JOURNAL OF VETERANSSTUDIES

Long-Term Sustained Recovery from Alcohol Use Disorders Among Veterans: A Grounded Theory Investigation

Anna M. Koch

Abstract

This grounded theory study explored veterans' conceptualization of recovery and factors contributing to establishing and maintaining long-term recovery. Alcohol misuse is a significant health challenge resulting in negative consequences across multiple dimensions. Alcohol Use Disorders (AUDs) are a significant problem in the general population, but they are even more prevalent among veterans as well as active duty military service men and women. Participants were nine veterans averaging 27.9 years in recovery. Six major themes emerged from veteran interviews including: (1) early negative life experiences, (2) early exposure and access to alcohol, (3) alcohol filled a need, (4) enabling of drinking behaviors in the military, (5) early recovery experiences, and (6) later recovery experiences. Veterans defined recovery as total abstinence and enhancement of quality of life. Implications for future research, exploration of deficits in recovery models, veteran-specific clinical practice, and the effect of trauma on the initiation of AUD in veterans and long-term recovery, is discussed.

Keywords: veterans, sustained recovery, alcohol use disorder

Introduction

Alcohol Use Disorder (AUD) is defined as a chronic disability that is characterized by relapse and progressively severe symptomology (American Psychiatric Association, 2013). One of the main challenges of AUD is relapse. While there are nuanced interpretations of what constitutes relapse, relapse in the context of AUD is typified by a return to a pattern of substance use, meeting the criteria for substance use disorders after a period of sustained full remission (Moss & Cook, 2012). There has been considerable research on the epidemiology of AUD and AUD treatment (Cloninger, Bohman, & Sigvardsson, 1981; Hein, Cohen, & Campbell, 2005; Institute of Medicine, 2010; Linehan, 1993; Nash, 2007; Penick, et al., 1990; Petraitis, Flay, & Miller, 1995); there has not been extensive focus on identifying factors that may predict long-term recovery (Moos & Moos, 2005). In fact, there is a paucity of research focused on individuals who have successfully navigated the journey from diagnosis with AUD to establishing and maintaining long-term recovery. This trend in the literature may be due in part, to researchers only focusing on social consequences, interventions, and individuals' experiences in early recovery. As a result of the focus on early intervention and early recovery, there has been less empirical evidence providing abundant insight or developed conceptual models to explain how individuals maintain long-term recovery from AUD.

The population of US military personnel and veterans has been identified as particularly at risk for developing AUD (Benda & Belcher, 2006; Blodgett, Fuh, Maisel, & Midboe, 2013; Hall, 2008; Hoge, Castro, Messer, McGurk, Cotting & Koffman, 2004; Lande, Martin, Chang, & Lande, 2007; Prigerson, Maciejewski, & Rosenheck, 2001). This risk is related to many factors including multiple environmental and internal stressors, military experiences, predominately male population, social acceptance of alcohol misuse in the military culture, co-occurring and primary mental health issues, stigma, physical health and disability issues, and interpersonal and familial problems (Aldridge-Gerry, Cucciare, Ghaus, & Ketroser, 2012; Hall, 2008; Stappenbeck, Hellmuth, Simpson, & Jakupcak, 2013). Pathways to acquiring AUD are diverse; individuals may experience substance use disorders (SUDS) prior to their military service, or they may develop SUDs during their service and

then continue that problematic use following discharge from military service and entrance into "veteran" status.

The questions for this study (see Appendix A) were inspired by identified gaps in the literature. Responses gained from these questions lend power to a greater understanding of the recovery experience of veterans from AUD.

Literature Review

Alcohol Use Disorders (AUDs) are a pervasive and exceptionally problematic health issue in the US. Unhealthy consumption of alcohol occurs on a continuum, from drinking behaviors that cause immediate and short-term negative effects on an individual's functioning (psychological, social, vocational, and physical), to persistent problematic use behaviors that meet diagnostic criteria for an alcohol use disorder (Room, Babor, & Rehm, 2005). Unhealthy consumption can be qualified within the "mild" range of the *DSM-5*'s diagnostic system very quickly (early stages of misuse), as only two of the eleven diagnostic criteria must be met to diagnose a disorder (American Psychiatric Association, 2013).

Misuse and other problematic uses of alcohol is a particularly common behavior within the veteran population. Estimates of alcohol use disorders among the veteran population range from 13% to 20% among Veterans Health Administration (VHA) enrollees (Bradley et al., 2010; Bradley et al., 2006; Kalman et al., 1999; Saitz, 2005). A study by Williams, McFarland, and Nelson (2012) found that 45% of veterans who classified themselves as "drinkers" screened positively for unhealthy alcohol use when evaluated. This finding is of particular relevance, given the sample examined in this study, included a geographically diverse group of veterans. Unfortunately, the problem may be even more pervasive than what studies report, as there appears to be a degree of ambiguity associated with the concept of AUDs.

Current service members are mostly young males and veterans are predominantly male. Researchers focusing on alcohol and other substance use disorders concluded that substance use issues occur most frequently among men, young adults, and those with the highest levels of self-reported alcohol consumption (Dawson et al., 2005 a,b; Rubinsky et al., 2010). The risk of alcohol misuse is greatest among men who are younger than 30 years old (Grant et al., 2004, Jacobsen, Southwick, & Kosten, 2001). Considering the propensity to acquire AUDs among these demographics, there should be no question regarding the vulnerability of veterans. As such, it is not surprising that those in the military between the ages of 18-25 report the highest rates of heavy drinking as compared to civilian counterparts (27.3% vs. 15.3% respectively) (Bray & Hourani, 2007). In the civilian population, those serving in and returning from the military that fall in the young male demographic, are at increased risk of alcohol misuse and possible AUD.

Being a young male service member is not only a risk factor for alcohol misuse, but in addition, researchers have identified problematic drinking to be associated with military culture, combat experience, and deployment (Ames, Cunradi, Moore, & Stern, 2007; Bray, Bae, Federman, & Wheeless, 2005; Jacobson, Ryan, & Hooper, 2008; Lande, Marin, Chang, & Lande, 2008). Alcohol, which is often readily available and accepted within the military culture, is commonly used to help deal with stress and trauma (Fernandez, Hartman, & Olshaker, 2006; Milliken, Auchterlonie, & Hoge, 2007). Veterans with combat exposure are at an increased risk for developing PTSD, major depression, substance abuse, anxiety disorders, and likely will also be dealing with social, occupational, and physical impairments (Hoge, Auchterlonie, & Millikeu, 2006). It is not uncommon for veterans of our most recent

conflicts to report longer tours of duty throughout the course of multiple deployments, as compared to prior generations of veterans, which may place them at greater risk for mental health concerns (Hall, 2008). Many of these individuals have experienced profound physical, psychological, and emotional stressors. Some examples include long periods of time away from family and loved ones, the stress of being in a foreign country, endless hours employed in highly stressful and less than ideal work conditions, and experiencing loss of life and property (Hall, 2008). With the combination of work-related stressors, age and gender demographics and a culture of acceptance of alcohol use to manage stress/problems versus help seeking, it seems plausible that problematic drinking may develop among this population.

