Psychological Trauma: Theory, Research, Practice, and Policy

Military Acculturation and Readjustment to the Civilian Context

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Objective: Attitudes and beliefs related to immersion in military culture can affect postseparation transition to the civilian setting. The etiology and complexity of these reactions are often overlooked by mental health providers, which can result in negative consequences for treatment. This qualitative study examined veterans' perceptions of military culture and the impact of military service on veterans' values, beliefs, and behaviors. The goal of this research was to identify aspects of military culture that are important for health care providers to consider as they care for veterans and to inform culturally sensitive mental health care for veterans. *Method:* Fifty-two military veterans completed a self-report survey and participated in semistructured focus groups. *Results:* Participants reported diverse military experiences, and many endorsed a high level of continuing identification with aspects of military culture. Seven broad themes related to military culture emerged from qualitative analyses: (a) military values, beliefs, and behaviors; (b) relationships; (c) occupational habits and practices; (d) acquired skills; (e) communication; (f) affiliation; and (g) psychological health and well-being. *Conclusion:* This thematic analysis elucidated strategies to improve mental health services for veterans, using a nuanced model that encourages providers to better distinguish aspects of cultural transition from psychopathology. Results underscored the importance of training mental health providers to ensure sensitivity to military culture.

Clinical Impact Statement
The present study examined veterans' perspectives of military culture and the role of military culture identification following military service. Despite varied military experiences and levels of exposure to combat, results suggest a number of aspects of military culture that present across veteran groups. Consideration of continued identification with military culture, in addition to assessment of the potential traumatic or stressful events experienced during military service, is critical to ensuring a comprehensive and valid clinical assessment. These findings highlight the importance of training in aspects of military culture for clinicians providing behavioral health care services to veterans.

Acculturation refers to a process by which members of one group culturally and psychologically adopt the beliefs and behaviors of another group (Sam & Berry, 2010). Given the unique set of values, beliefs, and cultural rules associated with the military (Koenig et al., 2014), it can be argued that both military enlistment and discharge require a process of acculturation to the military and readjustment to the civilian context. Military service is not only an occupation, but also a unique and all-encompassing lifestyle to which service members become identified with to varying degrees.

The process of enlistment into the military begins with basic training and includes intensive indoctrination into military culture. This process can lead to changes in the recruits' values, beliefs, behaviors, and orientations to relationships and work (McCormick et al., 2019; Meyer et al., 2016; Reger et al., 2008; Weiss & Coll, 2011). Military culture reflects the collectivist nature of war and military missions and differs from the more individualistic nature of contemporary civilian American society (Lunasco et al., 2010; Rose et al., 2017). The development of camaraderie and group cohesiveness in relation to military service was also observed by Meyer and colleagues (2016). In addition to the specific values of their service branch (i.e., Army—loyalty, duty, respect, selfless service, honor, integrity, and personal courage), recruits are explicitly taught the critical importance of operating within a hierarchy and protecting their fellow service members (Halvorson, 2010). Adherence to service-related values, beliefs, behaviors, and orientations may persist following military service. For example, it has been found that employers may seek veterans for employment due to their perceptions that veterans had obtained relevant experience, expertise, or skills following military service (Harrell & Berglass, 2012).

Identification with service-related values, as well as the military mission and lifestyle, can be adaptive while serving. For example, a strong sense of affiliation can facilitate an important sense of duty and responsibility toward comrades during combat (Weiss & Coll, 2011). However, immersion in the military context can also have a negative impact on those who may have aversive or negative experiences during military service. Women; members of racial and ethnic minority groups; members of the lesbian, gay, bisexual, and transgender (LGBTQ) community; those who experience disillusionment with a military mission; those with medical or mental health conditions; and/or those who experience trauma may experience varying degrees of exclusion and isolation in their military unit, depending on group dynamics, leadership, presence of discrimination and harassment within a unit, and other factors (Alford & Lee, 2016; Dardis et al., 2018; Foynes et al., 2015; Gurung et al., 2018). For these service members, the effects of estrangement, harassment, and/or discrimination can be compounded by the insulated nature of the military community.

The process of indoctrination experienced in the military is not generally mirrored when separating from service and returning to civilian life in the United States (Beder et al., 2011; Koenig et al., 2014). Although difficulties in the transition of combat veterans have been documented, including the impact on mental health (Faulkner & McGaw, 1977; Sayer et al., 2014; Steenkamp et al., 2017), the frequency of experiencing such transitional stress may be underestimated. Returning service members may feel disconnected from the civilian context due to changes in their attitudes and beliefs following immersion in military culture (Koenig et al., 2014; McCormick et al., 2019; Smart, 2016). The sense of nonbelonging may be further compounded by physiological and psychological changes related to intense training and exposure to combat (Koenig et al., 2014). For example, hypervigilance may emerge as a result of the need for heightened alertness in training and on the field, changing the nature of veteran engagement in everyday life.

