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# New Ways of Addressing the Psychological Traumas of War: Supplementing Traditional Social Supports to Prevent Homelessness Among Mentally Ill Veterans

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NEW WAYS OF ADDRESSING THE PSYCHOLOGICAL TRAUMAS OF WAR:  
SUPPLEMENTING TRADITIONAL SOCIAL SUPPORTS TO PREVENT  
HOMELESSNESS AMONG MENTALLY ILL VETERANS

A project based upon an independent investigation, submitted in partial fulfillment of the requirement for the degree of the Bachelor of Arts in Social Work.

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2009

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New Ways of Addressing the  
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### ABSTRACT

Both nationally and in Rhode Island, there is a high prevalence of veterans in the homeless population. Many homeless veterans suffer from serious mental health issues and military specific traumas, adding to the social stigma they face. To avoid homelessness, veterans need to treat their mental illness with the assistance of their social support networks. Despite incredible advances in technology and mental health care, provision of mental health services to veterans still remains very traditional. With an influx of veterans returning from the current conflicts in Iraq and Afghanistan, a greater number of younger clients will be entering the system. Because of their comfort with computers, the Internet and social networking tools, there is a natural progression for these veterans to use the Internet to support one another in their return from combat and readjustment to civilian life. To prevent isolation and encourage continued receipt of mental health services, online social support services can help veterans avoid homelessness when used as a supplement to traditional mental health treatment. A survey of nine (N=9) social workers at the VAMC showed that social workers who serve veterans would find online social supports helpful for their clients and would recommend these services as a supplement to their traditional therapeutic treatment.

## I. Introduction

### A. Problem Formulation

1. Both nationally and in Rhode Island, there is a high prevalence of homeless veterans
2. Many homeless veterans suffer from serious mental health issues and military specific traumas and face social stigma
3. These issues are obstacles to self-sufficiency for veterans

### B. Problem Justification

1. Social supports can help veterans avoid and/or overcome homelessness by helping them treat and overcome their mental illnesses
2. Veterans can rely on traditional social supports, like their friends and families, to overcome mental illness and avoid homelessness
3. Social workers in Veterans Affairs (VA) and other agencies, as both micro-level practitioners and as administrators, can help veterans reconnect with these traditional social supports
4. Social workers can serve as a social support for veterans

## II. Main Points

### A. *The Psychological Traumas of War:* Veterans suffer from a large number of military service-related traumas

1. Both nationally and in Rhode Island, a large percentage of veterans suffer from mental illness, often related to their military service
2. Common mental health issues of veterans include
  - a. PTSD, depression, anxiety
  - b. Substance abuse (alcoholism & drug addiction)
  - c. Abuse (especially of women)
    - i. In military
    - ii. Prior to military service
    - iii. Post-military service
3. Often, in readjusting to civilian life, veterans experience feelings of isolation and have trouble expressing their experience to their family and friends. Veterans may live far away from or have lost other members of their unit, the only people who have shared the veteran's experience

### B. *The Disproportional Representation of Veterans in the Homeless Population:* Veterans are disproportionately represented in the homeless population

1. Definitions of homelessness
  - a. Long-term vs. Short-term
  - b. Chronic homelessness
2. There is a high prevalence of homeless veterans in Rhode Island and nationally
3. The two most common causes of homelessness are a lack of affordable housing and having low or no income
4. Cause of homelessness in veterans include the aforementioned causes, but is also commonly caused by mental illness and substance abuse issues

## 5. Homelessness further isolates veterans

C. *The Importance of Social Supports*: Social supports in a veteran's life can aid the veteran's treatment of mental illness and prevent or end homelessness

1. Theoretical explanation of social supports
2. Traditional social supports can aid a veteran and prevent feelings of isolation
  - a. Families and friends can provide support in a veteran's return
  - b. For some veterans, spirituality can serve as a social support
3. In place of traditional supports, homeless veterans often establish social networks with other homeless individuals

D. *Social Workers as Social Supports and VA Case Management Services*

1. Social workers can facilitate relationships between veterans and their traditional social networks to encourage these networks to be social supports
  - a. Social workers can counsel families during a service member's absence to prepare them for that individual's return and the problems they may encounter, help service members maintain their social networks during time away from these people, or use group and/or couples and/or family therapy to facilitate communication during a veteran's readjustment to civilian life
2. Social workers can serve as social supports for veterans without a social network or without strong social supports
  - a. Social workers can support veterans through readjustment by being an empathetic and supportive person in the veteran's life
3. Social workers who are practitioners in the VA provide a multitude of services to help veterans

### III. Opposing Points

A. *Ineffective Social Supports*: Traditional social supports, like family and friends, are not successful in assisting veterans

1. Not all social networks are strong
  - a. Military marriages can be a negative social tie for a veteran
  - b. African American veterans tend to have larger social networks, but still suffer as much or more than their white counterparts with service-related traumas, mental illness, etc.
2. Social workers, and other formal services, are not needed to facilitate the relationships between veterans and their social networks
  - a. Individual families and the veteran's social networks can invest more time and energy in assisting the veteran
  - b. Veterans can also invest time into their relationships with their social networks to improve them, without the help of a social worker

### *B. Alternative Social Supports – Peer-to-Peer Support Groups and Online Support*

1. Peer-to-Peer veteran support groups are more effective in assisting veterans
  - a. “Combat to College”
  - b. Swords to Plowshares
  - c. Operation Stand Down RI
2. Social networking tools and online support groups may help veterans stay connected with members of their unit
3. Online support groups build social capital and aid in coping
  - a. National Veterans Foundation
  - b. Iraq War Veterans Organization
4. Online support groups are effective tools to assisting people battling from physical illnesses (i.e. - cancer, HIV/AIDS)
  - a. VA pilot program to provide internet-based substance use disorder treatment

### IV. Hypothesis

There is a role for both social workers and veterans’ networks in assisting mentally ill veterans who are homeless or at-risk for homelessness by facilitating their interaction with their social networks. By serving as a positive social support and assisting the veterans to maintain and grow their social supports, social workers can help mentally ill veterans increase their treatment success while avoiding and/or recovering from homelessness. Veterans’ networks can offer peer-to-peer support and can best relate to the experiences other veterans have had, especially for those with mental illness. Online support services may be the most accessible for young veterans due to their familiarity and comfort with online social networking tools and can help reduce the stigma associated with mental illness and treatment. Because access to all services often depends on a case manager’s recommendation, this research investigates social workers’ perception of the value of online support networks to supplement traditional therapeutic treatment and their likelihood to recommend these services to their clients.

