Fellow Application Submission

TO: American Academy of Healthcare Providers in the Addictive Disorders

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Noble Warriors turning to drink and drugs: The high costs of the isolation of gay and bisexual soldiers returning from tours of duty (a call to research).

Abstract

This is a call to study the insufficiently researched topic of lesbian, gay and bisexual (LGB) active duty personnel in the military who have recently returned from a stressful deployment often returning to a home in a foreign land prior to returning to the United States. It is clear in the research that individuals experiencing stressful deployments are at a higher risk for alcohol and drug addiction, mental health difficulties and other problems upon their return. What is not known, since the literature is largely silent on this issue, is the question of how lesbian, gay and bisexual soldiers cope with such experiences and whether risks of substance abuse and addiction, including co-occurring disorders, are equally as high for this group as other soldiers. The author hypothesizes that LGB soldiers are less inclined to link into support services due to potential social isolation and stigma. A further hypothesis is that this group is not utilizing existing medical supports due to confidentiality and other concerns. The author argues that if these hypotheses were to be confirmed and proactively addressed by the military, LGB soldiers would link in more with services and this would promote recovery and enhance productivity and job retention.

Research Rationale

It is a known fact that military personnel who deploy to war zones are at risk of developing or risk exacerbating existing problems with Alcohol, Tobacco or Other Drugs (ATOD) or other co-occurring disorders.[17] In persons who identify as being lesbian, gay or bisexual (LGB) these risks of substance abuse, addiction and other co-occurring mental health difficulties are likely as high as others in similar circumstances. The difference, however, is in how to properly screen LGB individuals in order to link them into relevant treatment providers and services that will meet their specific needs and maximize positive treatment outcomes. This distinction is important, in part, due to the stigma and confidentiality issues already attached to going for help when developing signs of alcohol, other drug problems or mental health difficulty. When this is combined with being part of a(n), often, disfavored minority group (as persons who identify as LGB are) the available supports and the typical social outlets often present for their heterosexual peers are either under-utilized or avoided altogether.[19] This call to research aims to show that the lack of familiarity, in particular, to the specific needs of the LGB soldier by treatment providers and community services will likely result in fewer self-referrals and treatment outcomes will likely not be maximally effective. This combined with reduced social connections in isolated LGB soldiers can plausibly drive an increased reliance upon alcohol and/or other drugs (ATOD) as a means to cope. Implications include not linking into available prevention and treatment programs from an early stage due to perceived confidentiality concerns or that the LGB soldier believes that they will be judged or that their individual circumstances will not be understood. Further, potential consequences include the

development and progression of treatment resistant alcohol or chemical dependency and related behavior problems potentially disrupting one's unit and the individual soldier's job performance. Serious lapses in judgment or behavioral difficulties as a result of substance use disorders can pave the way to expensive disciplinary proceedings leading to a dishonorable discharge from the military. All of these scenarios would be very costly to both the individual, his or her unit morale and, ultimately, to the greater military community who has likely invested tens of thousands of dollars worth of training into each and every individual soldier *(see Enforcing DADT cost $52,800 per troop).* [5]

Introduction

Every year American soldiers return from active deployments often in countries where the U.S. is in a state of war or fighting terrorism (recent examples include both Iraq and Afghanistan). Many times these soldiers have been in very stressful environments where extreme circumstances were present. [4, 9] Examples of these situations include individuals being in the immediate or close vicinity of combat areas or directly observing fellow soldiers in one's own unit or battalion suffering debilitating or disabling injuries or dying. Further, in war zones, there is always the imminent and possible daily threat of coming into contact with improvised explosive devices (IEDs) or being killed or captured and tortured. As will be demonstrated below there is a high correlation of soldiers being in these environments and experiencing traumatic stress and turning to substance abuse and having other co-occurring mental health difficulties (e.g. PTSD, Anxiety or Depression). It is the author's contention that gay, lesbian and bisexual (LGB) service members experience the same difficulties but potentially receive fewer services particularly when they are not open about their sexuality.[19]

