significantly more drinking after you got out at about 6 months. What about the motivation then?)* I felt out of place. The motivation was about the same, out of place, couldn't get anything done. Nobody really gave a shit about what I did in the military. Nobody respected what I did. Nobody valued it. I ended up living at home with my parents when I got back...I was 28.

Participant A shared how he felt disillusioned and left behind while reintegrating to civilian culture:

It was like a big "fuck you" from the military, and I'm like, damn, I feel like I wasted time because now all I really have is a GED and I had no understanding as to what a resume was, or how to apply for a job – nothing - because I had never applied for a job [prior to the military], so I was like, what do I do now? And super prideful, and that pride prevents you from seeking mental health services, and I remember they were like you need to go down to unemployment, collect unemployment, it was like 600 a week I was so prideful I was like I don't want anybody's unemployment, I'll work for everything that I get, fuck that, look how crazy that is, that's crazy.

One noncombat veteran, Participant H, shared that he ruptured one of the discs in his back while he was working as a bulk fuel specialist on a fuel truck. He was discharged, had to have back

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surgery, and was not allowed to re-enlist. Earlier participant H had stated that joining the military allowed him to stop using drugs due to their strident zero tolerance policies, though he stated that he was drinking heavily while enlisted. Following his return, and after his surgery, he shared that his addiction to drugs crept up again:

>I didn't really have a plan and they started giving me Percocet and the whole thing, addiction with drugs started all over again. I didn't have that brotherhood, I didn't have that focus, and it all just came back. I refer to myself as a dumpster. Whatever was around I would do. Cocaine, never heroin, pills muscle relaxants, LSD, mushrooms. So I was hoping I put that behind me. My back was pretty bad so they gave me Percocet. As soon as I put it in my body I knew it was not a good mixture. A month's supply would be gone in like three days. I would just crush it. Id snort it. I'd take 10, crush them, stir in a shot glass and drink it with just warm water to help it dissolve - it was not a good scene. It broke my heart a lot – not being able to re-enlist. You got a lot of pain you cover up with drug addiction and alcohol, if you look at it all the way back to school when I didn't fit in and then watching my mom die and kind of feeling like rejected or betrayed by the Marine Corps, and you got those three things, and when

you are caught up in your addiction that's more than

enough. That was the fuel I used as an excuse to just do

whatever I wanted. *(What motivated you to use after you got*

back?) The pain. It started out with opiates and then when

you don't have anything for the rest of the month, [you

think] Ok, I'll drink, I'll do this, I'll go get some coke.

It's just a whirlwind of disaster.

Participant H shared that at this time the "whirlwind of

disaster" was defined by drinking and using cocaine daily, and

when he began smoking crack, he eventually became homeless for a

period of time. He later pursued a path of recovery, which for

him was abstinence.

In terms of his motivation for use (drinking) following the

military, Participant J shared: "Motivation following the

military, I was just an alcoholic. I didn't even consider

anything that didn't involve drinking."

C. Moral Injury: A Motivating Factor for Substance Use?

I defined moral injury to my participants: "Moral Injury is

defined by the Moral Injury Project (2016) as "the damage done

to one's conscience or moral compass when that person

perpetrates, witnesses, or fails to prevent acts that transgress

their own moral and ethical values or codes of conduct" (para.

1). I then asked if they had experienced this while in the

military. After the fourth interview, I began paraphrasing this

definition by omitting use of the term "damage," as I found its pejorative nature unnecessary and considered how it may negatively influence participant responses, or alienate them. I asked the participants who reported experiencing moral injury if their substance use had any relationship with those experiences. Participant responses varied. Out of the seven combat veterans in the sample, all reported experiencing some type of moral injury. Of the five noncombat veteran participants, four reported never experiencing moral injury, while one noncombat veteran reported experiencing moral injury and using substances because of it. In total, eight participants reported experiencing moral injury, and seven of those explained how their substance use was related to moral injury, as well as other reasons.

Participant A shared his experience of moral injury:

> I think it was more so based on you start to blame yourself a lot, like I was mad at myself for not saying "no" to the recruiter in the first place. I was mad at myself now for never speaking up to this NCO. I knew that he was mistreating me, but because he had everyone manipulated I would just keep my mouth shut; I just felt like it was me against a machine, and he knew it. He thinks, all these kids are under the age of 23 and I'm their leader...I'm 40-something years old, I'm having sex with this 18-year-old

girl and not promoting people. I would tell people, listen,

this guy is horrible, and they were like, "What do you

mean? He is one of the greatest sergeants." He was married.

He clarified his own experiences of moral injury were:

Violating people and shooting at people and raiding houses.

Because we always had to support, we were called QRF, Quick

Reaction Force, so basically we were the infantry's primary

supports when they would go out, so we would follow them,

literally they would be the first responders but then it's

us right behind them.

When asked about moral injury, participant A also shared his

contemplations and perspectives about whether his deployment

experiences were morally justified, or if they had a purpose:

I didn't think any of it had a purpose, I thought the war

on terrorism was some straight bullshit. I would say 95% of

the people I deployed with felt the same exact way, but

again, because they were so ignorant it was something that

they would never articulate. I just recently read this

aphorism, and it stated that you can't convince a believer

of anything because their belief is not rooted in fact,

it's based on a deep seated need to believe, and

they just believe in the military. They wouldn't question

shit, they didn't need facts, it was just pointless. They

were like, "we have a mission, and I'm like, "what's the

mission? What mission do we have? To just die randomly as we deliver water that people don't want?" It's pointless.

When asked if he felt his substance use was related to moral injury, Participant A shared:

I just think that that experience was a moral injury in general, I think that even more so than the combat experience, I just think the experience of being in the military is traumatic....I think I was drinking to forget it, to suppress that experience.

Participant C responded to my inquiry about if he ever experienced moral injury:

Absolutely. Just having to be involved with supporting combat operations and knowing that people are gonna die and that it's gonna cause a chain of events that will lead to more destabilization, misery, pain, and suffering just in general, knowing that that's going to happen, knowing I was involved in that is deeply disturbing, and I've done things individually too, which I just have a huge amount of shame wrapped up in. You know, like I had to guard some prisoners once and this is one of the biggest shames of my life, and it has to do with not being something that I was told to do at all. We were told to harass the prisoners, nudge them and keep them awake and keep them harassed until they, you know, got where they were going, which is interrogation.

You keep them exhausted and sleep and food-deprived to the point that they're ready to break by the time you get them to the torture zone. We had to feed them, we gave them their food packets in a certain amount of time, they're allowed to stand for a certain amount of time, kneel, and lay on their side for a certain amount of time, very minimal amounts of time, like just long enough so they can sleep like a 30 second powernap, like "alright get back up again" kind of deal like, you know, just to harass. I had my pennywhistle there and there was this mean kid who was with me guarding, he was a fucking asshole, another Sergeant, and he wanted an excuse to abuse people. We were told by the guards that left before us which is total hearsay that like, "intel said that these were the guys that sold the explosives that killed [a military buddy]. Likely story, it just sounds fucking totally phony, like they want to provoke people to hate and hurt these guys that they have under their custody because they're venting and they're angry and this kid...one of the guys was delirious and starting to fall over and so he reached on me for support. You're not supposed to carry the axe handle weapon inside the prisoner tent, he's [another guard] got the weapon standing in front of the tent, and he breaches protocol and comes into the tent to take charge of the

situation 'cause this guy is falling over and using me for support a little bit and he comes up to him from behind and he comes out and kicks his legs out from his knees from behind and throws him on the ground, and I was like, "Why did you do that? That's totally fucking unnecessary." But then another time with the same prisoners, I had my pennywhistle [that he bought in Afghanistan on a previous deployment] and I was guarding [3 prisoners]. I still remember them. They have blindfolds on and they're flex cuffed and the ankles were cuffed, and one fat guy, his ankles were swollen and you could tell they were swollen from standing, and it was gross, it was bad. I've definitely been forced to stand in one place for a long time, and I know how it sucks, and I was playing my pennywhistle at one point, and I was kind of trying to find an excuse to play my pennywhistle, and one of the guys [prisoners] was like, "ohh, ohh," like it was the sweet sound of music on his deathbed, 'cause he doesn't know what's going to happen to him, he assumes he's going to get a bullet in his head, you know? And he probably really does after what happened to him at Abu Ghraib even if they [higher US authorities] were really interested in him. But so he did that, and I realized I can't, I'm not supposed to do things that are sympathetic to the prisoners, they are

supposed to be harassed, so I made them dance. I made them

go like this (moves feet up and down) and I yelled at them

until they did what I was doing, I played my pennywhistle

and made them dance along. So I felt really ashamed for a

long time...for a long time. [Gets teary-eyed.] I felt like

that killed music for me. It fucking killed music that I

had used music for something evil, you know, it's like, an

abomination, so that's uh, yeah, definitely, definitely,

that's a deep moral injury right there, aside from just

going to Iraq and not going AWOL like I should've, like

that little fucking dig was above and beyond, it was

antithetical to anything that I represented at that point

personally, no morals.

Participant C also expressed feeling "resentment" and "hatred"

towards other military personnel that were his authorities while

on base before deploying to Iraq for not actively dissenting

against the war and protesting it alongside him. When asked if

he used substances in relation to his experiences of moral

injury, Participant C responded:

Oh, absolutely. Shame is an everyday cause of depression

for me, so the depression I was treating was largely due to

the shame I felt for what I participated in, in addition to

the knowledge that it was still going on and there was

nothing I could do to stop it...so you escape from yourself

with things like alcohol.

Participant C had completed one deployment in Afghanistan.

