

Defining Elemental Components of Veteran Cultural Competency for Mental Health Professionals

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Abstract

Veterans and Military Service Members are separate and independent cultures. As a principle element, clinicians seek to become culturally competent to develop therapeutic rapport and improve treatment outcomes. Previous research has identified that mental health providers must be culturally competent to treat the Veteran population effectively. There are vital elements that need to be assessed: culturally specific contextual knowledge, professional competence, and confidence in working within the population. This research sought to identify the elemental components of cultural competence by evaluating a Veteran-specific cultural training program called “Healing Our Heroes”. The results concluded that direct military experience was not a significant factor in the ability to work within the population; however, possessing Veteran specific contextual knowledge was critical in obtaining cultural competence.

Keywords

Veteran, Military, Culture, PTSD, VA

1. Introduction

The Veteran population is committing suicide at an estimated rate of 22 lost lives per day (Department of Veterans Affairs, 2021). The Veteran Administration estimates that about 30 percent of all military members who have spent time in designated combat zones will experience PTSD at some point during their careers. Veterans represent a culture of their own within the United States, yet few health service organizations identify Veterans or Military Service Members as

representing a culture of its own (Cameron, 2023). Previous research has identified that community-based providers significantly lack cultural understanding and need to possess the capacity to deliver culturally competent mental health to Veterans and their families. The Rand Corporation was able to identify three critical elements to evaluate Veteran cultural competence in mental health professionals: culturally specific military knowledge, knowledge and awareness of proficiencies required to engage the culture, and confidence in individual skills and abilities (Tanielian, & Tanielian, 2014).

Lancaster et al. (2018), through Validation of the Warrior Identity Scale in the Chicagoland Veterans Study, provided support for the multidimensional nature of military identity. A correlational analysis identified the relationships between the subscales of “identity”, and the outcome variables differed in strength and direction depending on the form of identity, supporting a multidimensional structure of military identity and culture. Research to promote military, cultural competence among civilian care providers, Nedegaard, & Zwillling (2017) identified that assessments must measure military-specific knowledge to evaluate cultural competence for the Veteran population.

The review illustrates several critical elements in constructing a measure to identify cultural competency: direct knowledge about the population, a working knowledge of the necessary skills to work with the population, and confidence in the ability to work with the population. Without the required skills and cultural competence, there is a significant concern that mental health professionals may be overconfident in their perceived abilities to develop effective therapeutic rapport and effectively treat the Veteran population.

Previous research has also identified the need for an effective measure to gauge therapeutic cultural competence and a structure to provide education and training about the treated population. Cameron and Ginzburg (2019a) reviewed these studies all identified a need to be culturally competent, yet their measures lacked cultural-specific knowledge. Future research will need to evaluate specific knowledge related to the population, clinical understanding of the necessary skills to work with the population, the practitioner’s confidence in the ability to work with the population, and the effectiveness of the cultural specific training providers receive. The study aims to determine if Veteran contextual knowledge or prior military experience impacts a mental health provider’s capability to treat Veterans effectively.

2. Methodology

The study utilized an archival data set from an online quasi-experimental study on Veteran Cultural Competency training conducted by Anchor Therapy Clinic titled “Healing Our Heroes” in Sacramento, California (Cameron & Ginzburg, 2019a). In addition to demographics, the study targeted mental health professionals across the United States servicing the Veteran and military populations, evaluating the following domains: knowledge of military and Veteran-related

topics, self-reported cultural awareness, and self-reported confidence in the individual ability to perform mental health treatment within the population. Veterans are operationally defined as individuals formerly serving in the Armed Forces possessing a military discharge (DD 214). Service Members are members of the Armed Forces actively serving in a branch of the military in an active, reserve, or National Guard component. This study was approved by the Institutional Review Board (IRB) at Alliant International University.

2.1. Subjects

Inclusion in the study varied based on the user's self-reported role within the Veteran services workforce as mental health professionals. The composition included therapists, counselors, peer specialists, clinical social workers, psychologists, and psychiatrists. Veteran status and military dependent status was not required for inclusion in this study but had been identified during demographic data collection. The original data set consisted of 618 participants; participants for this study were randomly selected from the inclusion criteria to be evaluated as a part of the sample. Subjects were excluded if they were not identified as working in the mental health field or did not work professionally with Veterans, at any level, as a provider leaving a final total of 419 participants.

2.2. Measurements

Archival data self-reported measures were only administered to direct service providers and were analyzed across question clusters, professional credentials, and history of military service. These question clusters represent similar survey questions and include the following: attitudes towards clinical practice guidelines, comfort working with military-specific topics, implementation of clinical best practices, military contextual knowledge, and finally, self-reported cultural competencies. The Veteran Culture Competence Assessment (VCCA), developed by Cameron and Ginzburg of Anchor Therapy Clinic (2019), is an assessment measuring Veteran cultural competence consisting of three subsections: military contextual knowledge, professional competencies, and comfort working with the Veteran populations. Military contextual knowledge measured military-specific knowledge based upon necessary information taught in military basic training environments and military transition programs. The measure was provided to members of the United States military and Veteran populations across the United States for instrument validation.