This modest subset of individuals (likely 5% or higher) [8] have their problems compounded by societal or institutional homophobia and rejection. Depending on one's own inferences and beliefs this rejection can often become internalized, turning into unhealthy, morale killing, shame or depression. By not believing they can be open about their identity, aspirations and goals-including choice of partner, already difficult emotions are exacerbated leading to internalized homophobia. Further, combining this shame with a reluctance to link in to available services when exhibiting signs and symptoms of AOD problems or co-occurring disorders (this reluctance to link or disclose problems are common amongst all service members with AOD problems), [18] and experiencing relative social isolation are (this author believes) huge additional risk factors that require specialized knowledge, skills and non-judgmental attitudes of the military service provider.

Literature Citation

Some years ago Hoge et al. reported in a study of returning Iraq soldiers a high incidence of mental health problems (nearly 20% who returned from Iraq). [1] Further research has demonstrated a high incidence of PTSD and the link between PTSD and substance abuse. [9] My focus in this call to research is, specifically, on soldiers who self-identify as being of a gay, lesbian or bisexual (LGB) orientation and who have recently returned from deployment in the above mentioned circumstances. It is my contention (needing confirmation) that soldiers in these circumstances are at an increased risk of either not linking in to available medical and/or

community supports (non-military bisexuals in one study exhibited lower levels of self-disclosure and community connection as compared with gays and lesbians), [7] when needed, and/or are socially isolated and who would be more likely to turn to drink or drugs in the absence of this much needed community and social support.

An additional problem, by gender, present primarily in women, by proportion, is the prevalence of deployed women who experience sexual abuse and/or rape which was found to be 7% (in referencing a 1995 DOD study and noting that these crimes are often underreported by women who must continue to work with their perpetrator).[11] Also, estimates vary, but when looking at career military sexual harassment the estimate is much higher, anywhere from 34-78%, at the hands of their fellow servicemen.[13] This disturbingly high proportion surely affects all women service members' experience.[10] Additionally, it is another traumatic event (compounding an otherwise already stressful deployment), that, likely, further complicates and isolates, specifically, the female soldier who also identifies as lesbian or bisexual. When the above female soldier is not already linked into a supportive social network (who might assist in recognizing problems or recommending the need for treatment) and believes that she has nowhere to turn she would likely choose to delay or avoid treatment especially if confidentiality concerns exist. This is despite the fact that women, *generally*, are more likely to access and link into necessary medical services, [6] and seek out social support and have broader social networks than men. Unfortunately women in these circumstances would likely turn to drink or possibly drug (or prescription) abuse in the absence of other supports as a means to cope.

Further problems identified by gender are that men are less likely, generally, to access preventative and acute medical care. [6] As noted earlier all persons regardless of gender are less likely to link into needed supports when issues of alcohol or drug abuse are present. Men who identify privately as being gay or bisexual have additional risk factors and even more reason to isolate from others or refuse to engage with services. [14] In the author's view men are more severely judged by other men in relation to sexual identity and perceived differences in masculinity. Even at an early age boys experiencing sexual harassment by their peers are very troubled by pejorative references to being called "gay". [15] Men who experience anti-gay harassment, discrimination and violence are shown to have a higher association with problems of lowered self-esteem and report a significant increase in reporting suicidal ideation. [14] Additionally, one study showed that in men who have sex with men, low self-esteem and internalized homophobia can impact on risk-taking behaviors. [16]