Following this, he was promoted to platoon Sergeant and then did

a 2 month tour in Iraq. He shared his frustration about being

told he was going to Iraq, as well as the overall decline in

morale within his company, and his increase in drinking as a

result:

I got my Sergeant's stripes, was a forward observer once

again, and I hated where I was, and I wanted to be out of

the military and saw the possibility of going to Iraq as a

heinous force of military aggression, and occupying it as a

crime against humanity; I was telling everyone around me

that. I got verbally reprimanded but they knew what a good

solider I was and they refused to put me in any bigger

trouble than I was almost trying to get into. I kept

drinking. I started drinking more once it was determined

that we were going to Iraq. I was told...everyone who is

End Term of Service [ETS] is not going. I was out in

January of next year, so was within a year, so they said I

was not going...they said everyone who is ETSing in a year

put your social [security number] on this list and you are

not going. Ok, so in one week after putting that on the

list, everybody is going and we are leaving within 10

days...The morale shifted greatly after Afghanistan. It all seemed like they [soldiers] couldn't wait to get out and a lot of them were not on board for the Iraq idea. There was a bit hit in morale in general. I was so close to going AWOL, but I couldn't stand the thought of abandoning them, most of all just thinking about my grandmother, my grandmother's going to hear third hand how I've gone AWOL; in hindsight she would have been fine with that – she's pure love. But I couldn't deal with the stigma of grandma knowing her grandson is a deserter, and I thought she wouldn't understand and think I was some kind of traitor.

Participant D, when asked about his experiences of moral injury, spoke about it more hypothetically and pondered about whether the wars in Iraq and Afghanistan were moral to begin with:

My colloquial definition in my head is the fact that they send us to fight these wars that don't have moral purposes for freedom and stuff like that...you're really there pretty much as a mercenary. A lot of soldiers, my own research on it, they feel very disillusioned about the purposes and what they're doing. This isn't World War II anymore, this isn't about the Nazis, we're fighting terror, and terror is an amorphous thing and the state decides [who are terrorists] while ignoring the fact that there's tons of white terrorists here. A lot of veterans are

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experiencing this; we are told this war has all these meanings, right, to liberate Iraq, but we didn't liberate Iraq. It's nothing like that, we're going to get out of Afghanistan and we wasted billions of dollars, we were there, and we watched them not build schools for years, we just like, did something for nothing, you know, and it's hard to feel morally correct about it. It's not moral because you think you're doing it for one reason, and that reason doesn't exist. There are no things to liberate, there's no finishing it; the war never ends. It's like we're always to be at war with these people, and the state is going to continue using it...it's a myth that soldiers are completely oblivious to what's going on around them. We watch the news, we are the news, so. I could see it going both ways, it definitely is informed by the fact that I am an anthropologist and I am left-leaning, my opinion of the state and its goals is not rosy. But I could see it going the other way if you thought terrorism was bad. We didn't execute the war correctly, but terrorism is still bad, it's very subjective. I'm torn about moral injury still like I know what [scholars are] getting at, but is it something? I don't know...It goes back to the whole old story that the first time a soldier goes into combat he doesn't shoot at the enemy, he shoots above the enemy. I'm sure it's true,

it's probably a truism. But it's because no one actually

wants to kill people I don't think, and if you do, I would

suggest that you shouldn't be in the military, so, so no

one wants to go over there and do it and then they're

forced to do it, and you want to do it for the right

reasons, you don't want to just kill kids and blow up

houses and things like that, but you do, and then you come

back and it's like oh, actually we're actually not saving

anybody, you know, we're just in the middle of a bitter

sectarian conflict that we started.

When asked if he used substances in relation to any moral

injuries that he may have experienced, he shared:

I'm sure it was, I'm sure like because, you know, people

drink for a lot of different reasons that end up being kind

of the same. You get into, kind of like focused on whatever

it is that you can't process.

Participant E also shared that he experienced moral injury. He

responded:

Yeah, in Afghanistan I felt like we were too indiscriminate

in shooting and felt guilty how we treated some of the

locals in Afghanistan. *(How did you treat them?)* I didn't

do anything, usually I was not in the position to interact

with others because I was kind of behind the scenes or was

on a mounted gun on a Humvee, so I wouldn't be able to get

close enough to people typically. *(What did you see that made you feel guilty and compromised your values?)* Hitting or pushing them around for no reason.

Moral injury resonated with Participant F, who reported that he experienced multiple moral injuries and that for him, his substance use and misuse were directly related to these experiences: "I don't feel like I can talk about one without the other. They will always be tied together. They exist together."

Litz et al. (2009) defined three types of moral injury: those that are perpetrated, those that are witnessed, and those that one fails to prevent. Participant F related experiences of all three, which included disagreeing with what other Marines were executing, killing people, and feeling an incredible amount of guilt over not being able to save one of his military buddies who had died in an accident with him, despite his efforts in trying. In terms of witnessing other military authorities commit acts that violated his own moral code, he shared:

If you want to talk about moral injury, you know definitely you can say the problems are because I've got this elevated sense of right and wrong. I've got this elevated sense of justice. I've got this sense of the way things are supposed to be, who I was supposed to be or what I was supposed to do in life. That may be where that came from. Just the way that so much of it made sense but also too that just the

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fact so much of it is run by a "might makes right," or "rank makes right." So I struggled with that a lot. There is an abuse that goes on behind it. There is a lot of stupidity and ineptitude that hides behind rank both on the enlisted but especially on the officer's side. I struggled with that because I saw things that were done badly or poorly that shouldn't be done, but that's the way it is because that is the way the Marine Corps does it because that guy is a higher rank. But at the end of the day you saw people not doing the right thing for their Marines all the time. You saw people that would do what was the best for themselves or best for their careers all the time. People who were afraid of their bosses, who wouldn't speak up to their bosses. So you saw a lot of that stuff. There was an emptiness and a hollowness to the integrity of the Marine Corps.

Participant F reported feeling anger, rage, guilt, and disappointment toward himself for being unable to save one of his friends who had died during the war in Iraq in an accident they were in together, and shared that he had difficulty accepting the fact that neither he nor anyone could have saved the friend. When asked about how alcohol, his substance of choice, was related to moral injury for him, he shared: "Alcohol

was the only thing that could do anything about the anger and the disappointment in me."

Only one noncombat veteran, participant I, who was a field medic and a mental health specialist on a US base, shared that he felt he experienced moral injuries during his time in the armed forces:

Yeah. I had to do shit that I was completely against like chaptering people out of the military. Doing recommendations that I really didn't agree with that I had to go ahead and do. *(So in terms of chaptering people out of the military, I know there were times you had to and you felt justified in your clinical judgment that some people had to be chaptered out. Were there other times where you felt like it was compromising your values to chapter them out, and why so?)* Well, some I thought were a really good fit for the military and commands wanted them out. That was fucking command: they could do whatever the hell they want to. [the soldier was] a great fit, they were the only source of income, they had family and I had to chapter them out without no way to provide for their family and that wasn't okay with me. If they are shit bags I feel bad that they have kids and stuff and they should be taken in to foster care because some guys are morons...but I had to go and do some fucked up things that were not okay. Then I had

to also push people through to new deployments that needed

a rest that weren't okay.

Participant I also described other experiences that he felt

compromised his values while on the job that he was still

required to do, such as admit people into combat who did not

meet the weight and height requirements to then need to take

those individuals out of the forces to return to the proper

requirements. He said that he dealt with orders that compromised

his values while working as a mental health specialist in the

Army, and also as a civilian working in the Army as a substance

abuse counselor: "That is why I stopped being an Army substance

abuse counselor after a while because I just became a force

reduction tool. Not actually a treatment tool to help people

out."

When asked if he used substances (his substance of choice

was alcohol) in relation to these experiences which compromised

his values, he responded:

I guarantee it. They all added up one after another, after

another. It is never just generally one thing. Just like

when someone gets deployed and something shitty happens.

There is generally multiple instances of deployment where

something horrible happens.

It is revealing that the other noncombat veterans, while

sharing that they felt that they did not experience moral

injury, often responded similarly to how Participant H did: "No I don't think I ever did – I was fortunate. I think if I had gotten deployed or something."

This implies that many of the noncombat veterans believed that they would be more likely to experience moral injury if they were deployed and in a combat situation, although it is possible that moral injury can be experienced in other environments.

Substances of Choice and Personal Recovery Goals

Alcohol was the most widely used/misused substance among the participants. Ten participants reported that it was their primary substance of choice, and recognized that it was interfering with their daily functioning at one or more instances in their lives. Of those 10 participants, six shared goals of abstinence, while four expressed goals of moderation. Moderation of substances entailed greatly reducing use. While all four reached their goals of moderation, four have maintained goals of abstinence at the time of the interview. Two participants with goals of abstinence experienced a return to alcohol use, but renewed their goals of abstinence the following day. Participants G and K, both Vietnam-era veterans, reported heroin as their primary substance of choice. Both shared goals of abstinence.

D. Recovery: Pathways and Meanings

To the question, "what sustained your recovery?" participants' responses were varied; however, some themes emerged from the data. The theme of substitution, or switching substance misuse with other substances or other more nourishing activities, became a theme among the participants. Participant A shared:

Self-accountability, being accountable for myself and instead of blaming anyone else for my position. Focusing not on the negatives; looking at the positives. Because of this I have a strong work ethic, I can go out on my own, I can process things and I know how to self-adjust and auto-correct, so I just turned my negatives into positives and from there slowly but surely things begin to better themselves. I mean it definitely took a while, I would say it took 5 or 6 years, but imagine how many people slip through the cracks during that time because alcohol leads to harder drugs.

He also shared that he eventually began running and working out, and that became a substitute for drinking, which he began moderating:

After about a year of [being back and] me isolating I would sit all night in the dark and process life, and like, what am I going to do next, you know what I mean? And I think to

like not think like that, and to be able to sleep I was

drinking and smoking. You know, I didn't have those

problems in the military, I would sleep like a baby, it was

the routine, I don't think anybody recognizes that you have

PTSD. When I came home it was like instantaneous. I noticed

that I needed something else to fill that void and that

something else became alcohol. I first noticed that I was

gaining weight and I was just really not happy with myself,

I couldn't just stop drinking because again this was my

gateway to sleep, you know what I mean? Just that mental

relief, so it was like I needed something else to fill that

void. So I decided to go for the police test, and in order

to take the test you have to pass the physical fitness

portion, so I went back to the gym, and when I went back to

the gym and I started running every day, I stopped

drinking. Routine – literally just running for like hours.