Veterans likely experience both positive and negative feedback for early problematic alcohol use in the military, as military culture honors strength, independence, self-control, and reliability (Skidmore & Roy, 2011). Other military-specific factors related to AUD and SUD development include differences in the conflict or era in which the veteran served (Skidmore & Roy, 2011). These differences often resulted to different exposure to specific substances. During the current conflicts in Iraq and Afghanistan, returning veterans reported increased exposure to opiates (United Nations Office on Drugs and Crime, 2009). This use is also attributed to the increased rate of severe injury as a way to cope (Institute of Medicine, 2010). Several factors are related to the development of AUD in service members and veterans including age, gender, work-related consequences, and location of service.

Researchers have shown that a by-product of self-sufficiency in military culture is that individuals may resist seeking help for psychological issues. Receiving help for psychological issues might imply that there is something wrong with the individual, and they are unable to meet the demands and expectations placed upon them. Another hesitation to seek assistance is the belief of military personnel and their families, that such help could impact the military member's chances for career advancement (Hall, 2008). Due to the stigma and fear of potential, negative consequences associated with receiving assistance, mental health issues can go unaddressed (Pryce, Ogilvy-Lee, & Pryce, 2000).

There are many potential barriers for veterans in their attempt to achieve long-term recovery. These barriers may include presence of other disorders, perception of cause (stigma, shame, and prejudice), difficulties re-entering family and community systems, cultural factors related to individual characteristics, and general cultural factors that may have been acquired in adapting to military culture.

Understanding how veterans overcome these barriers and implement principles of recovery is a missing element in the research and professional literature. Exploring how veterans may have utilized one of the "natural recovery models" (addressed in the theories of recovery), self-help or peer support groups, formal treatment, and/or other recovery-oriented support systems to sustain recovery, can contribute significantly to adapting treatment and making it more accessible for this population.

Methods

This study examined participants' definition of long-term recovery and the factors participants identified as having contributed to their long-term recovery from Alcohol Use Disorder (AUD). This study is based on the phenomenological perspective of the veterans being interviewed. Given that the incidence of AUD in the veteran population has been higher than the general population and that there have been recent, extended deployments of troops over the past decade, it is likely that there will be even more AUD diagnoses in the future. The factors identified in this study that contributed to long-term recovery among

participants may help counselors when treating veterans diagnosed with AUD. The information gained from this study with veterans who have successfully navigated the journey of long-term recovery provides valuable insight to inform practice.

The definition of recovery, for the purpose of this project, evolved from participant input. Participants who considered themselves to be in long-term recovery shared their perspectives about what recovery is, how they initially achieved recovery, and how they maintain their long-term recovery status. Since the participants are veterans, identification of military cultural factors that impacted their recovery journey was also explored, and the influences of those experiences on the recovery process are described. This study identified key elements of implementation and maintenance of recovery that occurred with participants who identified themselves as veterans in long-term recovery.

Research design

The methodology on which this study is based is grounded theory. Grounded theory originated in 1967 with the publication of the book *The Discovery of Grounded Theory*, by Glaser and Strauss (1967). These researchers developed an alternative to the research practice of testing hypotheses to prove existing theories. According to Glesne (1999), Glaser and Strauss (1967) proposed an inductive strategy whereby the researcher discovers concepts and hypotheses through constant comparative analysis. Through this process, theory is developed by inquiry. These results are grounded theory. In comparison to quantitative research, grounded theorists neither test existing theory nor try to fit their data into preconceived concepts (Heppner & Heppner, 2004).

Heppner and Heppner (2004) stated, "The hallmark of grounded theory research is constant comparative method" (p. 150). Constant comparative method was used in this study. Coding was used to analyze collected data into relevant themes and concepts. Based on these developing themes and concepts, the theory of the research began to emerge, thereby allowing the research to be grounded in the empirical data collected.

Participants

The participants in this study consisted of veterans who defined themselves as being in long-term recovery from AUD. Some participants disclosed long-term recovery from other substances and/or psychiatric and/or physical disability, but this was not used as inclusionary or exclusionary criteria.

The goal in qualitative sampling is to select participants who will be good informants (Gay, Mills, & Airasian, 2006) that can contribute to the understanding of long-term recovery in veterans. Sampling in qualitative studies, therefore, tends to be more purposeful and less random. A degree of generalizability is forgone to find specific participants who will be able to provide the in-depth experiential information needed, since qualitative research focuses more on depth and examining representative cases (Stake, 2000). Unlike quantitative research, in qualitative research, having a specific number of cases is not as important.

To find participants classified as a veteran who had an AUD, criterion and snowball sampling was used. Participants were solicited from known individuals who meet the specified criteria (e.g., veterans, self-identified history of AUD, define self as being in long-term recovery from AUD, any age, any branch of service, any gender). Participants were then utilized to identify additional, potential participants until the following two criteria were met: sufficiency and saturation (Seidman, 2013). According to Seidman (2013), sufficiency occurs when participants reflect the population so that others outside the sample may connect with

the experiences of those in it. By use of maximum variation sampling, which attempts to gain diversity in participants, attempts were made to choose participants with different demographic variables like ethnicity, different branches of the military, and gender. Saturation occurs when the interviewer begins to hear the same information from participants and no new information is gained (2013). As this researcher strived for in-depth information rather than a wide variety of answers, a small sample size of eight to 10 participants was preferred (Patton, 1990).

The participants were solicited via in-person conversations, phone calls, and email inviting them to participate. Also, current participants were asked if they knew of other participants who may be interested in participating. All participants were informed of measures of confidentiality to protect their identity and personal information. They were each given information from the Institutional Review Board for the Protection of Human Subjects from the author's institution as a resource and were assured that their participation is voluntary and can be discontinued at any time. An informed consent outlining the purpose of the study, benefits and risks of participation, and asking for consent to be audio-recorded during interviews was signed by participants. All participants willingly gave consent to be audio-recorded.

Description of participants

The following is a list of demographic information for each of the nine study participants. In order to maintain confidentiality and the participants' anonymity, the participants will be listed by the number in which they were interviewed.

Participant 1 is a Caucasian male. He is 71-plus years old with two bachelor's degrees. He is career military, serving 31 years from 1960-1991 in the Navy. He reports 12 years since he last drank alcohol. His drug of choice is alcohol. He uses no other substances. He has two outpatient treatment experiences and one inpatient admission. He attends Alcoholics Anonymous (AA), reports no sponsor, and does not sponsor anyone else.

Participant 2 is a Caucasian male. He is 61-65 years of age with two master's degrees. He is career military, serving 20 years from 1970-1990 in the Marines. He reports 34 years since he last drank alcohol. His drug of choice is alcohol. He uses no other substances. He had no inpatient or outpatient treatment experiences. He attends AA, reports no sponsor, and does not sponsor anyone else.

Participant 3 is a Caucasian male. He is 56-60 years of age with a high school diploma. He reports having served during the Vietnam era for four years in the Navy. He reports 25 years since he last drank alcohol. His drug of choice is alcohol. He reports being addicted to cigarettes off and on since the age of 18 and currently smokes. He has one inpatient treatment. He attends AA, has a sponsor, and sponsors someone else.

Participant 4 is a Caucasian male. He is 66-70 years of age with a high school diploma. This veteran reports having served in the Vietnam era for three years in the Army. He reports 32 years since he last drank alcohol. His drug of choice is alcohol. He also reports using marijuana before going into recovery. He has one inpatient treatment. He attends AA, has no current sponsor due to his sponsor recently dying, and sponsors someone else.