Given the above circumstances which are unique to the LGB soldier it is often, therefore, easier to isolate oneself or at least keep ones sexual orientation a secret. In fact, this secrecy, regardless of gender, would be expected given the controversy surrounding even the repeal of Don't Ask Don't Tell (DADT) which had been hotly debated for years and only recently rescinded. Previously even the hint of a relationship with a same-gendered partner would bring up significant confidentiality concerns and the likelihood of discharge from the service.[2] There is debate both by current Presidential candidates and many in Congress to reinstate DADT so even the status of this legislation continues to be in question. This, understandably, is a continuing concern of LGB persons, who either have already, or, who are contemplating disclosing their orientation to treatment providers. Unfortunately, this secrecy around one's

sexual orientation (which can legitimately be seen as a means to protect ones career), can and does lead to further isolation and not linking into or fully utilizing (in terms of disclosing pertinent information), necessary services or community supports which can otherwise mitigate against a serious AOD problem from developing. In Frank's study (2004), soldiers who are open about their sexuality "report greater success in bonding, morale, professional advancement, levels of commitment and retention and access to essential support services".[19]

Suggested Research Plan

As the author is not, at this juncture, suggesting having the current means, or the funding, to carry out the proposed research (although he would welcome the chance should the opportunity arise), a detailed research plan and methods, and, obviously, findings are not included. A statement of relevant research questions and recommendations, however, are in order. It is believed that these would positively guide persons having the ability to respond to and carry out the proposed research.

-Policy Considerations

It was reported recently in the USA Today online (14 March 2012) that the U.S. Army is discontinuing plans for rolling out worldwide their pilot program of soldiers having their confidentiality assured in terms of reported alcohol abuse. This discontinuation was reportedly done due to the large number of treatment drop-outs.[12] The author could not, at this time, find other, more detailed explanations for this change and encourages the prospective research funding source(s) or reader contemplating this research to consider the following:

- Professionals treating addiction are aware of the vital importance of client confidentiality.
- Client confidentiality with all persons, including LGB soldiers, must be ensured both in terms of valid research findings but also to increase and prolong treatment participation.
- The therapeutic alliance will be severely compromised should a client's confidences be shared.
- If a client's confidential information is shared for reasons other than an imminent threat to life of self or others or a child protection concern, future therapy is compromised.
- Longer treatment duration (at minimum 10-16 sessions), often results in better outcomes. Better outcomes correlate with better job performance.
- It is necessary to look at and promote creative strategies to increase self-referrals and to minimize treatment drop-outs.
- The Army was on the right track by offering confidential treatment options, which are in line with international best practice standards.
- Resuming confidential counseling would demonstrate a commitment to soldiers wishing to achieve recovery and will significantly aid in relapse prevention.

-Research Questions stated

- Are LBG soldiers returning from stressful deployments as likely to abuse substances as their peers? If so, will they respond as well to existing treatments?
- Does perceived social isolation or the lack of confidentiality factor into the avoidance of early treatment or self-referral by LGB soldiers?
- What are the costs both to the individual and to the military of LGB soldiers developing advanced substance use disorders that could be screened and treated earlier?
- What strategies can be employed to promote earlier treatment enrollments and to encourage treatment longevity?
- How can the LGB soldier's positive and healthy social outlets be promoted?

-Further Suggestions as to time plan and sampling methods

The author wishes to give a couple of brief suggestions as to a time plan and sampling methods. One possible scenario would be over a three to six month period to confidentially sample a statistically representative portion of soldiers returning from deployment. Also, due to the fact that deployed female soldiers are a smaller group it would be important to oversample this group to have a representative data-set. This sampling could be achieved either through confidential web-based surveys or surveys given to randomly selected groups of soldiers who are being de-briefed after returning from stressful deployments. One option to maximize accuracy in reporting, and to further reinforce perceived confidentiality, is to disseminate the surveys at the end of the briefing and with the commanding officers not present. These could be collected by service personnel of a similar rank but not affiliated with the company or unit in question. At the end of the six month data collection period the information could be tabulated and decisions made to possibly pilot treatment strategies that are confidential and aim to demonstrate that the military values, as well, its LGB soldiers as a group and recognizes that there are distinct assessment and treatment needs to achieve positive outcomes. This could be set up as a double blind study where the experimental group receives services from the pilot group with special training and experience and the control group receives services as they currently exist (but preferably for a similar time period) and compare treatment outcomes and relapse rates at 3, 6 and 12 month intervals.