I would say I was lethargic for a while and I was more

stressed out because I just didn't have that same

intoxicated feeling. (Participant A did not choose to

follow through with the police test because other

opportunities arose for him that he pursued.)

Other participants also mentioned the importance of running

and/or working out as an important aspect of sustaining their

recovery, including Participant D. Participant I shared that

after he began moderating his drinking, he noticed that he began

to eat significantly more, another sort of temporary

substitution, which he said he was able to moderate as well, and

eventually began working out regularly.

Marijuana Use

Participants C and D reported that smoking marijuana was an

important factor in their recovery and helped with PTSD symptoms

of hypervigilance and startle responses. Participant C, who has

been abstinent from alcohol for 10 years, shared that he is

aware that marijuana is a substitute for alcohol, but one that

feels like an "acceptable addiction" to him. Participant D, who

has moderated his alcohol use, smokes marijuana almost daily in

the evenings to relax. Both participants shared that they

noticed one setback, which is marijuana's potential ability to

de-motivate them.

Marijuana's potential in treating PTSD symptoms is a

controversial topic within the peer-reviewed literature and at

the VA, and there are scholars on both sides of the debate

concerning its effectiveness. Further research needs to be

conducted to determine marijuana's overall potential in

assisting veterans with various mental health diagnoses,

particularly PTSD, especially with the advent of medical

marijuana. There are a number of studies that have investigated

this, and continue to do so today (Cougle, Bonn-Miller, Vujanovic, Zvolensky, & Hawkins, 2011).

Participant A shared why he feels that marijuana is an important aspect of his recovery:

> What I appreciate most about cannabis is it gives me the self-awareness of my physiology and my emotional states. There's this little bit of lag time, there's this little bit of distance that I get to sit back and think analytically about my feelings. I am not my feelings, drinking just makes me less aware of how I am and how I'm feeling and artificially makes me feel good, dopey, content, even after you're burnt out on it it'll make you feel content, comfortable, at ease, loose-tongued, just less inhibited, but with cannabis it's actually a little more socially stand offish, but it lets me become aware when I'm starting to freak the fuck out. Without cannabis I realize that I'm in a provoked state and it's not conducive to how I'm feeling, you know, it just goes off the chain real quick. With cannabis it's like I've got moments about how I'm feeling and make choices about how to proceed, it lets me catch the runaway train before it's gone. Without cannabis I don't even see it, I'm screaming and throwing shit and I'm like, what the fuck happened? How did I get here? It absolutely helps with PTSD. I could see how some

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people could have problems with it and how it could provoke

people's symptoms also, and I've seen people react to it

differently, and I've seen a great range of effects, but

for me personally, I feel like the startle trigger

prevention, the self-awareness and mindfulness and [being]

able to avert like panic type, rage like reactions and just

the overall keeping my stress level lower by not worrying

all....I feel like it reduces my anxiety greatly. I feel

the overall effect on my anxiety level is positive, making

me self-aware so I can make changes in my behaviors to help

me reduce my anxiety and reducing competitive and

regressiveness. The main problem is amotivational syndrome,

which I already have a problem with my existential stuff.

It's hard to attain my own level of accomplishment that I

want, but I don't feel like off the cannabis I could be as

rational and safe as I am.

Participant D shared that while he tried marijuana in high

school and would use it sporadically prior to the military, he

said that he now smokes regularly. I asked him what he

appreciates about marijuana. He shared why he prefers it to

alcohol:

I kind of switched over from alcohol to marijuana. No hang

overs. I can smoke a little, lay down, go to sleep and have

no effects, and it's essentially cheaper. I don't smoke a

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ton, usually once a night like a night cap, I'm not a part of that stoner culture where they put weed leaves all over everything. It's just a smaller version of what I used to do. I like that it relaxes me, it lets me open up emotionally about things I might not open up about, it allows me to relax myself because I do have a PTSD diagnosis, and I do have hypervigilance. It's pretty annoying sometimes, so it helps me. The only side effect is it creates apathy and makes you feel OK with not doing anything, which is a problem. I always say it's hard to be vigilant when you're super stoned, you can't pay attention to everything, you don't want to. Recently, I was high at the time, and a strong wind blew my back door and it rattled, and the first thing that came through my mind was, where's the nearest weapon so I can stab the person coming through the back door? My first decision was how do I secure this space and what do I have around me to secure the place, and it was just the wind. I was also high at the time, even though I was high it still kicked in, I was still ready to go, but it might help you not focus on it. Hypervigilance is like tinnitus: it's always going on and you just notice it more than others sometimes.

Participant D described activities that he threw himself into that helped sustain his recovery, such as "self-education,

college education, and physical education." He also said he enjoys "working on painting and drawing." He further clarified:

> The six months I spent reading and writing has pretty much been the catalyst. Since then I read quite heavily – [since] the six months between being off active duty and going to college when I was living at home. I started with Kerouac and have been collecting books, probably since that time I've read well over 400 books. I read like mostly American authors after WWII, some contemporary reading, I have a huge book collection, poetry, I read *Infinite Jest* between [age] 28 and 29. It helps me empathize with myself and understand how I'm feeling. Running is the same way – it gives you time – you don't know what your problems are after 4 hours of running, [also] a lot of being outside.

Medication-Assisted Treatment (MAT)

Two participants (F and K) are using medication-assisted treatment (MAT) — or types of prescribed drugs that curb cravings for their substances of choice: alcohol and heroin respectively.

12-Step Support Groups

Four participants (E, G, H, and J) reported that Alcoholics Anonymous (AA) and/or Narcotics Anonymous (NA) were influential to sustaining their recovery. These twelve-step groups declare that abstinence is the only road to recovery, and participants

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ascribing to these support groups all shared goals of abstinence from alcohol, cocaine, crack, opiates, and/or heroin. OF his AA/NA experience, participant G shared:

> I heard enough of it, you hear so much of this down talk. I said, you know what, I know I'm going to do better, 'cause I'm definitely not going down this road, you know, people going to these meetings and still using, it was tough. So the NA/AA meetings I did get something out of it; it wasn't something that hit me in the face, I had to extract it...You might want to call it a shortcut, but I picked out the ones [steps] that I knew that mattered [to me].

Participant E shared how AA helps to sustain his recovery:

> So AA has three main aspects to it: there's fellowship, basically networking, doing the steps, and going to meetings. So I do all three of those to the best of my ability, and I incorporate it into a routine....I don't schedule my life around AA, but it's definitely a part of my day. I make myself committed to partake in those three things.

Referring to AA and the contacts that he made through the support group, participant H shared:

> Another big part of my recovery was realizing that people are going through the same thing I'm going through. You

start sharing those emotions with other people and it does

something for you. You don't feel like the biggest shit in

the world, and when you don't, you actually start caring

about yourself.

Giving Back/Helping Others/Volunteerism

A number of participants mentioned that helping other

veterans who are struggling with substance misuse and/or

reintegration is an important component of sustaining their

recovery goals. Providing support to other veterans gave them

purpose and meaning, as they felt that they could uniquely

relate to them. Participant G shared that he is involved in

giving lectures and talks about his experience as a veteran,

which he enjoys. This is a direct example of this participant

engaging within the bounds of the military-civilian disconnect

by providing education to civilians. Of this experience he

shared:

The therapeutic value of that is that you have people that

will listen to you, which a lot of veterans just love -

just to have somebody sit down and listen to what they have

to say and hear their story.

Participant G also spends a significant amount of his spare time

assisting veterans in transition with their finances. Of

helping, he said:

Helping others is an important part of minimizing your

problem and then seeing the reward that you get from

others, no matter how little it is. They don't even have to

say thank you, you know, you help somebody and you know you

helped them, and they're on their way.

Participant K shared that he is also involved with providing

support groups to veterans in transition. Participant H shared

that he currently works with veterans in a supportive position

as a rehabilitation counselor. He also is an AA speaker about

once per month. He shared:

I get a lot out of sharing my story with other people and

to have someone come up to me and say, "I got a lot out of

that, you helped me do this." To be able to give that back,

that's such an honor.

Participant J also works in a full-time position where he

assists veterans in transition, and facilitates support groups.

In terms of how this sustains his recovery, he shared:

Doing what I do, putting my heart in it every day, helping

the guys [veterans] do what I tried to do, really helps.

The people not in recovery can help these guys just as

much, but I have something more. I know what it's like...I

know that you can make a better life because I did.

VA mental health services

While not every participant shared whether they received VA treatment and if they found it helpful or not, (A, E, I, K, L) the other seven participants had mixed responses. Four participants (B, F, G, and J) shared that they received some form of mental health treatment at the VA and found it helpful. Participant B shared that he had two negative experiences with therapists who were unhelpful until his third one, which contributed to him successfully moderating his alcohol use. Participant C shared that he had a number of negative experiences with VA therapists. Participant D shared that he refuses to seek treatment at the VA. Participant H shared that he had a therapist at the VA briefly, but did not find it helpful:

> I didn't get a whole lot out of that. I have a hard time, it just seems more authentic to me when I'm talking to somebody and I'm sharing some stuff with you and you're not looking at your watch and saying, "You have 5 minutes left." I got other people I can talk to.

