2019

Alcohol Misuse Among Veterans: Implications for Better Treatment

Annie Taylor
Antioch University of New England

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by

Annie Taylor

B.A., Saint Michael's College, 2014
M.S., Antioch University New England, 2017

DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2019

Keene, New Hampshire

Department of Clinical Psychology

DISSERTATION COMMITTEE PAGE

The undersigned have examined the dissertation entitled:

ALCOHOL MISUSE AMONG VETERANS:
IMPLICATIONS FOR BETTER TREATMENT

presented on January 10, 2019

by

Annie Taylor

Candidate for the degree of Doctor of Psychology
and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Roger L. Peterson, PhD, ABPP

Dissertation Committee members:
Barbara Belcher-Timme, PsyD
Vince Pignatiello, PsyD

Accepted by the
Department of Clinical Psychology Chairperson
Lorraine Mangione, PhD

on **1/10/19**

***** Signatures are on file with the Registrar's Office at Antioch University New England

Acknowledgements

Grandpa—Thank you for always believing in me and knowing—even when I didn't—that I could be a doctor. I love you and miss you eternally.

My husband—Thank you for reminding me of what's important and always supporting me. I love you and am very thankful for your patience, willingness, and encouragement.

My sister, Beth—You have stayed up late helping me with papers, been on the other end of the phone whenever I've needed you, and have been my mentor in psychology and in life. Thank you for loving me unconditionally.

My Mom and Dad—I will never be able to thank you enough for all you have done for me and my education. I love you both so much.

Trask, Kristin, and Jill—I have an endless amount of appreciation for all of your humor and support along the way. I love you all very much.

Casey—Thank you for all you have done to ground me during graduate school. I'm so lucky to have a friend like you.

My puppies, Huck and Sawyer—You two have always managed to put a smile on my face through all that life and graduate school have thrown at me. Thank you for always being there to lick my face.

Roger—Thank you for all your support along the way. I feel very fortunate to have had you as an advisor and a mentor. I have appreciated our time together and have valued your input. Thank you!

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Abstract

Veterans are at an elevated risk of alcohol misuse compared to civilians due to a convergence of factors that create a highly concentrated risk of alcohol misuse among this population. Given this troubling finding and the lack of research in the realm of clinician competence related to alcohol misuse among veterans, this study attempted to fill the apparent gap in literature by way of understanding the perceptions of alcohol misuse in the veteran population and the approach to treatment by mental health providers in the Veterans' Affairs (VA) system. In the current study, which utilized online survey methodology, VA mental health providers were asked about their perceived competence, clinical training, treatment modality, and views on the problem of alcohol misuse among veterans. This study's findings recognized the need for clinicians to have more training and a greater understanding of the veterans that they are treating. Additional findings include (a) clinicians need more consistent training on treating alcohol misuse; (b) clinicians are in fact using evidence-based interventions while treating alcohol misuse; (c) clinicians lack an understanding of gender, racial, and ethnic differences while treating alcohol misuse; and (d) clinicians believe veterans who misuse alcohol can benefit from therapy. Ultimately, this study identified strengths and areas for improvement in the treatment of veterans who misuse alcohol. This information can be used to increase training experiences of VA clinicians and thereby better the care of veterans who misuse alcohol in the VA system.

Keywords: alcohol misuse, veterans, integrated treatment, competence

Alcohol Misuse Among Veterans: The Increasing Need for Collaborative Treatment

Definition of Key Terminology

Alcohol Misuse

Alcohol misuse can be used to encompass a broad array of problematic patterns and uses of alcohol. These include risky drinking, heavy drinking, binge drinking, alcohol dependence, alcohol abuse, and all alcohol use disorders (AUDs; Fiellin, Reid, & O'Cononor, 2000; Hawkins et al., 2010; Whitlock, Polen, Green, Orleans, & Klein, 2004).

Veterans

The term veteran refers to "a person who served in the active military naval or air service and who was discharged or released under honorable conditions" (Kelsall et al., 2015, p. 39). Newer generations of veterans are those who have served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

Veterans are at an elevated risk of alcohol misuse compared to civilians. There are 21.8 million veterans in the United States, and as a period of continued combat endures, the number of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans will continue to climb (Adler et al., 2011; Bryan et al., 2015; United States Census Bureau, 2010). Veterans have higher rates of mental illness as compared to civilians (Adler et al., 2011; Golub, Vazan, Bennett, & Liberty, 2013), and alcohol misuse is one of the most common problems among all veterans, with even higher rates in OEF/OIF cohorts (Burnett-Zeigler et al., 2011; Hawkins, Lapham, Kivlahan, & Bradley, 2010; Lan et al., 2016). A long-standing history of alcohol misuse exists in the military and can be dated back more than 200 years (Jones & Fear, 2011). Currently, alcohol misuse is a widely recognized problem and while differing estimates exist as a result of varying self-reports, inconsistent diagnostic criteria, stigma, and other factors,

it is believed that between 12%-40% of the veteran population misuses alcohol (Burnett Zeigler et al., 2011; Calhoun, Elter, Jones, Kudler, & Straits-Tröster, 2008; Hoge, Auchterlonie, & Milliken, 2006; Hoge, Castro et al., 2006; Wilk et al., 2010). Despite these high rates, a lacunae of knowledge exists in regards to alcohol misuse among OEF/OIF cohorts of veterans (Calhoun et al., 2008; Kelsall et al., 2015; Seal, Bertenthal, Miner, Sen, & Marmar, 2007) and only recently has attention focused on the problem. Priority has been assigned to addressing other pressing issues such as posttraumatic stress disorder (PTSD) and depression (Fuerhlein et al., 2016; Hawkins et al., 2010; Hoge, Auchterlonie et al., 2006; Kelsall et al., 2015) while the problem of alcohol misuse has seemingly been neglected. This study addressed part of this problem by filling in an apparent gap in the literature related to the ways in which mental health providers in the VA system treat and understand alcohol misuse in this population.

Currently, research on the treatment provided to veterans and the views of alcohol misuse among mental health providers in the VA system is apparently lacking. Treatment for Substance Use Disorders (SUDs) in the VA is primarily managed by SUD specialists who provide treatment for SUDs. However, these specialists do not provide care for all those misusing alcohol as they are often reserved for veterans who meet the diagnostic criteria for SUD or AUD and/or who have a presenting problem that is directly related to substance misuse. Problems exist in this system as (a) the care provided by SUD therapists can be considered disjointed as specialists who treat SUDs do not always treat veteran's co-occurring disorders, and the internal referral policy encourages providers with clients who have substance use disorders to refer them to the SUD department; (b) great variability exists in regards to how providers treat SUDs and alcohol misuse; (c) actual practice has been known to differ from research and theory; and (d) little is known about how alcohol misuse is dealt with in the larger population of veterans who seek

treatment for problems not directly related to alcohol misuse. Therefore, the treatment and perceptions of mental health providers is vital in order to better understand veterans' care.

This study sought to understand the aforementioned problems by way of assessing the perceptions of mental health care providers who are currently working in the VA system. The study utilized an online survey methodology and VA mental health providers were asked about their perceived competence, clinical training, treatment modality (specifically about whether they use integrated treatments or sequential treatments), and views on the problem of alcohol misuse among veterans. This study also sought to provide information about the larger problem of alcohol misuse in the veteran population by way of allowing for a better understanding of how veterans who misuse alcohol are treated and understood by their providers in VAs. This was important information to obtain as it (a) provided information on the clinical training and the treatment modalities of clinicians treating alcohol misuse in the VA system; (b) helped to answer the question of whether or not clinicians are able to competently provide integrated treatments that address the association between AUDs and other mental health related issues; (c) asked clinicians about their views of alcohol misuse in the veteran population and examined their understanding of how racial, ethnic, cohort, and/or gender differences relate to alcohol misuse; and (d) uncovered any potential biases and/or discomfort that clinicians have while treating veterans with alcohol misuse. Ultimately, this study's results can help identify a need for treatment providers in the VA to become more skilled when working with alcohol misuse, which can then be translated into better treatment for veterans.

Literature Review

Understanding Risk Factors

Certain subgroups of the veteran population have been found to be at an increased risk of

misuse as compared to their veteran counterparts (Seal et al., 2011). Factors including (a) young age (18-24), (b) unpartnered or divorced status, (c) multiple psychiatric diagnoses, (d) unemployment, (e) white race, (f) lower education, (g) lower military rank, (h) male sex, (i) history of parental neglect, (j) lesser social support, and (k) lower annual household income are all identified with higher rates of alcohol misuse (Burnett-Zeigler et al., 2011; Fuehrlein, Mota, Arias, Trevisan , Kachadourian, Krystal, & Pietrzak, 2016; Golub et al., 2013; Hawkins et al., 2010; Jacobsen et al., 2008; Jones & Fear, 2011; Seal et al., 2007, 2011; Wilk et al., 2010). Alarmingly, many members of the OEF/OIF cohorts fit into several of these categories and are thus increasingly likely to develop a problematic relationship with alcohol (Hawkins et al., 2010). Further, military service appears to elevate the risk of alcohol use disorders (AUDs) (Adler et al., 2011; Kelsall et al., 2015) which have been found to increase and persist after deployment (Vazan, Golub, & Bennett, 2013). The degree of combat exposure and other specific wartime experiences (i.e. viewing killings/injuries, the action of killing others, and the perceived threat of being killed or others around you being killed) have been linked to increased rates of alcohol misuse (Hoge, Castro et al., 2006; Kelsall et al., 2015; Wilk et al., 2010). Evidently, the misuse of alcohol among soldiers warrants immediate attention as identification of those at risk can assist in preventing alcohol misuse among more vulnerable populations.