Readjustment difficulties can span the intra- and interpersonal and occupational domains (Bertoni et al., 2014; Koenig et al., 2014; McCormick et al., 2019). A study investigating transitional issues among recently separated veterans found that many felt disconnected from their civilian support system and missed the lack of structure and care provided to them by members of their unit, or military "family" (Ahern et al., 2015). It was noted that many found comfort in reconnection with other veterans, and some found purpose in acting as peer navigators for more recently returned veterans who struggled to connect with services within the community (Ruzek et al., 2004; Sargent, 2009). Occupationally, some veterans report lacking a sense of purpose in their work and a lack of connectedness with their coworkers (Koenig et al., 2014). Changes in worldview after military service may not be fully understood by civilian family, friends, and coworkers. Moreover, financial, academic, occupational, and relationship obligations of civilian life and diagnosis of mental health disorders and chronic medical conditions can lead to internalized stigma, shame, and negative self-attribution.

Efforts to increase veterans' access to mental health care have expanded the ways in which veterans can seek services within their communities (e.g., executive actions to allow Veterans Affairs purchased care in the community such as the MISSION Act of 2018; U.S. Government Publishing Office, 2018). Although providers will be delivering additional care for veterans in the community, some investigations demonstrate that a minority of clinicians providing services in the community are familiar with military culture (e.g., Tanielian et al., 2014, 2018). It is urgent that mental health providers better understand the ways in which military cultural identification and military experiences may influence patient presentation and patient engagement in treatment. This information can inform provider training and help to ensure that veterans will receive culturally competent services wherever they might seek care. The aim of the current study is to obtain a more thorough understanding of veterans' perception of military culture and the ways in which veterans' values, beliefs, and behaviors have been impacted by military service, with the goal of identifying aspects of acculturation to military service that are important for health care providers to consider as they engage with veterans

and to inform the development of training and treatment tools that can increase culturally sensitive service delivery.

Method

Participants and Procedures

Fifty-two service members and veterans participated across 15 focus groups, ranging from two to seven participants in each session. There were two groups with one participant because the other eligible participant(s) declined to participate immediately prior to or did not attend the group. These appointments were conducted as semistructured interviews using the same semistructured guide that was used for the focus groups. Consistent with findings from Guest et al. (2017), the unique codes derived from the interview sessions did not appear to differ greatly from the pattern of unique codes derived from the focus groups. Participants from different military service eras, branches, and combat versus no combat service were sampled to maximize representativeness of the veteran sample. Participants were not excluded based on type of index trauma as we aimed to include veterans with a range of experiences.

The majority of participants were male (78.8%, $n = 41$). Approximately a third of participants were White (38.5%, $n = 20$), 26.9% ($n = 14$) Black, 17.3% ($n = 9$) Asian, 3.8% ($n = 2$) Native Hawaiian/Pacific Islander, 11.5% ($n = 6$) Hispanic, and 1.9% ($n = 1$) multiracial/ethnic. Slightly more than half were over the age of 50 (53.8%, mean age = 50.37, $SD = 16.025$; ages ranged from 26 to 80). Participants were diverse in terms of their military branch (57.7% Army [$n = 30$], 11.5% Air Force [$n = 6$], 21.2% Navy [$n = 11$], 9.6% Marine Corps [$n = 5$]) and military service status (69.2% enlisted [$n = 36$], 19.2% noncommissioned officer [$n = 10$], 9.6% commissioned officer [$n = 5$], and 1.9% warrant officer [$n = 1$]). Nearly three quarters of the participants had served in combat (71.7%, $n = 33$). See online supplemental Table S1 for additional participant characteristics and online supplemental Table S2 for focus group and interview characteristics.

Participants were recruited from a U.S. Department of Veterans Affairs (VA) health care system and affiliated outpatient clinics, as well as from the community, using postings and clinician referral. Participants who responded to recruitment materials were screened for eligibility over the telephone. Eligible individuals were then scheduled for a study appointment, which included the consenting process, completion of self-report questionnaires, and participation in a single, confidential focus group discussion. Participants were required to provide a copy of their DD214 (official record of military service) or other evidence of military service so that their service and discharge status could be verified prior to engaging in the consent process for the study. Groups were stratified by gender, combat exposure, era (e.g., Vietnam, Gulf War, post-9/11) and/or military branch when possible to increase the likelihood that individuals would feel comfortable discussing their perspectives on military culture in the group setting. Each focus group was facilitated by one or two members of the study team, using the semistructured qualitative interview guide. Focus groups were conducted over 1.5 to 2 hours; study staff also conducted follow-up phone calls within 2 months of each session in order to allow participants the opportunity to provide any additional thoughts or feedback regarding the focus group discussion topics.