-Venue

The Kaiserslautern/Ramstein complex is quite large (54,000 persons), and is often a first stop after deployment to areas in the Middle East (where there is current substantial American deployment). As a useful venue there would be availability of a large contingent of soldiers returning from deployments in war zones who may be stationed in the vicinity for some months prior to being redeployed or in terms of completing service and returning to the U.S. The logistics of sampling the above group before they relocate elsewhere is more cost effective. Also, it will likely reduce memory bias in terms of asking questions about ATOD use immediately after deployment which is subject to change the longer the length of time between deployment

and the soldier's next duty station or return home. Furthermore, treatment options in this area of Germany are well staffed (from the author's personal experience) and can offer a potentially larger range of services. This would be ideal were the various hypotheses and the unique needs of the returning deployed LGB soldier to be confirmed and it was determined that a treatment program needed to be piloted, to assess outcomes and effectiveness, to serve the specific needs of this group.

Conclusion

This article was written to highlight that the problems and difficulties in providing effective prevention and treatment services to a service person returning from a stressful deployment is (like in many areas of treatment in the civilian context), additionally dependent on characteristics of the person and their background. Just as men and women service-members have different experiences and specific treatment needs (as do persons of different race and ethnicity), so too does the LGB soldier. One of these needs is when that person does not have a solid social network from which to draw support. Also, the necessity of a confidential service that is staffed by persons knowledgeable of the needs of this population, being able to demonstrate skill in working with this group and holding non-judgmental attitudes are absolutely essential to maximizing positive and meaningful measurable outcomes of success.

It is the author's hope that the need to research, and confirm (or debunk) the extent of these identified problems and hypotheses (which if true have implications for confidentiality, screening, outreach and individualized treatment options), has been sufficiently persuasive. The history of DADT (only recently repealed) and the threat of confidentiality being potentially compromised in medical settings factor into secrecy about oneself and discourage linking in to necessary prevention and treatment settings. In the absence of this medical, community and social support it is the author's strong belief that the LGB soldier, post deployment, and in isolation, has nowhere else to turn except to the use and misuse of alcohol and drugs which can result in the service person's life spiraling out of control. The author is excited at the prospect that this paper be published and the concerns thus brought to the attention of or disseminated to the military community. It is hoped that the military commanders who come across this paper in literature searches online or by other means will contemplate action in support of this group which is an otherwise under-researched albeit valuable segment of the military population in terms of knowledge, skill and training. The proposed argument for research and intervention targeting this specific population can ultimately save the military from unnecessary expense, boost morale and mental health, promote career development, and productivity and aid in the retention of valuable personnel.

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Author Biography:

Wes James Orr obtained his M.S.W. degree in 1999. He went on to obtain his L.M.S.W. from the State of Michigan which is the highest credential for independent clinical practice for Clinical Social Workers. He acquired subsequent certifications from the Academy of Certified Social Workers (ACSW) from the NASW and the Certified Addictions Specialist (C.A.S.) from the American Academy of Health Care Providers in the Addictive Disorders in 2002. This was immediately prior to accepting a contractor post as a Social Worker Addictions Counselor in the greater Ramstein/Kaiserslautern military community in Germany for the U.S. In this post (2002-5) he was credentialed by the Landstuhl Medical Flight and worked supporting and treating military dependents and their families where there were issues of ATOD abuse and addiction often existing with other co-occurring disorders. At various times in his career Wes has worked with individuals who were coming to terms with their sexuality as LGB individuals who were experiencing both difficulties in linking in to services and dealing with the prejudices of others and tending towards self-isolation. Recent training includes completion of the academic portion of a post-graduate diploma (3 years) in Rational Emotive and Cognitive Behavioural Therapy from the Institute of Cognitive Behavioural Therapy in Ireland. Wes currently lives in Ireland working as a Senior Clinical Social Worker for the Health Service Executive (Irish Health Service) practicing in an outpatient mental health setting for the last 5 years. In this role he works with a combination of persons having both acute and long-term mental health difficulties often accompanied by addiction or substance abuse issues.