Risk-Taking Personalities Are Linked to Externalizing Disorders

The military seeks to recruit risk-taking persons, but while these characteristics may serve individuals well in battle, they may simultaneously predispose them toward the development of various mental health disorders, such as substance abuse disorders, both before and after service (Jones & Fear, 2011). Risk-taking characteristics may have biological underpinnings as new research implicates “polygenic genes” in the development of the

"externalizing spectrum" (Iacono, 2014; Sadeh et al., 2016). This spectrum is characterized by the "propensity for behavioral disinhibition, or the tendency to act recklessly and impulsively" (Iacono, Carlson, Taylor, Elkins, & McGue, 1999; Kendler et al., 2003 as cited in Sadeh et al., 2016, p. 545). Research posits that the externalizing spectrum has an etiological basis and that the high psychiatric comorbidities among various externalizing disorders are due to their common biological pathways (Iacono, 2014; Sadeh et al., 2016). Therefore, the higher propensity for risk taking, which is a marker of a "good" soldier, may be associated with the development of AUDs as well as other externalizing disorders (Jacobson et al., 2008). Furthermore, research by Sadeh et al., which **"**examined the molecular genetic basis of this spectrum by testing polygenic associations with psychopathology symptoms, impulsive traits, and cognitive functions in two samples of primarily military veterans (n = 537, n = 194)" (p. 545), found that trauma exposure may increase the likelihood of persons to develop externalizing psychopathology. Thus, military personnel may be at an increased likelihood of developing a problematic relationship with alcohol due to combat exposure and their underlying biological vulnerability (Jacobsen et al., 2008; Sadeh et al., 2016).

High Rates of Comorbidity Exist Among AUDs and Other Mental Health Diagnoses

A considerable amount of research has documented the frequent co-occurrence of AUDs and other menta; illnesses in the veteran population as well as within the civilian population (Jacobsen et al., 2008; Roberts, Roberts, Jones, & Bisson, 2015; Seal et al., 2007). Specifically, mood disorders, anxiety disorders, and PTSD-related disorders are oftentimes comorbid with AUDs (Back et al., 2014; Fuerhrlein et al., 2016; Hawkins et al., 2010; Jacobsen et al., 2008; Killeen, Back, & Brady, 2015). A study by Seal et al. (2011), which used retrospective cross-sectional descriptive and multivariate analyses from 456,502 OEF/OIF veterans, found that

80-90% of veterans who met the diagnostic criteria for AUD or drug use disorder (DUD) had at least one other diagnosis. These psychiatric comorbidities have serious implications as "patients with both disorders have been found to have a more severe clinical profile than those with either disorder alone, lower general functioning, poorer well-being and worse outcomes across a variety of measures" (Schäfer & Najavits, 2007 as cited in Roberts et al., 2015, p. 26).

Veterans Misuse Alcohol and Other Substances to Dull the Pains of War

Various models have been used to explain the high rates of psychiatric comorbidities associated with military service. Many lines of research implicate similar etiological pathways (Iacono, 2014; Kessler, 2004; Roberts et al., 2015; Seal et al., 2011; Wolf et al., 2010), similar personality traits (Schaumberg et al., 2015; Weiss, Tull, Anestis, & Gratz, 2013; Weiss, Tull, Viana, Anestis, & Gratz, 2012) and similar environmental exposures (Kline et al., 2014) among those suffering from comorbid disorders. Although these factors contribute to the development of AUDs and other mental illnesses, the frequent co-occurrence and the difficulty treating comorbid symptoms have been explained by way of the self-medication model, which understands symptoms to be inherently interrelated (Bremner, Southwick, Darnell, & Charney, 1996; Breslau, Davis, & Schultz, 2003; Chilcoat & Breslau, 1998; Kelsall et al., 2015; Lan et al., 2016; Seal et al., 2011). This framework, which is consistent with past military beliefs that viewed alcohol as a means to ameliorate the pains of war (Jones & Fear, 2011), hypothesizes that veterans use substances in order to lessen the impact of their psychological illnesses **(**Lan et al., 2016**)**.

Although contrary findings remain, such as those that indicate that substance use disorders (SUDs) lead to other MIs and are not related to one another (Marquenie et al., 2007; Seal et al., 2011), other existing evidence supports this model on evidentiary and pragmatic

grounds. The following pieces of data provide strong backing for this model: (a) substance use increases after combat exposure (Burnett-Zeigler et al., 2011; Kelsall et al., 2015); (b) patients express that PTSD and AUD symptoms are related (Back et al. 2014); (c) longitudinal studies indicate that PTSD and related disorders occur before and are correlated with increases in alcohol and drug misuse (Bremner et al., 1996; Breslau et al., 2003; Chilcoat & Breslau, 1998; Jakupcak et al., 2010); (d) when PTSD symptoms are severe and/or untreated, there is an increased risk of alcohol misuse (Back et al., 2014); (e) past laboratory study findings identify emotional stress and negative affective states in the moderation of substance use cravings (Sinha, 2009); and (f) as PTSD related symptoms worsen, substance abuse related symptoms increase and vice versa (Back et al., 2014).

Untreated Alcohol Misuse is Costly to Veterans and Society

The consequences of not treating alcohol misuse are extremely detrimental to veterans and society in general as research suggests that (a) veterans with untreated substance abuse behaviors have higher rates of relapses as well as an increased likelihood of developing other MIs (Killeen et al., 2015); (b) veterans with alcohol misuse may have diminished coping capacities which can subsequently lead them toward increased vulnerability for continued harmful experiences (Fuerhrlein et al., 2016; Hobfoll, 1989); (c) veterans with untreated substance abuse disorders have higher rates of domestic violence and criminality (Kiernan, Moran, & Hill, 2015); (d) financial stress and work productivity are negatively correlated in veterans with alcohol misuse and it can lead them to have difficulty finding a job, maintaining a job, and being successful with employment (Adler et al., 2011; Wilk et al., 2010); (e) established connections between risky and impulsive behavior have been found to be a result of alcohol misuse among veterans and they have reported increased rates of driving under the influence,

driving with someone under the influence, driving aggressively, and having automobile accidents as the result of alcohol misuse (Strom et al., 2012;Wagner, 2007; Wilk et al., 2010); (f) family conflicts, divorce, and parenting difficulties are related to alcohol misuse among veterans (Bray, Fairbank, & Marsden, 1999; Kelsall et al., 2015); and (g) suicide in the veteran population is associated with alcohol and substance misuse (Brenda, 2005; Fuerhlein et al., 2016; National Institute on Drug Abuse, 2013).

Barriers to Care Are a Cause for Unmet Treatment Needs Among Veterans

Although alcohol misuse is one of the most common mental health issues among veterans, only a very small percentage of individuals seek out treatment (Golub et al., 2013; Hoge, Castro et al., 2006; Vazan et al., 2013; Wagner, 2007). The rate of untreated SUDs has been found to be twice as high as the rate of other untreated disorders, such as PTSD and depression, as veterans utilize services for these kinds of disorders at higher rates than the civilian population (Golub et al., 2013; SAMHSA, 2005). Alcohol misuse treatment is rarely utilized and, even when veterans seek out services for other mental health issues, very few report addressing substance misuse in treatment (Burnett-Zeigler et al., 2011; Golub et al., 2013). Additionally, fundamental barriers to care serve to further limit veterans' access to treatment.

Time, transportation, fears related to limited confidentiality, and the availability of care have been found to hinder the utilization of mental health services in the veteran population (Adler et al., 2011; Back et al., 2014; Burnett-Zeigler et al., 2011; National Institute on Drug Abuse, 2013; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Vazan et al., 2013). Veterans may be unaware of alcohol misuse as being problematic and may view it as part of their culture and/or service (Golub et al., 2013; Kiernan et al., 2015; Wagner, 2007). Research by Golub et al., which used data from the National Survey on Drug Use and Health between 2004

and 2010, found that “only 1% of all veterans reported an unmet need for alcohol or drug treatment compared to the 16% of unmet need for treatment estimated” (p. 112).

Further, stigma around substance abuse is related to lowered rates of treatment seeking in the veteran population (Pietrzak et al., 2009) as many veterans believe that treatment for alcohol misuse is a sign of weakness and/or that treatment will be ineffective (Burnett-Zeigler et al., 2011; Golub et al., 2013; Hoge, Auchterlonie, et al., 2006; Pietrzak et al., 2009). Stigma may also originate from providers who may not evaluate for substance misuse or who may be biased and therefore only assess within certain populations (Seal et al., 2011). For example, more educated people and people with higher incomes have been found to be less likely to receive SUD treatment or support (Calhoun et al., 2008; Golub et al., 2013). Undoubtedly, these barriers need to be addressed as they are relevant to the continued trend of alcohol misuse among veterans.

