Project Name: Joining Forces; Learning from Veterans over Lunch
Medical School: University at Buffalo Jacobs School of Medicine and Biomedical Sciences
Student Contact Information:
  Name: Alexandra Reis
  Email: aereis@buffalo.edu
OSR Representative Contact Information:
  Name: Alexandra Reis
  Email: aereis@buffalo.edu
Program Director/Faculty Sponsor Contact Information:
  Name: Dr. David A. Milling
  Email: dmillling@buffalo.edu

Program Description

Moderator:
Daniel Ryan, PhD, Director of Veteran Services Office at UB

Speakers:

Shauna Zorich, MD: ’05 graduate of the Jacobs School of Medicine and Biomedical Sciences
Dr. Zorich recently returned from service with the United States Air Force. She served as a Preventative Medicine Consultant for the United States Air Force School of Aerospace Medicine. She worked with the epidemiology consult service within the Department of Preventative Medicine and Public Health, where she led the Global Laboratory based Influenza Surveillance Program.

Matthias Williams, MS2, Jacobs School of Medicine and Biomedical Sciences
Matthias is a second year medical student and a member of the Army Reserve Unit originally stationed out of Fort Trotten in Queens, NY. He served as an XO (executive officer) for the first forward surgical team deployed to Afghanistan from April 2013 to January 2014.

Lisa Butler, PhD, Associate Professor, UB School of Social Work
Dr. Butler is an associate professor in the UB School of Social and Principle Investigator on Joining Forces – UB, a joint project between the schools of Social Work and Nursing. Joining Forces--- UB was developed to help train graduate social work and nursing students to work effectively with veterans and their families.

Susan Bruce, PhD, Associate Professor, UB School of Nursing
Dr. Bruce is a clinical associate professor in the School of Nursing, and one of her areas of research includes veterans and military families. Dr. Bruce is a co---PI on Joining Forces---UB, and she also co--leads an inter---professional seminar for nursing and social work students as part of the new Joining Forces –UB curricula.

On November 18th 2015, approximately 120 members of the Medical School, School of Social work and School of Nursing at UB joined in Butler Auditorium to hear from local veterans and researchers regarding the medical and psychosocial issues faced by veterans. Through this multidisciplinary panel discussion, we hoped to educate medical students so that we can better serve this important patient population as care providers in the future.
Dr. Zorich was our first speaker. She discussed how initially, she never considered the military as part of her career plan; she did not think that it was for her, or that it might be the right place to start her career. However, once she realized that she wanted to go into preventative medicine, she discovered that there were many opportunities within the Air Force for that line of work. Dr. Zorich ended up working for the office of the epidemiology consult service which is responsible for public health surveillance, food safety, military public health research and the Department of Defense Influenza Surveillance Program.

Dr. Zorich personally led the Influenza Surveillance Program, which took samples from patients with influenza and respiratory and acute respiratory type illnesses from over 90 sites across the globe. Using these samples, Dr. Zorich’s group tracked changes in the viral genome and shared this data with the CDC. Considering the fact that 180 million people in the United States receive the flu vaccine, Dr. Zorich found it very rewarding to be a part of a project that affected so many people.

Despite the many opportunities for leadership, Dr. Zorich emphasized that serving in the military does not come without its challenges. Mental health, depression and anxiety are all major issues, especially for female veterans. Up to one third of female veterans report having been involved in military sexual trauma------ the true number may be even higher as some service women do not report these incidences. Female veterans are also at higher risk for displaying other unhealthy behaviors such as smoking. The culture of the military and being a veteran may promote these behaviors and create a barrier to achieving health.

Finally, Dr. Zorich also noted that female veterans often go unrecognized for their service. She recounted a story of being invited to an event to recognize the service of veterans. When she took her baby with her to the event and tried to get on stage with the other veterans, she was told that the family area was in the back. She found this to be incredibly insulting. Disregard for the service and accomplishment of female veterans may contribute to mental health issues. The VA is currently exploring ways that it can try to improve the health of female veterans.

Matthias, a member of the Army Reserve spoke next. Initially, he was very apprehensive about being deployed to Afghanistan because he knew that there are a lot of changes that can potentially occur from pre--- to post---deployment. As a member of the first surgical team, he personally witnessed a lot of injury, death, and people in the process of dying. As a service member, it is imperative to learn how to deal with this.

Where Matthias was staying in Afghanistan, there was a family that used to provide information to the US troops and they had a ten---year---old son who was friendly with the American military. One day, he stepped on an IED and Matthias witnessed his death. Matthias noted that experiences like these leave an indelible impression and that when working with veterans as patients you must be aware that they may have seen things that are impossible for civilians to imagine. Often, It is hard for veterans to talk to people without a military background about these issues. For example, Matthias acknowledged that he could not talk about some of his experiences with his wife. While issues like these can potentially create a divide between a veteran and their family, veterans feel safest talking about these experiences with the people who were deployed and served with them.