### V. Methodology

- A. Sample
- B. Data Gathering
- C. Data Analysis
- D. Findings

### VI. Conclusion

- A. Restatement of thesis and findings
- B. Implications for social work research, social work practice, and social policy

In 2004, the National Coalition for the Homeless reported that approximately 760,000 people are homeless on any given day (as cited in Benda, 2006). Nationally, about 40 percent of all homeless men are veterans (Rosenheck, Frisman, & Chung, 1993, as cited in Rosenheck & Koegel, 1993). Rhode Island is not immune to the problem of homeless veterans, with 6,773 individuals being served by Rhode Island's emergency shelter system in fiscal year 2007<sup>1</sup> (Rhode Island Emergency Food and Shelter Board, 2008). Of the adult males who utilized emergency shelter, 18.6 percent were veterans (Rhode Island Emergency Food and Shelter Board, 2008). Although the data specific to Rhode Island is lower than the national average, homelessness among the state's veteran population is still an issue of great concern. In addition, 43.6 percent of homeless veterans reported suffering from mental health problems (Rhode Island Emergency Food and Shelter Board, 2008). Homelessness, depression and mental illness, drug and alcohol abuse, trauma and isolation are self-perpetuating issues that are prohibitive to self-sufficiency (Benda, 2006; Applewhite, 1997).

There is a moral issue with the high national and Rhode Island prevalence of homeless veterans, as homelessness among veterans is "particularly repugnant" considering their service to their country (Rosenheck and Koegel, 1993, p. 858). There is a negative public perception of the homeless, which creates additional obstacles to attaining self-sufficiency (Applewhite, 1997). This perception "often results in homeless people being victimized and blamed by the general public for their circumstances in life" (Applewhite, 1997, p. 24).

Homelessness is an additional trauma occurring in a series of traumas for veterans. Veterans are faced with problems specific to their population, including war-

related posttraumatic stress disorder (PTSD), problems readjusting to civilian life, and feeling of betrayal due to unmet promises for postwar benefits and treatment (Applewhite, 1997). Female veterans are especially vulnerable as they are often victims of physical and sexual abuse, both in the military and on the streets, which results in feelings of hopelessness (Benda, 2006). Bureaucratic service delivery systems compound the hopelessness and isolation of veterans, making them feel unwanted and unappreciated for their contribution (Applewhite, 1997).

Social supports can aid in recovery from mental illness, specifically addiction, in homeless veterans (Benda, 2006). Spirituality and social connectedness are especially important, as people have a strong desire to find meaning in traumatic events in their lives (Benda, 2006, p. 71). Social support from family and friends is more beneficial to female veterans than male veterans, a trend which is supported by adherence to gender roles and feminist theories (Benda, 2006).

Homelessness among the nation's mentally ill veterans is a concern for social workers because of the possible micro- and macro-level interventions that may help ameliorate the feelings of hopelessness and victimization. Despite the high value that homeless veterans have for the Department of Veterans Affairs (VA) and veteran's programs (Rosenheck & Koegel, 1993), many identify barriers within such systems to receiving services (Applewhite, 1997). The veterans commented that "their experiences [with these systems] included lack of respect for their human dignity, apathy, indifference, callousness, service-connected labeling, degrading comments, and put-downs" (1997, p. 25).



Social work practice in the VA was pioneered by Irene Grant Daymple after World War I (United States Department of Veteran Affairs, n.d. b). For social workers within the VA system or working for other veterans service providers, individual work to improve services to clients is necessary. Individual case workers can serve as the social supports instrumental to recovery or assist the client in restoring relationships with his or her family and friends (Benda, 2006).

Similarly, veterans in focus groups identified policies within such systems that were dehumanizing and unnecessarily bureaucratic, making them feel unwelcome and disrespected (Applewhite, 1997). For social workers in administrative positions, then, a change in policies on an organizational level is necessary. Also on a macro-level, efforts to eliminate barriers such as lack of affordable housing, poor education, lack of employment opportunities, and widespread poverty (Applewhite, 1997; Rosenbeck, et al, 1997; Rosenbeck & Koegel, 1993; Benda, 2006) would encourage self-sufficiency among homeless veterans with mental illnesses, as well as all other homeless individuals.

### *The Psychological Traumas of War*

Veterans suffer from of large number of military service-related psychological traumas. Since the Vietnam War, the psychological impacts of military service have been examined by many researchers (King, King, Fairbank, Keene & Adams, 1998; National Coalition for the Homeless, 2008c; United States Department of Veterans Affairs, n.d. e; National Coalition for the Homeless, 2008a; Gamache et al., 2003; Applewhite, 1997; Rosenheck & Koegel, 1993; Rosenheck et al., 1997; Humphreys & Rosenheck, 1998; Cable News Network, 2008; National Alliance on Mental Illness, n. d.; The National Council for Community Behavioral Health, n. d.; RAND Corporation,

2008). About one third of veterans from the wars in Afghanistan and Iraq, Operations Enduring Freedom and Iraqi Freedom (OEF/OIF), respectively, who were treated in the Veterans Affairs (VA) health care system received mental health and/or psychological diagnoses (Seal, Bertenthal, Miner, Sen & Marmar, 2007; NAMI, n. d.; CNN, 2008). VA records show that the total of mental health cases increased to 100,580 in 2007 from 63,767 in 2006 (NAMI, n. d.). Veterans of these conflicts are continuing to return home, and the number of them that suffer from mental illness also continues to increase.