Inadequate Preventative Measures Limit Access to Adequate Care for Veterans

A considerable amount of research has examined preventative mental health measures for OEF/OIF veterans as “knowledge of the prevalence and correlates of substance use disorders may facilitate early detection and inform targeted interventions to prevent chronic drug and alcohol problems in this current generation of returning veterans”(Seal et al., 2011, p. 93). For these reasons, the VA has implemented “Battlemind Training” and mandated screening measures in order to earlier identify mental health concerns among veterans (Calhoun et al., 2008; Hoge, Castro et al., 2006; Lan et al., 2016; Thomas et al., 2007 as cited in Wilk et al., 2010). However, problems persist with these measures and “while Battlemind has been validated for a number of positive mental health outcomes (Adler et al., 2009), it has not been validated for reducing rates of alcohol misuse” (Wilk et al., 2010, p. 120).

In addition, problems such as fear of the screening measures being put into permanent medical records, the difficulty with screening comorbid diagnoses, the use of invalid diagnostic criterion, and the delayed onset of symptoms make current screening measures less sophisticated at the accurate identification of at-risk veterans (Golub et al., 2013; Killeen et al., 2015; Lan et al., 2016). Furthermore, even though veterans endorse alcohol problems at rates similar to other MIs, they are still referred to alcohol treatment at lower rates than those suffering from other MIs (Maust, Mavandadi, Klaus, & Oslin, 2011; Milliken, Auchterlonie, & Hoge, 2007). Evidently, preventative measures, screening tools and referral practices need to be improved in order to better facilitate in the early identification of alcohol misuse.

Integrated Treatments That Address the Association Between AUDs and Other MIs Have Increasing Rates of Efficacy

Currently, several treatment modalities exist for the treatment of alcohol misuse. The stages of change model is widely used by clinicians treating SUDs in order to assess an individual's readiness to change and to guide interventions (Prochaska & DiClemente, 2005). This model and others have been used both in conjunction with other therapies and have also been used in a stepwise fashion, where abstinence was required before other symptoms were addressed. However, the high co-occurrence of alcohol related disorders and other mental health issues, including trauma-related disorders, has led to less of the once more traditional stepwise approaches and to more integrated approaches that treat disorders concurrently with a trauma informed approach to care (Killeen et al., 2015). Several integrated approaches, which commonly contain elements of cognitive behavioral therapy (CBT), psychoeducation, and skill building, have been researched and two distinct kinds of therapies have emerged (Killeen et al., 2015).

Trauma exposure-based integrated therapies and non-exposure-based integrated therapies have received a lot of attention as mixed conclusions have been reached about each type of therapy's respective effectiveness. With regards to integrated PTSD/SUD therapies, "the Institute of Medicine regards exposure-based therapies as the only interventions with sufficient empirical evidence for effectiveness in the treatment of PTSD" (Institute of Medicine, 2008 as cited in Killeen et al., 2015, p. 235). However, other studies note that coping skills training and CBT without exposure are also effective (Back et al., 2012, 2014; Killeen et al., 2015). One such non-exposure therapy, Seeking Safety (SS), is a widely used group CBT approach that "focuses on psychoeducation, cognitive restructuring, and developing interpersonal and self-control skills" (Back et al., 2014). This treatment has received considerable attention and "data from randomized controlled trials demonstrate that SS leads to significant improvement in PTSD and SUD symptoms" (van Dam et al., 2012 as cited in Back et al., 2014, p. 370).

With mixed evidence regarding trauma and non-trauma-based therapies, it is difficult to determine appropriate directions for care. A systematic review and meta-analysis by Roberts et al. (2015), which examined 14 randomized control studies using data on individual and group psychological interventions for the treatment of SUD and PTSD, found small treatment effects and varying results of effectiveness among several integrated therapies. The overall findings of the meta-analysis indicated that "individual trauma-focused cognitive–behavioral intervention, delivered alongside SUD intervention, was more effective than treatment as usual (TAU)/minimal intervention for PTSD severity post-treatment, and at subsequent follow-up" (Roberts et al., 2015, p. 25); however, the authors cautioned against broad generalizations and called for more research on effective treatments. Due to the chronic and delicate nature of AUDs and the continued period of combat, finding evidence-based models that treat symptoms

concurrently is of utmost importance (Back et al., 2014, p. 370).

Women and Racial/Ethnic Groups are the Fastest Growing Cohorts of Veterans

Women and racial/ethnic groups are the fastest growing cohorts of veterans (Maguen Ren, Bosch, Marma, & Seal, 2010; Manning, 2013). The "proportion of active duty women has risen from 2% to 15% between 1970 and 2000" (Quester & Gilroy, 2002 as cited in Benda, 2005, p. 107) and nearly "45% of women and 28% of men are members of racial-ethnic minority groups" (Maguen et al., 2010 as cited in Koo, Madden, & Maguen, 2015b, p. 507)—rates that are higher than in civilian population (Humes, Jones, & Ramirez, 2013 as cited in Koo et al., 2015b). Although these statistics prevail, a paucity of literature focuses on diversity issues in the veteran population (Elhai, Reeves, & Frueh, 2004; Koo, Hebenstreit, Madden, Seal, & Maguen, 2015a; Koo et al., 2015b). Moreover, there is a tendency to aggregate racial/ethnic groups within research: "until more recently, veteran race/ethnicity has most often been categorized as black, Hispanic, white, and 'other' due to missing race/ethnicity data in the VA healthcare system" (Seal et al., 2007, 2011; Williams et al., 2012 as cited in Koo et al., 2015a, p. 724). Thus, these historically understudied groups are systematized together causing differences to be masked or overlooked. Nevertheless, it has been demonstrated both in the civilian population and in the veteran population that racial/ethnic and gender group differences exist in regards to alcohol misuse (Golub et al., 2013; Hawkins et al., 2010; Koo et al., 2015a; Maguen et al., 2010; Schell, Tanelian, Rand Corporation, RAND Health, & New York State Health Foundation, 2011).

Research by Koo et al. (2015b), which involved a retrospective analysis using the preexisting VA records of 792, 666 OIF, OEF, and Operation New Dawn (OND) cohorts, found that American/Indian/Alaska Native males were diagnosed with substance use disorders at higher rates than other racial/ethnic groups. Furthermore, alcohol misuse patterns differ by

gender, and men are more likely to screen positive for alcohol misuse and are two times as likely to be diagnosed with substance abuse disorders as compared to women (Golub et al., 2013; Hawkins et al., 2010). Moreover, gender has been shown to have moderating effects on racial/ethnic differences in terms of alcohol misuse (Koo et al., 2015a, 2015b). When veterans are grouped together and placed in umbrella categories, the different associations among gender, race, and ethnicity are blurred.

Veterans Are a Socially Disadvantaged Group

The veteran population is marginalized and underserved (Luchins, 2008). Very little is done to address the social disadvantage that this group faces even as early as in the enlistment process "because the United States currently has a voluntary military, social inequality may now play a greater role in mental health outcomes as individuals from disadvantaged social locations enlist in the military for the income, skills-training, and educational benefits" (Luchins, 2008 as cited in Vazan et al., 2013, p. 888). Furthermore, "military recruiters tend to target low-income residents who are searching for a way out of poverty" (Anderson, 2009 as cited in Vazan et al., 2013, p. 882). However, financial strain and homelessness do not evade this population and are even more elevated when substance misuse is involved.

Homelessness among veterans has been an increasing problem in the United States (Tsai, Pietrzak, & Rosenheck, 2012) and the link between homelessness and substance abuse has been shown to be strong: "an estimated range of 41 to 84% of homeless adults have a substance use disorder" (Bassuk, Buckner, Perloff, & Bassuk, 1998; Goldfinger et al., 1996; Gonzalez & Rosenheck, 2002; North, Eyrich, Pollio, & Spitznagel, 2004 as cited in Tsai, Kasprow, & Rosenheck, 2014, p. 455). Mental health disorders, including substance use disorders, have high prevalence rates in the veteran population and "the majority of female (81.9%) and male (90.8%)

homeless veterans were comorbid with substance abuse and other psychiatric disorders" (Benda, 2005, p. 108). Furthermore, research by the Substance Abuse and Mental Service Administration found that "SUDs were more common among veterans who were younger and whose families earned less than $20,000 per year" (SAMHSA, 2007 as cited in Golub et al., 2013, pp. 107-108).

The complexity of the military's pension and disability policies as well as problems associated with attaining and maintaining employment compile to make financial hardships a real part of life for many veterans. Individuals who joined the military for financial gain may continue to endure poverty and homelessness even after serving their country. Moreover, they may be placed at increased risk of mental health issues, including substance misuse, due to their service (Vazan et al., 2013). Research by Vazan et al. (2013), using data from 269 veterans "who returned to predominately low income minority New York City neighborhoods between 2009 and 2012" (p. 880), found that "48% of veterans returning to the low-income and predominantly minority neighborhoods of New York City meet the criteria for either SUD or other mental health problems " (p. 888). Addressing veterans' social disadvantage is extremely difficult, as it requires action that extends beyond the military population into wider society. However, smaller and graded steps can be taken to address the disadvantage on a smaller scale. For example, by separating basic needs from treatment status, increasing pensions, helping veterans with financial planning, and giving this group mitigated options beyond that of the military, this group's social disadvantage can begin to be addressed.