Furthermore, Matthias emphasized that in the military there is a major mentality of “sucking it up.” He recalled that someone he was deployed with had a knee injury that was serious, but he brushed it off as minor in order to avoid being shipped away. When he finally returned home he discovered that he needed a total reconstructive surgery on his knee, which could have been avoided if he had initially acknowledged his pain when it first started.
As a veteran, Matthias knows that it can be very difficult to integrate back into society after being deployed. In the military, there is a different mental mindset. He discussed how it is possible to negatively react to things that are normal and a part of civilian life, and it can be really difficult to try to get back to how you were before deployment.

Matthias also dispelled the misconception of veterans receiving easy, free healthcare. He stated that his is really not the case; it is difficult and time consuming to navigate their health system and not every veteran is eligible. As future physicians he wants us to know that there is a hotline for veterans who may be having any mental health issues, and if we suspect a patient is having trouble to please connect them right away to someone who can help.

Next, Dr. Butler reminded us that not all veterans receive care at the VA hospital, and as care providers, we will be seeing a lot of veterans in private practice. She emphasized that we should always strive to remember to ask our patients if they have every served in the military. For some reason, it is a question that clinicians sometimes forget. It is extremely important to ask because their service could potentially have tremendous impacts on their presenting conditions and the response to treatment.

In her recent research “We don’t complain about the small things” results are reported from four focus groups that included military family members as well as female veterans. There are some important themes that emerged from these focus groups. The first is that respect for veteran’s personhood, including their history is very important, and this respect is conveyed when veterans are treated with compassion. Veterans in these focus group spoke about the VA system, and how they had some experiences that left them feeling disrespected and that their issues were being negated. One veteran specifically stated that as veterans they “do not complain about the small things” and that their issues should be taken seriously.

Some veterans felt that because they used the VA system, they were viewed as freeloaders. This eroded their trust in those treating them, and they were concerned about a lack of follow through in the system. They emphasized that what they really value is open and direct communication with their health care providers. They would like for their providers to have cultural competence and be aware of military culture and the general characteristics of military life.

Dr. Butler also discussed the findings of her other recent paper which was based off of focus groups with students who had placements at the VA hospital, but no specific training. The students spoke about the challenges of that placement.

Some of the difficulties they faced included a lack of military knowledge, which made it harder to build trust, rapport and an empathic connection. Students found that they had to supplement their knowledge with other materials and reading, and that they were not thoroughly prepared for their placements in advance. They had to learn to tolerate being uncomfortable, and being tenacious about getting answers to their questions.

Military veterans think that as health care providers we need more training in military culture, in specific medical issues, exposures, and how to meet the needs of the veteran’s family members.

Caring for a veteran is a multidisciplinary effort. Dr. Bruce acknowledged that much like other areas of medicine, to properly care for a veteran we will be on a team with nurses, social workers and other medical professional to ensure that are veterans receive proper care. She echoed the point made earlier by both Matthias and Dr. Butler that veteran’s families often have a difficult time and that they are a vulnerable population as well. As clinicians, it is important that we understand the needs of both veterans and their families.

Personally, Dr. Bruce grew up during a war. However, she realized that she only ever asked patients about their service if they had a “cool tattoo” or a hat that showing that they had served. However,
many patients will not have such obvious outward displays of their service. She realized that it is up to us as providers to put these things together.

As such, there is a course at UB that was developed to address the issues of veteran care. It is listed under social work, but medical students are welcome to take it as a 3 credit elective. It addresses military culture, mental health, social and physical aspects of being a veteran. Dr. Bruce would like us to remember to think about the patient that is sitting in front of us and what pieces we need when we put together their puzzle.

Questions were addressed at the end of this talk on a one on one basis because the discussion ran over on time.

Our discussion brought up some important points. As medical students we take part in preceptor and clerkships at the VA hospital without receiving specific training in military culture. We do not all learn how to take a proper history from a veteran. We also do not all understand the psychological impact of traumatic events many veterans have experienced— something that we must be aware of as providers. We learned that we will likely see many veterans outside of the VA hospital system, and as such we must always ask about military service. We learned that military service can be a traumatic experience not only for our veterans, but also for their families and we must keep their needs in mind as well. Going forward, we would like to see veteran care somehow integrated into our first and second year clinical practice of medicine courses.

This discussion also offered us the opportunity to hold an interdisciplinary event. Though we will work on teams throughout our careers, it is rare in our preclinical training to have the opportunity to speak with other medical professionals such as social work or nursing students about the care of specific patient populations. We hope that medical students will participate in the elective social work class regarding veteran care, and that in the future we can hold additional interdisciplinary events at the medical school.

We would like to thank the AAMC for supporting this event. Students who attended the discussion stated that they found it helpful and informative not only for our placements at the VA hospital, but also for learning how to care for all patients in general. This lunch reminded us to always be aware that there are patient populations with special needs.