Participant 5 is a Caucasian male. He is 51-55 years of age with a master's degree. He reports having served from 1982-1985 in the Navy. He reports 31 years since he last drank alcohol. His drug of choice is alcohol. He also reports using marijuana before going into recovery. He has one inpatient treatment. He attends AA, has a sponsor, and sponsors someone else.

Participant 6 is a Caucasian male. He is 66-70 years of age with a bachelor's degree. This veteran report having served during the Vietnam era and is career military for 21 years in the Navy. He reports 43 years since he last drank alcohol. His drug of choice is alcohol. He reports using no other substances. He attends outpatient services. He attends AA, has a sponsor, and is not sponsoring anyone else.

Participant 7 is a Native-American male. He is 71-plus years of age with a GED. He reports having served during the Vietnam era for 13 months from 1967-1968 in the Army. He reports 39 years since he last used alcohol. His drug of choice is alcohol. He also reports abusing prescription drugs before going into recovery. He has no history of inpatient or outpatient treatment. He attends AA, has a sponsor, and is not sponsoring anyone else.

Participant 8 is a Caucasian male. He is 71-plus years of age with a high school diploma. This veteran reports having served from 1959-1979 and is a career veteran in the Navy. He reports 23 years since he last used alcohol. His drug of choice is alcohol. He reports using no other substances. He has one inpatient treatment. He attends AA, has a sponsor, and is not sponsoring anyone else.

Participant 9 is a Caucasian male. He is 71-plus years of age with some college. This veteran reports having served during the Vietnam era from 1964-1967 in the Army. He reports it has been 34 years since he last used alcohol. His drug of choice is alcohol. He has one outpatient treatment. He attends AA, has a sponsor, and reports sponsoring someone else.

Context of the study

The researcher used a meeting room at the local library, as this meeting location provided free parking, and a private, quiet place to conduct interviews. The local library is open to the public and serves all members of the community. Taylor and Bogdan (1998) emphasized the importance of in-depth interviewing, getting to know study participants well enough to understand what they are saying and meaning, and creating an environment that promotes them to talk openly. Developing and maintaining rapport are essential components in building trust and helping the client feel as comfortable as possible during the interview process (Taylor & Bogdan, 1998). These authors also encouraged researchers to go where their participants are in their natural environment. The library is centrally located, open to all community members, and has private meeting rooms. Conducting interviews at this site enabled the participants to feel comfortable and safe in a way that enabled them to respond fully to the research questions (Taylor & Bogdan, 1998).

Data sources

The primary source of data gathering was individual interviews. Another source was current published literature. The final source was the researcher's observations. Participants were asked research questions (see Appendix A) during individual interviews. Participant answers were recorded and follow-up questions were utilized for clarification as needed. The literature review gave background information necessary to better understand the context of AUD and recovery issues faced by the participants. Personal observations were an important aspect of the data collection process because it allowed for identification of any discrepancy between what a participant was saying and what he expressed through body language. One potential risk is observation bias; misinterpretation can occur, as it is not always possible to consider personal habits or individual quirks and is based solely on the researcher's opinion.

All participants in this study were selected on a volunteer basis. This study was conducted with the participation of veterans who described themselves as having long-term recovery from AUD. Another criterion was that all participants had to be willing and able to discuss their experiences regarding their perception of long-term recovery from AUD.

Data collection

Qualitative data collection utilizes all of the human senses to collect information (Preissle, 2006). Keeping track of such extensive and rich information during the data collection process helps the researcher with analysis. Qualitative researchers study phenomenon and people in their natural environments, turning the world into a sequence of different representations through field notes, discussions with others, artifacts, and various kinds of visual media (Denzin & Lincoln, 2003). The type of strategies and methods chosen depend on the research questions (Berg, 2004; Denzin & Lincoln, 2003).

The structure used for this study was in-depth, phenomenological interviewing, following the Three-Interview Series discussed by Seidman (2013). Interview one was focused on the participant's life history; the interviewer worked with the participant to put his experience in context by asking the participant to discuss the topic up to the present time. In the second interview, the interviewee was asked to concentrate on the concrete details of his present lived experience in the topic area. Finally, in the third interview participants reflected on the meaning of their experience. Participants looked at their present experiences and within the context in which these experiences occurred. To accomplish the purpose of each of the three interviews, use of a 90-minute format was followed with a three- to seven-day span between interviews (Seidman, 2013).

The researcher considered data collection to be complete when saturation was reached. The researcher continued to add new participants to the study until that point was reached. Theoretical saturation was reached when the researcher could no longer analyze or break down the data in a way that led to any new categories.

Data analysis

Data was obtained and analyzed using the constant comparison method. The researcher transcribed the recorded interviews. An initial analysis of transcribed interviews took place within 48 hours of the interviews. The researcher reviewed the completed transcripts of the interviews looking for general themes and began coding by hand. The coding process, described as follows by Charmaz (2006), was utilized in this study.

> Grounded theory coding consists of at least two main phases: 1) an initial phase involving naming each word, line or segment of data, followed by 2) a focused, selective phase that uses the most significant or frequent initial codes to sort, synthesize, integrate, and organize large amounts of data. (Charmaz, 2006, p. 46)

Data analysis occurred throughout the research process through the use of the constant comparison method with new data compared to previously obtained data. Electronic data was kept in files on the researcher's computer to assist with data management and analysis. Interview tapes and transcripts were identified by the pseudonym chosen by each participant and were kept in locked storage. Data was backed up on an external hard drive, which was also kept in locked storage.

Trustworthiness, transferability, and confirmability

Trustworthiness in this study was acquired through multiple methods including the following: (1) use of various methods or triangulation of sources, (2) member checks, (3) peer reviewing and debriefing, (4) negative case analysis, (5) the use of a thick description, (6) clarification of any researcher bias, and finally, (7) the use of an audit trail. Triangulation permits the researcher to use different data sources to assess a research topic in-depth, in this case, the researcher compared the results of the interviews with the relevant research in the field (Lincoln & Guba, 1985). Member checks permitted the researcher to accurately portray the meanings and constructed worlds of

participants by having them look over their interview transcripts and provide clarification or corrections. This allowed all the participants to verify the reflections of the researcher and clarify any discrepancies between what was meant and how it was perceived (Glesne, 1999). The use of peer reviewing and debriefing occurred when colleagues from the same field as the researcher (i.e., addiction, rehabilitation counseling, clinical mental health counseling) reviewed transcripts and analysis and provided feedback on the process (Lincoln & Guba, 1985; Patton, 1990; Rossman & Rallis, 2003; Seidman, 2013).

Ethical considerations

The American Counseling Association (ACA) Code of Ethics (2014) mandates that counselors obtain and maintain the informed consent of all participants; further, this consent allows participants to know the perceived benefits and risks to the study as well as their right to participate voluntarily or withdraw at any time. Maintaining anonymity and confidentiality of the participants is of utmost importance for any study, but is especially salient when participants are chosen from a small group where they could be identified by process of elimination. Finally, accountability and accuracy are extremely important in qualitative research. To maintain the highest amount of accuracy possible, member checks and an audit trail was used.

