PART I

Introduction to Military and Veteran Health

CHAPTER 1

Military Culture

Tina M. Fanello, Jami Skarda Craft, and Catharine H. Johnston-Brooks

The views expressed in this chapter are those of the authors and do not reflect the official policy of the Department of the Army, Department of Defense, or the U.S. government.

Introduction

The intent of this chapter is to offer civilian healthcare providers a better understanding of the perspective veterans may bring to their healthcare encounters in civilian life. Exhibiting knowledge and cultural competency by acknowledging and incorporating awareness of military culture can lead to improved patient satisfaction and enhanced health outcomes (Alizadeh & Chavan, 2016; Meyer et al., 2016). The military has a shared set of behaviors, beliefs, and values that impact how one thinks, communicates, interacts, and views one's role in life and in health care. What is unique about culture in the context of the military is the mindset shift from self-reliance to one of an interdependence, with the collective mission to protect our country by rising above any one individual's needs. Many aspects of military culture contribute to and reinforce this group mindset, including training, uniforms, use of rank, and use of language. Recognizing the presence of subcultures within branches, ranks, and job categories is important to understand the larger culture of the military. The impact of expectations and values within these subcultures further influences veterans' views and experiences within healthcare settings.

Trust is essential to the process of creating an effective working relationship between patients and providers. Having a basic knowledge of military structure and demographics can serve as a foundation on which to build trust so that even without personal service in the military, civilian providers can effectively address the many complex physical and psychological healthcare needs of this population.

Military Language

Familiarizing oneself with the language of military culture includes understanding key terms and jargon, and recognizing the style of direct, concise, and honest communication commonly demonstrated within the military community. This familiarity will significantly enhance the development of a relationship between the civilian provider and the patient.

There are many commonplace terms unique to the military, with numerous acronyms,

abbreviations, and military concepts. Although civilian providers may not use this language, understanding key terms can be helpful to comprehend what a veteran is explaining and can support development of a therapeutic relationship. Terms or jargon can vary from one branch to another. For example, a service member (SM, actively serving in the military) is referred to differently across branches of the military. An individual currently serving or having served in the Army should be referred to as a "soldier." In contrast, Air Force members are "airmen and airwomen"; individuals in the Navy are referred to as "sailors," while members of the Marine Corps are simply referred to as "Marines." These distinctions may seem minor, but they can represent one of the most important uses of language that demonstrate respect for the veteran's branch of the service and acknowledgment of an important component of military culture.

Communication in the military is often directive and concrete. The military commonly communicates by providing only the amount of information necessary for the situation, without extensive explanation or emotion. This style of communication can come across as rude or demanding to those not familiar with the culture, but it is the language style to which veterans are accustomed. When building rapport, the civilian provider should be aware of how the veteran communicates. Being direct and providing the "what, why, and when" of information can ensure that the communication exchange is positive and accurate.

Within the healthcare setting, numerous terms that provide information regarding injury or health history may sound unfamiliar to a civilian provider. Geographic locations and timelines of injury are often provided within a military health record. Terms often used when discussing where an injury occurred are CONUS (continental United States—lower 48), OCONUS (outside the continental United States), and "theater" or "theatre" (geographic area of war operations). The medical evacuation of wounded personnel from a battlefield following an injury or medical event is communicated with the acronym MEDEVAC. Timeline of injuries or time of service may be designated by acronyms such as GWOT (Global War on Terrorism), referring to the conflicts that began after September 11, 2001. The most recent wars in the Middle East, including OEF (Operation Enduring Freedom [the war in Afghanistan]), OIF (Operation Iraqi Freedom), and OND (Operation New Dawn), can be referred to collectively as GWOT. As of 2020, troops continue to be deployed to the Middle East and across the world.

Military Ethos and Mindset

All branches of the military subscribe to the same fundamental set of beliefs and attitudes represented by the Military/Warrior Ethos (U.S. Army, 2020a). Strategies used to shift these beliefs and attitudes individuality to the unified group mentality that is essential to the success of the military begin at basic training and are reinforced through every aspect of the lived military experience.

I will always place the mission first.
I will never accept defeat.
I will never quit.
I will never leave a fallen comrade.

The term *mindset* refers to a unifying aspect of military culture that is used as a foundational component to teach perseverance, responsibility, motivation, adaptation, and service above self. A U.S. Army Research Institute report describes one intervention on the first day of new soldier training: "Typically, the days are regimented, and most activities are designed to make all Trainees look and act alike. Their individual identities and personalities are temporarily removed in the attempt to produce the basic Soldier." The intent of this intervention is to "inculcate

Warrior Ethos into Soldiers and leaders" and is referred to as "Soldierization" (Riccio et al., 2004). These actions include shaving recruits' hair, issuing uniforms, and memorizing of the Warrior Ethos, which begins to strip away individualism and create a member of the Armed Forces.

Table 1-1 demonstrates six specific traits, along with consequential strengths and vulnerabilities, recognized by the Center for Deployment Psychology as reinforced by the Warrior Ethos: selflessness (others above self), loyalty (commitment to mission and protecting others), stoicism (toughness), moral code (what is right and wrong), social order (defending societal values), and excellence (being the best) (Uniformed Services University, 2018). For many SMs, these traits become a permanent part of their identity and, as such, may have a powerful influence on how they engage with healthcare services.

To briefly illustrate, these traits will be considered as they might apply to a veteran having served as a combat medic in the Army. Medic training is comprised of a 10-week basic course and a 16-week advanced training course. Although medics are considered nonlicensed medical personnel, they are frequently referred to by peers as "doc" and are individually responsible for approximately 40 troops (Cooper, 2013).

Medics are indispensable on the battlefield and known for their selfless courage as they must put other's lives before their own. Many combat medics have seen "the worst" on the battlefield; therefore, they may view their own needs as minute in comparison. When contemplating if they should get their own injuries evaluated, medics may be inclined to decide that others' care is more important and forgo their own medical needs. This pattern, the vulnerability or downside of selflessness, may continue even years after leaving the military.