It is estimated that 15.2 percent of male Vietnam veterans and 8.5 percent of female Vietnam veterans suffer from post-traumatic stress disorder (PTSD) (King et al., 1998). PTSD is an anxiety disorder that can occur after witnessing or experiencing a traumatic event. It often leads to other mental health problems, including “depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health” (CNN, 2008). For veterans of OEF and OIF, PTSD is the most common mental health diagnosis (Seal, Bertenthal, Miner, Sen & Marmar, 2007). Thirteen percent of OEF and OIF veterans receive a mental health diagnosis of PTSD (Seal, et al., 2007), which accounts for more than half (52 percent) of mental health diagnoses. In comparison, about 3.5 percent of the general population suffers from PTSD (CNN, 2008). Despite being first addressed in Vietnam War veterans, PTSD continues to be a major mental health issue for veterans.

A RAND Corporation study (2008) had a higher estimate of 18.5 percent of returning service members meeting criteria for either PTSD or depression, equaling about 300,000 veterans. In addition, RAND (2008) estimates that 1.64 million deployed service members are currently suffering from PTSD or depression. The estimated cost of

treating PTSD and major depression for two years after deployment ranges from \$5,900 to \$25,760 per case, equaling about \$4 to \$6.2 billion in total societal costs (RAND Corporation, 2008). Yet, RAND (2008) notes that if all those needing care for PTSD and depression were treated and received evidence-based care, the cost could be reduced by as much as \$1.7 billion, or \$1,063 per returning veteran. These evidence-based interventions are more clinically effective, as well as cost-effective (RAND Corporation, 2008). In addition to the monetary savings, the improvement of the quality of life of these veterans is substantial (RAND Corporation, 2008).

Other common mental health disorders in the veteran population from OEF and OIF are anxiety disorder (6 percent), adjustment disorder (6 percent), depression (5 percent) and substance abuse disorders (5 percent) (Seal, et al., 2007). In 1996, prior to OEF and OIF, over 25 percent of all veterans undergoing inpatient treatment at VA facilities had a substance abuse diagnosis (Benda, 2001). In addition, in focus groups with veterans from the Vietnam War, alcoholism and drug abuse were frequently cited as mental health issues. General literature on substance abuse attributes abuse of alcohol and drugs to individuals attempting to “anesthetize themselves to feelings of depression, stress, fear, and guilt” (Benda, 2004, p. 724).

For veterans of OEF and OIF who were diagnosed with mental illness, more than half (56 percent) were diagnosed with two or more disorders (CNN, 2008). Co-occurring disorders are expected to “increase with time as new cases emerge and unresolved disorders become chronic, posing logistical and fiscal challenges for VA and non-VA mental health as well as primary care medical services” (Seal, et al., 2007, p. 479). The high complexity of addressing mental health disorders of veterans makes it difficult for

care to be comprehensive, considering differences in gender, race/ethnicity, age, the amount of trauma a service member faced during active duty and pre-military life experiences.

Women in the military, especially, are prone to sexual harassment and abuse. Many women have a history of abuse—65.8 percent of homeless female veterans in the ACCESS (Access to Community Care and Effective Services and Supports) sample were victims of childhood abuse (Gamache, Rosenheck & Tessler, 2003). Some women may volunteer for military service to escape abuse by their families or partners (Gamache et al., 2003). About 30 percent of female soldiers report that they are victims of sexual harassment during their time in military service, even if they are in combat roles (Benda, 2004). After returning home, female veterans remain at risk for sexual abuse and domestic violence (Gamache et al., 2003). High rates of sexual abuse in women veterans, during any time in their life, put them at higher risk for PTSD (Gamache et al., 2003).

Many veterans experience isolation after their return from military service. Again, female veterans who may have volunteered for service to escape “unstable family situations” may not be able to return to their families or previous social circles (Gamache et al., 2003, p. 1135). All veterans may face an aversion to returning home, as military service has made them accustomed to mobility (Gamache et al., 2003). Even veterans who return to family and friends may feel isolated due to the trauma they have undergone, which is unfamiliar to their social circles (Applewhite, 1997). Those who shared this experience, the other veterans who were members of their unit, may not be able to support them if they were killed in combat or if they live in a different part of the country.

*The Disproportional Representation of Veterans in the Homeless Population*

The McKinney-Vento Homeless Assistance Act defines homelessness as “an individual who lacks a fixed, regular, and adequate nighttime residence” or an individual whose primary nighttime residence is a shelter or a private or public place that is not intended as a sleeping accommodation for humans (National Coalition for Homeless Veterans, n. d.). The homeless population is typically broken up into subcategories based on the length of time spent homeless (Solarz & Bogat, 1990), either long-term or short-term. Chronic homeless individuals experience multiple episodes of homelessness and are typically longer-term. In line with the national trends, in Rhode Island, those experiencing long-term and chronic homelessness are more likely to be veterans (Rhode Island Emergency Food and Shelter Board, 2008).

There is a high prevalence of homeless veterans nationally and in Rhode Island. In the United States, about 40 percent of homeless men are veterans, although veterans only make up about 34 percent of the general male population (National Coalition for the Homeless, 2008b). The Department of Veterans Affairs notes that this means that about 154,000 veterans (both male and female) are homeless on any given night, and nearly twice that number experience homelessness during the course of a year (United States Department of Veterans Affairs, n. d. e). In Rhode Island, 18.6 percent of the homeless individuals who utilized the shelter system in fiscal year 2006 were veterans, with 592 male veterans and 34 female veterans (Rhode Island Emergency Food and Shelter Board, 2008).

Despite popular belief, research indicates that Vietnam veterans do not make up most of the homeless veteran population; instead, those who served in late Vietnam and

the post-Vietnam era are more commonly homeless (National Coalition for the Homeless, 2008a). The Department of Veterans Affairs also reports that the current number of homeless veterans from the Vietnam War is greater than the number of military personnel that were killed in that conflict (United States Department of Veterans Affairs, n. d. e).