Activism

Two of the combat veteran participants (C and F) mentioned their involvement with anti-war activism and grassroots organizing. Participant F noted how this allows him to work

through his difficulties in accepting himself following moral injuries that greatly impacted him after he returned home:

> So when I was in Afghanistan halfway through my time [in a civilian administrative position] there about five months through I decided enough of it. I had absolutely enough of it, I was sick of it. I knew so many people at the State Department, I got pointed there with the expectation we were going to wind that war down, not escalate it and we were choosing to escalate the war for political purposes, and I wasn't going to go along with it, so I ended up resigning in protest and that ended up being on the front page of the [newspaper] and I ended up being on the [talk show] and everything else. I became anti-war and in the peace movement and found a lot in it and it has given me a lot of purpose. It has given me a lot of work in that sense. So at first I worked at a think tank as kind of part of the establishment still but I've since kinda had the courage to break away from that and do more of my own thing and embrace more of what I kind of see things more honestly and do it my own way. Now I do that work. I work for [veteran anti-war organization] and some other groups too. I do a lot with the ladies from [anti-war organization]...A lot of activism. Over the past year we have done a lot of delegations and go places where we send teams of veterans

where we feel we can stand in solidarity with people who

are standing up against oppression. So we were just in

Palestine. I got arrested at Standing Rock last year, we

went to Okinawa. We go to Korea, we go to different places,

any place that we feel American government is taking part

in oppression; we are going to stand with the people who

are being oppressed and that is basically what we are

doing. It helps with moral injury as well. Are you familiar

with prolonged exposure therapy? *(Yes.)* So going to

Palestine was like prolonged exposure therapy meets Epcot

Center because what we saw and witnessed and endured in

Palestine was the Israeli Army doing to the Palestinians

exactly what we did to the Iraqis. We saw the Israeli Army

raiding the Palestinian homes, doing the checkpoints,

everything; that is exactly what we did, and so for myself

and a couple of other guys it was so really difficult,

really hard.

Though Participant C pursued anti-war activism and supports his

friends who are involved in this community, he found it too

emotionally draining, and also in conflict with an underlying

pessimistic worldview that he believes was aggravated due to his

experiences being deployed:

I got involved with peace activism and found that I was not

a good activist. I can sit here and rationally talk about

this stuff with you but on the picket line and when I got a

sign in my hands or when I'm at a demonstration and when

I'm being interviewed by somebody, you know, like with a

more live type setting, I just get confrontational and

angry, and I'm just not effective as a communicator and let

emotion rule me, and I don't want to be violent....I was

just too caught up in it and I had to save myself from it

and my sanity....It's cynical. I know that I can't

contribute in the activist world, and personally I think

that everything's fucked. I do believe that we're on a

collision course that's unavoidable. I think the human race

is fucked, but that's a really negative pessimistic stance,

that just happens to be the depressive realism that I

believe in....Which is why I stay away from them

[activists] and I want them to try and make the change that

I gave up on, and when I interact with them I don't want to

bring them down. I hate that I have to admit my stance to

you right now.

Participant C shared more here about how creative expression

provides him with meaning and purpose that helps to sustain his

recovery out of passion:

Now that I've estranged myself from the need to try and

right the wrongs of my past or try and contribute to

something that I helped destroy, instead of that I just

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want to be part of a conversation, and the conversation is

the evolution of metal crafts, metal art, and metal

sculptural art as a medium, the evolution of functional

metal objects in history. That's the artistic evolution

that I want to be commentaried in. I want to leave

something that ends up in a museum or in somebody's

home...that's how I deal with my mortality. As an artist

you can make something that lives on that becomes part of

culture. Why? 2 reasons: fear and I love it. I just love

metal...and finding meaning in all of it. I love what it

represents. I'm terrified of death and being totally

worthless and meaningless and just being another infinite

blip. We're all just infinite blips; we're here for a

flash. But the mortality thing scared me into wanting to do

something that will live on.

Defining Recovery

I read the following definition of recovery to my

participants, noting that though this is a broad definition,

recovery is subjective in nature: "a process of change through

which individuals improve their health and wellness, live self-

directed lives, and strive to reach their full potential"

(Substance Abuse and Mental Health Services Administration,

2017, para. 2). I then asked the participants how they would

define their recovery. Because first-hand accounts of recovery

are not well-represented in the peer-reviewed literature, I

provide all 12 of the participants' responses below.

Participant A:

> Self-Actualization; realizing I'm the subject matter
>
> expert; it's up to me to either accomplish things or not
>
> accomplish things, to want more or not want more: self-
>
> control, really.

Participant B:

> Just get back to being me. Enough of the shenanigans. You
>
> had your fun, now is the time for work, like alcohol is
>
> just gunna be like a temporary fix. It's a Band-Aid on a
>
> sucking chest wound. [It's] not gunna do anything for that
>
> sucking chest wound until you get it properly healed and
>
> taken care of.

Participant C:

> Just my own life experiences. And influence of family and
>
> friends. Like over the years they see it and they're like,
>
> "you're really gunna have another drink today, why are you
>
> doing that?" It's been a slow back and forth gradual
>
> improvement with setbacks and progress. I feel like I know
>
> I'm always going to have issues with addiction,
>
> always...even if I was able to manage without smoking
>
> cannabis, which I don't think I'd like myself there 'cause
>
> I've seen myself after a few months of being off of it and

it's still this ongoing anxiety that I can feel in my

fucking chest all the time and it's always impending

disaster mode, and I worry so much more, and I don't sleep

good. I know even if I was off it for a year I would have

issues, so I just don't want to go down that experimental

route; it's an acceptable addiction.

Participant D:

Me just trying to do anything else besides dwell on it,

'cause if you're busy you can't be home doing something you

shouldn't be doing. I felt really robbed of my high school

education because it was such a bad one. I didn't want to

be that stupid guy anymore, because I didn't feel stupid.

Participant E:

Recovery is about, to me, yeah sure, you do it so you won't

drink anymore, but you keep doing it because it helps so

much, and you get life, life gets back on track and you

learn how to prioritize things. I enjoy learning a lot, I

really do. At this point, I want to have some direction and

whatever, I mean, I still am all over the place, I want to

learn everything about everything and experiment, I don't

know, I just have an interest in that. But recovery for me

is all about growing, you can't stop growing, can't stop

learning, if you stop learning you stop putting yourself in

a place where you're teachable, and if I am not teachable,

then I become more prideful, and with that, I think more

about myself and there's more ego, and then ego runs hand

and hand with self-centeredness, and then self-centeredness

kind of evolves into thinking about woe is me, or I have

this problem, or it's all about me, so I have to continue

staying on top of my game of growing and learning and

connecting with others. It's ok, it's not a bad thing

because it's fun and I'm so busy, my calendar is full all

the time.

Participant F:

Recovery is just like a path I guess, an ongoing process of

not falling backwards. Not slipping back into the same trap

and pitfalls you were in, not going back down the same

paths you were on before, or that lead back to those ways

of life that were just going to continue to send you down a

darkness of ruin.

Participant G:

The first element is you have to know that you can do

better. You have to know that. You don't have to know how,

you don't have to know where, you just have to know that

you can. So I knew that I could do better.

Participant H: "You're not ready 'til you're ready. People can

talk to you 'til you're [sic] blue in the face. Unless you want

to quit and you're committed to that process, it's just not going to work."

Participant I: "Staying true to what is important to me. Stay true to my values and what I hold dear. Don't shy away from it."

Participant J:

> Recovery is a gift. Alcoholics and drug addicts that are sober have an insight into the world that people who aren't, don't. We've seen it from a different view. I think that every day is a gift. I've been in situations where I should be dead, made decisions that were not good. To have survived all of that, managed be here talking to you, wearing a tie, talking to you, contributing to their lives, is a miracle.

Participant K:

> When I'm clean and sober, I smile a lot more. I give a lot more. I'm a lot more involved. People like being around me because when I'm using, people miss me, cause they don't see me. I try to avoid the people that I care about and love, I don't want them to see me- I know right from wrong...I feel so good because I'm not carrying last night's guilt. I'm guilty of some wrong choices seven months ago, but not last night, not in the past seven months.

Participant L: "You gotta want it. You've really gotta want it in your heart, brain, soul. If you don't want it, it ain't gonna happen. This time I'm in. In all the way."

The purpose of this study was to explore the motivating factors for substance use and recovery among the US veteran population. The study's findings illustrate that a majority of participants drank or use drugs for social and recreational reasons prior to joining the military. Frequency of use and misuse increased during and after their time in the service. A majority of participants also shared that they were self-medicating following their return home from the military, including all of the combat veterans, and one noncombat veteran.

In terms of moral injury, all combat veterans and one noncombat veteran reported experiencing one or more moral injuries during their time in the military. Seven of those reported that their substance use was related to self-medicating moral injury. It was significant that a majority of participants reported that they were self-medicating the difficulties with reintegration. Two participants reported self-medicating with substances when returning home due to experiencing survivor's guilt, along with other reasons (participants B and D). While participant F reported using substances in relation to a traumatic loss of one of his buddies who he could not save that he was in an accident with, he survived with an incredible

amount of guilt. He referred to this experience as a moral injury and not as survivor's guilt. Although this event was akin to survivor's guilt, the participant did not construe it in this way, but rather as a moral injury due to his perceptions of feeling guilty that he could not save him.

The study participants shared their recovery stories, and there were a variety of pathways of recovery that helped them sustained their recovery goals. Participants shared goals of both moderation and abstinence from their substance or substances of choice. In the discussion chapter that follows, I will analyze the above findings in more depth, noting their significance to clinical social work practice and policies, describe the study's limitations, and recommend directions for future research.

CHAPTER V

Discussion

Overview of Findings

Statistics suggest that the prevalence of substance use disorders among military veterans returning from Iraq, Afghanistan, and other post 9/11 conflicts has increased since previous Vietnam War estimates (The National Institute on Drug Abuse, 2013). This is likely due to the multitude of contextual combat stressors discussed in the literature review, many of which are unique to these smaller insurgency wars where civilians are more challenging to distinguish from enemy combatants; this was true for Vietnam as well but to a larger extent in post 9/11 wars. While billions of dollars have been funneled into addiction treatment programs for both VA and non-VA organizations, positive treatment outcome rates are lower than desired. While recovery is possible through multiple pathways, there are a large number of veterans who refuse to seek treatment at the VA—or in general—for many reasons, including stigma, distrust in the therapeutic relationship, and past negative experiences in formal treatment.

