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Counseling Addicted Veterans: What to Know and How to Help

Cynthia A. Briggs and Stephanie Reneson

Briggs, Cynthia A., is an Assistant Professor at Winona State University. Reneson, Stephanie is a graduate student at Winona State University. Cynthia and Stephanie share a professional interest in providing effective counseling services to military professionals.

Addiction can manifest in any client population. Thus community-based counselors in all areas of specialization must be prepared to address addiction issues as they arise in their clients. Addiction is a powerful illness capable of destroying lives, particularly as permanent sobriety may take multiple attempts. For most addicted individuals, asking for help is a difficult task. Stigma and shame are hindrances to finding assistance. In addition, losing credibility, rank, family, and friends are grave concerns. These concerns are particularly problematic for addicted veterans of the Armed Forces (Campbell, 2008). Veterans, especially those who have been deployed, are often left with emotional and psychological wounds treated by “self-medication” or excessive alcohol and/or drug use (Hazelden Foundation, 2007).

Franklin (2009) challenged social workers with a call to action to meet the mental health needs of returning vets from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). Unfortunately, in this editorial, the author completely failed to acknowledge the addiction needs of veterans even though this population demonstrates heavier use of alcohol and other drugs when compared to non-veterans, and mental illness and addiction often go hand-in-hand (Wagner, Federman, Dai, Harris, & Luna, 2007). There has been no call to action to serve addicted veterans in the counseling profession, even though the need is great. Most troubling, there is a dearth in counseling literature about the needs of addicted veterans. Thus counselors may be left unprepared and unaware. This article serves as a call to action for counselors to meet the needs of addicted veterans of the OEF/OIF wars. The authors provide an overview of the significant substance abuse and addiction problems experienced by vets returning from combat zones. Specific interventions will be discussed, particularly employing bibliotherapy and distance counseling as a means for reaching vets who may not seek treatment through traditional venues (e.g., the Veterans Administration or traditional face-to-face counseling). These interventions are meant to encourage community counselors across settings to apply their clinical knowledge to assisting this most deserving of populations.

Overview of the Problem: OEF/OIF Veterans and Addiction

Veterans returning from OEF/OIF demonstrate significant problems with regard to substance use and addiction. While the U.S. Department of Veterans Affairs (VA) remains the primary source of counseling services for these vets, many do not seek help there due to stigma or red tape. “Veterans need an extra safety net to keep them from falling through the cracks... going to Veteran’s Affairs isn’t easy” (Thorp, 2009). In addition, the VA is simply overwhelmed with demand. Record suicide rates, post traumatic stress disorder, substance use, and other mental health needs for OEF/OIF veterans are significant, and the VA struggles to meet these needs (Klein, 2008). Thus, community-based counselors are perfectly positioned to fill gaps in service.

Specific statistics help convey the significance of this problem. The VA (2009) estimates that as of September 20, 2008, there were nearly one million living veterans of OEF/OIF. Just under half of these vets utilized VA services in 2008. In addition to OEF/OIF vets, the VA served nearly eight million veterans of other wars and non-combat vets in 2008. Clearly, the client population is huge. Among those served, mental health issues (which frequently co-occur with addiction in vets) were the second most cited reason seeking treatment (VA, 2009).

Research clearly demonstrates that veterans are more likely to abuse substances than non-vets. Wagner et al. (2007) found that 56.6% of veterans reported using alcohol in the past month, contrasted with only 50.8% of nonveterans. Veterans also reported heavier alcohol use (7.5%) than nonveterans (6.5%). As for driving under the influence of alcohol or illegal drugs, 13.2% of veterans reported that they had engaged in this dangerous behavior compared to 12.2% of nonveterans. Prescription drug use is also an area of concern, though more difficult to track. For example, it was recently estimated that one-third of soldiers in the 509 Engineer Company at Fort Leonard Wood in Missouri were abusing prescription narcotics, with many of them also illegally distributing the drugs (Zoroya, 2008). In spite of the prevalence of drug and alcohol use among vets, only 0.8% of veterans surveyed reported receiving treatment for substance abuse or addiction within the previous year (Wagner et al., 2007).