The two most common causes of homelessness both nationally and in Rhode Island are a lack of affordable housing and having low or no income (Rhode Island Emergency Food and Shelter Board, 2008; National Coalition for the Homeless, 2008e). Other common causes include lack of affordable health care, domestic violence, mental illness and addiction disorders (National Coalition for the Homeless, 2008e).

As mentioned above, mental illness and addiction are common among the veteran population. In Rhode Island, 43.6 percent of homeless veterans reported suffering from mental health problems, including 36.1 percent who suffer from alcohol problems and 24.9 percent who suffer from drug problems (Rhode Island Emergency Food and Shelter Board, 2008). Nationally, about 45 percent of homeless veterans suffer from mental illness and approximately half have substance abuse disorders (National Coalition for the Homeless, 2008a).

The combination of many factors, including mental illness and homelessness, isolates veterans from their families and friends. The National Coalition for the Homeless reports that homeless people with mental disorders remain homeless for longer periods of time and have less contact with their families (National Coalition for the Homeless, 2008c). The Coalition notes that many mentally ill people misinterpret help from others, causing them to push family, friends, and other caregivers away, contributing to homelessness (National Coalition for the Homeless, 2008c).

### *The Importance of Social Supports*

Regardless of the cause of homelessness, all homeless people lack the social supports that come with having a home “and, with it, a recognized place in larger community” (Solarz & Bogat, 1990, p. 80). Even very early research notes that homeless individuals experience isolation from their families and friends (Sutherland and Lock, 1936, as cited in Solarz & Bogat, 1990). The lack of social supports for veterans is a concern because it increases the likelihood that the veteran will develop a stress-related disorder or neglect treatment for their mental illness(es) (King et al., 1998).

“Social support generally is conceptualized as the provision or exchange of either emotional or informational support” and is especially essential in “coping with a particular stressful [life] event” (Wright et al., 1999, p. 235). In various research, social supports are operationalized by the size of the social network and by the perceived emotional and practical assistance the social network provides (King et al., 1998; Solarz & Bogat, 1990; Eyrich et al., 2003). A social support can be formal, such as a service provider, or informal, like a family member, friend, or acquaintance (Eyrich et al., 2003). Research also points to religion and spirituality as social supports (Benda, 2006; Benda, 2001).

Many theories are used to explain social support. Social support theory says that humans need assistance from others to address their inherent weaknesses, and all people depend on other individuals, professionals, communities and the larger society for these needs (Benda, 2006). Attachment or bonding theory asserts that secure attachments in infancy to caregivers allows a child to explore, which “is essential to discovering and developing a sense of self and one’s capacities” (Benda, 2001, p. 201). Attachment is a

life-long process that is strengthened by social supports throughout a person's life. "Social support and religion enhance elements of attachment through caring interactions and the feelings of security provided" (Benda, 2001, p. 201). Life-course theory is also used as an explanation, focusing on the assumption that there can be change over time if an individual develops healthy and secure attachments later in life.

For homeless individuals who have lost contact with their family and friends, new social networks are developed that are "based on the pursuit of survival needs and modified by other perceived needs such as alcohol and other drugs" (Eyrich, Pollio & North, 2003, p. 222; Wright et al., 1999). In other cases, the lack of social supports endures in homelessness, leaving the individual isolated from resources and help. Homeless individuals typically have smaller social networks than those who are not experiencing homelessness (Eyrich et al., 2003). For those experiencing long-term or chronic homelessness, there is even greater likelihood of isolation from families and friends.

For families and friends of veterans, it is often a struggle to reconnect with the veteran, despite their best efforts to provide social support. The family, too, struggles with the absence of the service member, and is unfamiliar with the traumas the veteran has undergone. Many are not equipped to care for a veteran suffering from PTSD, anxiety, depression or substance abuse (The National Council for Community Behavioral Health, n. d.).

#### *Social Workers as Social Supports and VA Case Management Services*

Social workers can assist a veteran's social network in providing mental health care to the veteran and in encouraging the social network to provide support to the



veteran. Traditional social support systems can be inadequate in helping a homeless veteran with mental illness (Wright et al., 1999), but social workers can help alleviate the veteran's mental health needs and eliminate some barriers to self-sufficiency.

In addition, social workers can educate families and friends on how to support the veteran. Providing help to the veteran is important, too, because "posttrauma negative life events serve to deplete intrapersonal coping skills" (King et al., 1998, p. 431). Because veterans with mental illness and substance abuse disorders may negatively perceive help offered by friends and family, there is an opening for social workers to mediate and to help veterans utilize the resources being offered by their social networks.

For homeless veterans who have lost connections with their social networks, social workers can provide support while simultaneously helping the veteran reconnect with or create new social networks. For those veterans experiencing short-term homelessness, families can be especially helpful resources with which a veteran can reconnect (Eyrich et al., 2003). For the long-term or chronically homeless, friends are often a good resource (Eyrich et al., 2003). Social workers can emphasize the strengths that homeless veterans have to help them survive in the community (Benda, 2001).

Social workers at the VA serve in a multitude of roles. An example are VA social worker liaisons working in seamless transition, who help recently injured service members move from the care of military treatment facilities (MTFs) to the VA system (Manske, 2006). Social workers in the VA system also "develop and implement treatment approaches" and "are responsible for ensuring continuity of care," including "coordinating discharge planning and providing case management services based on the patients clinical and community health and social services resources" (United States

Department of Veterans Affairs, n. d. b). VA social workers help veterans with their problems and concerns through assessment, crisis intervention, high risk screening, discharge planning, case management, advocacy, education and psychotherapy (United States Department of Veterans Affairs, n. d. g).

### *Ineffective Social Supports*

The aforementioned high incidence of homelessness among veterans suggests that traditional social supports are insufficient in assisting veterans with mental illness. Families and friend networks are either not adequately prepared to assist veterans or are not investing enough effort into supporting them. Many resources are available to help families and friends help veterans; perhaps these are not being utilized as necessary. Veterans, too, can invest more effort in their mental health treatment. While mental illness is often surrounded by stigma, it is up to veterans to self-advocate for proper treatment and care, and to ask their social networks for the support they need.

