Put Yourself in My Combat Boots: Autoethnographic Reflections on Forms of Life as a Soldier and Veteran

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Special Issue Introduction: Research on the Well-being of Service Members, Veterans, Dependents and Survivors by Service Members, Veterans, Dependents and Survivors

SPECIAL ISSUE EDITORS
Karl Hamner, Barton Buechner and Christopher Gill

Introduction

It was a cold day in November of 2007 when the town of Brunswick, Maine, held its annual Veterans Day ceremony in a picturesque park adjacent the parish church. It was my last day in town before moving down south for a new job. As I took stock of the group of people surrounding me, I began to retreat into myself. To my left were mostly civilian onlookers who came to pay their respects. On the stage were several Vietnam veterans talking about things that seemed so foreign to my recent experience. They talked about recovery from the postwar years, repairing relationships with loved ones, and the hope they found in sharing their experiences. In the rest of the crowd, a smattering of World War II veterans leaned on canes or sat in wheelchairs, along with a few Desert Storm veterans with the obligatory black biker vests denoting their service. There were no other War on Terror veterans that I could see. I believed these other veterans had somehow moved on in a way I could not. They seemed to have it together and to have put the war behind them, while I stood there as my life crumbled around me.

A short distance away, the sum of my 30 years of life, in the form of all my belongings, sat in a rusty old pickup. They represented war, a broken marriage, and a diffused sense of self that left me rudderless and adrift after 11 years of service in the Marine Corps. The truck’s incessant rattling taunted me with echoes of my failure to find sustainable work, hold my marriage together, and deal with the unrelenting images of war. The next day, the truck would take me from the brutal familiarity of Maine to the vast unknown of south Alabama. For the moment, however, I shivered in a park full of people unaware of the spiral I was in, with no notion of the challenges I would face in the coming months in a new town with no friends, no support. Everything I thought I was had proved transitory. I felt stuck in a liminal space, trying to outrun the haunting specter of “what was,” peering over the void of “what is,” with no hope of connecting to “what will be.” I was attending my first Veterans Day event as a certified veteran. I had no hope or desire of connecting to the civilians in the crowd, but I should have at least been able to feel like a part of this brotherhood around me and proud of my service. Instead, I was alone in a crowd of people.

Fourteen years on, I find myself on a new path as an aspiring researcher in the veteran space. I was given the privilege of joining the scholarly effort to produce this special military and veterans’ edition of JCES. Having the opportunity to help provide a place for my fellow veterans to add their voices to the body of research is a vital step toward ensuring that future veterans will be able to navigate transition to civilian life with greater support and connection.

— Christopher M. Gill, veteran, USMC
Background

This special edition of the Journal of Community Engagement and Scholarship (JCES) is the result of a 2-year effort to identify, compile, and publish scholarly research about military-to-civilian transitions conducted by service members, veterans, and their families (SMVF). It gives these SMVF voices center stage by representing a lived experience that speaks a truth to the scientific literature that bears careful and thoughtful consideration. This special edition was inspired by the awareness that many of the programs, policies and processes intended to facilitate social readjustment, transition, and mental health intervention for the SMVF community are largely based upon clinical research. Yet this research has historically limited the participation of individuals with lived experience in SMVF social worlds. As a result, scholarly representations have left out the full nature and diversity of the veteran community and the voices of the oft forgotten military family. As the project continued, we came to understand another compelling reason to publish this work. Scholarship reflecting the experiences of military veterans and their families (as a largely marginalized population) also holds valuable lessons for a society that struggles broadly with issues of identity, values, and belonging, including the balance between unity and diversity.

The genesis of this project was a conversation between two of this issue’s editors at an America’s Warrior Partnership (AWP) annual symposium about the apparent absence of a forum for publishing work—particularly socially engaged, community-based participatory research—by emerging SMVF scholars. Since this type of research often crosses traditional academic disciplines, it has been challenging to locate and disseminate. Additionally, many veteran-scholars who are coming of age in the era of the Post-9/11 GI Bill are just now reaching the point of creating original research and have not yet become well versed in the ins and outs of academic publishing. Thus, the necessary pathways and processes of mentoring are neither fully established nor well-known to them. We are grateful for the assistance and support of student veteran advocacy organizations, particularly the Student Veterans of America and the National Association of Student Program Administrators, in putting out the call for proposals and helping us to locate a good sampling of these emerging scholars.

Given the tendency of clinical, academic, and other institutional researchers to focus on prevalent veteran stereotypes, scholars have paid insufficient attention to family and community social dynamics, alternative forms of mental health support, and the salutary benefits of community-based integration programming for veterans. Most importantly, the authentic voices of veterans and family members have not had a large role in the research literature. Accordingly, we sought to bring to the fore a multitude of SMVF perspectives through a wide range of scholarship. These voices speak with clarity about the context of the transition experience, their vision for social change, evidence-based models for engagement, and cultural competency for researchers as applied to SMVF issues.

This special edition reflects a range of topics and contexts, with scholarship drawn from both seasoned individuals and teams and those newer to the field. The research approaches that appear in this edition are diverse—from qualitative and reflective analyses by individual scholars based on methods of autoethnography and phenomenology to participative empirical quantitative studies conducted by teams composed of SMVF scholars and experienced researchers. Each of the 13 studies included here is unique in its approach and design. However, for purposes of organization, we have found that the studies fit into several broad categories, which we have defined as follows: (1) models for engagement of SMVF scholars in participatory research, (2) contextualizing of veterans’ lived experience, (3) systems-focused research for driving social change, and (4) projects emphasizing cultural competency and moral injury.

Article Summaries

Section 1: Models for Engagement of SMVF Scholars in Participatory Research

These articles exemplify research practices that integrate SMVF perspectives in diverse and often multidisciplinary teams. The studies in this section are focused on evaluation of community programs intended to serve the social and mental health needs of veterans.

In the jointly authored piece “I Remember the Skills We Learned and Put Them Into Practice: An Evaluation of a Peer Support Training Program for Veterans,” coauthors Karen Besterman-Dahan, Jacqueline Sivén,
Kiersten Downs, and Tatiana Orozco describe an experimental and participatory research design that provides a multiperspective evaluation of a skills training intervention. While the purpose of the training was to enhance peer advisement skills, the evaluation comments also revealed transformed perspectives among the participants, who were a mix of veterans and nonveterans. This piece offers a good example of the use of an ethnographic research method to capture the lived experiences of veterans, and it also models community-based engagement through a public–private partnership approach. In reflexive terms, this study makes significant observations about the importance of self-awareness, mindfulness, and communication skills to the transition process, noting that these skills are not only critical in peer advisement but also transferable to family, work, and social situations. In this sense, it provides an excellent counterpoint to other pieces in this edition that deal with military and veterans' cultural competence.

The next study in this section, with the intriguing title “If You Don't Name the Dragon, You Can't Begin to Slay It,” represents the efforts of Gala True, Sarah Ono, Ray Facundo, Carlos Urbina, Sawyer Sheldon, and J. Duncan Southall. Their adaptation of participatory action research, grounded theory, and the photovoice technique offers a novel approach for building knowledge of veterans' lived experiences of traumatic brain injury (TBI) among the veteran and caregiver community. Their collaborative effort resulted in “community-informed solutions” for reintegration of veterans into the community and models the practice of “partnered dissemination” of study results. “Motivations of Older Veterans and Dependents in a Physical Activity Program” reports on community-based mixed methods research conducted by Candace Brown, Ismail Mustafa Aijazuddin, and Miriam Morey. The participatory framing of this study, which details the structure and evaluation of community engagement among veterans in an exercise program, results in a culturally sensitive assessment of an important medical/mental health issue. The study foregrounds the issue of motivation and long-term participation, and it also documents a novel partnership between a private health club and a veteran-serving nonprofit organization, Team Red, White, and Blue. The evidence provided here may be useful to support more public–private initiatives (or hybridized programs) following this model.

The last study in this category, “Creating Community for Women Veterans Through Social Networking Organizations,” was authored by a team led by Kate Hendricks Thomas, Caroline Angel, and Nicholas Armstrong, with Michael Erwin, Louis Nemec, Brandon Young, John Pinter, Blayne Smith, and Justin McDaniel. The study includes both comparative and aggregate findings about the improvements in mental state experienced by men and women veterans who voluntarily participate in community-based social/recreational activities. This research recognizes further potential for gender-specific services while acknowledging the role and value of single-sex programming and outreach in such recreational programs.

Section 2: Contextualizing of Veterans' Lived Experience

This section contains articles that contribute to an understanding of military culture through the authentic voice and lived experience of veterans and the analysis of contextual symbology and sensitivities that shape the SMVF experience from formation, to operational realities, through periods of transition.

The Australian research team of Jonathan Lane, Miranda Van Hooff, Ellie Lawrence-Wood, and Alexander McFarlane provides the lead article for this section, titled “Culturally Informed Interventions for Military, Veteran, and Emergency Service Personnel: The Importance of Group Structure, Lived Experience Facilitators, and Recovery-Oriented Content.” The study takes a mixed-methods approach to examining the effectiveness of culturally informed group therapy for military and first responders. It frames the distinction between clinical and community (recovery-oriented) approaches to mental health and helps to answer the question of why active-duty service members and veterans tend not to complete many evidence-based therapies despite their documented efficacy. This insightful work argues for the dual need to (1) develop military cultural competence among mental health and social service providers and (2) undertake psychoeducation of military clients to help make them more equal partners in their therapeutic interactions.
Shawn Dunlap's thoughtful, reflective piece, “Put Yourself in My Combat Boots: Autoethnographic Reflections on Soldiers and Veterans as a Form of Life,” reveals the potential of an individual veteran-scholar using the reflective discipline of autoethnographic research. Dunlap combines an analysis of his own lived experience with other academic studies in history and the social sciences to provide an intriguing firsthand account of how his lived experience is situated within a broader political-military context. Dunlap introduces the conceptual model of “community ethnography” as a means of unlocking the underlying meanings and symbologies within the military and veteran community. He positions this model as a way of interpreting these meanings and symbologies for others outside of the veteran experience. Dunlap's work also touches on the therapeutic nature of this type of self-reflective writing from a mental health perspective.

Kelly Wadsworth's study, “Profoundly Changed: The Homecoming of Veterans from Iraq and Afghanistan,” offers substantive insights into the essential structure underlying the lived experiences of transitioning veterans, analyzed through the lens of both essential and lifeworld versions of phenomenology. Her article provides a rigorous, accessible view of phenomenological methods, and it reveals some of the subtle yet profound changes in consciousness and perception that take place for returning veterans. Wadsworth considers the “expanded self” of a postservice veteran that includes both challenges to identity and enhanced awareness. She also explores the reflexive nature of this shift in identity and perception in community settings. Wadsworth's work challenges the commonly held notion that veterans reintegrate into a “static society” without the society itself being changed or impacted by their return.

The final article in this category, Derek Abbey's “How Veterans Make Meaning of the College Choice Process in the Post-9/11 Era,” similarly contributes to a deeper understanding of the student veteran experience by using qualitative interview data to critique an established theory of college selection (Gallagher's college choice theory). It also gives voice to the lived experiences of student veterans in a meaningful way, illustrating how qualitative research can be effectively conducted using automated tools that may make research projects of this type more accessible to beginning veteran-scholars. His paper outlines a replicable method that could be used at other college campuses to help create a shared understanding of the college selection and motivation process for student veterans.

Section 3: Systems - Focused Research for Driving Social Change

Articles in this section consider the bridging of values and social dynamics between service culture and the community setting via a systems perspective. Such a broadened view of the complexity of military-civilian relationships encompasses the international scope of research into the contemporary experience of veterans, as well as offering profound implications for local community settings. Among these are ideas for increasing cultural competency in interaction with veterans, and “normalizing” mental health care by identifying and providing forms of self-care that are consistent with military values and culture. These are types of approaches that may lead to a decrease in social isolation and marginalization of returning veterans, and work to reduce the stigma associated with seeking help.

The study “Military Culture and Its Impact on Mental Health and Stigma,” by Alexis Ganz, Chikako Yamaguchi, Bina Parekh, Gilly Koritzky, and Stephen Berger, makes a strong contribution to our understanding of both military culture's impact on help-seeking and cultural and intercultural aspects of service as they relate to transition and postservice community reintegration. The introduction and testing of a scale that measures both in-service and postservice identification with military cultural values stands as an important addition to the military psychology literature, but the bridging of these concepts to a nonmilitary context is our focus here. Ganz and team's research suggests that there is less of a difference than is generally believed between active-duty service members/veterans and those who have not served with regard to attitudes about mental health. The study also suggests that a strong response to values (either acceptance or rejection) appears to provide something of a protective factor, particularly with respect to suicide risk. These findings have strong implications for reimagining ways to help separating veterans, especially those who may have struggled to fit in with
military culture, “find their tribe” in the community after service.

“The Benefits of Brazilian Jiu-Jitsu in Managing Post-Traumatic Stress Disorder,” by Kelly Weinberger and Tracey Burraston, presents empirical evidence from a longitudinal assessment of how Brazilian Jiu-Jitsu (BJJ) affects the management of post-traumatic stress disorder (PTSD) symptoms over time. It also considers how veterans experience the practice of BJJ in community settings. BJJ is described as a somatically based practice that can serve in conjunction with supervised mental health support or as a freestanding wellness activity for those not inclined to seek formal help. This framing situates BJJ (and other martial arts) as complementary and alternative medicine (CAM) approaches for helping veterans manage their PTSD symptoms. The article also discusses cultural adaptations of practice facilities to create more “veteran-friendly” environments.

Section 4: Projects Emphasizing Cultural Competency and Moral Injury

There is a growing awareness in the social sciences of moral injury as a complex construct that includes elements of identity, culture, and values as factors contributing to well-being—which can be damaged by events that challenge deeply held concepts of self and worldview. Many of the articles elsewhere in this special edition touch on how cultural factors can contribute to moral injury among veterans, but those in this section are particularly focused on making these connections. Additionally, these articles invite readers to consider how factors underlying moral injury among veterans in community settings can be reciprocally addressed in ways that are potentially transformative for the community as well as helpful to veterans.

“Teaching Military Cultural Competency to Clinicians and Clinical Students: Assessing Impact and Effectiveness,” by Nancy Isserman and James Martin, documents and evaluates a community-based collaboration between mental health practitioners, academia, and nonprofit organizations for developing military cultural competence. This study accounts for the complexity of the military and veteran experience, including the impact on families and the barriers to communication created by misconceptions and stereotypes. Particularly promising is Isserman and Martin’s concept of “reciprocal cultural competency,” which addresses the mutually strengthening effect of giving veterans tools to translate their military experience while expanding the community’s capability to engage people from diverse or nonmainstream backgrounds.

The contribution by Daniel Perez, Paul Larson and John Bair, “U.S. Veterans Experience Moral Injury Differently Based on Moral Foundation Preferences,” seeks to advance understanding of moral injury. This study takes a novel approach by applying moral foundations theory to the psychological consequences of difficult and challenging experiences. This study adds a great deal to our understanding of the “moral” aspect of moral injury, which has been less explored (at least in the United States) than the “injury” aspect. The authors’ attention to “what is injured in moral injury” may help veterans assess for themselves the underlying nature of troubling experiences beyond the symptoms they are experiencing, which may in turn guide them in subsequent meaning making around these events.

The innovative study “Structural Examination of Moral Injury and PTSD and Their Associations With Suicidal Behavior Among Combat Veterans,” by Jeremy Jinkerson, Allison Battles, Michelle Kelley, and Richard Mason, examines possible connections between symptoms associated with moral injury and suicide risk. Their research offers evidence that symptoms associated with both PTSD and moral injury can be indicators of suicide risk, and it suggests ways that military and unit culture may affect the lenses through which individual service members interpret potentially morally injurious events. This contribution is significant in the sense that actions, perceptions, and intentions may become misaligned across cultural differences, either during service or in transition.

Conclusion

As the introduction to this special edition suggests, there is a sense of urgency to better understand the lived experiences of military members, veterans, and families in order to improve their well-being. There is an irony to the alienation often felt by those who have served their country, distancing them in many ways from other citizens despite their communities’ best intentions to welcome them home. It is our
hope that this collection of research articles by, about, and for members of the SMVF community will inspire further exploration in these and other areas. While the articles represented here only begin to capture the diversity of the SMVF experience, they do capture the passion and innovation of researchers from a wide range of disciplinary areas who have an interest in the well-being of those who have served and those close to them. Maybe just as importantly, many of these studies also reveal some of the potential reciprocal value to society (at both the system and the community level) of understanding the nature of the SMVF experience.

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"I remember the skills we learned and put them into practice": An Evaluation of a Peer Support Training Program for Veterans

Karen Besterman-Dahan, Jacqueline Sivén, Kiersten Downs, and Tatiana Orozco

Abstract

Community-based organizations (CBOs) are critical sources of support for veterans. CBOs offer innovative and informed initiatives and are often nexuses that allow veterans and their allies to gather. Out of a commitment to veteran reintegration, Growing Veterans (GV), a veteran-founded CBO located in western Washington, created and implemented an evidence-based peer support training program (PST) for veterans and their allies. Building upon years of collaboration, GV partnered with the Veterans Health Administration (VHA) to conduct a formative evaluation of GV’s PST program, funded through the Bob Woodruff Foundation. The evaluation revealed that participants described the PST in largely positive ways and reported using learned skills with both veterans and nonveterans across their personal and professional lives. Specifically, participants reported learning tools through the PST that increased their patience, mindfulness, awareness, empathy, and confidence, resulting in improved interpersonal relationships and communications across multiple domains. The success of this community-engaged collaboration was due in part to the inclusion of veterans, allies, GV employees, and VHA evaluators throughout the evaluation, from grant applications to the final analysis. Using ethnographic methods of participant observation, in-depth interviews, focus groups, and surveys, VHA evaluators were able to gain a deep understanding of participants’ experiences of the PST as well as the program’s perceived usefulness.

Introduction

Reintegration challenges faced by servicemembers, including anxiety, depression, post-traumatic stress disorder, and substance abuse resulting from or exacerbated by combat exposure and transition stress, have been well documented in the literature (Amur, 2011; Crocker et al., 2014; Hoerster et al., 2012; Sayer et al., 2011, 2014; Seal et al., 2007). Critical to mediating reintegration is that veterans learn how to negotiate norms in the communities to which they are returning or moving (Demers, 2011; Romaniuk & Kidd, 2018). Often these norms differ from what veterans were used to in the military (Cogan, 2016). Differences in cultural norms, a lack of preparation for what to expect after leaving the military, and the loss of a social network can all contribute to reintegration challenges for both servicemembers and their families. A growing body of reintegration research supports decreased social support as a major challenge for veterans (J.A. Gorman et al., 2018). To help ease servicemembers’ transitions, there has been a surge of reintegration program development over the past decade, especially in the nonprofit sector. However, evidence bases for such programs, rigorous evaluation to determine what programs provide for servicemembers, and evaluation of the programs’ impacts are often lacking.
Programming focused on community engagement can help ease postmilitary transitions. Community engagement within Western culture, however, has declined over the past 50 years, including downturns in overall participation in community organizations, volunteering, voting, and knowing one's neighbors (Putnam, 1995). Given this decline, returning veterans are likely to find fewer partners in the community looking to engage with them, reducing the chance that they will find social support and ultimately contributing to the “military-civilian divide.” However, current data indicate a positive trend in veterans' potential for social engagement. In comparison to their civilian counterparts, veterans are more likely to trust and talk with their neighbors, to participate and serve as leaders in civic organizations, and to be politically engaged (Tivald & Kawashima-Ginsberg, 2015). Veterans share a number of common values, including having a sense of community, wanting to give back, and wanting to be a part of something bigger than oneself. CBOs such as GV are important to veteran reintegration because they employ innovative community-building initiatives that involve peer support, which helps ease isolation and cultivate common ground between veterans and civilian communities.

A Framework for Community Engagement: Collaboration between VHA and GV

This evaluation of GV’s PST program stemmed from a previous collaboration between the VHA and GV. In 2014, the Veterans Affairs Office of Rural Health funded a VHA-led mixed-methods case study evaluation of GV in an effort to better understand the veteran health and reintegration outcomes of GV’s agricultural program (Besterman-Dahan et al., 2018). At that time, GV was in the process of developing its PST program (Brown et al., 2016). With funding from the BWF, GV went on to create its innovative PST based on best practices and elements delineated by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCOE) as essential to a successful military/veteran peer support program (Money et al., 2011). GV’s PST is a 3-day workshop in which veterans and allies of veterans (family members, care providers, people who work with veterans) learn and practice the skills necessary to be effective peer supporters for other veterans. During 2016 and 2017, GV conducted four PST sessions, resulting in 54 trained peer supporters who returned to their veteran service organizations (VSOs) and communities across the country to subsequently support over 1,400 veteran peers (Besterman-Dahan et al., 2019). In follow-up surveys, trainees (n = 24) overwhelmingly agreed that the PST encouraged their own self-care as well as increased their confidence in recognizing PTSD symptoms, serving as peer supporters, and making appropriate referrals to mental health care providers. GV then partnered with the VHA evaluators to develop a proposal for continued funding from BWF for (a) GV to continue its PST program and (b) VHA evaluators to conduct a rigorous, independent program evaluation of the GV PST from 2017 to 2019.

This evaluation used a community-engaged framework. In public health literature, community engagement has been broadly defined as “involving communities in decision-making and in the planning, design, governance and delivery of services” (Swainston & Summerbell, 2008, p. 11). Community engagement activities can take many forms and are usually described in terms of five levels of engagement (from least to most engaged): information-giving, consultation, joint decision-making, acting together, and supporting independent community interests (Wilcox, 1994). In this evaluation, the VHA evaluators implemented community engagement through their partnership with GV, continued communication with GV, and periodic feedback between VHA and GV. In addition, veterans were included as participants in the PST itself and as participants in the completion of the evaluation, and one coauthor of this article is a veteran.

Methods

VHA evaluators conducted an independent formative evaluation of the PST program using a community-engaged framework. The project was designated a quality assurance activity by the local VHA Research and Development Committee; institutional review board approval was not required. Evaluators used a mixed-method design that employed ethnographic methods of participant observation, in-depth interviews, focus groups, and surveys. Ethnography is a hallmark of anthropological research that is used to explore the lived experiences of others. The VHA evaluation data collection team consisted of two PhD-level applied anthropologists, both with extensive knowledge and applied research experience utilizing ethnographic methods in community-based research with veterans. The study’s principal investigator, an applied medical
anthropologist, had worked in collaboration with GV since 2014. The PST program was evaluated for its content, delivery, usefulness, quality, and alignment with VSO values. The evaluation team also examined barriers and facilitators to attending the training and influence of PST on participants’ knowledge, attitude, and intention. The program’s implementation was also assessed via a post training focus group and survey with PST trainers.

Collaboration is central to community engagement and was crucial to the success of this program evaluation. GV staff and the evaluation team worked closely with one another from proposal development through implementation of the evaluation. This collaboration began early. The VHA collaborated with GV in obtaining funding to both run the PST program and conduct a complementary formative evaluation. Evaluators facilitated a continuous cycle of feedback by conducting ongoing discussions via weekly team meetings before each peer support workshop, in addition to meetings during each workshop while on breaks, and after each session closed for the evening. Upon completion of each PST workshop, the evaluation team and GV staff would meet for a brief focus group, which also led to an organic process of debriefing among the evaluation team. Evaluators gathered feedback from workshop participants through observation, conversations with participants, and focus group results, and they both shared this feedback with GV staff daily and included it in final reports. Open dialogue and transparency built trust between the evaluation team and GV staff. The return on the investment of time spent in debrief sessions, staff focus groups, and informal conversations during each workshop allowed PST trainers to make small course adjustments in real time or in preparation for the following workshop.

Investigating and conducting evaluation and research with vulnerable communities demands the use of specific methods that not only engage the scholars involved but also protect the well-being and livelihoods of target populations (Pacheco-Vega & Parizeau, 2018). Ethnography as a research methodology offers a unique opportunity to understand social phenomena that occur within vulnerable populations while maintaining a rigorous research process (McGranahan, 2014; Warren, 2014). Engaged ethnography also requires researchers to pay attention to the relationships they are building with the communities they are working alongside.

Relationship building and collaboration with the GV community, including PST participants, were critical components of the evaluation. Of additional importance when employing community-engaged ethnographic methods is acknowledgment of the power dynamics intrinsic to ethnographic projects and writing. Methodological approaches inherent to ethnographic research allow researchers to engage with both the academic concerns of their discipline and the broader structural and cultural factors that perpetuate systems of inequality (Pacheco-Vega & Parizeau, 2018).

The nature of the PST required trust between all those present at the sessions hosted by GV. Because the evaluators were active participants in the PST during data collection, they held the safety and needs of PST participants as a top priority. The PST data collection process allowed participants to decide whether or not they welcomed the presence of the evaluators at their sessions. This element of choice was especially important during parts of the curriculum when participants were invited to share their personal experiences with one another, often revealing sensitive information related to their personal accounts with traumatic experiences. Evaluators and GV staff carefully prioritized gathering participants’ consent with regard to the attendance of the project team during the PST, frequently checking in with participants individually, during group exercises, and via anonymous qualitative feedback gathered from survey data. There were no instances in which participants asked for the project team not to participate with them in the PST.

During the 2017–2019 evaluation period, GV hosted four PST sessions, one each in February, April, September, and October of 2018. Each cohort of PST participants completed a pretraining focus group and survey, a post training focus group and survey, and an interview and survey 90 days after the conclusion of training. PST trainers were asked to participate in a post training focus group or debriefing and to complete a post training survey after each PST cohort. Table 1 summarizes the sources of data gathered from participants.

### Focus Groups

A total of eight focus groups were conducted with PST participants. Four focus groups (one per cohort) were conducted with PST participants (one per cohort) prior to starting the program to determine participants’ baseline knowledge of peer support and their expectations for the
training. Four focus groups (one per cohort) were conducted with PST participants immediately after training (one per cohort) to elicit their thoughts and reflections on the overall PST as well as the perceived usefulness, facilitators and barriers to understanding, and influence of the training. A post training focus group was also conducted with PST trainers to elicit their reactions to and reflections on the program.

Focus groups were either led or co-led by members of the project team, one of whom served as focus group moderator while another team member took notes. Focus groups were audio-recorded with permission, and salient themes from the focus groups were identified and grouped for analysis.

**90-Day interviews.** Fourteen participants spanning all four cohorts were interviewed 90 days after their PST using a semi structured, in-depth interview protocol. All participants had agreed to be contacted for a 90-day interview at the original training. Interviews were conducted via telephone and recorded with verbal permission. Salient themes were identified and grouped for analysis.

**Participant observation.** Participant observation is an ethnographic research method used to gain a holistic and in-depth understanding of how individuals and communities “describe and structure their world” (Creswell, 2014, p. 207). In a traditional sense, this usually entails the researcher engaging in the lives of the research participants for a long period of time, utilizing data collection activities such as direct observation, interviewing, document analysis, reflection, analysis, and interpretation. With the development of faster approaches to qualitative inquiry, participant observation can be successfully conducted over shorter periods of time while still meeting rigorous academic research standards of thorough data collection, analysis, and reporting. Following anthropological methods, field notes were taken during participant observation, compiled, and analyzed. Evaluation team members participated in all PST activities in all four PST sessions, which allowed for reflection on the activities and modules. By participating in the PST, the project team was able to build rapport with other participants and gain additional insight through casual conversations about the PST activities.

The project team took detailed field notes during all aspects of the PST, and evaluators carefully observed group dynamics, emotions, and environmental stimuli throughout the PST and evaluation process. For instance, participants engaged in storytelling and sharing with each other throughout the PST, which sometimes put them in vulnerable positions. Both evaluators took care not to take notes at these moments, as doing so could be observed by the participants as insensitive and intrusive and likely would have resulted in a breach of trust between the researchers and the participants. In turn, this could have caused an unwelcome power imbalance in group settings. The evaluators were committed to active, participatory engagement in the PST alongside participants. When it felt inappropriate to take field notes, such as during the storytelling circles, evaluators took time to debrief with each other after the conclusion of the day’s session, actively reflecting on their experiences with the group, then writing their field notes.

**Surveys.** The baseline surveys administered to PST participants collected data on their general demographics, history of military service, and VA service connection. Post-PST surveys asked participants to rate the PST modules and activities in terms of their usefulness and included 11 open-ended questions regarding the impact of the training, reactions to the training, and respondents’ intention to use the skills they learned during training. Similarly, the post-PST surveys for trainers asked respondents to rate the PST modules and activities in terms of their usefulness and rate their perceptions of how impactful the training was for participants.

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Participant focus groups</th>
<th>Participant surveys</th>
<th>Participant 90-day interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretraining</td>
<td>4</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Posttraining</td>
<td>4</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>90-day</td>
<td></td>
<td>13</td>
<td>14</td>
</tr>
</tbody>
</table>
The 90-day participant surveys asked participants to describe the most and least useful modules, how they had implemented PST skills in their lives since the training's end, and the same standardized measures as the baseline survey.

All surveys were administered in person in hard copy or electronically via a link to Qualtrics survey software. Responses were self-reported.

**Analysis**

Quantitative data (from the baseline, post, and 90-day surveys) were analyzed using Microsoft Excel and IBM SPSS. Qualitative data (from focus groups, field notes from participant observation, and 90-day interviews) were analyzed using rapid analysis to describe participant and trainer experiences; perspectives of the program for satisfaction; barriers to and facilitators of participation; and suggestions for program improvement, dissemination, and sustainability. Qualitative rapid analysis uses matrices to systematically organize and streamline data. These matrices, or compact displays, enhance the accessibility of voluminous qualitative data by condensing major findings and facilitating prompt assessment of similarities and differences within the data (Averill, 2002; Miles & Huberman, 1994). Matrices are formatted based on the purpose of the analysis; in this project, matrices were organized according to the different waves of data collection. A matrix within Microsoft Excel was used to organize data from transcripts around domains of interest established at the start of the program evaluation, and thematic analysis was conducted.

As this was a formative evaluation, evaluation team members shared their findings with GV through biweekly calls, debriefing meetings immediately after each PST session, and a written list of specific suggestions and findings delivered after each PST. This process provided GV the opportunity to implement the evaluation's recommendations for improvement as they emerged. Additionally, data-driven suggestions and strategies for improving the PST program were compiled and provided in the final report once all data were analyzed.

**Findings**

The PST program included a total of 38 veterans and nonveterans across four cohorts. A majority of all participants, 63%, reported veteran status, while 29% identified as civilian allies. 35% of participants identified as the spouse, partner or other family member of a veteran or active duty service member. Notably, participants could identify in more than one category (veteran, civilian ally, family/partner of veteran/service-member). The average age was 46.4, with a median age of 47 and a standard deviation of 10.3. In descending order of frequency, participants identified as White (71%), Asian (5.3%), Black or African American (5.3%), Hispanic or Latino (2.6%), Native Hawaiian or other Pacific Islander (2.6%), or Other (chose not to specify; 2.6%), with 10.5% declining to respond. The majority of participants identified as women (60.5%), with the remainder identifying as men (39.5%). All respondents identified as cisgender (i.e., their biological sex and gender identity matched). Participants tended to be married or have a partner (53%), though relationship status was unknown or not reported for 26.3% of participants. The median household size was two. Across all cohorts, all participants had at least some college or vocational school education, and a majority, 74%, had a bachelor's degree or higher. Half of the participants reported an annual household income of more than $45,000, with 21.1% reporting incomes of $35,001–$45,000, 2.6% reporting $25,001–$35,000, 7.9% reporting $15,001–$25,000, 5.3% reporting $10,001–$15,000, and 5% declining to respond.

Participants cited a number of reasons for wanting to attend the PST, including being a veteran, working with veterans, wanting to help veteran families, working with teens who have attempted suicide, wanting to serve the community, wanting to address their own personal issues, wanting to build communication skills, wanting to build/improve peer support programs or collaborate with other programs, having completed another PST program that “wasn’t good,” and wanting to get more involved in GV.

Overall, participants described the PST in largely positive terms, noting that it improved their knowledge of peer support and peer support skills as well as their confidence and willingness to use these skills. As a Cohort 2 participant stated:

[The PST] completely opened my mind to “peer support” as a technique for helping friends, family, coworkers, supervisees, and children work through issues for themselves rather than always be the person coming up with ideas to fix the problem and therefore take on the burden of solving the issue. It really frees up the load one carries.
Knowledge, Expectations, and Impressions

Pretraining. Participants’ baseline understanding of peer support was at varying levels before the training. Some defined the term as being about listening, understanding, and/or equality or a lack of hierarchical relationships. Several participants specified that peer support is not about solving other people’s problems or putting one’s own problems on someone else. However, several participants related that they did not know anything about peer support when they came to the training.

PST participants expected the program to have potential impacts across their personal and professional lives. In terms of their personal lives, they expected to gain the skills they needed to “get back to being me again,” improve their emotional resiliency, improve their social skills, help break down walls, encourage a parent who is a veteran and other older veterans, fine-tune their listening skills, and avoid secondary trauma from listening. In terms of their professional lives, they expected to learn skills that would help them improve suicide prevention, “reach someone who is frozen,” assist people without getting stuck in their own heads, help homeless veterans get back on track, support student veterans, and generally better understand the people with whom they work.

Post training. In post-PST focus groups and surveys, participants talked about the PST in overall positive terms, describing it as “transformative,” “powerful stuff,” and “incredibly enlightening” and saying that they were “impressed” by the training. They also described the PST as having had a positive impact on themselves and/or the community, said that GV is “making an impact in the community” through the training, and professed that the training “actually solved a couple of really big problems for me.”

Some participants described the PST in terms of skill building, stating that the PST was a “useful tool set” and “provided us with a structure we can use.” They also said that it “explained what peer support is and why it is important” and that they liked the structure of the curriculum.

When asked what surprised them most about the PST, emergent themes in focus groups and surveys centered around the camaraderie and closeness participants felt to each other and the ease and comfort they felt in sharing personal stories. Furthermore, participants were surprised not only at their own openness to sharing but also at how others have had similar experiences. Participants also noted the ability to use the skills they learned in everyday life. As one participant said, “You can apply these skills to just about any conversation. Peer support is not unique for just veterans. This is a life skill.”

Finally, though some participants had attended peer support trainings before, they still described GV’s PST as generating new knowledge for them. Participants stated that the new information (described as being 50% new), communication strategies, and veteran-centered nature of the program made the PST useful and that their “perception of peer support has been broadened.” One participant also said that the GV’s PST “modules are the best I have received.” Participants also noted that the training format—particularly its provision of a safe space for participants to be vulnerable—improved their use of PST skills. Participants described using these new skills in a variety of areas in their lives, including at work, when volunteering, and with family and friends.

Use of PST Skills

Plans to use PST skills. Participants were very motivated to use the PST skills across their personal and professional lives. Of those who completed the post training survey, 100% of participants across all cohorts answered affirmative to the question, “Do you plan to use the PST when you return to your organization?” As one participant said, “I can use this just about anywhere, school, work, my family. I love being able to support, even if the way I do it seems small.” Several participants stated that they planned to use the skills they gained from the PST in personal ways (e.g., to be “more self-aware,” to “dial things down,” and to “check-in”), with their family (e.g., to teach the skills to their children), with their coworkers (e.g., to help teachers at their college connect with veterans), and in their communities (e.g., to address teen suicide). Several participants also planned to use the skills to create or bolster their own peer support programs, including a peer support program for veterans. A male veteran from Cohort 3 reported, “The PST helped me recognize that every interaction I have with a veteran is an opportunity to be better. We grew up in a culture [where] everyone is taking stabs at each other.”

Post training use of PST skills. Surveys and 90-day interviews were conducted with PST participants (n = 14) to assess the extent to which they had used the PST skills in their communities and organizations since the conclusion of the program. These measures revealed that the PST not only influenced how participants interacted
at work and with family and friends but also influenced participants’ own ways of thinking.

Work. Of those interviewed 90 days post training, the majority of participants described using the skills that they gained from the PST professionally in both volunteer and paid work. They shared the PST exercises and activities with individuals and groups, including with support groups and in staff trainings. Participants also described the PST skills as improving their daily professional interactions with increased patience and an enhanced ability to build relationships. As a female nonveteran from Cohort 4 explained:

I have had numerous veterans reach out to me. I am trying to get my own organization going. Oftentimes what ends up as conversations about building business ends up being a conversation about our lives. That is where I find myself using the peer support skills. As soon as the conversation switches to “well I was in Iraq…”, then that is when I find myself putting on my peer support hat.

Family and friends. The PST also affected participants’ personal lives. Most of the 90-day interviewees described using PST skills with family and friends or in other informal relationships. They described improvements in communication skills, mindfulness, awareness, patience, empathy, and confidence, and some said they had used the skills to support friends in crisis. A male veteran participant from Cohort 1 said:

[The PST] gave me more confidence [with] how to deal with these issues, not to be afraid to confront it; so it gave me more confidence, ’cause I was afraid if I talk to [a] veteran who has been in combat, is this going to set him off, but now I feel more confident and understand.

Table 2. Influence of PST on Participants

<table>
<thead>
<tr>
<th>Domain</th>
<th>Themes</th>
<th>Illustrative quote</th>
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<tbody>
<tr>
<td>Work</td>
<td>Improved daily professional interactions</td>
<td>“I use it at work too—I work with veterans...like when one of my peers needs someone to listen to them, I have a lot more patience with that type of thing. I’m more understanding; I feel like overall I’m more calm and patient and understanding than I used to be.” (Female, veteran, Cohort 1)</td>
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<tr>
<td></td>
<td>Increased patience</td>
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<td></td>
<td>Enhanced ability to build relationships</td>
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<tr>
<td>Family and friends</td>
<td>Improvements to interpersonal interactions, including:</td>
<td>“The peer support training changed how I communicate with my boy. It has been transformational in that respect. It is in us to be that support system for others, but we need some training to bring it out.” (Female, nonveteran, Cohort 1)</td>
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<tr>
<td></td>
<td>• communication skills</td>
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<td>• empathy</td>
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<tr>
<td></td>
<td>• confidence</td>
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<tr>
<td>Self</td>
<td>Increased self-empowerment and connection to the outside world, including:</td>
<td>“I felt really helpless and really stuck for a long time. I felt really painted into a corner...I am starting to realize I can make changes when things aren’t working.” (Female, veteran, Cohort 4)</td>
</tr>
<tr>
<td></td>
<td>• confidence</td>
<td></td>
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<tr>
<td></td>
<td>• communication</td>
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<tr>
<td></td>
<td>• mindfulness</td>
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<td></td>
<td>• new relationships</td>
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<td></td>
<td>• feelings of empowerment</td>
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<tr>
<td></td>
<td>• empathy</td>
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<tr>
<td></td>
<td>• connection to the natural world</td>
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<tr>
<td></td>
<td>• recognizing veterans as leaders</td>
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</table>
Self. Many of the 90-day interviewees described the PST as positively impacting their ways of thinking. This included becoming more confident communicators, being more mindful, becoming more open to new relationships, experiencing feelings of empowerment, feeling an improved ability to relate to others and an improved connection to the natural world, and recognizing veterans as leaders. As one male veteran participant from Cohort 2 shared:

I've been going through a lot of therapy and drug counseling over the years, but I feel like since I took that course, it's helped me open up and not be so closed off. I don't feel so nervous about talking to strangers like I used to. And I've always been extremely shy for the most part.

Peer support recipients. Interviewees used their PST training in formal and informal capacities. Peer support recipients included veterans and their families, students, clients, coworkers, fellow PST participants, parents of children with mental illness, and, generally speaking, anyone with whom PST participants interacted. One female nonveteran participant from Cohort 4 described the PST as helping her in her suicide awareness work:

I talk to people that are going through a lot. I use the skills informally. And these are more parents who have children who are suicidal. But I remember the skills we learned and put them into practice about once or twice a month.

The vast majority of 90-day interviewees described using their PST skills with some frequency or regularity. For example, one female nonveteran interviewee from Cohort 4 explained that she uses the PST skills “almost daily, or at least multiple times a week where I am finding someone to use them [the PST skills] with.”

Barriers to Use of PST Skills

The evaluation revealed that cost can be a barrier for individuals seeking to enroll in the PST, and the program’s cost may also impede buy-in from small organizations with tight budgets. Most participants stated in the 90-day interviews that they were self-motivated to attend the PST; only a few interviewees stated that their organization had sponsored their attendance. Interviews revealed that a major barrier to using PST seemed to be a lack of organizational sponsorship.

Once participants gained sponsorship, it seemed that organizations were on board with implementing the PST in some manner. The one participant sponsored by an organization outside of GV stated that their organization has accepted the PST, that they had not had to tailor or change any part of the PST skills/practices, that the PST was a powerful tool, and that they believed their organization could improve delivery of training to veterans and families. The three interviewees sponsored by GV stated that the PST had made a difference, that it allowed them to care for each other, and that they were using the PST in their own organizations outside of GV.

The optimal way to assess barriers to and facilitators of PST implementation at other organizations, as well as overall organizational willingness, is to interview organizational leaders to determine if their perspectives align with those of PST participants. However, during this evaluation, none of the interviewees provided evaluators with contact information for their organizational leadership. It was also not possible to evaluate the effects of receiving peer mentoring from a PST trainee, as participants did not provide contact information for those they had supported.

Long-term PST benefits. Several major themes emerged concerning long-term benefits of the PST: clarification of the definition of and skills needed for peer support, improved communication skills, increased confidence with providing peer support, and a sparked desire to help others.

Clarification of the Definition of and Skills Needed for Peer Support

Participants overwhelmingly expressed positive reactions to the PST during the 90-day interviews. Much of this favorable response stemmed from participants’ improved understandings of what constituted peer support and the skills required to provide it. This included an understanding that peer support is not about “trying to fix” someone, as a female veteran participant from Cohort 1 explained, but more about being there for them:

Instead of listening to [people] and thinking, “Oh I need to help this person and I need to do something for them,” now it’s more of, “Well if they ask me for help or have something they want me to do, I’m willing to be there for
them if it’s something I am capable of doing.” Otherwise I listen, I don’t take it into myself as a part of myself. Which is probably way healthier.

**Improved Communication Skills**

This clearer understanding of the elements necessary for peer support (e.g., empathy, boundaries, etc.) as well as what is not needed (e.g., solving other people’s problems) translated into multiple other long-lasting benefits of the PST. Chief among these was improvement in professional and personal communication skills. Several participants also described learning the valuable skill of listening without judgment and “holding space” for other people, which improved their communication and ability to provide peer support. According to one female veteran participant from Cohort 1:

Learning how to sit with my feelings and let people say what they need to say without me putting judgment in it or taking it personally, thinking they are judging me; and the part where—the effective listening aspect. Hold space without losing my own value.

**Increased Confidence with Providing Peer Support**

Several participants explained that learning and mastering these communication skills improved their confidence in their peer support ability, skills, and effectiveness. This increased confidence was facilitated by improving their understanding of how to implement peer support in a structured way. As one female veteran participant from Cohort 1 explained:

[The PST] taught me what I’ve been seeking—it reinforced what I theorized what people needed—love, validation, structure. I felt like the training reinforced and showed me how to apply it in a more structured way instead of just winging it, which is what I had been doing.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Illustrative quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarification of definition and skills for peer support</td>
<td>“There is a large group of veterans similar to me who tend to tough it out. If just ‘being there’ is enough—I can be there. I don’t need to super analyze anything—I don’t need to solve anyone’s problem or think I should solve the problem. All I need to be is empathetic to the issue.” (Male, veteran, Cohort 3)</td>
</tr>
<tr>
<td>Improved communication skills</td>
<td>“It [the training] opened up my personal perspective on the fact that I do not know why people behave the way they do. It is just counterproductive to assume why they do. We can be supportive even if we initially don’t understand them.” (Female, nonveteran, Cohort 1)</td>
</tr>
<tr>
<td>Increased confidence to provide peer support</td>
<td>“I was making things way complicated in my [peer support] prior to the training. [Since training] I am able to communicate with people and ask them those open-ended questions...by asking the open-ended questions and listening. It increased my ability to listen and my courage to do well and hold a space for another veteran.” (Female, veteran, Cohort 2)</td>
</tr>
<tr>
<td>Sparked desire to help others</td>
<td>“I used to work with traumatized populations. [The training] allowed me to see I desired to help on this level and I have experience that can [be] useful in this world....The workshop was really good for me.” (Female, nonveteran, Cohort 4)</td>
</tr>
<tr>
<td>Other</td>
<td>Connection to network of like-minded community Provided understanding of veterans’ struggles</td>
</tr>
</tbody>
</table>

Table 3. Long-Term Impacts of GV PST
Sparked Desire to Help Others

Having a clear understanding of the elements of peer support and the necessary communication skills provided several participants with a spark of hope for their own potential contribution to peer support. As one female veteran participant from Cohort 4 explained, “[the training] gave me a sense of hope I would really like to use to help other people; it was just a positive force.” A male veteran from Cohort 3 described this spark as follows:

[The training] illuminated the idea that vets can play the role of NCO [noncommissioned officer] to people in their life; a great way to look at what a vet can be beyond the traditional role of a veteran. A network of others who have gone through the training.

Other Long-Term Benefits

Another long-term effect of the PST was the connection it provided to a network of like-minded people. As one participant, a male veteran from Cohort 3, stated, “[most impactful] was the network of folks I went to training with. I run into and connected with them, and that is valuable. They are all veterans.” Participants who were not veterans also described how the PST helped them better understand the struggles veterans face.

Discussion

Reintegration research has noted that a lack of social support is a key barrier to veterans’ efforts to reenter civilian life (J. A. Gorman et al., 2018). Programming focused on community engagement can help ease postmilitary transitions. GV’s evidence-based PST is particularly critical, given that it draws upon what the DCOE has determined are best practices and elements essential to a successful military/veteran peer support program (Money et al., 2011). Indeed, the results of this evaluation indicate that this PST provided the skills that participants needed to successfully and confidently connect with, engage, and support veterans. From better understanding their roles and goals as peer supporters, to active listening and having empathy, participants not only reported feeling more confident in their ability to communicate and connect but also expressed an increased desire to do so, ultimately increasing the community engagement opportunities available for veterans.

The content and format of the PST trainings was very personal and intimate. Group sizes were relatively small, ranging from 10 to 14 participants per workshop setting. Evaluation team members were cognizant of how their presence would affect group dynamics. Even though ethnographic research methods aim to cultivate transparency and trust between participants and researchers, power dynamics are always present and must be handled with care. As a best practice, GV staff informed all workshop participants prior to their enrollment in the program and again prior to their arrival at the workshop site that the organization was participating in a program evaluation. Before the start of each peer support workshop, the evaluation team always asked permission to attend the workshops alongside trainers and participants. This allowed the evaluation team to be active participants in the PST process as opposed to being passive participants observing and collecting data. There was never a situation in which participants did not approve of the evaluation teams participation.

Building rapport through participant observation was essential to this evaluation, as it eased any awkwardness that might have occurred in such an intimate setting. Participant observation involved meeting with participants the night before the PST to answer any questions they might have about the evaluation, attending PST breakfasts alongside participants, and attending the PST sessions. Evaluation team members agreed that spending extra time to build rapport with participants opened the door for the establishment of trust and the free flow of information between evaluation team members, GV staff, and workshop participants.

The evaluation team also found strength in the intersectional identities of the team members. The fact that one evaluator openly identified as a woman veteran provided the researchers with an insider’s perspective on the military-connected community. Her perspective was especially important when issues arose with minority service members, particularly women veterans. Her experience as a woman veteran and expertise in working with women veterans—including having written a feminist ethnography on women veterans’ experiences with the transition out of military service (Downs, 2017)—provided critical insight into how women veterans reacted to the PST. For example, after this evaluator drew attention to how participants’ experience of the PST might be affected by experiences of various traumas, including those perpetrated by other service members; feelings of isolation; and disconnection...
from “pride in service,” GV made course corrections that opened a conversation on understanding and respecting differences in military experiences. The transparent, collaborative relationship between the evaluators and GV allowed for changes to be made in real time to address input shared after the PST sessions.

GV made several other course corrections during the evaluation, including a change to the popular “council circle” activity, in which participants commonly discussed emotionally difficult or traumatic experiences. The council circle was meant to bring people together in a circle to bear witness and share with each other authentically (Growing Veterans Peer Support Training Manual, 2018). Though an experienced mental health counselor facilitated the activity, evaluators noted that it could be overwhelming for the counselor to both be attentive to participants’ emotions and facilitate the workshops; upon evaluators’ recommendations, GV added a cofacilitator and an emotions monitor to observe the room during activities that might elicit sensitive stories from participants.

A number of suggested modifications to the PST emerged from the collaborative process and partnership between the VHA and GV, and GV incorporated several of these suggestions into the program. Participants provided positive feedback on many modifications, including council circle and self-care and boundary modules. Participants also noted that the program helped them feel safe, allowed for vulnerability and sharing, and provided a clear understanding of peer support and required peer support skills. By being open to feedback and incorporating suggestions, GV continuously improved its PST to be more impactful and effective. The evaluators made additional recommendations in the final report, including consideration of a web-based or long-distance PST. This suggestion stemmed from the finding that cost can be a barrier to PST participation, with most participants self-funding PST participation and desiring alternative methods of enrollment. The barrier of cost was largely related to travel costs and the fact that the PST required several days of in-person participation. By offering web-based or other long-distance participation, GV could greatly improve the reach of the program.

Challenges and Limitations

So as not to overburden participants or take time away from workshops to collect survey data, attempts were made to collect pretraining surveys before the first session while participants were gathered for breakfast. The challenge with this method was that some participants showed up late, so several uncompleted surveys needed to be finished prior to the start of the PST workshop. In order to collect the survey data, GV changed the schedule to allow participants to complete the pretraining survey at the beginning of the agenda on the first day.

Other limitations may also have affected the data. For example, a potential issue inherent in focus groups is that the desire to belong and/or maintain social standing within the group may influence participants’ responses. These focus groups covered several personal topics, and as part of this group dynamic participants may have felt the need to focus their responses on experiences that they might not have shared otherwise. However, the key to good focus group facilitation is the art of allowing participants to share their experiences, feelings, and perspectives while guiding the group to stay on topic. Within this evaluation, a desire to compare traumatic experiences occasionally seemed to arise, which some participants found to be detrimental to the group dynamic; this feedback was provided to GV.

The demographics of the PST participants also necessarily limit these evaluation findings. Most participants were White, women, and veterans, so their responses do not capture the broadest possible scope of perspectives. It is not clear why more diverse participants did not enroll in the PST at similar rates, but this is worth investigation. Inclusion of more diverse perspectives would help researchers better understand the potential impact of the PST program and areas where it can be improved. Evaluators did provide GV with resources to widen its outreach to diverse veteran populations.

Conclusion and Future Directions

Partnerships between the VHA and CBOs such as GV are a valuable means of expanding support for veterans. This value is evident in PST participants’ descriptions of their experiences with the program. Overall, participants reported that the PST had a positive impact on their well-being, with implications for both their personal and professional lives. Their positive feedback demonstrated the power of the PST, and their suggestions for change make it possible to expand the program. GV’s PST trainers adapted workshop content based on participant feedback immediately after the completion of the first training workshop.
A new trainer and participant manual were also produced as a result of the evaluation and participant feedback.

This partnership also exemplifies how the VHA and CBOs can improve veteran care by including veterans in program formation, implementation, and evaluation. Veterans participated in the PST itself, participated in the completion of the evaluation, and are coauthors to this article. Having a community insider on the research team provided benefits and subjective knowledge production. Having a native anthropologist (an anthropologist who is a member of the population being evaluated, in this case veterans) on the team allowed for an easier time developing rapport with program participants and facilitated a deeper understanding of certain dimensions of cultural behavior that non-native evaluators may have struggled to comprehend, especially in veteran-centered evaluation and research where acronyms are often used when discussing work and service history. Given that evaluators participated in the PST as both observers and participants, rapport was developed rather quickly; this can serve as a useful model in future veteran-centered evaluation and research.

Findings from this evaluation indicate that, overwhelmingly, participants reported the GV PST to be a powerful, transformative, and positive experience. Importantly, this includes those participants who had previously attended other peer support trainings. PST participants reported implementing their peer support skills in all areas of their life, both formally and informally, and described an increased understanding of the steps and skills that peer support requires. Crucially, they noted that they do not need to “fix” anyone.

Finally, this evaluation gathered a few unintended consequences of note:

- Participants reported using their peer support skills with all different populations, veterans and nonveterans; many even say that they have been able to use the peer support skills among their families to improve relationships.
- Several nonveteran participants noted that a benefit of the PST was to heighten their awareness of veterans’ struggles.

GV will be utilizing the findings from this evaluation to further refine the PST and develop a new program (Train-the-Trainer). Future activities should include continued rigorous evaluation of the implementation of the Train-the-Trainer program and the impact of the suggested changes to both programs.

References


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Disclaimer
The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States Government.

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"If You Don’t Name the Dragon, You Can’t Begin to Slay It:” Participatory Action Research to Increase Awareness Around Military-Related Traumatic Brain Injury

Gala True, Ray Facundo, Carlos Urbina, Sawyer Sheldon, J. Duncan Southall, and Sarah S. Ono

Abstract

Hundreds of thousands of U.S. veterans and their families are significantly affected by traumatic brain injury (TBI), yet policy-makers and the general public often lack knowledge about TBI and other “invisible injuries” related to military service. Veterans may face delayed TBI diagnoses and trouble accessing needed health care, and they and their families may face stigma and misperceptions about TBI that impede successful community reintegration. Researchers in the Department of Veterans Affairs (VA) partnered with 45 veterans with TBI and 26 of their family caregivers on a participatory action research (PAR) study that used photovoice methods to explore and convey experiences of community reintegration after TBI. Interview data and images taken by participants were used to communicate stories, reflections, and insights. This paper reports participants’ reflections about (a) how they became aware of TBI-related symptoms and the impact of TBI on their lives and relationships, (b) challenges they have encountered—including misconceptions and stigma—when disclosing TBI and other “invisible injuries” to others, and (c) strategies and resources they draw upon to counter these challenges. The authors conclude by sharing participant-identified recommendations for supporting community reintegration after military service–related TBI. This work demonstrates the power of PAR to engage veterans and family caregivers in generating knowledge to inform the programs, policies, and public discourse that affect their lives. A priority for the dissemination of the study’s findings has been to raise awareness about TBI among veterans and military caregivers.