Institutional review board approval was obtained from the San Francisco VA Medical Center and the University of California, San Francisco.

Measures

Demographics and Military Characteristics

This measure included participant demographic information (e.g., age, gender) and military characteristics (e.g., branch).

Deployment Risk and Resilience Inventory 2

The Deployment Risk and Resilience Inventory 2 (Vogt et al., 2012) measure consists of 17 subscales and assesses a range of combat-related experiences. The following subscales were used in this study: (a) Combat Experiences, 17 items; (b) Postbattle Experiences, 13 items; (c) Deployment Concerns, 12 items; (d) Support From Family and Friends, 8 items; (e) Unit Support, 12 items; and (f) Postdeployment Support, 10 items. Subscales 1 and 2 were scored from 1 (*never*) to 6 (*daily or almost daily*); subscales 3 through 6 were scored from 1 (*strongly disagree*) to 5 (*strongly agree*). Internal consistency for the 17 subscales ranged from $\alpha = .70$ to .96, and the subscales were associated with measures of posttraumatic stress disorder (PTSD), depression, and anxiety (criterion-related validity; $r = -.15$ to .56) and demonstrated high discriminative validity (between veteran subgroups; Vogt et al., 2012). See online supplemental Table S3 for symptom and psychosocial measure means and standard deviations.

Social Context Questionnaire

This 26-item measure was developed by the first three study authors to characterize a participant's level of engagement in civilian and veteran activities and preferences for social affiliation (e.g., veterans/service members, civilians) and was used to supplement the standard demographics questionnaire. The first two questions on the questionnaire asked participants about the impact of and their identity related to their military experience ("Overall, what has been the impact of your military experience on your life?" and "My military experience defines who I am."), with scores ranging from 0 to 10 (*extremely negative* to *extremely positive* and *not at all* to *extremely,* respectively).

Posttraumatic Stress Checklist–5

The Posttraumatic Stress Checklist–5 (PCL-5; Weathers et al., 2013) is a 20-item measure of PTSD symptoms that corresponds to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*, 2013) diagnostic criteria for PTSD. Total symptom scores range from 0 to 80. Items are scored on a Likert scale from 0 (*not at all*) to 4 (*extremely*). It has been suggested that a PCL-5 score of 33 is an adequate cut score to infer a diagnostic level of PTSD symptoms (Bovin et al., 2016). The PCL-5 demonstrated good internal consistency ($\alpha = .96$), test–retest reliability ($r = .84$), and convergent and discriminant validity (Bovin et al., 2016). Participants' mean reported PTSD symptoms was 32.78 ($SD = 21.09$).

Abbreviated Screening for Anxiety and Depression

The Abbreviated Screening for Anxiety and Depression (Lang et al., 2009) was developed for use in primary care settings and

comprises four items derived from the Brief Symptom Inventory (BSI; Kroenke et al., 2007). The screener assesses depression and anxiety, with each subscale comprising two item pairs. Participants rated the extent to which they had been bothered by symptoms in the past week on a scale from 0 (*not at all*) to 4 (*extremely*). For both the anxiety and depression subscales, a cutoff score of 2.5 or greater was found to maximize sensitivity relative to specificity (Lang et al., 2009). The screener subscales demonstrated sensitivity (depression = .56; anxiety = .55) and specificity (depression = .89; anxiety = .85) comparable to that of the full depression and anxiety BSI subscale scores and similar convergent validity with other measures as the BSI full subscale scores (Lang et al., 2009). Participants' mean scores on the screeners for depression and anxiety were 2.30 ($SD = 2.05$) and 2.78 ($SD = 2.12$), respectively.