Tobacco use is also problematic among returning vets. Cigarette smoking is still the most deadly substance abuse disorder in the United States (McGinnis & Foege, 1993; Mokdad, Marks, Stroup, and Gerberding, 2004). Even though many people know how dangerous smoking is to one’s health, over 50% of troops in Iraq and Afghanistan have become smokers. Reasons for taking up the habit included stress and boredom (Forgas, Meyer, & Cohen, 1996). This addictive behavior does not necessarily mean that the troops will therefore try other substances later, but it does reflect the mindset that can contribute to future addictions.

Risk Factors for Veterans

Specific risk factors exist among veterans that increase the likelihood of developing addiction. Younger veterans appear particularly at risk for developing substance abuse problems. According to Jacobson and colleagues (2008), the number of veterans with substance use disorders is higher among young veterans as compared to older veterans, possibly because of limited life experience and less social support. Specifically among OEF/OIF veterans 25% of those ages 18 to 25, 11% of those ages 26-

54, and 4% of those ages 55 and older are classified as having a substance abuse issue. Age is a clearly a risk factor for younger veterans.

Additional risk for developing addiction exists for Reserve and National Guard troops after deployments when compared to full-time military members. This could be due to the fact that after the deployment ends, Reserve and Guard members return to civilian lives in which their necessary post-deployment transitions are not recognized as they would be on military bases or in full-time military occupations (S. Feeder, personal communication, October 24, 2008).

Location of service is a major predictor of addictions, specifically for those veterans who have been deployed to combat zones. Newly returned veterans from combat zones were 63% more likely to engage in heavy drinking and binge drinking as compared to veterans in non-combat zones (Jacobson et al., 2008). Alcohol abuse may be the only acceptable or available outlet for a veteran experiencing high levels of stress. For example, the emotional state of *hyperarousal* that can be useful on the battlefield becomes difficult to manage after deployment. Signs of avoidance, isolation, social detachment, and trauma can surface. Self-medication through substance use can numb these difficult emotions (Corrigan & Cole, 2008).

Other predictive factors for veterans at risk of developing addiction exist. According to Robins and Slodobyan (2003) in their study of Vietnam veterans, important predictors of substance abuse after deployment included previous anti-social behavior, fighting, dropping out of school, and use of drugs prior to military service. Although such results referred to Vietnam veterans, these same factors can be predictive for OEF/OIF veterans. Obviously, it is imperative for counselors to screen for pre-disposing conditions of addicted veterans prior to their service.

Correlates of Addiction Among Veterans

Addiction is not just a biological disease. Social, psychological, and physical functioning may become impaired for veterans as a result of or in correlation with addiction. Following their return from Iraq and Afghanistan, soldiers report experiencing anger and aggression that can lead to marital and relationship problems (Hazelden Foundation, 2007). The rise in anger and aggression often exists prior to discharge. Problems with alcohol correlated with the most violent crimes by U.S. soldiers while overseas (Zeilbauer, 2007). This violence is often carried home after the deployment ends and criminal problems may compound the addictive behaviors.

A second correlate of addiction is mental illness. The prevalence of mental illness among addicted veterans creates a cycle of unhealthy coping mechanisms. Post traumatic stress disorder (PTSD) often co-occurs with substance abuse. PTSD is also highly correlated with Traumatic Brain Injury (TBI) and both are linked to substance abuse because of the unhealthy self-medicating behaviors that develop as a means of dealing with traumatic experiences (Corrigan & Cole, 2008). According to a RAND study (Tanielian & Jaycox, 2008), 19.5% of veterans returning from Afghanistan or Iraq reported possible symptoms of TBI while 18.5% of soldiers reported symptoms consistent with PTSD and depression. The neurological deficits that may be related to TBI might contribute to the development of substance use disorders (Corrigan & Cole, 2008). This comorbidity of disorders elevates the counseling needs for these veterans as many suffer in isolation, compounding already unhealthy lifestyles.

Another correlate of substance abuse among veterans is homelessness. In a 1999 National Survey of Homeless Assistance Providers and Clients, 23% of homeless clients were veterans. Men account for 98% of the homeless veteran population. Twenty-eight percent of homeless veterans experienced combat at some point in their military careers and 33% of male veterans in the study spent some time in a war zone (Bur et al., 1999). Homeless individuals demonstrate high levels of substance use and mental illness: 38% of homeless individuals abused alcohol, 26% abused other drugs, and 39% had mental health problems (Bur et al., 1999). The high frequency of mental health and substance abuse issues may be attributed to a lack of resources for such veterans because of inadequate mental health care by the VA and community addiction services. Such community agencies were said to be of little help because of the mistaken belief that only the VA should and does assist veterans (National Coalition for Homeless Veterans, 2004). Sadly, many veterans have slipped through the cracks and end up on streets instead of in treatment.