On January 8, 2020, Iran launched ballistic missile attacks on two bases housing U.S. troops in Iraq. Despite early reports of no casualties, it was later revealed that at least 12 American servicemembers had sustained concussions and had been medically evacuated for evaluation and treatment of possible traumatic brain injury, or TBI (Lubold, 2020). At a press conference two weeks after the missile attacks, the U.S. president described the injuries as “not very serious,” saying, “I heard they had headaches and a couple of other things.” He went on to characterize the servicemembers’ injuries as less severe than those of troops who lost limbs in roadside bomb attacks, noting, “I don’t consider them very serious injuries relative to other injuries that I’ve seen…I’ve seen people with no legs and with no arms. I’ve seen people that were horribly, horribly injured in that area, that war” (Donnelly, 2020).

The Brain Injury Association of America, an advocacy and research organization focused on increasing the public’s awareness and understanding of brain injury, expressed concern that the president’s remarks minimized the severity of TBI as “a major cause of death and disability in the United States” (Brain Injury Association of America, 2020). At the same time, the cochairs of the Congressional Brain Injury Task Force released a bipartisan statement reiterating the nation’s commitment to providing “unqualified support and respect” to persons impacted by TBI, noting, “Brain injury should never be minimized. Unfortunately, too many people, including elected leaders, are not familiar with the terrible realities of traumatic brain injury” (Office of Congressman Bill Pascrell, 2020). The commander in chief’s remarks and the responses from brain injury advocates reveal a central tension around “invisible injuries” such as TBI. While these injuries may have serious, long-term negative impacts on an individual’s health and functioning, the fact that they often lack visible and physical manifestations can impede awareness of an injury and its effects in the eyes of the injured person, those closest to them, and outside observers (Tanielian & Jaycox, 2008).
Our work is informed by Paolo Freire’s critical pedagogy, the theoretical framework that underpins PAR (Freire, 2018). A goal of critical pedagogy is to help individuals develop critical consciousness around an issue affecting their lives, thereby facilitating their ability to create and share knowledge of their own history and experiences (Ada, 1990). We were guided by critical pedagogy and PAR’s recognition of researchers and participants as bringing different types of expertise to the research enterprise. Through the process of engaging participants as co-researchers—what Markham has called “respectful dialogue” (2019)—our goal was to connect their deeply personal experiences of living with TBI to the broader conversations around TBI that are happening in research and the public sphere.

The work described in this paper is built on several years of collaboration between researchers and veterans of the wars in Iraq and Afghanistan and was funded by the Department of Veterans Affairs (VA; True et al., 2015, 2021). We engaged veterans and caregivers in this study using photovoice methods, which involves giving people cameras and asking them to document, reflect on, and communicate their experiences and concerns to stimulate discussion and social change (Wang, 1999). Our goal was to illuminate and convey veteran and caregiver experiences of community reintegration after TBI and to ascertain participant-identified advocacy goals to promote recovery and improve TBI care processes, programs, and policies. In keeping with the principles of our theoretical framework, a goal of this work was to engage individuals with lived experience of military service and service-related injuries in generating scholarship and knowledge to inform programs and policies that directly affect their lives and, ultimately, to bring their perspectives to local and national policy discussions and public discourse regarding TBI and community reintegration (Minkler & Wallerstein, 2011).

**Background**

It is estimated that nearly 400,000 U.S. servicemembers have suffered a TBI since the onset of the wars in Iraq and Afghanistan (National Academies of Science, Engineering, and Medicine, 2019). TBIs are typically caused by a blow or jolt to the head, or less often by a penetrating head injury, and their effects can range from short-term symptoms that resolve over time to long-lasting and debilitating changes in cognitive and motor functioning, physical symptoms such as recurrent headaches and photosensitivity, and/or significant changes in behavior and mood (Sayer et al., 2008). TBI has been associated with negative impacts on employment and relationship functioning and with increased risk of suicide (Brenner et al., 2011; Madsen et al., 2018). Around 80% of military service–related TBIs are reclassified as “mild” or mTBI, and multiple studies have demonstrated strong associations between mTBI and post-traumatic stress disorder (PTSD; Bryant et al., 2010; Hoge et al., 2008).

Many U.S. servicemembers experience multiple lifetime TBI exposures, both prior to military service and throughout training and deployment, and these injuries often are not assessed or treated until servicemembers separate from military service (Brenner et al., 2010). Individuals who have sustained multiple lifetime concussions (i.e., mTBIs) are at a higher risk for emotional distress, decreased cognitive functioning, and dementia (Barnes et al., 2018; Spira et al., 2014). Barriers to diagnosis and treatment include servicemembers’ reluctance to request medical treatment and a military culture that emphasizes stoicism over seeking help (MacLeish, 2013; Smith & True, 2014); veterans may be hesitant to report a history of TBI or to attribute their symptoms to TBI (Brenner et al., 2015). In addition, the overlap between TBI and PTSD in terms of etiology and symptoms often complicates TBI diagnosis and treatment; psychological trauma often co-occurs with physical injury, especially in military populations, and both conditions are characterized by attentional problems and mood changes (Tanev et al., 2014).

In 2007, the VA instituted universal screening of post-9/11 veterans for TBI exposures and developed an integrated network of specialized rehabilitative programs to provide
interdisciplinary evaluation and care for persons with TBI and comorbid conditions (National Academies of Science, Engineering, and Medicine, 2019). While these measures have been highly successful in identifying veterans with TBI and connecting them with needed services, not all post-9/11 veterans receive VA care (Tsai & Rosenheck, 2016). Furthermore, an internal audit discovered that screening and evaluation policies had been inconsistently applied across the VA during a crucial 10-year period; consequently, many post-9/11 veterans had not been evaluated by a designated TBI specialist (VA, 2018). Thus, despite growing recognition of the importance of appropriate diagnosis and treatment of TBI in U.S. servicemembers, there is still a need for increased awareness and understanding of the condition and its impacts, advocacy efforts to ensure that veterans receive appropriate treatment for their symptoms, and services to support veterans’ community reintegration.

Partnered Research to Support Community Reintegration

Our work was guided by the belief that partnerships between researchers, veterans, and military caregivers will improve the relevance of research findings, lead to improvements in health care, and better inform policy downstream (Minkler & Wallerstein, 2011). Between April 2016 and March 2019, two VA researchers (GT and SO) with experience conducting veteran-engaged research and a combat veteran working in VA research (RF) collaborated with individual veterans with TBI and their military caregivers across two regions of the United States with the goal of developing community-informed solutions for improving community reintegration for persons with TBI and their families. For the purposes of our study, we defined community reintegration as encompassing the return of individual veterans and military families to meaningful participation in social, community, and civic life; work, education, and volunteering; domestic and family life; leisure; self-care; and spirituality and faith (Resnik et al., 2012).

In alignment with our theoretical framework, we have endeavored to disseminate our research findings through multiple channels to reach a broad audience, with veteran and caregiver participants co-presenting and coauthoring with members of the VA research team whenever possible (True et al., 2021). Partnered dissemination ensures that all types of expertise, including lived experience, can inform policies, programs, and public awareness that directly affect veterans’ and families’ transition from military service to civilian life. Three authors of this paper (CU, SS, and JS) who participated in the study and one (RF) who was project manager for the study have direct experience of military service, combat deployments, living with TBI, and navigating the transition from military service to civilian life.

Methods

Community-engaged research has been conceptualized as a continuum that spans three models: an advisory model, in which members of a community provide overall guidance and input throughout the life of the project; an employment model, in which community members are salaried members of the research team; and a participatory model, in which people affected by the research topic are collaborative partners in the research (Roche et al., 2010). Our photovoice study employed all three. We had an advisory board that included three veterans and three military caregivers, the study’s project manager was a veteran, and our veteran and caregiver participants were coresearchers throughout most phases of the project, including the identification of themes in the data and dissemination of findings. In addition, before beginning study recruitment, we developed relationships with leadership and staff at several veteran-serving nonprofits to facilitate the recruitment of participants and the dissemination of findings back to veteran communities. Institutional review boards at the Southeast Louisiana Veterans Health Care System and the VA Portland Health Care System reviewed and approved all study methods.

Recruitment

Veterans were eligible for study participation if they had served in the post-9/11 service era (Operations Enduring Freedom, Iraqi Freedom, or New Dawn [OEF/OIF/OND]) and had a TBI diagnosis documented in their medical record. We identified eligible veterans via the VA's electronic health record (EHR) and through referrals from VA staff in relevant clinics and community-based nonprofits, as described above. To confirm the eligibility of those veterans referred to the study, we verified the presence of a TBI diagnosis in the EHR. Veterans were mailed or handed a study flyer, and a member of the study team followed up by phone or in person with each prospective participant to describe the requirements of participation in more
detail and to answer questions. For each veteran who expressed interest in study participation, we asked, “Can you identify a family member or friend who is involved in supporting you in your health care and/or community reintegration?” We contacted these veteran-identified caregivers to see if they were interested in participating in the study with the veteran. Veterans who could not identify a caregiver were eligible to participate solo (i.e., without a study partner). Caregivers were not eligible to participate without a veteran study partner. Participants provided written informed consent and were compensated $40 for each in-person study visit they completed.

Sample
A total of 45 veterans enrolled in the study, of which 26 had a caregiver study partner. Most veterans identified as male (89%) and ranged in age from 24 to 56 years (mean = 37). Nearly three quarters (73%) were White and non-Hispanic. By design, all veteran participants had a TBI diagnosis; the majority also had a diagnosis of PTSD (91%) and/or depression (67%). About three quarters of the veteran participants had served as active duty military, and 22% had served in the National Guard or military reserves. Participants represented four branches of military service, with a majority having served in the U.S. Army or U.S. Marine Corps.

Of the 26 caregivers who enrolled in the study, most were women (88%) and non-Hispanic White (85%). Most were the spouse or partner of a participating veteran (81%); the remaining caregivers were parents, adult children, or siblings of the veteran participants.

Photovoice Procedures
The study sought (a) to encourage veterans and caregivers to reflect on their experiences with health, illness, and community reintegration after military service and (b) to engage them in advocacy for supportive services and environments designed to help them and other veterans and their families pursue valued life goals. We framed photovoice as a PAR method that has the potential to bring the lived experiences of veterans and caregivers to policy-makers and to raise awareness about the challenges facing individual patients and communities (Wang, 1999). We used a graphical

Figure 1. Photovoice Methods

THE PHOTOVOICE JOURNEY

Visit 1: Learn about Photovoice
Visit 2: Individual Interview and photo selection
Visit 3: Dyadic Interview
Visit 4: Group Discussion

Participants take/collect photos
Photo-narrative created

Dyads review photo-narratives together

Your Experiences Better Understood by Stakeholders

Traveling Exhibition of Photo-narratives in multiple venues
representation adapted from Lorenz (Figure 1) to outline study methods for participants (Lorenz & Chilingerian, 2011).

Study participation involved four distinct visits. During Visit 1, members of the research team met with veteran participants or with veteran–caregiver participant pairs (dyads) to discuss the principles of PAR and the goals of the study. Participants were given cameras and asked to take photographs to illustrate their daily lives and experiences with TBI and community reintegration. Between Visits 1 and 2, a period of approximately two weeks, participants took photographs or selected relevant photos from their personal collections.

At Visit 2, a member of the research team trained in qualitative methods met with each participant one-on-one to collect photographs and conduct a photo-elicitation interview, where photographs taken by the participant were used as prompts to generate reflections and evoke stories. For this interview, we used a semistructured interview guide adapted from Wang’s SHOWeD method (1999). At the end of Visit 2, each participant reviewed their photographs and shared with the researcher any special instructions regarding how a specific photograph could be used and how they wanted to be identified in the dissemination of findings (e.g., by their full name, by their first name only, or by a pseudonym). These interviews were digitally recorded and transcribed.

Once transcripts were available, a member of the research team developed a photo narrative for each participant by matching text (i.e., what the person said about their photographs) with each photograph. Photo narratives were laid out in Microsoft Publisher to resemble picture books, and these “books” were mailed to participants to make edits as needed until they were satisfied that the books captured their perspectives. This process provided an opportunity for member checking, whereby data are shared with participants to check for accuracy and resonance with their intentions and experiences (Birt et al., 2016). Veterans and caregivers who were participating together were also asked to share their photo narratives with each other sometime between Visits 2 and 3.

During Visit 3, researchers met with veteran–caregiver dyads and conducted semi-structured interviews to elicit joint reflections on how reading each other’s photo narratives affected their knowledge and understanding of one another’s perspectives and experiences. These interviews were audio-recorded and transcribed.

For Visit 4, we invited participants to attend one of six small-group meetings. The goal of these discussions was to support community building and co-construction of knowledge (Minkler & Wallerstein, 2011; Tang Yan et al., 2019). The researchers presented preliminary themes identified in the data and displayed illustrative excerpts from participants’ photo narratives on the walls to facilitate sharing and discussion. Researchers asked participants to reflect on what themes felt most relevant to their experiences and to consider whether there were themes they felt were missing or underdeveloped. Researchers and participants discussed priorities for the dissemination of the study’s findings, including preferred formats for dissemination (e.g., public exhibits and presentations) and target audiences (e.g., VA administrators and policy-makers, other veteran and caregiver groups). At these meetings, many participants spontaneously connected with each other, sharing knowledge of resources and exchanging contact information so they could stay in touch outside of the research project. These meetings often laid the groundwork for papers such as this one.

Data Analysis

We used a grounded theory approach (Chun Tie et al., 2019; Strauss & Corbin, 1998) to analyze data, which we modified to suit health services research conducted in a grant-based system. A modified grounded theory approach allows for analysis that involves initial open coding, the combination of a priori codes with any data-driven inductive codes that emerge, and iteration throughout the analysis process. Drawing upon two sources—(a) the preliminary coding of individual photographs and transcripts that we used to develop photo narratives and (b) an iterative review of eight randomly selected transcripts of photo-elicitation interviews—members of the research team (including three of the coauthors [GT, RF, and SO]) developed a codebook consisting of codes (i.e., brief labels assigned to a selection of text), code definitions, and examples from transcripts. Each transcript was coded in Atlas.ti by a primary coder who applied codes to the transcript and a secondary coder who “audited” the coded transcript and noted any areas of disagreement in the application of codes. Coding disagreements were tracked through written memos and discussed and resolved by consensus at biweekly coding meetings (Cascio et al., 2019).
Through the iterative process of (a) creating photo narratives by linking photographs to quotations from transcripts, (b) member checking with participants to refine the photo narratives, (c) gaining input from participants through small-group discussions, and (d) team coding of transcripts, we identified recurrent themes around veterans’ and caregivers’ experiences of living with TBI and other “invisible injuries” related to military service. These themes included barriers and facilitators to community reintegration as well as recommendations for policy and programmatic change to support veterans and their families in postmilitary life. To develop the current paper, we supplemented our previous analysis with two 60-minute phone calls during which researchers and coauthor veterans identified the themes and associated data (both illustrative images and quotations) that we wished to highlight and include in this manuscript.

Results
Many themes emerged from the larger photovoice study. Elsewhere, we have published the insights we gained into the experiences of family caregivers of veterans with TBI (Abraham et al., 2021; Wyse et al., 2020). In this paper, we chose to focus on themes relevant to different dimensions of TBI awareness, including (a) veterans’ reflections on how they became self-aware of TBI-related symptoms and the impact of TBI on their lives and relationships; (b) the challenges veterans and family caregivers encountered—including misconceptions and stigma—when disclosing “invisible injuries” to others, and how these challenges may be compounded by civilian-held stereotypes of veterans as homogeneous; and (c) strategies and resources that veterans and caregivers draw upon to counter these challenges. We included photographs and quotations to illustrate each theme; all identifiers used here were selected by participants.

Developing Self-Awareness of TBI
Many veterans described their recognition of TBI’s lasting impacts on their lives and relationships as a process that unfolded over multiple years post–military service. A veteran who identified herself by the name “Feral” provided a photograph of her bitten-down fingernails to convey the anxiety and frustration she experienced as she grew more self-aware of cognitive impairments related to her TBI:

I feel anxious in social situations. I feel anxious about meeting obligations. I feel anxious about not being able to focus on things. It feels like I’m always doing something wrong, and everything I do wrong feels like the end of the fucking world. Half of my problems are from my TBI. You feel stupid when you used to be a writer, an English major, and now you can’t find your vocabulary. You’re looking somebody in the eye and don’t remember their name.

Veterans and their caregivers recounted how TBI diagnoses helped the caregivers better understand their veterans’ initially frustrating behavior. One example came from John, who shared a photo of groceries to illustrate how his memory issues strained his relationship with his wife:

Image 1. I feel anxious about everything. You feel stupid when you can’t find your vocabulary.
In contrast to John's experience, in which his TBI diagnosis helped his wife accept changes in his memory and cognition, other veterans described the challenges they faced in getting their TBI recognized in a health care setting, even as their TBI symptoms created problems in their personal lives. As Josh relayed:

I feel there are a lot of guys that are missing out on their TBI diagnosis. When I went to talk with [the VA doctor], he was like, "Nah, you've got PTSD." And I was like, "Okay, is it possible I have both?" He looked at the scan of my brain and said there was no permanent physical damage, so I didn't have TBI. I can't argue with him, because if he don't think I got it, he ain't interested in treating it. But it's the inability to stay on track that drives me nuts now. I forget where I put my keys, I forget that I'm supposed to be somewhere. I had a relationship with a girl that was living with me, and she said, "I feel like I'm living with an old man who has dementia."

Josh eventually received a TBI diagnosis from a different VA doctor, but by that time his relationship had ended.

Veterans like Josh described how seeing themselves through the eyes of their loved ones helped them become self-aware of their TBI symptoms. Through photovoice, these veterans illustrated the negative consequences that accompanied their delayed self-awareness of their own TBI symptoms and their inability to access adequate care and support. Eddie, for example, provided two photographs to illustrate the painful loss of his family:

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This is what happens when you don't deal with what you need to deal with. You think everything is okay, and you put everything that's bothering you on the back burner...I was so used to the isolation that I didn't give [my wife] enough attention. This picture was taken when I was still with my son and his mom. This is us starting something new, trying to become a family, making plans. [But] there were so many unresolved issues, as far as my PTSD and TBI, I had so much going on in my brain and in my life, that it resulted in this photo of me standing alone.

Other veterans who developed self-awareness through observing the impact of their illness on their loved ones were able to access health care and begin the recovery process before those relationships were irretrievably lost. As Carlos relates:
My rock bottom was when my wife was crying almost every day. She was telling me all the things I needed to notice about myself, and it went in one ear and out the other. I finally took a step back and listened…and really dug deep and said, “Why is my wife crying? She’s crying because of me.” It opened my eyes to, “I’m not who I want to be. If I want to work towards my goal, that person I am supposed to be, then I need to start now…” The doctors are there, telling me something, so why don’t I start taking notes?” After that, every time I went to an appointment, I would say, “Well, can I come next week? Can I come twice a week? Can I come three times a week?” They would recommend or suggest things, and I would jump to them.

Finally, some veterans shared how the process of engaging in the study itself—of reflecting on their daily lives or hearing about the experiences of other veterans and families through study participation—led to increased self-awareness and a desire to educate others about symptoms and impacts of TBI. Ray, a combat veteran with multiple TBI exposures who was also the study’s project manager, observed:

It was astonishing how much I didn’t realize about TBI and the symptoms and the signs that I was feeling and going through during my transition. Hearing others’ stories made me reflect on the experiences I had in school, my relationships, my social life, and my professional life. It really took me aback. I struggled a lot more than I should have. It would have been less of a struggle if people understood more about what TBI is.

A common goal emerged from our study participants: to educate veterans, their families, health care providers, and other civilians about symptoms and impacts of TBI and to ensure that other veterans and families are able to access the resources they need to support their health and quality of life.

Copings With Misconceptions and Stigma Around Disclosure of TBI

Veterans and caregivers shared their frustrations and negative experiences with public misconceptions about “invisible injuries” such as TBI. Many veterans took photographs to illustrate the challenges they faced in social situations at work and school when others did not perceive them as injured, trust that they were experiencing TBI-related symptoms (e.g., photosensitivity or chronic migraines), or believe that they needed special accommodations (e.g., closed window shades, dim lighting, or wearing sunglasses indoors). JD shared his experience with an employer who, despite being a veteran, lacked a basic understanding of TBI:

I was trying to explain my own TBI to my employer, who was a military guy who didn’t see combat. And he said, basically, he doesn’t understand why I can’t get over it. Because people can get over alcoholism, and he related it to alcoholism. I mean, it’s just frustrating.

Caregivers also shared how ignorance about “invisible” military-related injuries caused stress in the course of their daily lives. As Sharon, caregiver to her Marine veteran husband, described:

The first time we went to the airport, I was terrified. There were no resources for me to reach out [for help], because he looks normal on the outside. He stands by himself. He can smile. When I went to the desk to ask if we could board first, I said, “I will sit in the back of the plane even though it’s more uncomfortable, so there is nobody behind him. He doesn’t feel comfortable [with someone behind him].” But [the gate agent] pushed back, saying, “He’s not disabled. He doesn’t look disabled.”

Another caregiver, Jennifer, contributed a photograph of a ripped coffee filter to represent how her husband’s TBI and decreased tolerance for alcohol resulted in his having a “torn filter,” which led to challenges in social situations even with close family:

My friends and family are understanding, but there are times when [my husband] says stuff. On New Year’s Eve, we were all drinking and he started going off about something. I could tell my family was getting kind of angry with him and I said, “You have to remember [he] has
a brain injury, he does not mean it this way.” This is one of the things I deal with on a daily basis because it is not going to change...The brain injury is not going to repair itself and he is not going back to a hundred percent again. I would like for people to be more understanding and take a step back and not get so easily offended.

In addition to expressing their frustrations with others' misconceptions and lack of knowledge about TBI, veterans spoke of how stigma and bias negatively affected their ability to engage in work and school. JD, who worked as a child welfare advocate after separation from military service, faced professional challenges related to public knowledge of his service-related injuries:

Unfortunately, the situation I was in [when injured], it was highly publicized so I’m in three or four different books and all these articles about what I did. If you Google my name, PTSD or TBI comes up...People will use that against me in court when I testify, [saying], “This guy shouldn't have been around my children because he has PTSD and TBI, and he's going to swipe my kids.” I get that all the time, so I fight on many different levels. You're not just in a personal fight with having TBI, but the populace itself is so prejudiced they can't see people like me.

Many veteran participants were using their Post-9/11 GI Bill benefits to attend school after separation from military service. Some reported a reluctance to disclose their TBI or to seek disability accommodations in school settings due to concerns about stigma. Veterans shared experiences of hearing civilian student colleagues repeat stereotypes about veterans with TBI and PTSD as “damaged.” As Sawyer recounted:

In grad school, a classmate of mine kept talking about veterans dealing with TBI that she was working with, she kept talking about veterans like we were puppies. Like, “They don't know how to get help and they are so confused and they don't know how to advocate for themselves.” And I finally snapped in class one day...There's a section of the population that thinks we're stupid because we had our brains scrambled.

Participants also observed how civilians tend to characterize veterans as a homogeneous community rather than as individuals with diverse backgrounds and perspectives. This general lack of awareness about individuals' intersecting identities compounded the negative effects of stigma and misconceptions about TBI and thwarted participants' efforts to connect with potentially helpful resources. Feral, a transgender woman, described her struggle to be recognized and accepted for her intersecting identities as both a combat veteran with a TBI and a transgender activist. JD, who served in the Marine Corps and later in the Army, shared two photographs—one of his Quran alongside his service medals and dog tags and another of his Marine Corps portrait and medals—to illustrate his multiple identities as a Muslim and a self-identified “queer, Marine-looking, bald male.” He shared the challenges he faced when navigating educational and professional settings where he does not always feel recognized or welcomed by other veterans:

You go to school or to an employment resource center, and there's a bunch of veterans. But when you mention that you're queer, you know then that you're no longer part of that sect or whatever. You lose that camaraderie... I understand there's prejudice in the world, but that's another aspect of this; that we're out in the professional world and we're being judged not just for TBI but for being veterans. And then we have a lot of stigmas to overcome.
Sawyer echoed and expanded on these sentiments; as a woman who returned to school after separation from military service, she pointed out that not all veterans experience the idealized notion of “camaraderie” emphasized in popular culture, and this can leave many veterans feeling unsupported even in spaces intended to serve student veterans:

Some veterans are going to be completely different [in terms of] their needs and wants and desires. What [women veterans] want from the veterans resource center may be different than a lot of the male soldiers, Marines, airmen. When I was in the Army, there is no band of brothers when you’re the only woman and 156 dudes. I never got that camaraderie. That doesn’t exist when you’re the only one of your gender. There’s institutional trauma that continues on in a lot of ways for women after we leave the service. So, when you walk into a resource center and you get told “one place fits all,” it’s definitely frustrating.

Sawyer’s observations also touch upon a common thread present in participants’ photo narratives: Many veterans, especially women or members of racial or sexual minority groups, experienced institutional betrayals and traumas during military service that may complicate community reintegration.

Sawyer can’t enjoy herself, because she’s in that headspace where crowds are bad and not something she is comfortable being in. It’s like, “Alright, we’re gonna have to vacate the premises, go home, and feed our puppies.”

Living With TBI and Navigating Community Reintegration

Veteran–caregiver pairs described the important role that caregivers played in recognizing and helping their veterans manage challenging situations. For example, Sean, caregiver to his Army veteran wife, Sawyer, shared a photograph from when he and his wife encountered crowds and other stressors while sightseeing and he recognized the need to cut their trip short:

We have a lot of stigmas to overcome.
Reflecting on the experience of participating in the study with her husband, Sawyer was surprised to realize how much her husband had absorbed the impact of her symptoms and helped her to manage them by anticipating potential triggers and adapting with her:

My husband participated [in the photovoice study] and seeing and hearing things he said that I had never heard him say before, that was really eye-opening for me. He has become hyperaware of things that will upset me. I had never considered that he would become considerate of that. It’s like a secondary learned trait that my trauma has brought; he had to learn, just from adapting to me.

In the face of these challenges, veterans and caregivers described strategies and resources they used to manage symptoms and pursue valued life activities. Participants often used humor to relate their frustrations and coping mechanisms. Ben, a veteran with a collection of T-shirts poking fun at stereotypes of combat veterans (e.g., as “dangerous” or “medicated”), provided a photograph of himself “giving the finger” to the camera to illustrate his difficulties with understanding people and his advice to people who want to communicate with him:

Speak slowly. It takes me a while to understand what you’re talking about, and it helps so you can communicate to me and I can relay it back to you. When you’re talking to me, I’m more focused on the words than on what’s being said, and I have to break it down for myself. It frustrates me that my mind works like that. A lot of times, I just sit there quiet and try to catch what I can.

Veterans explained how they came to terms with their own and others’ views of changes in their cognitive functioning and adjusted their expectations for professional pursuits post-TBI. JD shared photographs of two cars he was in the process of rebuilding and said:

I was on my way to be an academic… I am changing my path because of the cognitive delays I face. People that meet me now, they don’t see any problems with me. But people that knew me before say, “Oh, wow, you’re not as witty, you’re not as fast.” I know I can’t go back and get my PhD and do what I wanted to do before the war. But I’ve always enjoyed working on cars, and this is something with my deficits I can still do.

It is important to note that the veteran participants also described strategies that helped them pursue career and educational goals despite cognitive challenges. JD went on to a career in child welfare, and at the time of this writing Carlos and Sawyer were both pursuing higher education.

Discussion

We value photovoice for its rootedness in critical consciousness, which fosters in-depth understanding of social and political worlds through the eyes of people who have experienced...
stigma, oppression, or suffering in order to expose contradictions and help reframe public and policy conversations (Bowleg, 2017; Freire, 2018).

As evidenced by recent public discourse and the personal experiences of our veteran and caregiver collaborators, TBI is still a misunderstood condition. Participants’ narratives illuminated how delays in getting a diagnosis and developing self-awareness of TBI symptoms negatively affected their relationships, health, and quality of life. In this way, our findings build on previous studies of the impacts of TBI and other invisible injuries on family caregivers (Griffin et al., 2012; Moriarty et al., 2015, 2018; Voris & Steinkopf, 2019).

Even after veterans and caregivers gained insight into TBI, they still had to contend with the invisibility of the injury, the public’s general lack of knowledge about TBI, and stigma when navigating valued activities and life goals in community, work, and educational settings. Previous research has associated TBI with negative changes in self-concept, depression, and decreases in self-esteem (Carroll & Coetzer, 2011). Although participants in our study used photovoice to share journeys that included periods of grief and loss as they became aware of TBI-related changes in themselves, their stories also included acceptance, growth, and finding new purpose. After their injuries, veterans found support in their caregivers, coped through humor and self-awareness, advocacy for themselves and other veterans, and adopted new life goal. Many veterans noted the limitations of resources and services that treated veterans as a homogenous community and failed to account for veterans’ intersecting identities and diverse experiences of military service. Veteran and caregiver participants had specific advice and recommendations with respect to policies and practices that could best support community reintegration. First, they emphasized how important it is for veterans to recognize their potential exposure to repeated concussions as an occupational hazard of military service and to disclose any relevant history fully to their health care providers. Our participants acknowledged exposure to a wide range of concussive events, from “getting your bell rung” during basic training, to whiplash incurred by jumping out of airplanes, head trauma from falling equipment such as dislodged metal from makeshift up-armored vehicles, blast exposures from improvised explosive devices and rocket attacks, and overpressure from firing large weapons. Many veterans in our project faced years-long delays in getting their TBI diagnoses, and they shared their stories in hopes that other veterans would recognize shared experiences and seek out a TBI evaluation if they had not yet had one or pursue a second opinion if they felt an initial medical evaluation had been incomplete. Likewise, caregivers shared insights about their growing awareness that “something was going on” with their loved one. They explained how their own research or education from health care providers helped them understand how their veteran’s symptoms were related to TBI, and they wanted other military caregivers to have access to knowledge and resources before their relationships deteriorated beyond repair. A priority area for the dissemination of findings from our study has thus been raising awareness about TBI among veterans and military caregivers.

Second, participants had recommendations for improving veterans’ experiences in employment and educational settings. They observed that many veterans were reluctant to disclose their TBI and other invisible injuries to employers, instructors, and school administrators out of embarrassment or concerns about being stigmatized. As one consequence, veterans often missed out on services and accommodations that could help them succeed. Other researchers have reported similar findings among veterans seeking higher education (Rattray et al., 2019). An important goal for future education and advocacy work includes destigmatizing the disclosure of invisible injuries and ensuring that veterans are aware that their disclosures are confidential by law. Participants also noted the need for well-resourced veteran student centers with staff trained to help facilitate difficult conversations between veterans and faculty or veteran and civilian students. They emphasized the importance of maintaining these centers as welcoming spaces for veterans with diverse experiences and identities, and they noted that campus resources for women and sexual and gender minorities (i.e., LGBTQ students) could be important potential collaborators in program development for veteran student centers. Many participants in our study had gone into service professions or were pursuing education with the intention of helping other veterans; they emphasized their commitment to creating safe spaces for veterans to share their experiences, disclose their needs, and receive support.
Limitations

We analyzed photovoice data using a PAR framework, with a focus on identifying participant-informed goals for advocacy and education. Data analysis through a different lens may have yielded different interpretations. We drew our study participants from two regions of the United States, and most (although not all) were receiving care from a VA medical center. Veterans and caregivers drawn from a larger national sample, including more veterans who do not receive VA care, would likely provide additional experiences and perspectives on TBI and community reintegration. We focused on themes that we identified as important and relevant to most study participants based on data collected through photo narratives and small-group discussions (Visit 4). We also consciously incorporated the personal examples of our veteran-participant coauthors (CU, SS, and JS) to illustrate the selected study findings. The investigators leading this research share a background in feminist theory and an appreciation for standpoint theory, reflexivity, and positionalities, as these affect the perspectives that each contributor brings to a collaboration such as writing with study participants (Closser & Finley, 2016). Although the themes presented are grounded in the study data, a different combination of authors would likely foreground different examples while including additional participants as coauthors could have broadened the diversity of views represented. We have developed a traveling exhibit that includes photo narratives from every veteran and caregiver who contributed to the study, and we continue to find opportunities to co-present study findings with a variety of collaborators to make sure that as many voices and perspectives as possible are represented.

Conclusion

Veterans’ and caregivers’ contributions and insights demonstrate the power of using photovoice to engage persons with direct experience of living with invisible injuries related to military service in generating knowledge to inform the programs, policies, and public discourse that affect their lives. Photovoice is a PAR approach that facilitates co-ownership of data and research findings and makes engaging participants in data analysis, interpretation, and dissemination of findings more feasible and equitable. In this study, visual-narrative methods enabled participants to reflect on and articulate experiences related to TBI and community reintegration that may have otherwise been challenging to put into words. These methods also allowed participants to convey their views to policy-makers, program managers, and members of the wider public. Photovoice holds great promise as a research approach that can be led or co-led by military servicemembers, veterans, and their family members to challenge misconceptions about and misrepresentations of their experiences. Furthermore, we see photovoice and other forms of PAR as a potential tool for veterans and military families affected by invisible injuries, helping them to move toward healing and develop a new sense of mission and purpose through engaging in critical reflection on their reintegration experiences and advocating for social change in their communities.

References


Acknowledgments

We wish to acknowledge the veterans and family caregivers who collaborated on this work with us and shared their stories, experiences, and perspectives because of a desire to learn more about themselves and to be of service to others. We would also like to thank our families and loved ones for their support of us and of this work. We acknowledge the important contributions of other research team members over the years, especially Traci Abraham, PhD, for her involvement in coding transcripts from photo-elicitation interviews, Mary Frances Ritchie, MPH, and Ryan Bender, MSW, who collected data, coded, and maintained communication with participants. We thank the anonymous reviewers for their helpful comments. The study was supported by VA HSR&D award IIR 14-399. Gala True also receives support from the South Central Mental Illness Research, Education, and Clinical Center (SC MIRECC). At the time of this research Sarah Ono was supported by the Center to Improve Veteran Involvement in Care (CIVIC).

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Motivations of Older Veterans and Dependents in a Physical Activity Program

Candace S. Brown, Ismail Mustafa Aijazuddin, and Miriam C. Morey

Abstract

Motivation to engage in physical activity (PA) is of research interest due to the United States’ failure to achieve significant gains in the rates of individuals meeting national PA recommended guidelines. Veterans have physical deficiencies at a greater rate than the general population, and older veterans (≥ 65 years) are the least physically active of all veteran cohorts. The purpose of this pilot study was to ascertain the motivations of older veterans participating in an ongoing exercise program supervised and supported by the Department of Veterans Affairs. Participants (N = 63) self-reported their preferred exercises within the program and completed the Motives for Physical Activity Measure–Revised (MPAM-R), which assessed their exercise motivations in terms of interest/enjoyment, fitness, appearance, social factors, and competence. The most performed aerobic activity was walking, and the most popular anaerobic activity was yoga. Mean results of the MPAM-R indicated fitness as the highest rated motivation (M = 6.53, SD = 1.1), with a strong desire among participants for veterans to maintain health and well-being. The lowest rated statements were those related to social factors (M = 4.96, SD = 1.8), specifically, spending time with others. Fitness was statistically significant to interest/enjoyment, competence, and appearance (p < .01) but not to social motivation. However, interviews (n = 4) with participants of 10+ years revealed social factors to be a strong motivator for long-term participation in the exercise program. Exploring participants’ motivations produces valuable information that may broadly impact the development of future exercise programs.

The benefits of physical activity (PA) are well established, but veterans’ motivations for engaging in PA are of research interest due to the United States’ failure to achieve significant gains in the rates of older veterans meeting national recommended PA guidelines over the past decade. Older veterans represent the largest segment of the veteran population (Amaral et al., 2018), and they are the least physically active of all veteran age cohorts (Pebole & Hall, 2019). The Centers for Disease Control and Prevention (CDC, 2020) recommends that all older adults (age 65 and older) complete between 75 and 300 minutes of PA per week, including both moderate-intensity and vigorous-intensity aerobic PA. For additional health benefits, the CDC encourages weekly muscle strengthening of all major muscle groups on two or more days. However, the most recent data available indicate that only 53.6% of U.S. older adults are achieving the recommended minutes of aerobic activity, and only 23.7% are carrying out the recommended muscle-strengthening exercises (CDC, 2020). Although veterans are generally more engaged in PA than civilians are (Bouldin & Reiber, 2012; Littman et al., 2009), they consistently report poorer health (Schult et al., 2019), with only 43.1% of veterans age 50 and older meeting the CDC’s recommendations (Littman et al., 2009). Following military discharge, many veterans adopt a more sedentary lifestyle that, coupled with the stress of returning to civilian life, increases their risk of becoming overweight or obese leading to concerningly high rates of disease and disability (Batch et al., 2020) that are likely to continue to increase as the population ages (Amaral et al., 2018; Dattilo et al., 2014).
Behavioral intervention research focused on group exercise has demonstrated to be an effective strategy for increasing PA and decreasing the number of sedentary veterans. These interventions and programs have evaluated the potential effects of PA on function (Bulat et al., 2007; Morey et al., 2002; Paden et al., 2017), post-traumatic stress disorder (Hall et al., 2016), and depression (Harada et al., 2013).

Team Red, White, and Blue, a nonprofit, veteran-led organization, establishes supportive relationships among civilians and veterans through physical and social activities. Bringing civilian community members together with veterans reintegration into civilian life allows space for veterans to strengthen their physical health through community social networks as opposed to veteran-exclusive networks (Angel et al., 2018).

The national evidence-based management program MOVE! was introduced by the Veterans Health Administration in 2006 to support self-management of diet and PA among veterans (Romanova et al., 2013). Thousands of veterans have participated in the program and various studies have explored its impact on veterans with mental illness (Goldberg et al., 2013; Harrold et al., 2018), post-traumatic stress disorder (Goldstein et al., 2018), and programs adjacent to MOVE! (Fletcher et al., 2017; Harrold et al., 2018; Rosenberger et al., 2011).

While the health benefits of these interventions have been established, less work has been done to understand the factors of motivation that compel veterans to join and remain in these exercise programs. Recent research focusing on the MOVE! program has highlighted motivation and the importance of the program's social impact on veterans. Participants' desires to improve both their health and their laboratory reports (e.g., their cholesterol numbers) served as intrinsic and extrinsic motivators, respectively, for losing weight. Participants indicated they were more successful in the program when they attended group classes more regularly as they had other veterans encouraging them to show up (Batch et al., 2020). The extension program MOVE OUT provided peer leaders for the veteran exercise program, and participants reported that camaraderie, commitment, and regular meeting times motivated them to stay in the program (Fletcher et al., 2017).

Motivation is defined as the internal and external factors that stimulate a person to initially direct and sustain action toward a goal (Brown, 2019). Because motivation drives intent toward a goal, this behavioral construct is key to understanding why older people engage in PA. Drawn from theoretical perspectives including social identity theory (Pelssers et al., 2018, 2019), economic theory (Farooqui et al., 2014), and personal investment theory (Sullivan et al., 2002), research indicates that older adults who participate in PA interventions have increased levels of autonomous motivation guided by their desire to be healthier. However, time, finances, weather, and the opportunity for participation in other activities can serve as barriers to continued PA once the interventions have ended (Van Roie et al., 2015).

Self-Determination Theory (SDT), a macro theory of human motivation, describes how both intrinsic and extrinsic motivations relate to psychological, physical, and social domains of life (Deci & Ryan, 2008). It examines the differential effects of personal choice and/or outside influence on individuals' motivation to engage in PA (Deci & Ryan, 2008; Teixeira et al., 2012). Because behavior is not always intrinsically motivated, certain external pressures (e.g., social factors) may motivate individuals to participate in PA. The purpose of this exploratory study was to find out what motivates veterans who participate in an ongoing VA exercise program.

Methods
Design
We used a dual-method design in which quantitative and qualitative data were collected and analyzed independently. This approach helped us to obtain different yet complementary data to answer the research questions. Quantitative and qualitative data are reported separately in the results and then merged in the discussion to give an overall interpretation of the findings.

Training Program
Established in 1986 at the Veterans Affairs Medical Center (VAMC) in Durham, North Carolina, Gerofit is an ongoing exercise intervention program for veterans age 65 and older (Peterson et al., 2004). Currently, there are 17 nationally recognized Gerofit locations that span the country from Miami, Florida, to Honolulu, Hawaii. Program enrollment occurs on a rolling basis. Before veterans can participate, their primary care providers must confirm their stable health and their ability to independently function physically and cognitively in a group setting. Occasionally, when participation has been
low, enrollment has been opened to veterans of any age. Spouses of veterans can also participate in the program if a current primary care physician confirms their independent physical and cognitive function.

Upon joining the program, participants undergo a physical function assessment that includes the 8-foot up-and-go and a 6-minute walk. In addition, body height, weight, and waist circumference are recorded, and veterans respond to a series of questionnaires that assess their overall health, quality of life, current levels of PA, and comorbidities and symptoms. Based on this information, participants receive an individually tailored exercise prescription that focuses on improving any identified functional impairments. The full assessment is repeated at the third and sixth month of the first year and then annually afterward to facilitate continuous updates and monitoring of the exercise program for as long as the veteran participates (Morey et al., 2006).

Supervised exercise sessions are offered three times a week, with session times divided into two groups that each comprise 60 to 75 participants. Exercise-health professionals lead group exercise classes (e.g., stretching and floor exercises) and monitor personalized aerobic (e.g., elliptical, treadmill) and muscle strengthening (e.g., free weights) activities. These exercises both help participants meet national PA guidelines and target their functional deficits as identified by the annual assessments. Sessions occur year-round, and veterans are encouraged to attend as often as possible. Veterans’ active status in the program is changed to inactive following two months of unexplained absence (Brown et al., 2019).

Gerofit’s mission is to promote physical exercise among older-adult veterans. Initially, the Durham branch of Gerofit held its classes at the Durham V AMC. However, due to space constraints at the medical center campus, the V AMC contracted with a local, private, community-based fitness gym to provide access to the program for as long as the veteran participates (Morey et al., 2006).

Data Collection
The Durham V AMC institutional review board reviewed and approved the protocol for this ancillary study annually (MIRB# 02021/0027). Gerofit staff invited veterans active in the program to participate in this study, and they informed prospective participants that the study included a 30-item survey. Once survey data collection was complete, Gerofit staff asked long-term participants if they would agree to an in-depth, follow-up interview. Only those who had been in the program for longer than 10 years at the start of the study were eligible to participate in this stage of the research. Purposive sampling was used to select participants for these semi-structured interviews.

All Gerofit participants provided written consent to have their clinical data entered into a research database for use in future investigations. Each interviewee consented to an audio recording and field notes of the face-to-face interview. The quantitative data were collected starting in 2017, and the qualitative data were collected in April 2018 following the quantitative data analysis. The quantitative data guided qualitative development of the semi-structured interview guide.

Measures
A demographic questionnaire captured self-identified information, including age, race, gender, and the exercises prescribed and executed on a weekly basis. Exercises were separated into individual activities—including the treadmill, weights, stationary bike, and recumbent stepper—and group activities—stretching or floor exercises, balance or dance class, and tai chi.

Motives of physical activity measure–revised (MPAM-R). The MPAM-R survey was used to assess the strength of five motives for exercise in physically active veterans. These motives
are described by the measure’s Appearance, Competence, Fitness, Interest/Enjoyment, and Social subscales. The Appearance subscale measures respondents’ motivation to stay physically active to maintain or improve their physical attractiveness, such as by developing defined muscles or achieving/maintaining a desired weight. The Competence subscale measures respondents’ desire to stay physically active to improve, meet a challenge, or learn a new skill. The Fitness subscale refers to wanting to be physically healthy, strong, and energetic. The Interest/Enjoyment subscale measures PA motives set to a Likert scale ranging from 1 (Not at all true for me) to 7 (Very true for me).

MPAM-R semi-structured interview guide. We used the newer approach to qualitative methods, survey transformation, to develop an interview guide (Brown et al., 2018). By transforming the statements of the MPAM-R we aimed to gain a more in-depth understanding of why veterans participate in the Gerofit exercise program. Interviewees first answered four questions related to their experience with exercise, the consistency of their past exercise regimen, the time they have spent in the current program, and their reasons for beginning the Gerofit program.

Survey transformation allows researchers to develop semistructured interview questions directly from surveys. This method saves time and resources, as it is not always feasible to develop a qualitative survey for a new population. The difference between the formative grounded theory approach, which is used to develop new surveys, and survey transformation, which transforms a valid survey into a qualitative guide, is that the transformation method retains the original scales and statements of the survey and thus takes into account the general implications already believed to exist within the concepts of the survey. The open-ended questions created through survey transformation allow respondents to provide a more in-depth explanations of their beliefs of the statements from the survey (Brown et al., 2018). In a full version of the transformation, all 30 statements from the MPAM-R would be categorized into their respective categories and 30 questions would be written. For this study, a modified version of survey transformation was performed, including four of the five original MPAM-R subscales (Interest/Enjoyment, Appearance, Competence, and Social). Twelve open-ended questions were developed to capture deeper explanations of participants’ motivations.

For example, the MPAM-R survey asks respondents about the degree to which they relate to certain social motives for exercise, including “being with friends,” “meeting new people,” “friends want me to,” and “enjoy spending time with others doing this activity.” To further understand these social motivations, this open-ended question was added to the interview guide: “Some people talk about exercise as being another way to connect with people and make friends. What role does exercise play in your social life or connecting you with others?” This semistructured question allowed the interviewer to explore social motives of interest and allowed interviewees to discuss issues that the interviewer may not have anticipated.

Analysis

Quantitative analysis. We used descriptive statistics to analyze the participant demographics (i.e., race/ethnicity, exercise modality) and means and standard deviations to report the MPAM-R results. Next, t tests between the Fitness subscale and the other subscales were conducted to compare means. The significance threshold was set at .05.

Qualitative analysis. We used a predominantly inductive thematic approach to analyze the qualitative data (Braun et al., 2017). The lead author conducted the interviews and transcribed the data. Pseudonyms were provided to help protect the identities of the participants. Codes were generated transcript by transcript; codes developed and applied to earlier transcripts were applied to subsequent transcripts, and earlier transcripts were revisited as new codes were generated. Themes were then identified and reviewed by rereading coded material and the full data set. Qualitative analyses were completed before the quantitative analyses to minimize interpretation biases.

Results

Quantitative Results

Of all participants (N = 63), 57 were men and six were women. Four of the six women were veteran dependents, one was a veteran, and one was a volunteer who had a long-standing relationship with the program. Participants self-identified as being Black/African American (n = 32) or
White/Caucasian \((n = 28)\). One participant identified as being more than one race, and two veterans identified as being part of the “human race.” The average age of the participants was 75; the youngest participant was 58 years old, and the oldest was 93 years old.

Because exercise is individually tailored, many participants engaged in more than one individual and/or group activity focused on aerobic and muscle strengthening activities. Based on participants’ self-reports, the most performed individual aerobic activity was walking or jogging \((n = 43)\) on the treadmill or outside (when weather permitted), and the least performed individual aerobic activity was using a recumbent bicycle \((n = 21)\). The group activity with the most participation was the stretching group exercise \((n = 26)\), and the dance class had the least participation \((n = 7)\), as seen in Table 1.

Response means for individual MPAM-R statements ranged from 3.66 to 6.86 with fitness and social statements ranked highest and lowest, respectively (Table 2). Specifically, participants rated motivation statements representing the

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<th>Table 1. Descriptive Metrics as Reported by Participants</th>
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<th>Number of participants by demographics</th>
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<tr>
<td>Race/ethnicity</td>
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<td>----------------</td>
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<tr>
<td>Black or African American</td>
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<tr>
<td>White</td>
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<tr>
<td>More than one race/ethnicity</td>
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<tr>
<td>Not reported</td>
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<tr>
<td>Total</td>
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*Note. Mean participant age was 75 years old, with a range of 58–93 years old.*

<table>
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<th>Number of participants by exercise modality</th>
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<tbody>
<tr>
<td>Individual exercises</td>
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<tr>
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<td>Walking/ jogging</td>
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<td>Weights</td>
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<td>Recumbent bike</td>
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desire to “maintain health and well-being” and “to have energy” as highest. While there is not a large disparity between the means for each subscale, the lowest rated statements were those related to social motivation, indicating that participants were not motivated to exercise to “[spend] time with others” or “because friends wanted [them] to be physically active.”

To determine the statistical significance of the relationship between the Fitness subscale and the other subscales, a one-tailed paired t test was performed. Results indicated no statistical significance between the Fitness and Social subscales ($t[4] = 2.4, p = .02$); however, there was significance with Interest/Enjoyment, Competence, and Appearance ($p < .01$), providing strong evidence that the population means are different (Table 3).

Qualitative Results

Four participants who had been in the program for more than 10 years were interviewed to gain a more in-depth understanding of how motivations influenced their long-term participation. Since the results of the MPAM-R indicated fitness as the highest motivation quantitatively, questions for the interview guide were directed toward themes of competence, appearance, interest/enjoyment, and social motivations. The interviewees included two White veteran participants, interviewed separately, and a Black couple (a male veteran and his wife) who were interviewed together. We audio-recorded the interviews to keep verbatim accounts and took field notes during the interviews to assist in formulating relevant follow-up questions in the moment (Galli, 2009). The recorded interviews were transcribed, and out of 21 codes, two main themes were gleaned.

Maintaining health and wellness was a primary motivation to begin the Gerofit program. All the interviewees had previous experiences with exercise, ranging from jogging, hunting, playing semipro baseball, and being part of other gyms to doing home workouts with Jack LaLanne. The interviewees had all learned about the Gerofit program (i.e., from other physicians or other veterans) at a time in their lives when they were not active, and the idea of participating was desirable. Chris joined the program because of physical issues, stating, “I had been going to VA about my knees and the doctor here recommended Gerofit… I’ve been there ever since.” Sam gave his account of joining the program, stating, “I had a friend [and] he thought it was an excellent program. He said it was a ‘good way to exercise instead of sitting around and feeling sorry for yourself.’” It was not difficult to convince Sam’s wife, Sarah, to join the

<table>
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<tr>
<th>Subscales</th>
<th>Number of questions</th>
<th>$M$ (SD) total</th>
<th>Highest rated statement</th>
<th>$M$ (SD) highest</th>
<th>Lowest rated statement</th>
<th>$M$ (SD) lowest</th>
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<tr>
<td>Fitness</td>
<td>5</td>
<td>6.54 (1.1)</td>
<td>Maintain health and well-being</td>
<td>6.66 (1.0)</td>
<td>To have more energy</td>
<td>6.41 (1.1)</td>
</tr>
<tr>
<td>Interest/Enjoyment</td>
<td>7</td>
<td>5.75 (1.4)</td>
<td>Enjoy this activity</td>
<td>6.04 (1.3)</td>
<td>It’s interesting</td>
<td>5.20 (1.7)</td>
</tr>
<tr>
<td>Competence</td>
<td>7</td>
<td>5.61 (1.5)</td>
<td>Keep up current skill level</td>
<td>5.98 (1.4)</td>
<td>Want to obtain new skills</td>
<td>4.76 (1.9)</td>
</tr>
<tr>
<td>Appearance</td>
<td>6</td>
<td>5.17 (1.9)</td>
<td>Lose or maintain weight so I look better</td>
<td>5.88 (1.6)</td>
<td>Feel physically unattractive if I don’t</td>
<td>3.96 (2.0)</td>
</tr>
<tr>
<td>Social</td>
<td>5</td>
<td>4.97 (1.8)</td>
<td>Enjoy spending time with others</td>
<td>5.79 (1.5)</td>
<td>Friends want me to</td>
<td>3.06 (1.9)</td>
</tr>
</tbody>
</table>

Table 2. MPAM-R Results of Veterans
program when it opened up to spouses because she “was already interested in exercise.”

While fitness was the main reason why participants began the program, social interaction was a key motivator for interviewees continued and/or long-term participation. When asked about competence and interest/enjoyment motivations, participants responded with explanations related to social motivation. When describing what he had learned through participation in the program (competence), Sam answered:

I realize that if you participate you develop a circle of friends. It’s not just exercising, it’s a way to socialize. You develop a circle of friends. It’s a way of socializing and I think that’s what keeps a lot of people coming back—the camaraderies.


The interviewees were also asked specifically what they enjoyed about exercising. For Sarah, it was “the way y’all reach out.” She gave a lot of credit to the program director, who consistently reached out to follow up with participants. She continued, “The special holidays [are important]. We are not just coming to exercise. When somebody is missing, we know. We all feel like family.” Sam followed up by reiterating how being around a certain type of people is what makes the difference, saying, “I enjoy all of it—the activities and the socializing. And the relationship I maintain with the staff. I like all of it.”

The question of how the program helped participants stay connected (related to social motivation) elicited an unexpected answer from James. He said that he did not know if the program helped spouses and thought that it was an unnecessary expense to allow them to join. His point of view was based on personal experience; he noted that his wife “was in it for a while…I don’t know why she didn’t like it,” and he attributed her decision to leave to her inability to successfully perform some of the exercises. However, Sarah, the spouse of a veteran and a current participant, said that she looks forward to the program because she knows, “I’m going to see certain people…After I miss Mike, after several days I have an attitude, [I’m] more cranky.”

The interviewees all believed that their continued engagement in the program had a big impact on their health and wellness. They enjoyed the camaraderie and the opportunity to learn relatable health information from another, which added to their social interactions. Sarah also spoke of how important it was for her to be welcomed by the veterans. She suggested that the program’s social and physical aspects were equal, stating, “You can’t separate the two. Both are cherished.”

**Discussion**

The benefits of exercise are well known, and to increase the number of active older veterans, the Department of Veterans Affairs (VA) offers various exercise programs. While information has been reported regarding the barriers (Pebole & Hall, 2019), facilitators (Hoerster et al., 2015), and self-efficacy (Brown et al., 2019) of exercise among older veterans in various VA programs, previous research has not addressed their motivations for participation. To our knowledge, we are the first to explicitly collect primary data on the motivations of older veterans who participate in the VA exercise intervention program Gerofit.