Please see below for a copy of the press release written by the Communications Office of the Jacobs School of Medicine. Additionally, links to the press release on the UB website, and a local WBFO news story about the event with a sound clip are included below. University at Buffalo research that was discussed is also attached.
Media advisory: UB medical students reach out to veterans at Joining Forces event

Discussion features an alum who served in the U.S. Air Force, a former Army executive officer now a medical student, and UB research on barriers to veterans’ health care

BUFFALO, N.Y. — Veterans’ unique medical needs and ways that health care providers can better serve them is the topic of a lunch and panel discussion at noon on Nov. 18 in Butler Auditorium, 150 Farber Hall on the University at Buffalo South Campus. The event, which is free and open to UB students, faculty and staff, is being organized by students in the Jacobs School of Medicine and Biomedical Sciences at UB.

Media are invited. For on-site press arrangements, contact Alexandra Reis at 716-812-4871.

Reis and her UB colleagues received a grant to hold the event, one of 10 awarded nationally through the AAMC’s Joining Forces initiative. The initiative is part of Joining Forces, sponsored by the White House and launched in 2011 by First Lady Michelle Obama and Dr. Jill Biden.

Speakers at the UB event include:

- Matthias Williams, a second-year student in the Jacobs School of Medicine and Biomedical Sciences, who was an “XO,” (executive officer) for the First Forward Surgical Team deployed to Afghanistan from April 2013 to January 2014. Williams will discuss overseas service -- including trauma, loss and the immersive experience of deployment -- family issues, the veterans health care system and medical and psychological resources for veterans, including the suicide hotline.

- Shauna Zorich, MD, a 2005 graduate of the Jacobs School of Medicine and Biomedical Sciences, who has returned from service with the Department of Preventive Medicine and Public Health of the U.S. Air Force, where she led the Global, Laboratory-based, Influenza Surveillance Program. Zorich will discuss her career and her decision to join the military, even though it wasn’t part of her plan when she went to medical school. “I want the students
to know that joining the military is an option for them, and that they could potentially benefit from joining,” she says.

- Susan Bruce, PhD, clinical associate professor in the UB School of Nursing and Lisa Butler, PhD, associate professor in the UB School of Social Work, who will discuss their recent research: “On Working with Veterans: What Social Work and Nursing Students Need to Know.”

Reis, a Buffalo native, is personally interested in exposing her fellow medical students to the stories and experiences of veterans since many may not have had the opportunity to learn about them.

“Veterans do so much for our country, so it’s very important for us, as future care providers, to learn about them,” she said. UB medical students do preceptorships at the Veterans Affairs Western New York Healthcare System, she said, making knowledge about veterans’ medical needs all the more relevant.

Daniel Ryan, director, UB Off-Campus Student Services and Veteran Services, will moderate. The Jacobs School of Medicine and Biomedical Sciences is one of more than 100 medical schools around the country that have signed the AAMC’s Joining Forces pledge, recognizing the sacrifice and commitment of military service members, veterans, and their families, and committing to mobilizing their integrated missions in education, research, and clinical care to train the nation’s physicians to meet the health care needs of this community.

Founded in 1846, the Jacobs School of Medicine and Biomedical Sciences at the University at Buffalo is beginning a new chapter in its history with the largest medical education building under construction in the nation. The eight-story, 628,000-square-foot facility is scheduled to open in 2017. The new location puts superior medical education, clinical care and pioneering research in close proximity, anchoring Buffalo’s evolving comprehensive academic health center in a vibrant downtown setting. These new facilities will better enable the school to advance health and wellness across the life span for the people of New York and the world through research, clinical care and the education of tomorrow’s leaders in health care and biomedical sciences. The school’s faculty and residents provide care for the community’s diverse populations through strong clinical partnerships and the school’s practice plan, UBMD.
Links:
http://news.wbfo.org/post/ub---medical---students---discuss---care---veterans---war#stream/o
On Working with Veterans: What Social Work and Nursing Students Need to Know

The debt Tropical Medicine owes to the Military

A Military Second Opinion Mental Health Clinic
On Working with Veterans: What Social Work and Nursing Students Need to Know

Braden Linn1, Lisa Butler1, Susan Bruce1, Katie McClain-Meeder1, Mary Meeker2

Abstract

**Background:** Specialised care for veterans and military families is needed to respond to the unique health problems they experience. However, specific components of such training have yet to be examined.

**Purpose:** This investigation aimed to gather feedback from social work and nursing students on their experiences in a veteran-specific clinical placement to determine content for a new inter-professional training program at a large northeastern US university.

**Materials and Methods:** Two focus groups were conducted, one with master of social work students (n=8) and one with master’s level nursing students (n=4), all of whom had recent clinical placements in a veteran-specific site. A semi-structured interview guide was followed.