Finally, suicide is a frequent correlate with problematic substance use. Suicide rates among OEF/OIF veterans have skyrocketed in recent years and these veterans are twice as likely to commit suicide as non-veterans (Keteyian, 2009). Suicide rates among Army veterans is the highest it has been in 26 years, and veteran suicides make up an alarming 20% of all suicides nationwide (Franklin, 2009). Additionally, suicidal individuals who use alcohol are more likely to successfully complete a suicide attempt (Sher, 2006) a dangerous combination. Thus veterans who struggle with addiction and problematic alcohol use are particularly vulnerable to possible suicide completion. Greater access to addiction counseling is clearly warranted both to save veterans from living with pain as well as to save the lives of those who no longer want to live.

Barriers to Treatment for Addicted Veterans

Though the VA offers addiction counseling for veterans, it is essential for community-based counselors to understand why many veterans fail to seek out and receive treatment for such serious concerns. The dearth of literature on working with addicted veterans implies a lack of knowledge for providing counseling treatment to this population. Thus counselors may feel unequipped to work with addicted veterans, or may assume the VA is able to meet the needs for all addicted veterans. According to the 2003 National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Services Administration (SAMSA), only 0.8 percent of veterans underwent specific treatment for substance use, including alcohol and illicit drugs. About 3% of veterans reported being dependent on substances but received no treatment. These numbers only represented those who were seen by the VA, and only those who self-reported addiction. Actual numbers are estimated to be much higher due substance use issues being under reported among veterans (U.S. Department of Health and Human Services, 2005). Many more veterans likely suffer with addiction in the community without seeking help from the VA. This is a gap community-based counselors can fill.

Many veterans do not seek treatment for addiction problems because of stigma. Veterans may fear that seeking counseling might result in an inability to advance their military careers, or they may fear the addiction diagnosis will not be kept confidential (Campbell, 2008). In addition, the same military mindset that creates an effective soldier may be a significant barrier to seeking help after discharge from the military. The

military trains soldiers to be strong and independent, thus possessing a mental health problem or addiction and asking for assistance from a counselor may be perceived as weakness (Campbell, 2008). The stigma of needing help prevents many soldiers from seeking it. A soldier who struggles with substance abuse could also be deemed incapable of protecting others, a fundamental quality in military life (Hazelden Foundation, 2007). Thus when veterans do seek counseling, it is often at civilian centers in order to avoid unwanted attention from military personnel (Lewis & McCarthy, 2007). Thus community-based counselors are in a prime position to support the efforts of the VA and to address the needs of addicted veterans who might avoid counseling services offered within the VA system.

Counseling Interventions to Address the Needs of Reluctant Addicted Veterans

The dearth of counseling research and literature regarding the needs of addicted veterans implies a lack of awareness of the problem, and fails community-based counselors who are likely to encounter addicted veterans in their practice. In addition, cultural stigma about seeking counseling treatment for addiction may make it difficult for counselors to reach veterans in need, and may prevent addicted veterans from seeking treatment via conventional methods. Thus this article aims to provide community-based counselors with specific interventions that have been demonstrated to be effective with addicted clients who may be hesitant to seek out traditional, face-to-face counseling. Specifically, bibliotherapy and e-therapy interventions will be discussed. These interventions may be used separately or in conjunction with one another. A brief overview of each type of intervention and combined interventions will be presented followed by resources for counselors.

Bibliotherapy

Samuel Crothers coined the term *bibliotherapy* in 1916 to describe the therapeutic use of books (Crothers, 1916; Jackson, 2001). Since that time, both self-help books and literature have been used as both primary and adjunctive therapy for a variety of issues including addiction, grief, parenting concerns, depression, anxiety, and stepfamilies in transition (Apodaca & Miller, 2003; Briggs & Pehrsson, 2008; Coleman & Ganong, 1990; Corr, 2004; Floyd, 2003; Jones, 2002). Use of books as a counseling medium provides many benefits, including information, insight, clarification of personal values, reduction of isolation, increased problem solving ability, increased understanding of worldview and cultural values, and solution generation (Christenbury & Beale, 1996; Coleman & Ganong, 1990; Gladding & Gladding, 1991; Hynes & Hynes-Berry, 1994).