### Table 3. Fitness MPAM-R Subscales t Tests

<table>
<thead>
<tr>
<th>Subscale</th>
<th>t(df)</th>
<th>t stat</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest/Enjoyment</td>
<td>7</td>
<td>4.62</td>
<td>.001</td>
</tr>
<tr>
<td>Competence</td>
<td>8</td>
<td>4.16</td>
<td>.001</td>
</tr>
<tr>
<td>Appearance</td>
<td>7</td>
<td>4.44</td>
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</tr>
<tr>
<td>Social</td>
<td>6</td>
<td>2.44</td>
<td>.02</td>
</tr>
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</table>
According to our quantitative analysis, fitness (mean = 6.54) was the most noted motivation in both surveys and interviews. This was not a surprise, considering that most people who choose to participate in exercise programs do so because they have a vested interest in sustaining their physical health (Etnier et al., 2017). Extrinsic motivations can be self-directed or other-directed and are dependent on the attainment of extrinsic outcomes for maintenance. In this study, fitness was considered an extrinsic motivation because the veterans were exercising for outcomes (e.g., to have more energy) apart from participation itself (Ryan et al., 1997). However, the overall results for the Interest/Enjoyment subscale indicated that exercise and the purpose of the program also promoted intrinsic motivation (Deci & Ryan, 2008).

An innovation of our study was the survey transformation (Brown et al., 2018) of the MPAM-R, which expanded our understanding of some of the participants’ personal views on motivation. Social factors were the least likely to be indicated as motivators on the survey. When the questions from the MPAM-R were asked aloud, however, qualitative results confirmed that social factors (e.g., social support, reinforcement) provided extrinsic motivation and were important to the long-term participants of the exercise program. This is consistent with other findings from the literature that note the importance of social motives for exercise among civilians (Etnier et al., 2017; Rivera-Torres et al., 2019).

Regarding the development of future VA programming that promotes long-term exercise, our results suggest that a program may attract continuous participation if it is built around both fitness and social aspects that are important to the participants. Social motivation cannot be forced, but opportunities for organic social processes that promote camaraderie may allow for more social interaction and, thus, motivation. An inability to connect with others may support why James’s wife did not continue the program who was primarily concerned with fitness but unsuccessful at developing social connections. Exemplifying the organic social motivation that grew out of Gerofit, a group of five program participants regularly visited McDonald’s for breakfast after working out. Chris said, “I was in Gerofit, being a loner, minding my own business, and [a member] here asked if I wanted to come to McDonald’s... and we’ve been coming to McDonald’s ever since.” Although people may begin an exercise intervention program because of their interest in changing their current health or fitness status, our data suggests that it may be the additional connection, found through social motivation (i.e., camaraderie), that is associated with continuous participation.

In sum, the results from this study indicate that veterans’ high levels of extrinsic motivation to participate in Gerofit were driven by fitness, maintenance of their health and well-being, and the social opportunity to spend time with others. The highest rated intrinsic motivation (second overall) was interest/enjoyment, indicating that future research is needed to test how these and the other collected motivations (i.e., competence, appearance) may influence participation rates in group exercise programs aimed at older adults. Additionally, since the current study was limited in its number of participants (both men and women), its results cannot be generalized to the general population. With the increased number of Gerofit programs around the country, an expanded research agenda may be feasible. Using convenience recruitment methods to target participants, we could assess differences in participation rates based on program descriptions (as they differ) and locations. Environment has been shown to play a part in self-efficacy as it relates to participating in Gerofit (Brown et al., 2019), it and would likely have a direct effect on motivation. Filling gaps in knowledge by exploring the motivations of exercise program participants will produce valuable information that may help those who design exercise programs retain participants for a longer number of years.

References


About the Authors
Candace S. Brown, PhD, is an assistant professor at the University North Carolina, Charlotte and research collaborator with the Motivated Cognition and Aging Brain Lab at Duke University. She is a Navy veteran whose research focuses on understanding the motivation to exercise among aging adults. Ismail Aijazuddin is a Duke University graduate and an incoming MD candidate at the Wayne State University School of Medicine in Detroit, MI. Miriam C. Morey, PhD, is the Associate Director of Research of the Durham VA Geriatric, Research, Education and Clinical Center (GRECC) and a professor of medicine at Duke University School of Medicine. She directs the national implementation of the VA Gerofit exercise program which has been declared a VA Best Practice.
Creating Community for Women Veterans Through Social Networking Organizations: A Secondary Analysis of Team Red, White, and Blue New Member Surveys

Kate Hendricks Thomas, Caroline M. Angel, Nicholas J. Armstrong, Michael S. Erwin, Louis P. Nemec, Brandon B. Young, John M. Pinter, Blayne P. Smith, and Justin T. McDaniel

Abstract

In an effort to better understand mental health and enrichment differences between veteran women and men in a veteran service organization (VSO), a research team conducted secondary analysis of assessment data from Team Red, White, and Blue (Team RWB) veteran members who joined between 2014 and 2016. In this secondary analysis of the 2014–2016 Team RWB initial member survey data, frequencies and crosstab analyses were conducted for veteran respondents (N = 10,015), a portion of whom (31.5%) identified as former servicewomen (n = 3,152). Women were statistically overrepresented by a factor of 2–3 times in organizational membership. Gender-correlated differences were found with levels of enrichment; at baseline, women reported lower levels of social support as described by the subcategory of belonging (p < .001) and lower levels of sense of purpose as measured by two subcategories (p < .002 and p = .03). Primary findings from this study indicate an opportunity for future research on mental health and enrichment when a member joins a service or social networking organization. Lower levels of mental health and enrichment among new Team RWB members who are female veterans indicates an opportunity for the organization to actively focus programs and resources on this fast-growing subpopulation of veterans to enhance retention and the overall participant experience.

In the United States, veterans experience higher rates of mental health concerns than do nonveterans (Wilcox et al., 2013). A major issue affecting transitioning veterans’ mental health outcomes is the process of community reintegration during departure from active service (Thomas & Plummer Taylor, 2015). Transition is a challenging time for military personnel, many of whom self-report significant issues as they leave active duty to resume civilian life (Demers, 2011; Pease et al., 2016). A strong body of literature supports such self-reported data (Friedman, 2015), with much of the research focusing on mental health outcomes and the issues that often occur alongside mental health challenges, such as substance misuse, suicide, employment challenges, family disruption, and other psychosocial impairments (Thomas, Turner et al., 2015).

Suicide Risk

Careful study of suicide risk in the veteran population shows that suicide risk is almost four times higher among young veterans than it is among their peers in the general population, a difference made more statistically significant when analysis controls for age and time in service (Bossarte, 2013). Internationally, numbers indicate the same. A British study of recent combat veterans found the risk of suicide to be 2–3 times higher for former military members than for the general population, with the year immediately following discharge being a particularly risky time (Ilgen et al., 2012). These mental and social health challenges are found both globally and across regions in the United States, with research indicating an intimate connection between social well-being and mental health (Thomas & Albright, 2018). In a time of transition, veterans may experience struggles with finding a sense of purpose, both individual and shared, and can have difficulty relating even to well-meaning loved ones who have not “been there” or shared similar experiences (Hoge, 2010; Thomas & Plummer Taylor, 2015).

Social Cohesion

Veterans of all backgrounds report difficulty with social cohesion–related behaviors. Such behaviors, including awareness and communication of personal feelings, staying in close communication with friends and family,
connecting easily with civilians, acquiring and maintaining a job, and practicing self-care, promote well-being and protect against adverse mental health outcomes (Hoge, 2010; Jakupcak et al., 2007). After separation from the military, rates of interpersonal conflict increase, as do maladaptive coping techniques that can create behavioral health issues (Murray, 2013).

**Gender**

Gender is a potential demographic risk factor for anxiety, depression, and substance misuse (Ramchand et al., 2015; Thomas et al., 2016). Women constitute approximately 15% of the armed services (Murdoch et al., 2006) and represent the fastest growing segment of the veteran population (Carlson et al., 2013). Meeting and addressing the needs of female veterans, particularly when they are leaving active duty or returning from deployment, is important because of their increased risk for adverse health outcomes (Levahot & Simpson, 2013). In general, female veterans are more likely than their male counterparts to report mental health concerns such as post-traumatic stress (PTS), depression, and suicidal thoughts (Duhart, 2012; Koo & Maguen, 2014), and they use mental health services at higher rates than men (Albright et al., 2017). They also report higher percentages of adverse experiences while serving; specifically, servicewomen commonly experience feelings of alienation and decreased unit cohesion (Washington & Yano, 2013). Additionally, disproportionately high rates of female servicemembers (20–40%) experience military sexual trauma (MST) such as unwanted sexual advances, harassment, or assault, though this issue is still understudied and underreported (Kelly et al., 2011). For institutional, social, and cultural reasons, female, racial- and ethnic-minority, and sexual-minority veterans have higher rates of poor outcomes related to reintegration (Pelts & Albright, 2015; Wilcox et al., 2013).

**Community Engagement**

The literature indicates that interventions working to increase social connections and facilitate the cultivation of resource networks among veterans offer protective effects against isolation, loneliness, mental and physical health problems, and suicidality (Bossarte, 2013), but women veterans take advantage of such programming at lower rates than their male peers do (Thomas et al., 2017). However, military-connected women are numerically overrepresented in the membership numbers of some types of civic organizations (in comparison to their representation in the military), suggesting unique opportunities to reach this at-risk population. For these reasons, outreach to servicewomen is uniquely important to veteran service organizations (VSOs) like Team Red, White, and Blue (RWB), where servicewomen (active duty as well as guard, reserve, and veteran) comprise a third of new registrants.

**Team RWB**

Team RWB is a 501(c) nonprofit with the mission of enriching veterans’ lives by connecting them to their community through physical and social activity; it was founded to meet a perceived gap in military transition services (Angel & Armstrong, 2016). Since its inception in 2010, Team RWB has grown to over 200 locations and 195,000 members, representing an intergenerational community of 75% veterans or active duty servicemembers and 25% civilians (Team Red, White, and Blue [Team RWB], 2019). Team RWB offers a range of local, consistent, and inclusive activities to military-connected personnel and civilian community members in an effort to provide routine opportunities for veterans to engage with each other and their mostly civilian communities (Angel, Smith, et al., 2018). Some examples of Team RWB outreach activities include social events that invite families and members to get to know one another around a leisure activity, gatherings centered around a fitness activity, and even leadership camps designed to pull members together in retreat-like settings. The purpose is always to forge strong social ties. The organization has a wide reach geographically, and in 2018, Team RWB sponsored a total of 29,100 physical events, 6,049 social events, and 3,247 service events (Team RWB, 2019). In late 2019, TeamRWB rolled out a mobile app and added opportunities for members to engage in virtual events.

Team RWB works to operationalize its stated mission to “enrich lives.” In 2013, Team RWB defined enrichment as “quality relationships and experiences that contribute to life satisfaction and overall wellbeing” (Angel et al., 2018). As such, early assessments of member “enrichment” focused on social support (Cohen, 2004), satisfaction with life (Diener et al., 1985), and sense of shared purpose (Lynn, 2014). In subsequent years, Team RWB developed the “Enrichment Equation,” which describes an enriched life as an ideal combination...
of health ("health"), genuine relationships ("people"), and sense of individual and shared purpose ("purpose"; Angel et al., 2020). Consistent with a trend toward asset-based approaches to promoting well-being in military-connected populations (Thomas, Plummer Taylor, et al., 2015), the Enrichment Equation conceives of and measures welfare in terms of physical and mental health, social engagement, and sense of purpose (Angel, Smith, et al., 2018; Angel, Woldetsadik, et al., 2020; Jeste et al., 2015). Growing evidence that resilience is the predominant response to military service supports this approach (Angel, 2016; Tedeschi & Calhoun, 1996; Thomas & Plummer Taylor, 2015). Viewing reintegration solely through the limited lens of adverse outcomes limits program efficacy (Angel & Armstrong, 2016; Kobau et al., 2011).

Methods

Study Purpose

Each year since Team RWB’s inception, thousands of male and female veterans have signed up to join the organization. The purpose of this study is to explore differences in mental health (as measured by self-reported feelings of anxiety or depression) and levels of enrichment (as measured by social support, sense of purpose, and satisfaction with life) between veteran men and women who self-select participation in Team RWB at initial sign-up between 2014 and 2016. This analysis of differences in baseline levels of mental health and enrichment was conducted in hopes of tailoring future programming and communication efforts.

Study Design

The present study analyzed new member sign-up survey data gathered from 2014 to 2016. Specifically, this research sought to answer two primary questions:

1. Do differences in levels of baseline mental health exist between veteran men and women who self-select participation in Team RWB at initial sign-up?
2. Do differences in levels of baseline enrichment exist between veteran women and men who self-select participation in Team RWB at initial sign-up?

The study protocol was submitted to the institutional review board of Syracuse University for review. Because the proposed analyses were secondary in nature and did not involve contact with human subjects, this study received exemption from the review process.

An interdisciplinary research team began a secondary analysis of the data in September 2017. The purposes of the present study are (a) to examine demographic differences in new members by gender and service era, (b) to examine gender differences in veterans' self-reported mental health (anxious and depressed mood) upon joining Team RWB, and (c) to examine gender differences in veterans' enrichment levels (measured by social support, purpose, and satisfaction with life) upon joining Team RWB.

Measures

In 2014, Team RWB staff began to conduct initial accession assessments for new registrants to support organizational aims. Organizational leadership and the research team designed the instrument and conducted initial reviews with subject matter experts. After finalizing the instrument, the team formatted it using SurveyMonkey software. The resulting SurveyMonkey assessment was then pilot tested to determine its completion time and overall functionality. Using information from the pilot test, a format for the instrument was finalized for use with new members.

Data for this study were originally collected beginning in December 2014. Military-connected members signing up to join the organization completed an informational survey, incentivized by the opportunity to receive a free Team RWB shirt. In addition to incentivizing survey completion, providing a T-shirt to new members immediately gave them a visual marker of team membership, regardless of whether they could participate in a local chapter on a daily basis. The purpose of the survey was to gather baseline information about new members. At the close and completion of the survey, all data were de-identified and collected in aggregate to protect respondents’ privacy.

Since 2016, the organizational leadership team has revised the survey several times to collect different enrichment data. These changes reflected an organizational interest in a new core concept of enrichment as a program outcome and resulted in a very different new-member assessment survey. For the purposes of consistent reporting, the data source for the present study includes only responses from December 2014 to August 2016 (Angel & Armstrong, 2016).
Procedures

The sampling time frame for the current study was between December 14, 2014, and August 2, 2016. During this period, approximately 37,229 individuals, including active duty servicemembers, National Guard or reserve personnel, and military veterans, signed up to join Team RWB. Of these individuals, 19,443 completed the online questionnaire implemented through SurveyMonkey (a response rate of 52%). A limiting feature of the reported response rate involves a record-keeping gap in total sign-up numbers; data on the total number of new members joining was missing for the two-week period between December 14, 2014, and December 31, 2014.

For the present study, 225 respondents who self-identified as never having served in the military were dropped from the analyzed sample, yielding a resulting sample size of 19,218 new Team RWB sign-ups. Additionally, new members who were in the Guard or Reserves or still on active duty were removed to isolate veteran respondents only (N = 10,015). Service-connected women veterans represented 31.5% of that sample. This percentage is significantly higher than national estimates, which indicate that women comprise 10% of the American veteran population (U.S. Department of Veterans Affairs, 2017).

Study Variables

Covariates

Variables were chosen to highlight possible differences in service era, mental health, and enrichment levels of new team members (based upon the definition of “enrichment” and measurement items that existed in 2014). Researchers were specifically looking for gender-correlated differences that may predict an intention to join Team RWB in veteran men and women. Mental health indicators included questions meant to detect the presence of possible feelings of anxiety or depression. Enrichment indicators included questions meant to ascertain respondents’ self-reported perceptions of social support, purpose, and life satisfaction levels.

Age

Because Department of Defense personnel numbers indicate that most servicemembers fall within a given demographic age range, veterans were grouped into service eras based on their ages. (Defense Manpower Data Center, 2012). Recoding age involved taking the survey’s continuous age variable and categorizing it. Veterans who served in the most recent conflicts in Iraq and Afghanistan are those between the ages of 18–34 and were coded Operations Enduring Freedom and Iraqi Freedom (OEF/OIF). This age range also includes veterans who served during Operation New Dawn, the American operations in Iraq after 2010. Respondents between the ages of 35–55 were coded to the Gulf War category, while veterans age 55 and older were assigned to the Vietnam and Korean War era (Thomas, Turner, et al., 2015). Veterans of a given era often report having similar experiences that are affected heavily by the conflict that dominated their time in service and the government resources and policies prevalent during their service and reintegration period (U.S. Bureau of Labor Statistics, 2017).

Mental Health: Anxiety

Symptom overlap between depressive conditions and anxiety, including stress injuries, often leads to misdiagnosis or confusion about co-occurring conditions (Hoge & Castro, 2012; U.S. Department of Veterans Affairs, 2017). Self-reporting is useful for indicating the presence of a possible anxiety condition, the symptoms of which include anxious mood, nervousness, or being “on edge” (Hoge, 2010). A survey item derived from the Patient Health Questionnaire–4 (PHQ-4), a four-item measure of anxiety and depression (Kroenke et al., 2009), asked for a Likert scale response on a 5-point scale ranging from strongly disagree to strongly agree to the following question: “In the past month, I have felt nervous, anxious, or on edge.” To code the variable for analysis, respondents who answered agree or strongly agree were characterized as self-reporting noticeable feelings of potential anxiety. Respondents who answered disagree or strongly disagree were coded as reporting a low level of anxiety. For descriptive analyses, neutral responses were coded as neutral.

Mental Health: Depression

Self-reported symptoms are commonly used to diagnose depression in clinical settings (Martin et al., 2006). A survey question specifically asking respondents whether they had felt down or depressed in the last month, also from the PHQ-4 (Kroenke et al., 2009), was coded to indicate that respondents who chose agree or strongly agree were displaying a possible depressed mood, and those who chose disagree or strongly disagree were not exhibiting symptoms of depressed mood/feelings. For descriptive analyses, neutral responses were coded as neutral. Although depression symptoms
are varied and present differently in each individual, perception of overall poor mental health is a useful indication of the condition (Mayo Clinic, 2018).

Enrichment: Social Support

Several survey questions asked about people and resources that contribute to veterans’ perceived social support levels. Social relationships play an important role in promoting better health and alleviating symptoms of diseases (Rankin, 2013). While not all kinds of social interactions produce such health benefits, close friendships and partnerships are considered reliable indicators of social support (Cohen et al., 2000). Survey questions asked for Likert scale responses to the following items on a 5-point scale ranging from strongly disagree to strongly agree: “I feel a sense of brotherhood/sisterhood in my life,” “I have people I can turn to for information,” and “I have people I can turn to for resources.” To code the variables for analysis, respondents who answered agree or strongly agree were characterized as self-reporting high levels of belonging, social support, or resources. Respondents who answered disagree or strongly disagree were coded as reporting low levels of the same. For descriptive analyses, neutral responses were coded as neutral.

Enrichment: Purpose

Self-reporting high levels of purpose has been shown to be a protective factor against mental illness in military populations (Malmin, 2013; Thomas, Turner et al., 2015). Survey questions asked for Likert scale responses to the following items on a 5-point scale ranging from strongly disagree to strongly agree: “I feel a part of something bigger than myself” and “I have opportunities to inspire.” To code the variables for analysis, respondents who answered agree or strongly agree were characterized as self-reporting a high level of purpose. Respondents who answered disagree or strongly disagree were coded as reporting a low level of purpose. For descriptive analyses, neutral responses were coded as neutral.

Enrichment: Satisfaction with Life

Satisfaction with life is important to well-being and has been well studied as it relates to optimized mental health (Hoge, 2010; Rankin, 2013). Survey questions asked for a Likert scale response to the statement “I am satisfied with my life” (quality of life) on a 5-point scale ranging from strongly disagree to strongly agree. To code the variable for analysis, respondents who answered agree or strongly agree were characterized as self-reporting a high level of satisfaction with life. Respondents who answered disagree or strongly disagree were coded as reporting a low level of satisfaction with life. Neutral responses were coded as neutral.

Data Analysis

All data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 23 for Windows. Descriptive statistics—that is, percentages—were generated in SPSS for the demographic variables of gender and service era and for the dependent variables measuring mental health and enrichment. After dropping neutral responses to create dichotomous variables, crosstab analyses checked for the practical significance of the independent variable (gender) on dependent variables in order to provide macro-level practical significance information (Hosmer & Lemeshow, 2000). The dependent variables used to indicate baseline mental health included measures of feelings of anxiety and depression, and the variables used to indicate baseline enrichment levels included measures of social support, purpose, and satisfaction with life. Odds ratios, which provide an estimate of the association between categorical/binary variables in logistic regression analysis, were assessed for statistical significance with 95% confidence intervals (Szumilas, 2010), with significance levels set a priori at p < .05 (Chatterjee & Siminoff, 2012). The chi-square test, \( \chi^2 \), was used to assess model significance (Hosmer et al., 1991).

Results

Descriptive statistics were calculated for veteran service era, mediated by gender (see Table 1).

Of Team RWB’s 10,015 veteran respondents, 31.5% were women \((n = 3,152)\). Of the survey participants who answered the age question \((male n = 6,783, female n = 3,137)\), 28.0% of responding women served or were serving during the OEF/OIF era, 63.4% served during the Gulf War era, and 8.5% served during the Vietnam and Korean War era. Of responding men, 24.5% served or were serving during the OEF/OIF era, 61.1% served during the Gulf War era, and 14.4% served during the Vietnam and Korean War era.

A higher percentage of women than of men signing up for Team RWB reported poor mental health and low levels of the three examined enrichment variables (by subcategory) at baseline (see Table 3).
Crosstabs with chi-square tests of independence then further explored gender-correlated linkages between these two mental health and three enrichment variables in respondents. Specifically, univariate logistic regression analysis explored effect size linkages between the two mental health and three enrichment variables in male and female veteran respondents to see if baseline levels upon joining differ by gender.

Differences in male and female veterans’ responses to the mental health outcome measures (anxious mood/depression symptoms) were not statistically significant. Both male and female respondents self-reported symptoms of anxiety and depression, however. Of new members, 47.1% of men and 45.4% of women joined the organization with generalized symptoms of anxiety, and 32.1% of men and 31.4% of women joined with symptoms indicating possible depression. These prevalence data are interesting when considering the work of researchers who think that indicators of depression (such as black-and-white thinking, perfectionist standards and mental rigidity, 

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mental health</th>
<th>Social support</th>
<th>Purpose</th>
<th>Satisfaction</th>
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<tr>
<td>Anxiety</td>
<td>9,973</td>
<td>9,979</td>
<td>9,982</td>
<td>9,981</td>
</tr>
<tr>
<td>Depression</td>
<td>9,973</td>
<td>9,979</td>
<td>9,982</td>
<td>9,981</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>Male n</th>
<th>Male %</th>
<th>Female n</th>
<th>Female %</th>
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</thead>
<tbody>
<tr>
<td>Total sample of veteran members</td>
<td>6,863</td>
<td>68.5</td>
<td>3,152</td>
<td>31.5</td>
<td>10,015</td>
</tr>
<tr>
<td>Service era</td>
<td>9,920</td>
<td></td>
<td>5,781</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OIF/OEF</td>
<td>1,662</td>
<td>24.5</td>
<td>879</td>
<td>28.0</td>
<td>3,137</td>
</tr>
<tr>
<td>Gulf</td>
<td>4,147</td>
<td>61.1</td>
<td>1,990</td>
<td>63.4</td>
<td>6,137</td>
</tr>
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<td>Vietnam/Korea</td>
<td>974</td>
<td>14.4</td>
<td>268</td>
<td>8.5</td>
<td>1,242</td>
</tr>
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</table>

**Table 1.** Summary of Frequency Statistics for Sample of New Veteran

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Low %</th>
<th>Neutral %</th>
<th>High %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>9,973</td>
<td>35.7</td>
<td>17.7</td>
<td>46.6</td>
</tr>
<tr>
<td>Depression</td>
<td>9,973</td>
<td>31.8</td>
<td>19.2</td>
<td>49.0</td>
</tr>
<tr>
<td>Social support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel a sense of brotherhood/sisterhood in my life.</td>
<td>9,979</td>
<td>63.9</td>
<td>19.9</td>
<td>16.2</td>
</tr>
<tr>
<td>I have people I can turn to for information.</td>
<td>9,982</td>
<td>81.3</td>
<td>11.3</td>
<td>7.4</td>
</tr>
<tr>
<td>I have people I can turn to for resources.</td>
<td>9,967</td>
<td>72.5</td>
<td>17.8</td>
<td>9.7</td>
</tr>
<tr>
<td>Purpose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel part of something bigger than myself.</td>
<td>9,977</td>
<td>63.2</td>
<td>20.8</td>
<td>16.0</td>
</tr>
<tr>
<td>I have opportunities to inspire.</td>
<td>9,980</td>
<td>72.5</td>
<td>17.2</td>
<td>10.2</td>
</tr>
<tr>
<td>Satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with my life.</td>
<td>9,981</td>
<td>63.7</td>
<td>21.4</td>
<td>15.0</td>
</tr>
</tbody>
</table>

**Table 2.** Summary of Mental Health and Enrichment Levels by Variable for All Veterans (N = 10,015)
<table>
<thead>
<tr>
<th>Variable</th>
<th>Male $n$</th>
<th>Low %</th>
<th>Neutral %</th>
<th>High %</th>
<th>Female $n$</th>
<th>Low %</th>
<th>Neutral %</th>
<th>High %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>6,834</td>
<td>35.1</td>
<td>17.7</td>
<td>47.1</td>
<td>3,139</td>
<td>37.1</td>
<td>17.6</td>
<td>45.4</td>
</tr>
<tr>
<td>Depression</td>
<td>6,833</td>
<td>48.5</td>
<td>19.5</td>
<td>32.1</td>
<td>3,140</td>
<td>50.2</td>
<td>18.5</td>
<td>31.4</td>
</tr>
<tr>
<td><strong>Social support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel a sense of brotherhood/sisterhood in my life.</td>
<td>6,837</td>
<td>15.4</td>
<td>18.9</td>
<td>65.8</td>
<td>3,142</td>
<td>18.0</td>
<td>22.1</td>
<td>68.5</td>
</tr>
<tr>
<td>I have people I can turn to for information.</td>
<td>6,840</td>
<td>7.1</td>
<td>11.2</td>
<td>81.7</td>
<td>3,142</td>
<td>8.1</td>
<td>11.4</td>
<td>80.5</td>
</tr>
<tr>
<td>I have people I can turn to for resources.</td>
<td>6,828</td>
<td>9.4</td>
<td>18.0</td>
<td>72.7</td>
<td>3,139</td>
<td>10.3</td>
<td>17.6</td>
<td>72.1</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel part of something bigger than myself.</td>
<td>6,835</td>
<td>15.3</td>
<td>20.5</td>
<td>64.2</td>
<td>3,142</td>
<td>17.4</td>
<td>21.6</td>
<td>61</td>
</tr>
<tr>
<td>I have opportunities to inspire.</td>
<td>6,832</td>
<td>9.8</td>
<td>17.0</td>
<td>73.1</td>
<td>3,148</td>
<td>11.1</td>
<td>17.7</td>
<td>71.3</td>
</tr>
<tr>
<td><strong>Satisfaction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am satisfied with my life.</td>
<td>6,843</td>
<td>15.5</td>
<td>21.0</td>
<td>63.5</td>
<td>3,138</td>
<td>13.9</td>
<td>22.1</td>
<td>64.0</td>
</tr>
</tbody>
</table>
emotional suppression, and an overdeveloped sense of responsibility) are actually inculcated during military service and may contribute to postservice mental health issues (Whelan, 2016).

For the outcome variable of social support, with a p value equal to or greater than .05, gender was not statistically significant in the subcategories indicating that respondents have access to people who provide information (p = .05) or who provide resources (p = .166). The relationship between gender and social support as indicated by feelings of brotherhood or sisterhood was statistically significant (p < .001), however, as was gender’s relationship with each purpose subcategory. The correlation of gender with variable subcategories indicating purpose through connection to something greater than self (p < .002) and through the existence of opportunities to inspire others (p = .03) were statistically significant (p < .05). With an alpha level greater than .05, the variable of satisfaction with life lacked significance.

Though gender was statistically significant in social support’s brotherhood/sisterhood subcategory and in purpose models, it was not a predictor at practically significant levels, meaning important to the individual in terms of effect (odds ratios of 1.5 or higher). However, belonging was likely to be lower for new female members, with odds ratios of 1.2 for the brotherhood/sisterhood category (see Table 4).

Discussion

Across male and female veterans, men represented a majority of sign-ups. However, women signed up at a higher rate than they are represented in the military, a finding consistent with current Team RWB new-member data. The veteran women who joined Team RWB between 2014 and 2016 were more likely to be younger members of the Gulf War and OIF/OEF/Operation New Dawn service eras. Many veterans who joined Team RWB during these years self-reported the presence of mental health symptoms. Though not all gender differences were significant in the present study, overall percentages of new members with possible depressed mood (49.0% of new veteran members) and anxious mood (46.6% of new veteran members) were noteworthy (Whelan, 2016). This finding does not represent a clinical diagnosis of depression or anxiety, as the nonprofit-created, PHQ-4-inspired assessment items are limited without substantial psychometric validation. However, such high reports of feelings of depression and anxiety warrant further organizational attention and research. These results are not surprising. Rates of poor mental health outcomes vary wildly, but they are known to be an issue among the veteran population; many of the behaviors and mindsets that are adaptive in the service environment are less functional in the civilian sector (Hoge, 2010; Whelan, 2016).

Results of the present study indicate that while veteran women self-selected joining Team RWB at rates higher than their overall proportion of the veteran population, they were also more likely to have slightly lower levels of enrichment at the time they entered the program. Veteran women exhibited lower levels of social support and a lower sense of purpose—both of which contribute to enrichment—than veteran men. The brotherhood/sisterhood subcategory of social support indicates respondents’ sense of belonging. The purpose variables indicate respondents’ sense of connectedness and the self-reported existence of opportunities to make a difference to other people. Both of these are important indicators of social cohesion, an important contributor to mental and physical health (Thomas & Albright, 2018). Collectively, the challenges women veterans face with financial stability, family caregiving responsibilities, and social support upon reintegration contribute to stress injury and depression rates that are over 2.3 times higher than rates of incidence among male veterans (Thomas et al., 2016; Thomas, Turner, et al., 2015; Washington & Yano, 2013).

When considering ways to enable successful reintegration for veterans in general and for female veterans in particular, a high level of social support inevitably emerges as a predictor of successful transition and self-reported well-being (Egolf et al., 1992; Friedman, 2015). Studies have shown that there is an inverse correlation between social support and depression symptoms, comorbid depression and anxiety, decreased scores for health measures, and suicide attempts, specifically for female veterans (Lehavot & Simpson, 2013; Thomas et al., 2016). That is, as social support decreases, the latter outcomes all increase.

The service experiences of veteran women differ from those of their male peers (Cox & Albright, 2014; Thomas, 2016). Team RWB and other VSOs can play an important role in rebuilding eroded social support levels and creating a social bridge for transitioning veterans (Hoge & Castro, 2012). In this way, an
Table 4. Risk Estimate: Relationship of Gender to Likelihood of Veteran’s Low Mental Health or Enrichment Upon Joining

<table>
<thead>
<tr>
<th>Enrichment Variable</th>
<th>p</th>
<th>CI 95%</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health: Anxiety</td>
<td>.052</td>
<td>.830, 1.001</td>
<td>.911</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>.971, .943</td>
<td>1.0</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>1.00, 1.136</td>
<td>1.136</td>
</tr>
<tr>
<td>Mental health: Depression</td>
<td>.254</td>
<td>.859, 1.041</td>
<td>.946</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>.953, 1.013</td>
<td>.982</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>.973, 1.11</td>
<td>1.039</td>
</tr>
<tr>
<td>Social support: Brotherhood/sisterhood</td>
<td>&lt; .001</td>
<td>.693, .873</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>.887, .958</td>
<td>.922</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>1.098, 1.280</td>
<td>1.2</td>
</tr>
<tr>
<td>Social support: People to turn to for information</td>
<td>0.05</td>
<td>.728, 1.0</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>.899, 1.0</td>
<td>.968</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>1.002, 1.234</td>
<td>1.112</td>
</tr>
<tr>
<td>Social support: People to turn to for resources</td>
<td>0.166</td>
<td>.784, 1.03</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>.923, 1.01</td>
<td>.969</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>.973, 1.17</td>
<td>1.07</td>
</tr>
<tr>
<td>Purpose: Part of something larger than self</td>
<td>.002</td>
<td>.742, .936</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>.907, .98</td>
<td>.943</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>1.047, 1.22</td>
<td>1.131</td>
</tr>
<tr>
<td>Purpose: Opportunities to inspire others</td>
<td>.03</td>
<td>.753, .993</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>.910, .999</td>
<td>.954</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>1.006, 1.21</td>
<td>1.103</td>
</tr>
<tr>
<td>Satisfaction with life</td>
<td>.072</td>
<td>.990, 1.267</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>.998, 1.07</td>
<td>1.035</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>.897, 1.008</td>
<td>.924</td>
</tr>
</tbody>
</table>
organization like Team RWB that is attracting a large number of women veterans is uniquely poised to create higher levels of social support for this group of members. To retain and engage the large numbers of veteran women joining Team RWB, understanding the characteristics of this subpopulation and targeting outreach to them should be considered an important organizational aim.

Limitations

When considering the findings of this exploratory report, a number of limitations must be acknowledged. Secondary analysis of new-member survey data, while providing a large sample, limited the scope of questions that could be asked to only those included in the 2014 instrument. Subsequently, Team RWB has built upon its original data collection instrument, resulting in a psychometric instrument, the Enriched Life Scale (Angel et al., 2020), that clarifies and extends these early concepts. Additionally, the sample was delimited to respondents not in medical institutions, which may have had the effect of excluding or underrepresenting enrichment issues among veterans. Hospitalized veterans, particularly those hospitalized for mental health treatment, would likely have lower levels of enrichment than the respondents considered in the present study. Data were self-reported, which could be problematic due to respondent recall or reluctance to truthfully answer sensitive, personal questions. However, the use of self-reporting in survey-based research in the field is both accepted and common (Alvarez et al., 2012).

The variables of anxiety and depression considered in this study are broad, as questions asked in the survey capture self-reported information that indicates the likelihood of mild, moderate, and major levels of each condition (Crum-Cianflone et al., 2016; Thomas, Turner, et al., 2015). As a result, the present study’s prevalence rates indicate symptom self-report at a broad range of severity levels. The variable of veteran service era is also limited. Some respondents may fall into more than one service era, and all active duty respondents are automatically categorized as post-9/11 based on ongoing service, regardless of age. There is precedent for grouping age variables into service era in the literature (Thomas, Turner, et al., 2015; Thomas et al., 2016).

Conclusion

The findings of our study support the broader research literature that the prevalence of mild, moderate, and major depressed and anxious moods are significant problems for both male and female military veterans (Miller & Cano, 2009; Thomas et al., 2016). The present data differ slightly from the literature in that, based on the odds ratios in this study, depression and anxiety did not appear to be practically significant risk factors among women veterans who self-selected membership in Team RWB. Though some statistical significance indicates that women enter the organization with lower enrichment rates, odds ratios did not exceed 1.2. Previous research has indicated that women veterans are much more likely (1.5 times more likely than their male peers) to exhibit poor mental health outcomes or risks (Duhart, 2012; Haskell et al., 2011; Thomas et al., 2018; Thomas et al., 2016). The sample may indicate that male veterans joining Team RWB have higher than average risks for depressed and anxious mood states, though understanding prevalence rates for all levels of these conditions is a challenge; conditions are often co-occurring and undiagnosed (Hoge, 2010; Paykel & Priest, 1992). In total, 46.6% of all respondents indicated high levels of potentially mild, moderate, or major anxiety, and 49% indicated high levels of potentially mild, moderate, or major depression. This may indicate risk in the population generally and suggests a need for models that focus on assets and enrichment in the member base. The Department of Defense and Department of Veterans Affairs have prioritized combating both anxiety (including possible stress injury) and depression specifically because they are known predictors of suicide (Bossarte, 2013).

The findings of the present study conclude what the literature also does – namely that social support and feelings of purpose are known contributors to health and longevity, with recent studies indicating that high levels of both add 7.5 years to the average American’s life expectancy (Egolf et al., 1992; Rankin, 2013). Perhaps because the service experiences of women differ from those of their male peers in key ways, levels of social support and feelings of purpose are lower in military women (Thomas et al., 2016). Though the results of the present study indicate that women veterans who joined Team RWB between 2014 and 2016 came in at a higher risk for low social support and purpose levels, the fact that they are overrepresented in the community...
of military-connected personnel who self-select participation in a VSO like Team RWB indicates an interesting opportunity for engagement.

The current study’s finding is important because it suggests value in potentially expanding the scope of programming to serve Team RWB members beyond gender-neutral social support at the community/chapter level. It proposes new avenues to explore targeted, culturally informed programming that is organizationally-prioritized. Gender norms and differences in gendered experiences are incredibly valuable for contemporary military service organizations (MSOs) and VSOs to understand. Within this subpopulation of veterans, women-only programming has been demonstrated to be an appealing and effective outreach technique that creates feelings of belonging and may serve as a bridge to larger organizational participation (Godfrey et al., 2018). The findings of the present study present important feedback for Team RWB, an organization committed to reaching, engaging, and retaining women members.

Understanding the service challenges that many of these women are more likely to have or face can inform programming. Culturally competent programming could include enrichment-informed offerings in a single-gender environment that introduce members to the organization and encourage them to participate further in large-group settings. Gender norms in military family life could also be considered in VSO programming. Women are more likely to be the primary caregivers to dependent children (Mankowski & Everett, 2016), and not offering childcare at events could create a barrier to participation (Thomas et al., 2017).

The broad literature on VSOs indicates that programming should consider gender-based norms and recognize that barriers exist to women veterans’ participation in VSOs (Held & Owens, 2013; Rogers & Kelly, 2011; Thomas, 2016). Team RWB is already positioned through its successful recruitment of military-connected women to consider investing more proactively in this membership segment. Comparable initiatives, such as Veteran Women Igniting the Spirit of Entrepreneurship (V-WISE) at the Institute for Veterans and Military Families at Syracuse University, which offers training in small business ownership to active duty women, women veterans, and military spouses, have experienced rising demand for such tailored programming across the United States. Outreach must be thoughtful, peer-led, mindful of baseline enrichment differences, and considerate of the culture of women warriors (Richardson, 2002; Thomas, Plummer Taylor, et al., 2015).

References


Hoge, C.W. (2010). *Once a warrior, always a warrior: Navigating the transition from combat to home including combat stress, PTSD, and mTBI*. Lyons Press.


### About the Authors

An interdisciplinary team led by Kate Hendricks Thomas of George Mason University contributed to this research. Reach her with inquiries at www.DocKate.com. Researchers included leaders of Team RWB including Caroline M. Angel, Michael S. Erwin, Louis P. Nemic, Brandon B. Young, John M. Pinter, and Blayne P. Smith. Nicholas J. Armstrong of Syracuse University and Justin T. McDaniel of Southern Illinois University also contributed to the project.
Culturally Informed Interventions for Military, Veteran and Emergency Service Personnel: The Importance of Group Structure, Lived Experience Facilitators, and Recovery-Oriented Content

Jonathan Lane, Miranda Van Hooff, Ellie Lawrence-Wood, and Alexander McFarlane

Abstract

There is little available research on what constitutes a culturally informed program to treat mental health conditions among military, veteran, and emergency services personnel. The current study presents the qualitative participant evaluations of a modified group Skills Training in Affective and Interpersonal Regulation (STAIR) program. Participants were grouped with either lived-experience facilitators or non-lived-experience clinicians for the program, and 93 textual responses to a series of qualitative questions were analyzed. The findings suggest strong support for the postulated three primary components of a culturally informed program: a group structure; facilitation by peers with lived experience; and functional, skills-based, and recovery-oriented content.

There has been increasing interest over the last decade in the cultural competence of clinicians who manage military and veteran personnel. Military and veteran personnel form a distinct subset of society that is shaped by members’ service experiences, including training and deployment experiences, norms, traditions, and values (Atuel & Castro, 2018). The high rates of mental health conditions among active and veteran military personnel have received significant attention in Australia (Van Hooff et al., 2018) as well as the United States, and commonly reported conditions include post-traumatic stress disorder (PTSD), depression, anxiety, and substance abuse, among others (Hoge et al., 2004). Physical symptoms and conditions such as chronic pain are also more prevalent among military and veteran personnel compared to civilians (Graham, K., 2019), and they have been reported to have major impacts on individuals’ quality of life and mental health (Ahmadian et al., 2019).

Current clinical practice guidelines for the prevention and treatment of PTSD recommend both individual trauma-focused psychotherapies and pharmacotherapy for service members and veterans (Hamblen et al., 2019; Ostacher & Cifu, 2019). Most of these guidelines, however, are based on results from randomized control trials with moderate to large sample sizes investigating reductions in PTSD symptom severity as the primary outcome of interest, with psychological and pharmacological treatment as the target interventions. In contrast, there is less focus on and promotion of other, adjunctive interventions that can assist in the reduction of PTSD symptom severity but do not fit the criteria above. These include generalized “recovery-oriented” interventions for mental health and well-being, mind–body interventions, physical therapies, other psychotherapies, and psychosocial interventions. Another range of interventions and programs targets the issues that arise during specific stages of military members’ careers (i.e., the transition into civilian life). Unfortunately, there are also concerns about the efficacy of the mainstream care and interventions that are frequently offered (and promoted) to military personnel and veterans. Problems may arise from a one-size-fits-all approach to treatment that doesn’t necessarily work for all (Steenkamp & Litz, 2014). In particular, the evidence-based treatments recommended by PTSD guidelines (Steenkamp et al., 2015; Steenkamp et al., 2020) have had relatively poor clinical outcomes, particularly over the long term for these populations. Researchers have also argued that treatments should be formulated to address the different stages of PTSD and their associated physical and psychiatric comorbidities (McFarlane et al., 2017).

Lack of clinician cultural competence is considered to add to the barriers that service members and veterans face in accessing and remaining engaged with care, especially mental health services (Atuel & Castro, 2018). For these reasons, many clinicians with service experience
have promoted the need for, and elements of, cultural competence among clinicians in the American and Australian contexts (Atuel & Castro, 2018; Burek, 2018; Coll et al., 2011; Gayton & Kehoe, 2016; Lane & Wallace, 2020). These calls to action also raise the question, however, of what a culturally informed program or intervention for the treatment of mental health conditions among service members and veterans might look like in terms of its structure, format, and content.

Several recent peer-led, community-based interventions have shown promising results in reducing mental health symptoms among military veterans. Examples of such programs include Buddy-to-Buddy, a peer support program for U.S. National Guard and reserve service members (Greden et al., 2010), and the Team Red, White & Blue community-based model for developing positive social networks to enhance outcomes in military veterans reintegrating into civilian life (Angel et al., 2018). Another study examined the relationship between peer support, self-efficacy, and PTSD symptoms in combat veterans after an intensive weekend program run by the community support group Vets4Vets (MacEachron & Gustavsson, 2012). A range of peer outdoor support therapy (POST) programs have also been evaluated, and all of these programs indicate some beneficial outcomes for PTSD despite being nonclinical interventions (Bird, 2014).

These programs share several common features: They are based on a group structure; they do not involve individual one-on-one therapy from a clinician to a patient; they include peers with lived experiences of military culture and/or mental health conditions; and they emphasize psychosocial functioning from within a recovery-oriented framework rather than just “treatment.” These factors are all worth examining in detail in terms of how they relate to military culture and therefore why they should be considered essential for culturally informed practice.

Group Structure

There are a number of elements of group programs that are reminiscent of military culture. In fact it was John Rickman and Wilfred Bion, both British Army psychiatrists during World War II, who originally pioneered the therapeutic community model that is considered today to be the forebender of group programs (Mills & Harrison, 2007). Bion himself was a highly decorated World War I veteran who had fought in the tank corps, which gave him particular insights into the dynamics of teams (Gooch, 1998). Rickman and Bion's therapeutic communities minimized patient-practitioner hierarchical differences, creating a culture of inquiry that promoted self-investigation and awareness. They also created a culture of mutual support, whereby all members within the community united to support themselves and others within those communities (Mills & Harrison, 2007). Rap groups played a critical role in early self-generated support efforts for U.S. Vietnam war veterans and led to the emergence of counseling services, in which veterans played a key role in providing support, as an alternative to formal therapy (Egendorf, 1975; Shatan, 1973).

Modern-day group intervention programs for veterans and emergency service personnel have a similar ethos. They offer a format and structure that reflect normal service culture, defined by such tenets as a team-oriented approach to problem resolution. Such group interventions involve several people gathering together on a regular basis and engaging in the social connectedness that is essential to service life. These meetings offer opportunities to normalize stress and distress, and they challenge perceived stigmas about having mental health conditions and engaging with services for help with those problems. Through their provision of mutual support and understanding, group interactions help to validate participants' traumatic experiences and therefore reduce potential shame (Schwartze et al., 2019), just as happens in a normal service environment. Working as a part of a team and sharing a sense of loyalty, pride, camaraderie, and brotherhood are fundamental aspects of service and hence are often lost upon transition out of service (Burek, 2018). Group interventions' potential to restore these feelings might help explain the popularity of the format among veterans.

Peer Support

The desire for community explains why many service members naturally gravitate toward others who have shared experiences, values, norms, attitudes, beliefs, and expectations of behavior, both during service and beyond, when creating psychosocial bonds (Lifton, 1976). This affinity for others who have the same “lived experience” also helps explain the attraction and power of peer-driven programs for veterans and the benefits that culturally specific group programs can offer. Typical veteran attitudes include beliefs such as “If you haven’t been there, you don’t get
it,” “We believe in taking care of our own,” and “Other veterans can be trusted.” In contrast, many veterans mistrust mainstream clinical services and clinicians (Blank, 1982; Greden et al., 2010). As such, military personnel are used to relying on peers for support, consider them more trustworthy than other authority figures, and identify with leaders with similar experiences to model adaptive growth and change (Hundt et al., 2015). Peer support programs therefore meet an inherent need of service personnel.

They are also becoming increasingly popular because they can improve outcomes in inpatient programs, as evidenced by their formal introduction in the U.S. Veterans Affairs medical system (Jain et al., 2016). Additionally, when employed in a paraprofessional role, veterans themselves can augment existing services in low-resource communities (Jain, 2010). Finally, programs led by peers with lived experiences of both service culture and recovery from mental health conditions can augment and cement the group bonding and cohesion process because they mimic the general training and occupational format of service life—that of a leader with more experience and knowledge who serves as a role model, instructor, and guide for a group of others, within a task or purpose-oriented frame.

Recovery-Oriented Content

Recovery is defined in this context as “gaining and retaining hope, understanding of one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self” (Australian Government Department of Health, 2010). This definition of recovery fits well with the positive attributes of military culture, values, beliefs, norms, and behaviors. The concepts of self-efficacy, striving for excellence, and high-performance standards, all of which are facets of recovery, are also essential to military identity (Burek, 2018). Finally, the three characteristics (or values) of “integrity,” “team worker,” and “good judgment” were all ranked significantly above random assignment in Gayton and Kehoe’s (2016) work with Australian Army Special Forces soldiers. These characteristics seem to drive recovery-oriented behaviors—as also seen in the work of Dabovich et al. (2019) on values and identity redevelopment during rehabilitation and transition—hence the popularity of a recovery-oriented approach with military and veteran personnel.

Another aspect of military culture is the concept that performance of one’s task and mission is central to a positive sense of self (Lane & Wallace, 2020). A task- or mission-oriented approach allows for sublimation of distress, especially emotional distress, and therefore becomes an effective coping mechanism: Individuals derive a sense of purpose from their vocational tasks that allows them to push through their distress. Unfortunately, service members and veterans lose these adaptive coping mechanisms as their cognitive and motor functions decline due to mental health injuries. The reality of these functional losses represents a direct challenge to the positive self-concept characteristics described above; the individual loses the ability to demonstrate high performance, is no longer a part of a team, and may have been discharged from the military as unfit for service. However, the drive for individual improvements in effective functioning and positive identity improvements through teamwork can therefore also be used as components of a culturally appropriate, recovery-oriented program.

Functional losses often include difficulties with emotional regulation (ER), which are commonly seen in service members and veterans. Stanley and Larsen (2019) described how the typical military attitude to emotional distress is to “suck it up” and “drive through,” which ends up resulting in emotional suppression and therefore further distress and disability. They argue that high accumulated chronic stress loads from occupational, operational, and organizational factors of service increase ER challenges and maladaptive coping mechanisms, therefore increasing the risk of psychological distress and suicidality among both service members and veterans. Considering these risk factors in combination with personal societal stigmas against mental health diagnoses and treatment, which are linked to treatment avoidance and poor adherence (Vogt, 2011), it is not surprising that there are such high rates of mental health morbidity within this population.

Mainstream mental health treatment programs may further aggravate these problems. As described earlier, traditional interventions have been criticized because they are generally administered on an individual basis (one-on-one with a therapist and client) and provided within an institutionalized framework that defines clinicians as “experts” who deliver “treatment” to patients because they have a “disorder” (Lifton, 1976). This medical model disempowers
consumers, ignores their cultural context, and has the disheartening effect of dismissing any of the consumers’ strengths (Brende, 1981). In effect, mainstream services reinforce a negative sense of self-identity by reaffirming individuals’ lack of functional capacity and minimizing their sense of efficacy except within a narrow focus of trauma-focused psychotherapy. Indeed, Steenkamp et al. (2020) argued that trauma-focused psychotherapies may have low success and high dropout rates because veterans with PTSD typically struggle to cope with the prescribed, emotionally demanding therapies. This is not surprising given the difficulties with ER described by Stanley and Larsen (2019), but it should also be recognized that veterans and service members are engaging in these therapies without the support of their peers and without any leveraging of the inherent strengths and capabilities they developed during their service careers. In contrast, the adjunctive interventions that seem to be increasing in popularity among veterans do not have the same hierarchical structures, do not pathologize psychological distress, and focus on leveraging the strengths and positive characteristics of the veterans themselves to move them toward functional recovery. In other words, as stated earlier, these therapies have several key components: They involve peers; are goal-oriented toward functional improvement (recovery); and leverage the values, norms, and conditioned behaviors expected by military and veteran personnel.

A Potential Culturally Informed Model of Intervention

The discussion above suggests that a culturally informed intervention for active military personnel, veterans, and other service personnel should have three main factors: It should be group-based, with minimal hierarchy; it should be delivered and facilitated by leaders with lived experience; and it should have functional, recovery-oriented content. This model also implies that “treatment” for psychological disorders should have a staged approach, depending on the severity of participants’ symptoms and functional disability (McFarlane et al., 2017). This staged approach should also include a primary skills-based stabilization stage, preferably including an ER component, prior to active treatment. It is at this early intervention point that culturally specific interventions are considered to be most relevant, achievable, and effective.

The Skills Training in Affective and Interpersonal Regulation (STAIR) program by Cloitre et al. (2002) was originally developed to target ER among individuals with complex PTSD. STAIR is a manualized, skills-based program designed to educate individuals with PTSD on the personal impacts of trauma, and it uses various psychological tools (primarily dialectical behavior therapy) to help participants develop the skills they need to improve their own ER capability and the quality of their interpersonal relationships. It has primarily been used in the context of sexual trauma, with the psychoeducation and skill phase being followed by a narrative exposure therapy phase (a form of trauma-focused psychotherapy treatment), and it has been shown to improve both distress symptoms and functional outcomes in participants (Cloitre et al., 2014; Cloitre et al., 2016). STAIR has also been adapted to a group format (Cloitre et al., 2015), which has the added benefit of maximizing social support (Charuvastra & Cloitre, 2008). As such, group STAIR provides the perfect platform for creating a culturally relevant intervention delivered by peers whose lived experiences could help model functional recovery.

Finally, programs that deliver skills-based, function-oriented content with the goal of improving ER, social supports, and interpersonal relationships are also likely to appeal to the service member and veteran audience because they align with their predisposition to want to perform and succeed at given tasks within a recovery-oriented framework.

Summary and Current Research Project

While there is growing interest in the cultural competence of clinicians working with service members and veterans, there is little published research on what constitutes a culturally informed structure, format, and content for an intervention for mental health conditions among this population group. The purpose of this paper is therefore to examine the participants’ perspectives of a culturally informed and modified pilot STAIR program. This intervention was informed by the three key principles that we have so far discussed: It was conducted in a group format, the content of the program was functional and recovery-oriented, and it was delivered by facilitators with lived military and mental health experience.
Methods
This study is part of a larger mixed-methods effectiveness trial of a group STAIR program conducted with current and veteran military and emergency service personnel in Australia. This larger, modified group STAIR evaluation consisted of a range of common mental health inventories and open-ended questions in the form of a written survey. It was approved by the Australian Departments of Defence and Veterans’ Affairs Human Research Ethics Committee (DDVA 030-18) and the University of Adelaide Human Research Ethics Committee (H-2018-114) and was conducted as a real-world effectiveness trial over a 24-month period.

Participants
The sample evaluated in this paper was restricted to participants’ responses to the four open-ended questions at the end of the survey. Responses were collected from the 93 participants who completed the entire program. All participants were current or former military or emergency service personnel who were experiencing difficulties with their mental health. Participants were excluded if they had active psychosis or suicidal ideation with a plan to carry out self-harm. Emergency services personnel were actively recruited to the project because they have similar cultural norms, attitudes, beliefs, and behaviors to military personnel. In addition, in Australia they have similarly high rates of mental health conditions but much more limited access to care, especially culturally informed care (Harman, 2019).