Semistructured Focus Group Guide

This guide was developed based on relevant literature and informed by an advisory panel meeting that brought together experienced military service members and veterans from each branch, with the exception of the Coast Guard. During this daylong meeting, advisors provided their thoughts and opinions related to military culture, including military cultural values and beliefs, both across and within branches. During this meeting, perspectives on relationships and occupationally related beliefs and behaviors were also noted as important. Questions were then iteratively developed and refined through research team meetings and reviewed by a subset of advisory board members. Core questions were open-ended with the option of follow-up probes to elicit further information. The guide focused on understanding aspects of military culture such as beliefs, values, behaviors, and symbols, from the veterans' perspective. Open-ended questions were asked in reference to the following: (a) characteristics of someone who identifies strongly with the military, (b) indicators that someone continues to feel highly identified with military culture and with his or her service, (c) how identification with military culture has changed since entering active duty to present, (d) key factors that can influence how someone feels defined by their military experience, and (e) additional thoughts about understanding one's identification with military culture. Participants were not asked questions about trauma-related experiences, although some spontaneously shared such information.

Data Analysis

Quantitative analyses were conducted using SPSS Version 24.0 (IBM Corporation, 2016). Descriptive analyses were conducted to characterize the sample in terms of demographics, military service information, psychological symptoms, and social context.

Qualitative data were analyzed using thematic content analysis (Braun & Clarke, 2006) with a hybrid qualitative methodology incorporating deductive and inductive approaches. Focus group data were transcribed via a VA-approved transcription service and were checked for accuracy by a study team member. The initial codebook was developed using a combination of codes derived from the semistructured focus group guide, initial review of transcripts by the third author, and study team collaboration to resolve any discrepancies in opinions with regards to the initial codes. The initial review of the transcripts focused on explicit themes throughout the data, utilizing a realist method (Aronson, 1995) of understanding the participants' experience of military culture, while noting more implicit themes to be interpreted and explored later in the analysis. Additional codes were added in an iterative manner (based on new data emerging from interviews; Bradley et al., 2007; Guest et al., 2006).

Three members of the study team coded the data using AT-LAS.ti (2013) and a descriptive coding approach (Saldaña, 2013). Weekly meetings and meetings on an "as-needed" basis were conducted with staff engaged in coding to aid in the calibration of coding and to review and discuss discrepancies if necessary. Disagreements about coding and interpretation were discussed and resolved, with the goal of 100% agreement. Code definitions were expanded or modified if it were determined by team discussion that the passage aligned with an existing code. As new proposed codes arose, these were discussed during team meetings and added to the codebook if it was determined the item discussed did not fit within an existing code. This process was based on previous research in general practice that has used a team approach to resolving differences in qualitative coding (Campbell et al., 2013; Grayson & Rust, 2001).

Themes and overarching concepts were identified and iteratively refined through team discussions. This process was informed by guidance derived from the meeting with advisors and prior literature focused on: acculturation-related behaviors and orientations (e.g., Celenk & Van de Vijver, 2011; Sam & Berry, 2010); military culture indicating the importance of the values, attitudes, and beliefs (e.g., Reger et al., 2008); relational aspects (e.g., Meyer et al., 2016; Weiss & Coll, 2011); and occupational aspects (e.g., Harrell & Berglass, 2012) that may change in response to immersion in military culture. Seven overarching themes were derived from the coded data. We calculated the frequency of coded expressions relevant to the identified themes as they occurred by group (i.e., the number of groups in which a code occurred) and include this information in the results as additional support for our interpretations of the data (Maxwell, 2010).

Results

Military Affiliation and Social Context

In total, 32.7% of participants ($n = 17$) reported that their military experience has had no impact or a negative impact on their lives, whereas 67.2% ($n = 35$) reported that it has had a positive impact. Of the participants, 17.3% ($n = 9$) reported that their military experience defines who they are not at all to somewhat, while the majority, 82.7% of participants ($n = 43$), reported that their military experience defines them more than somewhat to extremely defines them. These two variables were not significantly related to one another, $r = .21$, $p = .14$. Of these two variables, only impact was significantly related to reports of mental health symptoms, such that more negative impact was related to higher symptoms (PTSD symptoms, $r = -.39$, $p < .01$; depression, $r = -.36$, $p < .05$; see online supplemental Table S4). Greater self-reported negative impact was also related to less postdeployment support, $r = .37$, $p < .01$. Impact of military service differed by gender, $t(50) = 2.86$, $p < .01$, with women reporting more negative impact (women, $M = 4.0$, $SD = 3.35$; men, $M = 6.88$, $SD = 2.87$). Level at which military service was reported to define them did not differ by gender, $t(50) = 1.50$, $p = .14$. A number of

participants continued to serve in the Reserves at the time of the study (13.5%, *n* = 7), and 42.3% (*n* = 22) reported remaining connected to military or veterans' groups such as American Legion, support groups, and veterans' groups in academic settings. A total of 26.0% (*n* = 13) reported volunteering for military or veteran groups or organizations, and 21.2% (*n* = 11) reported volunteering for other service organizations in the past month. The majority of participants felt most comfortable with a mix of civilian and service member or veteran friends (67.3%, *n* = 35), 21.2% (*n* = 11) felt most comfortable with service member or veteran friends, and 11.5% (*n* = 6) felt most comfortable with civilian friends.