Limitations

The geographic location of the participants in this study may pose a limitation. Initially, participants were expected to be from the Midwest. Based on the use of snowball sampling, participants of the study were identified outside of this region to not only include the Midwest, but also to include the Northeast and the South. By virtue of the different geographic regions, the participants' cultural norms and beliefs may be unique to the regions, and thus, these participants do not represent all veterans. Accordingly, the results of this study can not be generalizable to the general population of veterans. The research questions in this study included veterans' definition of long-term recovery and perceptions about what contributed to their sustained recovery over time.

One limitation of the study was that no female veterans volunteered to participate. Additionally, there was only one self-identified ethnic minority who participated. The lack of female and minority participation in this study may have been due to either the fact that the majority of service members and veterans have been Caucasian males, or that veterans in this geographic area represent the demographics of the region which is predominantly Caucasian. Further research that includes a more diverse sample could provide additional data helpful to working with the more diverse population of veterans in the 21st century. Gaining female and minority perspectives on long-term recovery and their perceptions about what contributes to their sustained recovery over time, would likely be worthwhile endeavors to ascertain whether or not there are gender, cultural, and ethnic differences in the recovery process. An additional consideration as a potential limitation includes the ages of the participants. One might question the generalizability of the experiences of this study's participants to the more recent experiences of current era veterans.

There are many unanswered questions that should be addressed by further research. First, this study observed that many veterans discussed the onset of their AUD and how that played a role in their choosing to join the military. While some of the participants did not choose to join but instead were drafted, it is significant that many participants felt that their AUD prior to service played a significant role in their later military service. Interestingly, participants felt recruitment standards had changed over time, and that potentially, recruitment standards are more rigorous now. They believed the relaxed standards during their era of service, may have played a role in the fact that they began their service with a potentially serious AUD. The literature review did not discuss the role of AUD as

a predictor of military service or the potential variance in AUD as a predictor of service in different military eras. This is another area where future research may reveal more about the relationship between AUD and military culture/service.

While this study focused on the veterans' perspective on the recovery process, it did not address the perspectives of the veterans' significant others and their views of the recovery process. Due to this study's lack of information regarding the perspectives of significant others, further research might address this aspect of recovery in the military veteran community.

Findings

Six major themes emerged from the research questions: (1) early negative life experiences, (2) early exposure and access to alcohol, (3) alcohol filled a need, (4) enabling of drinking behaviors in the military, (5) early recovery experiences, and (6) later recovery experiences. All of the participants of the study demonstrated some degree of congruence in identifying the impact of these thematic categories on the onset of their AUD, the maintenance of their AUD, and on their recovery from AUD.

Theme one: Early negative life experiences. The first theme encompassed childhood and adolescent experiences in the home and/or in educational settings. Veterans consistently indicated that varying forms of childhood trauma had played significant roles in the onset of their AUD. Participant 3 described his early negative life experiences as:

> I was about eight or nine I guess and my mother and father got into a violent divorce. I'm talking about him and my step dad got into a fight on Main Street of the town, bloody fight where there was gun play and kidnapping and all kinds of stuff and I became the prize of who's going to win the divorce.

Participant 5 described his early experiences living at home with a father who drank excessively and took his anger out on him:

> He was a mean drunk. There was no physical abuse, it was more verbal and emotional type stuff. My reaction to that was I just shut down. You know, some people fight back or whatever, I just stopped talking pretty much, so in that regard, I was very lonely—I was lonely because I just didn't know how to express myself you know, I just shut down.

Further, the interviews indicated that these traumas continued to influence veterans' attitudes, beliefs, values, and behaviors while in recovery. Finally, while veterans were aware of the impact of the childhood trauma on their AUD, the interviews did not provide any clear evidence that the veterans had been able to resolve these issues.

Given that all of the participants were members of peer support groups and had been actively involved in twelve-step recovery programs during their recovery process, participants may be identifying that while participation in peer support programs may have been sufficient to initiate and maintain abstinence, they may not have been sufficient to support resolution of more complex factors that appeared to have both contributed to the onset of AUD, and that continued to have direct effect on veterans' long term recovery and quality of life. Finally, while veterans indicated that these experiences influenced their recovery, they did not indicate willingness to seek help beyond peer support during the recovery process.

Research on AUD treatment has focused on the impact of trauma and suggested that trauma informed treatment may be critical to successful rehabilitation for persons with AUD disorders. Strine et al. (2012) identified that there were significant and direct connections between abuse, neglect, and household dysfunction and the onset of substance use disorders. These authors suggested that it may be important to identify the trauma that occurred prior to use and assess its impact on current adult psychological stress. The veterans in this sample

were aware of the trauma, able to discuss the trauma with varying degrees of detail and levels of comfort, but did not indicate that the recovery process had led to direct resolution of the trauma, or that the impact of the trauma on their current levels of stress had been completely addressed (eliminated), even though they all had lengthy periods of sobriety.

Theme two: Early exposure and access to alcohol. The second theme identified was that their parents or other family members were regular users and/or abusers of alcohol and that there was easy access to alcohol in their home environments. Veterans indicated that they had experienced family members encouraging them to use and experiment with alcohol. Participant 6: "I think I started to drink because it was, you know my parents drank, there was always alcohol around the house." Participant 5 described watching his dad and grandpa drink and how he found that attractive, enough so that he would sneak some:

> I remember as a kid my dad drinking and my grandpa drinking a little bit. I had some attraction to the alcohol. I always knew my grandpa had this whisky bottle in his closet and I would go in every once in a while, and I would take a skip or sneak a sip to experience it.

Participant 4 did not have easy access to alcohol at home but did find access through his work: "At 15 I was working in a grocery store and they had a beer license, beer and wine license for sale so…at 15 I was given the key to the store and I was closing up and locking up so I had access there." When Participant 7's grandfather found out he had started drinking, the grandfather invited him to drink with him:

> It just progressed every time I drank, my granddad drank orange juice and vodka. Well, he got me started on that too, with him. We drank on the way home [from work when the grandfather would pick him up] and in his house.

The fact that veterans reported familial alcohol use is not surprising, given that the connection between familial alcohol involvement and early onset of alcohol use is well documented (Mason and Spoth, 2012). Further, none of the veterans indicated that their families had been involved in treatment or had experienced formal clinical interventions to address the alcohol related problems in their family systems. It is also not surprising that veterans did not indicate that their families of origin had played significant roles in the establishment and maintenance of their recovery programs.

Another pattern reported was that they experienced a lack of responsible supervision and accurate information about the risks and impact of AUD when accessing alcohol in their home environments. Veterans appear to have received early messages around alcohol, including the purpose of alcohol use within the family system, and that these factors appeared to have played a significant role in the onset of their AUD and in the progression of their AUD. Given that the participants consistently reported that familial alcohol use had shaped their attitudes toward alcohol and their alcohol use behaviors, these factors should be noted. When researchers assess the impact of the military culture on AUD, or the impact of service related trauma on SUD, they may wish to note that many veterans' alcohol use behaviors may have been established prior to their military service. Familial use of alcohol may have directly impacted veterans' response to the culture of alcohol use in the military and their individual responses to that culture.