In an attempt to provide new insights to better address this problem, by giving voice to veterans' personal experiences navigating both substance misuse and recovery, and the military

and mental health systems, this study explored motivating factors for substance use/misuse and recovery among US veterans. To investigate whether one's military experiences had any relationship or impact on one's motivations for substance use/misuse, the study was guided by the following research questions: what motivated veterans to use/misuse substances before, during, and after their military experiences? I also asked participants if they experienced moral injury, and if so, if substance use/misuse motivated them to use/misuse due to the distressing nature of those experiences. Although studies suggest that many veterans use substances to self-medicate stressful military experiences, especially combat stress, I aimed to ask veterans in particular why they chose to use/misuse substances. There were three participants (J, K, and L) who reported using substances heavily or daily prior to entering the military. While their use continued during the military and after, it appeared for these noncombat veterans that their military experiences did not influence their motivation to use; rather, while their use continued, the military culture of drinking and drug use enabled that use, or enabled an increased frequency of use/misuse. Because these veterans were of an older generation, drug use was more frequent in the military than it is now for military personnel.

A majority of the participants shared that prior to the military, most of them used substances for social/recreational reasons. Two participants who noted that they did not like drinking prior to entering the military began drinking heavily during and after their military service. Upon joining the military, social and recreational reasons remained the motivation for some participants, although a number of participants expressed that they used substances due to peer pressure and the fact that using substances, especially alcohol and tobacco, was a part of military culture that was not only socially acceptable, but often ritualized. This was especially true for initiation into this military culture, as well as celebrating deployment returns.

A number of participants shared that they tried alcohol or drugs for the first time during their military experiences, and that their use increased at this time. While many veterans expressed that they did not use substances during deployments abroad in Iraq and Afghanistan, two participants (A and C) shared that engaging in substance use/misuse during their deployments was done for the purpose of stress management. A number of veterans, both combat and noncombat stateside veterans, also expressed the motivation to use/misuse substances to curb boredom or monotony. Upon returning home from their military experiences and becoming veterans, a majority of

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participants shared that their substance use/misuse increased,

and that their motivations were geared toward self-medicating

negative self-states and the challenges of reintegrating into

civilian life. The difficulties here were palpable and numerous

for nearly all of the combat veterans in the sample.

Challenges that caused veterans to self-medicate upon

returning included difficulty maintaining relationships,

insomnia, feeling misunderstood by their relatives, friends, and

loved ones, feeling disconnected from society, and having

trouble obtaining a job or making a smooth transition from

military life to academic student life. The combat veterans

expressed that their substance use/misuse was also related to

self-medicating or escaping from memories from their deployments

that troubled them, namely enduring survivor's guilt, the stress

of being at war, and concerns about engaging in violence during

the war.

Eight participants expressed experiencing moral injury or

moral injuries while being employed by the military; these

participants were all combat veterans except for one stateside

veteran. Moral injuries fall into three categories: those

someone has perpetrated, witnessed, or failed to prevent, all of

which compromise one's values and belief systems (Litz, et al.,

2009). It is notable that one noncombat veteran shared that

while he did not experience moral injury in relation to this

military experiences, he shared that his addiction caused him to experience moral injury. More research should be conducted on the relationship between substance misuse, addiction, and experiencing moral injury. This is worth exploring, as this research has the potential to uncover critical motivating factors (or lack of motivating factors) underlying the recovery process.

Limitations

This study is unique in its qualitative exploration of moral injury, substance use/misuse motivators, and recovery among veterans. Nevertheless, this study had several limitations.

While I attempted to recruit female veterans, I was not able to find any willing participants. Because female veterans endure their own vulnerabilities in the military, they are deemed a special population, and it is important to understand their perspectives on substance use/misuse, recovery, and moral injury. It would be worthwhile to compare their experiences to male veterans and determine what may be unique to female veterans in regard to substance use/misuse, recovery, and moral injury.

Recruitment for this study was challenging. There are various types of military personnel holding various positions in

various branches of the military. Initially, I aimed to find 12 combat veterans for my sample, which was already broad since there are many types of combat veterans. However, due to a limited amount of time and difficulty obtaining 12 combat veterans, I altered eligibility criteria about halfway through the recruitment process to include all veterans. This allowed me to obtain a sample that was large enough for a qualitative study within a limited timeframe. However, it also made the research and data analysis more time-consuming, as there were a multitude of findings on both combat and noncombat veterans. In retrospect, having a mixed sample of combat and noncombat veterans was helpful in that it allowed me to compare the two types of veterans. It was clear that those who experienced combat had more difficulties reintegrating upon being discharged than noncombat veterans. There are comparably more studies on substance use/misuse and on moral injury for combat veteran populations. In fact, it is challenging to find studies that explore substance use/misuse among noncombat veterans, partly because of the dominating emphasis on problems associated with formal treatment of the co-morbidity of substance use disorders and PTSD; these studies are voluminous. Moral injury is a newly emerging concept of interest within social work research, and the limited number of published studies primarily focus on combat veterans only, even though there are a small number that

study moral injury more broadly among civilians. Therefore, when it comes to exploring substance use/misuse trends and motivating factors, and incidences and experiences of moral injury, noncombat veterans are vastly understudied. That the considerable numbers of noncombat veterans are currently underrepresented in these studies is problematic since (a) substance use/misuse is very prevalent within military culture and remains a problem; b) moral injury is a relevant concept to be studied among noncombat veterans for a variety of reasons, perhaps especially due to the hierarchical nature of military rank, and the need to follow orders from one's superiors at the behest of one's conscience, in some instances.

Because the definition of moral injury involves three aspects–perpetration, witnessing/learning about, or failing to prevent acts that compromise one's values—anyone could potentially experience moral injury anywhere, whether they are in the military or not. In the US cultural psyche, moral injury appears to be automatically understood as occurring in war; furthermore, people more often seem to associate it only with the perpetration of morally questionable acts, and may not recognize the witnessing or failing to prevent acts also fall under the umbrella of moral injury. The noncombat veterans in this study recognized it this way, even though I read the full, comprehensive definition. It appears that those engaging in

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combat are at a higher risk of being in a position of experiencing this due to the nature of warfare. But there is a distinguishable difference between those who experience it and walk away from it or brush it off, and those whose lives are forever impacted by it due to the guilt and shame that they carry with them following the event(s). Nevertheless, more research is needed to operationalize the term moral injury. This study was limited in the sense that the veterans were not assessed for moral injury; rather, I asked them to assess themselves. Because they subjectively determined whether they had experienced it or not, there were varying degrees of moral injury represented in terms of severity. This points to the current problems with defining and operationalizing the term. The same is true for the term *recovery* to define those overcoming substance use disorders and addictions. This term may not resonate with everyone who has overcome addiction.

Another limitation of this explorative study concerns the validity of participant responses. I asked a variety of provocative questions, which are emotionally laden and not neutral, such as questions concerning moral injury, recovery, reintegration into civilian life, and military experiences. Due to the military-civilian disconnect, and the controversial nature of these questions, it is possible that participants may have been reserved in their responses, uncomfortable sharing

this content with a stranger, or withholding of particular

details that they may have felt uncomfortable sharing with an

outsider civilian. Overall, it appeared that participants were

forthcoming; while some shared less than others, they could take

solace in the fact that their responses would remain

confidential and free of identifying information. Additionally,

some of my questions may have been leading in nature, and may

have swayed participants to respond affirmatively to questions

such as, "Do you feel like your military experiences motivated

your substance use?" and "Do you feel like your experiences of

moral injury caused you use substances?" Because I was exploring

these particular relationships, it was challenging to create

questions that would be a less leading in nature. There was also

a range of self-awareness among the participants, and it was

clear that some participants had thought deeply about the

questions asked, while others had not previously spent as much

time considering the content of the questions. Participants may

have also chosen–consciously or unconsciously—to provide answers

that were socially acceptable, and may have had reservations

about sharing certain details for concern of being judged,

alienated, or abnormal. Because I am a female, and younger than

all of the participants, their perceptions of my identity may

have caused them to share or not share certain details that they

may have felt more inclined to share with men, older

individuals, and especially other veterans. Nevertheless, the participants provided rich details about their military experiences in relation to substance use/misuse, recovery, and moral injury.

Directions for Future Research

This study elicited three major avenues for future research. These include more research on substance use/misuse, recovery, and moral injury. In terms of substance use/misuse, updated statistics about rates of use among both active duty personnel and veterans will be helpful to determine how they have changed since the Institute of Medicine's 2012 report, which included anonymous surveys about alcohol and drug use. It would be worthwhile to replicate this study with a sample of combat veterans, or noncombat veterans. One could also replicate this study and focus on veterans from a particular army branch to obtain findings that are more specific and less varied in nature. Studies could also limit variability by choosing to focus on a particular substance of choice.

This study illuminated some interesting trends concerning motivating factors for substance use/misuse and recovery among the US veteran population. Though there are dozens of studies on the prevalence of substance use/misuse among military personnel and veterans, many of which target treatment effectiveness and

the comorbidity of PTSD and substance misuse, veterans' voices and perspectives within social work research are often unheard. This study intended to account for that. It also became clear that while the emphasis on the comorbidity of substance use disorders and PTSD for study is important, veterans are also self-medicating for reasons that may be unrelated to or additional to PTSD. More studies are needed to explore associations between substance use/misuse and topics such as survivor's guilt, depression, anxiety, reintegration difficulties, and other relationships. It is important, as participant D mentioned, that survivor's guilt is not "lumped into the PTSD" diagnosis. If survivor's guilt is not addressed within the confines of PTSD, is it addressed at all, and how so?

Because participants turned to substance use/misuse often in lieu of mental health treatment services for veterans due to stigma, it would be worthwhile to conduct a study about how often this occurs and why, in order to prevent it and incentivize engagement in treatment, and more positive treatment outcomes. Due to low rates of positive treatment outcomes, it would also be worthwhile to conduct studies that survey veterans on their positive recovery experiences both in and out of formal treatment, and to explore their successes and shortcomings with engaging in formal treatment in order to improve upon it.