The second and third subsections of the VCCA measure are an aggregate of an existing survey, the Health Provider Survey (MHPS). The MHPS was initially developed by the RAND Corporation (RR806) and had been vetted for validity and reliability. The MHPS survey instrument featured questions that aim to gauge 1) knowledge of the branches of the military, 2) knowledge of military training principles, 3) knowledge of military structure, 4) level of exposure to military treatment settings, 5) attitudes towards clinical practice guidelines, 6)

self-reported competency on clinical issues often seen in Veterans and military service members, 7) clinical problems that commonly occur within the Veteran population, and 8) attitudes towards treating Veteran clients. Researchers Cameron and Ginzburg initially identified that the MHPS lacked Veteran-specific cultural components and modified the measure to meet the survey requirement (Cameron & Ginzburg, 2019b).

The Military Knowledge Assessment validated the contextual knowledge used in the Healing Our Heroes program (Cameron & Ginzburg, 2019a). The questions were derived utilizing basic military training publications deemed unilateral across all military branches. The survey consisted of two subsections. The first subsection consisted of general military knowledge-based questions. The second subsection included a self-reported assessment to gauge the individual's perceptions of knowledge with overall military constructs. Military Veterans were recruited via social media. A reliability analysis was carried out on a scale comprising 39 items. Cronbach's alpha showed the questionnaire to reach acceptable reliability, $\alpha = 0.962$. All items appeared worthy of retention, resulting in a decrease in the alpha if deleted. From the recruited population, participants were randomly selected to be included in the survey assessments ($N = 172$). The surveyed population was predominantly male ($n = 132, 76.74\%$), with a mean age of 42.6 years of age.

Subsection 1 (SB1) of the military knowledge assessment was scored, with one point being possible for each correct response with a five-point potential. A reliability analysis was carried out on the scale comprising five items. Cronbach's alpha showed the questionnaire to reach acceptable reliability, $\alpha = 0.709$. All items appeared worthy of retention, resulting in a decrease in the alpha if deleted. The mean score for SB1 was 4.9 (98%) among all participants indicating a robust contextual knowledge base. Variations in scores had been attributed to the perceived number of military branches. Depending on the period of service, the Coast Guard was not a separate branch of the military, falling under the Department of the Treasury and later Homeland Security. Due to individual military, and cultural perception, the Marine Corps may have been identified as a separate branch of the military, although they are a part of the Department of the Navy. A single point was given for a response of 4 or 5 branches of the military to account for the status change of the Coast Guard during the periods of service spanning the population.

Subsection 2 (SB2) consisted of a self-reported assessment to gauge the perception of knowledge of general military constructs. The measure consisted of 13 questions rated on a five-point Likert scale ranging from "Strongly Agree" (5) to "Strongly Disagree" (1). The military contextual knowledge results were scored and compared against the mental health professional survey population. A reliability analysis was conducted; a Cronbach alpha identified the questionnaire to reach acceptable reliability, $\alpha = 0.963$. All items appeared worthy of retention, resulting in a decrease in the alpha if deleted.

2.3. Data Analysis

Data analysis was conducted using IBM's Statistical Package for the Social Sciences (SPSS) to identify demographic information about the sample, trends in response categories regarding clinical competency, attitudes towards clinical practice, and knowledge of military culture. Demographics were analyzed for central tendency, and to determine the distribution of mental health professionals versus clinicians. Differences between groups were determined by one-way ANOVA and utilizing paired sample t-tests. The number of practicing clinicians within the United States, individually working with the Veteran and military populations, and the distribution of professional credentials within this population was unknown. To account for a relatively low projected sample size, confidence intervals around a mean were based on the population of mental health professionals in the United States were determined based on the publication *Mental Health Professionals: U.S. Statistics 2011* (Grohol, 2019).

3. Results

An a priori power analysis was conducted using G * Power3 (Faul, Erdfelder, Lang, & Buchner, 2007) to test the difference utilizing one constant for a two-tailed test, a moderate effect size ($d = 0.20$), and an alpha of .05. Result showed that a total sample of 326 participants was required to achieve a power of 0.95. Survey population ($N = 419$) reflecting mental health professionals included in the study represented mental health therapists ($n = 243$), social workers ($n = 22$), and psychologists ($n = 22$) and "other" ($n = 132$) working in the field of mental health. Participants' mean age was 40.68 years of age, were predominantly female ($n = 308$, 73.68%), and had obtained a Master's ($n = 374$, 89.47%) level education. Although 68.42% identified having a family member who served in the military ($n = 286$), only 26.32% of mental health professionals had experience as a military dependent ($n = 111$), and only 21.05% had direct experiences as a military Veteran ($n = 88$). A one-way ANOVA identified a statistically significant difference between groups military contextual knowledge ($F(1, 37) = 23.037$, $p < 0.001$), clinicians confidence in their skills and ability to treat the Veteran population ($F(1, 37) = 16.915$, $p < 0.001$), and the clinicians self-reported clinical skills ($F(1, 37) = 45.228$, $p < 0.001$).