The loyalty and commitment involved in saving a wounded comrade in combat is immense. For this reason, medics might be driven to dismiss their own injuries, or even hide them, so as not to "abandon" the team. This vulnerability of loyalty can lead to minimizing personal injuries or symptoms—an "others have it worse" attitude—or even the

Table 1-1 The Warrior Ethos

Strength	Trait	Vulnerability
Placing the welfare of others above one's own welfare	**Selflessness**	Not seeking help for health problems because personal health is not a priority
Commitment to accomplishing missions and protecting comrades in arms	**Loyalty**	Survivor guilt and complicated bereavement after losing friends
Toughness and ability to endure hardships without complaint	**Stoicism**	Not acknowledging significant symptoms and suffering after returning home
Following an internal moral compass to choose "right" over "wrong"	**Moral Code**	Feeling frustrated and betrayed when others fail to follow a moral code
Meaning and purpose when defending societal values	**Social Order**	Loss of meaning or betrayal when rejected by society
Becoming the best and most effective professional possible	**Excellence**	Feeling ashamed of (or not acknowledging) imperfections

rejection of care if they perceive that they could have done more to help someone on the battlefield. Similarly, a vulnerability of excellence may be demonstrated by a self-perception of failure that can lead to complex psychological trauma, moral injury, and maladaptive behavior such as substance abuse.

In this example of a combat medic, the persistence of selflessness, loyalty, and excellence are values that may supersede the inclination to ask for help. As a healthcare provider, recognizing and addressing these vulnerabilities, and inquiring about the veterans' experience, can help patients move beyond the barriers to asking for help by demonstrating insight and fostering rapport.

Branches of Service

The Armed Forces of the United States consists of four main branches within the Department of Defense: Army, Air Force, Navy, and Marine Corps (U.S. Department of Defense, 2020). Another branch, the U.S. Coast Guard, falls within the Department of Homeland Security and operates under the Department of the Navy during times of war. The newest branch, Space Force, established in December 2019, operates under the Department of the Air Force. The overall collective mission of the military is to protect the United States and its territories. Each branch has its own specific focus, including a unique set of values and expectations, within this collective mission. The four main branches of the military account for the vast majority of the military veteran population and will be the primary focus of this section.

The **U.S. Army** is the largest branch of the military and is most engaged in land-based warfare. The Army's stated mission is "to deploy, fight, and win our Nation's wars by providing ready, prompt, and sustained land dominance" (U.S. Army, 2011). Most of the training and combat missions take place on foot or using ground military vehicles. Army troops tend to have the longest deployments, with an average of 9.66 months per deployment compared to all active duty (AD) branches' average of 7.52 months (Institute of Medicine, 2013).

The **U.S. Air Force** serves as the aerial warfare branch and the mission is "to fly, fight and win in air, space and cyberspace" (Gettle, 2007). Air Force training and combat support take place primarily in the air. The Air Force, on average, has the shortest deployments with an average of 4.89 months (Institute of Medicine, 2013).

The **U.S. Navy's** mission is "to maintain, train and equip combat ready Naval forces capable of winning wars, deterring aggression and maintain freedom of the seas," essentially protecting the United States "on, under and over the water" (Naval Medical Research Center, 2020). Another vital responsibility is training chaplains and nonlicensed medical personnel called corpsmen, serving both the Navy and the Marine Corps.

The **U.S. Marine Corps** is a part of the Department of the Navy but is considered a separate branch of the military. The mission of the Marine Corps is "to win our Nation's battles swiftly and aggressively in times of crisis" on land, sea, and air (U.S. Marine Corps, 2020). Essentially, the Marine Corps is "first to fight," and trained to be the most aggressive fighters in any environment. Of all branches, Marines tend to have the strongest branch-specific pride and enthusiasm demonstrated by their recruiting slogan: "The Few. The Proud. The Marines" (Schogol, 2017).

Reserves and National Guard

The **reserve components** refer to two organizations within the U.S. military: the Reserves and the National Guard. Five branches of the military (Army, Navy, Air Force, Marine, Coast Guard) have reserve components, with the Army and Air Force having additional National Guard elements. Reserve and National

Guard components are generally required to serve one weekend a month and two weeks a year unless mobilized to full-time AD for a mission. Members of both reserve components are considered members of the military, but they are only considered full-time military personnel if they are activated to deploy. Most members of these reserve components work full- or part-time civilian jobs and can live anywhere they choose in the United States. Members of both reserve components may be eligible for veteran benefits if they meet certain criteria (U.S. Department of Veterans Affairs, 2012). For further reference, visit https://www.benefits.va.gov/guardreserve.

There are a few differences between the two reserve components. The **Reserves** are a federal reserve force that augments each of the active military components as personnel resource needs dictate. The **National Guard**, on the other hand, has both federal and state missions. Activated by state governors, the National Guard's primary mission is to support the United States in times of natural and human-made disasters. The National Guard can also be activated by the president for federal service to support in times of national emergency, national disasters, or war.

The U.S. military has heavily relied on reserve components in the wars in Iraq and Afghanistan. At its peak, in 2003, approximately 40% of the total U.S. military fighting forces were Reserve and National Guard components (Segal & Segal, 2005).

There are several disparities between Reserve and Guard members when compared to full-time AD SMs; one of the most salient is access to culturally responsive health care following a deployment. Members of the Reserve and Guard have 180 days following deployment to access health care from the Military Health System (MHS). However, members of reserve components commonly forgo access to military medicine after a deployment due to travel distance and the logistics that may delay returning to homes, families, and jobs. Instead, these SMs rely on civilian healthcare entities in their home communities. As civilian healthcare providers, understanding limitations to healthcare access for reserve components is a vital consideration when discussing military service and may further inform assessment and treatment.