Thematic Analysis

Over 85 unique codes were identified from the focus groups (*n* = 15) and interviews (*n* = 2). Both groups and interviews will be referred to as "groups" in the section below. The number of unique times that a code was utilized, as well as the number of groups within which the topic was coded, is reported in online supplemental Table S5. Both code frequency (i.e., occurring across more than one group) and saliency of the code in relation to the research aims were considered when including a code in the thematic analysis (e.g., Buetow, 2010). Any percentages reported below refer to the percentage of focus groups (not individual participants) connected with that specific content area. Through qualitative analyses and team meetings, the following seven broad themes emerged from the coded data: (a) military values, beliefs, and behaviors; (b) relationships; (c) occupational habits and practices; (d) acquired skills; (e) communication; (f) affiliation; and (g) psychological health and well-being.

Military Values, Beliefs, and Behaviors

This theme comprises constructs that represent values, beliefs, and behaviors that arose across groups and interviews with regards to military culture. The most frequently noted areas within this theme included those related to the structure of the military (occurred in 88% of groups; e.g., the importance of a hierarchical command structure, clear schedule, clear objectives), a sense of working toward a higher purpose (82%; e.g., collective purpose), and a sense of commitment to what one is working toward (77%; e.g., once you're in, you're all in). "The biggest thing between civilian and military is the selfless service. You see a lot of this in the civilian world like 'how does this benefit me?' as opposed to 'what can I do to make things better?'"

Across 71% of the groups, additional values and beliefs were mentioned. The importance of social responsibility emerged (e.g., you need to do what you need to do to help the world or society); relatedly, within 53% of the groups, the perception of civilians having increased focus on self-interest was discussed. "A lot of times a team is [about] individuals [doing] what best can suit them . . . as opposed to the military. . . . It [teamwork] is the best way to accomplish a mission—does not really matter how it will benefit everybody, just matters how it will benefit the mission."

Participants also discussed the value of action (e.g., quick decision-making, seeing something that needs to be done and doing it) and, conversely, specifically mentioned and devalued inaction within several of the groups. "I will just stop and do what needs to be done. I will get things done, know what I mean? . . . I

think that was part of my military training. . . . You are still taking charge and telling people what to do and kind of putting yourself in a selfless position by doing that."

Focus group participants identified the importance of leadership, including what they considered to be ideals of leadership and their beliefs about what personal qualities of a leader should be, based on their military experience. Reshuffling of priorities during and following military experience such as a focus on mission and on profound issues such as life versus death was also discussed. Relatedly, devaluation of what veterans perceived as trivial (e.g., everyday concerns) arose within approximately a third of the groups. Finally, many participants noted the personal benefits or gains they or others derived from military service. "The whole military experience gave me a broader world perspective. We don't have it so bad here. . . . [There are] people worrying about . . . [why] this person got voted off this one reality show, when people are getting shot at or trying to find food in another country and just trying to survive, and hopefully you're not getting blown up by a bomb."

Additional topics that arose across groups included a focus on ideals emphasized in the military. These included timeliness and time consciousness (65% of groups), excellence (65% of groups, including the ideas of striving to be the best and avoiding and experiencing shame after failure), patriotism (e.g., 59% of groups discussed love of and a sense of duty to their country), and justice (35% of groups expected reward and recognition for excellence in performance). "You should take pride in [. . .] every job. Whatever you are doing, do it to the best of your ability because other people may be counting on that."

Relationships

Beliefs and values relevant to relationships were discussed across the majority of groups (71%). These included aspects such as collective responsibility (e.g., being responsible for the action of others), reciprocity (e.g., giving a lot and expecting a lot in return), loyalty (e.g., being unwavering loyalty to others; having one another's backs), respect for others, and interactions with civilians and society.

Sixty-five percent of groups noted dependability (e.g., doing what you say you will do), selflessness (e.g., putting others and the group first and devaluing individual needs), and the importance of complete trust in your relationships with others. The importance of and unique nature of team in military service was discussed in 35% of the groups. "There is a difference between running together and running at the same time."