**Results:** Three broad categories of themes emerged from the data: challenges encountered (including challenges related to forming relationships with veterans and in working in the American Veterans Affairs healthcare system); strategies for responding to these challenges; and insights for training future clinicians.

**Conclusion:** Clinical training programs should consider including content that will both prepare students to work with veterans and military families and to face the challenges that exist in healthcare systems. Specialised training that includes military culture and problems specific to the population may help improve outcomes for veterans and military families.

**Keywords:** social work, nursing, education, veterans, health care

On Working with Veterans: What Social Work and Nursing Students Need to Know

The recent conflicts in Iraq and Afghanistan have prompted an elaboration of the issues facing service members and families throughout deployment, during reintegration, and following separation from military service.1,2 Several countries have committed to providing quality care to veterans and their families.3,4 Specialised training has been called for so that clinicians are able to respond to the health and mental health needs arising in the context of military service.5,6 Presumably such training would positively impact outcomes for veterans and for military families; however, the potential content of such specialised training has only just started to be examined. In a recent focus group investigation,6 veterans and military family members observed that to deliver appropriate care, healthcare providers need to achieve a nuanced military/veteran cultural competency and receive training in the specific health and mental health issues facing veterans and military families.

Most specialised training for social work (SW) and nursing (N) students occurs during an advanced year clinical placement. Such a placement might be in a Department of Veterans Affairs (VA) hospital, a setting that provides care to veterans in the United States. In fact, to accommodate projected increases in demand from OIF/OEF (Operation Iraqi Freedom/Operation Enduring Freedom) veterans,7 the VA recently announced plans to add 1900 clinicians.8 Students who receive training in the care of veterans and military families may prove to be a vital component in the effective care of veterans in the US and elsewhere.

In spite of the availability of VA care, only about 30% of eligible veterans seek care at VA clinics.9 The rest seek care in community-based settings, where there has been a recent push for inquiries about prior military service.10 Consequently, clinicians working in any healthcare setting are likely to encounter veterans and military family members during their tenure in the field and may benefit from specialised knowledge about how to best respond to this population, given that military service may cause or exacerbate presenting problems.11
The present investigation sought to gather information from healthcare professionals in training who had a previous clinical placement in a veteran-specific healthcare setting. Participants were asked about their placement experiences and their views on needed pre-placement training. This information was gathered to inform curriculum development and content for a new inter-professional training program in veteran and military family care for graduate SW and N students at a large northeastern US university.

Method
In May 2013, two focus groups were conducted with SW and N students who had completed a recent veteran-specific placement. This research was conducted as part of a larger study that included four additional focus groups (three with veterans and one with military family members) assembled to gather information about their experiences seeking health care and recommendations for training future professionals; these findings are reported elsewhere.6

Recruitment
The names of graduate SW and N students who had completed a veteran-specific placement were provided from their departments. Students were contacted via phone and/or email to determine their interest in participating. Screenings were conducted in person or over the telephone to ensure eligibility and collect demographic information. Students were eligible if they were over age 18, were a current or former SW or N student, and had completed the placement in the past three years.

Reminder calls and/or emails confirmed the date, time, and location of each focus group. Participants received a US$30 gift card and a gas card(s) to offset transportation costs. Study protocol was approved by our university’s Institutional Review Board.

Participants
The SW group (n=8) were recent master’s level SW graduates. Six were women and two were men; the median age was 31.5 years (range=23-47); 50% were Caucasian, 25% African American, and 25% indicated two races. Three participants were veterans. VA placements included: behavioural health (25%); Healthcare for Homeless Veterans program (25%); women’s clinic (12.5%); medical SW (12.5%); a geriatric/hospice/rehabilitative care unit (12.5%); and multiple units (12.5%).

The N group (n=4) were female and identified as Caucasian; the median age was 46 years (range=31-55). Two were current students and two were master’s level N graduates. Specialisations included: psychiatric mental health (50%); gerontology (25%); and anaesthesia (25%). Clinical rotations at the VA were consistent with each student’s specialisation. One participant was currently an Army Reservist.

Instrument
A semi-structured interview guide was developed to elicit feedback on participants’ placement experiences. Participants were informed that the investigators were seeking: “...to learn from you about how to better prepare social workers and nurses to meet the healthcare needs of veterans and their families.”

Among the issues queried were the student’s level of preparation for working in a veteran-specific setting, challenges encountered, whether knowledge of military culture would be important to work effectively with this population, and what should be taught prior to placement.

Procedures
Two separate groups were held, organised by discipline, to maximise utility for the programs being developed in the respective schools. Each 90-minute group was facilitated by a 2-3 person team. Group content, including assent, was audio-recorded. To protect participants from perceived risk associated with sharing their views, no facilitator had an academic or supervisory relationship with any participant.

Data analysis
Qualitative descriptive content analysis12 was used to analyse transcript data following transcription and verification. This method is appropriate when the phenomena under investigation are complex13 and have not been previously studied. One researcher (BKL) performed initial analyses. Codes were refined by soliciting feedback from research team members who had facilitated focus groups or were familiar with the transcripts.

