Is your practice prepared to identify or treat post deployment problems?

The Importance of Understanding Military Culture for Civilian Health Providers

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Abstract

Providers must understand the uniqueness of military culture and the roll that it plays in creating, perpetuating and preventing servicemembers from seeking help. Failure to gain the trust of impacted servicemembers and their families may result in frustration, missed or delayed diagnosis and treatment, or lost opportunities to adequately help a growing population of servicemembers and their families.

"The most complex and dangerous operations and the most deadly wars, occur in the head"

Anthony Swafford, *Jarhead* from PBS video *Operation Homecoming* [1]

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The Importance of Understanding Military Culture for Civilian Health Providers

In order for civilian health providers to diagnose and treat the symptoms of military deployment related behavioral health, they must first understand the uniqueness of military culture and the roll that it plays in creating, perpetuating and preventing servicemembers from seeking help. Providers should know about our nation's history and about our present military conflicts; be familiar with the Department of Defense (DoD) and Department of Veteran Affairs (VA); ask each patient if he/she is a servicemember/veteran or a family member/significant other of a servicemember or veteran; know something about the different Service Branches and respect the difference! Failure to gain the trust of impacted servicemembers and their families may result in frustration, missed or delayed diagnosis and treatment, or lost opportunities to adequately help a growing population of affected servicemembers and their families.

"If You Don't Take the Temperature, You Can't Find the Fever!"[2]

Some Alarming Statistics:

Nearly 99% of counties in the United States have residents that deployed to Operation Iraqi Freedom (OIF) in Iraq, Operation Enduring Freedom (OEF) in Afghanistan, or both.[3] These wars impact nearly all communities. There are staggering reports of servicemembers and

their families reporting symptoms of posttraumatic stress disorder, (PTSD), traumatic brain injuries (TBI), and depression resulting in suicide, homelessness, unemployment, substance abuse, domestic violence and incarceration.

According to 2009 census data, there are roughly 21.9 million veterans living in the United States, over 2 million of whom have served in OEF/OIF.

In 2008 it was estimated that 18 to 20 percent of our OEF/OIF veterans, more than 300,000, show symptoms of PTSD, depression or both. An estimated 70 percent of these veterans do not seek help for their problems through traditional military mental health facilities.[4]

A recent study found 40% of National Guard members and 34% of their significant others met the screening criteria for at least one mental health problem. Significant others indicated symptoms that met the criteria for a PTSD diagnosis (17%), depression (22%), suicidal ideation (10%), and hazardous alcohol use (3%). National Guard members indicated symptoms that met the criteria for PTSD diagnosis related to a military event (11%), depression (21%), suicidal ideation (5%), and hazardous alcohol use (20%).[5]

Nationwide, over 50% of servicemembers who served in OIF or OEF and are eligible for VA services aren't registered with the VA. Many reside in areas where military treatment facilities and VA services are inaccessible or inadequate. For a variety of reasons, many seek care from local providers in their communities. To prepare civilian providers to address post deployment issues facing OIF/OEF veterans and their families, the Citizen Soldier Support Program (CSSP) has partnered with the North Carolina Area Health Education Centers (AHEC) and medical providers from the VA, United States Navy and United States Public Health Service

to create on-site and online courses for PTSD, TBI, Women Returning from Combat and Family Issues. www.aheconnect.com/citizensoldier/

Defining the uniqueness of military culture

The military is unlike any other career and the demands of military life create a unique set of pressures on servicemembers and their families. For most people, their job is what they do; it does not so deeply define who they are. For families, military life offers a sense of community with clearly defined rules and expectations.

Members of the military and their families share a unique bond, professional ethic, ethos, and value system. The military offers a sense of community and camaraderie unlike any other profession. But it also fosters a warrior ethos that rewards physical and emotional prowess and frowns upon weakness and timidity.

It is said that the military defends the Constitution it does not emulate it. There are strict rules limiting freedom of speech and association. To maintain "good order and discipline" commanders at all levels are given widespread authority over the personal affairs of their subordinates and held personally responsible to resolve any issues that could potentially affect performance of duty. For example, your command may be notified if you get drunk, bounce a check, fight with your spouse, if your kids go hungry, dirty, misbehave in school or get in trouble with the law. You need permission to leave the area, even on the weekend and holidays. You are subject to performing your duty at any time. You are told what to wear, where to live and who among your fellow servicemembers you can and cannot socialize. It wasn't that long ago that you needed your commander's approval to get married. You are told what you can and cannot put into your body and have restrictions on seeing a counselor, having a medical procedure or taking medications.

Military families endure many of the same restrictions and their actions reflect directly upon their servicemember. This burden increases with the pressures of maintaining the family household during extended military deployments that are becoming the norm for both active duty and Reserve Component (National Guard and Reserve) members. Over the last few decades the definition of a military family has also evolved as more servicemembers are single parents relying on siblings and parents to care for their dependent children. Many are in committed relationships outside of marriage, are separated, or divorced. Families in the Reserve Component often do not have access to the facilities and services offered on military installations.

Understanding the roll that military culture plays in creating, perpetuating and preventing servicemembers from seeking help in addressing their behavioral health issues

Why does my patient feel so responsible for the death of his friends?