Procedure
Participants for this study were referred into the modified group STAIR program by their community care clinicians, but they also continued to receive care as normal from their clinicians during the program. Psychometric evaluations (not reported in detail here) and qualitative evaluations were administered at four time points: (1) immediately before the program, (2) immediately at the end of the program (3 months), then at 6 months (3) and at 12 months (4) following commencement of the program. The qualitative data reported in this paper were collected from the immediate post program survey. The project procedures were approved through the Australian Departments of Defence and Veterans’ Affairs (DDVA) and University of Adelaide (UA) human research ethics committees.

The Program
The modified group STAIR program by Cloitre et al. (2015) consisted of once-weekly 90-minute sessions, which were run as closed groups over the course of 12 weeks in 2018 and 2019. Six sessions covered emotional regulation, and six sessions covered interpersonal relationships. The group STAIR program was modified by the author (a clinician with 30 years’ Army experience as an enlisted soldier, medical doctor, and psychiatrist) to make it more culturally specific and relevant to military, veteran, and emergency service personnel. Modifications included using appropriate language and providing detailed psychoeducation on the impacts of service and culture on identity, behaviors, patterns of maladaptive coping mechanisms, and relationships.

The program was delivered through two separate Australian nongovernmental community service organizations. These were The Road Home (TRH), a leading South Australian veteran and emergency services charity in Adelaide, South Australia, and Mates4Mates (M4M), another ex-service organization with Family Recovery Centres in Hobart, Brisbane, and Townsville. The TRH groups (n = 62) consisted of a mix of active military, veteran, police, and fire brigade personnel, and they were led by the primary author with an ex-policeman and a current military peer as cofacilitators. The M4M groups (n = 31) only had military and veteran participants and were led by clinical psychologists with no lived military experience.

Participant Mental Health Status
All participants completed a baseline battery of self-report mental health questionnaires prior to commencement of the STAIR program in order to provide initial measures of mental health symptoms and prior trauma history. These included the Kessler 10 (K10), a 10-item screening measure of psychological distress (Kessler et al., 2002); the seven-item Generalized Anxiety Disorder (GAD-7) scale to screen for anxiety symptoms (Spitzer et al., 2006); the nine-item Patient Health Questionnaire (PHQ-9) to screen for depressive symptoms (Kroenke et al., 2001); the 20-item PTSD Checklist for DSM-5 (PCL-5) to screen for PTSD symptoms (Wortmann et al., 2016); the Dimensions of Anger Reactions (DAR-5) scale, a five-item screening measure to assess anger frequency, intensity, and duration and anger’s perceived negative impact on social relationships (Forbes et al., 2004); and four items...
to examine suicidal ideation, plans, and behavior adapted from the Australian National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2007). The Lifetime Exposure to Traumatic Events scale was taken from the CIDI V3 (Haro et al., 2006). The 28 questions covered a range of potentially traumatic events and were endorsed by either “yes” or “no” answers from participants. The total number of times that participants were exposed to each of the 28 traumatic events was also obtained.

Qualitative Component
Qualitative data was obtained from written responses to the following questions:

1. In what way do you feel the clinician who facilitated your STAIR Program helped you understand yourself and some of the problems you might have experienced?

2. Were you able to relate to the facilitator? If so, what made this possible, and why?

3. Do you think it’s worthwhile training people to be Counsellors to help their Peers? If yes, then why?

4. What do you think the main potential benefits of having Peer Counsellors are?

The data analysis process used qualitative content analysis (Drisko, 2015) to derive common descriptive themes from the written responses to the four separate review questions. For the purpose of this paper, responses were coded for three themes. These themes represent the three factors suggested earlier to be implicit in the development of a culturally informed intervention for military personnel, veterans, and emergency service workers: group structure, lived experience peer support, and recovery-oriented content. Identified subthemes will also be discussed and illustrated by the inclusion of direct quotes from participants.

**Results**

**Demographics**

Ninety-three of the 130 participants who enrolled in the study between January 2018 and December 2019 completed the qualitative measures and hence were included in the sample for the current study. Of those 93 participants, 83% were current or ex-serving Australian Defence Force members, and 17% were current or ex-serving Australian emergency services personnel. Table 1 provides detailed demographic and occupational information for this sample.

The total number of times each participant reported exposure to a different traumatic event and the proportion of the sample exposed to each type of traumatic event are summarized in Figures 1 and 2. The figures show that the occupational and lifetime risk of exposure to traumatic events is high among military and emergency services personnel, with the mean level of exposure being six separate events. When looking at the specific types of trauma, 70% of participants endorsed witnessing death, 45% of participants reported witnessing the death of someone they were close to, and 40% reported being in combat.

**Mental Health**

Baseline scores on each of the mental health measures according to the standard scoring bands are provided in Table 2. Overall, 30% of participants scored in the severe range for anxiety, with 36% scoring greater than 50 on the PCL-5 and 30% scoring above

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**Table 1. Participant Occupational Demographics**

<table>
<thead>
<tr>
<th>Demographics</th>
<th>No. of participants (N=93)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>79</td>
<td>85</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range (22–73)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD=11.82</td>
<td></td>
<td>M=46</td>
</tr>
<tr>
<td><strong>Currently working</strong></td>
<td>50</td>
<td>54</td>
</tr>
<tr>
<td>Emergency services</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Defence</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Health and community services</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
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<td>10</td>
</tr>
<tr>
<td><strong>Retired</strong></td>
<td>43</td>
<td>46</td>
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<tr>
<td>Emergency services</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Defence</td>
<td>35</td>
<td>38</td>
</tr>
</tbody>
</table>
Figure 1. Frequency of Participants’ Total Lifetime Exposures to Trauma

![Figure 1](image1)

- Total Number of Lifetime Exposures to Trauma
- Frequency

- Mean: $M = 6.2$
- Standard Deviation: $SD = 4.14$

Figure 2. Percentage of Participants Who Endorsed a Specific Trauma Type

![Figure 2](image2)
15 on the GAD-7, both of which are indicative of a probable disorder. Severe levels of psychological distress based on K10 scores were reported in 48% of the sample, 49% reported some form of suicidality (either suicidal ideation or attempt), and 49% reported problematic levels of anger (a score of 12 or greater on the DAR-5). The quantitative results of the changes in the clinical measures are not reported in this paper as they will be presented in a separate article.

**Qualitative Question Results**

The participants’ responses were evaluated to derive their perspectives, perceptions, and opinions of the following three themes: (a) the importance of the group format; (b) peer support/lived experience; and (c) skills-based, recovery-oriented content. Direct quotes from participants that illustrate the derived themes are also included.

**Theme 1: Group Format**

There were no specific questions that asked participants about their perceptions of the group format. However, spontaneous answers demonstrated positive regard for the format, such as “Group situation good.” Most of the other relevant comments addressed the benefits of normalizing difficult experiences during service and within the treatment process, such as “Sharing learning and understanding behaviour” and “It was good to discuss other people’s situations and coping mechanisms.” The group format allowed for interaction and engagement, which participants appreciated. One participant noted, for example, the “opportunity to pass on knowledge and understanding, share personal experience and reflect on those.” Finally, the notion of support from others within the group was very strongly identified; participants wrote, for example: “understanding of the issues each other face, mutual support” and “Good to have that peer support.” It appeared that people felt they could relate to each other because of their shared experiences and shared understandings of similar problems, and they felt “more likely to open up about each other’s experiences” because there was “trust” and “understanding and connection within the group.”

The fact that these comments came from all the participant groups suggests that incorporating emergency services personnel within the groups did not diminish the trust, rapport, and sense of connection that participants felt with each other, and these factors emerged regardless of whether or not groups had lived-experience facilitators.

**Theme 2: Lived Experience**

Lived experience of military/service life and mental health conditions were the most prominent themes to emerge in participant responses,

<table>
<thead>
<tr>
<th>Test (range)</th>
<th>Well</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>K10</strong> (0–50)</td>
<td>M=28.2 (SD=8.4)</td>
<td>16 (18%)</td>
<td>12 (13%)</td>
<td>20 (21%)</td>
</tr>
<tr>
<td><strong>GAD-7</strong> (0–21)</td>
<td>M=9.9 (SD=5.9)</td>
<td>19 (20%)</td>
<td>29 (32%)</td>
<td>17 (18%)</td>
</tr>
<tr>
<td><strong>Suicidality</strong></td>
<td>Screen (y)</td>
<td>Ideation</td>
<td>Plan</td>
<td>Attempt</td>
</tr>
<tr>
<td><strong>PHQ-9</strong> (0–27)</td>
<td>M=12.6 (SD=6.8)</td>
<td>23 (25%)</td>
<td>51 (55%)</td>
<td>19 (20%)</td>
</tr>
<tr>
<td><strong>PCL-5</strong> (0–80)</td>
<td>M=36.9 (SD=20.9)</td>
<td>35 (37%)</td>
<td>35 (38%)</td>
<td>34 (36%)</td>
</tr>
<tr>
<td><strong>DAR-5</strong> (5–24)</td>
<td>M = 12.2 (SD=4.7)</td>
<td>46 (51%)</td>
<td>47 (51%)</td>
<td></td>
</tr>
</tbody>
</table>
particularly in response to Question 1. For example, the majority of the participants from the groups led by the facilitators with lived experience \((n = 62)\) spontaneously mentioned the importance of shared experiences and similar personal characteristics in relation to how they related to the facilitator or how they felt the facilitator related to them. This suggests the importance of the facilitator's lived experience in developing rapport both on a personal level as well as clinically. Responses included: “Service-related background established rapport, respect and confidence to disclose vulnerable information of myself,” “He was very familiar with what we were talking about and didn’t have to have everything explained to him,” “He was familiar with military and policing terms which is generally lacking in therapists,” “Via Military speak, true understanding of why I am thinking mostly the military way,” “Always made examples that were relatable,” “Related well. With his background in defence it made it easier to connect with him. And somehow could read my mind,” “Yes being in the ADF [Australian Defence Force] and the examples used, and the language and situations automatically built a trust and a relationship. So much respect,” and finally, “As a veteran who has served and then become a psychiatrist [he] truly understands the issues facing veterans because he has lived the military life. If you don't get it you don't get it, it's not just trauma from service it's training and culture.”

Shared language, culture, behavioral norms, beliefs, and attitudes were also very influential on participants' opinions of the lived-experience facilitators. The use of culturally informed language, although directly referenced by only a few participants, is likely to have influenced this as well. Participants noted, for example, that the facilitator “spoke in a manner that was so clearly understood—spoke layman’s language and not a lot of confusing jargon,” “Yes, down to earth, in layman’s terms not medical, very approachable, understanding etc.,” and “being in the ADF and the examples used and the language and situations automatically built a trust and a relationship.” In contrast, none of the participants in the groups led by the facilitators without lived experience \((n = 31)\) mentioned anything about lived experience or relating to the clinicians on a personal level because of their shared experiences.

Questions 3 and 4 both addressed participants’ opinions and perceptions of using peers in facilitation and/or counseling roles. The dominant themes to emerge here were shared understanding, shared experiences, and therefore also a perception that peers were likely to be more effective counselors. Examples included: “Very useful to have peers that already have some rapport with personnel and can provide immediate assistance. Often means there is no barriers [stigma],” “Yes, they can relate as they have been in the same situation,” and “We can all relate to each other, we have instant rapport and a level of trust, especially as peers in the military. We “get” each other.” Modeling recovery was also mentioned: “Yes. 100%. Because it helps the peers to relate to personnel that have first-hand experience in what they are feeling and going through. They are not alone. Also shows them that there is light at the end of the tunnel.”

Other themes to emerge in relation to the benefits of having peer counselors were equality, shared experiences, and common backgrounds and therefore more trust, rapport, and relatability between counselors and participants. These subthemes also encompassed stronger perceived psychosocial bonds between facilitators and participants as well as the benefits of normalizing difficulties and modeling recovery. Examples of these sentiments included: “Familiarity, shared experiences, shared understanding, trust, not a doctor,” “They’ve lived your problems and can empathize,” “Shared experience and understanding that others have been through it,” “Relatable experiences & see people as normal,” and “Like minded individuals who share a common experience of having experienced trauma, been diagnosed with it, and sought help through their relevant organisation, and the STAIR program.”

**Theme 3: Functional and Recovery-Oriented Content**

Although there was not a specific question asking participants about the importance of functional and recovery-oriented content, several themes emerged in participants’ responses that supported the importance of such content. For example, participants’ answers to Question 1 often referred to the skills components of the content in explicit detail and described how this content benefited them in functional terms: “My understanding of emotions and relationships has improved as well as tools to deal with my anxiety,” “Helped me understand my feelings are normal. Change starts with me,” “ability to break complex human thoughts and emotions down via explanation so that I was able to analyse and understand/interpret them. This info could then
be used to consciously change thoughts/feelings/behaviours moving forward allowing for greater understanding of self and others and therefore opening the door to improved relationships,” “Easy to apply the learning to my everyday life. Made the information very relatable and understood our lives and work,” and “It was presented in a way that made it real and relevant to the context I live and work in. He helped me understand that a lot of the issues I have are normal human responses and there are ways to combat the negative ones.”

Improved self-efficacy in ER, especially anger, was another strong theme to emerge in relation to content. Participants wrote, for example: “By breaking down the basic mechanics, so by getting myself to recognise my own emotions and how to regulate them. How my feelings in situations can affect my reactions to situations,” “Helped me gain control of my life back. Reduced anger and awareness of what's going on in my head, and how to control that,” “Helped me deal with anger and dealing with situations,” “I have been able to address my issues with conflict and realising that sometimes the pain of conflict is worth the conflict itself,” “Gained a lot of knowledge, and understanding about feelings emotions, helped improve communication within the family home.” All of these quotations imply a sense of mastery through skills acquisition, which had broader implications for participants’ psychosocial well-being, functioning, and self-identity.

Discussion

This investigation aimed to explore participants' perceptions of using lived-experience facilitators to deliver a small-group, skills-based intervention to improve emotional regulation and interpersonal relationships. It was hypothesized that this intervention met the requirements to be considered a culturally informed intervention because it used a group format, was facilitated by peers with lived experience, and was composed of skills-based and recovery-oriented content. The qualitative results suggest that the participants viewed the intervention and its outcomes favorably. Participants’ answers to all four questions also demonstrated positive regard for the three themes in question: the group format; lived-experience facilitators; and functional, skills-based, recovery-oriented content.

Lived Experience and Role

Modeling of Functional Recovery

Question 1 was aimed at exploring how well the facilitator was able to transfer the program content to participants. Facilitators were tasked with educating participants about the degree to which their mental health conditions and functional problems are consequences of exposure to chronic stress, trauma, as well as the conditioning effects of military and other service experiences, and they were also charged with providing participants with skills to address these challenges. The skills-based content primarily targeted the ER deficits identified by Stanley and Larsen (2019). Participants’ answers to Question 1 showed support for the functional ER skills obtained from the intervention, with a number of respondents reporting better perceived self-efficacy to manage themselves, their emotions, and their daily functioning. This finding is important given that the modified group STAIR content made it a psychoeducation and skills-based intervention rather than a typical “treatment” or trauma-focused psychotherapeutic intervention.

However, a striking aspect of participants’ answers to Question 1 was how respondents related to and spontaneously praised the lived experiences of their facilitators in terms of making the content relatable. They also commented on how this helped them develop knowledge and understanding of their own emotions and identified their rapport with the facilitator as a large factor in how they were able to normalize and understand their experiences so they could regain functionality.

The increased rapport that developed between the participants and the lived-experience facilitators is important because this sits apart from the intervention content and has to do entirely with the frame of the intervention. Participants’ responses to Questions 3 and 4 also reflected these attitudes; these questions were aimed at exploring participants’ opinions of whether it is important and potentially beneficial to have peers with lived service and mental health experience in therapeutic leadership roles. Responses were overwhelmingly favorable toward this proposition. The themes of increased understanding, trust, and rapport engendered by a common language, experiences, and histories were prominent, as was the idea that the therapeutic process would be more effective if peers with lived experience more commonly facilitated them.

The concept of peers being able to normalize psychological injuries from service was also prominent, suggesting that participants had previously felt abnormal or “different” in some way because of their operational stress injuries.
Similarly, peers (similar to the lived-experience clinician facilitators) were identified as modeling and demonstrating recovery and post-traumatic growth, therefore challenging negative beliefs and stigma about both mental illness and the potential for recovery. Responses thus demonstrated the importance of lived experience within the interventional frame and a strong desire from the participants for their facilitators to have this lived experience.

The finding that peers are important in terms of culture and context for increasing positive attitudes toward engagement is consistent with previous research, especially studies examining correlates and predictors of whether veterans initiate and remain engaged in care. In a comprehensive review of these factors, Johnson and Possemato (2019) argued that positive valence of veterans’ beliefs about mental health care consistently predicted more initiation and engagement in care. Hundt et al. (2015) has also supported the idea that perceived benefits from increased social support, purpose and meaning, normalization of symptoms, and actual therapeutic benefits are all factors that motivate veterans to engage in ongoing care and use skills-based interventions. Participants in the current study spontaneously recognized and favorably commented on these aspects of the program, potentially suggesting that the frame of the intervention was at least as important as the specific content.

Finally, Kumar et al. (2019) identified that peer support is also fundamentally important to the concept of global recovery in that it can help individuals with PTSD and other mental health conditions integrate their symptoms into their daily life and functioning, thereby reducing the distress they feel. This statement is effectively the definition of “recovery” used in this study and was identified as a goal for the majority of participants.

Summary

The demographic and mental health data in tables 1 and 2 demonstrate the morbidity of mental health conditions in this population group and therefore establish the need for care. The primary themes that emerged from this study’s qualitative data show strong support for the postulated factors of group-based interventions, leadership by those with lived experiences, and functional, recovery-oriented content as being culturally appropriate for a cohort of service members, veterans, and emergency services personnel. It could also be argued that it is difficult to separate these factors out because they appear to be fundamentally interdependent on each other, as demonstrated by the overlaps in participants’ comments. However, more research is clearly needed to quantify what constitutes clinician–client relationships. Nor were there power dynamics inherent to the program, which, again, is likely to have improved rapport and relatability among facilitators and participants.

Participants’ interpersonal relationships were further strengthened by the group format of the intervention, with cultural service factors encouraging members of the group to rapidly come together and rely on each other for mutual support. Participants’ shared behavioral norms, attitudes, and beliefs promoted positive attitudes toward each other, their facilitator, and engagement with the program content. However, the group format also mimicked participants’ previous educational or training experiences; the context of the program was familiar, which again improved participants’ rapport and relatability among each other and with their facilitators.

Finally, it would seem that the structure and format of the program represented the positive qualities of Rickman and Bion’s earlier programs in terms of reflecting a therapeutic community with a strong alliance between facilitators and participants. This is likely why it was popular with these participants, who potentially felt isolated within the wider civilian community because their loss of employment had entailed the loss of a meaningful service community. Their losses in terms of community, role, purpose, functioning, and identity were significant, and participation in the modified STAIR groups gave them back this sense of community, a shared set of values, and a sense of mutual purpose in terms of working with other participants toward the goal of improved functioning in their daily lives.
Other Community Engagement Potential

The results suggest that a culturally appropriate, skills-based, functional program delivered by peers with lived experience in a group format is highly attractive to the military, veteran, and first responder population. This raises the question of whether similar culturally unique population groups would also benefit from this approach. High-level athletes, musicians, and health care personnel are often more vocational than simply occupational populations, as they have similarly strong attachments to performance-related self-identities; hence they may be other suitable target populations for these forms of community-based, adjunctive mental health interventions. Similarly, other social or cultural groups should also be identified to determine whether the postulated factors of lived experience and group/community are transferable.

Limitations

The primary limitation of this area of investigation is the lack of recognition of the importance of interventions that deliver culturally specific structure and content to military and emergency service personnel. Results from this study provide a starting point for further explorations in the field. Limitations of this intervention evaluation include the small scale of the intervention, the limited qualitative data gained from participants, and the limited length of time of the evaluation. Quantitative data analysis demonstrating efficacy has yet to be published but would be beneficial for comparison to the more typical trauma-focused psychotherapeutic interventions. The group STAIR program had to be extensively modified to incorporate a culturally relevant structure and content, and it might therefore be more effective to develop a new program incorporating the recovery-oriented features of ER and interpersonal relationship skills alongside the necessary issues of identity, values, service history, conditioning, and transition that veterans and service personnel face. Finally, further identification of similar programs (such as the specific peer-support programs identified previously) and systematic review of their structures, modes of delivery, content, and integration into mainstream mental health services would help clarify the necessary components of a culturally informed intervention and allow for more specific interventions to be developed and evaluated.

Conclusions

This paper supports the position that context and empathy are critical to mental health interventions because treatment is not just about specific techniques. Culturally informed interventions for mental health conditions for military, veteran, and emergency services personnel are best undertaken in a group format, when delivered by facilitators with relevant lived experience, and with skills-based and recovery-oriented content. The qualitative evaluation of the modified group STAIR intervention demonstrated the inherent psychosocial benefits of group programs and showed that participants appreciated this format. Participants’ strong identification of the benefits of working with others with similar lived experience reinforces the important role of cultural expertise in delivery to maximize positive regard, and therefore minimize both stigma and barriers to care. Finally, the participants’ positive regard for the functional, skills-based, and recovery-oriented content, along with the ability of participants to identify and explain the perceived personal benefits of the program, also suggests that it is an effective intervention content modality.

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**About the Authors**

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Put Yourself in My Combat Boots: Autoethnographic Reflections on Forms of Life as a Soldier and Veteran

Shawn Dunlap

Abstract

The link that current and former service members have with the governments they serve is unique. Following Giorgio Agamben’s work on forms of life, this paper argues that those who choose to take part in military service exist as a unique, emergent form of life. This form of life often stands at the intersection of nationalistic mythmaking and the lived realities of service members prior to, during, and after their service. The author employs content relevant non-fiction vignettes. These sections follow Leon Anderson’s notion of “analytic autoethnography.” Topics explored include liminal experiences in military service and military operational realities. The paper also explores mechanical allegories of the soldier and veteran their implications on the life of the veteran. This research was conducted between August 2016 and May 2017. The author is a veteran and sole researcher for this work. Through the autoethnographic method, the work decodes and organizes the author’s personal military experience, highlighting service member and veteran voices that are often filtered through more traditional academic work on the topic as a means of demystifying military service and experience. The author concludes that by developing our understanding of service members and veterans as a form of life we can make the notions surrounding them more intimate and contextual, allowing us space to understand those individuals outside of the images and myth that often precede them.

Introduction

For many Americans, current and former service members historically represent the best values that they identify as being important in society. Military values like loyalty, duty, honor, integrity, and selfless service are ideas the nation is supposed to aspire to individually and collectively. In the contemporary War on Terror, the service member exists as a symbolic representative of those values. They are placed, literally and metaphorically, in opposition to the entities that sovereign governments identify as threats to peace and security. We often know these enemies as state and non-state actors or terrorists and insurgents, all of whom we are told threaten our way of life. Relative to these enemies, service members are mechanistic and necessary implements of conflict. Their bodies work to stem the real and perceived tide of external state and non-state (and, therefore, illegitimate) violence.

In the national narrative of the United States, service members are said to sacrifice themselves for the people, their freedoms, and their way of life. Their lives are sacrificed for ideas the nation values or, in the minds of some citizens, particular political views. They lionize service members and their service to the nation. The real rhythm of soldiers’ lives are starkly temporal, marked by deployments and training around the world. They define, for many, the proper exercise of state power and civic citizenship, two concepts that have become linked in the modern era. More graphically, they exist to kill and die for our security at home and abroad. This aspect is paramount, since, as Anna Simons (1999) tells us, “security remains the raison d’être of states” and these states “will continue to support militaries in order to protect their citizenry and/or themselves from being overrun, absorbed, and conquered” (p. 91).

Purpose and Method

The goal in this paper is to describe the experiences of U.S. service members and veterans in the War on Terror to explore how, more generally, those who perform military service exist in relation to the governments they serve and, more importantly, in relation to themselves, their service, and the reality that often entails. This examination of soldiering focuses on the experiences as a form of life specifically aimed at to demystifying military service in our larger societal narratives, exposing the functional realities of governments with their citizens. As is often the case, the actual material and social nature of military service can undercut larger narratives of civil engagement, whose fidelity is frequently referenced in policy making at the highest levels. More troubling, however, are the real results of conflict: injury and death, doubts,
fears, moral and emotional pain are downplayed in the wider narratives our society creates about military service. These consequences are almost always reserved for the individual, the veteran, their family, and their healthcare providers to deal with. The results of conflict represent a whole breadth of experiences that it seems can only be waded through in the past tense, often leaving the veteran feeling isolated from others, and many fail to negotiate these highly charged histories in ways that are productive, healthy, and not harmful. Although this paper is critiquing modern-day military service in the United States, it is not intended to be a wholesale indictment of it. Military service can be a source of great pride and meaning for service members and veterans, something that is inextricably linked to them as they move forwards in their lives.

Giorgio Agamben (2013) finds that a form of life is characteristically defined by a set of norms. These norms, he says, are “constitutive,” meaning that they “do not prescribe a certain act or regulate a preexisting state of things, but themselves bring into being the action or state of things” (p. 71). Forms of life are generally granted to ways of being that we recognize as unique based on how their inherent rules dictate the expressiveness of those involved. This analysis also follows the work of Didier Fassin et al. (2017) on immigrants as a form of life, who experience power in many more bleak and diffuse ways than service members and veterans, but who are also receptacles of it, nonetheless. This paper seeks to interpret service members’ experiences as they emerge in military service and labor and their collective aftermath in the veteran’s life. It also describes the unique relationship modern warfare has with the tools used to enact it and the soldier’s agency in using those tools, and conceives of soldiering, meaning the specific act of someone engaged in military service and its aftermath, as a specific form of life, a way of knowing, for its participants in a way that avoids deconstructing its various parts.

My own experiences in the military influence how I conduct my research and form my conclusions. I will employ Leon Anderson’s (2006) conception of analytic autoethnography to acknowledge this fact. Anderson defines analytic autoethnography as “ethnographic work in which the researcher is (1) a full member in the research group or setting, (2) visible as such a member in the researcher’s published texts, and (3) committed to an analytic research agenda focused on improving theoretical understandings of broader social phenomena” (p. 375). My involvement in the community is clear through my directly stated and described military service. My research agenda’s goal is to bring a closer understanding to the experiences of service members and veterans through an in-depth discussion of their being as a form of life. Military service members and veterans have injected their experiences, wittingly or unwittingly, into our social and academic discourses. These writings (both fiction and non-fiction) seem to pop up in the aftermath of conflicts as those individuals, myself included, seek to process their experiences.

Significance of Lived Experiences

The accounts I present in this paper happened several years ago. This was before I knew what anthropology was or what and how its preferred research methodologies are performed. The scenes are ones I’ve replayed in my head in the ensuing years, scenes which stand out to me as watershed moments in my larger experiences in the military. It should be understood that because of this lack of vocational rigor at the time the events happened that I did not document my experiences in any methodical way. What I do remember can only be bracketed in terms of things like rank, deployment location, or even weather. These specifically reflect an idea Birgitte Sørensen (2015) has called “ontological narratives,” which are representative of the complex negotiation that every veteran must go through as they seek to contextualize their experiences in relation to the state, public opinion, and actual on-the-ground realities of military service, especially abroad (p. 231). These memories are ontological exactly because forms of life themselves spring from specific forms of knowledge. The creation of these narratives conveys certain meanings about a veteran’s experiences while also working to create shortcuts through explanations for military service to society at large. They are war stories that reference the tools of war, injury, and life itself. My negotiation with the meaning of the vignettes is thus ongoing and my feelings toward them continue to evolve. It is through these vignettes, war stories, that I attempt to analytically acknowledge the realities of service members’ shared experience.

The majority of the uncited data about military structure and practice comes from my personal experiences in the United States Army from 2006 until 2014, appearing within the text as the uncited data about military practice and habit—the sorts of information that become so engrained in soldiers’ minds as they serve, sacrifice, and are sacrificed.
My experiences include two deployments in support of Operation Enduring Freedom to Afghanistan in 2008 and 2009. Later, between 2011 and 2014, I was in the Army Reserves assigned to an aviation company. Both groups of soldiers with whom I served taught me different things about the military. Though the missions of the units and my roles within them were very different from one another, the continuity of those experiences in my mind and their contributions to my lived experience and knowledge serve as a lens through which I view military service and its ensuing form of life. Throughout the text I use the term “soldier” as representative of all service members, which is interchangeable with other common terms for members of the military like troop, sailor, marine, or airman—the only difference being their branch of service, not their relationship to the government and the public.

Basic Combat Training, July–September 2006; Fort Jackson, SC

Arriving at Fort Jackson for United States Army Basic Combat Training (BCT) was a jarring experience. The in-processing center at Fort Jackson is best described in one word: chaotic. Upon arrival I was issued my first round of uniforms, which included clothes for physical training (PT) and fatigues (i.e., the Army Combat Uniform (ACU) blouse and pants, matching cover, desert tan boots, tan belt, tan underwear, tan shirts, and olive-green socks). Every recruit also gets a new haircut, several vaccinations, and new running shoes. Rumors swirl about what we should expect. It almost seems like a requirement that the information never be first-hand. There is a lot of what I later learned was called “hurry up and wait.”

As the first few weeks came and went, I adjusted to my surroundings. The uniform requirements for specific tasks and the schedule began to sink in and become more routine. For the record, the ACU is not complete without a belt, and when you are given a formation time, they really mean 15 minutes earlier than that. For us new soldiers, BCT seemed to operate at a company and platoon level, with drill sergeants running the daily trainings and offering guidance. They led us through our first trainings on military etiquette, directed us on the proper way to complete the Land Navigation course, and hastily educated us on the proper use and wear of the M40 gas masks before unceremoniously running us through the gas chamber. Together as a group of recruits we started to memorize the Army Creed and the Army Song (both of which are inspectable) packed our first rucksack, and learned the ins and outs of road marching. Within the first month we were issued our weapons without live ammunition and a blank firing adapter, which remained on our weapons at all times when we were not on the firing range. We fired what felt like an infinite number of blanks while learning about buddy movement and spent an inordinate amount of time cleaning our weapons and the barracks.

At some point in this seemingly endless stream of training, you start to buy into what you’re actually there to do and turn a corner. For me, that corner was the bayonet assault course. While not the deadliest weapon in the United States Army arsenal (in fact, they aren’t even issued regularly anymore to many units, even in deployment settings), the bayonet symbolizes the terror of face-to-face combat. As I learned later, if you come to the situation where you are using your sidearm you are already having a bad day. The bayonet brings this notion to an even closer meaning. It is the last weapon before unarmed combat, the last force multiplier available to a soldier to subdue the enemy. The bayonet course was no different from many of the other trainings I had and would receive in basic training and afterwards in my active duty unit, less intense than some, more intense than others. Somewhere someone checked a box on a training log with my name on it. As I lined up, bayonet fixed to the end of my M-16, I was ready to attack. The target was a sandbag, already full of holes, hung on a post. A switch in my mind seemed to click. I knew what I had to do and where the power had to come from: grab the weapon tightly on the narrow part of the buttstock. Firmly grasp the hand guards on the barrel, just above the slip ring. Muster up your strength and rush toward the enemy, thrusting the weapon into the meatiest part of the body. Withdraw, repeat, continue on past the post. It helps to get angry. Return to that feeling as necessary.
Service and Citizens

BCT is one of the universal, liminal rites of passage that all military service members and veterans share. Rites of passage, as defined by Arnold Van Gennep (1960), are identified by their three phases: separation, margin, and aggregation. While discussing rites of passage as defined by Van Gennep, Victor Turner (1969) points out that as the neophytes pass through the experience, they “among themselves…tend to develop an intense comradeship and egalitarianism. Secular distinctions of rank and status disappear or are homogenized” (p. 95). Basic training follows this example closely as it serves to sever, both socially and functionally, your former self from your newer military self in the same ways that many cultures use rites of passage to mark adulthood. Through the completion of a series of basic soldiering tasks, the individual arriving at basic training is transformed into the uniformed soldier, someone who can be relied upon to follow the orders of their superiors and train tirelessly in the defense of the duly elected government that they serve. This marking of the service member is the first key to the discussion of military service as a form of life. It is also the first understanding of how nation-states mark and unmark different categories of people to achieve political goals and exert political force. Obliquely speaking, the categorization of citizens and non-citizens into different legal statuses by the state is an archaic form of exclusion used by sovereign governments to justify their uses of force internally and externally (Agamben, 1998, p. 9).

A citizen’s qualification through social categories like “service member” and “veteran” further atomizes these distinctions. These categories are granted what Catherine Lutz (2001) calls “supercitizenship” as they are seen to exceed the public in discipline, virtue, and moral authority (p. 236). This image lands in the core of soldiering as a form of life. It is what is added to and taken from to produce the notion that there may even be something identifiable and reproduceable in those experiences of soldiering. However, as Lutz herself implies, it is something given to the servicemember, and is the precursor, I think, of endless waves of “thank you for your service.” Moreover, the part of my mind that could be labeled “veteran” is wary of any individual who would actively solicit these hierarchal distinctions between themselves and the service member. The ambivalence I feel is, for me, tied to mixed feelings about the purpose of my service, my agency in making those decisions, and the fact that I still do find some pride in the experiences. It could be summed up like this: I wouldn’t do it again but I would not (and cannot) change a thing.

Conceptions of Military Uniform(ity) on Forms of Life

In his discussion of what constitutes a form of life, Agamben (2013) describes how the habits and practice of a monastic way of life constitute an example of it. Describing the origin of the root term “habitus,” he tells us that the term originally “signified a way of being or acting”, noting that among the Stoics it “became synonymous with virtue” (p. 13). Classically defined by Pierre Bourdieu (1977), “habitus” are “systems of durable, transposable dispositions, structuring structures predisposed to function as structuring structures” of which he says that “even when they appear as part of the realization of the explicit, and explicitly stated, purposes of a project or plan” produce practices which enable “agents to cope with unforeseen and ever-changing situations” and “are only apparently determined by the future” (p. 72). Agamben’s discussion of the monk’s habit suggests that a great deal of how we morally understand different actors can come from their dress. The monk’s leather belt specifically denotes the actor “as a warrior of Christ.” The sight and symbol of the leather belt is directly connected to its sacred meaning, which Agamben (2013) calls a “sacred sign,” marking when the “neophyte takes off his secular clothes to receive the monastic habit” (p. 15). Without invoking the full meaning of religious sacrality onto the soldier, a service member’s uniform acts as a marker that conveys to the viewer details about the rites of passage the individual has gone through as well as their likely allegiance to the state. It also tells the viewer how the person might react to different stimuli and how their lives might be structured both in and after their enlistment ends. The fatigues, the tan shirt and tan boots, the cover, are all shorthand for this. These ideas are bound up with the uniform and its wearer and continue for the veteran indefinitely as their own habitus, an integral part of the form of life they now embody.

The understanding that dress can represent both morals and lifestyle should be seen as a part of the state-building project itself. State creation, as Phillip Corrigan and Derek Sayer (1985) tell us, is “always accompanied by the moral
regulation of society,” creating classifications of citizens as a byproduct of their relations to the means of productions in capitalistic societies (p. 4). Military service’s connecting of morality and citizenship, much like Lutz’s (2001) discussion of “supercitizenship,” is a defining way to understand the modern state’s economic and political goals. Moreover, the connection between dress and morality, combined with the access to arms defines how we think of soldier’s labor and what it means to us. Soldiering as a form of life is defined by the tasks contained within it. As the first vignette shows, these tasks are often physical in nature. They also work to build mental toughness and resolve in the recruit. The ability to be precise in uniform wear and proficiency in the use of military equipment is continually pressed into the mind of the soldier. This information is shorthanded in the image of the soldier. The uniformed body of the soldier is a transformed object. This uniform body is then used by the state to create cohesive national narratives.

Meaning and Sacrifice

This shift in status from civilian to soldier dictates how we should begin to understand service members’ experiences in the military. At the deepest level, they do serve as tools of the state, made to die if necessary, for its purposes and policies. More important, though, is to have that person sacrifice willingly for the state. This agentive action helps to create viable national narratives and supports claims made by states for continued legitimacy. The agentive difference between “being sacrificed” and “sacrificing” is an important one. By sacrificing themselves with agency for the security of the state, the soldier becomes part of a narrative which lends legitimacy to the actions that government has chosen to undertake. As Veena Das (2008) suggests, this yving for the soldier’s consent is mostly to “claim legitimacy for a nation’s own wars” as it “creates boundaries between so called civilized warfare and savage violence” (p. 287).

Thus, the problematic notion of sacrifice for the state is key to our understanding of the life associated with it, especially its aftermath. This seems to fall in line with more modern narratives of soldiers who “put themselves in harm’s way,” which as Lutz (2002) points out, “reverses the image of soldiers as warrior-killers and [elides] the state’s role in their movements” (p. 725). As Ivan Strenski (2003) suggests, “sacrifice is not just a social deed,” it also “has potent religious resonance” as the act of “giving something up” or the act of “a giving of” is what “makes something holy” (p. 8). This social aspect, again bordering on a sort of sacrality, is what makes military service a powerful force in politics and other national and social discussions. It has weight.

The notion that military service and sacrifice is a social act ties that act to our own cultural prejudices, coloring how the military is used and the context in which it is read. Sacrifice, who can make it, and in what context act as “the primary means, by which we give meaning to the world around us; they allows us to interpret what we see, and indeed, what we are” (Kertzer, 1988, p. 4). If the soldier does sacrifice themselves willingly, then the goals of the state are validated. Their coffins return home draped in an American flag and the soldier thereafter becomes a synecdoche for the state and its sacred goals (Kertzer, 1988, p. 7). Telling of this, as Kenneth MacLeish (2013) points out of modern combat casualties, is the fact that “even in death, one can’t be human” as most casualties in contemporary conflicts “just happen, unceremoniously” (pp. 88–90). This allows for both their easy absorption into the conflict’s political narrative and the completion of their sacred duty to the public. These deaths are often stark and violent. It solidifies the service member’s status, transitioning them into a permanent status in death.

Homecoming and Transition

The transition from service member to veteran is often invisible, however. As Sørensen (2015) describes, rather than experiencing homecoming in explicit ritual terms of death and living, modern Danish veterans experience homecoming as a “displacement into an unsettling environment,” which “constitutes a critical event that requires new social practices and relationships” inside an “entirely new narrative” (p. 231). United States military personnel experience a similar disconnect after service as they move from a visibly marked category, the soldier, to the unmarked veteran. Even more ambiguity exists in this transition when considering those service members and veterans whose bodies are permanently physically or mentally altered by their experiences. The presence or seeming absence of these changes again re-inscribes veterans’ bodies to society at large, marking them with assumed mental health diagnoses and other categories that fit into the cultural understandings of what and how the form of life exists.
Sørenson (2015) also describes how there seems to be a taboo among many former service members’ of speaking openly about the extent of their combat experiences to outside questioners who only seek to know the explicit details of their military experience. “Such questions,” she tells us, “are typically felt as an assault, a transgression of a moral boundary, that robs the Veteran of the privilege of controlling silence and disclosure about this most sensitive matter” (p. 234). The discussion of warfare and the individual’s role in it is thus a taboo for soldiers as they attempt to leave the military and transition into civilian life. They feel trapped in the context of trying to decode those experiences for people who do not share them and whose lives offer very little context for their discussion. This is when they must begin to control the narratives about their service and themselves, creating the war stories they choose to share with others while negotiating their meanings to themselves.

The vignettes included in this paper are the ones I felt I could share—they are coherent to me and their meanings have crystallized. The subtext, as I mention above, is steeped in deep ambivalence about my role in these experiences. As I explain later, those experiences are both anonymous and intimately familiar to me. As a part of the discussion around a form of life, however, we see that the making of this life extends from the deeply personal through to the broadest examples of the social, cultural, and political world.

**Soldiers and Warfare**

The social nature of conflict and how we define it to exclude certain forms of violence and life, like chemical weapons and the intentional targeting of civilians, is bound to the fact that we understand warfare as social action. All military conflict is tied to this notion as it disrupts, realigns, and forever alters social landscapes in the places where it occurs. The operational reality of these ideas in places like Afghanistan, however, has become more opaque as both sides of the conflict balance violence in terms that are both efficient and, seemingly, short term. Words like “detainee,” “insurgent,” and “Local Nationals” seemed to blend together. The long-term status of any one person could not be guaranteed as those groups shifted and changed, often in response to the time of year and our own actions. In Afghanistan, I saw Local Nationals hired to be gate guards, cleaners, and cooks in endless cycles of individuals who we as soldiers did not know and were not encouraged to know. They shared uniforms, especially winter boots, as the seasons and our missions changed.

To truly understand the landscape in which soldiers act, we must understand the nature of warfare and how the bodies in both sides of a conflict are reshaped to meet its task. Talal Asad (2007) defines the term “war” as “a defined activity in international law” that has “a formal cause and formal conclusion,” though one which should not be mistaken for the “beginning and end of organized killing by the state” (p. 26). This definition suggests that warfare can be legitimate and ostensibly morally justified. It also suggests a level of (a)temporality to the event that is war. Modern conflicts have shown how complicated this situation can be on the ground, however, as they create quagmires of meanings surrounding the purpose of specific military operations, often spanning multiple theaters, decades, and generations of service members.

The soldier is especially wrapped up in this violence. We are imagined to be constantly vigilant, kicking in doors, conducting convoy and dismounted patrols, finding the enemy and defusing the source of political violence thought to be being perpetrated against all United States Citizens. The reality for many of us, however, is a slow negotiation with goals and policies that often begin high above us. They echo down chains of command and intelligence, leading us to blacked-out planes and runways. The next vignette is an example of my own involvement in violence. However, I was so far removed from the decision-making that led me there that I was not even deemed as a need-to-know person in the events of my own life. As an image to our enemies, however, I did represent the powers necessary to have them detained in their own countries and essentially disappeared. As often is the case, soldiers are also themselves disappeared. The policies and practices that brought me to that intersection in time are easier to track. The veterans and, more troublingly the Local Nationals, slip offstage, leaving unresolved experiences in their wakes.
Operation Enduring Freedom, August–September 2008; Bagram Airbase, Afghanistan

I got orders from my NCOIC, the non-commissioned officer in charge of my section, to go over to Ops at 1600 for a detail. When I arrived, the sergeant on duty told me where to be and when and with what gear: body armor, weapons, Kevlar helmet, ear pro. Full battle rattle. We were going to pick up a high-value target one of our teams had recently captured. I wasn't told which team captured the person, the person's identity, or relative importance to our mission. I wasn't “read-in,” meaning I didn't need to know, for that level of information and it was not pertinent to the detail. I was joined by three other soldiers from different sections. Two non-commissioned officers (NCO) drove us to the flight line.

We flew out on a C-130 that evening after dark, landing about an hour later at a firebase I had been to before. The plane idled on the blacked-out runway while we waited for the prisoner to be handed off and prepared for transport. “Transport” in this context means zip tying the person's hands, blindfolding them with goggles that had been painted black, covering their ears with hearing protection, sitting them on a dog pee pad, and using a tow strap to strap them to the aircraft. The pee pad was there in case the detainee decided to soil themselves in a last-ditch protest, a situation the flight crew prepared for since it had happened frequently enough in the past. The entire transaction lasted less than ten minutes. The plane Taxied quickly, turning at the end of the short runway, and made a hasty exit. We flew with the ramp of the plane open, which undoubtedly created an unwanted sensory experience for our detainee exacerbated by his sensory deprivation.

We arrived back at Bagram less than an hour later. We waited on the dimly lit flight line for the truck, a white Toyota Hilux, to arrive. We loaded the detainee into the back of it, maintaining positive control to direct him into a kneeling position. The four of us, still wearing all our gear, got into the back with him, sitting on the edges of the truck bed as he knelt between us. We drove in silence down a small back road of the air base. We were taking him to be processed into the prison located on the base. We wouldn't see him again after that.

I was picked up for another guard detail a few weeks later. I was assigned to guard a detainee who one of our teams had recently brought in after a less-than-effective exchange of fire with one of our helicopters. The helicopter crew's report stated that the detainee shot at the Apache, an advanced attack helicopter, with an AK-47, the assault weapon of choice for enemy combatants in Afghanistan. The standing ROE (rules of engagement) required us to render aid because he hadn't been killed in the lopsided exchange of weapons fire. The information relayed to me was that the man was already apparently a single amputee before this incident. He was remarkably unscathed overall, I thought, considering the disparity in combat power between himself and the aircraft. He did, however, lose his second leg below the knee as a result of this encounter with U.S. forces.

He was unconscious when I arrived at the main base hospital in full gear to guard him. The NCO in charge gave me brief instructions on what I should expect and sat me down in a plastic chair facing the foot of the detainee's bed. A sucking sound periodically emitted from the machine that pulled fluid off the newly amputated leg. I was meant to guard him in case he “got out of control,” though even I knew there wasn't much he could do in his current state. The room was dimly lit and had no windows. The door was closed. The nurses weren't fazed by my presence there. I sat in the chair; it was night outside. I read a mystery novel that had been left there by some guard before me. Every few lines were punctuated by the sucking noise coming from the direction of his leg. He regained consciousness at some point. He looked down at his second leg, now lost. He didn't seem to notice me and I couldn't offer any consolation; I didn't speak any of the Afghani languages and nobody else was in the room.
Wars: Soldiers as Objects and Locations of Violence

As Lawrence Freedman (2005) suggests, the wars we fight now are no longer wars over national territories, what he calls “wars of necessity,” but, instead, modern wars are “wars of choice” as states attempt to police other countries’ spaces from within and outside their borders. These missions, often tied to the political clout of the leader in charge at the time, are, as Harald Müller (2012) observes, “complex” as “soldiers are expected to fight insurgents, protect civilians, and perform non-military tasks within environments where lines of distinction between ‘friend’ and ‘foe’ are increasingly blurred” (p. 283). “Force projection” is itself a regular activity for units operating in modern theaters of war, though the targets of that force are never fully described and are not intended to be. They are objects with which we interact. Shows of force are meant to dissuade local nationals and enemies from continuing their insurgent and supporting activities through a demonstration of military might.

The soldier’s role is identifiable in these exchanges. Their appearance signals their involvement in the military, like the uniform and standardized haircut. We use militaristic jargon. As Carol Cohn (1987) describes, the use of sanitized language by members of the military is a linguistic technique used to change humans into objects that can be killed more easily (p. 691). Throughout writing this series of vignettes, I often translated terms and meanings for the sake of clarity. The act of recoding often seemed to sanitize the events and remove me from them, as if I were hidden behind the orders and decisions made by those few who had a need to know.

Further, as historian John Keegan (1978) tells us, the rise of “thing-killing” weapons like heavy artillery, whose purpose is to remotely destroy objects with the side effect of killing people, so-called “collateral damage,” is the genesis of this type of speech. Its purpose is, arguably, the creation of bare life, meaning life that is reduced to its biological fact only and ignores how it might be lived (pp. 329–330). Using language in this way is also a method of euphemistically masking violence and, as Das (2008) suggests, this “discursive technique” allows “certain kinds of violence by dominant groups” to “disappear” (p. 289), thus allowing violence to continue while masking actual military practice with increasing jargon and self-reference. The social implications of this are well known. Dehumanization of the enemy is often the first step to more expansive violence and acts of this sort, things like massacres and, more broadly, genocide, are socially and culturally remembered as failures of leadership at every level, inhumane, and morally indefensible.

This is an important inflection point as we continue to interrogate forms of life in this vein, especially when we consider generational changes in how the military recruits and retains its forces. I joined the military as a means to an end, a fact that colors how I weigh my experiences and how I subsequently tell those stories. As mentioned above, war itself is a social action. So much of the reality of soldiering as a form of life appears to be violence visited upon and by the service member. This leaves less space to interrogate the soldier’s own motives in seeking out enlistment and these motives themselves should be understood to be within social and economic contexts. In their study of recruiting tactics in Sweden and the United Kingdom, Sanna Strand and Joakim Berndtsson (2015) identify several methods currently used to persuade new recruits to join those militaries. Recruitment rhetoric in both countries, they observe, promises new recruits “that they will grow as individuals” thereby making them more “employable and attractive to private labor markets” (p. 234). As Strand and Berndtsson (2015) further point out, modern military recruitment exists within the context of a long list of military transformations as soldiers now enter a “redefined global security arena” whose weapons, tactics, and premises are different from the wars of the past (p. 234).

Set within this roiling social context, forms of life and ontological narratives seem to become more convoluted. The question of how we reconcile these realities is hard to answer. This confusion is key, however, as we, the outsiders of personal experience, look in on the experiences of others. Soldiers like myself are recruited from small towns with long affiliations with the military, plucked, as it were, straight from our high school classrooms. We are sent to fight wars that no longer even make it onto the news. The terms for resolving these conflicts is ambiguous at best. We do so for economic, political, and social reasons. The reality of the experiences, however, are often morally gray and amorphous in their apparent larger purpose. As a view into the form of life, the unevenness itself is the most telling. It complicates easy narratives about war and peace, sacrifice and honor, and forces individual service members and veterans to continually weigh their own position in their own social worlds and beyond.
Operation Enduring Freedom, September 2009; Forward Operating Base Farah, Afghanistan

Our repair team was being sent out again. For this and most missions the repair team consisted of myself, one private, and a box of items that we thought we might likely need on-site. Functionally this meant components of our units preferred radio and night vision, the tools to fix them, a length of cable with its associated adapters, and the paperwork to document our work. Our mission this time was to Farah, a small firebase in southern Afghanistan. To get there we first had to fly to Kandahar, then catch a second Chinook flight further out to Camp Bastion, and then, finally, convoy a small distance further to reach our destination. We arrived with the knowledge that the group at Farah had recently lost a team member to an IED, an improvised explosive device, less than a month prior. We had been sent out by the battalion for routine equipment repair, meaning we'd check their radios and fix any broken NVGs (night-vision goggles) and probably make some radio cables for them. The movement to the firebase took about a day and a half. When we arrived, however, our point of contact told us that there wasn't much for us to do. A team from 2nd Battalion had been out to the base not long before us. The only thing they had for us was the grim task of trying to get the secure equipment, things like radios and the jammer, out of the rack of the truck that had been hit a few weeks before.

The “truck,” in this case was a GMV, a ground mobility vehicle, which is a Humvee that has been modified to the specs needed for the missions our unit carried out. They were favorites of the teams for a few reasons: they were easy to drive, had large stable wheelbases, and were familiar to most soldiers. The GMV, which shared a flat bottom with its predecessor, the Humvee, had by 2009 been deemed by the Army (and the enemy) to be an easy target for IEDs. The 120mm Howitzer shells preferred by the Taliban and the Mujahideen in their construction of IEDs could effectively punch a hole straight through the bottom of the vehicles, killing, maiming, or ejecting all the occupants inside. This would often lead to additional casualties as the enemy often set ambushes at these chokepoints, wounding additional troops as they rolled out of the trucks disoriented and injured. Not unsurprisingly, the United States Army had started to train its soldiers to identify the signs of IED emplacement while on mounted patrol.

By 2009, the various United States military branches had begun to replace GMVs with MRAPs, or Mine Resistant Ambush Protected vehicles, which, as the name implies, were designed to try and overcome some of the glaring weaknesses of the flat-bottomed GMV and Humvee. The MRAP was designed with a V-shaped hull and higher ride height, which lessened the intensity of the blast while also deflecting it, thereby protecting the vehicle's passengers. The entire vehicle could be buttoned up, making it a harder target than the vehicles it was meant to replace. The enemy responded in an almost ingenious way to this change in our military hardware. Rather than giving up on manufacturing IEDs or using other non-conventional tactics, they did something much simpler: they canted the angle at which they buried their explosives, instead placing the IED in the ground at a 45-degree angle, effectively nullifying the supposed protection of the hull.

Thus, we found ourselves in a GMV which had no chance of surviving the encounter in which it had been placed. The equipment in question had melted and become fused with its rack and still sat where it had been left when the blast hit the vehicle. The mangled remains of the vehicle had inoperable doors, and so we had to go in through the top, where the turret had been. The inside smelled of rust, like a nosebleed. It smelled of smoke. The smell burned in your nose. We weren't able to get the equipment out that day. We only had tools for radio and night-vision repair: screwdrivers and Allen keys. Nothing meant to cut metal or chisel out equipment that had effectively been fused to its rack. We added the relevant details about the situation to the paperwork. The truck, I can only assume, would be sent to the junk yard to be dismantled and processed by an army of military contractors.
Men and Machines

Soldiering and militaries have historically been at least partially defined by their armed nature, the nature of the armaments they employ, and to what success. The tools of contemporary soldiering materially compound and exponentially increase the body’s effectiveness for the realities of modern warfare. The tools of a given conflict shape a battle’s rhythm and expectations. Innovations in battlefield medicine and the widespread adoption of ceramic body armor to replace older flak jackets, an innovation that dates back to the Vietnam War era but whose premise goes back much further, have led to decreasing numbers of service members being killed by combat actions while weapons such as drones have increasingly removed the act of killing from the actor. Soldiering, as a form of life, derives a large part of its mandate from this.

Underscoring this focus on the material nature of the tools of conflict and their connection to the acts themselves, Woodward and Jenkins (2011) observed that when British soldiers were asked to describe the act of soldiering, they focused on its materiality as a means of measuring success in that role. Using the soldiers’ own descriptions of personal photographs, the authors identifies several key concepts linked to this, noting that for some “these skills were clearly identifiable as military tasks,” such as “accuracy in marksmanship” and “surveillance and observations skills,” or “the deployment of technical knowledge in the act of patrolling hostile urban areas” (p. 258). These are the factors that the soldiers themselves bring to the fore to explain their service and their success or failure in it. Through this it becomes clear that military identities, as Woodward and Jenkings (2011) suggest, “have a materiality to them in that they are constituted and expressed through the use of equipment,” extending all the way to weapons, the key part of what makes a soldier a soldier, and “the trained ability to correctly handle and use them” (p. 259). This connection to the proper use and deployment of military technology is paramount to understanding soldiering as a form of life. However, as MacLeish (2013) tells us, “modern warfare does not ensure the protection of the human body so much as it subjects it to previously unimaginable forms of harm and exposure—levels of violence…” (p. 53).