Issues Around Limited Confidentiality Pose Significant Ethical Concerns for Military Psychologists

Feelings of mixed obligations exist among military psychologists as there are various limitations in regards to confidentiality as a result of established military policies (Hoyt, 2013;

Johnson, Grasso, & Maslowski, 2010; Kennedy & Johnson, 2009; Warner, Appenzeller, Grieger, Benedek, & Roberts, 2009). While Standard 4.01 of the APA Ethics Code dictates psychologists' obligation to maintain confidentiality (Nagy, 2005), the military as an institution imposes additional specifications for psychologists in their setting. These polices can impact how soldiers and veterans view therapy as they may be weary of certain disclosures due to fear around how certain information could serve to negatively affect them and their status (Pietrzak et al., 2009). Stigma has been noted as a barrier to treatment for veterans (Burnett-Zeigler et al., 2011) and these confidentiality policies may influence how individuals view therapy. Although policies have changed in more recent years and there is now some degree of confidentiality that is maintained between psychologist and soldier, the many stipulations set forth by the Department of Defense have been noted by psychologists as being somewhat ambiguous and as contributing to confusion over knowing when breaches of confidentiality are required (Cho-Stutler, 2013; Dao & Frosch, 2009).

These complex protocols around confidentiality, which are provided to soldiers, may make them err on the side of caution and may influence their decision to seek treatment in the future. Further, psychologists may be challenged by such practices as evidenced through a New York Times interview with Kaye Baran, a military psychologist, who stated "there really is no confidentiality" (Dao & Frosch, 2009, para. 6) and "you can find an exception to confidentiality in pretty much anything one would discuss"(Dao & Frosch, 2009, para. 6). The cryptic guidelines, such as "commander's need-to-know" (Substance Abuse Policy and Treatment, 2016) and "the accomplishment of the military mission" (Dao & Frosch, 2009) can cause confusion and suspicion for psychologist and clients alike. Further, psychologists are unaware if the Department of Defense has access to the online medical records. Questions concerning

confidentiality, frequently arise in the context of therapy and the uncertainty of the clinicians, are passed onto their clients causing further confusions and questioning of the practice of therapy. Although no clear-cut solution exists for the apparent dual roles of a psychologist in this setting, clearer policies and a better understanding around the rationale for breaking confidentiality may help clients and psychologists feel more comfortable with such practices.

Summary

The problem of widespread alcohol misuse among the veteran population is cause for significant concern. The risks identified throughout this literature review provide a context for the worrisome trend of continued alcohol misuse in this population and the lack of appropriate care. More work is needed to better understand the needs of veterans. Interventions should incorporate evidence-based models that address and combat the misuse of alcohol. Veterans need ways to cope more adaptively after experiencing the atrocities of war as using alcohol to divert their pain comes at large costs for them and society.

The Relationship Between the Literature Review and the Study

Given that veterans are at an elevated risk of alcohol misuse compared to civilians due to the convergence of various risk factors that create a highly concentrated risk of alcohol misuse among this population, more information is needed on this subject matter. Therefore, the current study, which attempted to better understand clinicians' competence and clinicians' perceptions when treating alcohol misuse, offers valuable information to the literature on alcohol misuse among veterans. This study addressed the apparent gap in research concerning clinicians' competence and perceptions of alcohol misuse among veterans. This is important information to obtain as it (a) provided information on the clinical training and the treatment modalities of clinicians treating alcohol misuse in the VA system; (b) helped to answer the question of whether

or not clinicians are able to competently provide integrated treatments that address the association between AUDs and other mental health related issues; (c) asked clinicians about their views of alcohol misuse in the veteran population and examine their understanding of how racial, ethnic, cohort, and/or gender differences relate to alcohol misuse; and (d) uncovered potential biases and discomfort that clinicians have while treating veterans with alcohol misuse.

Method

Study Design

The aim of this study was to gain knowledge about the treatment of alcohol misuse in the veteran population. This was done by assessing the perceptions of mental health care providers who are currently working at VAs. The study utilized an online survey methodology and VA mental health care providers were asked about their perceived competence, clinical training, treatment modality, and views on the problem of alcohol misuse in the veteran population. The relationships between the aforementioned variables were then explored.

Research Questions

In the study, several research questions existed that guided how the study was conducted and how data was collected. In terms of correlations, three predictor variables (clinical training, treatment modality, and views/perceptions of alcohol misuse) were correlated with the criterion variable (competence). I hypothesized that (a) the more clinical training the clinician had, the more competent the clinician would feel and (b) the more negative views the clinician has (less hope, less optimism, more beliefs that alcohol misuse is not treatable, etc.), the less competent the clinician would feel. The competence score was derived from the question in the survey that directly asks how competent the clinician feels when treating alcohol misuse. In order to understand the relationship between competence and the other variables, I ran a series of

correlations. Specifically, the competence score was correlated with the clinician's set of knowledge/skills (highest degree, licenses, amount of years practicing, and the amount of trainings/classes on SUD) and their views/perceptions of treating alcohol misuse (comfort level, confidence, anxiety level, feelings of being calm, feeling hopeless, feeling empathetic, optimism, and beliefs that alcohol misuse is difficult/easy to treat). In addition to correlations, descriptive statistics were used to answer the following research questions:

1. What are clinicians' levels of comfort, hope, optimism, confidence, anxiety, and empathy when treating veterans who misuse alcohol?
2. How often is alcohol misuse being addressed in therapy?
3. How many trainings/classes on substance misuse have clinicians had?
4. How often are different treatment modalities being used to treat alcohol misuse?
5. How often do clinicians' beliefs differ about the prevalence of alcohol misuse across gender, race, ethnicity, and cohort?

Participants

Eligible participants were mental health workers at four VA medical centers within the Veterans Integrated Service Network (VISN) 1, which include Edith Nourse Rogers VA Medical Center in Bedford, Massachusetts, White River Junction VA Medical Center in White River Junction, Vermont, Manchester VA Medical Center in Manchester, NH and VA Maine Healthcare System in Augusta, Maine. Eligible participants from these facilities were those who (a) provide direct individual and/or group therapy to the veteran population and (b) have a master's degree and/or a doctoral degree in a counseling/nursing profession (i.e. LMFT, CMHC, LPC, LCSW, CAC, LDC, APRN, Psychologist, MD).

At the onset of the study, I had hoped to receive at least 90 eligible participants in order to obtain a medium effect size at a. 05 significance level. However, after many months of recruiting, only 51 participants completed the survey due to the high work demands that VA workers have.

Demographic Frequencies

Appendix A provides numerical representations of the demographic questions participants responded to. The ages of the participants ranged from 23-68, with the mean being 41.9 and the standard deviation being 12.8. Concerning the gender of the participants, 57% (n=20) identified as being male, 39% (n=29), identified as being female 2% (n=1) identified as being a transmale, and 2% (n=1) identified as being gender fluid. Concerning the ethnicities of the participants, 96% (n=49) reported "White or Caucasian," 2% (n=1) reported "Asian/Pacific Islander," and 2% (n=1) reported "Multiracial." When responding to the highest degree achieved, 4% (n=2) reported having their bachelor's degree, 18% (n=36) reported having their Master's Degree, 25% reported having their doctorate in clinical psychology (Psy.D.; n=13), 31% (n=16) reported having their doctorate in psychology (Ph.D.) and 4% (n=2) reported having their doctorate of medicine (M.D.). Their years spent providing therapy ranged from 1-42 with the mean being 14.4 and the standard deviation being 11.6. Regarding licenses and certifications held, 56% (n=29) reported holding a Psy.D. or Ph.D., 4%.(n=2) reported holding a M.D, 14% reported holding a license in social work (LCSW; n=7), 4% (n=1) reported holding a license in professional counseling (LPC), 4% (n=2) reported holding a LADC, 2% (n=1) reported holding a license in alcohol and drug counseling (LADC1), 2% (n=1) reported holding a license in independent clinical social work (LICSW), 2% (n=1) reported holding a license as a certified physician's assistant (PA-C), 2% (n=1) reported holding an American Board of Professional

Psychology title (ABPP), and 14% (n=7) reported not holding any licenses or certifications.

Measure

The measure was an online survey which obtained feedback from VA clinicians in the field. The measure consisted of 24 questions from 4 categories: (a) 11 questions regarding demographics/clinical training, (b) five questions regarding treatment modality, (c) two questions regarding competence/comfort/stigma, and (d) six questions estimating the prevalence of alcohol misuse in the veteran population. Questions consist of a combination of Likert-type, multiple-choice, and fill in the blank response choices. See Appendix B.