Special Operations Command

The **U.S. Special Operations Command** (**USSOCOM** or **SOCOM**) is the command center for a group of elite members of the military that spans across the four main branches of the U.S. military. It includes AD, National Guard, and Reserves. These specially trained members are called Special Operations Forces (SOF). Special operations require unique modes of employment, tactical techniques, equipment, and training. These operations are often conducted in hostile or politically sensitive environments and involve high-risk training and missions (Feickert, 2020).

The most common and familiar SOF organizations include:

- Army: Delta Force, Green Berets, and the 75th Ranger Regiment
- Air Force: Special Tactics Airmen, Pararescue Jumpers (PJs) specializing in personnel recovery and Special Operations Aviators
- Marine Corp: Marine Corps Forces, Special Operations Command (MARSOC) Raiders
- Navy: Navy SEALs (Sea, Air, Land)

Many SOF members transition into high-security government jobs such as the Department of Intelligence or other private military security companies after leaving the military. Due to their unique training, members of this population are often held to higher standards of performance and may face negative implications when deciding to seek medical or psychological care during and following military service. Loyalty (commitment to mission) often results in a higher

rate of deployments with less recovery time to address medical or psychological health concerns. This loyalty increases the long-term possibilities of untreated, often overlapping physical and psychological injuries. Excellence (being the best) is also a source of pride, and any perceived imperfections may be another prohibitive barrier to asking for help. An approach to building trust with this military subculture is that integrity, "straight shooting," and good judgment are essential. Civilian providers who are honest and display sound professional judgement, rather than merely asserting their competence, will be more likely to gain the trust of veterans with whom they work (Gayton & Kehoe, 2016).

Military Rank

Rank represents a position of authority and is a symbol of respect. Rank also determines pay grade, level of responsibility, housing, and social status. Rank establishes a clear chain of command by delegating a hierarchy of authority. Each SM has a specific individual to report to in the chain of command as established by rank. All military branches follow the same general command structure with two types of rank: enlisted and officer. Circumventing the chain of command can result in disciplinary action. Pay grades are designated salary levels, and these range from 1 to 10.

Enlisted E-1 up to E-4 are personnel usually within the first few years of their military career. **Enlisted Noncommissioned Officers (NCOs) E-5 up to E-9** are promoted through the enlisted ranks. They have advanced training in their military occupational specialty and provide direct supervision and leadership of other enlisted members of the military. **Commissioned Officers O-1 up to O-10** plan and direct personnel operations and materials management. Officers are required to have a four-year college degree. **Warrant Officers WO-1 up to CWO-5** fall between the ranks of enlisted personnel and commissioned officers, selected for technical skills and expertise in their field. For more information on rank within each branch, a rank structure chart can be very helpful (e.g., www.defense.gov/Resources/Insignia/). Members of the military are expected to utilize rank, but it is not appropriate for civilians to do so.

At any level, the responsibility of leadership brings an inherent attitude toward physical and mental health care. Traits of loyalty (accomplishing missions and protecting others) and excellence (being the best) are reinforced as an SM rises through the ranks. In addition, higher rank is associated with increased reluctance to seek health care due to stoicism (toughness) and the wish not to be perceived as weak. This shift in attitude may be attributed to a sense of accountability, responsibility, or a perception of dedication to the larger mission. Healthcare providers should be cognizant that higher rank may result in an initial guardedness until trust is established.

Jobs in the Military

Jobs in the military are assigned a combination of letters and/or numbers, referred to in the Army and Marine Corps as a Military Occupation Specialty (MOS), in the Air Force as Air Force specialty code (AFSC), and in the Navy as Navy enlisted classification (NEC). There are more than 800 job categories in the military; some examples include infantry, intelligence, military police, logistics, engineer, communications, medic, transportation, and aviation. All applicants take an Armed Forces Vocational Aptitude Battery (ASVAB) to determine for which branch and job they are best suited in the military. Once applicants have received their score on the ASVAB, other factors such as qualifications, security clearance, and physical requirements are considered. It is important for civilian providers to understand

that all SMs from all job categories are eligible for combat deployment and may experience combat exposure.

Within the larger construct of military culture, some job categories instill unique skillsets and values that shape attitudes about accessing health care. Given the high-risk nature of job categories such as SOF and explosive ordnance disposal (EOD), SMs may habitually focus on the here and now, while ignoring the implications of their job on long-term physical and psychological health. In addition, personnel in high-risk job categories tend to have a strong appetite for adrenalin-inducing activities, causing further wear and tear on a body already affected by years of harsh, high-stress circumstances. Veterans in these job categories may have experienced repeated blast exposures (even hundreds depending on the length of their military career), leaving them at high risk for traumatic brain injury, hearing loss, and headaches, as well as psychological impacts or personality changes. Acknowledging this mindset is critical to recognizing military attitudes toward personal health, moving past the toughness and sometimes dismissive attitude about health care that may have become part of the veteran's identity.

There are several helpful websites that detail various types of military jobs (e.g., www.todaysmilitary.com/careers-benefits/explore-careers).

Joining the Military

Fewer than one-half of 1% of the U.S. population currently serves as AD military personnel. Joining the U.S. military requires an individual to be a U.S. citizen or lawful permanent resident between the ages of 17 and 39 (age limit varies by branch), to be in good physical and psychological health, and to hold at least a high school diploma or GED (USA.gov, 2020). Individuals join the military from a variety of ethnic, social, geographic, and cultural backgrounds, and therefore the factors that influence a decision to serve in the Armed Forces are unique to each person. A 2018 RAND study found that the top three reasons recruits chose to join the military are (1) travel and adventure, (2) benefits such as health care and education, and (3) a response to a call to serve. Other reasons include perception of honor, job training, and pay (Helmus et al., 2018).