Finally, it should be noted that there may be several other "types" or "categories" of veterans who experience AUD disorders. The sample in this study were veterans who had developed AUD prior to their service and/or experienced co-emerging AUD with their service. There may be other veterans whose onset of AUD directly coincided with their military service and other veterans whose AUD did not develop until post-deployment. Onset of AUD and the relation of onset to time of service, could be a significant factor affecting the

long-term recovery of these veterans, but since their experiences were congruent, this study did not reveal any information about the potential "other" categories of AUD onset in military personnel. Koch and Koch (2014) discuss the issue of onset of AUD in another special population and indicate that there may be pre-existing substance use disorders, co-emergent substance use disorders, and substance use disorders emerging following other significant life experiences.

Theme three: Alcohol filled a need. The third theme reflects the idea that alcohol use by these participants served a need or purpose. In his seminal work on culture, onset of AUD, and predictors of alcohol misuse, Hanson (1995) described that variance in use patterns across cultures could significantly impact the rates of AUD in any population and could significantly affect the incidence and prevalence of AUD in those populations. Hanson (1995) is relevant to this sample because he described "personal effects drinking" and "alcohol as magic" as two cultural patterns that could predict development of problematic alcohol use patterns.

Study participants identified that they were using alcohol to address specific emotional, social, traumatic, adjustment, and recreational needs/issues (personal effects drinking), and that they believed that alcohol use would have an unrealistic ability to ameliorate or alleviate these challenges (alcohol use as magic). This was evidenced in the words shared by Participant 6 when describing his first exposure to alcohol with a sip of his parents' alcohol reported no significant response. However, when consuming larger quantities at the age of eleven, he described the following experience:

> But boy that first time I actually consumed any amount of alcohol, that had an effect on me, it was like, WOW, I could be anything I want, I could say anything I want, I could do anything I want. It was just MAGICAL.

His drinking quickly progressed as a response to the positive experience he had: "You know, I mean it was a significant event in my life and it's like wow, let's do this again. It wasn't long before it was again and then it was all the time." Participant 5 described the significant effect alcohol had on him:

> Thirteen is the first time I actually remember getting drunk, was with a friend, we stole a bottle of Mad Dog wine from a grocery store and basically guzzled half the bottle and got drunk. It had an effect on me you know, it's kind of one of those-I LIKED it-I like what it did for me you know, and I kind of remember making a decision that I wanted to do that again and that's kind of what I did. That's why I drank at that point you know, to get that feeling I got.

The ability to use alcohol as a way to change feelings was also a powerful incentive for Participant 4. He stated:

> Primarily, it was an escape mechanism. It enabled me to change how I felt. So at 14, ever since that time I first drank at 14, I had the idea at that instant or that…incident that whenever I could get alcohol I would drink for what it would bring to me, and that was the motivation for all my drinking.

Veterans in this study believed that alcohol would be an effective tool for managing their emotional, social, vocational, recreational, and familial issues.

Themes two and three, although distinct, are inter-related. The veterans in this study expressed that their family systems role modeled the personal effects of drinking (Hanson, 1995). These participants' use of alcohol led to many of their needs being left unaddressed at some level. As a consequence, the veterans may have been unable to develop necessary coping skills due to their alcohol use. For those veterans, lacking in coping skills likely left them less

able to cope with and adjust to the impact of those experiences during their service and after discharge.

Theme four: Enabling of drinking behaviors in the military. The fourth theme identified by participants suggested that there were direct interactions between military experiences and the continuation or exacerbation of earlier established drinking behaviors. Participants suggested that they experienced relaxed rules and consequences related to alcohol use while serving in the military and that this pattern (similar to the patterns experienced in their families of origin), likely contributed to the onset of more severe AUD, progression of AUD, and/or exacerbation of AUD and AUD related problems.

Two subthemes emerged: (1) easy access and cheap, and (2) minimal consequences and accountability for actions. Seven participants shared about how alcohol was easy to access and was cheap to purchase, while eight participants discussed experiencing minimal consequences and accountability for their actions. Participant 1 stated he drank a little bit in high school, but a lot more when he was in a fraternity at a local university. He stated that his drinking was primarily binge drinking. He decided to drop out of school and join the Navy and stated this is where his drinking really began. Participant 1 reported his binge drinking continued when off ship and at the ports. "All nice and clean and no alcohol, but then you hit the port and hit it hard for a day or two you know." Participants described drinking as not being looked down upon while in the military; in fact, it was discussed how drinking would even occur during work hours. Participant 2 described one of his typical days in the military:

> I worked with these guys and they…even the captain, they'd go out at lunch and we'd get drunk and come back to work basically, you know, since the captain was there nobody said anything."

This too was the experience of the following participant. Participant 6 also experienced easy access and acceptance of alcohol while on duty: "I mean it was routine, everybody would be at the club drinking with their lunch."

Participants stationed overseas quickly learned that access to alcohol was easy, especially for service members, and what alcohol there was, had little cost. The physical and social availability of alcohol is a factor that seems to influence heavy drinking among young adults in the military (Ames & Cunradi, 2004). When military personnel were on shore leave in foreign ports the alcohol was inexpensive, there were few underage drinking laws, and bars were located near disembarkation (Ames et al., 2004). Availability of cheap alcohol was what Participant 1 found when stationed in Puerto Rico: "When I was stationed in Puerto Rico a half gallon of rum was a dollar and a half, so we kept one in our locker." Cheap and easy access to alcohol was also the reality for the following participants. Participant 2 reported:

> There was a lot of drinking and carousing, I mean, I would buy a case of beer for a little over a dollar. It was really good beer, so you know, we would be on guard duty like two days and off two, so we would have a case of beer waiting when we got off at the gate.

Participant 6 shared his experiences regarding alcohol accessibility.

> At sea I had alcohol available, in Vietnam I had three back-to-back tours in Vietnam and I always had alcohol available. I mean it was…even when I wasn't supposed to have it available I had it available and I would always figure out ways to use non, what was supposed to be non-beverage alcohols to use as alcohol.

Participant 6 further stated that it was not hard to manage his alcohol use in the military.

> It was routine we would all go, even those who didn't have an alcohol problem, we would all go to the service clubs at lunch time and have lunch and usually have a couple of beers or something like that…And folks didn't really know that I drank like that because I was always

> loaded and loaded was normal for me. Nobody thought that my behavior was any different than it normally would have been. I mean, so it was never questioned.

For Participant 3, who had only used alcohol prior to his military service, started using drugs during his service, as they were easy to obtain.

> So, I met some interesting characters and did a lot of drinking and then I started getting into drugs. The thing I noticed about drugs, was I can get there quicker and easier with drugs and so I did the drugs and alcohol thing for the whole time I was in the military, except for probably the last six months and I tried to straighten up and quit everything.

Having easy access to alcohol that was also inexpensive encouraged continued excessive drinking. With peers also participating in excessive drinking, service members openly engaged in the activity of drinking which they enjoyed. With many members actively engaged in the consumption of alcohol, it was not uncommon for alcohol to be stored on base or even taken on naval ships. The overall acceptance and desire for alcohol, outweighed any potential negative consequences that may have occurred if found out.

Theme five: Early recovery experiences. This theme identified by participants was that their pathways into recovery were typified by the desire to escape negative consequences that they attributed to their AUD. The type and nature of consequences varied, but participants tended to discuss the impact of the AUD on their professional/vocational effectiveness as well as on their personal and family lives. The veterans in this study established their recovery based in response to negative life experiences and then their later recovery evolved as a way to avoid negative experiences and to alleviate the impact of AUD related problems in their personal and professional lives.