Specifically in the addiction counseling field, bibliotherapy has been a long-standing component of the 12-Step movement, as Alcoholics Anonymous (AA) provides the Big Book for all who choose to join. The Big Book includes stories and narratives from other alcoholics in recovery, providing a sense of connectedness and universality for new members. The Big Book is available in both a paper and online version, so alcoholics unsure of whether AA is right for them can examine the literature before making a decision. Narcotics Anonymous (NA) provides a similar resource for drug addicts in the Basic Text, and both organizations offer pamphlets and other written material to supplement the 12-Step meeting experience (Briggs & Pepperell, 2009).

Specifically for veterans, bibliotherapy along with other online resources has been identified by the Veterans Administration (VA) as an effective stand-alone or adjunctive counseling technique for a variety of mental health or substance abuse disorders. Use of both self-help type material and fictional works is recommended (Riordan & Wilson, 1989). However, the VA does recommend that bibliotherapy be used primarily as an adjunctive technique, combined with counselor feedback and involvement (Department of Veterans Affairs, n.d.).

Bibliotherapy may be particularly effective for substance abusing veterans as it is a non-threatening way to address problematic behaviors. Research literature demonstrates that through reading, clients gain greater insight and awareness of their own problems and a diminished sense of isolation and aloneness (Briggs & Pehrsson, 2008). Because stigma in the military about seeking addiction counseling is significant (Campbell, 2008), veterans may be reluctant to initiate counseling, or may refrain from initially acknowledging substance use problems at the onset of counseling. Thus using bibliotherapy may be a non-threatening, “back door” method for initiating addiction counseling. Clients who used bibliotherapy in reducing alcohol consumption preferred this method because it provided anonymity, avoided blame, and allowed for autonomy of decision making (Apodaca & Miller, 2003).

Cautions exist when using bibliotherapy. While most counselors and therapists acknowledge using books with clients, if books are not carefully chosen, this intervention may cause more harm than good. For example, books may exceed clients’ reading ability or academic interest. In these cases, clients may experience increased anxiety or sense of personal failure when assigned literature (Hynes & Hynes-Berry, 1994). Also, books that seem benign to the prescribing counselor may be offensive or adverse to clients based on differing values (Gladding & Gladding, 1991; Pehrsson & McMillen, 2005). Most importantly, counselors should review all books before assigning them to clients. The VA specifically indicates that few books have been empirically tested for effectiveness (VA, n.d.).

E-Therapy

E-therapy falls under the larger umbrella of distance counseling, where client and counselor are not in each other’s physical presence during the therapy hour. Specifically, e-therapy “...is defined as a licensed mental health care professional providing mental health services via e-mail, video conferencing, virtual reality technology, chat technology, or any combination of these” (Manhal-Baugus, 2001).

Distance counseling itself is not a new phenomenon and forms of it have long been available, such as telephone counseling and emergency hotlines. On the internet, e-therapy is normally carried out in one of two forms: email (asynchronous communication) and instant messaging (synchronous communication; Robson & Robson, 2000). E-therapy has been suggested for a variety of issues including smoking cessation programs (Beckham et al., 2008). And e-therapy is considered an appropriate measure to address veterans’ concerns for confidentiality (Jacobson et Al., 2008).

E-therapy, particularly email and instant messaging (IM), provide other significant benefits that may be particularly appealing to veterans. First, the process of writing often allows clients additional time and space to create more reflective responses than might occur verbally. Clients often find they are able to process significant life

issues more deeply than in traditional counseling (Manhal-Baugus, 2001). For veterans who may be struggling with a mental illness in addition to a substance abuse issue, having time to write thoughts out may facilitate more significant intrapersonal processing.