Finally, while moral injury is a complex, subjective human experience that is not new, the empirical study of moral injury in social work research and related fields has seen increased interest in the last five years (Haight, Sugrue, Calhoun, & Black, 2016, p. 190). There is limited research that explores the associations between moral injury and substance use, which this study aimed to augment. In order to address the lack of veterans' voices and perspectives within social work research, it will be important for more studies on this topic to be conducted and published, including quantitative, qualitative and mixed methods studies. Though they can at times be challenging to fund and maintain, longitudinal studies concerning veterans' relationship with substance use/misuse (and perhaps how it may relate to moral injury) would be helpful to note the evolution of these relationships over time.

In addition, more quantitative studies on veteran's perspectives would benefit the field of social work research in the following ways: larger, random samples would allow the researchers to make inferences about the population based on the generalizability of the data. Researchers could answer research questions such as, "What are the most common motivating factors for substance use/misuse and recovery among the veteran population?" Using the most reliable measures of moral injury, researchers could also ask, "How often do instances of moral

injury motivate US military personnel and/or veterans to use or misuse substances?"

This study's findings inform clinical social work practice. They illuminate the need for clinicians to embrace a biopsychosocial approach to grasp the multiple factors that may influence a veteran to use/misuse substances, and to determine if early life experiences may put him/her at a higher risk for developing a SUD. It is possible that military experience(s) may have impacted or influenced this risk. The findings also highlighted the unique reasons as to why these veterans may choose to use/misuse substances, and how such reasons may be related to their military experiences. This is especially true for combat veterans, though not limited to this population. The findings emphasized self-medication for reintegration difficulties, as a substitute for mental health treatment, and for experiences of moral injury. Moral injury is a concept that not all clinicians may be familiar with, and it is important that clinicians educate themselves about how it manifests within individuals.

Because many veterans choose to seek mental health treatment outside of the VA, it is the responsibility of clinical social workers in non-federal behavioral health settings to educate themselves on US veterans and military

culture, as well as the unique challenges and experiences that this population may endure so that they may welcome them and serve their needs.

This study will hopefully inform social workers within the VA setting as well by giving voice to veterans and their positive recovery experiences. If Litz and other PTSD researchers who have taken an interest in moral injury are correct in discovering that shame, guilt, and remorse are different and distinguishable from fear-based PTSD and cause great distress, then how might social workers and other mental health professionals account for addressing these moral conundrums that veterans endure? What if, in some instances, moral injury *is* the culprit that is contributing to low positive treatment outcomes, chiefly because it is unaddressed and overlooked in the psychological setting? If substance use/misuse plays a large role in self-medicating these moral emotions, is moral injury a problem in addition to PTSD symptomology, instead of PTSD symptomology, or both? While it may likely be all of the above, what are the clinical treatment implications for addressing moral injury? This study's focus on moral injury (and its relationship with substance use/misuse) is important in its psychoeducational value for clinical social workers who work in VA settings because it is rarely broached there. Wood (2016)

noted moral injury research has had minimal influence at the federal level so far:

> The San Diego program is the only government initiative I could find that specifically addresses moral injury. There is nothing like it in all of the Defense Department's medical facilities or at the VA, beyond the kinds of research that Shira Maguen and a few others are doing and some individual VA therapists who provide moral injury therapy. In fact, the world of those working with war-related moral injury is exceedingly small. Many of the published research on moral injury, for instance, lists the same people: Bill Nash and Brett Litz; Amy Amidon; Matt Gray of the University of Wyoming; NYU clinical psychologist Maria Steenkamp; Matthew Friedman of the VA's National Center for PTSD; Richard Westphal, a former navy psychiatric nurse; and a few others. "It's only us," Litz told me. It's a small world." (p. 255).

These findings also inform social work policy. The participant responses illuminate the already established problem of stigma as an obstacle to mental and behavioral health treatment. Clinical social workers share a responsibility to dismantle stigma by reviewing policies and evaluating treatment programs within and outside of the VA in order to enhance positive treatment outcomes among those struggling with

substance use disorders. Part of this process includes embracing

the fact that there are multiple pathways of recovery for

veterans, and of exploring the multitude of options, while

giving voice to veterans who have overcome substance use

disorders, and conducting more research on the correlates of

recovery.

REFERENCES

American Psychiatric Association. (2013). Diagnostic and
statistical manual of mental disorders: DSM-5 (5th ed.).
Arlington, VA: American Psychiatric Association.

American Society of Addiction Medicine. (2016). Definition of
addiction. Retrieved from http://www.asam.org/quality-
practice/definition-of-addiction.

Barry, C., McGinty, E., Pescosolido, B., & Goldman, H. (2014).
Stigma, discrimination, treatment effectiveness, and
policy: public views about drug addiction and mental
illness. *Psychiatric Services*. Retrieved from
http://ps.psychiatryonline.org.libproxy.smith.edu:2048/doi/
full/10.1176/appi.ps.201400140.

Brancu, M., Straits-Tröster, K., & Kudler, H. (2011). Behavioral
health conditions among military personnel and veterans:
Prevalence and best practices for treatment. *North Carolina
Medical Journal, 72,* 54-60. Retrieved from
https://www.ncbi.nlm.nih.gov/pubmed/21678693.

Bray, R. M., K. L. Rae Olmsted, J. Williams. (2012). Misuse of
prescription pain medications in US active-duty service
members: From recruitment to returning troops. In *Pain*

syndromes—from recruitment to returning troops, edited by

B. K. Wiederhold, 91. Amsterdam: IOS Press.

Burnett-Zeigler, I., IIgen, M., Valenstein, M., Zivin, K.,

Gorman, L., Blow, A., Duffy, S., & Chermack, S. (2011).

Prevalence and correlates of alcohol misuse among returning

Afghanistan and Iraq Veterans. *Addictive Behaviors, 36,*

801-806. Retrieved from

http://www.sciencedirect.com.libproxy.smith.edu:2048/scienc

e/article/pii/S0306460311000074?via%3Dihub.

Castro, C. A., Kintzle, S., & Hassan, A. M. (2015). The combat

veteran paradox: Paradoxes and dilemmas encountered with

reintegrating combat veterans and the agencies that support

them. *Traumatology, 21,* 299-310.

Cornish, M. A., Thys, A., Vogel, D. L., & Wade, N. G. (2014).

Post-Deployment difficulties and help seeking barriers

among military veterans: insights and interventions

strategies. *Professional Psychology: Research and Practice,*

45(6), 405-409.

Cougle, R. J., Bonn-Miller, M. O., Vujanovic, A. A., Zvolensky,

M. J., Hawkins, K. A. (2011). *Psychology of Addictive*

Behaviors, 25, 554-8. Retrieved from

http://libproxy.smith.edu:2048/login?url=http://search.ebsc

ohost.com/login.aspx?direct=true&db=edo&AN=66800802&site=ed

s-live&scope=site.

Currier, J. M., Holland, J. M., Jones, H. W., & Sheu, S. (2014).

    Involvement in abusive violence among Vietnam veterans:

    Direct and indirect associations with substance use

    problems and suicidality. *Psychological Trauma: Theory,*

    Research, Practice, and Policy, 6, 73-82. Retrieved from _

The Department of Defense. (2015). 2015 Demographics: profile of

    the military community. Retrieved from

    http://download.militaryonesource.mil/12038/MOS/Reports/201

    5-Demographics-Report.pdf.

Edlund, M. J., Steffick, D., Hudson, T., Harris, K. M., &

    Sullivan, M. (2007). Risk factors for clinically recognized

    opioid abuse and dependence among veterans using opioids

    for chronic non-cancer pain. *Pain, 12,* 355-362.

Elliott, J. (2005). *Using narrative in social research:*

    qualitative and quantitative approaches. London: Sage

    Publications.

Frankfurt, S., & Frazier, P. (2016). A review of research on

    moral injury in combat veterans. *Military Psychology, 28,*

    318-330. Retrieved from

    https://www.researchgate.net/publication/303502453_A_Review

    _of_Research_on_Moral_Injury_in_Combat_Veterans.

Gray, M. J., Schorr, Y., Nash, W., Lebowitz, L., Amidon, A.,

    Lansing, A., ... Litz, B. T. (2012). Adaptive disclosure:

    An open trial of a novel exposure-based intervention for

service members with combat-related psychological stress

injuries. *Behavior Therapy, 43,* 407-415. Retrieved from

http://www.sciencedirect.com/science/article/pii/S000578941

1001298?via%3Dihub.

Hart, C. (2017). Busting the drug addiction myth. Retrieved from

https://www.opensocietyfoundations.org/voices/busting-drug-

addiction-myth.

Haight, W., Sugrue, E., Calhoun, M., & Black, J. (2016). A

scoping study of moral injury: Identifying directions for

social work research. *Children and Youth Services Review,*

70, 190-200.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting,

D. I., & Koffman, R. L. (2004). Combat duty in Iraq and

Afghanistan, mental health problems, and barriers to care.

The New England Journal of Medicine, 351. Retrieved from

https://www.law.upenn.edu/live/files/4743-hoge-2004pdf.

Institute of Medicine. (2010). Returning home from Iraq and

Afghanistan:

preliminary assessment of readjustment needs of veterans,

service members, and their families. Washington, DC: The

National Academic Press. Retrieved from

http://www.nap.edu/catalog/12812.html.

Institute of Medicine. (2012). Substance use disorders in the US

armed forces. Washington, DC: The National Academies Press.

Retrieved from https://www.nap.edu/catalog/13441/substance-
use-disorders-in-the-us-armed-forces.

Jacobson, I. G., Ryan, M. K., Hooper, T. I., Smith, T. C.,
Amoroso, P. J., Boyko, E. J., & ... Bell, N. S. (2008).
Alcohol use and alcohol-related problems before and after
military combat deployment. *Journal of the American Medical
Association, 300,* 663-675. Retrieved from
https://jamanetwork.com/journals/jama/fullarticle/182376.