Results
Three categories of themes emerged: challenges students encountered; responses to these challenges; and recommendations for future pre-placement training.

Challenges in Veteran-Specific Settings
The challenges that SW and N students described in their placements involved issues encountered working with veterans and military family members
and issues related to the VA healthcare system.

**Forming relationships with veterans and military family members.** Students from both disciplines noted difficulties in forming professional relationships with veterans, particularly building trust, rapport, and empathetic connection. One N student remarked, “...one challenge I noticed was building trust, having veterans trust me enough to ... open up in front of me.” Another N student affirmed this concern, “It takes a lot of work to build rapport with them.”

According to SW participants, clients were often concerned about whether their providers would be able to relate to or empathise with them. Many SW students noted that veterans often asked trainees if they were veterans themselves. Some students were, in fact, veterans and noted that it did not necessarily facilitate rapport. One student explained, “I'm a veteran; not a combat veteran...some of them didn't think I was able really to quite relate to their experiences.”

A parallel process took place with military family members: they were reticent to trust someone who did not have first-hand experience. One SW student noted:

> I think my biggest challenge—and sometimes it was the veterans, but... sometimes even more so with the family—was: “how do you know?” Because I’m not a veteran. I'm not married to a veteran. I sometimes had a challenge of breaking through, “how can you be the one counselling us when you really haven't been in our shoes at all?”

Another SW student explained, “military families would become emotional or angry at us because we don’t understand what’s going on.”

The second group of challenges that students noted were imposed by the procedures or policies of the VA healthcare system. These challenges frustrated students because they were seen as a threat to providing quality care.

**Inadequate time allocation.** Several SW students explained that the time they were given to perform their duties was insufficient. One student remarked:

> ...we had to do a full assessment in 15 minutes and figure out what kind of services that veteran needed in a short amount of time. and then actually had to write a [progress] note. For me that was a challenge because you can't possibly assess anybody in 15 minutes and give them a diagnosis...

They also commented on the challenge of completing clinical documentation within 24 hours of client contact, per VA policy.

**Limited medication options.** N students did not comment on time limitations, however they did voice concerns about apparent medication limitations. One explained, “There were some medications that were not allowed at all, that if you were under any other health plan, they would have been covered.” Another, who specialised in anaesthesia, remarked, “...in anaesthesia there was always kind of a shortage of [propofol]...That’s a drug we use day in and day out.” N students seemed bewildered by some of the differences between the VA system and other healthcare systems.

**Rules that limit veterans’ eligibility for services.** Several students noted that the VA system imposes eligibility restrictions. One SW student explained,

> I would say one of the biggest challenges I had was, you have to have an honourable discharge to be able to receive services. Some of the veterans... didn't have an honourable discharge, but they were some of the neediest people. A lot of drug and alcohol and mental health needs. It was hard just having to turn them away...and trying to refer them to other services.

**Rules that limited hiring students after graduation.** N students also expressed frustration with some of the VA’s policies, in particular the requirement of at least one year of post-degree experience before they will be considered for VA employment. Although N students expressed a desire to work for the VA, one student explained that it was unlikely that she would seek employment there:

> I've got to tell you that where I'm at right now, I probably won't change after a year of experience; I won't try to apply. Whereas if I had been allowed to [apply] right out of school, I definitely would have. I'm kind of sad about that.

As a consequence, highly talented N staff may not seek employment at the VA. SW students did not report a similar limitation.

**Compartmentalised training.** Students from both groups also noted that they felt isolated due to the way the VA is structured, and thereby missed opportunities to experience the full array of people and health concerns in the veteran population. For example, one N participant explained, “I didn't get a
lot of exposure to female primary care there. I had very few patients that were women.”

Responses to Challenges

Although participants were not expressly asked to discuss how they adapted to the demands of their placements, a number of strategies were spontaneously described, suggesting that the VA is unique among healthcare systems and future students would benefit from knowing how to respond to common challenges.

Using supervision and informal consultation. Students are not expected to know everything upon entering the placement, however it is important for students to be aware of the limits of their own knowledge. One SW student explained, using his own military service as an analogue, “…you have to be assertive, and you have to be honest. The one thing about being in the military is that if you don’t know something, you’d better say you don’t know it.”

Students from both disciplines valued developing knowledge and used supervision as a means to close information gaps. One N student commented:

…don’t be afraid to ask questions. Ask the questions and ask for explanations of things, because so many times when it gets super busy or the [preceptor] is just trying to get from one patient to the next and get through the day, you’re wondering about stuff and you don’t get enough of a chance to talk about it and find out why they did something or why they said something.

A SW student elaborated, “I had a wonderful preceptor… [she] would make time almost every shift to sit down with me…I would write things down during the day to ask her at the end of the day.”