Each veteran shared about his reasons for beginning recovery, but also for staying in recovery. Six subthemes emerged: (1) way to get out of trouble, (2) sobriety is your main priority, (3) early exposure to AA, (4) giving up control, (5) support and belonging, and (6) unresolved issues hidden by alcohol. Four participants shared that they entered recovery as a way to get out of trouble. Nine participants discussed how they learned that sobriety had to be your main priority. Additionally, nine participants had exposure to AA during their early recovery. Six discovered the importance of giving up control in their lives to support their recovery efforts. Eight participants discussed the importance of support and belonging in their early recovery. Finally, eight out of nine total participants discovered that once the alcohol was no longer part of their lives they had unresolved issues hidden by the alcohol.

Participant 6 crossed the line between acceptable drinking to what was considered problematic drinking and inexcusable drinking-related behaviors. Once he knew he was in trouble, he was desperately seeking an easy out with minimal negative consequences: "I heard about the Navy having a program, and I went over seeking help, not because I thought that I had a drinking problem, but I thought this was a way to get out of trouble." Participant 3 quickly started accumulating numerous drinking related consequences once he was out of the military and back in civilian life. He thought he could manipulate his way out of the situation, much like he had done during his military experience:

> I had a series of incidents that happened to me that just plain forced me to realize that I had a problem … car wrecks, incarcerations, hospitalization from injuries, run-ins with the law, things like that. I finally realized, it was one of those circumstances where I either went to a treatment center or went to prison. I chose the treatment center thinking that would con the judge into thinking I was a real great guy.

Participant 7 was also out of the military when he first contemplated quitting alcohol. He unexpectedly found support from fellow co-workers who he was unaware were in recovery. By asking for help at his first meeting, his co-workers reached out to him:

> As soon as I asked for help, even though it was in the way of getting my family back and my house, you know, they didn't pressure me or nothing. They just told me that after work we would go have coffee.

Even without the motivation to change, other than to escape consequences for their actions, or even the perception of having a drinking problem, these early recovery efforts had an impact on the participants. Once in treatment and/or 12-step programs, participants began to see a different way of living that did not result in as many negative consequences. Participants learned how not having alcohol as part of their lives led to a simpler and more honest existence, which was easier to maintain than the one they had with alcohol.

Theme six: Later recovery experiences. The sixth theme is related to the fifth, but focused more on the long-term recovery experience. As the interviews unfolded, it appeared that veterans typically formed a firm and rigid belief system regarding their recovery, and that this belief system continued to operate even after decades of recovery. Veterans in this sample appeared to be describing how they entered into recovery, established a recovery identity, and then spent the duration of their recovery either fighting to maintain or to re-establish that recovery identity.

The participants of this study identified the theme of later recovery experiences as a progression from what was learned early on in their recovery. For some, the close ties to AA continue, while others have extended their supports to reflect the larger community and personal interests and activities. The following subthemes were identified as influential to later recovery: (1) monitor and manage emotions, feelings, behaviors and thoughts, (2) community reintegration, foster interests/activities, (3) maintaining recovery practices/routine, and (4) role model/giving back. Nine participants shared how they monitor and manage emotions, feelings, behaviors and thoughts as part of their later recovery experiences. Nine discussed how community reintegration, fostering interests/activities, is part of the later recovery experiences. Additionally, all nine participants shared about the importance of maintaining recovery practices and having a routine, as key components of their later recovery experiences. Finally, eight participants discussed how being a role model/giving back helped them maintain their recovery.

One helpful strategy is to learn coping skills. There are many reasons, such as the ones to be discussed, that result in individuals seeking out professional counseling services to help them learn to better manage emotions, feelings, behaviors, and thoughts (Sommer, 1997). For participant 3, when discussing the continued resentment he has toward his parents, stated,

> I came to be at peace with this and when looking back at how they were raised and the things that they…the environment they were raised in…if I get too critical or negative in my mind about them at any given time, that's where I go to try to remember their humanity about what happened to them.

Participant 2 has found different outlets that he feels keep him on the path of recovery while keeping his mind, body, and spirit in check:

> I keep growing you know, creatively, spiritually. I got a different spiritual path, I really continue to work out, you know, daily almost, because I think the more physically fit you are, the less you would think about being in a place where you are a lot less about things that would damage you physically.

Participant 5 describes the process for him to identify when his thinking and feelings become problematic. Having had experienced suicidal ideation in the past, he feels that he is much better at recognizing when a problem comes up before it gets too out of hand, and identifying where he went wrong and what he needs to do to address it:

> I have moments of frustration and stuff like that. I don't feel hopeless at all you know. When I get back in those places like that, I typically can trace it back to either I'm not doing something I should be doing, or I've done something I shouldn't have done. You know, and reacting, reverting back to old behavior. That can lead back to that negative perspective of life.

Participant 8 discussed his process for identifying when his thinking becomes problematic and needs to do something to address it before it become a larger issue:

> When you start getting back to what we call "stinkin' thinkin,'" or going back to behaving in the old mannerisms; taking people's inventory, getting short tempered, finding fault, feeling you are better than…it's hard to see that in yourself, so in that, we kind of rely on our sponsor and/or meetings, but mainly it is our sponsor to tell us when we are getting off track.

When discussing how to identify a problem within yourself, participant 8 went on to say:

> It's just when you start to feel uneasy within yourself, then it's time to take a look at yourself and see if you can figure out what it is that's causing you to behave in such a manner that's making you feel uneasy."

Owning his issues and deficits is one way participant 6 keeps on track and continues to strive to be a better person:

> I'm a firm believer of the fact that I still own each and every one of the defects of character I had when I was a full-fledged alcoholic. They are still here, they just don't play the same role in my life that they used to.

The six themes emerged from systematic and structured reviews of the participant interviews. The participants' experiences cohered in a very congruent way, for the most part, with all but one of the interviewees establishing and maintaining patterns of recovery that were recognizable across the sample. Given that there has been so little research in this area, this study may provide a unique contribution to the existing research base by providing counselors information regarding the components of the recovery process for veterans with AUD. Counselors may use this information as a guide to assist them when working with veterans who are recovering from AUD. This knowledge may influence counselors regarding AUD assessment and treatment, including discharge planning. Findings from this study provided insight into veterans' unique phenomenological experiences as youth, military experiences, and life after active duty. There are numerous studies on alcohol use in veterans, but few studies on components of long-term recovery in the veteran population.

Figure 1 (next page) represents the progression of alcohol use from onset through development of more severe AUD disorders and later entry into recovery. External factors described by participants in the study are linked to each stage of progression and recovery identifying the role they play in contributing to each of the stages of progression. Additionally, themes reported by participants relating to internal factors are also linked to the stages of recovery. This model suggests that AUD onset is driven by filling an internal need related at least in part to early exposure and access to alcohol as well as to factors related to early negative life experiences. As the AUD progressed in veteran participants, their military experiences were reported to serve primarily as means for enabling and supporting progression toward later stage AUD. Finally, participants differentiated how social connectedness, quality of life, and recovery behaviors were established, adopted, and differentiated in early and later recovery.