Jakupcak, M., Tull, M. T., McDermott, M. J., Kaysen, D., Hunt,
S., & Simpson, T. (2010). PTSD symptom clusters in relation
to alcohol misuse among Iraq and Afghanistan war veterans
seeking post-deployment VA health care. *Addictive
Behaviors, 35,* 840–843. Retrieved from
http://www.sciencedirect.com/science/article/pii/S030646031
0001024?via%3Dihub.

Killgore, W. D., Cotting, D. I., Thomas, J. L., Cox, A. L.,
McGurk, D., Vo, A. H.,... Hoge, C. W. (2008). Post-combat
invincibility: Violent combat experiences are associated
with increased risktaking propensity following deployment.
Journal of Psychiatric Research, 42, 1112–1121. Retrieved
from
http://www.sciencedirect.com/science/article/pii/S002239560
8000034?via%3Dihub.

Lewis, M. (2015). *The biology of desire: Why addiction is not a disease.* New York: Public Affairs.

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review, 29,* 695-706. http://www.sciencedirect.com.libproxy.smith.edu:2048/science/article/pii/S0272735809000920?via%3Dihub.

Litz, B. T., Lebowitz, L., Gray, M. J., & Nash. W., P. (2016). *Adaptive disclosure: a new treatment for military trauma, loss, and moral injury.* New York: The Guilford Press.

Maguen, S., Vogt, D. S., King, L. A., King, D. W., Litz, B. T., Knight, S. J., & Marmar, C. R. (2011). The impact of killing on mental health symptoms in Gulf War veterans. *Psychological Trauma: Theory, Research, Practice, and Policy, 3,* 21-26. Retrieved from https://www.researchgate.net/publication/232573899_The_Impact_of_Killing_on_Mental_Health_Symptoms_in_Gulf_War_Veterans.

Mate, G. *In the realm of hungry ghosts: Close encounters with addiction.* California: North Atlantic Books.

The Moral Injury Project (2016). What is moral injury. Retrieved from http://moralinjuryproject.syr.edu/.

The National Center for PTSD. (2017). Treatment of Co-Occurring

    PTSD and Substance Use Disorder in VA. Retrieved from

    https://www.ptsd.va.gov/professional/co-

    occurring/ptsd_sud_veterans.asp.

The National Institute on Drug Abuse. (2013). Substance abuse in

    the military. Retrieved from

    https://www.drugabuse.gov/publications/drugfacts/substance-

    abuse-in-military.

The National Institute on Drug Abuse. (2016). The science of

    drug abuse and addiction: The basics. Retrieved from

    https://www.drugabuse.gov/publications/media-guide/science-

    drug-abuse-addiction-basics.

Nieuwsma J. A., Walser, R. D., Farnsworth, J. K., Drescher, K.

    D., Meador, K. G., & Nash. W. P. (2015). Possibilities

    within acceptance and commitment therapy for approaching

    moral injury. *Current Psychiatry Reviews, 11,* 193-206.

    Retrieved from

    https://s3.amazonaws.com/academia.edu.documents/39750021/20

    14.Nieuwsma.Possibilities_of_ACT_for_moral_injury.pdf?AWSAc

    cessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1512091186&Signature

    =vYle1iKGAlWTQoav9jWWVPH%2BvuY%3D&response-content-

    disposition=inline%3B%20filename%3DPossibilities_within_Acc

    eptance_and_Comm.pdf.

Peele. S. (2000). What addiction is and is not. Retrieved from
        http://www.peele.net/lib/mistakennotions.html.

Robins, L. N., J. E. Helzer, & D. H. Davis. (1975). Narcotic Use
        in southeast Asia and afterward. An interview study of 898
        Vietnam returnees. *Archives of General Psychiatry, 32,* 955-
        961. Retrieved from
        https://jamanetwork.com/journals/jamapsychiatry/article-
        abstract/491395.

Seal, K. H., Cohen, G., Waldorp, A., Cohen, B. E., Maguen, S., &
        Ren, L. (2011). Substance use disorders in Iraq and
        Afghanistan veterans in VA healthcare, 2001-2010:
        Implications for screening, diagnosis and treatment. *Drug
        and Alcohol Dependence, 116*, 93-101. Retrieved from
        http://www.drugandalcoholdependence.com/article/S0376-
        8716(11)00026-3/pdf.

Seal, K. H., Maguen, S., Cohen, B., Gima, K. S., Metzler, T. J.,
        Ren, L.,…Marmar, C. R. (2010). VA mental health services
        utilization in Iraq and Afghanistan veterans in the first
        year of receiving new mental health diagnoses. *Journal of
        Traumatic Stress, 23*, 5-16. Retrieved from
        https://msrc.fsu.edu/system/files/Seal%20et%20al%202010%20V
        A%20mental%20health%20services%20utilization%20in%20Iraq%20
        and%20Afghanistan%20veterans%20in%20the%20first%20year%20of
        %20receiving%20new%20mental%20health%20diagnoses.pdf.

Shay, J. (2014). Moral injury. *Psychoanalytic Psychology, 31,* 182-191. Retrieved from https://www.law.upenn.edu/live/files/4602-moralinjuryshayexcerptpdf.

Sherman, N. (2015). *Afterwar: healing the moral wounds of our soldiers.* New York: Oxford University Press.

Stone, A. L., Becker, L. G., Huber, A. M., & Catalano, R. F. (2012). Review of risk and protective factors of substance use and problem use in emerging adulthood. *Addictive Behaviors, 37,* 747-775. Retrieved from https://www.sciencedirect.com/science/article/pii/S0306460312000810.

Substance Abuse and Mental Health Services Administration. (2017). Recovery and Recovery Support. Retrieved from https://www.samhsa.gov/recovery.

Substance Abuse and Mental Health Services Administration. (2012). Behavioral health issues among Afghanistan and Iraq U.S. war veterans. *In Brief, 7,* 1-8.

Substance Abuse and Mental Health Services Administration. (2014). *Trauma-Informed Care in Behavioral Health Services.* Treatment Improvement Protocol (TIP) Series 57. Rockville, MD.

Substance Abuse and Mental Health Services Administration. (2017). Veterans and Military Families. Retrieved from https://www.samhsa.gov/veterans-military-families.

US Census Bureau. (2016). Facts for features: Veterans day 2016: Nov. 11. Retrieved from https://www.census.gov/newsroom/facts-for-features/2016/cb16-ff21.html.

US Department of Health and Human Services (2016). Office of the surgeon general, *facing addiction in America: The surgeon general's report on alcohol, drugs, and health.* Washington, DC: US Department of Health and Human Services.

Valentine, T. (2016). Vietnam war draft. Retrieved from http://thevietnamwar.info/vietnam-war-draft/.

Villa, L. (n.d.). Shaming the sick: addiction and stigma. Retrieved from http://drugabuse.com/library/addiction-stigma/.

Wilk, J. E., Bliese, P. D., Kim, P. Y., Thomas, J. L., McGurk, D., & Hoge, C. W. (2010). Relationship of combat experiences to alcohol misuse among U.S. soldiers returning from the Iraq War. *Drug and Alcohol Dependence, 108,* 115–121. Retrieved from http://www.sciencedirect.com/science/article/pii/S0376871609004396.

Wood, D. (2016). *What have we done: The moral injury of our longest wars.* New York: Little, Brown and Company, Hachette Book Group.

Yager, T., Laufer, R., & Gallops, M. (1984). Some problems associated with war experience in men of the Vietnam generation. *Archives of General Psychiatry, 41,* 327–333. Retrieved from https://jamanetwork.com/journals/jamapsychiatry/article-abstract/493304.

Appendix A Table 1

Demographic Information

P	Age	Race	Ethnicity	Economic Status	Education (highest)	Service Branch	Rank	MOS/Rating (in Navy)	Combat Theater
A	33	African-American	African-American	Low Class	Masters candidate	Army	Sergeant E-5, NCO	Truck Driver	Iraq
B	37	Hispanic	Hispanic	Middle, Working Class	Masters candidate	Marine Corps; Army Reserves	Lance Corporeal E-3, junior NCO	Supply (for both)	Iraq
C	36	Caucasian	Scottish, English, Irish	Working Class	Associates degree	Army National Guard; Army	Sergeant E-5, NCO	Guard: Infantryman; Army: Fire Support Specialist	Afghanistan; Iraq
D	29	Caucasian	Scottish, Polish	Working Class	Masters candidate	Army; Army Reserves	Specialist, E-4 (Special Forces Unit)	Army: Computer/Detection Systems Repairer; Reserves: Geospatial Intelligence Imagery Analyst	Afghanistan
E	32	Asian & Hispanic	Cuban, Korean	Middle Class	Master's level	Army; Army National Guard (current)	Platoon Sergeant E-7	Infantryman (both)	Afghanistan, Iraq
F	43	Caucasian	German, Spanish, Irish	Upper Middle Class	Bachelors level	Marine Corps; Marine Corps Reserves	Captain, Commissioned Officer	Combat Engineer	Iraq
G	65	African-American	Jamaican, Portuguese, French	Working Class	High School	Army	N/A	Field Wireman	Vietnam
H	37	Caucasian	English, Irish	Middle Class	Bachelors level	Marine Corps	N/A	Bulk Fuel Specialist	N/A
I	38	Caucasian	English, Irish, French-Canadian	Middle Class	Master's level	Army	Specialist, E-4	Field Medic; Mental Health Specialist	N/A
J	58	Caucasian	English, German	Poor, low income	Bachelors level	Marine Corps	Corporeal E-4	Combat Engineer	N/A
K	63	Caucasian	Italian	Working Class	High School	Navy	N/A	Boatswain's Mate	N/A
L	54	Caucasian	Polish, French	Low Class	High School	Marine Corps	N/A	Rifleman	N/A

Appendix B

Recruitment Email

Hello _____,

    I hope that you are doing well! I write to ask for your potential assistance with something that I am working on.