Second, clients often find that e-therapy via email or IM makes it easier to reveal aspects of themselves they perceive as embarrassing or shameful. Counseling via these methods reduces stigma about “hot” issues such as addiction or suicidality (Manhal-Baugus, 2001). As veterans often struggle with issues of shame and stigma, using e-therapy may increase the likelihood of substance abusing veterans seeking help. “The reluctance to seek treatment in a population that is vulnerable to suffering psychological crises indicates that there may be a need for specific services to manage the crises of ... veterans who avoid conventional counselling [sic] agencies” (Bryant, 1998, p. 590).

Finally, the timing and convenience of e-therapy may have advantages over face to face methods. Many veterans experience problems after typical office hours. Evenings and weekends are when alcohol and drug problems are more likely to flare up or get out of control, so having resources available via the internet can help manage crises (Malone, Ravis, & Miller, 2006).

Challenges exist in e-therapy as well. The same anonymity that often makes it easier to share via email or IM also may present a barrier; both counselors and clients remark that the lack of face to face contact inhibits the ability to read emotions and non-verbal cues. In spite of this barrier, e-therapy has been shown to be an effective mode of building therapeutic relationships (Manhal-Baugus, 2001). Technological barriers may prove troublesome if clients lack access to computers and equipment in private locations. Additionally, counselors must ensure they possess the appropriate encryption software for protecting confidentiality during electronic transmission (Malone et al., 2006). Finally, there exists some concern that e-therapy is not ideal for dealing with client crises such as suicidality, or for significant mental health issues, such as sexual abuse as a primary concern (Manhal-Baugus, 2001). However, other research has shown that suicidal clients may actually seek help more quickly via online counseling versus face-to-face, and that clients with significant mental health concerns such as eating disorders find online counseling to be helpful (Malone et al., 2006). Thus the literature is mixed about efficacy, and further study is needed.

Bibliotherapy and E-Therapy Combined

Using a combination of bibliotherapy with e-therapy shows great promise for substance abusing veterans. “A potentially interesting strategy to aid problem drinkers is self-help, web-based intervention” (Jacobson et al., 2008). Recent developments in the field of distance counseling imply bibliotherapy may be effective when combined with Internet technology (Malone et al., 2006).

Community-based counselors may use bibliotherapy and e-therapy in a variety of ways. First, counselors may make addiction-related material available to veterans online via a webpage. Materials available online have the benefit of anonymity. Veterans who may be concerned about their substance using behaviors can seek out information even before they are ready to ask for help. Providing these materials online may assist veterans in engaging in counseling; however, providing self-help materials can also assist some in reducing problematic substance-abusing behaviors without counseling (Lampropoulos &

Spengler, 2005). Cognitive-behavioral self-help materials providing specific techniques for reducing substance use appear to be most effective (Apodaca & Miller, 2003). Materials placed online might include specific book or self-help manual referrals, pamphlets in PDF formats, reference to websites or self-assessments, or addiction information composed by the counselor.

There is some indication that veterans who first seek help via the Internet may eventually seek out more formal counseling. For example, clients who engaged in alcohol reduction via self-help materials appeared more likely to ultimately engage in face-to-face counseling, as the reading material reduced stigma and fear about the counseling process (Apodaca & Miller, 2003). It appears that use of these materials “opens the door” to counseling in general, and may provide a gateway for reluctant veterans. In addition, including brief motivational sessions to a bibliotherapy regimen is encouraged by the VA (n.d.) and may increase the efficacy of the whole intervention for some clients (Apodaca & Miller, 2003). Counselors may ask addicted veteran clients to first perform a self-assessment of alcohol use online, and engage in IM or email conversations to provide motivation enhancement for commencing behavior change. Thus the use of bibliotherapy and e-therapy together can provide an important gateway for addicted veterans reluctant to enter counseling.

Resources for Counselors

For counselors unfamiliar with either bibliotherapy or e-therapy, additional reading and training are recommended. The Bibliotherapy Education Project (<http://www.library.unlv.edu/faculty/research/bibliotherapy/>) offers a listing of reviewed books and resources for counselors interested in this modality. In addition, the VA provides a comprehensive listing of reading material appropriate for veterans (http://www.mirecc.va.gov/docs/VA_Bibliotherapy_Resource_Guide.pdf).

For counselors interested in training in distance counseling techniques, training and certification is available through the Center for Credentialing and Education (CCE) at <http://www.cce-global.org/credentials-offered/dccmain>

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