Occupational Habits and Practices

Eighty-eight percent of groups noted the compulsory compliance with leaders in the military hierarchical structure. The importance of being competent (e.g., doing your job effectively, 71% of groups), work completion (e.g., getting the job done and not leaving things unfinished, 82% of groups), and the importance of accountability (e.g., taking responsibility for your actions, 53% of groups) were also discussed across the majority of sessions. Other areas that were less frequently noted across the groups included attention to detail (e.g., believing that every detail matters, 47% of groups), uniformity (e.g., doing everything the same way every time, 29% of groups), importance of recognition (e.g., acknowl-

edging and awarding service and excellence, 29% of groups), and consequences of not doing a good job (i.e., using punishment [29% of groups] or shaming [12% of groups]). These results reflect findings from other studies (e.g., Harrell & Berglass, 2012), which found that organizations perceived veterans as having obtained experience, expertise, and skill sets as a result of their military service. "I just always did my job . . . I'd do my job in a timely manner. Very seldom did I ask for help. But that's the problem I admit now, because I never asked for help and I'm aching pretty good. . . . But I wanted to do my job and do it right. Don't take shortcuts."

Acquired Skills

Learned responsibility (e.g., responsibility for expensive equipment, other service members, marriage at an early age) was discussed in 59% of the groups. Increased ability to attend to the environment (e.g., experiencing increased awareness of surroundings) was noted in more than slightly half of the groups (53%). Fewer than half of the groups (41%) also discussed the following: learned resiliency and ability to manage or adapt to chaotic situations. A small number of groups discussed acquiring adaptive responses to potentially traumatic events (18%). "With our training in being able to pinpoint every little thing—having an inspection line, making sure that every single soldier is doing exactly the same thing—yeah, we are hyper-aware now, aren't we? I mean, that is our thing." The difficulty in skills translation from the civilian to the military setting was also noted by some participants. "[There are] skills maybe that you learned in the service that you aren't able to use all the time, and it's kind of a bummer because you use them for x amount of years and you probably get really good at whatever it is."

Communication

This theme includes both nonverbal and verbal means of communication learned within and about military service. Appearance was mentioned across all groups as a means of communicating something about one's self (e.g., neat grooming, being "squared away" and cognizant about one's appearance). In one group, it was noted that attention to detail in one's appearance communicates respect for self and others. Communication about one's military service through the use of symbols (e.g., uniforms, patches, hats, stickers) arose in 71% of groups, while 59% of groups noted the habits and rituals developed through military service that are indicative of having served (e.g., how one makes their bed). "When you see a guy that's dressed up sharp, I sometimes go over [and ask], 'Are you in the military?' Invariably, 'Yes, I'm a vet.'" Verbal communication was noted to be direct (e.g., communicating with an objective, being to the point, getting across the bottom line first, 59% of groups), laden with acronyms and military lingo (e.g., using military speak, 59% of groups), and exact (e.g., saying precisely what you mean, in explicit terms, 41% of groups). "Four words: Be real, be direct. That's about as succinct as I can make it."

Affiliation

Across the groups, participants discussed their experience of inclusionary and exclusionary practices and those things that impacted the strength of their sense of affiliation with the military. In 88% of groups, participants discussed experiences that bind service members together. Notably, this included an assumed credibility between veterans. Sixty-five percent of groups identified how service in a combat theater led to membership in an exclusive group with shared experiences, both positive (e.g., camaraderie) and negative (e.g., losses of comrades, increased hardships). Continued affiliation with military service through membership in veteran organizations arose in 47% of groups. "You get used to the brotherhood—you get used to the comradery . . . and it's like that environment is not something you can find easily unless you find it in other vets when you get out."

In addition to shared experiences, participants shared experiences and practices that were exclusionary (59%) or inclusionary (59%) in nature. Exclusionary types of experiences included those related to racial or gender discrimination or harassment, service-specific aspects (e.g., branch, rank), or general sense of not fitting in while serving. Discrimination based on gender or race/ethnicity made up 44.12% (15/34) of the passages coded (29.4%, gender discrimination; 14.7%, racial/ethnic discrimination). "[You'd get hurt] and you'd go like, 'No, I'm okay.' You would do that every time you got hurt because there were only six women in my field. The best compliment for me was when they would say, you know, 'Oh, it's [name], she's one of the guys,' and I felt like I had achieved really what I want. . . . I couldn't get hurt. . . . I couldn't be 'less than.'" Inclusionary types of experiences included those that reflected a sense of community or collectivism in the military and those that illustrated a sense of belonging. "Brothers and sons of and daughters, of course, and sisters of the general population, we [are a] reflection of them. I don't see any class, that's all. Rich, poor, middle class. I saw [people] from every background [. . .] joining the military."