Additionally, social workers are not necessary in many cases to assist veterans and their families and friends. Social networks have dealt with internal issues without social work intervention for many years, and many families are capable of assisting veterans on their own. Helping professionals and formal service delivery systems are often rejected by veterans and seen as too bureaucratic (Applewhite, 1997). In addition, formal service delivery systems can also fail in assisting individuals, including veterans (Solarz & Bogat, 1990).

Some social supports in a veteran's life are harmful. As mentioned earlier, women may enter military service to avoid a bad family situation (Gamache et al., 2003).

These women have difficulties returning to their families, knowing that they will continue to be unsupportive or, in the worst case, abusive (Gamache et al., 2003).

Having a social network does not always mean that a veteran has a supportive social network; veteran “satisfaction with social support was *not* related to the presence of local relatives, to having ever been married, or to the number of young children” in one study (Solarz & Bogat, 1990, p. 85). While African American homeless veterans in their sample had larger social networks and more social contacts, they showed less improvement compared to their white counterparts (Rosenheck, Leda, Frisman, & Gallup, 1997). Marital status does not prevent veterans from being homeless; military marriages may not be a social support, due to the stress of frequent moves and large periods of separation (Rosenheck & Koegel, 1993). For female veterans, marriages and other romantic relationships may be an opportunity for domestic violence (Gamache et al., 2003).

#### *Alternative Social Supports – Peer-to-Peer Support Groups and Online Support*

Veterans may be more effective in assisting other veterans in confronting and treating their mental illnesses. Peer-to-peer veterans support groups are a strong social support because veterans “who share similar difficulties, misery, pain, disease, condition, or distress may both understand one another better than those who do not and offer mutual emotional and pragmatic support” (Barak, Boniel-Nissim, & Suler, 2008, p. 1868). Groups for student veterans have been successful in creating social networks, like the Student Veterans of America (Alvarez, 2008). This organization has helped veterans deal with the pressures of returning from military service and of college life, keeping them from feeling isolated (Alvarez, 2008).

Other non-profit organizations are run by veterans to assist other veterans, such as Swords to Plowshares, a community based non-profit organization in San Francisco. It provides health and social services (including an emergency shelter), housing assistance, employment training and educational assistance, and legal services (Swords to Plowshares, 2008). Swords to Plowshares also serves as an advocate for veterans' issues in local and national policy issues (Swords to Plowshares, 2008).

In Rhode Island, Operation Stand Down RI is committed to assisting veterans who are homeless or at risk of homelessness by providing social services, counseling, vocational assistance and emergency and permanent housing (Operation Stand Down Rhode Island, 2008). The annual Stand Down event connects veterans to one another, as well as to various services available in the state, including legal aid, medical care, VA benefits, clothing, AA and NA meetings and referrals for public aid. Other services offered over the weekend include temporary housing, hot meals, haircuts, massage, cigarettes and entertainment (OSDRI, 2008). Operation Stand Down is committed to ensuring that no veteran leaves a Stand Down without a place to stay (OSDRI, 2008).

Veterans' organizations are also providing virtual assistance. The Internet holds a wealth of information about benefits and services for veterans. The Iraq War Veterans Organization (IWVO) provides information and support for veterans of OIF, OEF and the Global War on Terror (Iraq War Veterans Organization, Inc., 2008). The website contains countless links to veteran information on health, mental health, employment, education, military travel, and disability claims, among many other topics (IWVO, 2008). Through discussion boards, veterans and active duty servicemen and women can support one another in dealing with common issues, including PTSD (IWVO, 2008).

The National Veterans Foundation (NVF) has similar resources, but also offers additional online supports, like a life chat with an NVF counselor, who is a fellow veteran (National Veterans Foundation, 2008). There are also blogs and “Community Chat” chat rooms for veterans to interact and offer support to one another (NVF, 2008).

Online support groups have similar positive results to traditional support groups (Beaudoin & Chen-Chao, 2007; Mo & Coulson, 2007; Barak, Boniel-Nissim, & Suler, 2008). They have proven to be effective tools in helping people coping with physical illnesses, like cancer and HIV/AIDS (Beaudoin & Chen-Chao, 2007; Mo & Coulson, 2007). These groups use online communication to increase social interaction, thereby creating social supports and resulting in improved health outcomes (Beaudoin & Chen-Chao, 2007). Different types of social support exist in online support group interactions, including informational support, tangible assistance, esteem support, network support and emotional support, with informational support and emotional support being most common (Mo & Coulson, 2007).

Online support groups are successful in building social support, which aids in coping (Beaudoin & Chen-Chao, 2007; Barak, Boniel-Nissim, & Suler, 2008). The anonymity and online disinhibition effect of online support groups can be particularly helpful for veterans who are concerned about the stigma surrounding mental illness treatment (Barak, Boniel-Nissim, & Suler, 2008). Online support groups can lead to “decreases in stress and depression and an increase in coping” (Beaudoin & Chen-Chao, 2007, p. 587). They are particularly successful as an ongoing resource to exchange practical information, “provide and receive emotional support, socialize and form

interpersonal relationships, and experience comradeship with others sharing a similar distress” (Barak, Boniel-Nissim, & Suler, 2008, p. 1868).

The VA system has already recognized the high potential that internet-based support can have for veterans of OIF/OEF. A pilot program was implemented to provide internet-based substance use disorder treatment by the Veterans’ Mental Health and Other Care Improvements Act of 2008 (S. 2162, 2008). This program is aimed at addressing service gaps for veterans living in rural areas, decreasing the stigma associated with mental illness, utilizing the comfort young veterans have with computer technologies and providing web-based resources for veterans and their families (S. 2162, 2008). Yet, Rhode Island does not offer specific online support services for its veterans.

For all these reasons, creating online support groups for veterans, including ones specific to Rhode Island veterans, to address all types of mental illness would be very productive in decreasing feelings of isolation and encouraging treatment of mental illness, thereby preventing homelessness.