Consultation with other staff was another way SW students had their questions answered in the moment and without waiting for scheduled supervision. As one SW student explained, “If I had problems and [my preceptor] wasn’t around, I made connections with other social workers… and we would just talk with them.” Another added:

[The] connections that you make [with other clinicians are useful] so that if you do run into a problem and you can’t get in touch with your preceptor, [then] you know someone else who might be aware or knowledgeable about that situation.

A SW participant affirmed that staff seemed open to students seeking impromptu consultation, “It’s a city. It really is. It’s a huge city and the staff responds very well to people that are asking questions.”

Use supplemental readings. Although all students reported using supervision to great benefit, it appeared that N students were less likely to use informal consultation. Instead, they reported turning to articles or other resources to supplement their knowledge. Reading materials were either supplied by a preceptor or independently located.

Learn as you go. Students also stressed that to adjust to the challenges one had to be prepared to both learn and adapt on the job. One SW student noted that this was akin to her own military experience:

In the Air Force, we called it ‘on the job training.’ It’s basically learn as you go and create what we call ‘standard operating procedure,’ but you create your own based on your notes and your experiences. You create your own little guide so that should something similar come up again, then you’ll better know how to respond.

Learn to tolerate discomfort/be tenacious. Students from both disciplines also explained how they had to learn to tolerate the discomfort that accompanies being a novice in a demanding setting. As one SW student related.

My preceptor said, ‘get comfortable with the discomfort.’ …I just remember feeling so unconfident, like I didn’t know what I was walking in to… You’re set with a situation and you just do something and you learn from it… Did I know that going in? No, but do I think it made me a better social worker? Absolutely.

Another student, commenting on being transparent and genuine as a strategy to overcome difficulties in forming professional relationships with patients, advised:

If you show your passion, that you want to work with them too, and that you’re willing to … listen to them, they respond very well to that. Instead of just kind of sitting there … not knowing what they’re talking about. They pick up on that instantly. So just having a will to listen to them and let them know: “I may not have been through what you’ve been through, but I really want to sit here and listen to what you have to say.”
Students also explained the importance of tenacity. This sentiment often emerged in response to the challenges they encountered and to the steep learning curve required in a placement where missteps are inevitable. One student advised, "If you’re not willing to get bumped and bruised in the process, to jump in, to ask questions, to be ready to get dirty a little bit, this might not be the placement for you."

**Recommendations for Pre-Placement Education**

Students from both disciplines provided recommendations concerning what they thought should be taught (or taught more comprehensively) prior to the start of a placement.

**Military culture.** Many students in both groups reported that it would have been useful to have training in military culture before starting their placements. One SW student observed, “There needs to be a class on military culture not only to explain the basics, the acronyms, but also...the functions of the different branches...that would help the students be prepared... and not feel so timid.” Another added, “Because it’s a kind of culture all its own and they all have this bonding thing,” referring to the camaraderie and cohesion that develops among service members. A N student, who was also a military officer, added, “I was shocked at everything that soldiers have to do... the boot camp they go through... the sacrifices they make... I think it would be good to learn more about it.” Of note, students observed that pre-placement training in military culture might accelerate the development of rapport with veterans.

**Issues specific to veterans.** Students also reported that it would have been helpful to be better grounded in the literature and clinical practice concerning the psychological issues that afflict veterans. N students recommended deepening their knowledge of PTSD, including co-morbidities, and how it may interact with other treatments, like anaesthesia. One N student remarked: “In the classroom, they need to go over a little bit more about PTSD...it was mentioned but not a lot was explained.”

Additionally, students voiced their desires to know more about how specific issues manifest in the veteran population, such as how the effects of grief, loss, and psychopathology are experienced. One SW student suggested, “Adding a grief and loss component... [and] teaching students to understand...[that] it may not just be PTSD, it could be loss of a lifestyle, loss of a limb...things like that.”

**Discussion**

In this study, graduate SW and N students were asked to share the challenges they had encountered during clinical placements with veterans and military families and insights for training future students. This information was sought to inform curriculum development, joint course content, and an interdisciplinary seminar for two new programs to train N and SW students to work with veterans and military families. Qualitative content analysis identified three categories of themes: challenges students encountered; responses to these challenges; and insights for training future students.

Both groups of students commented on the challenge of building trusting relationships with veterans. Veteran and family concerns about whether students without personal military experience can understand or be empathetic was a common barrier to establishing this relationship. Students also reported vexing issues with the VA system itself. SW students were frustrated by the limited time afforded to perform assessments and process required forms. N students were frustrated by the unavailability of some medications, possibly due to the integrated formulary, which required them to identify alternatives. N students were particularly aggrieved that the VA would allow them to train at their facilities but deny them consideration for immediate employment following graduation. The rationale eluded students given the VA’s recent commitment to increase mental health staff. Students may be better prepared to navigate these challenges if they are apprised of them in pre-placement training.