Procedure

In terms of working within the VA system, the online measure chosen, SurveyMonkey.com, had been given unofficial authorization by the VA when being used on internal staff on non-sensitive topics (Guidance for Surveys used for VA Operational and Research Purposes, 2016). Given that the survey was administered to less than 1,000 VA mental health providers and from fewer than nine VA medical centers, the survey did not require approval from the Organizational Assessment Sub-Committee (Guidance for Surveys used for VA Operational and Research Purposes, 2016). However, union notification from various unions at each facility was needed in order to disseminate the survey to employees. In accordance with this policy, the human resource (HR) director at the centralized office (VISN 1) was contacted. This employee provided the names of HR employees at the Edith Nourse Roger VA Medical Center, the White River Junction VA Medical Center, the Manchester VA Medical Center, and VA Maine Healthcare System. Upon contacting the HR employees at these four VA medical centers, the HR employees then contacted the needed unions about the purposes and the content

matter of the proposed study. After reviewing the survey, all of the unions gave the proposed study union approval contingent on IRB approval from Antioch University New England.

Once Antioch University New England's IRB approval was given, I emailed a recruitment letter (provided in the Appendix section) for research participation to the mental health supervisors (the names of the supervisors were provided by the HR employees at each respective site) at the aforementioned VAs. Providers whose supervisor forwarded them the invitation were provided with a brief survey (15-25 minutes), which was be hosted by SurveyMonkey.com. The survey included a page that discussed the confidentiality, benefits, risks, and a brief description of the study.

Statistical Analysis

The study sought to understand clinician's perceived competence and clinician's perceptions on alcohol misuse by using correlations and descriptive statistics. For example, one working hypothesis was that treatment providers have had inadequate training treating alcohol misuse and therefore feel incompetent. The null hypothesis would include that there is no relationship between perceived competence and clinical training. To test this hypothesis, a correlation was performed to look at the relationship between perceived competence and level of clinical training. Other correlations regarding clinicians' perceived competence were conducted including (a) the relationship between the clinicians' optimism when treating alcohol misuse and their perceived competence, (b) the relationship between clinicians' beliefs that alcohol misuse is treatable and their perceived competence, (c) the length of time clinicians have been treating clients and their perceived competence, and (d) the amount of clinical training clinicians have had and their perceived competence. These correlations as well as others were performed in order to understand how clinician's perceived competence relates to treatment. Descriptive

statistics were also performed on each survey question regarding competence in order to understand clinician's perceived competence and their level of comfort, hope, optimism, confidence, anxiety, and empathy when treating veterans who misuse alcohol.

In addition to the aforementioned correlations and descriptive statistics concerning clinicians' perceived competence, other descriptive statistics were conducted in order to look at (a) the frequency of how often alcohol misuse is being addressed in therapy, (b) the amount of trainings/classes on substance misuse that clinicians have had, (c) how often different treatment modalities are being used to treat alcohol misuse, and (d) how often clinicians' beliefs differ about the prevalence of alcohol misuse across gender, race, ethnicity, and cohort. This information helped to better understand how clinicians' beliefs and practices impact the care that veterans receive.

The data collected in the study helped to answer a wide variety of questions concerning alcohol misuse treatment for veterans, mental health providers' perceptions of alcohol misuse among veterans, and clinicians' perceived competence when treating veterans who misuse alcohol. All the questions asked provided valuable information about the treatment of alcohol misuse in the VA setting which is important due to the varying approaches to treatment and the widespread misuse of alcohol in the veteran population. Given the trend of alcohol misuse among veterans, it is crucial to understand what treatment providers do and believe in terms of alcohol misuse.

The results of the study can allow the field to better understand how alcohol misuse is being addressed in the VA and answer the question of whether or not more training is needed for treatment providers. This information can help identify a need for treatment providers in the VA to become more skilled when working with alcohol misuse, which can ultimately allow for better

treatment for veterans. Veterans need ways to cope more adaptively after experiencing the atrocities of war as using alcohol to divert their pain can come at large costs for them and society.

Results

Given that not enough participants were recruited for the current study in order to have the results be generalizable to all VA clinicians, great caution is advised when interpreting the findings. This study can be used as more of an exploratory study and the results can be used to guide future research.

The purpose of this study was to learn more about the problem of alcohol misuse among veterans by way of understanding the perceptions of alcohol misuse in the veteran population and the approach to treatment by mental health providers in the Veterans' Affairs (VA) system. This was to be accomplished by asking VA mental health providers about their perceived competence, clinical training, treatment modality, and views on the problem of alcohol misuse among veterans. An additional purpose of this study was to fill in a gap in the literature and allow for a better understanding of how veterans who misuse alcohol are treated in VAs. There were multiple hypotheses proposed before data was collected. One hypothesis was that the more clinical training the clinician has had, the more competent the clinician feels. It was hypothesized that the better trained/educated that the clinician was, the more competent they would feel when treating veterans with problematic patterns of alcohol misuse. The null hypothesis included that there is no relationship between clinical training, education, and the feeling of competence that a clinician may have.

Extent of Clinical Training Regarding Substance and/or Alcohol Misuse

Participants responded to the multiple-choice question "How many classes/trainings did

you have during the course of your training that pertained to treating alcohol/substance misuse" with either (a) 0; (b) 1; (c) 2; (d) 3; (e) 4; or (f) 5 or more. Four percent (n=2) of participants reported that they had zero classes/trainings on substance/alcohol misuse, 31% (n=16) of participants responded that they had only one class/training on alcohol/substance misuse, 18% (n=9) of participants respondents reported that they had two classes/trainings on alcohol/substance misuse, 6% (n=3) of participants reported that they had three classes/trainings on alcohol/substance misuse, 6% (n=3) of participants reported that they had four classes/trainings on alcohol/substance misuse, and 35% (n=18) of participants reported that they had five or more classes/trainings on alcohol/substance misuse.

Concerning the specific types of classes/trainings that participants reported having on treating alcohol/substance misuse, 68% (n=32) reported that they had taken a Motivation Interviewing (MI) course, 57% (n=27) reported that they had taken a Cognitive Behavioral Therapy (CBT) course, 17% (n=8) reported that they had taken a Dialectical Behavior Therapy (DBT) course, 17% (n=8) reported that they had taken a Psychodynamic Therapy course, 11% (n=5) reported that they had taken an existential therapy course, 70% (n=33) reported that they had taken a Substance Use Class in graduate school, 55% (n=26) reported that they had taken a Substance Use Workshop during the course of their career, and 2% (n=1) reported that they had many continuing education courses on substance misuse.

Desire for Additional Training in Treating Alcohol/Substance Misuse

Participants were asked whether they have sought out additional training on treating alcohol/substance misuse. Sixty-seven percent (n=34) responded "yes" and 33% (n=17) responded "no." Participants were then asked if they would be interested in additional substance/alcohol use training: 92% (n=47) responded "yes" and 8% (n=4) responded "no."

Participants also responded to the question of "What might you hope to learn at such a training." With regards to this question, 62% (n=32) responded with "best treatment practices for alcohol misuse," 22% (n=11) responded with "treatment approaches for alcohol misuse," 8% (n=4) responded with "the psychological functions of alcohol misuse," 2% (n=1) responded with "using technology to assist with sobriety," 2% (n=1) responded with "N/A," 2% (n=1) responded with "all of the above, would like training over all," and 2% (n=1) responded with "I am at the end of my career and as a therapist I am kind of done."

Treatment Modality Used and Experiences of Success While Treating Alcohol/Substance Misuse

Participants were asked "Regarding your most recent client who has misused alcohol, what treatment approach best describes your therapy with this particular client?" and were supplied with a list of 20 treatment modalities as well as an option for "Other (please specify)." Thirty-nine percent (n=20) of participants responded to the question with *MI*, 35% (n=18) responded with *CBT*, 4% (n=2) responded with *Interpersonal therapy*, 4% (n=2) responded with *Eclectic Therapy*, 4% (n=2) responded with *Integrative Therapy*, 2% (n=1) responded with *Acceptance and Commitment Therapy*, 2% (n=1) responded with *Cognitive Interpersonal Therapy*, 2% (n=1) responded *DBT*, 2% (n=1) responded with *Person-Centered Therapy*, 2% (n=1) responded with *Psychodynamic Therapy*, 2% (n=1) responded with *Narrative Therapy*, and 2% (n=1) responded with *Behavioral Therapy*.

Concerning whether clinicians use a sequential approach to therapy (abstinence/controlled use) or an integrated approach (addressing alcohol misuse alongside comorbid disorders), 96% (n=49) of participants reported using an integrated approach and 4% (n=2) reported using a sequential approach. Regarding whether or not clinicians ask about

alcohol misuse during the course of therapy, 94% (n=48) reported that they do ask and 6% (n=3)stated that they "only ask at the intake." Concerning whether or not alcohol misuse is addressed in therapy, 84% (n=43) of participants stated "yes" is it addressed 2% (n=1) reported "using MI, I ask if we can talk about ETOH abuse," 2% (n=1) responded "contextual and situational, based on expressed goals of client," 2% (n=1) responded "depending on their motivation," 2% (n=1) responded "sometimes, in some cases I use a harm reduction approach and don't address the substance misuse just yet," 2% (n=1) responded "if it is a mutually-agreed upon goal," 2% (n=1) responded "depends on their goals, in what context we're meeting, etc.—my preference is to incorporate it," 2% (n=1) responded with "client dependent," and 2% (n=1) responded with "yes, if they are willing to discuss it."