### *Hypothesis*

There is a role for both social workers and veterans’ networks in assisting mentally ill veterans who are homeless or at-risk for homelessness by facilitating their interaction with their social networks. By serving as a positive social support and assisting the veterans to maintain and grow their social supports, social workers can help mentally ill veterans increase their treatment success while avoiding and/or recovering from homelessness. Veterans’ networks can offer peer-to-peer support and can best relate to the experiences other veterans have had, especially for those with mental illness. Online support services may be the most accessible for young veterans due to their

familiarity and comfort with online social networking tools and can help reduce the stigma associated with mental illness and treatment. Because access to all services often depends on a case manager's recommendation, this research investigates social workers' perception of the value of online support networks to supplement traditional therapeutic treatment and their likelihood to recommend these services to their clients.

### *Methodology*

#### *Sample*

A convenience sample of 40 VA Medical Center (VAMC) social workers were asked to complete a survey, distributed by VAMC social work department supervisors, on their perceptions of online social supports and their likelihood to recommend these services to their clients (see Appendix A). The anonymous questionnaires were returned to the supervisors, who collected them and returned them to the researcher in sealed envelopes. Nine completed surveys were returned (N=9).

#### *Data Gathering*

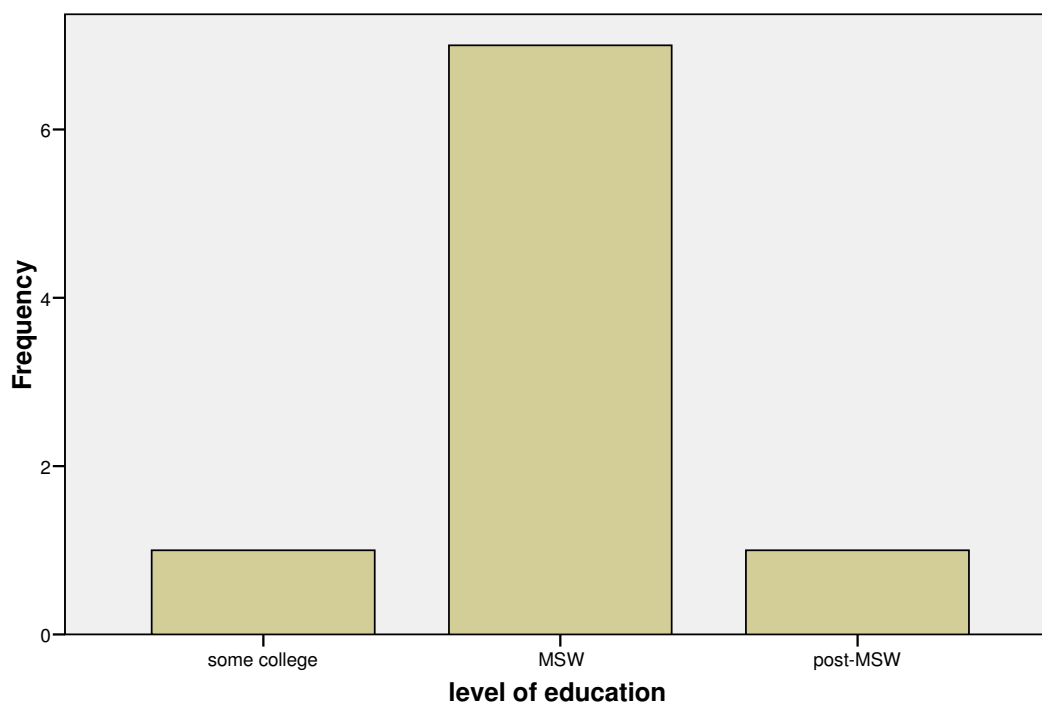
Subjects were asked to report their age, gender, and level of education/degree. Using a Likert-like scale, subjects self-rated their own comfort with the Internet. They also reported the number of clients on their caseload and the ages of these clients. Online social support networks were briefly described, and subjects were asked to consider their clients in the younger age brackets (i.e. 18-35) in answering the remainder of the questions. These questions explored the likelihood that their clients would have access to a computer, the likelihood that these clients would use online social support networks, if

such supports would be helpful for these clients, and if the social worker would recommend this as a supplement to their treatment.

### *Data Analysis*

Most of the subjects were female, with only one male respondent. The mean age of respondents was 41 years old, with a standard deviation of 11.09. All surveyed individuals were in the field of social work, with nearly all having a Masters of Social Work (MSW) or higher, as seen in Chart 1.