Challenges that students encountered were often attenuated by the working relationship between the clinical preceptor and the student. SW students were supported by virtue of having access to both their preceptors and other clinical staff. N students did not identify consulting with their preceptor as a solution to the challenges they encountered; off-site reading also filled knowledge gaps. It should be noted that N students came from different training programs and preceptors’ approaches may differ among these specialties. Students from both disciplines acknowledged that clinical placement with veterans requires that students meet challenges head-on to provide quality care.

Students in both groups concurred that military culture should be included in pre-placement graduate curricula. They suggested that an understanding of the background, experiences, and basic needs of this population would facilitate the patient/provider relationship. These findings echo sentiments of veterans and military family members who, in a recent report, indicated that practitioners in training should receive instruction in military/veteran culture, veteran-specific health and mental health issues, empowering and supporting veterans,
and addressing needs of military families. Future research should establish if increased clinician knowledge in this domain is associated with changes in patient satisfaction and quality of care.

Although students were not queried about their experiences with inter-professional care, several reports, including one from the US government, have called for the expansion of such care as an optimal way to respond to the unique concerns of veterans and military families. Results from this study can inform the content of clinical training programs, especially when combined with other studies highlighting learning outcomes associated with veteran clinical placements that have an inter-professional component. Complementary pre-placement classroom learning, including training related to interdisciplinary care, may optimise outcomes and should be investigated.

Strengths of the present study include its timely focus on veterans and their families, its focus on the training needs of two central healthcare professions with international counterparts, and the potential of its findings to enhance the education of future practitioners. However, several limitations should be noted. The small sample size, especially of the N student group, requires that results be interpreted with caution. Moreover, because of N student subspecialties, each experience may be more unique to the individual and not representative of the cohort. Students were also recruited from SW and N training programs in one northeastern US university, and placements had been at one VA; consequently, the gaps in training and challenges in the placement setting may be specific to the US, the student’s school, and/or the placement.

As the results of this study suggest, students who aspire to work with veterans and military families should expect challenges related to establishing rapport and the constraints imposed by contexts in which care is delivered. Focussed pre-placement education, supervision, and on-the-job training should attenuate these and other challenges students encounter. Specialised training may be one important step towards improving outcomes and realising the international commitment to provide quality care for veterans and military families.

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Authors’ affiliations: 1University at Buffalo, School of Social Work, Buffalo, NY 14214 USA, 2 University at Buffalo, School of Nursing, Buffalo, NY 14214 USA.

Corresponding author: Braden K. Linn. email: bradlinn@buffalo.edu

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“We Don’t Complain About Little Things”: Views of Veterans and Military Family Members on Health Care Gaps and Needs

Lisa D. Butler, Braden K. Linn, Mary Ann Meeker, Katie McClain-Meeder & Thomas H. Nochajski

University at Buffalo, Buffalo, New York

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"We Don’t Complain About Little Things": Views of Veterans and Military Family Members on Health Care Gaps and Needs

Lisa D. Butler, Braden K. Linn, Mary Ann Meeker, Katie McClain-Meeder, and Thomas H. Nochajski

University at Buffalo, Buffalo, New York

This qualitative investigation examined the views of veterans and military family members on the needs and gaps they perceive in health and mental health care provision. Four focus groups (N = 33) were conducted (two with male veterans, one with female veterans, and one with military family members). Ten themes emerged regarding highly valued and unsatisfactory aspects of care received from providers and health care systems; four topic areas for training providers were also identified. Findings suggest it is critical that health care providers and systems master the military/veteran cultural competence necessary to work effectively with veterans and military family members.

Keywords: Veterans, military families, health care, VA, military/veteran cultural competence

With U.S. Armed Forces’ involvement in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) over the past decade, there has been a resurgence in research (e.g., U.S. Government Accountability Office [GAO], 2011; Institute of Medicine [IOM], 2013; Tanielian & Jaycox, 2008) and media coverage concerning the challenges that veterans and military families face during reintegration, particularly with respect to receiving health care. Indeed, veterans of all eras, including female veterans, are increasingly seeking health and mental health care (Department of Veterans Affairs [VA], 2014a, n.d.; GAO, 2011). Although the preponderance of veterans seeking mental health care from the VA served in eras prior to OEF/OIF/OND, with Vietnam era veterans representing the largest subgroup (GAO, 2011; VA, 2014b), the proportion of OEF/OIF veterans increased from 4% to 12% between fiscal years 2006 and 2010 (GAO, 2011). To address these increasing demands, former Secretary of Veterans Affairs Eric Shinseki (VA, 2012) announced that the VA would add 1,600 mental health clinicians, including nurses, social workers, psychologists, and psychiatrists, and 300 support staff to its existing mental health workforce.