AD demographics paint a picture of a predominantly young population, with 71% of enlisted SMs age 30 or younger (the Marine Corps has the largest percentage of enlisted members age 30 or younger, at 86.4%). In addition, 69% of all AD SMs identify as White with the second largest population being Black (17.1%). Of all AD SMs, 16.5% identify as women, increasing from 14.7% in 2000, and the percentage is expected to continue to rise (Department of Defense, 2018). The six states providing the highest number of recruits are California, Texas, Florida, Georgia, North Carolina, and New York (Department of Defense, 2018).

The 2018 U.S. Census Bureau reports that approximately 18.2 million people, or 7% of the adult population, are veterans of the U.S. Armed Forces (Vespa, 2020). The overall number of veterans is predicted to steadily decline over the next 30 years to 13.6 million due to increasing mortality rates of World War II, Korean conflict, and Vietnam era veterans. Census data reveal that the median age of all living veterans is 65. The median age of post-9/11 veterans is 37, while Vietnam era (the largest living cohort, at 6.4 million) and World War II veterans have median ages of 71 and 93, respectively (Vespa, 2020).

States with the highest number of veterans are California (1.47 million), Texas (1.4 million), and Florida (1.4 million), while the state with the highest percentage of veterans is Alaska, at 10.7%. Post-9/11 veterans, on average, have a 43% chance of having a service-connected disability compared to Gulf War (27%) and Vietnam era veterans (16%).

Reasons for this increase are complex and include improved lifesaving measures in the battlefield (fewer people died on the battlefield in recent wars) and improved recognition by the Veterans Affairs (VA) of service-related disabilities (Vespa, 2020).

Female Veterans and Military Service

Women have proudly served their country throughout the history of the United States, but the extent of their involvement and recognition of their contributions have changed dramatically over time. Prior to being formally recognized as part of the U.S. Armed Forces with the Army Nurse Corps in 1901, women served during the American Revolution and Civil War disguised as male soldiers (U.S. Army, 2020b). Since the early 1900s, women served primarily as nurses, but have slowly integrated into other roles such as flying aircraft, gathering intelligence, and engaging in communications operations with minimal recognition for their contributions. The wars in Iraq and Afghanistan have significantly changed the roles of women in the military. For example, women have been involved in combat with limited acknowledgment for many years. In 2015, the Pentagon lifted a ban on women serving in combat arms units, allowing women to apply for any job available to men, provided that they meet the same physical requirements (U.S. Army, 2020b).

Women currently make up approximately 9% (1.7 million) of the veteran population. By 2040 that number is projected to rise to 17% (Vespa, 2020). Although the proportion of female SMs and veterans is growing, they are still significantly outnumbered by their male counterparts. Given these numbers and the history of women's service, there are aspects of a woman's military experience that continue to be unique and challenging, such as ill-fitting gear, navigating family life, and unique healthcare challenges.

Sadly, one of the most significant health issues facing female veterans is military sexual trauma (MST), a term used to describe sexual assault or harassment that takes place during military service. While men also report MST, women report it in much higher numbers. One in 4 women and 1 in 100 men screened at the VA reported MST (Wilson, 2018). Frequently, MST is not disclosed until leaving the military because despite a strict no-tolerance policy, many victims fear retaliation from the perpetrator or believe that nothing will be done about the incident even if it is reported. This lack of disclosure is particularly true when the perpetrator is someone in the individual's chain of command upon whom the individual must rely for safety and well-being (Andresen et al., 2019). Screening for MST is a crucial healthcare consideration for these veterans, as it is strongly associated with mental health conditions including posttraumatic stress disorder (PTSD), dissociative disorders, eating disorders, and personality disorders. In addition, veterans with MST are at a higher risk for suicide and intentional self-harm, as compared to their peers without MST. This further reinforces the need for heightened awareness of, and screening for, suicide risk in the female veteran population (Kimerling et al., 2007).

Sexual Orientation, Gender Identity, and the Military

The formal targeting of homosexuality in the military began in 1942 when psychological examinations were used to screen homosexuals out of military service, including males demonstrating "feminine-like behaviors" (Rubin et al., 2012). In 1981, the military outlawed any form of homosexuality and discharged any individual, regardless of gender, suspected of homosexual activity. With the evolution of social attitudes, the familiar policy of "Don't Ask, Don't Tell, Don't Pursue" (DADT) was signed

into law in 1993, prohibiting the military from screening for homosexual behaviors. Once in the service, SMs could not be asked about sexual orientation. This policy also meant that individuals were forced to conceal their sexual orientation; choosing to reveal it put them at risk for being dishonorably discharged and potentially losing their military career and all military benefits. As social attitudes continued to change, a repeal of DADT went into effect in 2011. As of 2020, gay, lesbian, and bisexual individuals openly serve in the military without any lawful repercussions of disclosure (Rubin et al., 2012).

Obtaining sexual identity and orientation history is best practice for any healthcare assessment, including that involving veterans. It is important not to assume that, because a veteran is married or has been married to someone of the opposite gender in the past, the individual has not also had same-sex partners. Gay and lesbian veterans may have married someone of the opposite sex as an avenue of safety during times when their personal safety or career may have been jeopardized as a result of being suspected of being gay.

In 2016, the Pentagon announced a new policy to allow transgender individuals to serve in the military, and for those who were already serving, to do so openly. In 2018, the policy was reversed and as of 2020, individuals who identify as transgender are banned from serving in the U.S. military (Council on Foreign Relations, 2020). During this short period of time, both the MHS and the VA offered some medical and psychological gender transitioning services, only to be revoked in 2018 when the policy was reversed (Human Rights Campaign, 2020).

Relevant to healthcare assessment and treatment of this population in the civilian healthcare sector, understanding that gender identity and sexual orientation may often be hidden while serving in the military is important. Individuals may only feel safe to disclose this information upon leaving the military. For many lesbian-gay-bisexual-transgender (LGBT) patients, discrimination in health care is associated with negative perceptions of health care (Ruben et al., 2019). This situation further reinforces the importance of creating a trusting and a safe relationship to truly help these individuals with what are often complex medical and psychological health needs.