Psychological Health and Well-Being

Participants discussed emotional and mental health–related experiences related to during and following military service within many of the groups. Most frequently mentioned mental health concerns across groups included PTSD (59% of groups), anger (59%), grief (47%), substance use (35%), aggression (29%), and fear (18%). Some participants expressed views of emotions as a liability (e.g., being deemed dangerous to self or others, 24% of groups) or weakness (e.g., not wanting to be seen as emotional, 24% of groups). "You don't let anybody know that you're vulnerable, because they'll take advantage of you and you most likely—you learn from it if you survive. Don't ever let anybody know that you're hurting." Several were judgmental of their emotional experience (e.g., socialized or internalized judgments, such as not wanting to be seen as a "stereotype" of a veteran with mental illness, 35%). In some groups, participants discussed positive emotions such as pride (59% of groups), joy (12%), and compassion (29%). In terms of coping, more than half of groups had participants who expressed using substances (59%) and avoidance (65%). Nearly half of groups discussed numbing or compartmentalization of emotional experience (e.g., low emotional expression, except anger, 42%). "I had experiences in the military that excited me, motivated me, encouraged me, and built me up, you know?"

Discussion

This study sought to better understand veterans' perception of which aspects of military culture are reflective of military culture identification and the transition from the military to civilian setting with the overall goal of informing culturally sensitive care. Al-

though the participants in this study shared diverse responses and experiences, many of them endorsed a high level of identification with the military. The majority of participants reported that their military experiences both defined them as individuals and impacted their lives either somewhat or more than somewhat. Scores on these two scales varied, underscoring the potential diversity in perceptions of and identification with one's military experience. Interestingly, these two items were not significantly related to one another in this sample. Self-reported impact of military experience, not the level at which one reported their military experience defined them, was related to symptom reports. Previous research indicates that one's sense of military identity may also be differentially associated with functioning. Lancaster et al. (2018) found better functioning to be related to having high regard for and feeling connected to the military, while poorer functioning was associated with military identity exploration and viewing the military as family. Moreover, views of the military and one's sense of military identification were predicted by postdeployment social support and levels of positive affect (Lancaster & Hart, 2015).

Our preliminary finding implies that there may be two somewhat distinct areas related to military service that clinicians should assess: (a) the events that occurred while in the military and their impact on mental health and functioning and (b) identification with military culture. Evaluation of both of these areas may prevent confounding sequelae of potentially traumatic or stressful events that may have occurred during military service and the ways in which military service may shape or change one's identity.

One example of an area in which such confounding may occur is when assessing for symptoms of PTSD. Skills acquired during military service, including heightened sensitivity and awareness to their surroundings and responsiveness to threat, were noted by some participants. These skills are valued and, at times, necessary while serving in the military, particularly in combat. However, one can easily see how, after transitioning out of military service, this heightened awareness can lead to feelings of being different from those around them. Providers who are less familiar with skills valued during military service or when under threat may be more likely to view these physiological changes as psychopathology (e.g., symptoms of PTSD), as opposed to conditioned physiological changes that may require time to adapt to a new environment (e.g., the civilian setting). Providers, although well intentioned, may make judgments without understanding the psychological and physiological changes that can occur during military service; these can then lead to inaccurate diagnoses. Such judgments may also lead the veteran to develop a greater sense of disconnect with the provider and increased internalized stigma regarding their emotional experience. Understanding how to draw such distinctions is worthy of future study.

Women in our study reported greater negative impact of their military service. Some participants spontaneously shared experiences of gender and racial discrimination. Exploration of the intersectionality of identification with military culture, gender, race/ethnicity, and LGBTQ identity is an important future direction since negative experiences (e.g., race-based trauma) during service related to one's identity may interact with identification with military culture in a way that impacts one's views of military service, mental health, and functioning. The simultaneous reporting of both positive and negative experiences was also reflected by participants who noted the adverse impact of a negative home-

coming after already experiencing difficult or traumatic events while in combat. The impact of redeployment reception on veterans who served during the Vietnam War has been documented in previous literature (e.g., Steenkamp et al., 2017). Many of the participants discussed the impact of military service on their occupational values and behaviors.

Although this study was focused on better understanding the role of military culture in providing behavioral health care treatment, this information can also enable employers to be more appreciative of and sensitive to the perspective and skills that veterans bring to the workplace. Previous research suggests that veterans themselves have difficulty identifying how their skills, occupational experience, and qualifications can translate from military to civilian jobs (Hall et al., 2014; Harrell & Berglass, 2012; Keeling et al., 2018; Kintzle et al., 2015). However, our findings point to how the military environment may instill specific values and behaviors that are likely to cause veterans to be reliable, detail-oriented, respectful, and principled members of their various organizations after service. Moving forward, both employers and veterans would be well served by identifying and understanding the positive effects of military acculturation in the civilian workforce.