Warfare is inherently violent and traumatic. Those that experience it often remark that it truly cannot be understood by those who have never experienced it themselves. Our military is now retiring personnel who have spent the majority of their service during wartime. For those who experience it, war has an impact on the psyche. For some the consequences are acute and pass quickly. For others the passage of time is needed to recover from the trauma they have experienced. For some the changes in their mental health are profound and last a lifetime. We know that the incidence of PTSD rise precipitously with the number of deployments, number of months deployed and dwell time between deployments. In your patient's case, understanding the

cultural aspects (military, ethnic, gender) of those coping with trauma is vital to understanding how individuals deal with survival guilt.

Why did this emergency room trauma patient drive his motorcycle into oncoming traffic?

Many believe that what they are experiencing is simply part of their chosen profession, a hazard of the job that others seem to handle better. They see that older generations experienced similar or worse circumstances yet returned to their communities without asking for help, carrying their secrets to their grave, never sharing their experiences with family or friends. They have a sense that their feelings or issues are going to continue forever and that they just need to learn to deal with them. They engage in high-risk behavior, substance abuse or turn to suicide. You'll never know about your trauma patient if you don't ask if they served in the military.

Why do patients often refuse to accept referrals to see a behavioral health professional?

Many uniformed personnel believe there is a stigma attached to the difficult emotions they experience. Some experience guilt or self-loathing because they perceive themselves as "weak." Others turn to alcohol or other substances to dull their feelings. For far too many the fear of ridicule from peers and superiors, or the loss of respect from subordinates, inhibits them and forces them into suppressing emotions they do not understand.

Those in the military understand that they can receive help, but it may come at a high professional cost. Those who wish to make the military a career know that any perceived weakness weighs heavily on their opportunities for promotion and increased responsibility. An

admission of behavioral health issues may mean that they are no longer eligible for the things that define professional success.

For those who suffer from PTSD or depression, the decision to seek therapy is a difficult one and every effort must be made to remove the barriers, real and perceived.

How can civilian providers overcome this lack of understanding?

A 2008 RAND study on addressing psychological and cognitive injuries states that: “Addressing PTSD, depression, and TBI among those who deployed to Afghanistan and Iraq should be a national priority."[6] It goes on to say that “mental health and cognitive conditions are widespread; in a cohort of otherwise healthy, young individuals; they represent the primary type of morbidity or illness for this population in the coming years.”[7]

The report offers a number of specific recommendations designed to increase the cadre of providers who are trained and certified to deliver evidence-based care and to encourage active-duty members and veterans to seek needed care, including:

- Development of a certification process to document the qualifications of providers. Providers would also be required to demonstrate requisite knowledge of unique military culture, military employment, and issues relevant to veterans.[8]
- Expansion of existing training programs for psychiatrists, psychologists, social workers, marriage and family therapists, [educators] and other counselors. Programs should include training in specific therapies related to trauma and to military culture.[9]

While such a national certification does not yet exists, there are steps that civilian providers can take to make their practices more military friendly."

It starts with establishing a military friendly clinic, recognizing that our nation has a moral responsibility to ensure that all mobilized and returning servicemembers and their families have

effective, affordable and readily accessible behavioral health services. When we collaborate to deliver local services, we build stronger and essential communities who value and respect their mobilized and returning servicemembers and families.

Establishing a military friendly practice can best be achieved by first determining the military status and deployment history of your patients or their loved ones to see if it may be a contributing factor to the issues they present. It is followed up by some simple dos and don'ts:[10]

Do

- Thank them for their or their loved one's service.
- Listen non-judgmentally, with empathy and acceptance
- Learn about the symptoms the veteran is experiencing
- Ask them open-ended, general questions about their or their loved one's military service
- Be aware the veteran may be feeling shame and treat him or her with "respect, dignity, and privacy"
- Make sure they are aware of available services through the VA and others in their community.
- Offer to make a "warm handoff"
- Reinforce that they are doing the right thing by seeking help
- Be sensitive to concerns about impact of help-seeking on their career
- Be sensitive to the impact deployments have on family members (spouse, children, parents, siblings, significant others) and how the symptoms may manifest

Don't

- Assume the servicemember wants to leave the military

- Assume the servicemember is a male, or if the patient is male, that he is the servicemember
- Assume that just because the servicemember is a female, that she has not been exposed to the same horrors as her male counterparts
- Assume that that family members (spouse, children, parents, siblings, significant others) are not directly impacted by military deployments
- Try to "talk the talk." Nothing will discredit you more than a misuse of terminology
- Give your armchair general or political analysis of the war
- Press for details of a traumatic event, but be prepared to listen when they are offered
- Tell the servicemember they are "lucky" to have survived or that things could have been worse

Taking Action:

CSSP offers a model for training and outreach intended to increase access to local, culturally competent providers through its on-site/on-line courses and provider database www.warwithin.org. Developed in cooperation with the Department of Defense (DoD), the Department of Veterans Affairs (VA) and the North Carolina Area Health Education Centers (AHEC), these courses serve as a model that has seen nearly 8000 providers trained (with trained providers in all 50 states) and over 1700 providers enrolled in their provider database (with over 1200 in NC and 96% of NC counties).

Servicemembers are honor-bound to accomplish their mission by maintaining their physical and mental fitness. Free from the chilling cultural influence that discourages seeking treatment. The current military treatment facilities and VA facilities cannot handle the need for services requiring both servicemembers and their families to use civilian providers. It is

imperative that all health care providers fully understand the importance of military culture to effectively deal with this growing problem.

References:

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6 "Invisible Wounds of War Summary and Recommendations for Addressing Psychological and Cognitive Injuries" *RAND Center for Military Health Policy Research*, 2008 page 41

7 Ibid, page 36

8 Ibid, page 36

9 Ibid, page 37

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