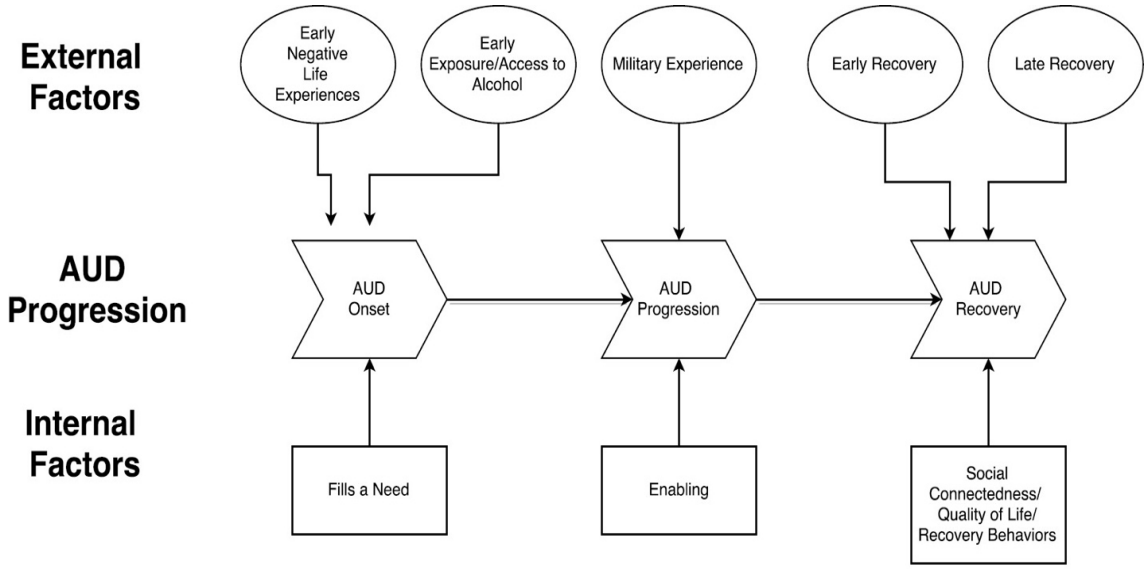

Figure 1. Flow chart representing a linear progression of AUD in military veterans with associated internal and external thematic factors contributing to onset and progression of AUD, as well as initiation and maintenance of long-term recovery.

Discussion and Implications for Practice

Research participants in this study affirmed findings from the literature review in that they found it difficult to define long-term recovery. This appeared to be due to both the broad scope of the concept itself, as well as the complexities of the factors identified as components of the recovery process (Betty Ford Institute Consensus Panel, 2007; Laudet, 2003; Hansen, Ganley, & Carlucci, 2008; White, 2007). Despite the fact that recovery, as a concept, was difficult for participants to operationally define, it was evident that participants had clearly established attitudes, beliefs, values, and behaviors derived from their early experiences in self-help groups and that these early beliefs and values were maintained throughout their later recovery.

Participants identified multiple factors as essential to establishing and maintaining their ongoing recovery. These factors included but were not limited to mere abstinence from alcohol consumption over an extended period of time. Additional components of recovery included: a) expressed difficulty in resolving core issues (family of origin roles and early identity formation, abuse, neglect, and exposure to AUD in the family of origin); b) establishing new identities apart from the self-concept that had evolved as part of their involvement in substance misuse cultures; and c) evolving new behaviors reflective of their recovery-oriented beliefs and values once the recovery process was established. Additionally, it is critical to note that these veterans' recovery programs included a wide variety of tools to prevent relapse, including but not limited to daily monitoring and management of emotions, feelings, behaviors and thoughts; development/reinstitution of healthy recreational and social activities/skills; community reintegration (social connectedness); maintaining recovery practices/routine; and role modeling/giving back.

Long-term recovery for the participants in this study, meant that they were able to establish and develop an identity that does not include the consumption of alcohol. Additionally, they established the supporting cognitions, beliefs, values, and behaviors that supported the new recovery identity, which were viewed as contributing to an overall higher quality of life. In describing the indirect factors involved in recovery (i.e., those not related to consumption of alcohol), participants

supported findings of previous research on the importance of establishing multifaceted dimensions of recovery so as to achieve and maintain long-term recovery (Betty Ford Institute Consensus Panel, 2007; Biernacki, 1986; Hansen, Ganley, & Carlucci, 2008; Koski-Jännes, 2002; Laudet, 2003; Margolis et al., 2000; White, 2007).

Professionals working with this population should recognize that the veterans who achieved long-term recovery had, in most cases, been able to initiate and maintain a multidimensional model of recovery that is reflective of current evidence-based practices. The data collected from this study has implications for counseling veterans beginning the recovery process, by suggesting that this time period is critical for predicting later success in maintaining abstinence. Clearly for the participants of this study, the establishment of a body of recovery skills, across multiple personal and interpersonal dimensions, promoted long-term recovery and improved quality of life in later sobriety. Given that participants maintained the behaviors they established early in their recovery experience, outcomes could be improved by quickly focusing on multidimensional interventions rather than restricting attention to the alcohol use disorders alone.

Additional implications for theory may include an added awareness concerning the etiology of addiction and how it impacts early recovery and continued recovery. This included the impact of family experiences as a significant factor in initiation of AUD, progression of AUD, and exacerbation of consequences of AUD. Participants learned to use alcohol as a tool for managing problematic emotional, social, familial, recreational, and vocational problems. Continued use becomes a way to lessen uncomfortable states such as stress, anxiety, or depression. This behavior of alcohol consumption then gets repeated and dependence on the substance can occur. As described by study participants, the initiation and continuing of alcohol use had many purposes, such as, alleviating boredom, having new experiences, altering mood, and to heighten senses.

Recommendations for Future Research

In order to provide effective, appropriate, and accessible counseling services to veterans, counselors may benefit from developing awareness of early life experiences and how these experiences are perceived by the veteran experiencing AUD. For participants in this study, how they conceptualized their families of origin, both contributed to their use of alcohol and affected their self-concept and conceptualization of recovery, even after long periods of sobriety. While it is not clear that these factors, if left unaddressed, may lead to relapse, it is evident that these veterans continued to attribute great significance to their families of origin and their experiences as children and adolescents.

For young individuals exposed to a work environment that is open to the use and misuse of alcohol as a coping strategy or as a primary recreational outlet, it could be quite difficult to maintain healthy behaviors related to alcohol consumption. The role modeling of misuse behaviors in the military culture, could lead to the potential development of problematic use or exacerbation of an existing AUD. Research has shown that service members may find themselves in a culture that encourages the use of alcohol to avoid the consequences of the daily stressors of military service and/or service related trauma, instead of directly identifying and resolving those stressors and traumatic experiences through more healthy approaches, such as seeking help and communicating about these challenges with others (Ames, Cunradi, Moore, & Stern, 2007; Bray, Bae, Federman, & Wheeless, 2005; Fernandez, Hartman, & Olshaker, 2006; Hall, 2008; Jacobson, Ryan, & Hooper, 2008; Marshall, 2006; Milliken, Auchterlonie, & Hoge, 2007). When working with veterans, counselors should ask about the extent of alcohol use prior to military service, the extent of alcohol use during military experience, and post military use of alcohol, to gain a better understanding of the scope of problematic use and its inter-relationship with the attitudes, beliefs, and values of the

military work culture. Additionally, it is important for the counselor to identify and explore service related stressors, traumas, co-occurring disorders and disabilities so as to develop a comprehensive assessment of why problematic alcohol use began and why it was maintained after the effects of that use exacerbated rather than relieved the initial symptoms that veterans may have been seeking to medicate.