Much like the discussion of thing-killing as a language device, the actual act of killing is now facilitated by the implements of war that variously and simultaneously protect and expose the soldier to harm. As a soldier, I was explicitly aware of the shifts in armor technology and the resulting contracts the government would use to help reduce death tolls. But I, like many other service members and veterans, was also aware of the futility of the process in which I found myself. From flak jackets that dated to the Desert Storm era, to more modern interceptor body armors (IBA) that use ceramic plates as their main method of survivability, I felt as though I understood the material evolution of protecting soldiers from small arms fire and other anti-personnel weaponry and the logic surrounding it. The result of this type of warfare offers what MacLeish (2013) calls a false sense of “technomagical invincibility” to the troops, at least in the United States military, which belies the number of ways in which it can fail, resulting in the death of the individual soldier (pp. 53–54). As a form of life marker, there are few things closer to a soldier’s heart as they train and toil. It pervades the stories we tell ourselves about who will win, who will lose, and what our odds of coming back alive from deployment are for any one of us. The results of thinking of oneself in these terms is what MacLeish (2013) describes as a state “biological precarity” for the soldier, as they are “the agents and instruments of sovereign violence, but also its objects: equipped and trained to kill, kept alive in extreme circumstances, and placed deliberately in harm’s way” (p. 54). Thus, the greatest irony of the soldier, and the resulting cynicism, is that they exist as lives “kept alive” by great bulwarks of technology that are “fundamentally linked to the logic that endangers them in the first place” (p. 54).

Often, however, the discussion of war itself is limited to this discussion of machinery. War in the mechanical context suggests a certain scalability, functionality, and modularity to the body of the soldier. It lends a notion of replicability to the soldier’s body. Machine-centered thinking is also a tool for the soldier, though, as “cyborg” thinking allows soldiers to interact with their weapons in more useful and meaningful ways. As Gusterson (1996) points out, “the figure of the cyborg does not so much describe a literal phenomenon as provide a metaphor for the increasing technicization of daily life and interdependence of humans and machines” (p. 121). The notion of cyborgism is related to soldiers, Gusterson continues, as it “makes symbolic connections” between weapons and bodies, allowing the creation of metaphors that allow the soldier to “make sense of the world” (p. 123). These connections build into stories and ontologies. Haraway (1991) concurs by telling...
us that the “cyborg is a condensed image of both imagination and material reality, the two joined centres structuring any possibility of historical transformation” (p. 150). It is through this understanding that we see how the image of the soldier, their material being, and their meaning and purpose, create the hierarchies of meaning necessary to a form of life being formed, with the weapons of war being references for the violence level of the conflict and, often, how we as soldiers and the public expect or imagine death to arrive to ourselves and our enemies.

Referencing the last vignette, the presence of the wrecked Humvee and my knowledge of its shortcomings as a platform allowed and allows me to frame its destruction and the death of the soldiers in it into a larger personal and political commentary and understanding. In doing so, it becomes part of the ontological narrative I create for myself and others about the meaning of the conflict and my place within it. It is the memory work of soldiers and veteran's, however, that tells us how these machines work. Reflecting on his own ethnographic information, MacLeish (2013) notes how they concurrently inform us of the effects of war that are “necessary and worthy” and those that are “abhorrent and avoidable” (p. 10). There is often a great deal of moral ambiguity about which actions represent each category.

**Time and Horizons**

Inasmuch as soldiers can be approximated to machines, they should also be understood regarding the temporal nature of their experiences. As MacLeish (2013) accurately tells us, soldiers experience their service as an unfinished present. In the case of his informants, he describes how they are “repeatedly shuttling between home and Iraq,” often returning home with the foreknowledge of their next deployment (p. 8). However, this same precarity seems to be a defining feature when we think of what makes soldiering a form of life. I have a sense of what time of year I was in the truck, my futile attempts at trying to pry out the sensitive equipment so that our unit could do the necessary paperwork to make sure it was taken off of the inventory, but that is not my focus. My focus is on the heat of the sun, the jagged metal, and the smell of rust and smoke generated by the bodies lost in the vehicle. MacLeish (2013) details this sentiment thoroughly, describing how “the soldier goes to war, and labors at it for months and months, perhaps in a job in which he never even takes a shot at an enemy combatant”. Depressingly, he continues, “at the end of it, though things may seem to have changed strategically or politically for better or worse wherever he was, the war typically has been neither won nor lost” (pp. 14–15). This sort of slow encounter with the possibility of death creates feelings of being stuck in slow time, where every ping of a rock or shake of the ground can mean the death of you or your comrade.

**Community Engagement and Forms of Life**

In a larger sense, the discussion around forms of life is a chance to reflect on shared notions about groups with which increasingly few people engage. In a time where “thank you for your service” seems almost reflexive for many people, the ability to peer deeply into what that experience is or might be is crucial. The personal stories used to frame the discussion in this paper are unique to my experience, but they are also universal for many veterans across many generations of conflict. Autoethnography can then be seen as a point of departure from theory into experience.

As a form of community engagement, disclosing my own experiences creates spaces into which other service members, veterans, and their families can inject their own knowledge. This then begins to flesh out our larger communal understandings of their lives in relation to military violence and its aftermath. The decision to do so stems from my desire to describe experiences that, far from heroic, represent the laborious nature of military service. While service members and veterans are far from marginalized, in the contemporary sense of the word, they are at risk of something much worse: being taken for granted. As so many other communities work to get their stories into a mainstream consciousness, so do many veterans feel great isolation from a lack of appropriate cultural spaces available for them to process their own experiences.

This work further seeks to engage researchers in fields related to military and veteran studies in the social sciences with first-hand accounts from members of that community. The decision to use autoethnography allows the readers from those fields of study to understand very clearly where I am drawing my conclusions from, thus allowing them to challenge and expand on those findings while demystifying military service realities that they often do not share with their subjects. This translation, so to speak, is the major draw for researchers who are also community members, like myself, who find gaps in the literatures...
surrounding their own experiences. The use of forms of life compliments this, working as a concept that allows the topic to be understood in more contextual way, as veterans’ lives continue well after their military service but always, and in many intangible ways, relative to it. As one veteran said to me, “[in my mind] there is no time before the Army, and while you’re in, there isn’t any time after.”

As a vehicle for researchers who seek to work with the military and veteran communities, the usefulness of understanding the layered experiences of military service cannot be understated. The very notion that there may exist something recognizable as a discrete form of life opens up the possibilities of what types of research might benefit both the community and the researcher. Qualitatively speaking, it expands many things we already know about the benefits of interviews, ethnographic, and other more subjective and contextual types of data collection. For those who work with more quantitative data, models, and frameworks, this work allows those researchers to reflect on more confounding issues that might not yet have been accounted for in their work.

One limitation inherent in this paper is the fact that I do not speak for all service members or veterans, each with their own unique experiences. The work I produce, especially in regard to this topic, is biased by my education, worldview, time in service, time of service, and the sheer opportunity to work in this space. What is needed for true community engagement, beyond the premise of forms of life, are opportunities for other members of this community to speak their truths. Many of those stories will be far from my own, influenced, like mine, by political narratives and personal beliefs. My assumption, however, is that their confluences and the meanings for those individuals will reflect and build on the discussion here even as the details are parsed out. True community engagement thus moves forward from this as dialogues and concepts are created for those discussions to take place. This is echoed by Shalowitz et al. (2019) because, as they point out, “the process of engaging community members… represents the necessary ‘first step’ in conducting a research project” (p. 353).

Conclusion

Forms of life, as a concept, presupposes a generalizable notion of the service member and veteran and calls it into contention. It acknowledges that the experiences necessary to define it are as much a set of activities as they are political imaginings. The continued use of ideas like forms of life are calls for stakeholder engagement in research to disentangle those two incarnations of life from each other. An acknowledgement of this call, in turn, points towards an alternate future to the categories of service member and Veteran, one where they are understood more representative by the individuals which inhabit them. The uncoupling of this relationship between image and reality is, most importantly, the path forward in truthfully speaking to the realities and needs of service members and veterans.

As a form of life, soldiers are trapped between dichotomies of logic. They are wedged between our ideas of individual responsibility and institutional practice. They also straddle the intersections between harm, biological precarity, and strength. They are equipped with the most modern weapons, disciplined to endure pain and hardship, and taught to create stories out of these difficult experiences that define them as veterans and people throughout their lives. Service members are expected to, if necessary, commit acts that, outside the context of military service, exact the highest forms of penal punishment. They assert to all of this for what could be seen as purely personal gain, such as a college education, healthcare, and financial stability. All the veterans (myself included) who I spoke with felt that their military service was a beneficial stepping-stone for their careers and personal lives. Service, accordingly, becomes very linked closely to our narratives about ourselves.

Conversely, our understanding of the actual lived realities of soldiers and those who would become soldiers undermines our notions of honor and sacrifice. They confound our understanding of the military as a body that represents the public it serves. Soldiers’ day-to-day experiences in combat zones, MacLeish (2013) says, demand a “complex synthesis of practical knowledge, emotional discipline, and bodily discipline” (p. 77). This habitus remains with them long after their service ends, creating meaning and trauma for the veteran as they attempt to make sense of the lives lost around them for politically ambiguous goals. They return to a climate that concurrently venerates their “service” while placing them into stigmatized mental health categories.

I use an autoethnographic method in this paper to discuss the realities as a form of life to reveal the heterogeneous nature of military
experience. Intriguingly, beyond that, is that the universality of those experiences can be made into any one coherent notion like a form of life. It changes the service member and veteran from passive beings into active creators of their own experiences as the activities concomitant to their service define their social intelligibility to others. There is no vignette describing my life as a veteran after my military service. As a category of my experience, the time in it is marked by normal experiences that need no explication: college graduation, relationships, changing vehicles, moving to different cities and states. These are universal experiences, but they are framed by my military service in ways of which even I am only slowly becoming conscious.

It is arguably this process of reflection that truly marks soldiering as a form of life. By understanding the processes that bring about the “soldier” category in modern armies as an act that itself creates a form of life, we are better able to see how these experiences fuse into what we recognize as a person, rather than an object or image. This recognition of a soldier’s humanity outside of a category is what will enrich the discourse surrounding them for some time to come. The veterans’ acknowledgment that their body was and is the currency upon which the state makes its calculations when contemplating new and existing wars causes waves in that person’s life that they must endure. We can and do know that through different intersecting subjectivities, service members are made to act as controlled but agitative agents, at once docile subjectivities, service members are made to act from passive beings into active creators of their own experiences as controlled but agitative agents, at once docile and veteran are intertwined in these facts. The task beyond this work, in this light, becomes how to understand the intersections of these forces as they emerge in service members’ experiences as they negotiate the mediated, ongoing meanings of those realities while also attempting to move forward with their lives.

References


**About the Author**

Shawn Dunlap is a Health Science Specialist and anthropologist at the Center for Healthcare Organization and Implementation Research. His most recent work involves engaging veterans experiencing homelessness using ethnographic methods aimed at identifying transitions into and out of housing and using those findings to create a mobile application that reproduces their detail. His research interests include the implications of policy on Veterans experiencing homelessness, moral economies surrounding healthcare, stakeholder engagement, and the use of technology to facilitate healthcare engagement and research.
Abstract
This phenomenological research study, conducted from 2017 to 2018, rigorously and methodologically investigated Iraq and Afghanistan (OIF/OEF) veterans’ first-person accounts of their experiences of profound change after war. This study explored the existential themes of homecoming, betrayal, grief, guilt, meaning, and truth-telling through the lens of OIF/OEF veterans. This existential investigation built on the methods of Husserl’s phenomenology, which explored human consciousness, and Heidegger and others, who deepened the phenomenological exploration to address the question of human existence. Key to the investigation of human phenomena is allowing the core encounter to emerge through rich, authentic description. In this study, OIF/OEF veterans described an experience in which they recognized that they had been profoundly changed by war. In-person interviews were recorded and transcribed. Data was analyzed using Colaizzi’s (1978) seven-step approach. The findings highlighted how profound change after war was a matrix of psychological and spiritual expansion for both the individuals and their communities. The fundamental structure of this phenomenon had three essential facets. First, experience, awareness, and impact collectively constituted one another in a circle of influence. Second, a before-deployment self stood in stark contrast to an expanded after-deployment self. Finally, profound change was enduring and had wide-sweeping implications throughout many levels of each veteran’s life. Psychological-spiritual growth may result in symptomatic behaviors that are easily attributed to psychological disorders. These results also illuminate the need for social support at the community level as well as the need for veterans to cultivate self-awareness as part of the transition process.

The Iraq and Afghanistan conflicts of the 21st century have ushered in a new generation of war veterans. For many, these encounters will bring about psychic changes so profound that the war itself will pale in comparison to what lies ahead. There is no guarantee whether a transformative maturity or a regressive disintegration will emerge. What happens in the short span of the homecoming years, often when veterans are at their most vulnerable, can have lasting effects on their health and efforts at reintegration. Experiences of combat and related phenomena may resist easy quantification and are subject to ongoing debates about their place in the human psyche as well as their proper role in society at large. The political, economic, social, and personal implications of combat experience may complicate matters even further. More robust approaches to transition are needed that can address the multifaceted and multilayered realities of veterans’ wartime experiences. It can be a disservice to both veterans and society when only piecemeal or partial understandings of veterans’ combat encounters are recognized and integrated into both the personal and the collective narrative. A transition that is arrested or inadequate can leave veterans ill-prepared to face the war-related phenomena that may emerge in their lives 2, 5, 10, or 20 years down the road.

Descriptive phenomenology is a comprehensive approach to qualitative research that accounts for the complexity of consciousness, and it is therefore a particularly vital tool in veteran-related research. This research sought to uncover the essential structure of profound change after war as encountered by Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) veterans. The essential structure is the scaffolding that makes the phenomenon at hand what it is. It describes the features and contours of a cohesive mental process that are shared between those experiencing it. The phenomenologically informed conceptual model of profound change after war offers a clear structure of awareness, expansion, and impact that shapes and defines the nature of homecoming for returning veterans.
Brief History

In 2008, the number of U.S. servicemembers deployed to Iraq and Afghanistan peaked at over two million combined troops (Belasco, 2009). Operation Enduring Freedom began in late 2001 when U.S. military personnel arrived in Afghanistan in response to the attacks of September 11, 2001. Troop numbers hit their peak a decade later in 2011 at over 30,000, and the operation officially ended in 2014 with a shift to Operation Freedom's Sentinel (OFS), an ongoing training and advisory mission of 5,000–10,000 personnel (Torreon, 2016). Operation Iraqi Freedom began in 2003, hit its peak in 2008, and then officially transitioned to an advisory and support mission with Operation New Dawn (OND; Torreon, 2016). Taking into account OEF/OIF/OFS/OND and the more recent Operation Inherent Resolve (OIR), which began in 2014, the U.S. military has steadily deployed an all-volunteer force to the Middle East for nearly 20 consecutive years. As those troops separate or retire, the transfer of personnel from military to civilian status has real-world implications for both the returning individuals and the community at large.

Homecoming

Homecoming is a critical juncture and generally refers to major transitions from deployment to home, from active duty to reserve/guard status, or from military service to civilian status. Even though each of these transitions has psychological, emotional, social, and spiritual implications, the physical tends to be emphasized. There are departure ceremonies when a unit deploys; battlefield rituals for valor, heroism, and death; as well as redeployment celebrations upon return. Rites of passage that highlight psychological or psychic transformations tend to be limited (Demers, 2011). Servicemembers engaged with the existential tasks of homecoming, such as moral reflection, consciousness raising, or spiritual reckoning, are likely to find fewer resources to guide them through these transitions than they can find for their physical transition home. This can result in alienation from critical social support and perpetuate a cycle of distress (Ahern et al., 2015).

The challenge of alienation has been articulated in a number of different ways over the past half century. Merleau-Ponty (1968) emphasized the ways that people perceive entire worlds rather than simply discrete things. In his work, he implored the wider community to recognize the importance of the whole and not just the parts. In this vein, how things appear in front of us matters because phenomena can cast multidirectional shadows and shape life in a multitude of ways. A previous battlefield experience can influence and color a veteran's world by shaping how they see their future on the horizon. Similarly, Relph (1976) advanced that the physical aspects of space do not stand alone but instead coexist alongside the perceptual qualities of how we imagine and remember space. Individuals are more than timelines of events, and people embody physical space carrying with them a whole host of accompanying worlds rather than as a blank slate. For the veteran, physical presence at home carries with it the previous world of combat. Schuetz (1945) recognized early that communities and veterans underwent significant changes in their time apart and that a successful homecoming required deep cooperation from both parties. For example, civilians steeped in the war propaganda issued by the U.S. State Department to raise money for World War II war bonds would need to adjust their expectations so that they could welcome home their veterans, whose military service often was nothing like what had been depicted in radio and film (Schuetz, 1945). Homecoming as a discrete, physical act, rather than as a mythic journey, remains the normative approach for OIF/OEF veterans. Tick (2005) warned against understanding war in terms of isolated facts and figures as opposed to an entire world to be grasped and faced by the entire community. Beshai and Tushup (2006) argued for the recognition of combat as a complex world where questions of life's sanctity and societal responsibility were treated as foremost concerns rather than secondary afterthoughts.

In the autobiographical milieux of memoir, journals, and poetry, veterans themselves articulate similar critiques of homecoming: that there is not enough emphasis on existential concerns or societal responsibility (Harris, 2014; Holmstedt, 2007; Jones, 2013). There have also been calls for post-traumatic stress disorder (PTSD) to be applied to the wider society and not just the individual (Tick, 2005). The dominant framework currently assumes that the reintegration of veterans into a static society, one that does not change itself, is psychologically healthy and personally desirable, when it may in fact be neither (Marlantes, 2011). Too often, the wider culture forgoes the possibility that the veteran might have something to offer that the civil sector may need, like the hero's boon or gift earned along the journey (Campbell, 2012).
Design Background

First-person OIF/OEF accounts often tackle phenomena such as ineffable experiences, the presence of the soul, and the human community as chief postwar concerns (Tick, 2014; Williams & Staub, 2005). Existential-phenomenological themes touching on meaning, identity, belonging, death, guilt, and shame have been endorsed by veterans across geography, gender, rank, and age (Castner, 2012; Gordon, 2014; Luttrell, 2007). These first-person voices, however, often fall outside of academic and medical research, which drive veteran-related policies and programs. Overreliance on the empirical scientific method as performed by these institutions confines the field and restricts its knowledge base. As a result, the limits of reality have frequently been assumed to be synonymous with the limits of method (Giorgi, 1970). More bridges are needed to connect veterans’ self-identified concerns with the programs that are designed for them. Since the self-observer has greater access to the intricacies of their experience than does the external, third-person observer whose lens is more restricted, first-person accounts are an essential and irreducible perspective (Von Eckartsberg, 1989). Descriptive phenomenology and its focus on first-person experiences does not “wish for third person, ostensibly objective accounts of our lifeworld to wear the mask of truth to dominate the field of lived-experiences” (Steinbock, 2012, p. 594).

This study sought to excavate the lived experiences of Iraq and Afghanistan veterans through the lens of descriptive phenomenology in order to strengthen the conceptual foundation of homecoming. By prioritizing subjectivity, descriptive phenomenology shifts the veteran from the object of research to the subject (Colaizzi, 1978) and in this way allows veterans to reclaim the primary voice in postwar reflection.

Methodology

Descriptive phenomenology is the methodological framework for this study. Phenomenology is the exploration of the lived experience and a study of how events show themselves to the human person amid the complex layers and intricacies of life. As a methodological approach, phenomenology emerged in the Western philosophical tradition as scholars wrestled with questions of authentic knowledge about humanity and the surrounding world. The study of phenomena can be understood as “a philosophically consuming fascination with the question of origin, sources, and meaning of meaning and meaningfulness” (van Manen, 2014, p. 74). In the early 20th century, Husserl (1913/1983) advocated for the importance of the relationship between the mind and objects rather than solely the objects themselves and called for human consciousness to be explored with all the rigor and gravitas that had been afforded to the scientific pursuit of the natural world. He understood phenomenology to be “the science of the essence of consciousness” (p. 33), or the systematic study of subjectivity, and he argued that it was necessary because the natural sciences had become untethered from their philosophical roots and were therefore incapable of adequately addressing human concerns (Husserl, 1936/1970).

In this study, veterans were asked to describe an experience of profound change after war—one in which they came to understand their postcombat lives in a new way. The concept of “profound change” allowed for a wide range of experiences to emerge beyond the traditional categories of trauma or psychological injury. In this way, the method aligned with the goal of uncovering veterans’ existential interests, concerns which tend to be highly interconnected and not always discretely categorized. Clinical settings, particularly the Department of Veterans Affairs, which is traditionally called the VA, capture only a small fraction of both veterans themselves and the challenges, distress, and reintegration hurdles that they face (Demers, 2011). By investigating at the deeper level of profound change—rather than through the lens of a specific diagnosis like PTSD, spiritual distress, or moral injury—this research was equipped to capture the ways in which the sum of veteran experience is greater than its parts.

In addition to the overarching directive to “describe an experience of profound change after war,” veterans were also asked a set of phenomenological interview questions (Barrell et al., 1987), including:

1. Briefly describe the setting of your experience. Where were you? What were you doing?
2. Attempt to get back to a short interval of time when you experienced the phenomenon. As you relive this brief interval, share your first-person, present tense experience.
3. Report both what you were experiencing and how you were experiencing it.
This pilot study aimed to uncover the shared structure of profound change among six OIF/OEF veterans. Priority was given to saturation and alignment of the data over the number of participants. This research was designed to allow veterans’ concerns to emerge in their own language and to guide the outcome. Participants who could describe in detail an experience with profound change after war were selected, and participation was limited to Iraq or Afghanistan servicemembers who were able to engage in a 45–60 minute interview in a public setting. Prospective participants who were not able to describe or who did not report having had an experience of profound change were not eligible for the study. Participants were recruited until a full accounting, or saturation, of the phenomenon was reached. Variety was sought in terms of participants’ age, gender, veteran status, and time in service. Specific medical or mental diagnoses were neither inclusive nor exclusive and were not asked about. Physical ability, substance use, and/or employment status likewise were not limiting factors. A service-connected disability or a particular military occupation specialty (MOS) was not required, although at least one post-9/11 combat deployment to Afghanistan or Iraq was a necessary qualification. The Saybrook University institutional review board approved and oversaw this study. The interviews were professionally transcribed for analysis. Table 1 presents biographical data for all participants (P).

Data Analysis
Data was analyzed using Colaizzi’s (1978) seven procedural steps for phenomenological analysis of a qualitative inquiry. Step 1 was the first, full read through the transcripts to get a sense of the collective body of data. Step 2 focused on extracting significant statements that were in the data that were pertinent to the phenomenon at hand. The extracted significant statements were then compiled into a complete list. In Step 3, the meanings of the significant statements were drawn out and highlighted. The analysis moved from what the participants said to what they meant and thus illuminated meanings that might have otherwise remained hidden. In Step 4, the formulated meanings were gathered into clusters of themes. Validation took place in this step, as the themes were referred back to the original descriptions to ensure that the findings remained rooted in and closely tied to the raw data and that they did not contain anything foreign to the original descriptions. Likewise, the themes were allowed to stand in whatever contradictions or ambiguity that arose, and any discrepancies were noted. In Step 5, an exhaustive description pulled together all of the findings into an integrative account of the phenomenon. In Step 6, an exhaustive description of the phenomenon offered “as unequivocal a statement of identification of its fundamental structure as possible” (Colaizzi, 1978, p. 61). In Step 7, the final phase, the researcher returned to the participants and inquired about the findings, asking, “How do the descriptive results compare with your experiences?” (Colaizzi, 1978, p. 62). New data that emerged in this step was integrated into the analysis and the final outcome. In descriptive phenomenology, the goal of analysis is to create an essential structure of the phenomenon that outlines its mental contours and psychological features.

Summary of Findings
The phenomenon of being profoundly changed after war incorporated an important circle of experience, recognition, and impact. The experience of the change occurred first. Then came the ability to recognize it, followed finally by the ongoing impact of the event. In the findings, this

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cycle repeated itself rather than being finite, and it was not limited to just one sphere of life as veterans felt the cycle and its impacts in multiple places, such as family, work, and school. Veterans came to fresh recognitions about their experience of change and saw the impacts of this change evolve, and they uncovered new aspects of their identity both at the level of the self and at the communal level. This created a marked contrast between the before-profound-change self and the after-profound-change self. The interviewees’ endorsement of “who I was before” versus “who I am after” illuminated the rupturing quality of profound change. This schism resulted from experiences that included but surpassed conventional definitions of trauma and were marked by the quality of expansion. The after-change self was not merely different or changed but was an expanded self with a greater capacity for sensory input, perspective, knowledge, or relationships. This bigger and fuller self, however, was not always accompanied by corresponding coping skills or ego strength. Personal transformation that moved more rapidly than either the individual’s mental structures or social support could keep up with usually resulted in distress. In sum, the essential structure of profound change after war was (a) an unpredictable and erupting awareness of the profound change; (b) a rapidly expanded self, regardless of corresponding ego strength or social support; and (c) widespread implications in nearly all spheres of life.

**Awareness**

The awareness that profound change had even occurred was a key piece of the phenomenon's essential structure. The awareness itself emerged unpredictably and was often disruptive when it arose. For some, awareness developed at the moment of a key experience, while for others awareness took on more of a cumulative, unveiling effect. P1 had spent 4 out of 5 years on deployments with significant losses and an increasing feeling of the “heaviness of what we experienced.” The snowballing effect of loss and the long exposure rate eventually culminated in a profound transformation. P5 endorsed a similar experience of key events “over time” rather than at “a specific time.” P2 and P4 both had discrete transcendental encounters that were immediately recognizable, but it was not until a later time that they more fully understood the impacts of these encounters. P2 experienced an “unexpected slowing of time” amid “absolute confusion” as a first foray into nonordinary time, an encounter which drastically reformed P2’s understanding of the nature of reality. P3 and P4 had similar transcendental moments, with the former able to “see sounds” and the latter “seeing pain and suffering” in an energetic, third eye kind of way. P6 only began to recognize the depth of what had changed after his discharge from military service. After a childhood marked by “masculine betrayal and abuse,” P6's newfound trust in male peers as a result of service in the Marine Corps was a source of deep healing.

**Before-Deployment Self and Expanded, After-Deployment Self**

The findings highlighted that veterans experienced themselves as having a before-deployment self and an after-deployment self. The profound changes that they encountered were often so extensive that they felt as if a new person had been born. The data supported the new self as being marked by an expansion and/or enlargement of sensory capabilities (i.e., heightened hearing, smell, and perceptions), empathy and spiritual sensing, or moral sensibilities. For some, this expansion was a positive change marked by growth, maturity, and perspective. For others, this expansion ushered in a breakdown of their coping skills and ego structure. On some occasions, growth and disintegration took place simultaneously. Interviewees described the emergence of a new self in a number of ways. For P1 it was “a major change;” and for P2 it was “something that's going to stick with me and it's going to be a big deal.” P1 described a “shaken faith” and said that “in the course of those experiences, the details of my life just lost all worth.” P3, knowing that he had experienced changes in perception and cognition, still “doesn’t know how to explain it to [my health care providers],” continuing “I still can’t get help because they say I don't have it.” P4’s transcendental “seeing” of the suffering and pain of war while in the basement of a building immediately allowed him to start seeing that same suffering and pain in the “impact on civilians,” something which he could then not unsee. P5's after-deployment self struggled with the “flow of civilian life,” and after experiencing the grit and determination of his military peers, he found it difficult to interact with civilians who lacked such traits. P6’s expansion of self came in the form of new trust, an ability “to actually have faith that I can trust another man in my life. And [that he] isn’t like there to like crush you.”
**Widespread Implications**

The third piece of the essential structure was the profound change's widespread, continually expanding implications. The effects of the change implicated not only the veterans but also their personal networks and their wider communities. Whether or not veterans were accepted and supported by their immediate friends and family often made a big difference in the nature of their homecoming. Describing the return home, P1 said, “like before, life was a bunker, and now it is just a lot of crushed stone….I have absolutely no shelter, no sense of protection or security.” In addition, P1 realized what “a gaping hole I was in this fabric” of a familiar community. P2 had internalized the ethical questions of combat and found little outlet for them upon his return home, resulting in a pressure cooker–like internal life that deteriorated beyond recognition. P3 had managed to integrate a newfound sensitivity to sound by balancing an avoidance of “shopping at Walmart, football games, and musical concerts” with more time spent building a foundation “for reimagining custody of my children.” P4 entered homecoming with a “greater level of sensitivity to what was here” and reaffirmed the wisdom of homecoming with a “greater level of sensitivity to what was here” and reaffirmed the wisdom of homecoming. Describing the return home, P1 noted that homecoming was a time where contrast had a number of disorienting impacts; characterized by a lack of or broken trust. This was taking place. In the military, P6 had experienced trust in personal relationships, a departure from his preservice relationships characterized by a lack of or broken trust. This contrast had a number of disorienting impacts; P6 noted that homecoming was a time where “things you don't remember come up for you,” in reference to abuse that had occurred in his past.

**Discussion and Implications**

With the data analyzed for its essential structure, it becomes possible to look at the phenomenon of profound change after war apart from medical diagnosis, psychological categorization, or political influence. In this level of analysis, often called lived experience, the participating subject is as close as can be to the phenomenon and is able to provide a sweeping view of the encounter. Lived experience, when described soon after the phenomenon itself, is freer of explanations or justifications. This kind of proximity allows the subject to craft a cohesive and internally organized accounting, in this case, of the profound change. The interviewees’ narratives seamlessly wove together combat exposure, trauma, grief, trust, betrayal, family, community, intimacy, spiritual encounters, transpersonal experiences, heightened sensory perception, expanded perspectives, families of origin, religious communities, theology, psychological development, traumatic brain injury, mental illness, and physical injury, just to name a few. Rather than disjointed collections of separate themes, the accounts were coherent and connected. The findings at this subjective level of encounter produced a high-level accounting of the phenomenon that is closer to a conceptual model or a cohesive system than to a diagnosis or set of symptoms. Profound change after war could not be reduced to experiences, symptoms, emotions, or coping skills, although it embraced all of these. It also was not simplified to trauma, mental illness, grief, or moral injury, even though it incorporated these as well.

This understanding of the phenomenon of profound change after war may thus contribute to a more nuanced and informed understanding of homecoming by equipping veterans ahead of time with realistic expectations and appropriate resources. The essential structure of profound change, which includes continual awareness, an expanded self, and ongoing implications, suggests that an informed homecoming, rather than a laissez faire one, is crucial. For the veterans who have encountered profoundly transformational experiences, understanding a map of the terrain to come might be a central step toward an effective homecoming. The landscape might not only include traditional mental health services but also models of psychospiritual development that have the potential to align with servicemembers’ systems of making meaning (Harris et al., 2015).

The ways in which veterans can be deeply and profoundly changed also shed light on practical concerns, such as diagnosis and treatment as defined by the VA. The work of preparing servicemembers for the cycle of awareness, integration, and impact extends far beyond the health care traditionally offered by the VA. A specific challenge in receiving adequate care is the task of demonstrating eligibility and the ways in which a servicemember must show that they are psychologically injured in connection with their military service. Such parsing may not be consistent with the integrated nature of the phenomenon at hand. The findings from this study show that veterans experiencing profound change...
after war are engaged in critical psychological, spiritual, and social tasks on many levels and in many areas at the same time. This raises questions about the degree to which the practical services of the VA reflect the reality that veterans who have been profoundly changed may experience.

The findings also can provide insight for practitioners who encounter Iraq and Afghanistan veterans throughout the course of their work. Such practitioners may include university professors, clergy, counselors, medical personnel, veteran service officers, social workers, mental health professionals, and even family members, to name a few. Profound change after war takes place on an iterative continuum whereby experience, recognition, and impact mutually inform one another, and a before-change self stands in contrast to an expanded, after-change self, with ongoing implications. Profound change after war involves the complex work of awareness and integration in the midst of an expanded being; the phenomenon could be described as one of development and expansion. Psychological, moral, and spiritual developmental theories might be considered essential tools when engaging with a veteran who has experience with this phenomenon. The movement of the psyche has been addressed by a number of scholars, including Erikson's (1982/1997) psychosocial stages, Kohlberg's (1984) moral development, Fowler's (1981) stages of faith, Steinbock's (2009) structures of mysticism, and Loder's (1989) transformative growth. These models have the advantage of serving as a map and a guide to a rapidly changing interior life, something which is lacking in the symptom reduction approach that many veterans receive.

Community Engagement

Profound change after war shows that the homecoming of veterans is neither an individual pursuit nor simply a medical or diagnostic problem. The phenomenon illuminates how an integrated conceptualization of homecoming should include broad social involvement and community engagement. The relationships among veteran homecoming, the VA, PTSD, and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) may overly simplify experiences of profound change. For instance, combat-related PTSD has relied almost exclusively on cause-and-effect factors for diagnosis, whereby a veteran's distressing symptoms at home are assumed to be the direct result of prior events in combat. While causality may be a legitimate factor, on its own it fails to account for a host of other influences. Quite a bit of time and life experience may elapse between combat and coming home, such that the conceptualization of postwar stress as a narrow linear equation in which A causes B has been shown to be problematic (Paulson & Krippner, 2007). Likewise, the operationalization of PTSD through the lens of the DSM-5 remains focused on the individual and does not address higher-order factors, such as the fact that the rate of PTSD in veterans decreases as cultural support for war increases (Greenberg et al., 2008) or the argument that higher levels of moral attainment may signal an increased risk of PTSD (Kempton, 2008). Sociological research on the relationship between social abandonment and PTSD-like symptoms raises questions about the proximate causes of trauma (Brown, 2012). If homecoming and combat-related phenomena are primarily conceived of in individual terms, there may be a failure to recognize the inevitable changes that war has wrought on individuals and their society at large (Tick, 2005). An ethical diagnosis of PTSD must rely upon the clear articulation of personal and communal sources where individual notions of disease and disorder are secondary to societal notions of the same (Beshai & Tushup, 2006). Community engagement is critical for new conceptualizations of homecoming; specifically:

Practical and theoretical anchors for understanding and treating PTSD rest on deep, foundational social, psychological, philosophical, and existential questions ...and the dangers associated with the increased clinical attention to the condition are that these difficult, fundamental issues are overlooked in favor of approaches that ignore important nuances and deal merely with symptoms, approaches that offer respite from bad dreams, or tranquilize a veteran who has been overrun by paranoia, without fully restoring the person. That kind of profound recovery relies on an equally profound awareness of the circumstances involved in a person's life, as well as the nature of the trauma. (Paulson & Krippner, 2007, p. xvi)

Conclusion

Profound change after war is a phenomenon that weaves together key experiences, awareness,
References


Harris, S. (with Cox, R.O.). (2014). Steel will: My journey through hell to become the man I was meant to be. Baker Books.


About the author

Kelly Wadsworth is a faith leader, a guest lecturer, and a community speaker in the Pacific Northwest. Her professional interests center on the intersection of health, spirituality, and community life including the ways perspective-taking fosters human growth and development. Using a phenomenological lens, she seeks to explore both inner and outer experiences of the sacred and the engagement with meaning-making. Kelly received her PhD from Saybrook University in 2018 with a focus in existential psychology as well as her M.Div from Princeton Theological Seminary (2003). She served as an Army Chaplain from 2001–2011 which included a deployment to Balad, Iraq with the Washington State Army National Guard. She can be reached at Kelly.wadsworth.squarespace.com
How Veterans Make Meaning of the College Choice Process in the Post-9/11 Era

Derek M. Abbey

Abstract

The Post-9/11 GI Bill was implemented in 2009. Since then, more than 1.9 million people have used the benefits afforded by the bill to attend college, and more than $90 billion has been paid to institutions of higher learning and Post-9/11 GI Bill beneficiaries. During this time, the types of colleges that veterans attend as well as the educational models they select have shifted. Veterans are more likely to utilize online or distance education models. Additionally, veterans attend for-profit universities at an increasing and greater rate than do their nonveteran counterparts. These shifts differ from the trends observed among the general population. The purpose of this study was to learn from veterans how they make sense of decision-making related to college choice prior to matriculation into a 4-year institution. Qualitative methods were utilized to examine the lived experiences of 12 post-9/11-era U.S. Navy and U.S. Marine Corps student veterans during the college choice process. The experiences shared by the participants in this study were used to further examine and critique an established theory of college selection. This study provides practitioners and academics with insight into how to better engage with this diverse and unique community of prospective students on and off campus through greater understanding of how they make meaning of the college choice process.

Since its inception, the United States military has represented a cross section of the American community. In recent years, the veteran population has been shrinking because fewer citizens serve in the military today than served in previous decades (U.S. Department of Veterans Affairs, 2015). Despite this trend, a steady stream of student veterans continues to flow onto college campuses (U.S. Department of Veterans Affairs, 2014). Individuals who serve in the military become part of a unique, rich culture that is present in varying levels across the entire country and national community. These potential students bring with them this culture and a set of experiences that can contribute positively to the breadth and depth of the diversity of campus communities. In 2009, the Post-9/11 GI Bill took effect. This new version of the GI Bill significantly increased the level of support provided to student veterans. Since its inception, more than 1.9 million people have benefited from it, and more than $90 billion has been paid to institutions of higher learning and to Post-9/11 GI Bill beneficiaries. During this time, the types of colleges and universities that veterans attend as well as the educational models they select have shifted. The number of veterans attending for-profit institutions has increased from 14% of the student veteran population to 24%. Although the total number of veterans attending all models of public colleges has increased, the overall percentage of student veterans who choose these school settings has decreased from 63% to 56%. Additionally, veterans are more likely to access higher education online when compared to their nonveteran independent counterparts. Independent students are students over the age of 24 and those students under age 24 who are married, have dependents, were orphans or wards of the courts, were homeless or at risk of homelessness, or are determined to be financially independent by a financial aid officer using professional judgment (Radford et al., 2016). The factors influencing these changing enrollment trends have yet to be thoroughly researched. The number of new Post-9/11 GI Bill students entering higher education averages 200,000 per year and is forecast to remain the same in the coming years (U.S. Department of Veterans Affairs, 2015).

The recruiting practices of many institutions catering to veterans have been called into question (Ochinko & Payea, 2018). In 2012, U.S. president Barack Obama issued Executive Order 13607, which condemned colleges’ predatory practices of recruiting veterans and called for the creation of principles of excellence for colleges serving veterans. Despite widespread condemnation of colleges’ practices and the establishment of administrative boundaries to prevent them, evidence suggests that these practices continue (Ochinko & Payea, 2018). A 2018 brief released by
Veterans Education Success stated that six of the top 10 schools receiving Post-9/11 GI Bill payments “were being investigated by, sued by, or had reached settlements with federal or state law enforcement agencies for actions such as misleading advertising and recruiting and fraudulent loan programs” (Ochinko & Payea, 2018). Additionally, ITT Tech, which received close to $1 billion in Post-9/11 GI Bill payments—the third-highest amount of Post-9/11 GI Bill funds received by any institution—closed in 2016 while under investigation by multiple state attorneys general and federal agencies (Ochinko & Payea, 2018).

There is an understanding that first-generation college students often lack the social and cultural capital that helps prospective students efficiently access the higher education system. The U.S. Department of Veterans Affairs has stated that 62% of veterans are first-generation college students (2015). This fact, combined with the significant financial benefit for veterans who attend college using the Post-9/11 GI Bill, may explain why institutions are using predatory practices to lure veterans into their systems. Without data on the factors that influence veterans’ college choice decision-making processes, quality colleges and universities have little information that they can use to inform and adjust their recruiting methods to meet the needs of veteran students.

Academics have been examining the reasons why students choose the colleges that they attend since the middle of the 20th century. This research initially focused on high school students and the impacts of counselors and parents on their decisions. Over time, the theories have expanded to examine a broader range of factors and influences on college choices. In the 1980s, multistage models of college choice theory were created, including Donald Hossler and Karen Gallagher’s college choice theory (Chapman, 1981; Chapman & Jackson, 1987; Hanson & Litten, 1982; Hossler & Gallagher, 1987; Jackson, 1982; Litten, 1982). Since it was created, Hossler and Gallagher’s theory has been used to examine the general population, and in recent years it has been used to study the college choices of specific racial and ethnic groups (Hurtado et al., 1997). However, this theory has yet to be used thoroughly as a theoretical frame to explore the factors influencing veterans’ decision-making related to college choice.

A significant amount of research has focused on veterans in higher education. The majority of this research has explored the experiences of veterans once they arrive on campus as well as the frictions they face in the transition to the higher education environment (Ackerman et al., 2009; DiRamio et al., 2008; DiRamio & Jarvis, 2011; Heitzman & Somers, 2015). These studies are often prescriptive, offering best practices for serving these students once they are on campus. In recent years, researchers have started to examine the college choice process for veterans at specific types of colleges (Circle, 2017; Hill, 2016; Ives, 2017; Vardalis & Waters, 2011). However, there remains a significant need for research in the post-9/11 era that explores the period before veterans matriculate into a college.

In this study, the researcher used qualitative research methods to develop a theoretical understanding about how post-9/11 veterans make meaning of the college choice process, how they decide which universities or colleges to consider and apply to, how they decide which educational model is right for them, and in what ways emotions influence the college choice process. The significance of this study is in providing data to colleges and universities that could influence their recruitment and outreach practices in order to better serve these potential students. Additionally, practitioners that work with veterans will be able to use these data to better inform their work with student veterans.

Methodology

Qualitative methodology was applied because of the gap in current data related to the veteran population during the college choice process and the need to develop a theoretical understanding of the phenomenon. Semistructured interviews following an interview guide were used as the primary source of data collection. This approach allowed for flexibility in the interviews and gave the researcher more opportunities to explore topics as they emerged. The interview guide in this study was based on several sources: Hossler and Gallagher’s college choice theory (1987), a review of interview guides used in other studies based on the same theoretical framing (McWhorter, 2015), common influencing factors as outlined in the *Handbook of Strategic Enrollment Management* (Hossler & Bontrager, 2014), and unpublished pilot studies (Abbey, 2016a; Abbey, 2016b) conducted in preparation for this study. Additionally, as part of the daily requirements of working at a university and with appropriate approval, the researcher conducted document analysis and worked as a participant observer with the student veteran population.
Participants in this study were a convenience sample of 12 student veterans from eight different 4-year universities (see Table 1). The 12 participants included three male Marine Corps veterans, three female Marine Corps veterans, three male Navy veterans, and three female Navy veterans who were either attending a 4-year university or had attended and completed a 4-year degree during the Post-9/11 GI Bill era, which spans from August 2009 to the present. In keeping with institutional review board approval for this study, pseudonyms are utilized throughout this article to protect the identities of the participants.

All interviews were transcribed and uploaded to NVivo for coding. A variety of first cycle coding methods were used, including initial, in vivo, emotion, longitudinal, and value coding (Saldaña, 2012). This initial coding identified the tentative codes by highlighting verbatim quotations from the interviews that represented emotions, values, beliefs, knowledge, understandings, and respondents’ experiences through the college choice process. Once all of the interviews and first cycle coding were complete, second cycle coding was conducted using holistic, focused, axial, and longitudinal coding (Saldaña, 2012). The second cycle coding process examined both the experiences of the participants as a whole over time and the frequency of their experiences in order to group the codes into the major themes of the study. Triangulation was used not only to search for convergence across data sources to support findings but also to note inconsistencies and contradictions in the data (Mathison, 1988). Data sources used for triangulation were the participants, literature, and data gathered through document analysis and observation. Member checking was conducted with all participants to further confirm findings and minimize bias.

**Findings**

**College Choice Theory**

Hossler and Gallagher’s college choice theory (1987) was used as the theoretical framing for this study. The interviews were conducted using this theory as a foundational guide. The questions were divided according to the theory’s three phases: predisposition, search, and choice. The predisposition stage is when the student first decides to either attend college or pursue other routes, such as entering the workforce or military service. The search phase occurs next, once the student has decided to attend college. In this stage, the student gathers information about the potential colleges in consideration and adds these colleges to a selection pool. The choice stage is when the student applies to one or multiple institutions and finally chooses one to attend.

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**Table 1. Participant Demographics**
Predisposition

All of the participants were veterans of the Navy or Marine Corps. However, five of the participants attended college prior to joining the military. Two of the five that started college directly out of high school struggled academically. When they did not find initial success in college, they enlisted in the military. Three of the five that started college directly out of high school faced additional life circumstances that interfered with desired college track. Of the seven participants that entered the military directly, all expressed a desire to go to college. However, many did not have the resources to pay for a college education. Additionally, some lacked the social and cultural capital associated with successfully applying to and accessing college.

Although all of the participants aspired to attend college, they were not always sure how to achieve this goal. Both first-generation college students and students whose parents had college degrees demonstrated a lack of knowledge about the college application process. A lack of cultural and social capital obstructed these students early and also influenced some participants’ decisions to join the military before going to college.

Search

This study focused on student veterans at 4-year universities. However, all but one of the participants attended multiple colleges, with seven of the 12 participants attending more than two colleges. The search phase for these students took many routes: from searching universities in high school, to exploring courses offered through military programs, to starting at a community college after separating from the military. For this study, the researcher examined how the participants searched for their current university or the university from which they graduated.

When exploring which university to attend in order to attain their 4-year degree, the participants in this study did not conduct in-depth searches. The majority of the participants selected a region or city and then briefly researched local universities using online search engines or websites. When asked how she searched for her college, Melanie, a Mexican female Navy veteran attending a private, nonprofit university, stated, “So I knew I wanted to move to San Diego and I literally just typed in ‘colleges in San Diego.’” In addition to or in concert with online research, most of the participants received guidance from trusted relational partners. Advice came from relatives, other people with whom participants had previously established relationships, or perceived persons of authority. Persephone, a Hispanic female Marine Corps veteran attending a for-profit university, used a social media platform for female Marines and sought guidance from her colleagues there. She said, “I didn’t have an opportunity really to visit places. I talked to other veterans, you know, the female Marines Facebook page. ‘Hey ladies,’ you know, ‘What have your experiences been at these universities?’” Figures of authority included professors or guidance counselors as well as leaders in university or college veterans programs. The participants gave significant weight to the input of these trusted relational partners, with some making decisions to apply for and attend a university based on the guidance of a single person.

Choice

Although most of the participants attended more than one college, all of the participants only applied to one university when accessing the institution from which they would ultimately strive to attain their 4-year degree. The participants decided on the college they wanted to attend, confirmed that it had the degree they were seeking, and applied without a backup plan for their education. Kyle, a multiracial male Navy veteran attending a private, nonprofit university, only applied to one university, although he was aware that there was a chance he would not be accepted. He said, “I chose to go with [this university] and I put all my eggs in that basket and took a leap of faith and it worked out okay.”

The participants in this study decided whether or not they were going to continue their education at a university prior to applying. For these participants, the scope of the choice phase was limited to this point. Since each student submitted an application to only one institution, choosing between multiple institutions was not part of the process; they did not consider multiple options nor compare them to each other after being admitted. For the participants, the search and choice phases were thus blended together into one phase. This finding is notable because it suggests that a better theoretical framing could be developed or utilized to examine how the veteran population accesses higher education. It appears that the factors that influenced the college choice process for these participants encouraged them to follow a different course than the one outlined by Hossler and Gallagher’s college choice theory (1987).
Themes Influencing Meaning Making for Veterans During College Choice

Numerous themes emerged throughout the interview process. Through first and second cycle coding, these were combined and narrowed down to seven major themes: lack of social and cultural capital, receiving little guidance and lots of discouragement about going to college, using and seeking out trusted relationships when making college choices, significant outside responsibilities while selecting and attending college, joining the military as a means to education, fear and anxiety during the college choice process, and the influence of location and convenience when selecting a college.

Lack of Social and Cultural Capital

All of the participants lacked social and cultural capital related to higher education. While 62% of veterans are first-generation college students, and this sample closely mirrored that percentage, the students that were not first-generation college students also lacked capital related to higher education. For example, Melinda, a Hispanic female Marine Corps veteran attending a private, nonprofit university, had several family members who were college graduates, including her parents. However, in explaining the steps she took to apply to her current university, she said, “I honestly did not know how to do that crap. I was just like, why do you do this? And then I had to get these stupid letters of recommendation… I just kinda went with the motions.” Additionally, all of these students lacked a thorough understanding of how their veteran education benefits would work while they were attending college, or they maintained a complete lack of awareness of some benefits. This general lack of awareness exacerbated the negative effects of their lack of social and cultural capital related to higher education.

The deficit of cultural and social capital in the veteran population has been discussed significantly in the literature, primarily in relation to the large portion of the population that is composed of first-generation college students. The fact that this lack of capital extends beyond first-generation college students was noted in the pilot studies that preceded this study. In the role of observer, the researcher noted that the staff of the military and veterans program at their university regularly worked with students who did not know how to access the university nor what the application timelines were. The addition of complex military education benefits seemed to make this situation even more difficult, as the participants expressed a lack of understanding of higher education, their benefits, and how the two systems work together.

Receiving Little Guidance and Lots of Discouragement About Going to College

Multiple participants expressed that the resources available to them while they were actively serving were lacking in quality. In addition, all of the participants either felt that they were not provided guidance along the way or that they were discouraged, directly or indirectly, from seeking higher education or certain options. This deterrence came from multiple sources. Donald, a multiracial male Navy veteran attending a private, nonprofit university, said that the Navy failed to inform him fully and completely about all of the education benefits that were and would be available to him. He indicated, “So that, I guess was… a failure, you know, on the Navy’s part.” Participants were discouraged directly and indirectly not only by military representatives but also, for two participants, by a community college counselor and a university faculty advisor. For instance, Melinda shared that her assigned faculty advisor at her current university was very discouraging. She stated, “He told me I wouldn’t make it. It made me angry. I’m an ambitious person and positive. I always want to achieve success. That’s just my personality. It just made me angry and I never went back to him.” Despite the participants’ eventual success, the limited amount of quality resources, lack of guidance, and discouragement that they described had a negative impact on their educational pathways.

Using and Seeking Out Trusted Relationships When Making College Choices

Participants’ decisions to research colleges and ultimately select a college were often based on perceived relationships of trust. When asked how they heard about or why they selected a college, several of the participants expressed that their friend told them about the college or their friend attended the college. Participants placed a great deal of trust in the thoughts and input of these friends, enough to select the college they finally pursued. David, a White male Marine Corps veteran attending a private, nonprofit university, explained, “I got so much more support from peers and nontraditional advisors than I did from anyone whose job it was to help me.” Other times, students developed trusting relationships with professors or counselors on the campuses they were exploring.
Hokage, a Black male Navy veteran attending a private, for-profit university, visited the campus he was considering and found trust in a counselor that he consulted. He said, “I walked around the school then visited a counselor. . . . She was really adamant about the school, so I took a leap of faith. Say just gave it a shot.” At times, students found trusted relationships in a veterans center on the campus or in students who were already attending the college. In all, 10 of the 12 participants sought out and placed significant weight in these relationships while going through the college choice process.

**Significant Outside Responsibilities While Selecting and Attending College**

The study participants fell into the category of nontraditional students. One common characteristic of many such students is outside responsibilities. Given that nontraditional students, like the participants in this study, are emancipated from their parents and have had professional careers as well as families of their own, the influence of these responsibilities is predictable (Hossler & Bontrager, 2014).

All of the participants maintained significant responsibilities outside of class. Half of the participants were married, and four of them had children. The majority worked on or off campus. Additionally, these participants were very engaged in the various on-campus student veteran organizations. These other responsibilities came with competing time commitments and stress in addition to the regular strain of college life. Scott, a White male Navy veteran attending a public, nonprofit university, said, “I am participating in a federal work study and I also hold a leadership position in my college’s student veteran organization.” Many of these responsibilities existed prior to attending their current university and would remain upon leaving or graduating. Lynn, a White female Navy veteran attending an online, public, nonprofit university, shared, “You know, I kind of anticipated, you know, the stress of, of working full time and going to school full time. It was just a hard thing to learn to balance at first.” When asked about outside responsibilities, many of the participants had to be asked multiple times about specific responsibilities before they acknowledged them, as though they had become so routine that they forgot that they were still responsibilities and took up a significant portion of their time.

Beyond the participants’ underselling of their outside responsibilities, they also held responsibilities not readily apparent to the common observer. Familial relationships that held the same commitment as blood relationships, strong commitments to extended family, and obligations to causes or beliefs all brought with them significant commitments. The time required to meet the obligations of college, social interactions, formal roles, work, family, and more maximized these students’ schedules. Given that the researcher had to probe for answers related to responsibilities, it appeared that the participants were not completely conscious of how busy they were and how much responsibility they maintained.

**Joining the Military as a Means to Education**

Nine of the 12 participants explained that they were able to go to college because they served in the military. Some described how the intangible drive, confidence, and discipline that they gained while serving allowed them to attempt to seek out higher education. For instance, Kyle shared that the military provided him with the ambition and determination to face challenges like college and be successful. He stated, “I just feel I have the drive, the perseverance. I have overcome the adversity. You know, in the military there’s a lot of adversity.”

Education is one of the top reasons why people join the U.S. military today. The benefits earned through service provide a way for people who may not have been able to afford the costs otherwise or who want to avoid being a financial burden on their families to pay for college. Additionally, the significant support provided by military education benefits like the Post-9/11 GI Bill expand education options to include universities with high attendance costs. When Donald was asked if he would be in college without the GI Bill, he stated, “Absolutely. But not here.” Donald is attending a private university and studying engineering. Each of the participants in this study expressed that they would not have been able to attend the university that they were attending or had attended if not for their service in the military and its attendant benefits.

**Fear and Anxiety During the College Choice Process**

Many of the participants expressed that they gained confidence, discipline, and drive from the military. Yet, 10 of the 12 participants also voiced substantial fear about the idea of going to college. Scott shared, “I was terrified, and it took a couple years before I finally settled in.” This fear was based on the perceived potential for failure, doubts about their own aptitude, and the lack of a distinct pathway toward success. It should be noted that
the two participants that did not experience these emotions had previously attended college.

The participants were asked specifically about the emotions that they felt when going through the college choice process because fear had emerged as a theme in previous pilot studies (Abbey, 2016a; Abbey, 2016b). It proved to be common again in this study. Given that this population is departing a very structured system, the military, and now venturing into another system that, as the previous findings in this study show, they know little about, it makes sense that there would be a fear of the unknown. The military system provides strict guidelines in the form of documented standard operating procedures for everything from daily tasks to career progression. This strict guidance is missing in the higher education environment. As an observer, the researcher witnessed several veterans display anxiety when seeking out a solid pathway or specific answers at the university. This anxiety increased when they discovered that the solid answers that they were seeking many times did not exist.