Lastly, participants were asked "in your experience as a mental health provider, do most clients who misuse alcohol decrease their drinking with the support of therapy" and were provided with the options of "yes," "no," or "other (please specify)." Sixty-seven percent (n=35)of participants responded "yes," 22% (n=11) responded "no," 2% responded (n=1) "they say they do," 2% (n=1) responded "depends on a range of factors," 2% (n=1) responded "I don't have a large enough sample size," 2% (n=1) responded "mixed," and 2% (n=1) responded "it varies, most do, but not all."

Clinician's Perceptions and Views on Treating Alcohol Misuse in the Veteran Population

Participants were asked whether they believe alcohol misuse is higher in the veteran population; 76% (n=39) responded with "yes," 8% (n=4) responded with "no," and 16% (n=8) responded with "not sure." Concerning whether or not participants believe that younger generations (OIF/OEF/OND) of veterans misuse alcohol at higher rates than older generations of veterans (Vietnam, Korean War era), 68% (n=34) responded "no" and 32% (n=16) responded

"yes."

Regarding gender, 63% (n=32) of respondents reported that they believe "male veterans misuse alcohol more often" and 37% (n=19) reported, "no gender difference exists regarding alcohol misuse." Participants were asked "Do you believe differences exist between races/ethnicities in terms of alcohol misuse," 35% (n=18) responded "yes," 22% (n=11) responded "no," and 43% (n=22) responded "not sure." To explore the extent that gender and/or racial differences affect treatment, participants were asked "Do gender and/or racial differences affect how you treat alcohol misuse?"; 49% (n=25) of participants responded "yes," 35% (n=18) responded "no," and 16% (n=8) responded "not sure."

Participants were asked "When thinking of providing treatment for clients who misuse alcohol, which of the following statements best describes how you feel?" Forty-five percent (n=23) responded "most clients who misuse alcohol are similar to most clients who do not misuse alcohol," 43% (n=23) responded "most clients who misuse alcohol are more difficult to treat than most clients who do not misuse alcohol," 8% (n=4) responded "I am unsure," and 4% (n=2) responded "most clients who misuse alcohol are easier to treat than most clients who do not misuse alcohol."

Participants rated seven variables (knowledge, optimism, confidence, competence, hope, empathy, and calm) in regards to how they feel while treating alcohol misuse on a Likert scale of one to five, one being *not at all*, two being *slightly*, three being *neutral*, four being *mostly*, and five being *completely*. Concerning feeling knowledgeable, 14% (n=7) of participants rated "slightly," 20% (n=10) rated "neutral," 59% (n=30) rated "mostly," and 8% (n=4) rated "completely." Regarding feeling optimistic, 12% (n=6) rated "slightly," 22% (n=11) rated "neutral," 62% (n=31) rated "mostly," and 4% (n=2) rated "completely."

When asked how confident participants feel about treating alcohol misuse, 18% (n=9) responded “slightly,” 33% (n=17) responded “neutral,” 45% (n=23) responded “mostly,” and 4% (n=2) responded “completely.” Concerning competence, 16% (n=8) of participants responded “slightly,” 20% (n=10) responded “neutral,” 55% (n=28) responded “mostly,” and 10% (n=5) responded “completely.” Regarding participants’ levels of hopelessness, 53% (n=27) responded “not at all,” 26% (n=13) responded “slightly,” 18% (n=9) responded “neutral,” 2% (n=1) responded “mostly,” and 2% (n=1) responded “completely.” Concerning level of empathy, 2% (n=1)of participants responded “slightly,” 6% (n=3) responded “neutral,” 63% (n=32) responded “mostly,” and 29% (n=15) responded “completely.” Regarding participants’ feelings of being calm, 4% (n=2) responded “slightly,” 4% (n=2) responded “neutral,” 67% (n=34) responded “mostly,” and 25% (n=13) responded “completely.”

Competence and Negative Views of Alcohol Misuse

A Spearman’s rho analysis was performed to determine any significant correlations between a clinician’s competence score and their knowledge score, optimism score, confidence score, hope score, empathy score, calm score, or score related to their beliefs of how difficult veterans with alcohol misuse are to treat compared to veterans who do not misuse alcohol. Correlations are considered significant at the 0.01 level. Consistent with initial hypotheses, significant positive correlations were found between (a) the competence score and the confidence score (r_s =. 69, p <. 01); (b) the competence score and the knowledge score (r_s =. 84, p <. 01); (c) the competence score and the optimism score (r_s =. 51, p <. 01); (d) the competence score and the empathy score (r_s =. 42, p <. 01); and (e) the competence score and the calm score (r_s =. 56, p <. 01). No significant correlations were found between the competence score and the hope score (r_s = -.16, p <. 01) or the competence score and the score related to a clinician’s belief

about whether or not veterans with alcohol misuse are more difficult to treat compared to veterans who do not misuse alcohol (r_s = -.15, p <. 01).

Competence and Clinical Training

A Spearman's rho analysis was performed to determine any significant correlations between a clinician's clinical training and competence. Consistent with initial hypotheses, significant positive correlations were found between the competence score and the number of years a clinician has been practicing (r_s =. 44, p <. 01) as well as the competence score and the number of trainings a clinician has had on alcohol treatment (r_s =. 53, p <. 01).

Discussion

The results of this study and interpretation regarding my hypotheses are explored in the following paragraphs. Based on the results of this study, it is possible to discuss the beliefs and treatment preferences of the VA providers surveyed. It is also possible, based on the results of this study, to discuss possible factors that contributed to beliefs and treatment practices of the VA providers surveyed. However, caution is advised against making broad generalizations given the limited number of participants in the current study. This study should be viewed as more of an exploratory study that can be used to guide further research.

Education in Alcohol and Substance Misuse

Based on participant's ratings of the clinical training they have received on treating alcohol misuse, it is clear that the amount of training that clinicians have had was highly variable and dependent on individual clinicians. While nearly one third of clinicians have had more than five classes/trainings on alcohol misuse, two thirds have not. In fact, 31% of participants reported that they had only one class that related to treating alcohol misuse. This is extremely

alarming given the high prevalence of SUDs and the high comorbidity between these disorders and other mental health disorders.

In terms of specific classes/trainings, it is obvious that CBT, MI, and specific substance use trainings/classes were the most common educational experiences that addressed treating alcohol and substance misuse. This finding is consistent with research supporting these kinds of treatments while treating alcohol misuse.

Desire for Additional Training in Treating Alcohol/Substance Misuse

Even though nearly 35% responders reported having had five or more classes related to substance use disorders, the data suggests that there is clearly a desire for increased training on this subject matter. In fact, 92% of all responders reported that they would be interested in more training on alcohol and substance misuse if it were offered to them. Interestingly, the majority of responders (62%) were most interested in learning best treatment practices for alcohol misuse. Moreover, 67% reported having to seek out additional education in alcohol misuse, as it was not being offered in their program. This data clearly suggests that more education on alcohol and substance misuse needs to be incorporated into training programs in order for clinicians to feel competent and well versed in best treatment practices.

Treatment Modality Used and Experiences of Success While Treating Alcohol/Substance Misuse

Concerning the treatment modality most preferred by VA providers when treating alcohol misuse, it is clear based on participant results that MI and CBT were the most common approaches. In line with best practice, 96% of VA providers endorsed using an integrated approach as opposed to the once more common sequential approach. Moreover, 84% of participants reported that they asked their clients about alcohol use. Based on participants'

responses regarding whether or not they believe therapy is effective in treating alcohol misuse, the vast majority (67%) reported that they believe clients who misuse alcohol get better with the support of therapy. Given that hope is a large variable in treatment success, especially while treating substance use disorders, this finding is encouraging.

Clinicians' Perceptions and Views on Treating Alcohol Misuse in the Veteran Population

The data clearly indicates that 76% of VA providers in this study are acutely aware that the veteran population misuses alcohol at higher rates than the civilian population. More than half of respondents (63%) also understood that younger male veterans misuse alcohol at higher rates than female veterans and older veterans. Interestingly, almost half of respondents were unsure (43%) whether or not racial differences exist in terms of alcohol misuse. Moreover, 22% responded that no racial differences exist. This left only 35% responders stating that they belief differences exist in regards to race/ethnicities and alcohol misuse. Moreover, only half (49%) of participants reported that racial and/or gender differences do not affect their treatment considerations—this left 22% stating that they do not incorporate gender/racial/ethnic differences in their treatment and almost half (43%) stating that they are "not sure" if they incorporate gender/racial/ethnic differences into treatment. These findings were more worrisome given the research, which states that differences exist in regards to gender, race, and ethnic backgrounds and that treatment may be optimized if a veteran's culture is taken into consideration (Golub et al., 2013; Hawkins et al., 2010; Koo et al., 2015a; Maguen et al., 2010; Schell et al., 2011).

In terms of participants' feelings while treating veterans who misuse alcohol, the results indicate that most clinicians do not feel like they are easier to treat, rather, the majority were split between believing they are (a) more difficult to treat (43%), or (b) similar to treating other veterans without alcohol misuse (45%). This finding stands in opposition to research which

shows that providers find patients who misuse substances to be more difficult to treat (Pietrzak et al., 2009; Seal et al., 2011).