Era of Service

Healthcare providers should also be mindful about the era in which an individual served. Societal attitudes about the era of service, and a veteran's experience with that era of service, may elicit different attitudes about sharing service-related mental or physical health concerns. For example, many Vietnam veterans returned home to widespread antiwar protests while often enduring physical conditions from environmental exposure to Agent Orange and psychological burdens from atrocities they experienced during deployment (Llorente & Ritchie, 2020). Shame and guilt related to the political and social climate of the Vietnam War may have left some veterans guarded about even disclosing their service during this time.

Not all veterans have been provided the same access to healthcare services, especially related to psychological health. It was not until the Vietnam era that mental health challenges such as PTSD were truly acknowledged and treated by the healthcare community. Over time, more physical, cognitive, and psychological healthcare resources have become available to treat these "invisible war wounds," but the stigma of asking for help persists (Sharp et al., 2015).

Unique health concerns of the Vietnam era veterans are exposure to Agent Orange, along with the high prevalence of hepatitis C, PTSD, and homelessness. Those exposed to herbicides such as Agent Orange between the years 1962 and 1975 in Vietnam, as well as other locations (e.g., Korea and Thailand), may be at higher risk for certain medical conditions including AL amyloidosis, ischemic

heart disease, noninsulin-dependent diabetes mellitus, Parkinson disease, peripheral neuropathy, skin conditions, and various types of cancers (Board on Population Health and Public Health Practice Health and Medicine Division & Committee to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides, 2018). These conditions may be eligible for care and compensation through the VA (U.S. Department of Veteran Affairs, 2020a).

Often referred to as "signature wounds" of the wars in Iraq and Afghanistan, traumatic brain injury (TBI) and PTSD, both addressed elsewhere, are essential to consider, especially in GWOT veterans. However, there are other important physical and psychological health considerations of this era. The impact of multiple blast exposures impacts the brain and other systems of the body, often resulting in sleep disorders, hearing loss, chronic pain, and gastrointestinal issues (Przekwas et al., 2019). The psychological implications of war and the stress of multiple deployments, with inadequate access to acute treatment, may result in not only PTSD but also anxiety disorders, depression, and other stress-related conditions (Macgregor et al., 2014). In addition, exposure to burn pits (incinerated waste including chemicals, weapons and ammunition, plastics, medical waste, rubber, and human waste) is common in Iraq and Afghanistan veterans and can potentially result in respiratory diseases and other health risks (Sotolongo et al., 2020). These considerations help explain why veterans from this era are at such high risk for polysubstance abuse, depression, anxiety, and other stress-related conditions.

Many of the wounds of service and war are shared by veterans despite their era of service. Although risks may be greater during time of war, injuries and psychological trauma can occur outside wartime. Military training is dangerous, and many injuries and deaths occur every year due to vehicle accidents, accidental gunshot wounds, large weapon system accidents, or psychological trauma from losing a comrade due to an accident or suicide. Using an open-ended question such as "What was your experience with serving during that time?" saves providers from trying to guess what might be relevant and allows patients to share what is most important to them.

Military Families

Military life comes with its own set of rules, traditions, and restrictions that must be observed and followed by all members of the SM's family. Family plays a central role within military culture and is often involved in support of readiness, meaning that if an SM's family needs are not met, the entire mission can be impacted. This concept is another example of the military cultural value of placing the collective group over individual needs. It may mean family members delay or limit recommended health care due to a move, deployment of a family member, or general demands of military life.

There are many unpredictable variables that limit opportunities and create stress for families. Fears of death or injury are obviously stressful situations during training and deployment, but also of concern to the overall health of a family unit is the isolation of a single parent who must manage a household and children for long periods of time. Depending on the branch of service, job training, missions, and deployments can vary in length from a few weeks to many months. At the height of the GWOT, for example, some combat deployments lasted 15 to 18 months. Not only is the time an SM is away from the family stressful due to worry, single parenting, and missing loved ones, but also significant is the time following the return home when family members must adjust to different parenting styles, schedules, shifts in roles, and expectations. If an SM is returning home from a difficult combat deployment there may be psychological or physical injuries to contend with as well. Children may not understand

why their parent is acting differently, and spouses may be dealing with changes in the marital dynamic. Research has indicated that children of deployed military members are apt to abuse substances and have higher rates of externalizing behaviors (e.g., physical fights, carrying weapons). There is also evidence of higher rates of suicidal ideation in children with a deployed parent as compared to civilian children (Williamson et al., 2018).

Adjustment and change can be particularly challenging if the child of a military family has special needs. This added burden can impact psychological and social development. Military families are seven times more likely to relocate than civilians, and with each move come new schools, new friends and neighbors, and different housing conditions. Adult children of military members report that geographic mobility is the single most stressful aspect of growing up in the military (Ender, 2000). For spouses, meaningful career paths can be difficult without an established support system or adequate child care in new locations. Of female military spouses, 90% report being underemployed with respect to their education and experience, and tend to make 38% less income than their civilian counterparts (Community Salute, 2017).

There are a few considerations to keep in mind when working with veterans and their families with respect to the caregiver role and the diversity of support systems. A spouse, adult child, or extended family member may take on a caregiver role if the veteran is struggling with issues such as memory loss, physical injuries, or psychological difficulties as a result of military service. The VA provides compensation for eligible veterans requiring a caregiver due to their service-connected disabilities (see, for example, https://www.va.gov/family-member-benefits/comprehensive-assistance-for-family-caregivers/). SMs and their families may have diverse support systems beyond their immediate family unit. Often parents or in-laws, as well as friends, neighbors, and extended family members, may be involved as primary supports.

In summary, it is important to recognize that military families are a relevant component of military culture. Many of the cultural components that are life principles for veterans, such as group mindset and Warrior Ethos traits including loyalty and social order, also extend to military families and have similar implications.