Factors Influencing College Choice

Over the decades, college choice researchers have examined the factors that influence college choice decisions among a variety of populations. The Handbook of Strategic Enrollment Management recognizes nine key predictors that influence college choice (Hossler & Bontrager, 2014). The six factors that were noticeably present in this study were peer effect, social and cultural capital, information sources, personal characteristics, academic ability, and location and convenience. Three factors were missing as influencers in this study: family income, high school attended, and cost of attendance and financial aid.

Peer Effect

As described in the previous section's discussion of common themes, peer effect significantly influenced college choice for the participants in this study. Multiple student veterans made the decision to apply for and attend a given university based on the suggestion of a peer, sometimes without any previous knowledge of the university. Additionally, participants emulated the paths taken by respected peers.

Social and Cultural Capital

The participants in this study lacked social and cultural capital related to higher education. While the majority of the participants were first-generation college students, social and cultural capital were also lacking in the participants that were not first-generation college students. Additionally, all of the students lacked knowledge related to military education benefits and how those benefits work with the variety of higher education institutions. This factor had a negative influence on the college choice process for the participants.

Information Sources

Hossler and Bontrager's Handbook of Strategic Enrollment Management (2014) states that "having information sources that can provide accurate college information is...associated with positive
college choice outcomes” (p. 54). It can be inferred, in turn, that not having quality information sources may have a negative impact on these outcomes. In this study, the participants expressed and displayed that they lacked information sources: They described the deficiencies in official military education programs and displayed a lack of knowledge about where to access quality information. Like social and cultural capital, this factor had a negative impact on the college choice process for these student veterans.

**Personal Characteristics**

Studies of college choice as it relates to students’ personal characteristics have often examined differences between male and female students. Although gender was examined during this study, no obvious differences between genders were observed. Additionally, no differences were observed between Navy and Marine Corps veterans. However, veteran status itself appears to be a unique characteristic that influences the college choice process, as this paper has so far outlined. The study participants shared how the drive, maturity, and confidence they gained while serving in the military influenced them on their path toward attaining their higher education goals. Additionally, emotions of fear and anxiety were common across most of the participants.

**Academic Ability**

Academic ability influenced participants’ college choice processes in multiple ways. It most directly affected students who were not eligible for some universities because of their grade point averages and previous performance in college or high school. In a more common but less direct way, the students’ negative perceptions of their own academic ability and resultant fear and anxiety influenced them to narrow their searches to a single institution.

**Location and Convenience**

Location and convenience significantly influenced the college choice process for the study participants. Participants picked a location and restricted their search to a small region without considering universities outside of their chosen location. As outlined previously, these restrictions were based on personal, professional, or familial connections to the area. For those without a tie to their chosen region, convenience replaced relational influence. Participants striving to complete their degree on active duty or who expected to move selected programs that allowed them to travel or move while continuing their studies with the same institution, such as online or hybrid programs.

**Three Factors Not Found in This Study**

Family income, high school attended, and the cost of attendance are common predictors that influence college choice (Hossler & Bontrager, 2014), but they were not observed factors among these participants. The participants came from families with varying incomes and socioeconomic statuses. However, as nontraditional students, the participants had emancipated from their parents and were no longer legal dependents. Although family income and cost of attendance did not affect the colleges participants attended, they were common reasons for joining the military. The participants came from various high schools across the nation, but their high schools did not appear to affect college choice. Cost of attendance did not influence college choice for the participants, but some of the students noted that they would not have selected the college they were attending if the cost to attend were not covered by military education benefits.

**Limitations**

The sample used for this study is not representative of the entire veteran population, as it lacks participants from all of the military branches. Additionally, the demographic breakdown does not proportionally represent the veteran population in terms of gender, ethnicity, race, and more. Although participants represented multiple 4-year universities from multiple regions, the sample is heavily weighted in the southwest region of the United States and primarily includes resident programs where students attend most of their courses in classrooms on a physical campus. Lastly, all participants were highly engaged students on their campuses, which is not representative of all student veterans and could be connected to some of the homogeneity in their responses.

The researcher’s own social identities and positionality must be named and acknowledged for how they might influence bias related to eliciting biased responses and interpreting participants’ answers. At the time of the study, the researcher was a student veteran, first-generation college student, veterans’ advocate, and the leader of a highly visible military and veterans program at a large public university. These circumstances motivated the researcher to study this topic and
influences their views and beliefs connected to it. Subjectivity is always an issue in research. At the beginning of all interviews, the researcher announced their veteran status and explained their own personal experience to establish a bond with the participants and create openness and comfort in the interview process. These efforts created an environment of trust that encouraged the participants to more quickly open up and share their experiences. However, bias and positionality cannot be ignored, despite the efforts taken to minimize them.

Acknowledging researcher’s subjectivity related to this study was only one step that was taken to create awareness and minimize the impact of bias. Although only one participant attended the university where the researcher worked, it cannot be ignored that the researcher’s military background and position at the university had the potential to sway participants’ answers. Sound interview techniques were used to minimize the influence of these factors on the interview responses. These included avoiding encouraging or discouraging responses through voice or body language. Additionally, member checking was utilized with the participants to ensure that their responses were interpreted accurately and not misrepresented.

This was a qualitative study and therefore is not generalizable. However, it still provides valuable and actionable data for the consumer. Donmoyer (2000) outlined how a single qualitative study does have value in providing vicarious experience. Through processing this research, the consumer can create a more integrated cognitive structure that will inform their future research and work as a practitioner.

**Recommendations**

Additional steps should be taken by the Departments of Defense and Veterans Affairs to build active duty service members’ and veterans’ knowledge of the higher education system and how to successfully access it. Although the general nontraditional student population may lack social and cultural capital related to higher education, these students do not have to also determine how to use complex benefits like the Post-9/11 GI Bill. The combination of complex military benefits and a convoluted higher education system exacerbates the issue of access and makes this recommendation even more important.

Understanding that active duty and veteran populations are generally lacking cultural and social capital related to accessing higher education, it is imperative that the people working with them in mentorship and guidance roles on college campuses are knowledgeable of all education models, how to access them, and how military education benefits will work or may not work with specific systems. This knowledge is vital when recruiters and outreach specialists focus their efforts within a limited region, as location and convenience are given significant weight by the population they are serving. Providing insight into all of the options available and how they are similar and different will allow veteran students to make more informed decisions when selecting...

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**Figure 1. Study Theme Flow and Opportunity for Intervention**

<table>
<thead>
<tr>
<th>Opportunity for Intervention</th>
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<tbody>
<tr>
<td><strong>Joining the Military as a Means to Education</strong></td>
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<tr>
<td>Receiving Little Guidance and Lots of Discouragement About Going to College</td>
</tr>
<tr>
<td>Significant Outside Responsibilities While Selecting and Attending College</td>
</tr>
<tr>
<td>Fear and Anxiety During the College Choice Process</td>
</tr>
<tr>
<td>The Influence and Convenience When Selecting a College</td>
</tr>
<tr>
<td>Using and Seeking Out Trusted Relationships When Making College Choices</td>
</tr>
</tbody>
</table>

*Note. The shaded area indicates where opportunities for intervention exist.*
universities to apply for. It is recommended that professionals working in recruitment roles receive appropriate training and guidance to better understand this information and the best ways to transfer it to their constituents.

Universities and colleges that seek to conduct outreach among or recruit veteran students should ensure that lines of communication are easily accessible and as open as possible. This is especially true for campus military and veterans programs. Facilitating communication allows potential students to connect and build trust with individuals and teams on these campuses. As outlined in this study, trusting relationships carry significant weight as prospective students decide which institutions to explore and attend. Additionally, these professionals can provide quality information to students who may lack information or find themselves confused as they research universities.

Recruiters and practitioners on college campuses need to be aware that student veterans are independent students with significant outside responsibilities. They should communicate their mindfulness of students’ responsibilities in recruiting practices, and steps should be taken to address this on campuses. Beyond establishing a college or university center for military-connected students, additional actions may help student veterans manage their increased responsibilities, including those associated with their education. These steps could include but are not limited to childcare options, a commuter center, prioritized parking privileges, and other things that help minimize the load associated with outside responsibilities.

There are multiple opportunities to conduct positive interventions along the pathway outlined in this study. An intervention in the form of providing quality information or building a positive relationship with veterans could be of significant benefit. As seen in Figure 1, such an intervention could occur early in prospective students’ active duty careers as a counter to the discouragement and lack of guidance they receive, all the way to the point where veterans are deciding which university to apply for and attend. This type of intervention and community engagement could provide the vital information many veterans are seeking during the college choice process.

Conclusion

The participants in this study struggled when making meaning of the college choice process. All of the participants had early aspirations of going to college but either were not initially successful in college or utilized the military to mature or earn resources that would allow them to go to college. For several participants, the military and subsequently college provided an escape from their earlier circumstances. Participants’ overall lack of social capital, cultural capital, and guidance added burdens to the process. Additionally, the college choice process was exacerbated by discouragement and misinformation along the way. Without a strong understanding of the process or where to find quality information—and scared of failing— the participants sought out perceived trusted relational partners for information and guidance. These relationships were one of the primary contributors to the direction participants would take in searching for and selecting a college. Given their narrow searches and commitments early in the process to one institution, the participants limited the amount of risk they took on in their search for and choice of a college. The college choice process was further limited due to the circumstances that restricted their searches to specific locations.

Colleges and universities are extensions of their communities. By achieving a better understanding of their own roles on and off campus, these institutions can deepen their bond with and understanding of the communities they serve and in which they participate. Results from this research demonstrate that veterans follow a unique path through their college choice journey. Certain distinctive characteristics influence veterans’ decision-making as they consider and ultimately select a college to apply for and attend. With a greater awareness of how veterans make meaning of the college choice process, college recruiters and practitioners can open and maintain quality lines of communication while establishing relationships of trust with these potential students. This approach will ultimately minimize friction in the process and have a positive impact on the campus and surrounding community. Veterans are present in all communities across the nation. The recommendations listed provide opportunities for community engagement that are often missed by colleges and align with efforts on many campuses to connect with the nontraditional and independent student population.

Having led military and veterans programs at two separate universities, the researcher used the data gathered from this research to influence their work as a practitioner. They implemented a policy of providing student-focused advising to
potential student veterans and military-connected students in both programs. This practice included asking the potential students about their professional and higher education goals and from there recommending quality university options that allowed them to efficiently pursue those goals while getting the most out of the education benefits they had earned through their military service. Many times, the researcher and their staff referred students to other colleges and universities. Despite referring students to other universities, upon implementing these protocols at the first military and veterans program the researcher led, the student veteran population increased by 30% within the first three semesters as student veterans began to refer their peers to the military and veterans program for guidance on higher education. By establishing relationships of trust and connecting with these students through outreach, all of those involved in the process benefited, including student veterans, the campus military and veterans program, the university, and the greater community. This campus community was recognized as welcoming to the military and veterans program for guidance on higher education. By establishing relationships of trust and connecting with these students through outreach, all of those involved in the process benefited, including student veterans, the campus military and veterans program, the university, and the greater community. This campus community was recognized as welcoming to the military population, and as a result they were trusted and engaged by potential student veterans. Ultimately, this unique population of students became active university participants once they matriculated, and the university became more highly engaged with the surrounding community.

References


**About the Author**

Derek Abbey is the President and CEO of Project Recover.
Military Culture and Its Impact on Mental Health and Stigma

A. Ganz, Chikako Yamaguchi, Bina Parekh
Gilly Koritzky, and Stephen E. Berger

Abstract

This article reports two studies that used the Ganz Scale of Identification with Military Culture (GIMC), developed for these studies, to evaluate the relationships between military culture and aspects of mental illness, such as stigma (Study 1), substance use, and trauma (Study 2). The first two authors are veterans of the United States Armed Forces. Study 1 found that active-duty military scored higher on the GIMC total score, and on the component values of duty, selfless service, honor, and personal courage than did a general population sample, but not on the values of loyalty, integrity, and commitment. Level of GIMC endorsement (low, moderate, high), was related to attitudes toward those suffering from mental illness. Additionally, level of GIMC endorsement was found to be either a risk or protective factor toward self-harm and suicide. Study 2 found that service personnel who had sought mental health treatment after joining the military reported less concerns about whether such treatment would hurt their careers than did those who did not seek mental health services. Combined, the results of the two studies indicate that acculturation to the military culture can have positive or negative effects, and mental health stigma and concern about one's future in the military are impediments to service members obtaining mental health services.

As the wars in Iraq, Afghanistan, and elsewhere draw on, service members are often surviving what were once lethal incidents. This is largely due to improved war fighting technologies such as enhanced personal and vehicle protection, along with advances in medical care. The cost of increased survival of traumatic incidents is represented by the growing number of service men and women, and their families, who live with physical and behavioral health consequences. For example, as of September 10, 2019, since 2001 a total of 52,981 military troops were physically wounded in action while deployed (Blum & DeBruyne, 2019). These statistics represent a small fraction of those negatively impacted by their service. The mental health concerns of service members and veterans, including suicide, are higher than ever experienced in the United States, with epidemic levels of suicide, posttraumatic stress disorder (PTSD), traumatic brain injuries (TBIs), and other mental health-related injuries.

For example, approximately 8.4% of the overall military force (ranging from 6.8% to 10.0% across services) were formally diagnosed with a mental health disorder in 2019, which accounted for 1.9 million outpatient encounters (Department of Defense [DOD], 2019). Of these, 3.8% were formally diagnosed with PTSD, 7.3% with anxiety, and 7.5% with depression, and 2.6% with Alcohol and Substance Related Disorders (DOD, 2019). This is concerning on account of the 'healthy soldier effect,' which suggests that because recruits are screened prior to enlistment, mental health rates in the military should be well below civilian norms. Also of concern is the fact that many military members do not report their mental health symptoms or substance use issues, and therefore go undiagnosed (Dabovich et al., 2019b). This means that the statistics presented here may represent a small fraction of the military's actual mental health burden.

In addition to elevated mental health diagnoses in the military, suicide rates are the highest since data from the recent wars have been collected (Orvis, 2019). In 2018, a total of 325 active-duty military members completed suicide (Orvis, 2019), with the suicide rate varying between 256 and 325 deaths annually since 2012. This represents an average of one service member completing suicide every 30.5 hours (Orvis, 2019). Unlike physical wounds, which are often visible and thereby objectively validated, mental health issues and suicidal ideations are invisible, which means they are harder to recognize and validate in both the self and others. This invisibility inhibits an individual's willingness to engage in clinical care and community support (i.e., help-seeking behaviors) in the military, which may otherwise be of benefit.
Specifically, the reasons include concerns about being seen as weak, being treated differently, losing the confidence of fellow soldiers, and harming their own careers (Zinzow et al., 2013). Other barriers to treatment are associated with issues of trust and confidentiality among the individual, the military health system, and command structures (Miggantz, 2013; Quartana et al., 2014; Zinzow et al., 2013), all of which amount to a loss of personal agency when exposing personal vulnerabilities (Dabovich et al., 2019a). With these concerns in place, many service personnel choose to “tough it out” (Miggantz, 2013), which means they ignore their symptoms and hope they will resolve on their own (Miggantz, 2013). Alternatively, some service members report the practice of self-treatment and self-medication is common, which often includes substance misuse (Dabovich et al., 2019b).

To highlight the extent of these problems, one study found that of returning service members who screened positive for PTSD, 75% acknowledged they had mental health concerns, and only 40% of those were interested in seeking help (Miggants, 2013). This is problematic because PTSD is often comorbid and also because it is widely accepted that early help-seeking behavior and interventions for mental health issues are one of the most reliable predictors of recovery across a wide range of conditions. The help-seeking barriers faced by military personnel and the behaviors they espouse suggest further examination of the military culture and its impact on help-seeking behaviors and outcomes.

A widely accepted component of the military culture is to “tough it out,” which has also been described as the inclination to “push through” limitations to achieve mission success (Dabovich et al., 2019a). Failures to “tough it out” and “push through”—that is, to unflaggingly perform one’s role in the military—are often associated with personal failure, weakness, and therefore vulnerability, which can have devastating psychosocial consequences for the individual, in addition to the original physical or psychological trauma (Dabovich et al., 2019a). This attitude, and the culture it creates, is often strengthened by military leaders. For example, a major general (2-star General) at Fort Bliss, Texas, stated, “I have now come to the conclusion that suicide is an absolutely selfish act” (National Alliance on Mental Illness [NAMI], 2012, p. 6). Such a response reinforces the notion that psychological or emotional suffering is akin to personal failure within the culture of the military. Indeed, Zinzow et al. (2013) documented that military leaders believed service members with mental illness were malingering. This skewd view increases stigma toward help-seeking behavior within the unit, which poses a significant barrier to mental health treatment (Zinzow et al., 2013).

Although the attitude of needing to “tough it out” or “push through” (Dabovich et al., 2019b) can be problematic to help-seeking behavior in the military, it must be acknowledged that the attitude is adaptive in context and begins during basic training (Dabovich et al., 2019a; Hsu, 2010), when the core values are inculcated. For example, the US Army has a core value of “Selfless Service,” which encourages putting the unit or the mission before the individual self. The other core values among the military are “Loyalty,” “Duty,” “Respect,” “Honor,” “Integrity,” “Personal Courage,” and “Commitment” (www.army.mil/values; www.navy.mil). Of these, the greatest barrier to treatment may stem from the core value of Personal Courage, which encourages members to face fear, adversity, and danger with both physical and moral courage (U.S. Army Center of Military History, 2011)—all of which are necessary for mission success. The degree to which this core value extends to enabling service members to ask for help when facing their personal fears, adversity, or dangers, remains underexplored.

### Study 1: GIMC and Military Mental Health

#### Stigma

Study 1 was designed to identify the prevalence of negative attitudes and beliefs toward mental health services among military members who do not seek mental health treatment. The targeted sample was active-duty personnel who had not sought mental health services, and an additional sample of civilians (or general population) who had never been in the military was created as a comparison. The essential component of Study 1 was the implementation of the GIMC, constructed for this study, along with two other measures that assess mental health stigma between active-duty personnel and a non-military civilian sample.

#### Methods

**Participants**

Samples of active-duty military personnel and individuals from the general population were recruited using snowball and purposive sampling. A snowball sample technique was used due to the close-knit nature of the military group, in an attempt to increase the flow of participation and
maximize authenticity of participants’ inclusion criteria and eligibility (minimize hesitation on the part of the participants and maximize authentic responses). The two primary authors of this study initiated the snowball samples with their personal contacts who then subsequently recruited additional military participants to complete the survey. The inclusion criteria for Study 1 were active-duty participants who were at least 18 years old. There were no restrictions regarding gender, rank, or ethnicity.

Initial contact with all participants (both active-duty military and the general population) was made via e-mail through personal contacts. There were no known connections between military and general population participants, and these were two separate snowball samples. The e-mail contained information about informed consent, how to access the digital Qualtrics survey, the time requirements of the study, what participation entailed, risks and benefits of participation, voluntary participation, and where to seek additional information regarding the study. Participants were required to complete the survey and give their consent. The participants were asked to forward the e-mail to other prospective participants. Additionally, the recruitment e-mail and a hyperlink to the Qualtrics survey were posted to a social media website. The goal of recruitment was to locate service members who had not had professional mental health treatment. Participants from the general population needed to be at least 18 years old, and they could not have any history of service in the United States Armed Forces. The final active-duty sample was 129 participants; the final general population sample was 80 participants. The mean age of active-duty personnel was 26.38 years (SD = 9.26, range 18 to 60). The general population mean age was 43.65 years (SD = 9.07, range 18 to 72).

The sample included participants from the Air Force (n = 23), Army (n = 18), Marine Corps (n = 86), and Navy (n = 2). The rank breakdowns were: Junior Enlisted (E1-E5; n = 86); Senior Enlisted (E6-E9; n = 26); Junior Officer (O1-O4; n = 10); and Senior Officer (O5-O9; n = 6), and one “no answer.” Of the 129 active-duty participants, 49 (38%) indicated they had deployed to a combat zone at least once and 80 (62%) indicated they had never deployed to a combat zone. Twenty-five (19%) indicated they had received mental health treatment before serving, and 103 (79%) indicated they had not received treatment, and one participant did not answer the question.

Measures

Demographic questionnaire. The demographic questionnaire was included in the e-mail and participants need to complete it as part of the online Qualtrics survey. All measures were anonymous and no personally identifiable information was collected. The demographic questionnaire asked for the branch of service, the status of service (active, reserve, or national guard), rank, age, marital status, number of dependents, occupational status, and gender. The respondents indicated whether they had received treatment for mental health concerns, believed they needed treatment but did not get treatment, or did not need treatment.

Attribution questionnaire. The Attribution Questionnaire (AQ-27; Corrigan et al., 2003) was used to assess stigma. The AQ-27 consists of 27 items regarding attitudes toward individuals with mental illness. Each statement has a 9-point Likert scale answer choice labeled from not at all to very much, indicating the respondent’s disagreement or agreement with the attitude toward an individual with mental illness. With permission from the author of the AQ-27, the scale was adapted for the military population to include a vignette that was more representative of mental illness within the military culture and values.

Scoring AQ-27 consists of using the AQ-27 Score Sheet, which identifies the questions loading onto each of the nine factors (Corrigan et al., 2012). Validity and reliability of the AQ-27 were psychometrically tested by Brown (2008). It was found to have an overall high reliability and validity, and to have high convergent validity with other measures of stigma (Brown, 2008).

Self-stigma of mental illness scale—short form. The respondents completed the Self-Stigma of Mental Illness Scale—Short Form (SSMIS-SF; Corrigan et al., 2012), which consists of 20 items that respondents rated on their level of agreement on a 9-point Likert scale from I strongly disagree to I strongly agree. The SSMIS-SF is scored using the SSMIS-SF Score Sheet, which identifies which questions load onto the four subscales: Awareness, Agreement, Application, and Hurts Self. Hurts Self refers to whether the application of the stereotype to oneself is increasing harmful behavior. The higher the score, the more the individual endorses negative beliefs and attitudes related to mental health stigma. Corrigan et al. (2012) conducted psychometric analysis on the SSMIS-SF to psychometrically compare it to the original SSMIS, and found internal consistency ranged from α = .65 to α = .87 across the four subscales.
Ganz scale of identification with military culture. At the time this research was conducted, there did not appear to be an existing instrument measuring identification with the US military culture. Therefore, a scale was created for this study to address the extent to which the individual endorsed the components of military culture core values delineated in the literature (www.army.mil/values; www.navy.mil). The GIMC consists of eight statements that addressed eight core values of the armed forces without naming the value on a 5-point Likert scale from Not at All to Very Much. Table 1 shows the list of statements and corresponding core values. As this was the first use of the GIMC, its reliability and validity are currently unknown. This scale was given to the general population participants to begin to develop a validity indicator. Active-duty personnel scored significantly higher than the general population on overall GIMC scores, thus supporting the validity of this measure.

**Procedures**

The prospective participants who accessed the online Qualtrics Survey were first presented with an Informed Consent page on the screen. Participants acknowledged consent by selecting “yes” at the bottom of the first page of the survey. Another way in which participants consented was by completing the survey. After indicating their consent to participate, all sample participants completed the GIMC, the AQ-27, the SSMIS-SF, and the demographic questionnaire, in that order. The total time for survey completion was approximately 15 to 20 minutes. The final page of the online Qualtrics survey contained a Debriefing Statement that included general information about the study and mental health resource information in case the study caused any distress or participants were interested in seeking services. Also, respondents were notified in the Informed Consent that their voluntary participation in this research study would result in a $5.00 donation to the Wounded Warrior Project for each completed survey, up to $750.00, as a token of appreciation for their participation. This study was approved by the Argosy University, Southern California Institutional Review Board.

Statistical analyses for both studies were conducted using the SPSS software (Version 2017) package.

**Study 2: Military Culture and Substance Use**

Study 2 was designed to focus on the etiology of substance misuse among service members, as it relates to military culture and help-seeking behaviors.

**Methods**

**Participants**

The respondents were active-duty US Military service members, aged 18 or older, with at least one year of time in service including boot camp and military occupational specialty school. There were

<table>
<thead>
<tr>
<th>Table 1. GIMC Items and Corresponding Core Values</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Item Statement</strong></td>
</tr>
<tr>
<td>Believe in and devote yourself to something or someone; allegiance to others.</td>
</tr>
<tr>
<td>Fulfill obligations to the military, mission, and unit.</td>
</tr>
<tr>
<td>Trust that all people have done their jobs and fulfilled their duty, putting forth their best effort.</td>
</tr>
<tr>
<td>Put the welfare and needs of the nation, the military, and your peers and subordinates before your own.</td>
</tr>
<tr>
<td>Live by the military moral code and value system in everything you do.</td>
</tr>
<tr>
<td>Do what is right, legally and morally.</td>
</tr>
<tr>
<td>Face fear, adversity, and danger, with both physical and moral courage.</td>
</tr>
<tr>
<td>Exhibit the highest degree of moral character, technical excellence, quality and competence in what I have been trained to do.</td>
</tr>
</tbody>
</table>

*Note. GIMC items were scored on a Likert Scale from Not at all to Very Much.*
no other restrictions. The sample was recruited using snowball sampling for the same reason as specified for Study 1. An initial survey was sent via email to a list of active-duty military personnel from personal contacts for further dissemination to their personal contacts. The email included a recruitment letter that provided details about the expected time required to fill out the survey. A digital form of informed consent was attached to the recruitment email and included instructions on the SurveyMonkey survey. Completion of the survey on SurveyMonkey indicated that the informed consent was acknowledged and given by participants.

A total of 90 service personnel completed a portion of the questionnaires, with 81 members responding to every question. Of those 81, 17 were men and 64 were women. Three branches of military service were represented: 2 Navy, 6 Army, and 73 Marines. In terms of years of service, 44 had 1–5 years, 21 had 6–10 years, 9 had 11–15 years, and 7 had 16 or more years of service.

**Measures**

**Demographic questionnaire.** The demographic questionnaire was kept anonymous and did not collect any personally identifiable information. The demographic questionnaire asked for branch of service, status of service, rank, age, gender, marital status, military occupation, time in service, combat experience, and whether they had sought treatment for mental health concerns prior to or after joining the military, were open to mental health treatment, were open to physical health treatment, had used substances (such as alcohol and/or prescriptions prior to joining the military), or had been diagnosed with or treated for substance-related disorders.

**Ganz scale of identification with military culture.** The GIMC (as described above and in Table 1) consists of eight statements that address the eight core values of military service. Each statement allowed the participant to identify their level of agreement with how each core value affected their views or beliefs relevant to the military culture. A 7-point Likert scale was used with ratings ranging from *Not at All* to *Very Much* to indicate how each value applied to them.

**Procedures**

By accessing the survey, participants acknowledged consent to participate. Participants then completed the Informed Consent form, then completed in sequence, the online survey that consisted of the demographic questionnaire, along with other questions to identify participants’ beliefs, attitudes, and behaviors related to aspects of mental health, lifestyle, and GIMC. All information was anonymous as no identifying information was obtained. Once the survey was completed by a participant, each respondent received a digital debriefing statement. Respondents were notified that their voluntary participation in this study would result in a $5.00 donation to the Disabled American Veterans Charitable Service Trust for each completed survey as a token of appreciation for their participation. This study was approved by the Argosy University, Southern California Institutional Review Board.

**Results**

A multivariate analysis was conducted for gender differences between the military sample and general population sample. No significant differences were found regarding gender on the GIMC (Pillai's Trace = 1.864, *p* = .073), AQ-27 factors (Pillai's Trace = 1.488, *p* = .162), or the SSMIS-SF subscales (Pillai's Trace = .228, *p* = .922).

A multivariate analysis was also conducted to determine whether age and gender combined contributed to any significant differences between the military and general population samples on the GIMC, AQ-27, and SSMIS-SF. No significant interactions were found for any of the measures used. Therefore, further analyses combined the two genders. Age was assessed as a covariate when differences were found and was indicated where necessary.

**Overall Differences between Active-Duty Military and General Population on the GIMC**

Study 1 compared the scores for the general population and active-duty military personnel on the GIMC, for which the means and standard deviations are presented in Table 2. As there was a difference in the mean age between the two groups (*F* = 11.201, *p* = .000), age was used as a covariate in these analyses. Analyses of Variance (ANOVAs) were analyzed for the GIMC, with the active-duty military having significantly higher scores for overall GIMC (identification with military culture), and the individual core values of Duty, Selfless Service, Honor, and Personal Courage. Interestingly, the general population had a statistically significantly higher score on Respect.
Further Analyses of GIMC Scores

The active-duty service members were classified into GIMC categories of low (total score ≤ 24), moderate (total score 25–32), and high (total score ≥ 33) on the GIMC to determine whether there were any differences on the separate measures and endorsement of the GIMC. The GIMC was used as an independent variable with three levels (i.e., high, medium, and low) along with the general population sample. These analyses are reported in the following sections.

Relationship of Levels of GIMC Endorsement to the AQ-27

An analysis was conducted to determine within-group differences of GIMC endorsement on scores on the AQ-27. Results of a multivariate analysis revealed a significant difference between levels of GIMC endorsement among active-duty military on the linear combination of the AQ-27 constructs and the SSMIS-SF scales (Pillai’s Trace = 2.006, $p = .003$).

Follow-up univariate ANOVAs revealed a significant difference between the level of GIMC endorsement on the AQ-27 attitudes of help and coercion. Means and standard deviations for the three levels of GIMC endorsement and the factors of the AQ-27 are presented in Table 3, showing that the only effects were for the attitudes of help and coercion.

Because significant overall differences were found for the help and coercion factors, pairwise comparisons were conducted to identify which levels of the GIMC differed from which other levels. With regard to the help scale, Table 3 shows that active-duty military members who were classified as having the lowest identification with the military culture (low GIMC score) endorsed helping behaviors (e.g., talking to someone with mental health problems or helping them seek treatment) less frequently than both those who scored moderate ($p = .014$) and those who scored high ($p = .000$) on GIMC endorsement. Additionally, the active-duty military personnel who were classified as having the highest identification with military culture (high GIMC score) endorsed helping behaviors more frequently than those who scored moderate ($p = .003$). Thus, those who scored the highest in their endorsement of the military culture endorsed helping behaviors higher than either the moderate or the lowest endorsers of the military culture.

Taken together, the findings related to help and coercion indicated those who identified the least with the military culture endorsed lower levels of helping behavior for people with mental

### Table 2. GIMC Statistics for Military vs. General Population

<table>
<thead>
<tr>
<th></th>
<th>Active Duty</th>
<th>General Population</th>
<th>$F$ (1, 197)</th>
<th>$p$ ($\alpha=.05$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total GIMC</td>
<td>34.65 5.380</td>
<td>31.49 5.584</td>
<td>13.563</td>
<td>.000</td>
</tr>
<tr>
<td>Loyalty</td>
<td>4.56 .904</td>
<td>4.50 1.052</td>
<td>-</td>
<td>n.s</td>
</tr>
<tr>
<td>Duty</td>
<td>4.69 .905</td>
<td>3.49 1.172</td>
<td>58.838</td>
<td>.000</td>
</tr>
<tr>
<td>Respect</td>
<td>3.22 1.193</td>
<td>3.66 1.040</td>
<td>7.171</td>
<td>.008</td>
</tr>
<tr>
<td>Selfless Service</td>
<td>4.36 .957</td>
<td>3.62 1.083</td>
<td>20.421</td>
<td>.000</td>
</tr>
<tr>
<td>Honor</td>
<td>4.23 .972</td>
<td>3.37 1.056</td>
<td>40.213</td>
<td>.000</td>
</tr>
<tr>
<td>Integrity</td>
<td>4.56 .839</td>
<td>4.55 .855</td>
<td>-</td>
<td>n.s.</td>
</tr>
<tr>
<td>Personal Courage</td>
<td>4.57 .818</td>
<td>3.95 .965</td>
<td>10.862</td>
<td>.001</td>
</tr>
<tr>
<td>Commitment</td>
<td>4.46 .769</td>
<td>4.36 .875</td>
<td>-</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

*Note. Active Duty, n= 129. General Population, n=80. n.s. = not significant. GIMC items were scored on a Likert Scale from Not at all to Very Much.*
illnesses, but also endorsed less use of what many would consider coercive behaviors toward people obtaining treatment for mental illnesses than did both those who scored moderate \((p = .004)\) and those who scored high \((p = .005)\) on GIMC endorsement. Coercive actions with regard to treatments for mental illnesses could be involuntary medication, involuntary treatment, and medical discharge of personnel with mental illnesses. An alternative way to express these findings is that those who identified with higher levels of endorsement of the military culture endorsed higher ratings of providing help to people with mental illnesses, including actions that many would consider coercive, such as forced treatment or discharge from service.

**Relationship of Levels of GIMC Endorsement and the SSMIS-SF**

Follow-up univariate ANOVAs were conducted to examine the relationships among the three levels of the GIMC and the mental illness stigma measure \(\text{(i.e., SSMIS-SF)}\). Means and standard deviations for each of the three levels of GIMC endorsement and the subscales of the SSMIS-SF are presented in Table 4. A significant difference was found between levels of GIMC and the SSMIS-SF subscale of **Hurts Self**. Post hoc analysis revealed active-duty military with the highest GIMC level scored lower than those endorsing moderate identification with the military culture with regard to supporting self-injurious beliefs about mental illness \((\text{Hurts Self subscale}; p = .003)\). The **Hurts Self** subscale finding indicates active-duty military with moderate identification with military culture believe if they had a mental illness they would be at fault for having such an illness, and they would be dangerous, unpredictable, and unable to recover or take care of themselves. Those with the highest endorsement of the military culture asserted less than any other group that these negative beliefs \(\text{(i.e., stigmas)}\) would apply to them if they suffered from mental illness.

**Table 3. Military GIMC Endorsement and AQ-27 Attitudes**

<table>
<thead>
<tr>
<th>Low GIMC Endorsement</th>
<th>Moderate GIMC Endorsement</th>
<th>High GIMC Endorsement</th>
<th>(F(2, 121))</th>
<th>(p(\alpha=.05))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Help</td>
<td>16.20</td>
<td>10.085</td>
<td>21.32</td>
<td>5.588</td>
</tr>
<tr>
<td>Coercion</td>
<td>7.00</td>
<td>3.808</td>
<td>13.92</td>
<td>4.663</td>
</tr>
</tbody>
</table>

*Note. Low GIMC, \(n=5\). Moderate GIMC, \(n=25\). High GIMC, \(n=94\). AQ-27 items were scored on a Likert Scale from Not at all to Very Much.*

**Table 4. Military GIMC Endorsement and SSMIS-SF Scales**

<table>
<thead>
<tr>
<th>Low GIMC Endorsement</th>
<th>Moderate GIMC Endorsement</th>
<th>High GIMC Endorsement</th>
<th>(F(2, 121))</th>
<th>(p(\alpha=.05))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Application</td>
<td>19.40</td>
<td>6.580</td>
<td>20.36</td>
<td>8.225</td>
</tr>
</tbody>
</table>

*Note. n.s. = not significant. SSMIS-SF Subscales were scored on a Likert Scale from I Strongly Disagree to I Strongly Agree.*
Endorsement of GIMC and Substance Use
Analyses were conducted to determine if there were relationships between endorsement of the military culture (GIMC scale) and the measures reflecting substance use. None of those analyses revealed significant results.

Comparing Service Members Who Did and Did Not Have Mental Health Treatment after Joining the Military
Of the 81 respondents, only 8 reported having had mental health treatment prior to entering the military, while 50 reported having had mental health treatment after joining the military. In

Table 5. Means, Standard Deviations, and One-Way Analyses of Variance in Differences Between Service Members Who Sought Treatment and Those Who Did Not after Entering Military

<table>
<thead>
<tr>
<th>Item Theme</th>
<th>Yes</th>
<th>No</th>
<th>F (1, 77)</th>
<th>p (α=.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support within Command</td>
<td>2.98</td>
<td>2.19</td>
<td>8.26</td>
<td>.005</td>
</tr>
<tr>
<td>Talking About Struggles is Weak</td>
<td>2.14</td>
<td>2.90</td>
<td>6.905</td>
<td>.010</td>
</tr>
<tr>
<td>Exercise as Self-Care</td>
<td>2.32</td>
<td>1.74</td>
<td>4.987</td>
<td>.028</td>
</tr>
<tr>
<td>Self-medicating emotions</td>
<td>3.46</td>
<td>4.13</td>
<td>5.972</td>
<td>.017</td>
</tr>
<tr>
<td>Negative Consequences for personal problems</td>
<td>2.20</td>
<td>2.96</td>
<td>7.644</td>
<td>.007</td>
</tr>
<tr>
<td>Unfit for Duty if talk to Chaplain or Psychologist</td>
<td>2.58</td>
<td>3.23</td>
<td>6.035</td>
<td>.011</td>
</tr>
<tr>
<td>Asking for help is looked down upon</td>
<td>2.14</td>
<td>2.77</td>
<td>8.239</td>
<td>.005</td>
</tr>
<tr>
<td>Experienced lasting effects of traumatic event</td>
<td>1.12</td>
<td>1.39</td>
<td>7.840</td>
<td>.006</td>
</tr>
<tr>
<td>Constant worry and anxiety</td>
<td>1.12</td>
<td>1.65</td>
<td>3.142</td>
<td>.000</td>
</tr>
</tbody>
</table>

Note. Total n = 81, Service Members Who Sought Treatment: Yes n = 50; No n = 31. Participants responded to multiple choice questions based on agreeableness.

Table 6. Means, Standard Deviations, and One-Way Analyses of Variance in Relationship of Deployment and Military Culture (GIMC)

<table>
<thead>
<tr>
<th>Deployed</th>
<th>Loyalty</th>
<th>Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Yes (n= 38)</td>
<td>3.89</td>
<td>1.351</td>
</tr>
<tr>
<td>No (n= 45)</td>
<td>3.36</td>
<td>1.264</td>
</tr>
</tbody>
</table>

Note. Total n = 83, Service Members Who were Deployed: Yes n = 38; No n = 45. Participants responded to multiple choice questions based on agreeableness.
particular, some significant differences were shown on nine questions. The means, standard deviation, \( F \), and \( p \) values are presented in Table 5.

**Relationship of the Military Culture (GIMC) and Deployment**

**Deployment**

Two significant effects were found on the GIMC for those who were deployed compared to those who were not. The means and standard deviations for those two significant differences are presented in Table 6. It can be seen in Table 6 that those who were deployed more highly endorsed the military values of Loyalty \((F (1, 81) = 6.54, p = .012)\) and Commitment \((F (1, 81) = 6.54, p = .019)\) than did those who were not deployed.

**Discussion**

In general, the results of the current studies support the finding that identification with military culture is related to beliefs about seeking mental health treatment. The military culture does not tend to foster an environment that is conducive to seeking mental health services. Service members are indoctrinated to “tough it out,” and to identify any sign of a problem as a weakness or vulnerability (Hsu, 2010; NAMI, 2012). Interestingly, we found that those who reported having obtained treatment since joining the military report less concern about negative consequences from the military than those who reported not having mental health treatment. This could be due to the fact that their individual level of distress was strong enough to overcome any stigma-related barriers to treatment.

**Differences between Active-Duty and General Population Participants on GIMC**

One of the first steps of these studies was to develop some validity data for the GIMC. A significant difference was found between the active-duty military personnel and the general population participants with regard to the GIMC total score. Active-duty military participants endorsed a higher overall identification with military culture than the general population participants, which supports the validity of the GIMC.

Concerning the individual military cultural constructs, active-duty military endorsed those values that are seemingly more unique to military culture, such as duty, selfless service, honor, and personal courage (Hsu, 2010; U.S. Army Center of Military History, 2011). Though the general population participants are likely dutiful, honorable, and engage in acts of personal courage, the wording is unique to military culture.

Selfless service is the concept of putting the welfare and needs of the nation, military, peers, and subordinates before one’s own. The idea of putting an entire nation and military before one’s own needs is likely what bonds service members together. It is also possible that identification with this cultural construct is a barrier to treatment. Identifying as having a mental health problem that needs treatment is contradictory to this military value.

Honor is defined as living by the military moral code and value system. The finding that the active-duty military participants rated honor more highly than did the general population participants may be the result of the wording, as it is likely that individuals in the general population who have strong religious or moral codes or who greatly value integrity would endorse this construct more strongly if it did not uniquely state the military moral code.

Personal courage is defined as facing fear, adversity, and danger with both physical and moral courage. This cultural value is unlikely to be generalizable to the general population but may be generalizable to law enforcement and first responders; however, it is the basic understanding that military personnel face danger and fear as a way of life.

The finding that the general population participants endorsed the construct of respect higher than did the active-duty participants may be an artifact of the idea that the military is defined by a rank structure and power differentials. Therefore, lower-ranking individuals may not feel they have experienced respect from higher-ranking individuals. With regard to the military values identified as loyalty, integrity, and commitment, these are not unique to the military culture or lifestyle. Therefore, it makes sense that there were not statistically significant differences between the general population participants and the active-duty military participants regarding these values. Our data shows that the military and the general population share some values equally. Specifically, the general population and the military sample both endorsed the same (moderate) level of identification with military culture values.

**Differences between Levels of GIMC Endorsement within Active-Duty Military**

The service members who had the lowest endorsement on the GIMC also had the lowest
endorsement of seeking help or talking with others regarding their mental health problems and helping them seek treatment. Those with the lowest identification with military culture may not think of the military as a brotherhood and other service members as family to the same extent as those who identified more strongly with the military culture. Consequently, they may not feel as compelled to help a fellow service member, as one would if he or she considered that individual similar to a family member. This was consistent with the finding that those with the lowest endorsement of identification with military culture also had the lowest endorsement of coercion or using coercive means to force treatment (e.g., involuntary medication, hospitalization, or medical discharge). In contrast, those who endorsed a high level of identification with military culture had the highest level of endorsement of helping behaviors as well as forcing (i.e., coercing) treatment.

Another significant difference is related to the epidemic of suicide among military personnel and veterans (Blum & DeBruyne, 2019; NAMI, 2012). This study shows that individuals who endorsed a moderate level of identification with military culture had a statistically significantly higher endorsement of the Hurts Self subscale. The Hurts Self subscale reflects whether the application of the stereotype toward oneself increases the risk factors for harmful behavior, such as decreased self-esteem, increased depression, and decreased help-seeking efforts. The Hurts Self subscale consists of items that describe mental instability, including being dangerous, unpredictable, at fault for one’s mental illness, and unable to recover or take care of oneself. The belief that one is unpredictable, unable to take care of oneself, unable to recover, and to blame for the mental illness could decrease self-esteem and increase depression. Our study suggests that a moderate level of identification with military culture is equivalent to feeling marginalized or isolated from any culture, which may be a key risk factor for engaging in self-harm or suicidal behaviors and avoiding treatment. Research shows isolation and a lack of cultural identity are risk factors for suicide (Best Practices Advocacy Centre New Zealand, 2010). The World Health Organization (WHO, 2014) identifies a lack of social support and isolation (i.e., feeling disconnected from one’s social circle such as partners, family, peers, and friends) as a contributing factor for suicide. Social cohesion creates a sense of purpose, security, and connectedness, which may be lacking in the service members who identified a moderate level of endorsement (WHO, 2014). Additionally, Thompson et al. (2017) discuss the development of identities while transitioning across major life events, which include joining military service, and that “identity crisis” and “culture shock” can occur when one struggles to adapt to the unfamiliar culture (e.g., military culture). They argue that when an individual feels socially isolated and has difficulty immersing in the new culture, it can have profound negative effects on mental and physical health and well-being (Thompson et al., 2017).

**Effects of Having Received Mental Health Treatment after Joining the Military**

Those who reported receiving mental health services after joining the military indicated that they were less likely to use alcohol to deal with their problems than service members who did not seek help, that they felt that the military had not been as much of an influence on them to self-medicate, and that they were more likely to use physical exercise to “refresh” their minds. They reported feeling that someone in the chain of command understood them, that seeking mental health services did not likely make them look unfit for duty, that they were less likely to feel that telling a superior about personal problems may lead to a negative consequence, and that they were less likely to feel that talking to a chaplain or military psychologist may be perceived as unfit for duty. In addition, they also felt less concerned that asking for help will be looked down upon.

In contrast, those who had not obtained treatment after joining the military reported feeling that such action would be looked down upon, would cause them to be seen as unfit for duty, that even talking about such problems would make them look unfit, and even more so if they talked to the chaplain or a psychologist.

**Effects of Deployment and the Military Culture (GIMC)**

Findings related to those who deployed to a combat zone and military culture indicate that those who had been deployed at least once indicated greater endorsement of the military values of loyalty and commitment. However, it is not possible to assert whether deployment itself increased their endorsement of loyalty and commitment. It is possible that deploying to a combat zone would increase one’s loyalty to the mission, the unit, and other service members because lives are at
stake. Therefore, seeking treatment for any mental health issues would be contradictory to loyalty and commitment to others.

Smith et al. (2008) find that self-reported symptoms of PTSD were significantly higher among service members with combat exposures in comparison with service members without exposures. Moreover, a large longitudinal study of effects of military service in 2001 indicated that there was a significant correlation between service members who have deployed to combat areas and substance abuse, especially alcohol abuse (Jacobson et al., 2008). McCabe et al. (2008) identified a rising trend of prescription misuse over the previous 20 years in the general population of the US. This is consistent with our findings from Study 2. A majority of service members who did not or could not seek mental health-related treatment reported using alcohol as coping mechanism. It is crucial to recognize that a majority of service members endorsed prescription use, which is an increasing problem. The high endorsement of loyalty and commitment could be contributing to the misuse of substances, as drinking alcohol is socially acceptable in the United States and widely condoned within the US military.

Clinical Implications and Recommendations

Based on our findings in these studies, those working with active-duty personnel might want to be especially sensitive to identification with the values of military culture. Our findings suggest that the moderate endorsement of the military culture (as reflected in the GIMC) may be a risk factor for suicide due to endorsing the Hurts Self subscale more than other levels of endorsement of military culture. Moderate levels of the GIMC were also consistent with the themes of lower self-esteem, depression, and other mental health risk factors, while high levels of endorsement of loyalty and commitment were associated with increased substance use and misuse of prescription medication. Therefore, the military leaders who have expressed negative views toward mental health or who have expressed the opinion that suicide is a selfish decision (NAMI, 2012) can be educated on the risk and protective factors for self-harm in relation to military culture. Educating the Military Leadership on risk and protective factors for self-harm, especially as it pertains to military culture, will hopefully highlight how mental health treatment contributes to the overall mission and readiness of the force. The GIMC can also be used as a screener in mental health treatment or medical settings, in conjunction with other suicide risk factor screeners.

One positive finding from the research suggests that service members who obtained treatment after joining the service did not appear to be as affected by treatment-seeking stigma than those who did not seek help. Seeking treatment decreased self-medicating behaviors. Requiring counseling sessions with mental health professionals as a routine activity would be beneficial. It would remove much stigma from mental health services by including treatment in the same way as any other basic training activity or medical physical. It is essential for military culture to mainstream mental health services to address issues before they become unmanageable and to support the well-being of all service members.

This research found that job security is a concern regarding treatment-seeking behaviors. Prior to 2008, any mental health treatment had to be reported for a security clearance, which then changed in 2008 to no reporting requirement for mental health treatment by reasons of “combat-related” and family/marital issues (Dingfelder, 2009). It is important to note that this policy still limits which service members qualify for mental health services.

Limitations and Directions for Future Research

A limitation of the present research is that a majority of potential participants were from one branch of service (US Marines). Compared to other branches, the Marines have relatively low mental illness diagnoses (DOD, 2019). The relationship between identification with the military culture and alcohol use may differ among the branches of the military. Similarly, the study samples did not represent the genders equally or represented the gender breakdown within the military. Another limitation is that no independent data were available regarding participants’ actual uses of substances. Additionally, although the new GIMC does not yet have established reliability and validity, it produced meaningful results in the present studies. We hope it will be a useful tool for future work.

Future research may focus on finding ways to overcome barriers to mental health help-seeking that are introduced by the military culture. This may be done by highlighting other aspects of this culture, such as the importance of peer-support and reliance on peers’ assistance (Caddick et al., 2015; Greden et al., 2010). Military members and veterans may be more willing to seek psychological
help if the therapist is also a veteran (Johnson et al., 2018). If more veterans and service members are provided with psychotherapy, it might reconcile the perception that service members who seek mental health services are incompatible with military culture.

Conclusion
Although there are many behavioral programs designed to address mental health concerns of service members and promote engagement in mental health treatment, the rate of mental health problems is high and suicide rates are holding alarmingly steady. More must be done to address negative mental health behaviors and substance misuse in the military from a cultural and etiological perspective.

This research adds to the body of literature regarding the stigma related to mental health and treatment-seeking behaviors among active-duty military personnel. This article presents a new tool for evaluating the relationships between military culture and aspects of mental illness, such as stigma (Study 1), substance use, and trauma (Study 2). Using the new Ganz Scale of Identification with Military Culture (GIMC), we conducted two studies to compare how samples from active-duty military and the general population scored on the GIMC total score and on several values (e.g., duty, selfless service, honor, and personal courage). We find that level of GIMC endorsement (low, moderate, high) was related to attitudes toward people with mental illnesses. Additionally, level of GIMC endorsement was found to be either a risk or protective factor toward self-harm and suicide. Specifically, individuals who identified moderately with military culture endorsed a significantly higher belief of self-harm. Our research finds that service personnel who had sought mental health treatment after joining the military reported less concerns about whether such treatment would hurt their careers than did those who did not seek mental health services. The results of the two studies indicate that acculturation to the military culture can have positive or negative effects, and mental health stigma and concern about one's future in the military are impediments to service members obtaining mental health services.

References


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Benefits of Brazilian Jiu-Jitsu in Managing Post-Traumatic Stress Disorder: A Longitudinal Study

Kelly Weinberger and Tracey Burraston

Abstract

The longevity of the United States’ armed conflicts has resulted in a substantial portion of military personnel being at risk for post-traumatic stress disorder (PTSD). Fewer than half of veterans needing mental health services receive treatment for PTSD. For those who do receive treatment, less than one third are receiving evidence-based care. Additionally, one third of first responders develop PTSD. The need for additional treatment options is staggering. Brazilian Jiu-Jitsu (BJJ) is evaluated here as a complementary and alternative method (CAM) that promotes discipline, structure, camaraderie, concentration, and mind-body coordination. These effects are measured in terms of their impact on veterans’ capacity to manage PTSD symptoms. Participants for this longitudinal study include armed-service personnel, veterans, and first responders. There were 32 participants, ranging in ages from 25 to 50 years old, with no prior BJJ training. Participants completed five questionnaires both prior to starting the study and after every 20 hours of BJJ that they completed. All participants initially displayed symptoms of PTSD, which significantly reduced over the course of the study. Participants report that the therapeutic benefits of BJJ practice include assertiveness, self-confidence, self-control, patience, empathy, empowerment, improved sleep, and mindfulness. Qualitative data was used to determine impact of these beneficial capacities to manage PTSD symptoms, and to assess the attractors that allow veterans to initiate and stick with BJJ training in community settings. These findings suggest that the inclusion of opportunities and financial support for veterans to practice BJJ as a form of somatic psychotherapy would be highly beneficial.

Many U.S. veterans suffer from untreated post-traumatic stress disorder (PTSD). Long wait times and overcrowded facilities at U.S. Department of Veterans Affairs (VA) medical centers contribute to this problem, as does the social stigma regarding mental health. Since the attacks of September 11, 2001, the ensuing conflicts in Iraq and Afghanistan have contributed to substantial visible and invisible wounds for U.S. soldiers. PTSD, which affects approximately 8 million Americans each year, is far from a military-only disorder (PTSD: National Center for PTSD, 2018). But veterans have additional challenges when facing this debilitating disorder due to barriers in accessing adequate treatment (U.S. Department of Veterans Affairs, 2015).

PTSD prevalence in returning service members varies depending on wars, eras, and service branch. A 2014 VA study found that of the 60,000 Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans screened for PTSD, 13.5% of study participants screened positive (Dursa et al., 2014). In addition, it is estimated that 30% of first responders develop behavioral health conditions including, but not limited to, depression and PTSD (Abbot et al., 2015).

The RAND Center for Military Health Policy Research reported that only half of returning veterans who needed mental health services sought help from a provider, and of those receiving treatment for PTSD, just slightly more than half of them received minimally adequate treatment (Tanielian et al., 2008). Furthermore, a 2013 report from the VA and Department of Defense (DoD) states that veterans account for approximately 20% of the deaths from suicide in the United States, with estimates that 18–22 veterans die from suicide each day. Veterans are also more likely than their civilian counterparts to own firearms, which is a risk factor for suicide attempts being more successful in this high-risk population. The need for additional community-based treatment options is therefore crucial.

The use and optimization of non-traditional therapies, such as somatic psychotherapy, for active-duty service personnel, veterans, and first responders with PTSD can provide this population with a community support base, structure, physical fitness, and a means to complete mental, spiritual, and emotional healing. Somatic psychotherapy utilizes the awareness of sensorial experience and embodiment to integrate the mind and body in...
the process of healing (Peña, 2019). The practice of martial arts promotes discipline, structure, camaraderie, self-control, concentration, and mind-body coordination. Martial arts are carried out through ritualization of combat moves (katas), the requirement of respect to the teacher (sensei), to the practice space, and to one another. Martial arts also highlight the importance of mindfulness meditation and teaching of philosophical concepts and values such as peace, benevolence, humanity, and self-restraint (Nosanchuk & MacNeil, 1989). The therapeutic benefits of martial arts for those experiencing PTSD have been known to reduce anxiety and depression, while improving psychological well-being (Wang et al., 2014). Martial arts are more than just sports or avenues to physical fitness; they are paths to better physical, mental, emotional, and spiritual health and well-being, and studies find that they promote empowerment, self-protection, and self-development (Phillips, 2011).