3.1. Provider Responses

Independent sample t-tests were conducted to compare means across all levels. Results of the independent sample t-tests indicated that there were no significant differences ($t(-69.30) = 396$, $p < 0.001$) in military contextual knowledge and professional competencies domains. Military lived experience was significantly correlated (0.35) with confidence in the ability to work with military populations ($t(-85.056) = 418$, $p = 0.437$).

3.2. Military Contextual Knowledge

Contextual knowledge of general military culture was identified as the most significant predictor of cultural competence for the Veteran populations. Contextual military knowledge was generally lacking. The analysis of responses indicated that overall, providers scored 33.5% ($n = 6.03$, $SD\ 2.79$). Mental health professionals with no military lived experience as a Veteran or military dependent scored significantly below average (31.58%, $SD\ 3.67$). These results indicated a disparity in contextual knowledge among mental health professionals compared to the Veteran population ($n = 26.96$, $SD\ 3.7$). A separate independent analysis was conducted to determine the differences between groups. The between-group analysis identified that mental health providers with direct military contextual knowledge significantly outperformed mental health professionals without lived experience or individuals with only causal experience, such as having a family member in the military or being a military dependent ($m = 22.67$, $SD\ 3.67$).

3.3. Self-Reported Professional Competencies

Providers reported higher-than-average abilities and skills that pertain to mental health. The analyses comparing Veteran lived experience to non-lived experience revealed statistically significant differences in clinician self-perceptions in knowledge and awareness of Veteran related clinical knowledge. Clinicians with military experience endorsed that they were more likely to be ambivalent about their ability to understand Veterans' values and beliefs ($m_1\ (m = 24, SD\ 9.25)$, $m_2\ (m\ 12.79, SD\ 2.79)$).

3.4. Self-Reported Confidence Working with Veterans

Provider attitudes towards working with Veterans, military personnel, and their families around topics that are commonly found within the military were generally positive. Mental health professionals without lived military experience reported moderately higher confidence ($M = 50.68$, $SD\ 16.54$) in their ability to work with the Veteran population than the Veterans with lived experiences.

4. Discussion

This initial research validated the hypothesis that Veteran-specific contextual knowledge is a critical predictor of cultural competency in the Veteran population. Researchers were surprised by the results that identified that prior military lived experience had little to no impact on the overall model of the study yet did show significance within the subsection of contextual knowledge. Much like the Survey of Mental Health Providers conducted by the RAND Corporation (Tanielian & Tanielian, 2014), clinicians with lived military experience reported more ambivalence surrounding their self-reported confidence and professional abilities to treat the Veteran population compared with clinicians with non-lived experience. This disparity in perception may be due to confounds not assessed in

the model, such as prior education about military culture, or clinicians without lived experiences or training may be overconfident in their abilities to work with this population.

The future of this research should take a multitude of directions. First, research should seek to identify the elemental nature of the Veteran culture, principal subcultures, normative cultural behaviors, and comparisons to the environments they reside in after military service. Secondly, culturally-based training should be evaluated for the potential application of improving cultural competence in mental health providers. If the need for culturally specific training is validated, then the training itself should be looked at to determine what key elements need to be included to facilitate a shift in the perspectives of clinicians. Lastly, as Veterans and Military Service Members continue to be professionally recognized in psychology and sociology, professionals in the field need to seek out training to understand those cultures outside the stereotyping illustrated in film and television.

Limitations

Although there were significant differences between mental health professionals with and without military lived experience, the results of this study are modest. Several limitations suggest potential directions for further research. First, there needs to be a comparative study to evaluate changes in perceptions of mental health providers once they have completed a standardized training module on Veteran culture to determine if self-reported assessments and confidences are embellished due to a lack of understanding. Second, a more diverse sample considering individual professional experiences would provide better insight into potential confounds within the research. Another element to evaluate in future research would be to look at perceived treatment outcomes of mental health professionals with and without education in the field of Veteran culture to determine if specific Veteran cultural training is a necessary element in treatment outcomes for this population.

5. Conclusion

In summary, the data identified that military contextual knowledge was a significant predictor for confidence in military and cultural competency. However, military or Veteran status had no significant direct impact on being professionally and culturally competent for the Veteran population. Although direct military experience was not a significant predictor, the data suggests that direct expertise plays a crucial element in understanding the Veteran community. Clinicians without military contextual knowledge may need to explore their own biases around perceived Veteran cultural competence. Aspects of militant-based culture differ significantly from other civilian clients. The values, support structure, and elements making up Veteran culture need may need to be learned rather than rationalized through deductive reasoning. The Veteran culture has a

language and culture all to their own, and to allow for authentic disclosure, the client needs to feel that they are heard and understood. Meeting the Veteran population where they are only strengthens the therapeutic relationship, allowing for more substantial treatment outcomes.

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The Author declares no conflict of interest regarding the publication of this paper. The Author wished to acknowledge that they have lived cultural contextual knowledge and cultural competency for both the Veteran culture and Military (Armed Forces) culture.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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