The Military Healthcare System

"The Military Health System (MHS) is the global health system for the Department of Defense (DoD) with a principal mission of readiness: maintaining a medically ready fighting force, and a ready medical system that is prepared to respond to the full spectrum of military operations" (Department of Defense, 2020). The MHS delivers care to AD SMs and their families in more than 50 military hospitals and 600 clinics worldwide, and is supported by private sector providers on a referral basis under Tricare coverage (Department of Defense, 2020).

The civilian healthcare system is very different from the military healthcare system. In civilian health care, patients are required to articulate their own health needs, navigate insurance benefits, find providers, and make their own appointments, often requiring self-advocacy and persistence. Military healthcare culture, much like military culture as a whole, is directed by others. Service members are often told where to go and what to do to address their health needs, in order to meet the principal mission of readiness. An annual medical assessment called the Periodic Health Assessment (PHA) is required and used to evaluate medical readiness (Military Health System, 2020). Veterans may be required to have certain conditions evaluated and cleared in order to do their job, such as a pilot requiring medical clearance following a concussion

or an SM being required by the commander to seek psychological services for symptoms of PTSD that are impacting the ability to perform acceptably.

Civilian health care requires a certain amount of self-advocacy that may be unfamiliar to veterans. Therefore, it may be advantageous for the provider to be direct and specific by giving concrete and clear recommendations for medications and follow-up care. Providing written recommendations or speaking to a family member may also be helpful.

The Veterans Health Administration (VHA)

The VA provides a comprehensive system of benefits to assist with the transition back to civilian life, one of which is health care provided under the VHA. Some of the more popular VA benefits include assistance with education, home loans, and life insurance. The structure of the VHA, commonly referred to as "the VA," is comprised of approximately 170 large VA medical centers located in major cities across the United States that offer traditional hospital-based services and some specialty care. In addition, the VHA offers medical and/or mental health services at approximately 1,400 outpatient sites:

- Community-Based Outpatient Clinics (CBOC) provide veterans with common outpatient services such as primary care and mental health services.
- Community Living Centers are skilled nursing facilities for veterans with stable chronic conditions who need rehabilitation or require hospice care.
- Vet Centers offer free readjustment counseling to all combat veterans (U.S. Department of Veteran Affairs, 2020b).

With some exceptions, anyone having served 24 months of AD with an honorable discharge is eligible for VA healthcare benefits. Since there are exceptions to the minimum duty requirements, the VA encourages all veterans to apply to determine enrollment eligibility. Any veteran can apply for healthcare benefits at a local VA facility. To find the closest VA facility, visit www.va.gov/find-locations/.

Veterans can receive care for medical and psychological conditions at no cost if these conditions have been determined to be "service connected." Service-connected conditions are any medical or psychological health diagnoses that had their onset during time of service. Veterans may also receive care at the VA for nonservice-connected conditions with low-cost copayments based on a financial assessment by the VA. After a medical or psychological condition is determined to be service-connected, the VA has a complex evaluation system to determine "service-connected disability ratings" determining both monetary compensation and access to other VA resources. A lack of a service-connected disability for a specific condition does not necessarily mean that the injury did not occur. For example, an SM may have sustained an injury during time in service but because the VA evaluation did not find the condition disabling enough to warrant compensation, or the event was not documented properly while the individual was in AD, a disability rating may not be assigned.

Like many large government organizations, the VA system can be challenging to navigate, and this process leaves some veterans feeling dismissed. Although most individuals have positive experiences at the VA (Veterans of Foreign Wars, 2019), others may not, and this perception may be precisely the reason care is sought from a civilian provider. It can be easy to get drawn into a veteran's negative past experiences with VA healthcare providers, and it can be disruptive to a veteran's sense of safety and stability when specific providers or past care are openly criticized. The best approach is to employ empathy and listen carefully to what specific concerns exist about previous care, as these may be the areas needing extra attention and consideration. The act of truly listening without judgment assists with the crucial task of building trust.

Medications

The many medical and psychological problems experienced by veterans imply that medications are often prescribed and being taken. An accurate history of medication use is therefore pivotal in the care of these patients. There are two significant healthcare culture considerations when discussing medication history with the veteran population: multiple prescribers and medication adherence.

Referred to as "dual healthcare system use," some veterans have multiple avenues to healthcare resources, depending on their benefits, including the VA, the MHS, civilian health care, and private pay health care. As a result, veterans may have multiple prescribers. They may possibly have two different primary care providers, one at the VA and another in the community under Medicare or private insurance. That same patient may have a psychiatrist, psychiatric nurse practitioner, or other specialty care providers such as a cardiologist or neurologist at the VA, in the community, or both. Outside clinics such as hormone replacement centers or substance treatment programs may also prescribe certain medications. Data reported by the VA in 2018 reported one in five VA enrollees are "dual" users of healthcare systems. Unless disclosed by the patient, there is no formal way to track where patients receive all their medications. Nevertheless, providers should ask veterans if they are receiving medication from more than one prescriber to avoid problems such as high-risk adverse drug interactions and the perpetuation of addiction or overuse.

Medication adherence is another crucial cultural consideration in the veteran population. Some veterans self-discontinue medications, often psychotropic drugs, because they think the medication is not working, they feel they should be able to manage their mood without medication, or they have undesirable side effects (Fortney et al., 2011). It is important for civilian providers to investigate a veteran's attitudes and beliefs about taking medications before prescribing.

Supporting veterans in properly adhering to medication use is another example of the importance of developing trust to foster honesty about their experiences with medications. One specific example might be a veteran experiencing erectile dysfunction as a side effect of a psychotropic medication. Being direct and creating safety by displaying openness to discuss problems further may help build trust and allow the patient to be more informed and communicative about personal concerns. In summary, the following considerations are important when taking a medication history from veterans:

- Ask if more than one source is prescribing medication, including medical, mental health, and other outside settings such as hormone therapy clinics.
- List all prescribed medications and the reasons for taking them (remember that some drugs are used off-label).
- Ask if patients are taking the medications as prescribed. It is not uncommon for some patients to take their daily medications "as needed" rather than as prescribed.
- Inquire about any adverse experiences from medications in the past (not just allergies). Individuals may have had multiple trials of psychotropic or headache medications—two of the more common medication categories—while they were in the military or at the VA, and it is meaningful to understand why these medications did not work or produced an adverse response.