Brazilian Jiu-Jitsu (BJJ) is a form of martial arts that has until recently been overlooked in terms of its therapeutic benefits for PTSD. Whereas many martial arts schools teach self-defense, BJJ is mainly practiced as a combat sport. The aim of BJJ is to bring the fight to the ground, control the opponent’s movements, and apply a submission hold (Pope, 2019). Although many people have espoused the psychological and physical benefits of BJJ, as of 2021 there has been only one formal study on how BJJ reduces symptoms of PTSD1 (Willing et al., 2019). Participants in this study demonstrated clinically meaningful improvements in their PTSD symptoms, decreased symptoms of major depressive disorder, decreased generalized anxiety, and decreased alcohol use. The present study is intended to expand on this earlier work.

Methodology

Participants for this longitudinal study included 32 armed-service personnel, veterans, and first responders who resided in Arizona, who had not received previous BJJ training, and whose ages ranged from 25 to 50 years. Research for this study has been ongoing since it was first implemented in August 2016. The study was initially approved by Columbia University Institutional Review Board.2 Participants completed five questionnaires both prior to starting the study and after every 20 hours of BJJ that they completed. The following questionnaires were used: Primary Care PTSD Screen (PC-PTSD), Trauma Screening Questionnaire (TSQ), Generalized Anxiety Disorder 7-item (GAD-7) scale, Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder (GAD) Screening Tool.

In addition to the quantitative questionnaires listed above, participants took part in semi-structured qualitative interviews throughout the course of the study, with an emphasis on discussing how BJJ works to manage PTSD, and why. Furthermore, an additional qualitative survey was sent out through social media platforms to veterans across the United States who practiced Jiu-Jitsu. Recipients were asked if they had experienced any of the following benefits from practicing Jiu-Jitsu: improved physical fitness, self-defense skills, confidence, a sense of community, reduced anxiety, increased calmness, structure, focus, empathy, and improved sleep.

The military-connected author involved in this study participated in the collection, analysis, and interpretation of both quantitative and qualitative data.2

Results of Quantitative Study

Analysis of overall data gathered from the participants questionnaires are presented in the following charts. Through comparison of the spectrum of questionnaire types, we can view the progression of symptoms reported throughout the length of the study. All participants displayed evidence of significant symptoms of PTSD.

All of the participants’ initial scores on all surveys demonstrated clinically significant PTSD symptoms. Throughout the study the questionnaires were repeated every 20 hours of BJJ practice. The participants showed marked decrease in scores on the questionnaires with each subsequent reporting. Figure 1 illustrates the mean scores of all questionnaires for participants with corresponding hour of training completed. Further analysis of the individual questionnaires with mean scores and standard deviations is broken down further in subsequent figures. Figure

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1 PTSD is characterized by four clusters of symptoms: (1) re-experiencing; (2) avoidance symptoms; (3) negative changes in cognitions and mood; and (4) alterations in arousal or reactivity symptoms after exposure to trauma. (Lancaster et al., 2016).

2 As part of this Special Edition, research that has been undertaken under primary leadership of service members, veterans, dependents and survivors (SMVDS) students has been selected. Identification of SMVDS role is noted accordingly.
2 illustrates the PC-PTDS results which decreased 37% from a baseline of 3.5 ± .88 at zero hours, 2.83 ± 1.11 at 20 hours, 2.30 ± 1.25 at 40 hours, 1.3 ± 1.34 at 60 hours. Figure 3 illustrates TSQ scores which decreased 51% from a baseline of 7.31 ± 2.32 at zero hours, 5.75 ± 2.80 at 20 hours, 5.4 ± 2.24 at 40 hours, 3.7 ± 2.54 at 60 hours. Figure 4 illustrates that the participants’ GAD-7 scores decreased 52% from a baseline of 12.72 ± 5.57 at zero hours, 9.92 ± 5.76 at 20 hours, 8.00 ± 5.72 at 40 hours, 6.67 ± 4.25 at 60 hours. Figure 5 illustrates the mean PHQ-9 scores which decreased 39 % from a baseline of 14.90 ± 7.38 at zero hours, 10.16 ± 7.63 at 20 hours, 8.50 ± 6.31 at 40 hours, 5.10 ± 4.9 at 60 hours. Finally, Figure 6 illustrates the GAD-IV scores which decreased 49% from a baseline of 42.13 ± 17.36 at zero hours, 36.17 ± 18.36 at 20 hours, 34.30 ± 13.99 at 40 hours, 20.80 ± 14.93 at 60 hours.

Note. Figures demonstrate the decrease in symptoms/scores according to the various questionnaires through the hours of BJJ completed. The standard deviation is represented on the datapoints.
Results of Qualitative Study

The quantitative results presented above show that participants who regularly practice BJJ report improved scores in standardized tests that measure PTSD symptoms. The purpose of the qualitative part of this study was to determine how BJJ practice might support evidence-based therapies for PTSD, and why the veterans involved in this study were able to stick with the practice in a community setting. The qualitative data was extrapolated from multiple group and individual interviews with participants through a process based on grounded theory. The authors coded the data, compared data and codes, and identified analytic leads and tentative categories to develop through further data collection (Charmaz & Belgrave, 2015). Both authors interpreted the data using keywords, and organized participant responses into the following themes; managing aggression, sublimation, submission, empowerment, discipline, social support, and mindfulness.

In addition, a qualitative survey with five questions was sent out via social media to veteran BJJ practitioners, prompting 16 responses. The questions included:
1. Are you a veteran of the military or a first responder?
2. Do you practice Brazilian Jiu Jitsu?
3. Do you consider your gym/dojo/academy/center veteran friendly?
4. What do you feel makes your center Veteran friendly or not friendly?
5. How can other centers create a more veteran friendly atmosphere?

The authors eliminated one response from a participant who did not affirm to be a veteran of the military or first responder. The authors then extrapolated data from the remaining 15 responses to incorporate suggestions for how BJJ academies could better encourage, support, and promote the veteran community.

Benefits of the Practice of Brazilian Jiu Jitsu
Managing Aggression

Given the aggressive connotations associated with some martial arts, it may be counterintuitive to learn that BJJ is a useful resource for managing the fight-or-flight response associated with combat-related PTSD. As a philosophically grounded somatic practice, martial arts training can be a powerful resource for learning how to control the body while exploring ways to let go of habitual ways of responding and interacting (Phillips, 2011).

Prior studies show that the practice of BJJ can lead to the reduction or elimination of the frequency of aggressive behavior (Wojdat & Ossowski, 2019). As BJJ trainings teach forms of engagement appropriate to the situation and level of threat, participants who train learn how to deal effectively with emotions rather than falling into panic. In fact, studies show that long-term Brazilian Jiu-Jitsu practice significantly reduces levels of aggression for both men and women, and that BJJ is suitable for preventing and treating excessive and uncontrolled aggression in social relations (Wojdat & Ossowski, 2019). Participant A stated:

BJJ has definitely decreased my PTSD symptoms. I sleep better than I have in years. I’m less hypervigilant and I have far less aggressive tendencies. I believe this is due to what I refer to as ‘supervised mutual aggressive expression’ all bound together with consent and trust. Specifically, I can legally express my aggressive disposition with a partner that gets to practice the same with me. So much in my experience with psychiatry involves medications to pacify aggression. BJJ feeds and channels the aggressive nature in me to be productive.

Sublimation

BJJ can be used as an effective tool that demonstrates Freud’s concept of sublimation, a process in which socially unacceptable behaviors are internally repressed and later channeled into behaviors that can expel aggressive and provocative drives in a manner that is socially acceptable (Collura, 2018). Many definitions of violence assume a negative moral judgment and are viewed as fundamentally illegitimate. BJJ allows participants to direct aggressive drives towards socially valued goals, including customary norms in times of war, rites of passage and educational means in various cultures, and various medical, scientific, body care, entertainment, and other sports practices (Even-tzur & Hadar, 2019).

Participants reported that they could work through the fight-or-flight response associated with PTSD using BJJ principles, in a manner similar to that accomplished by prolonged exposure therapy (PE). PE is considered to be a highly efficacious and effective treatment for PTSD, ameliorating a wide
variety of related symptoms, including anxiety, depression, functional impairment, mild suicidal ideation, and anger (Brown et al., 2019). BJJ allows participants to explore the mental pathways of “fight or flight” that were set in the military, and it re-conditions participants to fight within a set of conditions that serve as new “rules of engagement” (Collura, 2018).

Brazilian Jiu Jitsu requires submission as the experience of being physically dominated cultivates humility and understanding of one’s limits. Tapping out is the ultimate admission of defeat because it signifies recognition that further application of the technique could have led to unconsciousness, injury, or death (Pope, 2019). Participant B stated, “In BJJ, you have some control in what would be an uncontrolled situation elsewhere, as you can tap out at any time.” This act of tapping on your training partner’s body with an open hand, is an admission that such techniques have been successfully applied, before unconsciousness or injury occurs (Pope, 2019).

When reflecting on the experiences in a recent tournament, Participant C stated:

I was really concerned with hand-to-hand combat, and I was afraid I was going to lose it. In the military, we answered everything with “kill.” But in Jiu-Jitsu, tunnel vision is counterproductive. You’ve got to be centered and just flow. There is no room for ego. You can’t get mad because then you’ll just get smashed. You have to be controlled. It’s productive as opposed to destructive. This has really helped with my road rage. Whenever someone cuts in front of me now, I just take that breath and let it happen. You learn self-control and that you are responsible for your own safety. I have far more patience than I used to.

The practice of BJJ requires a high degree of trust and builds confidence while teaching patience. BJJ encourages practitioners to live in the moment and deal with the immediate; when participants come onto the mat, they immediately learn what they can and cannot control. It takes trust, and it takes submission.

Empowerment, Confidence, and Discipline

“Empowerment” was a word that came up many times during qualitative interviews. Empowerment has been described as having mental, emotional, spiritual, and physical resources, or pre-conditions, to take action in/on one’s life and the agency to move forward, that is, the ability to define one’s goals and to act on them (Phillips, 2011). Participant D reported that the physical activity associated with BJJ builds physical and psychological strength:

I have so much more confidence now than I ever did. I feel strong. BJJ teaches balance, control, self-control, empathy, trust, and faith. I first started Jiu Jitsu for the self-defense aspect of it. Later on it became the camaraderie, discipline, and all the other things I missed so much about the military...I’m clean and sober almost five months, I’m in the best shape of my life since being out of the military, I’m far more confident, and I rarely get depressed or anxious. I’d say my quality of life has improved to a point far beyond what I ever thought it would.

Brazilian Jiu-Jitsu is goal-directed, providing practitioners with the opportunity to set goals for nutrition, physical training, and scheduling. This discipline transfers to everyday life. Participant D also reported that through this empowerment, he was able to return to school and excel due to the tools that he learned from BJJ. “It’s brought discipline into my life. If I want something now, I go for it.”

Social Support/Sense of Purpose

In addition to the physical and psychological benefits of BJJ, the practice offers social support. Participants in this study who experienced isolation—a classic symptom of PTSD—reported that the BJJ unit mimicked the brotherhood that is traditionally found within the military. The camaraderie, support, and accountability to the group motivated participants to attend regular classes and venture further out into society, often together.

Brazilian Jiu Jitsu provides participants with a sense of purpose, the lack of which many veterans struggle with when transitioning from the military. Learning BJJ etiquette and techniques involves ritualistic hurdles that participants undergo as their competence progresses. The “tribal nature” that is found within respective BJJ academies demands allegiance, loyalty, and doing ones’ best in order to represent the credibility of the BJJ academy (Collura, 2018). The representation of the senior
instructor, their lineage, and the etiquette that is fostered within the respective school also foster cultural elements that resembles “mission-focused identity,” which is a core aspect of military culture (Collura, 2018). Participant E reported:

One of the biggest struggles I had transitioning out of the military, was that I did not have anything to fight for anymore, and I didn't have that brotherhood and mission. Jiu-Jitsu, more than anything else, is a family unit, and brings that brotherhood back. It helped with reintegration so much. When I first went to tournaments, I expected this animosity from civilians, but everyone was shaking hands and hugging, which completely blew away the myth of “us versus them.” We are more connected to the civilian community than we have ever been.

Participants reported that this sense of brotherhood increased their sense of purpose; as they trained together, they trained harder for each other. As they fought together, they fought harder for each other. Participant A stated:

It builds a bond between people, which is a remedy for isolation. It brings peace and clarity to the mind, builds empathy for your classmates and other people, and the benefits to a person struggling from PTSD-related aggression to have grown in empathy is priceless! Empathy and forgiveness for yourself, and others, can prevent suicide and pointless acts of violence against other people.

Cultural Rituals

When military service members or BJJ practitioners wear their uniforms, it paints a picture of who they are and what their experiences are, and it symbolizes how they should conduct themselves (Collura, 2018). Participants found that putting on their gi (a lightweight, two-piece garment traditionally worn in martial arts, pronounced “gee”) with the corresponding belt provides the physical shifts and rituals necessary to frame their warrior identity; yet the gi is a reminder that BJJ is a sport rather than combat in the militaristic sense. In BJJ, the various belt colors correspond with certain levels or ranks; white for building the foundation of the BJJ practice; blue for developing technical proficiency; purple for learning how to use skills and strategies to suit the students’ own style of practice; brown for refining students’ techniques and learning how to think conceptually; and black for those students who have achieved the highest levels of practice. The black belt levels are the start of students’ journeys of mastery, teaching, and reflection of how the practice is applied to their daily lives.

Although many practitioners utilize BJJ to fulfill combative aspirations, practitioners often find that the cultural rituals foster a strong sense of community that encourages healthy social interactions, promotes understanding of both stress and self, and contributes to positive physical habits that can mitigate substance abuse as well as sedentary behavior (Collura, 2018).

Flow

Perhaps one of the primary ways in which BJJ manages PTSD is through the experience of “flow,” a state that occurs when a person maintains deep focus while performing an activity, becoming one with the activity while losing consciousness of time and being detached from the ego (Kohoutková et al., 2018). This flow state is often connected with intrinsic motivation, and brings feelings of happiness, pleasure, and satisfaction (Kohoutková et al., 2018). Participant F said, “We appreciate, or perhaps more important, get addicted to those freeing moments, because with PTSD they are few and far between.”

As the practitioner’s competence in BJJ progresses, the ritualized moves create muscle memory. To achieve flow state in BJJ, there needs to be a balance between the level of the challenge and the grappler’s skill set, which need to match (Pope, 2019). Participant G reported:

Jiu-Jitsu gives you amazing clarity. When I drive home every night, I’m more centered than I’ve ever been. Nothing else works this way. It helped so much just getting out of my head. I was able to get off all the meds I was prescribed and go back to school.

Pope (2019) describes three ways that BJJ provides practitioners with the opportunity to embody spirituality. First, the engagement in a physical activity reminds practitioners of embodiment of their spirituality and provides them with a corrective practice to replace “escapist theology” (Pope, 2019, para. 39). Second, BJJ allows the practitioner to reach a flow state in which the
pursuit of excellence matches the physical and psychological challenges of the activity. Third, and above all, BJJ teaches humility.

Making BJJ Veteran Friendly

Brazilian Jiu Jitsu academies can offer structure for veterans that enhances the warrior ethos that was ingrained within service, while allowing veterans to restructure their perspective on how their understanding of violence, trauma, and combat plays out in civilian life (Collura, 2018). This section examines ways for how martial arts academies might offer more veteran-friendly environments.

During the course of this study, a brief survey was sent through social media groups to veterans across the United States who practice BJJ. Survey questions asked veterans if they considered their gym/dojo/academy/center to be veteran-friendly, and if so, to describe what aspects of the center were veteran-friendly, and to suggest how other centers could create veteran-friendly atmospheres. Out of the 15 responses to this survey, 100% of respondents considered their respective academies to be veteran-friendly. Respondents reported believing that their centers were veteran-friendly because they allowed veterans to train alongside other veterans; hired instructors who understood PTSD symptoms and offered space or support when needed; offered free or discounted training for veterans; provided open mats for veterans; permitted veterans to sew military patches on their gis; and were veteran-owned and -operated.

In addition, survey respondent suggested that gyms could be made more veteran friendly by offering safe and supportive environments that avoid stigmatizing persons with PTSD. One survey participant suggested:

Just make veterans welcome. Offer a safe place to train and let them know it’s ok to have physical and mental difficulties and this should not hold them back from trying something new. Let the veteran know it’s not about fighting. It’s about respect for BJJ.

Another survey respondent suggested that gym owners should “treat veterans like everyone else. They are there to train. Ask about service and be a friend.” Respondents also suggested that encouraging veterans to assimilate to the culture of the gym at their own pace, would be beneficial. As would discounted or free training for veterans.

Survey respondents also recommended that gym owners and BJJ instructors who wish to make their facilities more veteran-friendly consult with other instructors who run veteran-friendly BJJ programs and discuss what works, what is needed, and why. One of the respondents suggested that representatives from their own program (not the program where the study was implemented) be involved at every academy across America, no matter how small, to encourage veterans to train by offering free and/or discounted training.

Conclusion

Brazilian Jiu Jitsu promotes growth, encourages socialization, generates exercise, creates a healthy and acceptable outlet to build upon combative identity, and provides a culture that is rooted in familiar notions of hierarchy that give purpose to participants on the mat and subsequently in the civilian world (Collura, 2018).

While BJJ does not replace cognitive therapies and/or medications, it provides physical, social, psychological, emotional, and spiritual means to manage the components of PTSD, and it can be a highly effective form of somatic psychotherapy. As Csikszentmihalyi (1990) stated:

The best moments in our lives are not the passive, receptive, relaxing times…The best moments usually occur if a person's body or mind is stretched to its limits in a voluntary effort to accomplish something difficult and worthwhile (p.2).

The clinical approaches that are typically pushed at VA facilities can be foreign and intimidating for many veterans, compounded with social stigma associated with mental illness and difficulties getting timely and adequate care (Returning Home, 2014). BJJ offers an alternative means of stress and trauma mitigation that focuses on physical fitness, interactions with peers, biological and somatic release, social cultivation, and reframing of the warrior identification (Collura, 2018). The results from this study show that the practice of BJJ is a powerful tool for alleviating the overwhelming symptoms of PTSD. Going forward, we suggest that the VA explores how to provide veterans with opportunities and financial support to practice BJJ as a form of somatic psychotherapy. The physical and psychological benefits of BJJ, along with the camaraderie and identity reformation that are essential aspects of reintegration, provide an alternative to the more
expensive traditional clinical approaches and dependence on prescription medications.

References


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Kelly Weinberger served in the Military Police in the United States Army and has a master's degree in psychology, specialization in military psychology from Adler University. Tracey Burraston has a master's degree in psychology, specialization in military psychology from Adler University and is pursuing a master's in clinical mental health with a specialization in trauma as well as a PhD in psychology at Grand Canyon University.
Teaching Military Cultural Competency to Clinicians and Clinical Students: Assessing Impact and Effectiveness

Nancy Isserman and James Martin

Abstract

Military members, veterans, and their families belong to a unique American subculture. Studies have identified the need for mental health professionals to attain military cultural competency to practice more effectively within this subculture. As an 88-year-old counseling and training agency with a record of service to the military/veteran communities, it was appropriate that Council for Relationships commit to providing training in military culture for its therapists and students. From 2017 to 2019, the course highlighted in this paper was part of an approved Institutional Review Board (IRB) study intended to assess the success of graduate-level instructional activities focused on promoting participants’ military and veteran-related cultural competency. This article includes an evaluation of the 2013–14 four-day training on military culture that preceded the course. In both, the unique cultural factors associated with military and veteran service were addressed within the context of evidence-based behavioral health treatment. A survey of the four-day participant training and qualitative interview follow-ups revealed that information about the military and its impact on veterans and families promoted changes in attitudes, knowledge, and clinical practice for both experienced and newly trained clinicians. These findings were replicated in the three-year evaluation results. This assessment provides valuable insight about military culture training for practicing and future mental health clinicians. Since there is very little information available in the literature on successful military culture competency training, sharing these results with the broader military and academic communities will give others information on the important components of effective training programs for clinicians, thus, potentially improving therapeutic services to these populations.

Introduction

Culture Defined

The culture of an organization is defined by its values, customs, rules, traditions, and unique language (Koenig et al., 2014). Military culture, including service specific subcultures, is comprised of implicit values and beliefs shared through specific rituals and customs and reflected in organizational traditions. Military culture is transmitted through training and experiences that are integrated into the service members’ mind, body, and spirit, often enduring into civilian life after completing military service.

Why Military Culture Matters

Military members, veterans, and their families belong to a distinct and multidimensional American subculture (Martin et al., 2016) defined by shared values, rules, observances, and routines (Koenig et al., 2014). Yet this culture is not monolithic (Mackenzie et al., 2018). The diversity within this military/veteran subculture is reflected in the unique military missions and lifestyle differences within as well as across the various service components and various US military branches (i.e., the Air Force, Army, Navy, Marine Corps, Coast Guard, and newly created Space Force) (Zimmerman et al., 2019). This diversity, an amalgamation of overlapping, interrelated and sometimes conflicting subcultures (Goodale et al., 2012), is supported by the different recruitment and selection criteria used by the various branches of the military for meeting personnel levels and skill requirements. For example, members of the Marine Corps are more likely to be younger and serving in some type of direct combat specialty that requires significant physical capacities, while members of the Air Force are more likely to be older, many with college degrees, and mostly trained in some type of technical skill. The Army and Navy are the largest branches, and they reflect the widest array of occupational specialties required to support their varied and numerous missions.

While there is great diversity among the various sectors of our armed forces, there are implicit cultural values and beliefs shared within and across all components and service branches. For example, the concept of service before self,
represents a core military value that stresses integrity and requires service members to place their duty responsibilities before their own personal interests and desires. Many of these core values are ingrained early in military service and remain with military members and their families even after transitioning from military service to veteran status. While basic training focuses on training recruits in military values and customs, no comparable training returns service members to the civilian world when they leave the military (Koenig et al., 2014). These values and cultural beliefs typically become a part of the veteran’s identity. Aspects of this identity, the warrior ethos, and training for success “outside the wire” (outside the base in a combat area or in operational environments) can lead to behavior that is normal in a combat environment but abnormal in the civilian world. Such behaviors sometimes precipitate a reverse culture shock when veterans return to civilian status (Koenig et al., 2014).

The Importance of Military Cultural Competence
Numerous studies have identified the need for behavioral health professionals to acquire what is referred to as “military/veteran cultural competence” to effectively engage with this population (Nedegaard & Zwilling, 2017; Kilpatrick et al., 2011; Petrovich, 2012; Meyer et al., 2016). Behavioral health providers who seek this cultural competence strive to recognize the diversity that exists within the US armed forces while at the same time become familiar with the core values that anchor military/veteran culture. Culturally-competent clinicians understand the importance of learning to recognize how a client’s life experiences and/or relationships have been impacted by military service and/or veteran status (Meyer et al., 2017). This competency includes developing an understanding of the basics of military life and language (Hall 2011) and the impact of military lifestyles and military duties on behavioral and physical health, especially combat-related exposures, family separations, and various workplace challenges confronting the armed forces—issues like sexual violence, addiction, and suicide. Competent behavioral health providers understand that military cultural competence promotes improved mental health outcomes for military and veteran clients (Hoge 2011).

Service members, veterans, and military/veteran-connected family members seeking assistance have a basic expectation of behavioral health providers—that they recognize and acknowledge their client’s military service and that they appropriately use this knowledge to inform treatment (Cogan, 2011; Lighthall, 2010). Service members, veterans, and military/veteran-connected family members expect that providers will have a basic cultural appreciation, understanding, and interest in their military/veteran-related experiences and how these experiences may have influenced their lives (and the lives of those they love) both positively and negatively (Meyer et al., 2017). They expect behavioral health providers to be competent and caring professionals who are able—when invited—to listen to their experiences, even when these stories may be horrific and painful (Martin et al., 2016). Everyone’s life experiences are unique, including the military member/veteran experiences. It is critical that behavioral health providers recognize this and not let their own personal biases interfere with their understanding of a military/veteran-connected client and the client’s unique military duty and/or military life experiences. From the discussions at the beginning of the course each year it is clear that military culture evokes strong feelings in many of the students. Their lack of familiarity with people who have served and often their distaste for war have frequently given them images of veterans that could, if not addressed, impact the client-therapist relationship (Gross, 2019).

In support of these military/veteran cultural competency goals, the Council for Relationships (CFR), a community-based mental health agency serving the greater Philadelphia region, has taken on the specific mission to promote awareness, knowledge, and the practice of skills related to the mental healthcare needs of the military/veteran population. CFR’s primary focus is directed at improving clients’ (individuals, couples, family systems) interpersonal relationships by providing exemplary “talk” therapy, as well as educating and training clinicians in family systems approaches (B. Hollander-Goldfein (personal communication, March 10, 2021; Nichols & Davis, 2016; Gurman et al., 2015), and by advancing behavioral health practice through research and evaluation. CFR has a long history as a training center in marriage and family therapy, as well as a distinguished record of service since the end of World War II to the military and veteran communities.
Recognizing the behavioral health needs of veterans and their families in the Philadelphia region, CFR initiated a specific veteran-focused initiative in 2007—Operation Home and Healing (OHH)—focused on assisting veterans and their families by promoting emotional healing and assisting veteran and veteran-connected clients to become better partners, parents, family members, and community members. In addition to private counseling, OHH focuses on promoting military/veteran culturally-competent clinical education and clinician skill building. While the primary focus is on the veteran (and veteran-connected family members), services are also available for those currently serving in the military, and in particular, for members of the National Guard and other Reserve Component branches and their family members.

From the beginning of the OHH program, CFR offered a five-hour introductory workshop in military culture to CFR staff. The CFR commitment to clinical training in military/veteran cultural competency further evolved in 2013–14 because of a four-day mental health training course highlighting military/veteran culture. In 2012, CFR received a specific grant from The Helen Bader Foundation to provide training for clinicians on the topic of military/veteran cultural competency. Over the past several years, and supported by OHH, CFR's continuing education programs have offered local area behavioral health providers educational seminars focused on promoting military/veteran cultural competency.

Around the same time as the four-day behavioral health training program, a study by the RAND corporation, "Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families" (Tanielian et al., 2014), reported that only 13% of the community-based providers surveyed were viewed as ready to deliver high quality, evidenced-based, culturally-competent behavioral health care to veterans and their families (Tanielian et al., p. 18). Following this study, and the impact from the OHH training program, CFR made a commitment to provide clients with behavioral health therapists who are both knowledgeable about military/veteran culture and who utilize CFR's intake screening procedures to identify veterans and family members seeking CFR counseling services. These CFR program initiatives, coupled with CFR's counseling services that rely on evidenced-based treatment modalities, continue to provide a high level of service to military and veteran clients in this region.

To accomplish the goal of educating therapists who are knowledgeable regarding military/veteran culture, CFR made a commitment to require that all students in its Commission on Accreditation for Marriage and Family Therapy Education postgraduate certificate program receive training in military/veteran cultural competency. The first 15-hour course was conducted in June 2017. This course was made available to all agency staff, as well as non-CFR behavioral health clinicians in the Philadelphia region. Clinical students enrolled in CFR's Master's in Couples and Family Therapy program at Jefferson University were also invited to participate in this course. The course is based on a generic syllabus for introducing therapists to military culture. It is designed for clinicians who engage in couple and family therapy using a systems perspective and whose clients are not primarily composed of veterans.

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1CFR therapists are grounded in the Systemic Model of Therapy. The foundation of Systemic Therapy is an understanding that the psychosocial development of individuals is based on the primary influence of relationships combined with genetic predisposition and innate potential. This approach assumes that the etiology of an individual's emotional problems stems from the quality of family attachment experiences that influence coping and adaptation in adulthood. Psychological difficulties that result from challenging adult experiences are influenced by the developmental history of key relationships that determine the emotional, cognitive, and behavioral functioning of the adult and are expressed within the relationships that are primary in the adult's life. Therefore, Systems Therapy focuses on significant relationships past and present to help individuals work through their difficulties and achieve change. This therapy model is relevant in working with veterans and their families who are best served by focusing on current relationships and family of origin influences to help work through the impact of their military experiences.

2The first author of this paper, CFR's Director of OHH, created and teaches the Understanding Military Culture course. In addition, with an advisory team she planned the four-day training program. The second author serves on the OHH advisory committee for CFR and was involved in planning the four-day training.

3Subsequent grants to OHH were from this foundation's successor, The Bader Philanthropies.

4The Couple and Family Therapy Master's degree program is a unique collaboration between CFR and Thomas Jefferson University's College of Health Professions. It is a full-time, two-year, 66-credit program, which is modeled on the core curriculum developed by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). CFR administers the program, teaches its courses, and supervises the students in their clinical internships.
This article discusses both the OHH military/veteran cultural competency continuing education initiatives, as well as the CFR fifteen-hour postgraduate course titled *Understanding Military Culture and Behavioral Health Treatment for Veterans and Their Families*. In both the continuing education initiative, as well as the postgraduate course, the unique cultural factors associated with military service and veterans’ status are addressed within the context of evidence-based behavioral health treatments.

Insights learned from these two principal OHH endeavors are discussed in the hope that they will add value for those looking to develop and/or enhance their own training efforts. Some of the limitations of these OHH initiatives are also noted. Finally, there is a discussion of the Council’s plans for moving forward, addressing both the evolving nature of military and veteran experiences, as well as advances in related behavioral health treatments and the impact of these advances on the services offered by the Council.

**The Foundation of the CFR Training Program — The First Initiative**

“Helping Vets Get Help”: A Four-Day Training Program in Military Cultural Competency


This intensive training program focused on enhancing clinician knowledge and skills for serving veterans and their families by educating clinicians on important aspects of military culture and about basic behavioral health concerns for veterans and their families. The training program presenters were CFR staff as well as national experts in military culture, behavioral health problems and treatments, and aspects of trauma associated with military service.

The goals of the program focused on imparting to participants an understanding of military culture and structure. Specifically, these clinicians learned about the challenges and the problems facing active-duty service members including issues associated with post-deployment challenges. Since the participants were experienced therapists, seminar presenters concentrated on the distinct military aspects of these issues. Topics included challenges facing families and successful treatment approaches; suicide and suicide prevention; the impact of trauma on veterans and their families; marital and partner relationship challenges; infidelity; depression; reintegration; and the unique issues facing members of the National Guard and other reservists.

A total of 89 clinicians and advanced clinical students participated in this training. The majority (63%) of the clinicians were staff members of the CFR or students enrolled in CFR’s two postgraduate programs. The remainder were clinicians in private practice or with other local agencies. No other demographic information was collected on the training participants.

**Evaluation of the Training Experience**

A year and a half after completion of the training program, a survey was sent to 77 of the original 89 participants (those with current/know contact information). The evaluation was an initiative of a new OHH director who wanted to understand the impact of the earlier training.

The survey was posted on Qualtrics in June 2015 and included 26 content questions about the training material and sessions along with 10 demographic questions. Survey questions included: whether training met the goals listed; how respondents rated the quality of various training components; and whether the training had an impact on their practice. Answers were placed on a Likert scale. All answers were tabulated through Qualtrics. Thirty-nine of the participants (roughly 50%) completed the voluntary self-assessment survey. In addition to the 39 survey responses, nine respondents were interviewed in-person or over the phone to gain additional insight into the training program’s strengths and weaknesses. The nine individuals volunteered to be interviewed from the 39 who participated in the survey. The interviewees mirrored the original distribution of agency affiliation between CFR clinicians and its students versus those from other agencies or private practices.

The demographics of the survey participants closely reflected the demographics of the CFR’s staff members who comprised the bulk of the training program attendees. The majority (67%) were women, while just over half of the attendees (51%), were over 55 years old. The rest of the participants were fairly evenly distributed among three age categories: 25–35, 36–45, and 46–55 years old. The racial demographic characteristics of the attendees were: Hispanic (3%), African-American (5%), and white (92%). Slightly more than half (55%) of survey respondents were employed full-time and 8% were unemployed.
The participants were mostly clinicians with master's or doctoral degrees. Three of the 39 respondents were students in the Post Graduate Certificate Program in Couple and Family Therapy or the master's degree in Couple and Family Therapy at Jefferson University. The majority of the participants (59%) held either an MSW/MSS or an MA/MS degree, 2% held a BA degree, and 39% either had obtained or were working toward their doctorate.

The respondents primarily represent four professions: psychologists, social workers, marriage and family therapists, and psychiatrists. Not surprising given the CFR's focus on training marriage and family therapists, 59% of the respondents were marriage and family therapists (MFTs). Over half of the MFT respondents were not yet licensed as therapists. Licensed psychologists (21%) and licensed social workers (25%) represented 46% of the total group. A small percentage of the survey participants (5%) were psychiatrists and 15% listed other professions (e.g., professional counselor, lawyer, sex therapist, American Association of Marriage and Family Therapists supervisors).

Most of the respondents had either been in clinical practice less than ten years (51%) or more than 20 years (33%). These demographics reflected the makeup of CFR: seasoned staff, trainees, and newly practicing professionals. Most of the respondents (61%) attended all four sessions and almost 80% attended at least three sessions.

Results of the Survey

Strong majorities, ranging from 87% to 100% either agreed or strongly agreed that the training had achieved important educational goals. Given the range of experience among the participants, the overwhelming support for the effectiveness and appropriate level of training is remarkable. This finding may be the result of a lack of knowledge on this topic among all the participants regardless of experience. It also may be a result of the training decision to assume that the participants were experienced clinicians and to focus the training on the unique clinical challenges presented by military/veteran populations.

The evaluation findings suggested that the training changed the professional behavior of many of the attendees, with 61% indicating that they had changed their own practice activities to encourage military members, veterans, and their families to use their services. A slightly smaller number (54%) said that they now regularly screen for military/veteran status or connections. Thus, a substantial number of clinicians, over half, who replied to the survey noted that the training changed their clinical behaviors and enhanced their interactions with veteran clients and family members. However, one quarter still were not screening clients for military/veteran status or connections. Since CFR, as an agency, screens for military/veteran status, the respondents who are CFR affiliated may have benefited from this agency-wide procedure. Further research on the impact of training clinicians may yield additional methods of changing clinician attitudes and behaviors.

The survey highlighted specific content and techniques that are important to include when presenting new material to clinicians. Moreover, the survey responses demonstrated that a well-designed program can benefit participants with diverse years of experience and professional/educational backgrounds.

Qualitative Interviews

To learn more about the participants' post-training views and to expand on some of the questions asked in the survey, nine respondents were interviewed in brief in-person or phone interviews. These interviewees had indicated on the survey their willingness to be interviewed, and they had attended the full four days of training and spoke in very positive terms about the training experience. Selection bias is always a factor to consider. However, in this case 90% of all the survey responses from the total agreed or strongly agreed that the training achieved its educational goals.

Summary of the Findings from the Qualitative Interviews

The interviewees valued the following characteristics of the training program: the clarity and quality of the military and academic presenters; the videos about military experiences especially on the effects of war and combat; and information that enhanced their understanding of the deployment experience and the effects of these experiences on the family. Information about basic military structures, the different branches and vocabulary, and the unique aspects of more recent wars was also seen as helpful. Specific implications for clinicians, such as how aspects of Posttraumatic Stress Disorder (PTSD) may differ for this particular population, and information on the impacts on families, specifically the impact of multiple deployments, were all noted as important information for clinical practice.
The evaluation of CFR’s 2013–14 training helped CFR structure its new course on understanding military culture. The survey highlighted content and techniques that were important to include when presenting material on this topic to clinicians. Moreover, the survey and interview responses demonstrated that a well-designed program can benefit participants with varying years of experience and professional/educational backgrounds.

The Second Initiative, Understanding Military Culture and Behavioral Health Treatment for Active Military/Veterans and Family Members, Deepens the Training Experience

This training experience was a 15-hour minicourse in the Post Graduate Certificate Program in Marriage and Family Therapy accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). The course offered 15 continuing education credits to licensed behavioral health clinicians.

The course focused on the unique cultural factors associated with military service and veteran’s status in the context of behavioral health treatment. The acute and chronic stressors that often accompany military duties and lifestyle, and the challenges associated with veteran reintegration into civilian life were examined within a framework of clinical behavioral health practice. The tension between empathy and vulnerability within the therapeutic relationship, and a culture in which vulnerability and help-seeking are often perceived to be stigmatizing, was explored during the course in order to identify potential client and systemic barriers clinicians face in treating this unique and diverse population. Topics included stressors related to the military deployment cycle, reintegration, women in the service, as well as post-deployment challenges, grief and loss, suicide, moral injury, military sexual trauma, PTSD, traumatic brain injury, intimate partner violence, substance use disorder, and intergenerational trauma through the lens of the impact of military culture and experiences.

The students were behavioral health professionals, mostly at the master’s level, and from various disciplines seeking to become credentialed as MFTs. Participant ages ranged from early adulthood to middle age. The course was open to master’s students in the CFR training program and students in Jefferson University’s Couple and Family Therapy course. Some CFR staff clinicians also participated in the annual course, as did several non-CFR therapists over the course of three years.

There were five main goals of the course. First, to identify and examine potential military-related prejudices and biases. Second, to understand the impact of military culture on service members, veterans, and/or military connected family members and their sense of self, others, and worldview. Third, to identify how a military ethos may contribute to stress, stigma, help-seeking, and behavioral health behaviors. Fourth, to explore the research on problems related to military service and identify the unique behavioral health needs of military/veteran personnel and military connected family members. The course focused on the unique cultural factors associated with military service and veteran’s status with regard to establishing and sustaining effective clinical relationships. The role of both acute and chronic stressors that accompany military life and reintegration into civilian life were examined. The tension between empathy and vulnerability within the therapeutic relationship, as well as a culture in which vulnerability and help-seeking are often perceived to be stigmatizing, was explored to identify the potential client and systemic barriers clinicians often face in providing mental health counseling to this population.

Each year a small number of postgraduate students enrolled in the course for credit (nine in 2017, six in 2018, and four in 2020). Over the three years the total enrollment for all three classes, including auditors, was 35.6

The course included an evaluation component (part of an IRB-sanctioned study6) intended to examine the success of graduate-level instructional activities that focused on promoting participants’ military and veteran-connected cultural competency in preparation for clinical practice. The evaluation study included a pre- and postmilitary cultural competency checklist, a participant focus group, and a follow-up qualitative interview six months later. Students participated in class

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6Specifically, in 2017 enrollment was 11; in 2018 it was 14; in 2019 it was 10.
6Both IRB projects in this article were approved by Bryn Mawr College, Bryn Mawr, PA.
discussions at the end of the course that centered on their perceptions of how various components of the course influenced changes in their personal/professional views regarding a range of military and veteran issues. In addition, the six-month follow-up interview explored the impact of the course experience on the clinician's subsequent practice behaviors. Each year the findings from this multidimensional assessment have been used to modify the subsequent years' course materials.

Methodology

As previously noted, three evaluation instruments were used in the class each year to measure the impact of the course on participants' knowledge about military culture and their comfort with counseling veterans.

The bias checklist was developed by the Center for Deployment Psychology (CDP) and used in their online course, Military Culture: Core Competencies for Health Professionals (Center for Deployment Psychology, n.d.) The CDP created this self-assessment checklist to enable healthcare providers to identify the assumptions they bring to their work with the military or veteran community with the goal of shifting implicit bias about military culture to explicit awareness.7

As part of the CFR training, the first time the course was taught each student completed the CDP self-assessment prior to the first day of class and then completed a reassessment on the last day of class. A focus group held after the completion of the second assessment concentrated on general responses and changes to the assessment and on the impact of the course experience on student attitudes and practices.

Six months after the class ended students were invited by email to participate in a short interview on the impact of the class on their practice. The course instructor (and lead author) followed up the email invitation with phone calls until four students in each class agreed to be interviewed. Interview questions centered on routine screening and military history taking for veterans and families; familiarity with military terms and information; retention of military/veteran clients; and how and why the course information impacted their clinical practice. Interviews were taped but not transcribed.

The CDP self-assessment bias checklist was intended to reflect stereotypic images about the military and service members and their families. These items were meant to challenge current beliefs and attitudes. In the second year of the course the checklist was slightly modified to better relate to the material in the course.

Findings: The Survey Instrument 
Self-Assessment Test for Bias

The CDP self-assessment checklist, originally intended as a quantitative measure of change in attitudes toward the military, did not provide useful information (even when tailored in the second year of the course to better fit the course material). The original bias checklist items reflected stereotypic images about the military, service members and their families, beliefs about war and were meant to challenge beliefs and attitudes about them. The items did not reflect the material covered in the course and so did not illuminate potential bias that clinicians could hold that could interfere with the client-clinician relationship. This lack of usefulness as a quantitative measure was also experienced by educators at the CDP and the measure has not been further developed. However, in all three years the statements of bias on the checklist did stimulate useful class discussions around stereotypes—especially in the three focus group discussions.

The Focus Groups

During the fourth and final class session each year, the last 30 minutes were devoted to a focus group discussion. Students had been presented earlier with the general questions that would be discussed. Each year the focus group was taped and a transcript was created of the discussion. The focus group questions were:

1. Overall did your views on military personnel and veterans change from those you held before the class started? Why or why not?
2. Please give an example of a change in your viewpoint.
3. Which part of the class materials made the biggest impact on changing your attitudes: the readings, the videos, or the class discussions?
4. Why did the teaching strategy you just identified have such an impact?

7Private email from Richard Westphal, Ph.D., RN, PMHCNS/NP-BC, department chair for Family, Community, & Mental Health Services, UVA School of Nursing, one of the creators of the checklist. Dated: 9-17-17.
5. How will the material you learned in this class help you with counseling the military/veteran community in the future?

The focus group discussion revolved around three issues: confidence gained from the course information for working with veterans and their families; the change in their attitudes toward the military and veterans resulting from taking the course; and the lack of clarity in the bias assessment statements. The students commented that it was difficult for them to rate their answers because the terms used in these statements were unclear. As noted earlier, after three years of trying to use the self-assessment checklist as a measure of bias, including revising it after the first year to try to tailor it more to the course content, it became clear from the student discussions that the instrument itself did not provide a quantitative measure to stimulate discussion and expand student thinking around bias. Still, some individual items were useful within the context of the focus group discussions.

Reflecting on the impact of the course, many students in each year felt that their personal opinions on war and serving in the military had become more nuanced as the class progressed and/or that they were now better aware of their own attitudes and personal biases. They attributed these changes to their enhanced understanding of the factors associated with military culture—factors that impact clinical work with veterans and associated family members. The examples given in the class about the various military/veteran and related family situations helped clarify and/or expand their understanding.

The heterogeneity of the veteran population became clear through class material. Students stated that their ideas were no longer simply “black and white” about the military. Of note, a few of the students in each class were veteran-connected family members as were the instructors. The sharing of their personal experiences about what it was like to be married to someone in the military or to be a child or parent of a service member appeared to foster empathy and seemed to create an openness toward future counseling with this population. One student commented:

The whole point of this class is that no two situations are the same, you can never know what that person experienced, and you must have unqualified empathy...At the same time, I'm aware that it's important to be aware of my own personal stuff.

Another student stated:

After taking the class, and throughout the [course], I was able to take all these different perspectives in...It allowed me to kind of open up and be okay about actually thinking about this and feeling comfortable about it and having empathy, and also just accepting that war today is part of our human condition, and that vets and families are part of our society.

A third student noted the relevancy of the course to her current practice:

You know the way that she said in the beginning people's eye glaze over when you talk about the military? That is definitely me. Eyes glaze over; I really don't want to know anything about this. This is about killing; this is about government; this is about coercion. So, to humanize that and to break it down into...the impact...on real men and women, who serve, why they serve, and the effects...on them, was a real eye-opener. And then just coincidentally, getting a case yesterday with a military family suddenly brought the whole thing home to me, very relevant, and suddenly I'm like all ears. So, it's just quite a difference from where I was at the beginning.

The course gave the students information about conditions and mental health issues that they did not normally receive in their postgraduate curriculum such as characteristics about traumatic brain injury, moral injury, and military sexual trauma. Students remarked that covering this material gave them a framework to know what to explore, to understand what questions to ask, and to know how to better support the clients. They noted that the myth that “everyone comes out of the military with PTSD” was dispelled during the course. They gained a fuller understanding of why people join the military and gave them a different perspective on service members and veterans.

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Footnote: We used a five-item Likert scale for each statement on the checklist. This allowed us to use quantitative methods to analyze the students’ responses.
As one student declared:

I feel like I very much was walking around with that stereotype like there are no other options for these folks, they're just in such a deep situation that this is their only out. And for some people, yes, they have those pre-traumas, but for a lot of folks they are in a fine situation, they actually just want to go invest in their education. And then the other part that was really shocking to me is that with PTSD we only actually see that in 20% of vets, and I thought that was everybody that comes out of a combat situation, which isn't true.

Another student noted that:

Even just asking the question: Have you served? Of course, developing rapport is very important, but I wasn't trained to ask “have you served” in my training… and then also learning… the unique nuances of military life and military culture. Certain things, like how military sexual trauma is different than incidences of sexual harassment or trauma…in a civilian workplace, learning those kinds of differences, learning differences in domestic violence situations, how a military family might be different, those kinds of responses, was helpful just to apply…the knowledge that I've already accumulated is more nuanced and more specific.

Follow-Up Six-Month Interviews

Over three years, a total of 12 students, four each year, volunteered to be interviewed roughly six months after taking the course. The interviews focused on the impact of the course on subsequent practice. Volunteers were solicited by email until the number of four was reached each year. Since class sizes were small, four interviews represented a reasonable percentage of the enrolled students (44%, 66%, and 100%).

The interviews lasted up to 30 minutes in length. Interviews were conducted either in-person or on the phone. Oral consent was given, and the interviews were recorded on a digital tape recorder. Questions on the semi-structured interview guide asked about the clinician's routine screening and military history taking in their clinical practice. The interviewees were asked if the course increased their understanding of terminology associated with military/veteran issues; about the impact of the course material on their clinical practice; and whether the class videos, materials, and class discussions were helpful.

Findings

Findings from these interviews support comments made during the focus group at the last class session of each course. No discernable differences were noted among the responses from the members of the three classes. This is probably because all the students were enrolled in CFR's postgraduate courses and interning at CFR. Thus, they had all experienced one or two years of classes and clinical supervision given by CFR staff who follow a systemic model of therapy. Findings from these interviews can be aggregated into five categories.

1. Routine checking of clients for military or veteran status is important and affirms the value of the systemic framework that is a key element to the mission of the agency. Ten of the 12 interviewees stated that after taking the class they routinely screened clients for military service. Some remarked that they paid more attention to the agency's registration form on which there was a box for the client to check veteran status. Two interviewees reported that they did not look at the box on the registration form asking about veteran connections. They also noted that none of their clients mentioned having any military connection.

   One interviewee stated regarding the importance of asking about military experience, “I am more aware of it [military experience] as something that's systemically important considering how much the military family is affected.” A second student noted that after taking the course she is more mindful of the experience of military culture as a process or way for clients to express their feelings and that it has a role in a client's development and relationships.

2. Knowledge about military culture promoted the clinician's comfort with veterans as clients. The students noted that knowing what questions to ask and what the military terms meant gave them a level of comfort in working with the military community clients. A student who had decided prior to taking the course not to work with military or veteran clients due to his beliefs and values changed his perspective. He remarked in the interview, “You realize that there is more than I have experienced; different perspectives
The interviewees were asked if the course increased military history taking in their clinical practice. Asked about the clinician's routine screening and length, interviews were conducted either in-person (44%, 66%, and 100%). Classes were small, four interviews represented practice. Volunteers were solicited by email until focused on the impact of the course on subsequent six months after taking the course. The interviews followed up… the knowledge that I've already domestic violence situations, how a of sexual harassment or trauma… in a sexual trauma is different than incidences and then also learning… the unique very important, but I wasn't trained to situation, which isn't true. Another student noted that: everybody that comes out of a combat that in 20% of vets, and I thought that was me is that with PTSD we only actually see the other part that was really shocking to pre-traumas, but for a lot of folks they are a deep situation that this is their only out. And for some people, yes, they have those. As one student declared: than I have experienced; different perspectives and values changed his perspective. He remarked with military or veteran clients due to his beliefs military community clients. A student who had gave them a level of comfort in working with the questions to ask and what the military terms meant. The students noted that knowing what client's development and relationships. The course she is more mindful of the experience considering how much the military family is important, but I wasn't trained to the course she is more mindful of the experience. Some remarked that they paid more attention to options for these folks, they're just in such with that stereotype like there are no other. As one student declared: or veteran status is important and affirms the comments made during the focus group at the discussions were helpful.

Findings from these interviews support specifically, why understanding military culture how they viewed military or veteran clients; their impact their military clients’ behavioral and key factors that could address an intimidation factor that the students felt at the beginning of the course. The course dispelled preconceptions that the students held about the military. They gained an understanding of the values that informed their clients’ identities and key factors that could impact their military clients’ behavioral and relational difficulties. Several students noted that the course broadened their perspective on how they viewed military or veteran clients; specifically, why understanding military culture is important for mental health professionals and how it may shape the behavior of the client. One student stated the course taught her,

how to speak with veterans in the most respectful way. I had always heard people say there's one question you never ask a veteran (e.g., "did you ever kill anyone?") and I didn't know what that question was—it was really helpful to know what not to ask.

Students echoed similar thoughts in several interviews:

I had a lot of trepidation about working with this population, my perceived notions were that there was a lot of trauma that existed in this population that I wouldn't be qualified or helpful because of my inexperience and lack of specialty in that area but watching the videos it was impressive that even having therapists outside of…therapists without military experience can be helpful to them and so many of the military and veterans on the videos had positive experiences with clients and not so specialized treatment that I don't have to shy away from it.

Another student supported this view, claiming that the material in the course from a civilian professional’s “viewpoint revealed key insights, made the material easier to absorb, and encouraged empathy and a sense of the terrain and signposts that therapists need to recognize.”

5. Finally, several respondents mentioned a number of specific components of the course that were the most helpful. They included pragmatic discussions that contained structured questions to ask when working with military clients with specific problems around trauma including military sexual trauma, intimate partner violence, PTSD, and behavioral health issues as well as what signs and symptoms might be present. In addition, each student received a folder containing articles to read, information about additional resources, handouts on military culture and language, and useful infographics on military culture versus civilian culture for different conditions such as moral injury to PTSD, challenges faced during deployment, military grief for children.

Insights from the Student Interviews

During the follow-up interviews, students offered recommendations to improve the quality and impact of the course. One suggestion was to add more case studies of veterans facing behavioral health challenges. Case studies are a way to actively engage the students in learning and applying the material they have absorbed in class to realistic situations. Each class session now contains at least one case study.

A second suggestion focused on the discomfort that students felt when starting the course. One interviewee characterized this as feeling “resistant and intimidated” to learn about this particular population. The student suggested starting the first class session with an exercise in which each student partners with another to discuss their fears, biases, and personal issues about participating in this course. Following this brief exercise students are then asked
to share some part of the discussion of what they learned about themselves with the entire class.

Another recommendation centered on the value of exposure in the course to someone who had actively served in the military. In this course over the three years, the participation of someone with an identified military-related background included the co-instructor, who had served as a chaplain in the National Guard for over two decades, and students who had parents, spouses, or siblings who had served. The “lived experiences” that they were able to contribute to the course added a richness to the class discussions.

**Future CFR Plans to Train Professionals**

The positive impact on students and training participants of specialized training in military culture has reinforced the commitment of CFR to continue to provide military/veteran cultural competency training. Every year, a half day or whole day training on specific relevant topics has been provided by CFR to clinicians and other professionals in the region. Presentation topics to date have focused on PTSD, suicide, military sexual trauma, reintegration, and moral injury. In the last three years, 130 individuals, including CFR staff and other professionals from the region have participated in these training sessions.

In addition, OHH personnel have begun training clergy and students in seminaries in the Philadelphia region to understand military culture in the context of pastoral care. These courses are either a 42-hour intensive version of the 15-hour CFR course for seminary students or a shortened three-hour workshop version presented to working clergy. The courses and workshops build from the premise that clergy are “first responders” to the veteran population, administering to their needs because veterans and their families are likely to join and participate in religious institutions following service.

Finally, the authors are committed to developing a bias questionnaire to use before and after each course to uncover stereotypes and misinformation about service members and/or veterans. Wording will be reviewed to remove response bias (acquiescence) from the process. Post-evaluation questions will also be reviewed and modified to avoid response bias.

**Conclusion**

Over the past seven years, CFR has conducted two substantial training programs for clinicians working with the military and veteran populations. Both programs, the four-day clinician training, and the three 15-hour postgraduate course had positive impacts on the participants. A survey of the four-day training and subsequent qualitative interview follow-ups revealed that information about the military and its impact on veterans and families promoted changes in attitudes, knowledge, and clinical practice for both experienced clinicians as well as clinicians just beginning their careers. The therapists expressed the view that the knowledge the training provided informed their attitudes and behavior in their work with military and veteran clients and family members. These findings were replicated in the findings from the three-year evaluation of the postgraduate course.

Students who enrolled in the *Understanding Military Culture* course changed their attitudes and their practices in working with clients who had military experience. One benefit of the course was that students who initially were not interested in serving military clients or who felt insufficiently trained to work with this population gained confidence from the course and became more interested in seeing clients with military experience. Without the course experience—and given the small percentage of people now serving in the military compared to the current US population (Council on Foreign Relations, 2020) and to previous eras prior to the volunteer military and the diminishing number of veterans still living (Schaeffer, 2021)—it is unlikely that these therapists would have changed their attitudes on their own.

Furthermore, changes in practice resulted from participating in the course. Students realized the value of asking about military experience with all their clients as well as the impacts of serving in the military on the individual and on the family. Moreover, the knowledge about the military, about its impact on the family, and on a range of behavioral health issues gave them insights into better ways of addressing their clients’ problems.

Drawing conclusions from the evaluation of CFR’s training efforts regarding military culture competency has limitations, including: the small numbers of students participating in the study through the different parts of the evaluation process; the issues noted with the limitations of the CDP bias assessment checklist; and focus group and the follow-up interviews with a limited number of respondents. In addition, most of the participants were enrolled in an agency with
a particular framework of practice (i.e., the systemic model), which focuses on the important relationships in clients’ lives. All the students in the course base their practices around the belief that relationships are at the core and provide the basis of mental health. The four-day training, however, reached a wider group of clinicians, of which some had more experienced, and others were not involved with CFR and the systemic model.