In the current study, self-reported negative impact of military service was negatively related to postdeployment support. Across many previous studies, social support has been found to be associated with and predictive of recovery, functioning, and quality of life (e.g., Arenson et al., 2019; McCaslin et al., 2019). In a study examining service members' experience of the transition home from deployment, social support from military peers and civilian friends and family was found to positively impact participants' experience of their transition home (Fink et al., 2014). Of note, some participants described characteristics and expectations of individuals they considered to be trustworthy and supportive. Findings also suggest that veterans may carry additional expectations from military service (e.g., achieving work of a specific quality, having a "squared away" appearance, communicating in a direct style, being prompt) into their encounters as clinical patients. Such expectations can lead to frustration if a health care provider cannot meet, or is perceived not to meet, these assumptions. Future studies should aim to better understand veteran expectations for health care providers and services. This information could guide providers as they attempt to build alliances and gain the trust of the veterans they serve.

The potential of engagement in continued service as an adjunct to psychotherapy deserves further attention. Consistent with the values of purpose and social responsibility, community involvement has promise to provide psychosocial support as well as a sense of connection and mission (McCaslin et al., 2020). Participants in this study commonly endorsed volunteer service during the survey as well as in a number of the focus groups (25% of participants endorsed that they volunteered for military or veteran groups such as the American Legion; 78.8% volunteered for other groups such as Meals on Wheels). Other interests noted during the focus groups included outdoor recreation and those that involve physical fitness, survival skills, and competition. A number also self-reported engaging in outdoor activities such as hiking and camping, fishing, biking, and walking as well as exercise in a gym setting. The identification and discussion of such activities may be useful to veterans during their transition into civilian contexts.

The preliminary findings of this study suggest additional directions for future research. It was observed that participants with a history of combat service may have been more likely to discuss threat to life and loss of comrades as important aspects of their military experience. The sheer intensity of serving in a combat theater may enhance the acculturation and conditioning process, such that those serving feel even more bonded to comrades, experience increased hypervigilance, and find certain aspects of service to be accentuated (e.g., deepened sense of priorities). Future studies examining the relationships of these variables may help to further understand how trauma exposure might influence identification with military culture. Moreover, given experiences of discrimination and injustice that some veterans experience during or after their military service, posttraumatic embitterment disorder (PTED; Lehrner & Yehuda, 2018; Linden & Rotter, 2018) should be further examined in relationship to both PTSD and identification with military culture. PTED arises from stressful life events that are not distinctly fear based and can negatively impact functioning (Lehrner & Yehuda, 2018; Muschalla et al., 2018). PTED may be relevant to experiences of discrimination while serving in the military or negative societal reactions following separation from the military and return to the civilian setting. In this study, the level of identification with military service was not related to mental health symptoms, while the impact the military has on one's life was, and these two variables were not related to one another. The military experience is a complex one, and veterans have diverse military service trajectories. This study aimed to understand what aspects of military culture might be seen as important to identity and self-concept by veterans who served across eras and combat/noncombat environments. Understanding aspects of military culture can increase providers ability to deliver culturally sensitive care. Health care providers who are engaged with patients who have a military background can gain a better understanding of their patient's background and can use this information to inform treatment and to gain a more comprehensive understanding of how military service affects one's experience, identity, and clinical presentation. Assessment of military culture may also facilitate discussion of positive experiences during military service as well as difficult or traumatic experiences.

This study has a number of limitations, including the use of self-report questionnaires and lack of representation by the Coast Guard. Although we attempted to stratify groups, this was not always possible and may have affected disclosure about and discussion of military experiences. Although the study was designed to utilize focus groups, in two instances, participants either rescheduled or decided not to participate, leaving two sessions that had one participant. Despite the fact that many participants experienced traumatic events and endorsed mental health symptoms, a comprehensive evaluation of traumatic events and psychological symptoms was not conducted. Moreover, qualitative analysis and thematic development were influenced by content derived from an advisory meeting of subject matter experts and drawing on both acculturation and military culture literature. It is thus possible that the participants in this study may not be fully reflective of a larger sample and that further study is needed to replicate the findings that emerged through the qualitative analysis in this study. Despite these limitations, this pilot study provides unique insights into aspects of military culture from the veteran perspective across

groups of veterans with diverse service histories and can inform clinical care.

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