Nonprescription Substances

Asking about nonprescription substances such as alcohol and marijuana, both of which are frequently used to manage symptoms such as sleep disturbance, anxiety, and pain, is also important. In addition to alcohol and marijuana, some veterans resort to other unconventional

substances to manage their symptoms such as hallucinogenic mushrooms (psilocybin), peyote, and ayahuasca. These plant medicines are not legal for use in the United States, apart from some religious exemptions. However, veterans may participate in retreats to the Amazon of South America or other regions such as Costa Rica where some individuals report experiencing profound psychological transformations as highlighted in the 2018 documentary *From Shock to Awe* (Cote, 2018).

A recent comprehensive review of psychedelic drugs such as MDMA, ketamine, classic psychedelics (psilocybin, LSD, dimethyltryptamine), and cannabinoids concluded that all of these drugs have some therapeutic potential (Krediet et al., 2020). Although much is unknown about the risks, it is important to be cautious about displaying judgment when discussing use of these substances with veteran patients. Veterans have likely encountered judgment in other healthcare settings, which may leave them guarded about fully disclosing important health information. Acknowledging that many veterans are feeling desperate to get relief from their symptoms and exhibiting curiosity about their use of these substances is the path to help build trust in this realm.

Conclusion

The aim of this chapter has been to provide an understanding of components of military culture as a way of better understanding perspectives some veterans bring to their civilian healthcare encounters. Specific aspects of military culture such as training, rank, and language that are used to cultivate and maintain the culture of a unified mindset have been highlighted. Traits representing both strengths and vulnerabilities were identified in the Military/Warrior Ethos and used as a framework to explore attitudes and beliefs that may impact how some veterans view health care. In addition, recognizing subcultures within the larger construct of the military such as branch, rank, and job categories was emphasized as offering additional insight into veterans' beliefs about their health. Finally, possessing a basic knowledge about the demographics of veteran populations, and the complex structure of the military, can serve as an important avenue to the building of trust.

Establishing trust is at the heart of the message in this chapter. Knowing if an individual served and in what capacity is the first step. The foundation for building trust truly begins by assessing what is most meaningful, and this process can naturally start with a question such as "What was your experience with serving in the military and do you have any health concerns related to your service?" Applying basic knowledge and understanding of military culture as an avenue to successfully creating a positive therapeutic alliance will provide a road map forward to address some of the most relevant and critical health concerns of veterans.

References

Alizadeh, S., & Chavan, M. (2016). Cultural competence dimensions and outcomes: A systematic review of the literature. *Health & Social Care in the Community, 24*(6), e117–e130. doi:10.1111/hsc.12293

Andresen, F. J., Monteith, L. L., Kugler, J., Cruz, R. A., & Blais, R. K. (2019). Institutional betrayal following military sexual trauma is associated with more severe depression and specific posttraumatic stress disorder symptom clusters. *Journal of Clinical Psychology, 75*(7), 1305–1319. doi:10.1002/jclp.22773

Board on Population Health and Public Health Practice Health and Medicine Division, & Committee to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides. (2018). *Veterans and Agent Orange: Update 11 (2018)*. National Academies Press.

Community Salute. (2017). *Supporting veterans and military families: Understanding the community*. https://www.imls.gov/sites/default/files/publications/documents/supporting-veterans-and-military-families-understanding.pdf

Cooper, C. E. (Producer). (2013). Combat medics are always in the fight. https://www.army.mil/article/98620/combat_medics_are_always_in_the_fight#:~:text=The%20combat%20medic%20was%20established,responsible%20for%20about%2040%20troops

Cote, L. (Writer). (2018). *From shock to awe* [Film]. In K. Kraus (Maxi Cohen). U.S.A.

Council on Foreign Relations. (2020). Demographics of the U.S. military. https://www.cfr.org/backgrounder/demographics-us-military

Department of Defense. (2018). *Profile of the military community*. https://download.militaryonesource.mil/12038/MOS/Reports/2018-demographics-report.pdf

Department of Defense. (2020). *Fact sheet: Overview of the Department of Defense's Military Health System*. https://archive.defense.gov/home/features/2014/0614_healthreview/docs/Fact_Sheet_Overview.PDF

Ender, M. (2000). Beyond adolescence: The experiences of adult children of military parents. In J. Martin, L. Rosen, and L. Sparacino (Eds.), *The military family: A practice guide for human service providers* (pp. 241–255). Praeger Publishers.

Feickert, A. (2020). *U.S. special operations forces (SOF): Background and issues for Congress*. https://fas.org/sgp/crs/natsec/RS21048.pdf

Fortney, J. C., Pyne, J. M., Edlund, M. J., Stecker, T., Mittal, D., Robinson, D. E., & Henderson, K. L. (2011). Reasons for antidepressant nonadherence among veterans treated in primary care clinics. *Journal of Clinical Psychiatry, 72*(6), 827–834. doi:10.4088/JCP.09m05528blu

Gayton, S. D., & Kehoe, E. J. (2016). The character strengths of special forces personnel: Insights for civilian health care practitioners. *Military Medicine, 181*(9), 996–1001. doi:10.7205/milmed-d-15-00440

Gettle, M. (2007). *Air Force fosters a "warrior ethos" in all airmen*. https://www.af.mil/News/Article-Display/Article/127527/air-force-fosters-warrior-ethos-in-all-airmen/#:~:text=The%20warrior%20ethos%20is%20also,aging%20aircraft%20and%20space%20inventories

Helmus, T. C., Zimmerman, S. R., Posard, M. N., Wheeler, J. L., Ogletree, C., Stroud, Q., & Harrell, M. C. (2018). *Life as a private: A study of the motivations and experiences of junior enlisted personnel in the U.S. Army.* RAND Corporation.