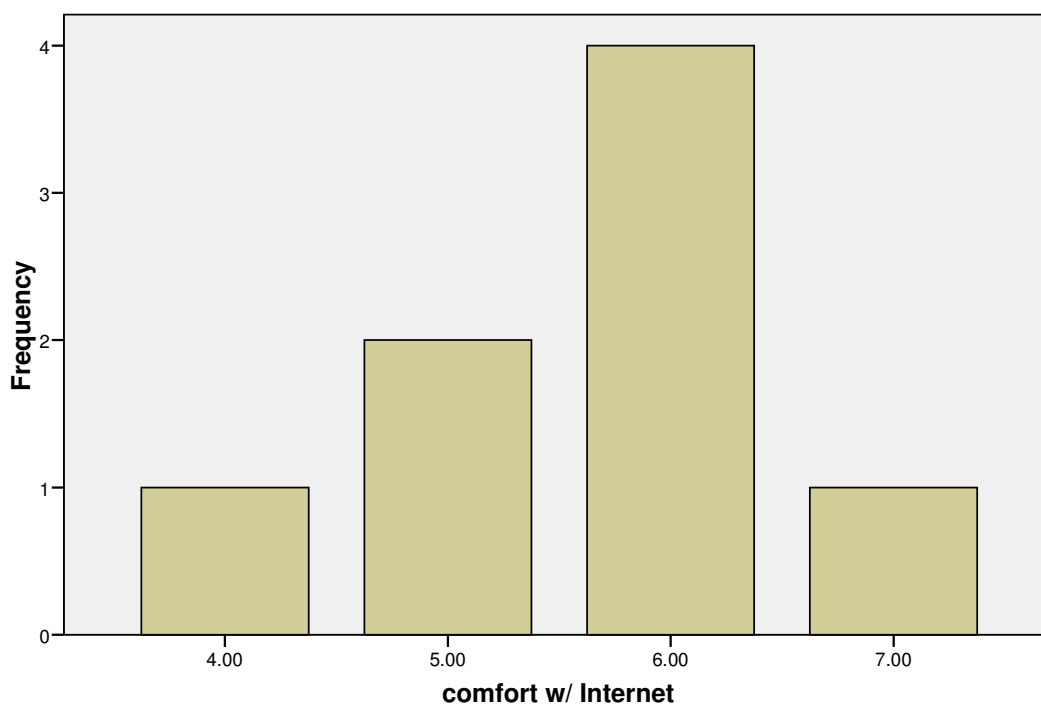
Chart 1: Level of Education



On the seven-point Likert-like scale, most respondents rated their comfort with the Internet very high, with an average of 5.63; the frequencies of responses are displayed in Chart 2.



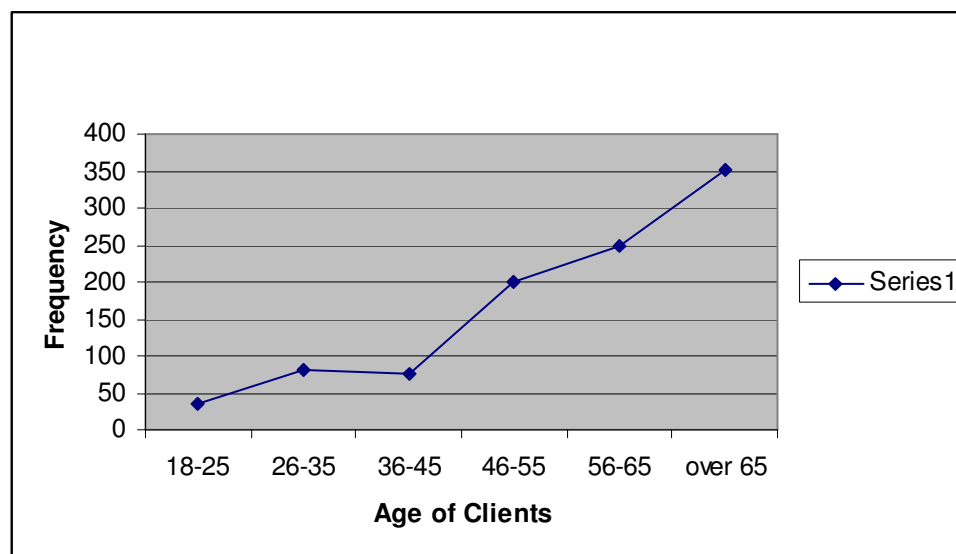
Chart 2: Comfort with the Internet



The subjects then described their client composition. The number of clients a case worker had depended on their position, i.e. those working in emergency services have many clients that they may only speak to once, while other case managers may have a clientele that they carefully monitor and meet with regularly. This explains large differences in client caseload, with one respondent, an emergency services social worker, recording that he or she had over 9,000 clients. This is compared to a case manager with a caseload of 12 or 15.

The ages of clients in each age bracket from all respondents were added together to show the distribution of the ages of the respondents' caseloads. As evidenced in Chart 3, older clients were much more common.

Chart 3: Client Age Distribution



Despite having an older clientele, the social workers were instructed to think of their clients in the two youngest age brackets in considering their answers to the remaining questions. One respondent had no clients in this age group and did not answer the rest of the survey questions. Of the remaining respondents, the mean scores for their responses are depicted in Chart 4.

Chart 4: Responses to Online Social Supports Survey Questions

## Descriptive Statistics

	N	Mean
access to computer	8	5.6250
client would use	8	5.1250
supplement case management	8	5.6250
recommend to client	8	5.1250
Valid N (listwise)	8	

*Findings*

The researcher found that VA social workers would find online social supports helpful for their clients and would recommend these services as a supplement to traditional case management services. This confirms the researcher's hypothesis that

peer-to-peer online social support services can be a valuable supplement to the services offered by social workers and by a veteran's social support network.

Despite the trend that a majority of clients were older than the group that the researcher was interested in learning about, the subjects were able to consider the needs of these younger veterans in completing the survey. Perhaps a setting dealing with social workers who deal with veterans immediately returning from combat would be a better one to draw a sample, as they would be more likely to serve younger veterans.

Other obvious limitations are the small sample size of this study (N=9). Although the return was high considering that the VAMC has about 40 social workers on staff (22.5 percent return), this small sample cannot be considered representative of the entire population of VA social workers. Because data on demographics of all VA social workers in the United States is not available, it is unknown if the sample is representative of the larger population of VA social workers.

### *Conclusion*

Both nationally and in Rhode Island, there is a high prevalence of veterans in the homeless population. Many homeless veterans suffer from serious mental health issues and military specific traumas, adding to the social stigma they face. To avoid homelessness, veterans need to treat their mental illness with the assistance of their social support networks. Despite incredible advances in technology and mental health care, provision of mental health services to veterans still remains very traditional. With an influx of veterans returning from the current conflicts in Iraq and Afghanistan, a greater number of younger clients will be entering the system. Because of their comfort with computers, the Internet and social networking tools, there is a natural progression for

these veterans to use the Internet to support one another in their return from combat and readjustment to civilian life. To prevent isolation and encourage continued receipt of mental health services, online social support services can help veterans avoid homelessness when used as a supplement to traditional mental health treatment. A survey of nine (N=9) social workers at the Providence VAMC showed that social workers who serve veterans would find online social supports helpful for their clients and would recommend these services as a supplement to their traditional therapeutic treatment.