It is clear from both the four-day training and the postgraduate course that these are effective means of providing clinicians with training in working with military and veteran populations. While the 2014 RAND study pointed to inadequacies in the knowledge and practices of community health practitioners nationwide; this small evaluation study points to possible remedies.

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Abstract

This study is the first to examine the relationship between moral foundations preferences and the severity of moral injury symptoms reported by U.S. veterans. A total of 85 participants were recruited through social media pages for veterans, and participants completed an online survey assessing their severity and type of moral injury and their preferences for each of the five core moral foundations. Viewing moral injury through the lens of the moral foundations theory allows for an in-depth understanding of the cause and nature of moral injury. Overall, veterans’ preferences for different groups of moral foundations had a significant relationship with the severity of the subtypes of moral injury they experienced. Veterans who have experienced a potentially morally injurious event (pMIE) and are suffering from moral injury as a result are likely not receiving adequate treatment, as moral injury is often masked and presents as alternative diagnoses (PTSD, depression, etc.). Assessing veterans’ moral foundations preferences in addition to determining the severity of their self- and other-directed moral injury will allow for more effective treatments to be developed and implemented.

Moral injury is a fairly new concept that has arisen in recent years from research into post-traumatic stress disorder (PTSD) and trauma among U.S. veterans. The particular manner in which moral injury affects individuals differentiates it from previous understandings of trauma and symptomatology associated with traumatic experiences. Distinguishing indicators of moral injury from symptoms of PTSD in veterans is a difficult task, but it may ultimately determine the effectiveness and outcome of therapeutic interventions. There are currently two “gold standard” evidence-based practices (EBPs) implemented at the U.S. Department of Veterans Affairs (VA) to treat PTSD in veterans: cognitive processing therapy (CPT) and prolonged exposure (PE) therapy (Foa et al., 2013; Resick et al., 2012). While both treatments have been proven to significantly reduce PTSD symptoms in veterans who complete either program, both also have high dropout rates (Hoge et al., 2014). Research also indicated that veterans do not perceive these EBPs as sufficient to address moral injury (Borges et al., 2019).

In order to develop more effective interventions that focus on treating moral injury specifically, it is important to first gain an understanding of how individuals’ moral foundation may dictate how they interpret a pMIE. Morality is a concept that is often thought of in dichotomous terms (right vs. wrong or good vs. evil), and it often takes on a spiritual or religious quality (Haidt, 2012). Conceptualizing individuals through this rudimentary lens of morality not only hinders a clinician’s ability to fully comprehend the subjective nature of moral injury symptoms but also negates the aspects of foundational moral systems that are crucial in understanding morality as a whole. (Graham et al., 2013). Viewing morality as an adaptable, pluralistic framework rather than as a rigid binary allows for a more comprehensive and holistic understanding of adverse symptoms of moral injury and creates space for the development of treatment interventions for these complex issues.

Moral Injury

Developing an understanding of moral injury can be challenging, as many of its features are abstract which makes it difficult for many individuals to describe. The primary cause of moral injury is believed to be exposure to a transgressive act or acts or to pMIEs. Moral injury is not the event itself, nor is it the negative emotions that occur immediately after experiencing a pMIE. Moral injury is better explained as the result of ineffective attempts to manage adverse emotions, or moral pain, that have developed over time as a direct result of one’s experience of a pMIE. Moral pain refers to the natural emotions that an individual commonly experience after their values have been transgressed, and these emotions...
alone are nonpathological. It is the intense, often untreated, moral pain that continuously disrupts an individual’s life that ultimately creates moral injury. There is currently no universal consensus or explicit definition that captures moral injury, but two main definitions are used in outlining what constitutes an event that leads to moral injury.

The first definition by Litz et al. (2009) outlines a morally injurious event as one that involves “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (p. 700). This definition serves as a general inclusion condition in that this standard must be met in order for there to be moral injury, much like the Diagnostic and Statistical Manual of Mental Disorders (DSM) Criterion A for the diagnosis of PTSD. There is currently no DSM diagnosis for moral injury. Therefore, language such as Litz et al.’s definition can be extremely helpful to clinicians as they clarify and rule out diagnoses for veteran patients by differentiating nonoverlapping moral injury symptoms from PTSD symptoms.

The second definition takes a more dynamic approach to understanding pMIEs and asserts that the transgressive act or acts must involve “(a) a betrayal of what’s right; (b) by someone who holds legitimate authority; (c) in a high stakes situation” (Shay, 2014, p. 183). This description differs from the definition proposed by Litz and colleagues as it requires a violation of one’s moral beliefs by an individual who holds a position of authority and hinges on a determination of “what’s right.” It is important to understand that the term “right” is inherently subjective, as what is right for one person may be wrong for another. The differences in these two definitions are subtle but will help to explain differences in subtypes of moral injury and how moral injury can develop in some individuals but not others.

Building on these two core definitions of moral injury, Jinkerson (2016) offered a more encompassing, conceptual definition of moral injury from a syndrome perspective. His work built upon previous research into moral injury by establishing more concrete criteria and symptoms caused by moral injury and listed both “core” and “secondary symptomatic features” (p. 126). Work of this nature will ultimately advance the understanding of moral injury and provide empirical evidence should moral injury become an official diagnosis in the future. In addition to defining moral injury in a broad sense, recent research has found evidence of moral injury subtypes, differentiating symptoms that are internalized or directed at the self (guilt, shame, and depression) from symptoms that are externalized or directed at others (anger, distrust, and lack of connection with others; Currier et al., 2018).

Acts that constitute a violation of one’s deeply held moral beliefs, regardless of which definition is used, will undoubtedly have a profound impact on an individual’s moral foundation. These violations often cause intense feelings of shame and guilt in those who have been affected (Nash & Litz, 2013; Shay, 1991). The damage caused by pMIEs has been shown to contribute not only to the development of PTSD symptoms in veterans but also to long-term emotional, spiritual, psychological, behavioral, and social difficulties (Yan, 2016). According to Jinkerson and Battles (2019), exposure to pMIEs “statistically predicted guilt (five of six measures), meaning in life (negative relationship), depressive symptoms, anxiety symptoms, reexperiencing, and avoidance” (p. 37).

In addition to these symptoms, other symptoms have been associated with moral injury, including a loss of trust in oneself, others, or one’s chosen deity; feelings of betrayal; and self-deprecation (Bryan et al., 2014; Bryan et al., 2016; Currier, McCormick, et al., 2015; Jinkerson, 2016; Shay, 1994, 2014). The extent and complexity of the symptoms that may result from experiencing a pMIE demonstrate that a complex understanding of morality is needed to comprehend the nature and dynamics of moral injury.

Moral Foundations Theory

The moral foundations theory was initially developed to define differences in moral values systems across cultures and was later used to assess such differences among U.S. individuals with disparate political preferences (Graham et al., 2009). One of the theory’s major premises proposes that people make moral judgments using a continuum of moral intuitions rather than one or two foundational values. The authors of the moral foundations theory proposed a nonexhaustive list of five core moral foundations: Care/Harm, Fairness/Cheating, Loyalty/Betrayal, Authority/Subversion, and Sanctity/Degradation (Haidt, 2012, 2013; Haidt & Graham, 2007).

Researchers discovered a divergence within the core foundations while measuring the moral domain in terms of self-reported political ideology, which they termed the individualizing–binding distinction. Researchers hypothesized that the “individualizing” foundations (Care and Fairness)
place the individual as the locus of morality, whereas the “binding foundations” (Loyalty, Authority, and Sanctity) place society, family, and one’s relationship with God as the locus of morality.

The Care foundation emphasizes protection of vulnerable individuals, particularly children, and underlies the virtues of gentleness and nurturance. The Fairness foundation stresses the importance of equality, rights, and justice, and it also underlies the value of proportionality (Graham et al., 2011; Graham et al., 2009).

The binding foundations place more importance on duty, sacrifice for the good of the community, and purity. The Loyalty foundation emphasizes the virtues of patriotism and group responsibility and is related to humans’ historical inclination to form changing coalitions. The Authority foundation underlies ideals of leadership, followership, and respect for legitimate authority figures. The ethics of divinity are a major tenet of the Sanctity foundation, as are principles related to religion, cleanliness, and suppressing humanity’s carnal desires of greed, hunger, and lust (Graham et al., 2013). When making moral judgments, individuals give each of these foundations more or less importance, and their relative weights are influenced by biological processes, childhood experiences, parental and caregiver relationships, and cultural and societal norms (Haidt, 2012).

Examining moral injury through the lens of the moral foundations theory will provide clinicians with a more advanced understanding of the cause and extent of moral injury and will inform the most appropriate avenue of treatment for each affected individual. An individual’s preference for one moral foundation over another may serve as a protective factor in the development of moral injury, while, conversely, holding on too tightly to one’s moral foundation may serve as a risk factor.

**Method**

**Participants and Procedures**

Participants for this study were a sample of veterans who had served in any military branch on active duty at some point during the years 2001–2014. Having never deployed to a combat theater was not an exclusion criterion, as transgressions to one’s moral belief system need not occur solely in combat. Participants were recruited throughout the summer of 2018 using convenience sampling from online groups for veterans, including Facebook and LinkedIn groups and groups organized by Iraq and Afghanistan Veterans of America (IAVA) and Division 19 of the American Psychological Association (APA). Participants each completed an online survey and submitted a total of 116 responses. Of these 116 responses, 31 were discarded due to incompleteness, resulting in a total sample size of 85 participants. For detailed demographic information on the participants, see Table 1.

This study was exploratory in nature and was designed to determine if the severity of moral injury reported by U.S. veterans is correlated with a preference for any of the five core moral foundations. The study procedures and documents were approved by the institutional review board of the Chicago School of Professional Psychology and complied with APA’s ethical standards for the treatment of human subjects. Informed consent was obtained from each of the participants prior to initiation of the online survey.

**Measures**

**Moral Foundations Questionnaire (MFQ)**

The MFQ was designed to quantify the degree to which respondents prefer each of the five core moral foundations. It was initially used to measure differences in moral foundations preferences along lines of self-reported political ideology. Results indicated that political liberals significantly preferred the two individualizing foundations (Care and Fairness) over the three binding foundations (Loyalty, Authority, and Sanctity). Political conservatives, on the other hand, generally preferred each of the five foundations proportionately (Graham et al., 2009; Graham et al., 2012). The survey has since become a universally reliable measure of moral foundations preferences across a wide variety of variables beyond political ideology.

The MFQ is a 32-question self-report measure designed to determine respondents’ levels of preference for each of the five core moral foundations (Graham et al., 2011). The first 16 responses measure moral relevance by presenting participants with scenarios and asking them to rate how relevant each scenario is to them when deciding right from wrong on a 0–5 Likert scale, where 0 = Not At All Relevant and 5 = Extremely Relevant. The second part of the survey consists of 16 statements that measure moral judgments and asks participants to rate their level of agreement with each statement on a 0–5 Likert scale, with 0 = Strongly Disagree and 5 = Strongly Agree. Each of the five core moral foundations is measured by
six associated questions. To determine how closely related these five moral foundations are as a group, Cronbach’s alpha was used as a measure of internal consistency. Cronbach’s alphas for the six-item measures of each foundation are .68 (Care), .60 (Fairness), .75 (Loyalty), .66 (Authority), and .76 (Sanctity).

Expressions of Moral Injury
Scale–Military Version (EMIS-M)

The EMIS-M is a 17-statement self-report instrument that is designed to measure the overall and subtype levels of moral injury symptoms endorsed by participants (Currier et al., 2018). For each of the 17 statements, respondents are asked to rate their level of agreement on a 1–5 Likert scale, with 1 = Strongly Disagree and 5 = Strongly Agree. The sum of the measure produces an overall score ranging from 17–85. In addition to producing this score, the instrument further examines two subtypes of moral injury: self-directed moral injury (SDMI) and other-directed moral injury (ODMI). Nine of the 17 statements inquire about SDMI and eight statements address ODMI, and when totaled, they produce scores ranging from 9–45 and 8–40, respectively. For the purpose of this study, only the scores of the subset moral injury scales were calculated, and the overall score was not used. Cronbach’s alphas for the items that measure SDMI and ODMI are .94 and .91, respectively.

Data Analysis

From the MFQ results, sums of the sets of questions pertaining to each of the moral foundations were calculated to produce scores between 0–30, with 0 signifying no preference for the foundation and 30 indicating extreme preference for the foundation. These scores were rank ordered to display preference, with the highest number being the most salient foundation. The sums for each foundation were then categorized into one of three distinct groups illustrating the participant’s level of preference, as follows: 0–10 = Low, 11–20 = Moderate, and 21–30 = High.

The sums of the SDMI and ODMI scores obtained from the EMIS-M were calculated for each of the three groups, producing scores ranging from 9–45 (SDMI) and 8–40 (ODMI). These scores were then placed into groups based on the participants’ level of preference for each foundation. From each group, means were obtained and analyzed using Pearson’s correlation coefficient. This process was completed five times for each participant, once for each of the five foundations. See Table 2 for detailed results.

<table>
<thead>
<tr>
<th>Table 1. Participant Demographic Characteristics</th>
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<tr>
<td><strong>Variable</strong></td>
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<tr>
<td>Total number of participants</td>
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<td>Age</td>
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<td>40+</td>
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<td>35–39</td>
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<tr>
<td>African American</td>
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<tr>
<td>Hispanic/Latinx</td>
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<tr>
<td>Prefer not to answer</td>
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<tr>
<td>Other</td>
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<tr>
<td>Political ideology</td>
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<td>Liberal</td>
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<tr>
<td>Moderate</td>
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<tr>
<td>Conservative</td>
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<tr>
<td>Prefer not to answer</td>
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<td>Other</td>
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<td>Branch of service</td>
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<td>Marines</td>
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<td>Navy</td>
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<td>Air Force</td>
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<td>Coast Guard</td>
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<td>Campaign deployed</td>
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<td>OEF</td>
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<td>Both</td>
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Note. OIF = Operation Iraqi Freedom; OEF = Operation Enduring Freedom
Results

Table 2 illustrates the means, standard deviations, Pearson correlation matrix, and Cronbach's alphas for each of the variables used in this study. The results indicate a strong positive relationship between the outcome variables measuring SDMI and ODMI, $r = .65$, $p < .001$. There is also evidence of strong positive correlations within predictor variables measuring individualizing foundations (Care and Fairness, $r = .66$, $p < .001$) and variables measuring binding foundations (Loyalty and Authority, $r = .66$, $p < .001$; Loyalty and Sanctity, $r = .61$, $p < .001$; and Authority and Sanctity, $r = .58$, $p < .001$). Only one foundation was significantly correlated with a outcome variable in the preliminary examination (Loyalty and SDMI, $r = .22$, $p = .04$ .05), while the relationship between Care and SDMI was marginally significant ($r = .21$, $p = .06$).

Given the strength of correlations within the individualizing foundations and binding foundations, new variables were produced in order to minimize the potential of error due to multicollinearity. Rather than examining each moral foundation individually, a multiple regression analysis was used to evaluate variance in both SDMI and ODMI in terms of individualizing and binding foundation preferences. The results indicate that individualizing and binding foundations explain a marginally significant amount of the variance in the reported severity of SDMI ($F(2, 82) = 2.71$, $p = .07$, $R^2 = .06$, $R^2_{adj} = .04$). The results also indicate that individualizing and binding foundations preferences were not statistically significant predictors of variance in the reported severity of ODMI ($F(2, 82) = .86$, $p = .43$).

Figure 1 is a visual representation of how respondents reported severity of SDMI in terms of preference given to both the individualizing and binding moral foundations. This chart shows that individuals who endorsed moderate to high preference for the individualizing foundations reported higher amounts of SDMI than those who reported less preference for the individualizing foundations. There is also evidence that as individuals report higher preferences for binding foundations, they will also report more severe SDMI. Figure 2 shows that individuals who endorsed moderate to high preferences for both the individualizing and binding foundations will report more severe ODMI than individuals who reported low preferences for both groups of foundations.

Discussion

The results of this study yielded several notable findings. First, these findings show that there is a meaningful relationship between the amount of preference an individual gives to specific

<table>
<thead>
<tr>
<th></th>
<th>SDMI</th>
<th>ODMI</th>
<th>Care</th>
<th>Fairness</th>
<th>Loyalty</th>
<th>Authority</th>
<th>Sanctity</th>
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<tr>
<td>SDMI</td>
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<td></td>
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<tr>
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<td>.12</td>
<td>.66**</td>
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<td>Loyalty</td>
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<td>.02</td>
<td>.14</td>
<td>.03</td>
<td>.66**</td>
<td>(.66)</td>
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<tr>
<td>Authority</td>
<td>.15</td>
<td>.10</td>
<td>-.08</td>
<td>-.03</td>
<td>.61**</td>
<td>.58**</td>
<td>(.74)</td>
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<tr>
<td>Sanctity</td>
<td>.12</td>
<td>-.02</td>
<td>.03</td>
<td>.01</td>
<td>.61**</td>
<td>.58**</td>
<td>(.74)</td>
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<tr>
<td>Mean</td>
<td>19.48</td>
<td>22.39</td>
<td>19.85</td>
<td>20.66</td>
<td>18.47</td>
<td>18.84</td>
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Note. SDMI = self-directed moral injury; ODMI = other-directed moral injury.
**Correlation is significant at the .001 level (2-tailed)
*Correlation is significant at the .05 level (2-tailed).
Cronbach's alphas are shown in the diagonal.
moral foundations and the severity of moral injury symptoms that they endorse. Specifically, distinguishing whether a veteran identifies more closely with either binding or individualizing moral foundations can explain how they interpret a pMIE. Veterans who demonstrate a high preference for either individualizing or binding foundations would likely benefit from treatment that differs from treatment given to individuals who endorse low preferences in either group of moral foundations. Examining preference given to each moral foundation and comparing those results with a veteran’s moral injury symptoms can provide insight into the nature of the perceived transgression and can ultimately help to indicate the best course of treatment for the specific individual.

Although examining each individual’s moral foundation preferences is a crucial step in the treatment of moral injury, this study also illustrates the importance of evaluating patients’ symptoms in terms of moral injury subtypes. Veterans who identify with individualizing foundations over binding foundations may be prone to endorse higher SDMI than ODMI, while those who prefer binding foundations to individualizing foundations may endorse higher ODMI than SDMI. From a practical perspective, it makes sense that an individual who is more concerned with aspects of equality, nurturance, and caring for those unable to care for themselves would interpret a pMIE much differently than would an individual who differentiates right from wrong based on respect for authority, a sense of group responsibility, and purity.

Internalized moral injury is likely to arise after an individual has witnessed, failed to prevent, or even perpetrated acts that violate their moral foundation, and it is often manifested in symptoms such as shame, guilt, remorse, and depression. These symptoms are closely associated with individualizing foundations, as they place more emphasis on the individual as the locus of morality. When someone else (whether it be peers, superiors, society, or deity) violates an individual’s binding foundations the transgression is externalized, which often results in anger. This violation can be perpetrated by peers, superiors, society, or even one’s deity. When an individual’s moral foundations are violated, understanding which foundations were violated, how they were violated, and how the patient has manifested symptoms will allow clinicians to develop and implement more effective treatments.

**Clinical Implications**

Recent studies have illustrated the need for new treatment interventions to specifically address moral injury. They have also illuminated the ways in which current EBPs used to treat trauma-related symptoms in veterans are ineffective in treating moral injury: Clinicians do not discuss moral injury during treatment, often have poor rapport with the veterans they serve, and implement therapeutic interventions too rigidly (Hoge et al., 2014). Additional studies highlight the need to treat moral injury using a more functional, adaptable approach that allows for changes in agenda. Farnsworth et al. (2017) demonstrated the positive aspects of treating moral injury with acceptance
and commitment therapy (ACT) as an alternative to the “gold standard” EBPs for treating PTSD. Farnsworth et al. stated that while traditional EBPs designed to treat PTSD focus on trauma symptom reduction, ACT invites the experiencing of guilt, shame, disgust, and so on, “allowing their presence to inform those suffering from moral injury, evaluating themselves as inhuman, that they are human and the pain of their experience is a reminder of their intact, but unlived, values” (p. 396). Treating moral injury with more holistic and encompassing approaches, such as ACT, will most likely decrease dropout rates and increase veterans’ quality of life.

In addition to creating more functional and adaptive therapeutic interventions for the treatment of moral injury, understanding how patients’ moral foundations can influence the type and extent of their moral injury will help dictate appropriate courses of treatment. As stated earlier, religion and spirituality are often heavily emphasized in common conceptions of morality and moral injury; thus, some current treatment interventions stress spiritual- and faith-based aspects of forgiveness, repentance, and atonement. One such intervention, spiritually-integrated cognitive processing therapy, was created by adapting the current CPT protocol to emphasize religious/spiritual aspects of the patient (Pearce et al., 2018). While this approach may benefit a small sample of veterans, this form of therapy is likely to be counterproductive in the treatment of moral injury not only because CPT has been shown to insufficiently address moral injury but also because veterans do not place as high of a preference on religion/spirituality as was previously hypothesized.

In this sample, veterans overwhelmingly exhibited the least preference for the Sanctity scale, which is highly influenced by religion. Furthermore, Question 16 on the MFQ asked participants to what extent they believe “whether or not someone acted in a way that God would approve of” is relevant when determining right from wrong. In this study’s sample of veterans, the mean was 1.95 on a 1–5 Likert scale, indicating Not Very Relevant–Slight Relevance, and was the least preferred statement overall when deciding moral relevance. These findings suggest that emphasizing religion and spirituality may not be as important as was previously believed, particularly among younger veterans, and that addressing the other four core foundations will likely produce more active engagement in therapy.

Limitations

There were several limitations in the present study. First, the study’s sample size (N = 85) may not allow for the results to be generalized to the entire veteran population and may not fully encompass the experiences and attitudes of all veterans. Future studies would be wise to investigate the changes that occur to veterans’ moral foundations after exposure to pMIEs, provided a larger sample size is obtained. The use of additional measures, including those that assess for moral injury exposure, would provide detail that cannot be obtained using only

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**Figure 2.** Other-Directed Moral Injury Severity as a Function of Preference Given to Individualizing and Binding Moral Foundations
the EMIS-M. Measures such as the Moral Injury Questionnaire–Military Version (MIQ-M) and the Moral Injury Events Scale (MIES) are examples of reliable and valid measures that may be used to evaluate moral injury in veterans and should be incorporated into future studies (Bryan et al., 2016; Currier, Holland, et al., 2015).

While examining the data for additional results, another limitation was discovered. Question 28 on the MFQ, which asks respondents to evaluate the statement “It can never be right to kill a human being,” is one of the most essential items in determining moral judgment preference for the Care foundation. The original MFQ study found the mean score for this item among the general population to be 2.50, midway between Slightly Disagree and Slightly Agree. The mean for Question 28 in this sample of veterans was significantly lower ($M = 1.27$), indicating that participants universally disagreed with this statement. Given the nature and purpose of the military, this is to be expected; however, it indicates that the MFQ may not be an entirely valid instrument for determining moral foundations preferences among this population. The development of a military version of the assessment may be necessary.

**Directions for Future Research**

Current research into moral injury has allowed for the development of several measures and treatment interventions that specifically address symptoms of moral injury. This study is the first to incorporate the concept of moral injury with the moral foundations theory in an attempt to discover previously unknown or misunderstood implications of how moral foundations preferences can influence one’s development of moral injury. Future research should utilize these findings alongside other measures of moral injury and moral foundations to more specifically address concerns specific to the veteran population. The development of a military version of the MFQ to measure moral foundations preferences in active-duty servicemen and women and veterans may allow for a more specific understanding of the effects one’s moral foundation development may have on the development of moral injury.

**Conclusions**

The findings of this study are meant to elicit discussion of new, alternative interventions for the treatment of moral injury in U.S. veterans. The study was also designed to provide insight to clinicians who work with veterans suffering from moral injury. It provides empirical support for a better understanding of why the current emphases on EBPs and religious aspects of treatment are often ineffectual, and it suggests that a more holistic, functional view of morality may be needed in order to fully encompass the complexity of moral injury. The study also offers insights into the use of conceptual models informed by moral foundations theory; these models may be helpful in creating treatment modalities for moral injury that address each of the five core moral foundations. These treatments can be adapted to meet the needs of individual patients based on their endorsements of particular moral foundations and the severity of their individual experiences of SDMI and/or ODMI.

**References**


### About the Authors

Daniel Perez, Psy.D., obtained a doctorate in clinical psychology from the Chicago School of Professional Psychology and is currently a clinical psychologist at the Loma Linda VA Medical Center in Loma Linda, CA. He is also a veteran of the U.S. Army who served from 2001–2005 as an enlisted airborne infantryman. Dr. Perez is the recipient of the Combat Infantryman Badge, Army Commendation Medal, Parachutist Badge, Afghanistan Campaign Medal, Global War On Terrorism Expeditionary Medal, and National...
Defense Service Ribbon. Paul Larson, Ph.D., J.D. obtained a Ph.D. in 1977 from the University of Utah and a J.D. from DePaul University in 1993. He served as a full professor in the clinical psychology program at the Chicago School of Professional Psychology from 2004-2019 and currently holds professor emeritus status. John Bair, Ph.D., obtained a Ph.D. from Northwestern University in 1990 and is currently a staff psychologist at the Lovell Federal Health Care Center in North Chicago. He instructs courses in group and social systems for psychiatry residents and psychology students. Bair also serves as a clinical associate professor at Rosalind Franklin University.
Structural Examination of Moral Injury and PTSD and Their Associations With Suicidal Behavior Among Combat Veterans

Allison R. Battles, Jeremy Jinkerson, Michelle L. Kelley, and Richard A. Mason

Abstract
Moral injury and post-traumatic stress disorder are argued to be distinct yet related constructs. However, few studies have evaluated the factors distinguishing moral injury from PTSD. The present study sought to extend the work of Bryan et al. (2018) by differentiating the symptomology of moral injury and PTSD and their associations with suicidal behaviors among combat veterans. The study evaluated data from 129 combat veterans exposed to potentially morally injurious events. Exploratory structural equation modeling evaluated a measurement and structural model. Results revealed a four-factor solution, with the relevant factors being PTSD symptoms, guilt/shame, psychiatric comorbidities, and meaning in life. Guilt/shame and psychiatric comorbidities had significant positive effects on suicidal behaviors. The present findings suggest that combat veterans have a complex, dimensional response to combat trauma and pMIE exposure. These results diverged from previous research to suggest that moral injury symptoms may not constitute a single factor but rather a multifaceted constellation of symptoms. The present study also provided evidence that moral injury symptoms are both unique and overlapping with PTSD symptoms. Suicidal behaviors are a major area of concern among veterans, and the findings here implicate guilt/shame and psychiatric comorbidities as related to these suicidal behaviors.

Over the past decade, greater attention has been given to the psychological consequences of wartime transgressions that may violate servicemembers’ moral beliefs and result in moral injury. Moral injury is believed to be the result of potentially morally injurious events (pMIEs), such as excessive violence, leadership failure, failure to save a life or prevent injury, or the act of injuring or killing a noncombatant (Frankfurt & Frazier, 2016). Although some combat veterans are able to resolve the dissonance or internal conflict of perpetrating or witnessing an act that transgresses one’s moral code, for others, these actions result in strong emotional reactions, such as guilt, shame, loss of meaning, difficulties with forgiveness, and spiritual/existential crisis. Collectively, these reactions and emotions have been termed moral injury (Jinkerson, 2016; Litz et al., 2009; Shay, 2002, 2014). Core symptoms of moral injury (e.g., guilt, shame) are believed to drive secondary outcomes (Jinkerson, 2016; Litz et al., 2009), such as depression, anxiety, suicidal thoughts and behavior, and hazardous substance use (Battles et al., 2018; Battles et al., 2019; Bryan et al., 2014; Bryan et al., 2018; Jinkerson, 2016; Jinkerson & Battles, 2019; Kelley et al., 2019).

Although moral injury has received considerable attention, a theoretically fundamental issue is how moral injury differs from post-traumatic stress disorder (PTSD). In a pioneering study, Bryan et al. (2018) examined the similarities and differences between the symptoms of PTSD and those of moral injury and explored how PTSD and moral injury were associated with suicidal thoughts and behaviors. They found that among Army National Guard members, moral injury was uniquely characterized by anhedonia, anger, shame, guilt, and hostility toward oneself, whereas PTSD was uniquely characterized by flashbacks, memory loss, nightmares, insomnia, and startle reflex. Although the Bryan et al. (2018) study was groundbreaking, only 58.2% of the study’s sample had ever deployed. Combat veterans are arguably more likely than other military members to have been exposed to pMIEs due to the increased opportunities they have had for high-stakes moral decision-making (Shay, 2014). Subsequently, they may be more likely to develop PTSD (Xue et al., 2015) or moral injury (Shay, 1991, 2002). Moreover, combat is associated with PTSD (Maguen & Litz, 2012; Stein et al., 2012) and moral injury symptoms (Drescher et
al., 2011; Nash & Litz, 2013). For this reason, we examined moral injury and PTSD symptoms in a sample consisting solely of combat veterans.

In general, investigators have found that both moral injury and PTSD are associated with suicidal behaviors. For instance, Bryan et al. (2018) found that the interaction of moral injury and PTSD predicted both suicidal ideation and attempts. Combat veterans, in particular, have been found to be at a higher risk for suicidality compared to noncombat veterans (Fanning & Pietrzak, 2013). This appears to be statistically explained, in part, by combat experiences, as those exposed to killing and atrocities of war have a 43% greater risk of suicide-related outcomes than deployed servicemembers without combat experiences (Bryan et al., 2015). Additionally, combat experiences, particularly killing and exposure to disproportionate violence (e.g., pMIEs), tend to have a stronger association with suicide than does deployment in and of itself (Bryan et al., 2014).

**Purpose of the Present Study**

Similar to Bryan et al. (2018), in the present study we conducted factor analyses of moral injury and PTSD symptoms. We extended the work of Bryan et al. (2018), however, by examining additional factors that have previously been construed as moral injury symptoms, such as impaired trust and loss of meaning in life (Currier, Holland, & Malott, 2015; Harris et al., 2015; Jinkerson, 2016). It was hypothesized that a measurement model of these constructs would provide additional support for as well as extend the model delineating the unique and shared symptoms of moral injury and PTSD as proposed by Bryan et al. (2018; see Figure 1). We anticipated that a PTSD factor would emerge separately from a moral injury factor but did not hold other specific hypotheses. Next, we examined whether moral injury symptoms and PTSD symptoms were associated with suicidal behaviors in combat veterans. Similar to the findings by Bryan et al. (2018), we hypothesized an interaction effect between moral injury symptoms and PTSD symptoms on suicidal behaviors.

**Method**

**Participants**

The final sample consisted of data collected from 129 combat veterans (99 men). Criteria for participation were (a) a history of at least one deployment lasting for 90 days or more and (b) being a “combat veteran,” defined as anyone who “attacked enemy combatants, was attacked, or who served in a military-designated dangerous region during wartime.” Most participants were male (77.3%), White (70.5%), and/or married (50.8%), with an average age of 36.72 years ($SD = 10.52$ years). Of the participants, 95 (73.6%) were former military members, 17 (13.2%) were presently serving on active duty, and 17 (13.2%) were currently National Guard/reserves members.

![Figure 1. Expanded Model of the Theorized Overlap of PTSD and Moral Injury Components](image-url)

**Note.** Constructs in bold were measured in the present study. Original model created by Bryan et al. (2018).

*New proposed symptom evaluated in current study.*
Branches of service (which were not mutually exclusive) represented in the current study included the U.S. Army \( (n = 77, 59.6\%) \), U.S. Marine Corps \( (n = 20, 15.5\%) \), U.S. Navy \( (n = 16, 12.4\%) \), and U.S. Air Force \( (n = 16, 2.4\%) \). Participants were involved in the following conflicts: Operation Enduring Freedom \( (n = 54, 41.9\%) \), Operation Iraqi Freedom \( (n = 81, 62.8\%) \), Persian Gulf War \( (n = 14, 10.9\%) \), and Vietnam War \( (n = 10, 7.8\%) \). Most participants were enlisted \( (110, 85.3\%) \). On average, they had deployed 2.92 times \( (SD = 0.83) \) and had served in the military for 9.14 years \( (SD = 6.58) \). All participants reported exposure to at least one pMIE during deployment, per the Moral Injury Questionnaire–Military Version (MIQ-M).

**Procedure**

Participants were recruited through Amazon’s Mechanical Turk (MTurk) service. Those who provided informed consent were presented with demographic questions followed by survey questionnaires, which were administered in a counterbalanced format. Two validity check items were administered: “What is the acronym for the location where physicals are taken prior to shipping off for basic training?” and “What is the acronym for the generic term the military uses for various job fields?” (Lynn & Morgan, 2016). Of the 496 individuals who responded affirmatively to having served in the U.S. military, only 132 answered the two validity checks accurately; of those 132 individuals, only 129 endorsed exposure to at least one pMIE. Data from these 129 participants was used in all analyses. Participants were compensated $2 through MTurk. Following survey completion, participants were provided with service branch–specific and veteran-specific national mental health resources. The study received institutional review board approval.

**Measures**

Mirroring the approach of Bryan et al. (2018) and to reduce the burden on respondents, select items were used to represent corresponding constructs. For example, the PTSD symptom flashbacks was represented with the PTSD Checklist–5 item “Suddenly feeling or acting as if the stressful experience were actually happening again.” Items or sample items for each construct are shown in Table 1. See Table 2 for descriptive statistics and reliability indices for all measures. For all constructs, item scores were summed to create a total score; higher scores reflected higher levels of a construct.

**Exposure to pMIES**

The Moral Injury Questionnaire–Military Version (MIQ-M; Currier, Holland, Drescher, et al., 2015) is a 20-item self-report measure that assesses the degree of exposure to pMIES (e.g., “I did things in the war that betrayed my personal values.”). Participants rated each item on a 4-point Likert scale ranging from 1 (never) to 4 (often). Item scores were summed, with higher scores reflecting higher levels of pMIE exposure.

**PTSD Symptoms**

The PTSD Checklist for DSM-5 (PCL-5; Blevins et al., 2015) is a 20-item self-report measure that evaluates PTSD symptoms per DSM-5 criteria (American Psychiatric Association [APA], 2013). In the present study, two items were used to measure hypervigilance, one item was used to measure memory loss, two items were used to measure intrusive memories, and one item was used to measure nightmares. Items were rated on a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely). Item scores were summed; higher scores reflected higher levels of PTSD symptoms.

**Trauma-Related Guilt**

The Trauma-Related Guilt Inventory (TRGI; Kubany et al., 1996) is a 32-item self-report measure that assesses guilt after a traumatic event. Items were rated on a 5-point Likert scale ranging from 0 (not at all true) to 5 (extremely true). Two items were analyzed as representative of trauma-related guilt. Item scores were summed; higher scores reflected higher levels of trauma-related guilt.

**Trauma-Related Shame**

The Trauma-Related Shame Inventory (TRSI; Øktedalen et al., 2014) is a 24-item self-report measure of feelings of shame following a traumatic event. Participants rated their responses on a 4-point Likert scale ranging from 1 (not true of me) to 4 (completely true of me). Two items were used to represent trauma-related shame. Summed responses yielded continuous scores, with higher scores reflecting higher levels of trauma-related shame.

**Trust**

The World Assessment Questionnaire (WAQ; Kaler, 2009) is a 25-item self-report inventory that assesses an individual’s fundamental assumptions about the world. Given the study’s focus on trust in others, only the Trustworthiness and Goodness of People subscale was administered. Items were rated on a 6-point Likert scale ranging from 1 (strongly
agree) to 6 (strongly disagree). Two items were used to represent levels of trust in others. Responses were summed to yield continuous scores, with higher scores reflecting greater levels of trust.

**Meaning in Life**

The Meaning in Life Questionnaire (MLQ; Steger et al., 2006) is a 10-item self-report instrument with subscales measuring the presence of and search for meaning in life. Given our focus on subjective meaning in life, only items from the Presence subscale were administered. Items were rated on a 7-point Likert scale ranging from 1 (absolutely untrue) to 7 (absolutely true). Two items were analyzed as representative of subjective meaning in life. Responses were summed to yield continuous total scores, with higher scores reflecting higher levels of subjective meaning in life.
The Meaning in Life Questionnaire (MLQ; Steger et al., 2006) is a 10-item self-report measure of meaning in life. Given our focus on subjective meaning in life, only items from the Presence subscale were administered. Two items were analyzed as representative of our focus on subjective meaning in life, only items from the Presence subscale were administered. Two items were analyzed as representative of higher scores reflecting greater levels of trust in others. Responses were summed to yield continuous scores, with higher scores reflecting higher levels of trust.

Table 1. Indicator Variables Selected to Measure Each Symptom of PTSD and/or Moral Injury

<table>
<thead>
<tr>
<th>Measure</th>
<th>M (SD)</th>
<th>Range*</th>
<th>Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIQ-M</td>
<td>39.20 (9.74)</td>
<td>41 [21, 62]</td>
<td>.89</td>
</tr>
<tr>
<td>PCL-5</td>
<td>47.52 (18.14)</td>
<td>69 [20, 89]</td>
<td>.96</td>
</tr>
<tr>
<td>TRGI</td>
<td>78.02 (23.21)</td>
<td>98 [38, 136]</td>
<td>.94</td>
</tr>
<tr>
<td>TRSI</td>
<td>42.22 (18.18)</td>
<td>65 [24, 89]</td>
<td>.98</td>
</tr>
<tr>
<td>WAQ-T</td>
<td>15.10 (3.89)</td>
<td>20 [6, 26]</td>
<td>.77</td>
</tr>
<tr>
<td>MLQ-P</td>
<td>23.11 (7.48)</td>
<td>28 [7, 35]</td>
<td>.92</td>
</tr>
<tr>
<td>PHQ-2</td>
<td>5.22 (2.01)</td>
<td>9 [3, 12]</td>
<td>.83</td>
</tr>
<tr>
<td>GAD-2</td>
<td>4.07 (2.1)</td>
<td>6 [2, 8]</td>
<td>.84</td>
</tr>
<tr>
<td>DAR</td>
<td>11.30 (4.31)</td>
<td>17 [5, 22]</td>
<td>.85</td>
</tr>
<tr>
<td>SFQ</td>
<td>13.54 (2.53)</td>
<td>13 [6, 19]</td>
<td>.78</td>
</tr>
<tr>
<td>SBQ-R</td>
<td>5.24 (2.78)</td>
<td>12 [3, 15]</td>
<td>.82</td>
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</table>

Note. N = 129; MIQ-M = Moral Injury Questionnaire–Military version (modified); PCL-5 = PTSD Checklist for DSM-5; TRGI = Trauma-Related Guilt Inventory; TRSI = Trauma-Related Shame Inventory; WAQ-T = World Assumption Questionnaire–Trustworthiness and Goodness of People subscale; MLQ-P = Meaning in Life Questionnaire–Presence subscale; PHQ-2 = Patient Health Questionnaire–2; GAD-2 = Generalized Anxiety Disorder–2; DAR = Dimensions of Anger Reactions; SFQ = Social Functioning Questionnaire; SBQ-R = Suicide Behaviors Questionnaire–Revised.

*Range represents the range of scores for study participants and includes the [Min, Max];

Depression

The Patient Health Questionnaire–2 (PHQ-2; Kroenke et al., 2003) is a two-item screening measure of anhedonia and depressed mood (“Little interest or pleasure in doing things” and “Feeling down, depressed, or hopeless”). Responses were recorded on a 4-point Likert scale ranging from 0 (not at all) to 3 (nearly every day). Responses were summed to yield continuous total scores, with higher scores reflecting higher levels of anhedonia and depressed mood.

Anxiety

The Generalized Anxiety Disorder–2 (GAD-2; Kroenke et al., 2007) is a two-item screener for generalized anxiety symptoms. Items were rated on a 4-point Likert scale ranging from 0 (not at all sure) to 3 (nearly every day). Responses were summed to yield continuous total scores, with higher scores reflecting higher levels of anxiety symptoms.

Anger

The Dimensions of Anger Reactions (DAR; Forbes et al., 2004) is a seven-item self-report measure of anger directed toward others. Participants rated their degree of anger on a 9-point Likert scale ranging from 0 (not at all) to 8 (exactly so). One item was analyzed as representative of anger.

Social Functioning

The Social Functioning Questionnaire (SFQ; Tyrer et al., 2005) is an eight-item self-report measure of perceived social functioning. Items were rated on a 4-point Likert scale ranging from 0 to 3, with response options corresponding to the nature of each question.

Suicidal Behaviors

The Suicidal Behaviors Questionnaire–Revised (SBQ-R; Osman et al., 2001) is a four-item self-report questionnaire that assesses history of suicidal ideation and attempts, frequency of
ideation, suicidal verbal expressions, and likelihood of future suicide. At the request of the institutional review board, the item regarding likelihood of future suicide was excluded. Response options vary by question. Responses were summed to yield continuous total scores, with higher scores reflecting more suicidal behaviors.

Data Analyses

After removing data from participants who did not accurately respond to validity checks, no missing data were found. Analyses were conducted using Mplus 8.3 (Muthén & Muthén, 2017). Prior to testing the proposed hypotheses, common method variance was examined by conducting a factor analyses of all items to determine the presence of a single latent variable (Kline et al., 2000; Lindell & Whitney, 2001). No single latent variable was found, suggesting the presence of multiple variables. Individual items rather than full-scale sum scores were used in identifying latent variables, as is the preferred methodology for assessing latent factors.

To test the hypothesized model of overlapping constructs, a measurement model was examined using exploratory structural equation modeling (ESEM). ESEM allows for less restrictive measurement models by permitting correlated residuals among observed variables and potential cross-loading of observed variables onto multiple variables (Asparouhov & Muthén, 2009; Marsh et al., 2014). Select items were used from each measure as representative of their corresponding construct, mirroring the approach of Bryan et al. (2018), to ensure that each construct had a similar number of items and to reduce subject burden (see Table 2). Model fit criteria suggested by Hu and Bentler’s (1999) recommendations for evaluating overall model fit (i.e., CFI > .95, TLI > .95, RMSEA < .06, and SRMR < .08), the four-factor model was determined to have acceptable fit (Byrne, 2012). When considering only statistically significant factor loadings exceeding a minimum value of .30, the first factor was uniquely characterized by flashbacks, memory loss, startle reflex, and nightmares, which largely correspond with the proposed composition of PTSD (see Table 4). The second factor was composed of guilt/shame, which corresponded with proposed core symptoms of moral injury. The third factor was characterized by anhedonia, depression, anxiety, anger, loss of trust, and social alienation, which appeared to correspond with psychiatric comorbidities often associated with trauma exposure. The fourth factor was solely characterized by loss of meaning in life.

Results of Structural Model

As shown in Figure 2, results of the ESEM structural model demonstrated that the factors guilt/shame (β = 0.34, SE = 0.15, 95% CI [0.02, 0.64]) and psychiatric comorbidities (β = 0.77, SE = 0.17, 95% CI [0.44, 1.07]) had a significant positive effect on suicidal behaviors such that Guilt/Shame and Psychiatric Comorbidities were associated with increased risk of suicidal behaviors (see Figure 2). Neither the PTSD factor nor Meaning in Life were associated with suicidal behaviors. No significant interaction effects were found.
### Table 3. Correlations Between Study-Developed Item Constructs and Covariates

<table>
<thead>
<tr>
<th>Construct</th>
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<th>13</th>
<th>14</th>
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<th>16</th>
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<tr>
<td>1. Guilt</td>
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<tr>
<td>2. Shame</td>
<td>.68**</td>
<td>—</td>
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<td>3. Trust</td>
<td>-.10</td>
<td>-.06</td>
<td>—</td>
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<td>4. MiL</td>
<td>.05</td>
<td>.10</td>
<td>.01</td>
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<tr>
<td>5. Alienation</td>
<td>-.37**</td>
<td>-.36**</td>
<td>.25**</td>
<td>-.11</td>
<td>—</td>
<td></td>
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<tr>
<td>6. Anhedonia</td>
<td>.38**</td>
<td>.39**</td>
<td>-.28**</td>
<td>-.09</td>
<td>-.54**</td>
<td>—</td>
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<td>7. Depression</td>
<td>.44**</td>
<td>.51**</td>
<td>-.22**</td>
<td>.04</td>
<td>-.53**</td>
<td>.71**</td>
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<td>8. Anger</td>
<td>.37**</td>
<td>.33**</td>
<td>-.30**</td>
<td>-.10</td>
<td>-.35**</td>
<td>.53**</td>
<td>.43**</td>
<td>—</td>
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<tr>
<td>9. Anxiety</td>
<td>.50**</td>
<td>.55**</td>
<td>-.22**</td>
<td>.03</td>
<td>-.62**</td>
<td>.74**</td>
<td>.74**</td>
<td>.56**</td>
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**Note.** N = 129; Guilt = Trauma-Related Guilt Inventory items 13 and 25; Shame = Trauma-Related Shame Inventory items 3 and 8; Trust = World Assumption Questionnaire–Trustworthiness and Goodness of People subscale items 2 and 4; MiL = Meaning in Life Questionnaire–Presence subscale items 4 and 5; Alienation = Social Functioning Questionnaire item 7; Anhedonia = Patient Health Questionnaire–2 item 1; Depression = Patient Health Questionnaire–2 item 2; Anger = Dimensions of Anger Reactions item 1; Anxiety = Generalized Anxiety Disorder screener–2; Nightmares = PTSD Checklist for DSM-5 item 2; Hyperarousal = PTSD Checklist for DSM-5 items 17 and 18; Memory loss = PTSD Checklist for DSM-5 item 8; Flashback = PTSD Checklist for DSM-5 items 1 and 3; Suicide = Suicide Behaviors Questionnaire–Revised Gender was dummy coded (men = 1; women = 0); BoS = Branch of Service was dummy coded (Army = 1; Other branches = 0). Pearson product-moment correlations were conducted for associations between two continuous variables and point-biserial correlations were conducted for associations consisting of one continuous variable and one dichotomous variable. *p < .05 **p < .01.
Discussion
To extend the work of Bryan et al. (2018), we examined their model of the similarities and differences between moral injury and PTSD among combat veterans, included additional constructs key to moral injury and PTSD, and conducted factor analyses to test their model (see Figure 1). We then examined how these factors were associated with suicidal behaviors in combat veterans.

Delineation of Expressed Factors
The first factor was uniquely characterized by flashbacks, memory loss, startle reflex, and nightmares and was nearly identical to a factor identified by Bryan et al. (2018). This factor corresponds closely to the PTSD criteria described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (APA, 2000). In the shift from the DSM-IV-TR to the DSM-5 (APA, 2013) diagnostic system, negative changes in mood and thoughts were incorporated into the PTSD framework (p. 271). This alteration in diagnostic criteria from DSM-IV-TR to DSM-5 could be indicative of various PTSD diagnostic subtypes, an issue that Bryan et al. (2018) considered along with Griffin et al. (2019). It may also be viewed as an inclusion of proposed “moral injury” symptoms into the broader PTSD framework.

As to moral injury, our outcomes diverge from Bryan et al. (2018), as their “Moral Injury” factor contained items/symptoms that, for us, were distributed across three factors. Our second factor

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Note. Significant factor loadings are bolded and are based on a minimum eigenvalue of .30; PCL-5 = PTSD Checklist for DSM-5; TRGI = Trauma-Related Guilt Inventory; TRSI = Trauma-Related Shame Inventory; PHQ-2 = Patient Health Questionnaire–2; GAD-2 = Generalized Anxiety Disorder–2; DAR = Dimensions of Anger Reactions; WAQ-T = World Assumption Questionnaire–Trustworthiness and Goodness of People subscale; SFQ = Social Functioning Questionnaire; MLQ-P = Meaning in Life Questionnaire–Presence subscale.
Note. Standardized path coefficients are shown. Significant effects are in bold.
was characterized by guilt and shame symptoms, which have been referred to as the linchpin components of moral injury (Jinkerson, 2016; Litz et al., 2009). Consistent with previous research (Bryan et al., 2013; Currier, Holland, & Malott, 2015; Marx et al., 2010; Stein et al., 2012), our results underscore the primacy of guilt and shame symptoms for moral injury.

The third factor, however, posed greater difficulty with respect to nomenclature, as it included items indicating depression, anhedonia, anxiety, anger, loss of trust, and social alienation. As shown in Bryan's et al's model (2018; see Figure 1), this third factor appears to be best categorized as psychiatric comorbidities involving negative alterations in thought and mood that frequently co-occur with both PTSD and moral injury (Griffin et al., 2019; Jinkerson, 2016; Litz et al., 2009). Thus, the third factor appears consistent with both the symptoms of moral injury (other than guilt and shame) as well as the negative alterations in thought and mood that characterize PTSD.

In accordance with Jinkerson's (2016) formulation, the second factor (Guilt/Shame) could be viewed as encompassing the core moral injury symptoms, whereas the third factor, Psychiatric Comorbidities, might represent secondary, potentially co-occurring, mental health conditions that may be indicative of either PTSD or moral injury. Further, recent research has distinguished between self-directed moral injury and other-directed moral injury (e.g., Bravo et al., 2020). Acts of commission (i.e., perpetrating an action) and acts of omission (i.e., not limiting others' wrongdoing) may be more likely to result in self-directed moral injury. That is, when servicemembers feel personally responsible for perpetrating a transgressive act or not limiting others' wrongdoing, they may be more likely to experience guilt and shame. In contrast, acts of betrayal or leadership failure may result in experiences of other-directed moral injury and may be more likely to result in anger, disgust, and mistrust (Currier et al., 2019). Although our measure of pMIEs and moral injury symptoms does not allow us to test this premise directly, this would be an important direction for future research.

The fourth factor, Meaning in Life, was comprised of items from the Presence subscale of the Meaning in Life Questionnaire, with higher scores denoting greater awareness of meaning in one's life. In the context of moral injury research, we are most concerned with the loss of meaning in life (e.g., Jinkerson, 2016; Litz et al., 2009). The inclusion of meaning in life was distinct to the current study and marks meaning in life as an important outcome variable for consideration in future studies.

Differences between our findings and those of Bryan et al. (2018) may reflect the nature of the two studies' populations. Bryan et al. (2018) examined Army National Guard members, of which 58.2% had deployed. In contrast, participants in the present study all reported combat experience and exposure to at least one pMIE. It is possible that Bryan et al's (2018) findings may be most generalizable to a National Guard sample (and especially one of a western/southwestern demographic), whereas our findings may be more generalizable to a broader sample of pMIE-exposed combat veterans. Additionally, the current study included members of all service branches, which may have partially accounted for the differences. Service branches are known to have cultures specific to themselves in addition to the general military culture and warrior ethos. It is possible that these distinct service-branch cultures and additional subcultures may influence the development and cause of combat-related reactions. Although the current study cannot speak more to the influence of military culture on PTSD and moral injury, it is imperative that future research adopt a multicultural lens to examine the role of military culture in moderating veterans' responses to service-related traumatic events.

Our findings highlight the complexities of combat trauma reactions and emphasize that the moral injury construct may not be as clear cut as previously found. Although there are unique differences between our findings and those of Bryan et al. (2018), both studies suggest clear differences between PTSD and moral injury factors. Both studies also demonstrate, however, that some constructs, such as depression and anhedonia, may overlap between PTSD and moral injury. Overall, our factorial findings paint a cloudier picture of the symptomatology of PTSD and moral injury. The diversity of symptom clusters found here suggests that conceptualizations of moral injury may need revision, possibly to include loss of trust as a comorbidity rather than a core symptom, though that is speculative at this point.

**Structural Model Outcomes**

**Suicide Behaviors**

Our results suggest that Guilt/Shame and Psychiatric Comorbidities may be key to
suicidal behaviors in combat veterans. It was not surprising that the Psychiatric Comorbidities factor was associated with suicidal behaviors, as its components of depression, anhedonia, and social alienation are included in many models of suicide (e.g., Jobes, 2012; Stanley et al., 2010; Van Orden et al., 2010). Surprisingly, the PTSD and Meaning in Life factors were not associated with suicidal behaviors. This finding was unexpected given that previous research has shown that PTSD is robustly associated with suicide attempts and deaths (Hendin & Haas, 1991; Koven, 2016) and that loss of meaning in life tends to be a primary predictor of suicide (Kleiman & Beaver, 2013). Our findings suggest that core symptoms of moral injury (i.e., guilt and shame) and other comorbid mental health concerns (e.g., depression, anhedonia) may have a greater association with suicidal behavior in combat veterans than do symptoms unique to PTSD, such as intrusive memories and hyperarousal. This emphasizes the salience of negative changes in mood and cognition when considering risk for suicidal behaviors among combat veterans.

Limitations
Several limitations of the current study warrant discussion. First, our findings are based on cross-sectional data and therefore limit the current investigation’s ability to determine temporal associations. The current study also utilized retrospective self-report measures subject to response bias. Additionally, akin to Bryan et al. (2018) and to reduce subject burden, in some cases, we analyzed one or two items to measure each construct. Our findings deviated from those found by C. Bryan and colleagues (2018), and sample size may have played a role in the differential outcomes. Alternatively, within-factor shared method variance may provide some explanation for the current findings. As such, future research will benefit from replication of and expansion of the current research, utilizing alternate means of assessing the variables in question.

Future Directions and Conclusion
The present study reevaluated the symptomatic profiles of moral injury and PTSD found in Bryan et al.’s (2018) seminal research among a group of pMIE-exposed combat veterans. Consistent with Bryan et al., a clear PTSD factor was identified; however, our results suggest that moral injury may not represent a single factor but rather a multidimensional constellation of symptoms. This dimensional argument is not intended to defeat existing theories/constructs but rather to spur moral injury research to embrace construct flexibility. The differences found between the current study and Bryan et al. (2018) leave us wanting to understand the divergence in addition to the convergence. One promising area for further exploration may be to consider how military and unit culture affect servicemembers’ moral expressions and responses to their military experiences. Ultimately, a deeper understanding of the symptomology and implications of moral injury and PTSD may help us understand and fight against the persistent rise of suicidal behaviors among combat veterans.

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