Human Rights Campaign. (2020). *Transgender military service*. https://www.hrc.org/resources/transgender-military-service

Institute of Medicine. (2013). *Returning home from Iraq and Afghanistan: Assessment of readjustment needs of veterans, service members, and their families*. National Academies Press.

Kimerling, R., Gima, K., Smith, M. W., Street, A., & Frayne, S. (2007). The Veterans Health Administration and military sexual trauma. *American Journal of Public Health, 97*(12), 2160–2166. doi:10.2105/ajph.2006.092999

Krediet, E., Bostoen, T., Breeksema, J., Van Schagen, A., Passie, T., & Vermetten, E. (2020). Reviewing the potential of psychedelics for the treatment of PTSD. *International Journal of Neuropsychopharmacology, 23*(6), 385–400. doi:10.1093/ijnp/pyaa018

Llorente, M., & Ritchie, E. C. (2020). Moral injury in Vietnam veterans: What community providers need to know. *American Journal of Geriatric Psychiatry, 28*(4), S5–S6. doi:10.1016/j.jagp.2020.01.019

Macgregor, A. J., Heltemes, K. J., Clouser, M. C., Han, P. P., & Galarneau, M. R. (2014). Dwell time and psychological screening outcomes among military service members with multiple combat deployments. *Military Medicine, 179*(4), 381–387. doi:10.7205/milmed-d-13-00314

Meyer, E. G., Writer, B. W., & Brim, W. (2016). The importance of military cultural competence. *Current Psychiatry Reports, 18*(3). doi:10.1007/s11920-016-0662-9

Military Health System. (2020). Periodic health assessment. https://archive.defense.gov/home/features/2014/0614_healthreview/

Naval Medical Research Center. (2020). The Navy ethos. https://www.med.navy.mil/sites/nmrc/pages/navy_ethos.htm

Przekwas, A., Garimella, H. T., Tan, X. G., Chen, Z. J., Miao, Y., Harrand, V., Kraft, R. H., & Gupta, R. K. (2019). Biomechanics of blast TBI with time-resolved consecutive primary, secondary, and tertiary loads. *Military Medicine, 184*(1), S195–S205. doi:10.1093/milmed/usy344

Riccio, G., Sullivan, R., Klein, G., Salter, M., & Kinnison, H. (2004). Warrior ethos: Analysis of the concept and initial development of applications. The Wexford Group International.

Ruben, M. A., Livingston, N. A., Berke, D. S., Matza, A. R., & Shipherd, J. C. (2019). Lesbian, gay, bisexual, and transgender veterans' experiences of discrimination in health care and their relation to health outcomes: A pilot study examining the moderating role of provider communication. *Health Equity, 3*(1), 480–488. doi:10.1089/heq.2019.0069

Rubin, A., Weiss, E., & Coll, J. (2012). *Handbook of military social work*. John Wiley & Sons.

Schogol, J. (2017). *Marines are once again "the few, the proud."* https://www.marinecorpstimes.com/news/your

-marine-corps/2017/03/30/marines-are-once-again-the-few-the-proud/

Segal, D. R., & Segal, M. W. (2005). *U.S. military's reliance on the reserves*. https://www.prb.org/usmilitarysrelianceonthereserves/

Sharp, M. L., Fear, N. T., Rona, R. J., Wessely, S., Greenberg, N., Jones, N., & Goodwin, L. (2015). Stigma as a barrier to seeking health care among military personnel with mental health problems. *Epidemiologic Reviews, 37*(1), 144–162. doi:10.1093/epirev/mxu012

Sotolongo, A., Falvo, M., Santos, S., Johnson, I., Arjomandi, M., Hines, S., Krefft, S., & Osterholzer, J. (2020). Military burn pits. *American Journal of Respiratory and Critical Care Medicine, 201*(7), P13–P14. doi:10.1164/rccm.2017P13

Uniformed Services University. (2018). Military culture: Core competencies for healthcare professionals. https://deploymentpsych.org/military-culture-course-modules

U.S. Army. (2011). *Our mission*. https://www.army.mil/about/

U.S. Army. (2020a). *Warrior ethos: US Army values*. https://www.army.mil/values/warrior.html

U.S. Army. (2020b). *Women in the Army*. https://www.army.mil/women/history/

U.S. Department of Defense. (2020). *Our forces*. https://www.defense.gov/Our-Story/Our-Forces/

U.S. Department of Veterans Affairs. (2012). Summary of VA benefits for National Guard and Reserve members and veterans. In *VA PAM 27-12-5*. Veterans Benefits Administration.

U.S. Department of Veteran Affairs. (2020a). *Agent Orange exposure and VA disability compensation*. https://www.va.gov/disability/eligibility/hazardous-materials-exposure/agent-orange/

U.S. Department of Veteran Affairs. (2020b). Office of Rural Health. https://www.ruralhealth.va.gov/aboutus/structure.asp

U.S. Marine Corps. (2020). *Our mission*. U.S. Naval Academy. https://www.usna.edu/MarineCorps/index.php

USA.gov. (2020). Join the military. https://www.usa.gov/join-military

Vespa, J. E. (2020). *Those who served: America's veteran's from World War II to the war on terror*. https://www.census.gov/content/dam/Census/library/publications/2020/demo/acs-43.pdf

Veterans of Foreign Wars. (2019). *Our care: A report evaluating veterans health care*. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5328

Williamson, V., Stevelink, S. A. M., Da Silva, E., & Fear, N. T. (2018). A systematic review of wellbeing in children: A comparison of military and civilian families. *Child and Adolescent Psychiatry and Mental Health, 12*(1). doi:10.1186/s13034-018-0252-1

Wilson, L. C. (2018). The prevalence of military sexual trauma: A meta-analysis. *Trauma, Violence, & Abuse, 19*(5), 584–597. doi:10.1177/1524838016683459