#### *Implications for Further Study*

The limitations mentioned above provide opportunities to improve this methodology for future research. The VAMC was selected to draw this sample because of its role as a provider of traditional services to veterans, as well as its convenience for the researcher, who had a professional relationship with a supervising social worker at the VAMC. Future qualitative research (i.e. in-depth interviews with social workers) or a survey of more social workers at multiple VAMC locations might provide clearer evidence. Increasing the sample size, too, would help improve validity.

Alternatively, surveying service providers at community-based Vet Centers, which are also operated by the VA, might be an informative option for future research. Vet Centers provide readjustment counseling to veterans and their family members, including individual, group, family and bereavement counseling and referrals to medical care, employment resources, community resources, and VA benefits (United States Department of Veterans Affairs, n. d. h). Thus, they are more likely to interact with younger veterans and new veterans, who are the key group to utilize online social support

services. Other similar community-based programs run by private agencies may also provide valuable information.

In addition, the most preferable information would be from the veterans themselves. Future research should evaluate the veterans' perceptions of online support services and their likelihood of using such services. Veterans who are clients of agencies mentioned above would be appropriate subjects for such research.

Lastly, pilot programs like the one proposed in the Veterans' Mental Health and Other Care Improvement Act of 2008 (S. 2162, 2008) to provide internet-based substance use disorder treatment should be expanded to include treatment of other mental illnesses. Results of these pilot programs would demonstrate if online social supports are valuable to veterans and cost-effective.

#### *Implications for Social Work Practice and Social Policy*

Advances in technology and the possible value of online social supports should be considered not only in practice with veterans, but with all populations. The natural use of social networking tools among younger people provides countless opportunities for social workers to encourage their clients to retain and expand their social support networks, preventing isolation. Social workers must understand the tremendous impact that technology is having on their practice, which both provides opportunities to help clients and demands that they continue to emphasize the importance of a true helping relationship. It also demands that they continue evaluating ethical issues that go along with expanding their practice to the virtual world.

With the veteran population, it is essential that practitioners and policymakers consider the differences in combat that the veterans of OIF/OEF have experienced and

the necessity to adjust current services to meet these needs. Advancements in mental health care in the general service provision community must be adapted to treatment of veterans and applied in the VA and other settings. Best practice should also be adapted for work with female veterans to ensure proper care for their unique needs as well. Continuing to make services available to veterans in their communities and expanding to veterans who are in rural areas is essential.

Efforts to decrease stigma of mental illness among the veteran population and among society as a whole will help improve access to mental health care for veterans and other people with mental illnesses. Education and awareness campaigns about the psychological rigors of war, and transitional services to veterans to help them understand that mental health issues are normal and treatable, would help reduce or eliminate the stigma that veterans face in accessing care. In addition, support for families and friends of veterans, those in their social support networks, will help improve care and ensure a smoother transition to civilian life.

Both practitioners and policymakers should uphold the belief that homelessness is not acceptable for any American, particularly for veterans who have defended our country. Many improvements are needed to ensure that no veteran will ever be on the streets, from large societal changes in the stigma associated with mental illness and veteran status, to practical changes for how mental health care is administered to veterans. But these changes must be made. The dignity of this nation's veterans should be the foremost concern of all citizens, and services to veterans should be an example of innovation and excellence in care, without exception.

### Endnotes

<sup>1</sup>This number is a count of unduplicated clients, but only represents those homeless individuals who sought shelter. Excluded in this figure were any individuals who were turned away from shelter for any reason or those “who remained on the street or sought shelter with friends or family” (Rhode Island Emergency Food and Shelter Board, 2008, p. ii).

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*Appendix A*

**Online Social Supports Survey**

***Demographic Data***

1. Age: \_\_\_\_\_ 2. Gender: \_\_\_\_\_ 3. Level of education/ degree: \_\_\_\_\_

4. Please rate your comfort with the Internet:

*No comfort* *Expert*  
 1            2            3            4            5            6            7

***Client Information***

5. How many clients are currently on your caseload? \_\_\_\_\_

6. Please write the number of clients you have on your caseload in each of the following age groups:

18-25: \_\_\_\_\_ 26-35: \_\_\_\_\_ 36-45: \_\_\_\_\_ 46-55: \_\_\_\_\_ 56-65: \_\_\_\_\_ Over 65: \_\_\_\_\_

***Online Social Supports***

Online social supports are support groups on the Internet designed for peer-to-peer support. The use of such support groups is determined by the users, but are regularly used for information sharing, social networking and the sharing of common experiences. The groups are monitored by peers trained in facilitation and mental illness.

Please consider your clients in the two youngest age brackets (18-25 and 26-35 years of age) when answering the following questions about online social supports:

7. What is the likelihood that these clients would have access to a computer?

*Very unlikely* *Very likely*  
 1            2            3            4            5            6            7

8. What is the likelihood that these clients would use an online social support?

*Very unlikely* *Very likely*  
 1            2            3            4            5            6            7

9. Would online social supports be a valuable supplement to case management for your clients?

*Not valuable* *Very valuable*  
 1            2            3            4            5            6            7

10. What is the likelihood that you would recommend an online social support to your clients as a supplement to your case management services?

*Very unlikely* *Very likely*  
 1            2            3            4            5            6            7

*Appendix B***Informed Consent**

Dear Potential Participant:

I am a student at Providence College and I am currently working on my senior thesis. I am interested in collecting information regarding social workers' perceptions of online social supports in the treatment of mental illness in veterans.

I am asking for your help with this study. I have prepared a brief survey that I hope you will complete.

There is no anticipated risk with involvement in this study, but at any time it is possible to discontinue participation. Participation in this study is voluntary.

Confidentiality of participants is ensured because the responses will not have any identifying information on them. Please return the survey and this informed consent form to the social work executive. There is a possibility that some of the responses will be included in the final write up, but with no identifying information.

Please return the informed consent and survey by FRIDAY, FEBRUARY 27, 2009.

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

Thank you for participating in the study.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

LeeAnn Byrne, Providence College Undergraduate  
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