Early identification and intervention activities may be a valuable tool in reducing the consequences of alcohol misuse for military personnel. Further, these tools may reduce the overall harm that can occur as a result of AUD's interactions with both the military culture and military experience. For example, reduction of the long-term consequences of military related trauma (likely to be exacerbated by AUD) may be possible, if individuals were identified prior to being exposed to extreme conditions/circumstances, such as those common to some active duty personnel. Given that maladaptive alcohol use may have already resulted in these individuals having a reduced capacity to manage stressful and traumatic situations, along with an increased vulnerability to trauma, it makes sense to identify AUD as early as possible.

The combination of high stress, high demands, discouragement of sharing feelings, and readily available and accepted use of alcohol have been shown to correlate with high rates of problematic use of alcohol (Ames & Cunradi, 2004; Fernandez, Hartman, & Olshaker, 2006; Milliken, Auchterlonie, & Hoge, 2007). The harm resulting from AUD and the consequences of alcohol misuse are significant. For example, binge drinkers have reported higher rates of accidents, problems with the criminal justice system, and other military related job issues (Adams, Larson, Corrigan, Ritter, & Willians, 2013; Mattiko, Olmsted, Brown, & Bray, 2011; Santiago, Milliken, Castro, Engel & Hoge, 2010; Stahre, Brewer, Fonseca, & Naimi, 2009). Problematic alcohol consumption leads to problems for the individual engaged in the behavior; it also impacts others through drinking related consequences.

For Vietnam veterans, it was initially thought that drug use was the most significant issue; however, recent research has shown that alcohol consumption was a much larger issue (Kuzmarov, 2007). A study done by the US Department of Defense in 1972 determined that 88% of servicemen drank alcohol during their tour of duty (Kuzmorov, 2007). In a study by Huffman (1970), 18.5% of 610 psychiatric patients had severe alcohol dependency. According to Jones and Fear (2011) there have been no studies performed to determine the long-term consequences of excessive alcohol consumption in Vietnam by service members serving during this period.

Current research on the most recent veteran population show that co-occurring disorders and co-existing disabilities (e.g. mild traumatic brain injury, depression, PTSD, AUD, SUD, anxiety disorders) exist and need to be assessed for and treated (Cucciare, Simpson, Hoggatt, Gifford, & Timko, 2013; Hall, 2008; Hawkins, Grossbard, Benbow, Nacev, & Kivlahan, 2012; James, Van Kampen, Miller, & Engdahl, 2013; Laudet, Timko, & Hill, 2014). Counselors serve an important role assessing for potential co-occurring disorders and co-existing disabilities, and discussing treatment options with veterans.

There are many factors associated with active duty service such as missing loved ones, long deployments, family issues, financial problems, stress, exposure to combat, physical injury, numerous deployments, psychological trauma, and pre-existing experiences/issues prior to service that present significant challenges for veterans. Of course, these factors common to military service are also highly correlated with increased risk for AUD during active military service and after discharge from service (Cucciare, Simpson, Hoggatt, Clifford, & Timko, 2013). For veterans who report longer active addiction periods and more severe consequences, there is a reluctance to seek help for mental health and substance use problems (Laudet, Timko, & Hill, 2014). As the AUD related consequences of military service are more widely recognized, it may be possible for the military culture to develop

more appropriate attitudes toward seeking help for AUD as well as support strategies to decrease the stigma associated with AUD. As both help seeking efforts and AUD related problems are perceived less negatively, there is a greater likelihood of the military culture being able to acknowledge and accept the role of counselors and other mental health professionals and providing positive support and encouragement for those seeking help (Laudet, Timko, & Hill, 2014).

Addiction is a chronic condition that can be treated and managed. For those with severe dependence, abstinence is a requirement (Laudet, 2007). Although there is no consensus in the research and practice regarding the definition of recovery from alcohol (Laudet, 2007), based on input from participants in this study, recovery is much more than just not consuming alcohol. Recovery encompasses living a fulfilling and meaningful life. Being free from alcohol typically means that recovering persons have more time, money, and energy to focus on other components of living that may have been neglected or overlooked while in active addiction. It may take time and soul searching on the part of the individual who spent the majority of their time consumed by their addiction to define what recovery means to them. According to the participants of this study, recovery is a journey, which at times may be scary because of the fear of going too far off the path of what is known to keep them sober, coupled with a desire to move beyond the rut into fulfilling activities and endeavors.

Conclusion

Review of the research literature pertaining to veterans' experiences with recovery from AUD revealed that there has been a paucity of studies focused on identifying how veterans progressed into serious AUD as well as how they established and maintained recovery. It should be noted that while there has been considerable attention paid to veterans' challenges and experiences with substance use disorders, this literature does not seek to explain the connections between the early use experiences, progression, and long-term recovery. This study was able to provide new information about this process through reliance on interviews with veterans who had sustained their recovery for significant lengths of time.

First, the study revealed that veterans, even after very long periods of sobriety, continued to be impacted by early life experiences. These experiences included developmental deficits related to both dysfunction in their family systems and the impact familial and personal AUD disorders as components of familial problems. Although participants were able to identify how these factors contributed to their later AUD problems, in most cases, these issues were still unresolved for the men in the study.

Secondly, it was significant that veterans reported AUD as primarily filling unmet needs. Alcohol became a tool to enhance coping and social skills and to support management of complex emotional challenges. While veterans reported using alcohol for recreational purposes, it was clear that for many of the men in this study, alcohol filled the need created by the inability to respond to, and resolve emotional and social challenges, before deployment, during active duty, and after discharge.

Thirdly, veterans reported that they felt that their involvement with the military culture supported their alcohol misuse and that it may have accelerated their progression toward more severe AUD. It is significant that veterans reported that their colleagues not only supported their use and advocated for irresponsible use, but that the network of personnel surrounding them while on active duty, in many respects, served as a buffer for negative consequences of their alcohol misuse. The findings of this study are corroborated by other research on drinking in the military culture and previously identified patterns of enabling of problematic drinking by active duty personnel.

Finally, participants clearly connected their early recovery experiences with successful maintenance of long-term recovery. The veterans in this study became actively engaged in

peer supported recovery programs and initiated new attitudes, believes, values, and behaviors congruent with those of the recovery community. Additionally, nearly all participants reported that they had continued to maintain those behaviors as well as their connections to peer support groups throughout their recovery. The new information provided by this study, sheds light on the importance of the earliest periods of recovery on later recovery, and the real significance of initiating and maintaining change across multiple clinical dimensions as early as possible in the treatment process.

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Anna M. Koch, PhD, NCC, CRC, LPCC
Assistant Professor
New Mexico Highlands University
amkoch@nmhu.edu

Appendix A

The following research questions guided this study:

- How do veterans define long-term recovery?
- How do veterans describe the impact of their military experiences on their AUD?
- What other disorders do veterans indicate may have played a role in the development of their AUD?
- How do veterans describe the impact of their military experiences on their recovery from AUD?
- What other factors do veterans identify as being critical to entering into recovery?
- What factors do veterans believe may have been critical to maintaining recovery?