With regards to clinicians' beliefs while treating alcohol misuse among veterans, more than three-quarters of respondents reported that they feel "mostly" or "completely" knowledgeable, competent, hopeful, empathetic, and calm while treating alcohol misuse among veterans. Although these clinicians reported feeling knowledgeable, competent, hopeful, empathetic, and calm while treating alcohol misuse among veterans, less than half of all respondents reported feeling "mostly" or "completely" confident while treating alcohol misuse. This is interesting to note and more information is needed to understand why clinicians are not reporting being "confident" while treating alcohol misuse, yet are reporting they are knowledgeable, competent, hopeful, empathetic, and calm while treating alcohol misuse among veterans.

Competence and Negative Views of Alcohol Misuse

When considering competence and clinicians' views on alcohol misuse among veterans, it became clear that many factors are related to a clinician's perceived level of competence including their confidence, knowledge, empathy, optimism, and ability to remain calm. Interestingly, neither hope nor the clinician's belief about whether veterans who misuse alcohol are harder to treat compared to other veterans who do not misuse alcohol were correlated with the clinician's competence score. These are interesting findings given that (a) research has found that clients who misuse substances have poorer treatment outcomes than those who do not misuse substances, and (b) both the clinician's hope and the client's hope influence treatment outcomes. Given that the current study's findings stand in stark opposition to the current research, more information would be needed to make sense of this finding.

Competence and Clinical Training

The data clearly indicates that a relationship exists between the amount of years that a clinician has been practicing and their perceived competence. Similarly, there is a clear trend with regards to the number of trainings a clinician has had on substance use and their level of perceived competence. These findings, though not surprising, support the idea that clinicians need training and experience in order to feel competent while treating alcohol misuse.

Limitations of the Current Study

One of this study's most notable limitations is the number of participants in the study. The recruitment process proved to be far more difficult than anticipated. Feedback from multiple clinicians at the surveyed VAs was that VA clinicians have limited time and large workloads. Therefore, many clinicians were unwilling to take even a brief survey because of the time restraints imposed on them in the VA system. Although I had hoped to have 90 participants, I was only able to recruit 51. Given the relatively small number of participants, the results of the study need to be interpreted with caution.

Another possible limitation in this study involves how the clinicians' self-reports may differ from actual practice and beliefs. There is considerable literature indicating that clinicians hold stereotypes and negative biases about clients who misuse alcohol and substances (Pietrzak et al., 2009; Seal et al., 2011). However, the clinicians in this study did not indicate holding any such stereotypes. Although it is possible that clinicians in this sample are not biased and do not hold negative views of veterans who misuse alcohol, it is also possible that these clinicians may have attempted to hide their negative beliefs in order to appear more socially desirable.

Future Research

Given that this was an exploratory study, more research is needed in order to generalize

the results of this study. Similar methods may be used in order to better understand clinicians' perceived competence and their beliefs about treating veterans who misuse alcohol in the VA system. In addition, more research may also incorporate the veterans' beliefs about their care. By doing this, more information would exist about veterans' personal experiences and how they relate to their clinicians' experiences.

Overall Concluding Remarks

The rising number of veterans compiled with new research suggesting that the OEF/OIF/OND veterans have higher rates of alcohol misuse (Adler et al., 2011; Bryan et al., 2015; Burnett-Zeigler et al., 2011; Hawkins et al., 2010; Lan et al., 2016; United States Census Bureau, 2010) creates a dire need for clinicians to be competent in treating AUDs. Although alcohol misuse is a widely recognized problem among veterans, it is largely ignored in the research (Calhoun et al., 2008; Kelsall et al., 2015; Seal et al., 2007) and only recently has attention focused on it. This study sought to build upon the existing data on alcohol misuse among veterans in a desperate attempt to better understand the perceptions and the approach to treatment by mental health providers in the VA system that treat veterans who misuse alcohol. The results of this study provide a better understanding of the ways in which veterans who misuse alcohol are treated in the VA system. Moreover, this study, although small in size, recognized the need for clinicians to have more training and a greater understanding of the veterans that they are treating.

Clinicians Need More Consistent Training on Treating Alcohol Misuse

A key finding in this study was that clinicians' training experiences were highly variable. Given the inconsistency among providers' training, it is fair to assume that great differences exist in regards to how individual providers treat alcohol misuse. Therefore, the current study's results

suggest that clinicians need to have more consistent training in order to know best treatment practices when treating alcohol misuse in veterans. In addition to needing more standardized training, this study's findings also suggest that clinicians need more training on treating alcohol misuse overall. Thirty-one percent of the clinicians in this study reported only having one class on treating substance misuse and 92% voiced a desire for more training when treating alcohol misuse. Given that the findings of the study suggest that the more trainings and the more years of experience that a clinician has had and the more competent they feel, it is reasonable to suggest that standardizing and increasing training would increase the level of competence among VA clinicians treating veterans who misuse alcohol.

Clinicians are Using Evidence-Based Interventions While Treating Alcohol Misuse

A study by Seal et al. (2011), which used retrospective cross-sectional descriptive and multivariate analyses from 456,502 OEF/OIF veterans, found that 80-90% of veterans who met the diagnostic criteria for AUD or drug use disorder (DUD) had at least one other diagnosis. These psychiatric comorbidities have serious implications as "patients with both disorders have been found to have a more severe clinical profile than those with either disorder alone, lower general functioning, poorer well-being and worse outcomes across a variety of measures" (Schäfer & Najavits, 2007 as cited in Roberts et al., 2015, p. 26).

The findings of the current study are encouraging in that nearly all the clinicians in the sample had a very strong understanding of the high rates of psychiatric comorbidity and the need for using integrated treatment practices as opposed to sequential treatment practices. This is extremely promising given that integrated treatments have been found to be the most effective form of treatment for SUDs and other commonly occurring disorders such as PTSD (Institute of Medicine, 2008 as cited in Killeen et al., 2015, p. 235; Roberts et al., 2015, p. 25). Moreover,

CBT-style treatments have been backed by research as being the most effective form of treatment for SUDs (Roberts et al., 2015). Consistent with this research, the findings of the current study indicate that CBT was the most commonly used treatment among. Therefore, the findings of this study suggest that the surveyed VA clinicians are using integrated evidence-based interventions.

Clinicians Lack an Understanding of Gender, Racial, and Ethnic Differences While Treating Alcohol Misuse

Empathy, a commonly described and essential component of all therapy can be described as '"putting oneself in someone else's shoes," and informally, it is described as an attempt to know what it feels like to be in another person's situation" (Barnes, 2014, p. 560). Although clinicians in this study indicated that they have high rates of empathy—as well as other common factors including hope, optimism, knowledge, calmness, and competence—they appear to be lacking a crucial element of what it means to be empathetic: having a true understanding of the other person.

The clinicians in this study understood that the rate of alcohol misuse and substance use is higher in the veteran population but failed to understand that gender, racial, and ethnic differences exist and need to be incorporated into treatment. This is of dire importance given that (a) women and racial/ethnic groups are the fastest growing cohorts of veterans (Maguen et al., 2010; Manning, 2013); (b) alcohol misuse patterns differ by gender, and men are more likely to screen positive for alcohol misuse and are two times as likely to be diagnosed with substance abuse disorders as compared to women (Golub et al., 2013; Hawkins et al., 2010); (c) substance use disorders are higher in certain racial/ethnic populations, including American Indian/Alaskan populations, and are affected by genetic factors; and (d) gender has been shown to have

moderating effects on racial/ethnic differences in terms of alcohol misuse (Koo et al., 2015a, 2015b). Clinicians in this study failed to acknowledge that gender, racial, and ethnic differences exist and need to be incorporated into treatment. Therefore, based on the results of this study, more training is needed in this particular area.

Clinicians Believe Veterans Who Misuse Alcohol Can Benefit From Therapy

This study's findings indicate that the majority of the clinicians are hopeful that their clients will get better through therapy. Moreover, the clinicians in this study didn't view this population as being more difficult to treat. Clinicians endorsed being knowledgeable, hopeful, empathetic, and calm, while treating veterans with alcohol misuse. This is encouraging given that the literature indicates that people who misuse substances are often stigmatized by their providers (Pietrzak et al., 2009; Seal et al., 2011).

Conclusion

Overall, this study supports the need for changes to be made in the treatment of veterans with alcohol misuse by way of (a) increasing overall training on treating alcohol misuse; (b) having more consistency in training programs with regards to treating substance misuse; and (c) increasing clinicians' knowledge of cultural differences in terms of gender, race, and ethnicity in the context of treating alcohol misuse among veterans. Additionally, this study also found encouraging findings in that most clinicians (a) have an understanding that veterans have higher rates of substance abuse compared to their civilian counterparts; (b) incorporate evidence-based models that address comorbid symptoms; (c) report being hopeful, calm, empathic, optimistic, competent, and knowledgeable about treating veterans who misuse alcohol; and (d) are asking about substance misuse and incorporating it into treatment.