    I'm in the process of obtaining my MSW from Smith, and I am conducting an explorative, qualitative study concerning veterans and their narratives on their substance use and recovery.

    I focus on motivating factors for use and how military involvement may or may not have been related to their substance use/misuse. I plan to conduct 60-90 minute semi-structured interviews.

    I write to ask if you know any organizations or individuals that would be interested in participating. They can be located anywhere in the US - I can Skype with participants. *See the attached flyer for information about the study and eligibility. All identifying information will be kept confidential.

    I hope that you may be able to assist me. I know that I'm asking a lot - but I hope and think the study will be illuminating and important. If you have any questions, please do not hesitate to contact me via email.

    Thank you for your time. I look forward to your response. Please feel free to circulate anywhere you think would be appropriate, or forward this email to others.

Chelsea C. Faria XXX-XXX-XXXX

Exploring Motivating Factors for Substance Use and Recovery among Veterans

Volunteers Needed for Research Study

Purpose

- This study is concerned with humanizing the experience of Veterans by giving voice to their recovery narratives to fight stigma, as well as explore their military experiences.

- Your contributions may benefit Veterans by strengthening our understanding of Veteran's motivation(s) to use substances.

Method

- I am looking for Veterans to partake in semi-structured 60-90 minute interviews about their experiences with substance use and recovery.
- All identifying information will be kept confidential.
- Interviews will be completed in person at the VFW in Northampton, MA, Skype, or phone.
- If in person, I will provide food and coffee or tea.
- This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Who is Eligible?

- All Veterans who…

- Have had a relationship with substances of any kind (while in the military and/or in one's life) and consider yourself to now be in "recovery" - this is subjective, and might mean that you noticed that you were leaning on substances, and later decided to moderate this, or become abstinent from one or more substances.

Focus

- What are the motivating factors for substance use and recovery in the military population?

- Was your relationship with substances related to military experience in any way? If so, how? If not, what motivated you to use?

- How have military culture, moral injury, or self-medication been relevant factors, if at all?

If interested, please contact Chelsea C. Faria, on or before March 20th, 2017 at xxx-xxx-xxxx

(email address)

Biographical Sketch

- I am currently a student at the Smith College School for Social Work and am a candidate for a Master's in Social Work in August of 2017. I also intern at the Substance Use Disorder Clinic at the VA in Leeds, MA.

Appendix D

HSR Approval Letter

SMITH COLLEGE

School for Social Work

Smith College

Northampton, Massachusetts 01063

T (413) 585-7950   F (413) 585-7994

January 27, 2017

Chelsea Faria

Dear Chelsea,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.
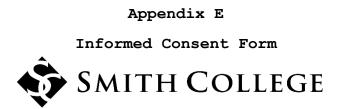

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Michael Murphy, Research Advisor

SMITH COLLEGE

2016-2017

Consent to Participate in a Research Study

Smith College School for Social Work ● Northampton, MA

………………………………………………………………………………….

Title of Study: An Explorative Study on Substance Use & Veterans

Investigator(s): Chelsea C. Faria, ccfaria@smith.edu

………………………………………………………………………………….

Introduction

- You are being asked to be in a qualitative research study concerning the experiences of Veterans who consider themselves to be in recovery from drugs and/or alcohol or a behavioral addiction.
- You were selected as a participant because you are a Veteran, are 18 years or older, and consider yourself to be in some form of recovery from an addiction that you feel interfered with your daily functioning for one year or longer.
- I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to explore the unique individual narratives of those who are in recovery from an addiction in order to discover new insights into veteran's unique motivating factors to engage in substance use. The study also aims to highlight individual's resiliencies as testimonies to the stigmatized nature of addiction. What does recovery look like for those who are working toward recovery from an addiction? How did you successfully support yourself in this, and what were the obstacles that you experienced in possibly attaining substance use treatment and maintaining recovery in the process?

- This study is being conducted as a research requirement for my master's in social work degree from the Smith College School for Social Work.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will meet with me for an interview for 60-90 minutes concerning drug and/or drinking problem unique experiences in overcoming addiction, and you will be audio-recorded. I will ask you some open-ended questions. I may also ask follow-up questions to make sure I understand everything you tell me. After we're done I will type up the interviews and use what you've told me for my thesis study. We will meet at a local private office, for instance, at a local veteran's support office. You can request a summary of the study. I will use the information you give me but will not use your name to protect your privacy. I will write my theses sometime in the spring, and can mail you a summary of the study in July.

Risks/Discomforts of Being in this Study

- The study has the following risk: Because I will be asking you questions about your past experiences with addiction, it is possible that some of the questions may be emotionally challenging or triggering. Please feel free to answer the questions as honestly as possible. You have the right to decline to answer any questions that you may not feel comfortable answering, or even ending your participation at any point.
- If you feel that that you would benefit from follow-up support services, you may refer to the attached reference guide of mental health crisis and outpatient services in the local area.

Benefits of Being in the Study

- The benefits of participation include a confidential, safe space with which to process and reflect on your experiences with addiction and recovery. Because the study will be distributed, you may feel a sense of contribution and hope-giving to others who may be struggling with addiction who read you story, or serve as a meaningful testament against stigmatizing discourses on addiction. Being in this study may also help you to learn more about how you are coping with your addiction. I will provide juice and a light, healthy snack.
- The benefits to social work and society are: 1) providing alternative stories in the face of stigmatizing notions that those struggling with addiction cannot overcome it 2) contributing to the literature of addiction studies by publicizing uncommonly voiced recovery narratives, and 3) inspiring conversations surrounding policy reform in addiction treatment practices, particularly in terms of highlighting the obstacles to recovery.

Confidentiality

- Your participation will be kept confidential, which means that no one but me will know that you participated, unless you tell someone. Absolutely no identifying information about you will be published in the study. I will change your name, and the interview transcripts will be kept on a flash drive secured in a locked filing cabinet at the researcher's home. Only me and my thesis advisor will have access to the transcripts, and I won't tell even my supervisor your name. The records of this

study will be kept strictly confidential. The audio recordings of the study will not be heard by anyone except me. I will store all research materials including recordings, transcriptions, analyses and consent/assent documents in a secure location for three years according to federal regulations. In the event that I need materials beyond this period, I will keep them secure until I no longer need them, and then will destroy them. All electronically stored data will be password protected during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by March 1, 2017. After that date, your information will be part of the thesis report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Chelsea Faria, at   or by telephone at   5-   If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the above information. You will be given a signed and dated copy of this form to keep. You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

…………………………………………………………………………………….

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

…………………………………………………………………………………….

1. I agree to be [audio or video] **taped for this interview:**

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____   Date: _____

Signature of Researcher(s): _____   Date: _____

Appendix F

Interview Questions

Chelsea C. Faria   12/17/2016

Smith College School for Social Work

Interview Guide

[Bulleted items to be used if participant needs prompts to answer open-ended questions]

1. Demographics

-Age, socioeconomic status, ethnicity/race, education, household composition, employment status

2. Tell me about yourself.

-Where are you from?

-Where did you grow up?

-What was your family like growing up?

-Do you have a trauma history?

3. Is there a history of substance use in your family? If so, please describe.

-Is/was anyone in recovery?

-Any mental health diagnoses in you or your family?

4. Please describe why you decided to join the military.

-Were you recruited?

-Tell me your MOS and what you did while in the military.

-What did you enjoy about being in the military?

-What did you not like about it?

5. Describe your substance use history including frequency, date of first use, duration and patterns of use.

-What are your substance(s) of choice?

-Can you identify triggers that lead to use?

6. Describe how this changed when you were in the military, if at all.

-Did you start using more, or begin using certain substances while in the military?

-How did it change when you returned from your military experience, if at all?

-What were the factors that motivated you to use?

-Do you feel that using served a purpose?

-If so, what was its purpose for you?

7. Moral Injury is defined by the Moral Injury Project as "the damage done to one's conscience or moral compass when that person perpetrates, witnesses, or fails to prevent acts that transgress their own moral and ethical values or codes of conduct."

-Have you heard of this before? Where did you hear about it?

-Did you experience this while in the military? If so, please describe this and what it was like for you. How was your daily life affected by this?

-Would you say that your substance use had any relationship with this?

8. When did you realize that using was interfering with your daily functioning?

-When you began seeking help for your addiction, what did that look like for you?

-What forms of help did you seek?

-Please describe any and all help that you sought out, including formal and informal treatment.

-Please describe any treatment barriers or obstacles that you experienced to your recovery process.

9. Did you experience stigma or negative attitudes and judgments about your use from peers, family, significant others, and those working within the treatment system?

-Give some examples of what this stigma looked like.

-How do you believe that people perceived you?

-How was it different from the way that you perceived yourself?

-How did you respond to it?

-How would you say, if at all, it contributed to your relationship with your recovery?

10. What did you find most helpful and sustaining in your recovery process?

-Please include individuals, types of treatment, relationships with therapists, medication-assisted treatment, 12-step meetings, detoxes, harm reduction supports, mentors, sponsors, abstinence, and other things that you can think of.

-What lifestyle changes did you make, if any? Did your recovery lead to any new coping skills, interests, hobbies, recreational or volunteer opportunities?

-What personal values, commitments, hopes and dreams sustained you throughout your recovery process?

-Do you have a supportive network of individuals in recovery with whom you communicate with regularly?

11. Substance Abuse and Mental Health Services Administration (SAMHSA) broadly defines recovery as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (2017, para. 2). I am wondering what you think about this definition. I am also curious as to how you understood recovery to be defined in the larger society, and how your treatment providers defined it. Was their definition cognizant of being specific to the individual, or requiring the individual to fit into it. I am wondering about if they ever asked you about how you defined your own recovery. How would you personally define it for yourself?

12. How often do you share your recovery story with others?

-Is being in recovery a part of your social identity?

-If you work, is your boss and co-workers aware that you are in recovery?

-Did you share your story with them? Why or why not?