This study's results have provided valuable information regarding the treatment of veterans in the VA system. More information is now known about VA providers' clinical training, treatment modalities, and views of veterans who misuse alcohol. This research will add to the current dearth of literature on this topic and can be used as to guide future studies. Ultimately, this study identified weaknesses and areas for improvement in the treatment of veterans who misuse alcohol. This information can be used to increase training experiences of VA clinicians and thereby better the care of veterans who misuse alcohol in the VA system.

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Appendix A

Survey

Alcohol Misuse Among Veterans: Implications for Better Treatment

This is a survey about the treatment and perceptions of mental health providers and how they relate to veterans' care in Veterans Affairs (VA) facilities. This survey will give you an opportunity to discuss your perceived competence, clinical training, treatment modality, and views on the problem of alcohol misuse among veterans.

Your responses will (a) provide information on the clinical training and the treatment modalities of clinicians treating alcohol misuse in the VA system; (b) help to answer the question of whether or not clinicians are able to competently provide integrated treatments that address the association between Alcohol Use Disorders and other mental health related issues; (c) give clinicians' views of alcohol misuse in the veteran population and examine their understanding of how racial, ethnic, cohort, and/or gender differences relate to alcohol misuse; and (d) uncover any potential biases and/or discomfort that clinicians have while treating veterans with alcohol misuse.

There are minimal, if any, risks from participating. Your identity will be anonymous and confidential. You will not be asked for your name and all demographic data being collected will be reported as aggregated information. No personally identifiable information will be associated with your responses to any reports of these data. The survey will take approximately 25-30 minutes to complete. This survey is part of my dissertation research at Antioch University New England in the Clinical Psychology, PsyD, Program under the supervision of Roger Peterson, Ph.D., Professor & Distinguished Senior Scholar, [redacted]. The study results may be included in future presentations and publications.

Your participation is voluntary, and you may elect to discontinue your participation at any time. If you have any questions about the survey or the research study, please contact me at: [redacted]

This project has been approved by the Institutional Review Board at Antioch University. If you have any questions about your rights as a research participant, please contact Kevin Lyness, Chair of the Antioch University New England Institutional Review Board [redacted] or Dr. Barbara V. Andrews, Interim Provost and CEO, [redacted]).

I have read and understood the above information. By clicking "Next" below, I am indicating that I have read and understood this consent form and agree to participate in this research study.

Please print a copy of this page for your records.

Thank you for your participation!

Demographics/Clinical Training

1. Please Indicate Gender:

2. Ethnicity origin (or race): Please specify your ethnicity

3. What is your current age?

4. What is your highest degree?
   a) B.A.
   b) B.S.
   c) M.A.
   d) M.S
   e) Psy.D.
   f) Ph.D
   g) Ed.D
   h) MD

5. What license(s) or certification do you hold? (Please check all that apply)
   a) LMFT
   b) CMHC
   c) LPC
   d) LCSW
   e) CAC
   f) LDC
   g) APRN
   h) Psychologist
   i) MD
   j) Psy.D.
   k) Ph.D.
   l) LPC
   m) CMHC
   n) LMFT
   o) LADC
   p) ABPP
   q) LICSW
   r) None

6. For how many years have you been providing therapy services? (Specifically, since you began acting as primary therapist with your own caseload, even if under supervision, as with a clinical practicum or internship)?

7. How many classes/trainings did you have during your training that pertained to treating alcohol misuse?

a) 0
b) 1
c) 2
d) 3
e) 4
f) 5 or more

8. If you had any classes/training in treating alcohol/substance misuse, which course(s) were they part of (Please check all that apply):

a) Motivational Interviewing (MI)
b) Cognitive Behavior Therapy (CBT)
c) SUD Cognitive Behavior Therapy (SUD-CBT)
d) Dialectical Behavior Therapy (DBT)
e) Psychodynamic Therapy
f) Existential Therapy
g) Substance Use Class in Graduate School
h) Substance Use Class or Workshop
i) Workshop focused on Substance Use
j) Other (please specify)

9. Have you ever sought out additional education or training regarding alcohol misuse due to working with a client who misused alcohol?

a) Yes
b) No

10. Would you be interested in substance use training if it were accessible to you?

a) Yes
c) No

11. What might you hope to learn at such training?

a) Recognition and Identification of alcohol misuse
b) Assessment of alcohol misuse
c) Psychological functions of alcohol use
d) Treatment approaches for alcohol misuse
e) Best treatment practices for alcohol misuse
f) Other (please specify).

Topics/ Treatment Modality

12. Regarding your most recent client who engaged in alcohol misuse that were addressed in therapy, to the best of your recollection, what treatment approach best describes your therapy with this particular client?

a) DBT
b) CBT
c) Interpersonal Therapy
d) Gestalt
e) Cognitive Therapy
f) Person-Centered
g) Relational Cultural
h) Psychodynamic
i) Psychoanalysis
j) Family Therapy
k) Hypnotherapy
l) EMDR
m) Group Therapy
n) Eclectic
o) Integrative Therapy
p) Rational-Emotive
q) Feminist
r) Narrative Therapy
s) Existential
t) Behavior Therapy
u) Internal Family Systems
v) Transtheoretical
w) Object Relations
x) Emotion-Focused
y) Time-Limited Dynamic
z) Rogerian
aa) Other (Please Specify)

13. In terms of treatment modality, do you use a sequential approach to treating alcohol misuse (abstinence/controlled use) or an integrated approach (addressing alcohol misuse alongside other problems)?

a) Yes
b) No
c) Sometimes

14. In your experience as a mental health provider, do clients who misuse alcohol decrease their drinking with the support of therapy?

a) Yes
b) No
c) Other (please specify)

15. Do you ask about alcohol misuse?
    a) Yes
    b) No
    c) Only at the intake

16. If a client states that they misuse alcohol, is it addressed in therapy?
    a) Yes
    b) No
    c) Other (please specify)

Prevalence

17. Do you believe alcohol misuse is higher in the veteran population?
    a) Yes
    b) No
    c) Not Sure

18. Do you believe the younger generations (OIF/OEF/OND) of veterans misuse alcohol at higher rates than the older generations of veterans (Vietnam-era, Korean war era)?
    a) Yes
    b) No
    c) Not Sure

19. Do you believe male or female veterans misuse alcohol more often?
    a) Males misuse alcohol more often
    b) Female veterans misuse alcohol more often
    c) No difference exists between genders
    d) Not Sure

20. Do you believe differences exist between races/ethnicities in terms of alcohol misuse?
    a) Yes
    b) No
    c) Not Sure

21. Do gender and racial differences affect how you treat alcohol misuse?
    a) Yes
    d) No
    e) Not Sure

22. In your current practice, how many clients are on your current caseload?

Clinicians' Views/Perceptions/Competence

23. When thinking of providing treatment for clients who misuse alcohol, which of the following statements best describes how you feel?

a) Most clients who misuse alcohol are more difficult to treat than most clients who do not misuse alcohol
b) Most clients who misuse alcohol are similar to most clients who do not misuse alcohol
c) Most clients who misuse alcohol are easier to treat than most clients who do not misuse alcohol
d) I am unsure

24. When thinking of providing treatment for clients who misuse alcohol, which of the following statements best describes how you feel?

a) Knowledgeable: Not at all, Slightly, Neutral, Mostly, Completely
b) Optimistic: Not at all, Slightly, Neutral, Mostly, Completely
c) Confident: Not at all, Slightly, Neutral, Mostly, Completely
d) Competent: Not at all, Slightly, Neutral, Mostly, Completely
e) Hopeless: Not at all, Slightly, Neutral, Mostly, Completely
f) Empathetic: Not at all, Slightly, Neutral, Mostly, Completely
g) Calm: Not at all, Slightly, Neutral, Mostly, Completely

Table 1

Table 1: Spearman's rho Correlations Among Participants' Competence Scores and Their Knowledge, Skills, Views, and Perceptions of Treating Alcohol Misuse

		Competence Score (r_s)
Spearman's rho	Knowledge Score	.84
	Optimism Score	.51
	Confidence Score	.69
	Hope Score	-.16
	Empathy Score	.42
	Calm Score	.56
	Beliefs about level of difficulty	-.15
	Number of Years Practicing	.44
	Number of Trainings	.53

Table 2

Table 2: Participant Demographics (n=51)

Characteristic		n	%	M	SD	Range
Age (years)		51	100	41.9	12.8	23-68
Years Providing Therapy		51	100	14.4	11.6	1-42
Number of Classes/Trainings on Treating Alcohol Misuse		51	100	3.1	1.8	0-5+
Gender						
	Male	20	57			
	Female	29	39			
	Transmale	1	2			
	Gender Fluid	1	2			
Ethnicity						
	White	49	96			
	Multiracial	1	2			
	Asian/ Pacific Islander	1	2			
Highest Degree						
	B.A.	2	4			
	M.A.	7	14			
	M.S.	11	22			
	Psy.D.	13	25			
	Ph.D.	16	31			
	M.D.	2	4			
Licenses and Certifications Held						
	Psy.D.	13	25			
	Ph.D.	16	31			
	M.D.	2	4			
	LCSW	7	14			
	LPC	2	4			
	LADC	2	4			
	LADC1	1	2			
	LICSW	1	2			
	PA-C	1	2			
	ABPP	1	2			
	None	7	14			