However, only 7.2 million of the more than 22 million living U.S. veterans sought health care (of any type) from the VA over the five-year period from fiscal years 2006 to 2010 (GAO, 2011), suggesting that many veterans seek their care in the community. Indeed, the National Survey of Veterans (VA, 2010) found that fewer than one in three veterans reported using VA health care services at any point. These factors underscore the need for specialized training for all health care providers who work with veterans and their families, regardless of setting, and additional research to inform that instruction.

Previous investigations have focused on barriers to veterans accessing care through the VA, in particular a lack of awareness of benefits and how to obtain them, affordability, convenience, transportation/distance, the potential impact on a service member’s military career (for those who want to continue serving), and concerns about the VA’s reputation as not providing the best care (GAO, 2011; Randall,
announcements were aimed at veterans generally (or female veterans specifically, or family members of veterans) and asked them if they would consider participating in a study and sharing their experiences accessing health care services. Recruitment was also conducted in person at a local community organization serving veterans, and key community veteran stakeholders helped identify and recruit other potential family participants. Due to VA restrictions, recruitment was not conducted at any VA settings. All potential participants were screened either in person or over the phone to determine eligibility and collect demographic information. Veterans were eligible if they were at least 18 years old and had served at least one deployment overseas. Military family members were eligible if they were at least 18 years old and had an immediate (or close) family member who had served at least one deployment overseas.

Eligible participants were invited to participate and provided reminder calls and/or e-mails to confirm the date, time, and location of their focus group. Participants each received a $30 gift card and a gas card(s) or bus tokens to offset transportation costs. The study protocol was approved by our university’s institutional review board prior to the commencement of recruitment efforts.

Participants

A total of 33 people participated in the veteran and military family focus groups. An additional three male and two female veterans and one family member were screened but found to be ineligible or could not be scheduled. Originally, the two male veteran groups were intended to comprise different eras of service (one made up of OEF/OIF/OND veterans; the other, veterans from earlier eras), but due to scheduling issues the groups were mixed in era.

Sixteen men and seven women (n = 23) participated in the three veteran focus groups. Their median age was 50 (range = 24 to 80), with 57% Caucasian, 39% African American, and 4% indicating “other.” One (4%) participant indicated Hispanic ethnicity. Branches of service included Army (48%), Army National Guard (9%), Marine Corps (17%), Navy (22%), and Air Force (4%). The majority (74%) had experienced only one deployment, with 22% deployed twice, and 4% deployed three or more times. The largest group had served in OIF/OEF/OND (n = 11), but service in peacetime (n = 6), Gulf War I (n = 4), Vietnam (n = 2), and Korea (n = 1) were also represented; one veteran had served in two eras.

Eight females (80%) and two males (20%) participated in the military family focus group (n = 10), and the sample was Caucasian and African American in equal numbers. Seven participants were spouses or partners of a veteran. (In one case, the veteran spouse had never been deployed overseas but had significant service-related health issues.) Among the spouses/partners, two had other immediate family relationships with veterans/service members; in one

2012; Washington, Bean-Mayberry, Riopelle, & Yano, 2011). Feelings of embarrassment, pride, not wanting to be seen as weak or as a freeloader, and stigma may also impede efforts to seek services (Randall, 2012). However, less research has been done to examine the views of veterans and military family members on features that characterize desirable or unsatisfactory health care experiences in any setting.

More than a decade ago, patient-centeredness, defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions” (IOM, 2001, p. 6), was identified by the IOM as a key aim for enhancing health care quality in the United States. More recently, the VA committed to transform its system to improve the timeliness of care delivery and make it more veteran centered (VA, 2009), and its efforts have been lauded as a model of patient-centered care (Kuehn, 2012). Despite these goals and improvements, the VA has endured significant criticism of late regarding backlogged benefit processing times (Kennedy, 2014), malpractice claims (Greene, 2014), and lengthy wait times for appointments (and falsified records thereof; Wagner, 2014). Moreover, a recent national study (Hepner et al., 2014) of patient perceptions of behavioral health care services at the VA found that, although overall responses were favorable, there was considerable room for improvement across all domains assessed.

The primary aim of this investigation was to gather information from veteran and military family members regarding their experiences seeking health care (in any setting) to inform curriculum development and content for a new interprofessional training program in veteran and military family care for social work and nursing students at a large Northeastern university.

METHOD

We conducted six focus groups (N = 45) over three weeks in May 2013: two composed of male veterans (n = 9, n = 7), one of female veterans (n = 7), and one of military family members (n = 10); two additional focus groups were conducted with social work and nursing students who had worked in veteran-specific clinical placements (the student group findings will be reported elsewhere).

Recruitment

Veteran and military family member participants were recruited via convenience sampling in our community. Flyers were posted and/or mailed to more than 20 local veteran-specific community or service organizations (including American Legion and Veterans of Foreign Wars posts), and announcements were made at community meetings and trainings specific to veterans. The flyers and
case, as the parent of two veterans; in the other case, as both a child and a sibling. Of the remaining three participants, one was a sibling of a veteran, one was both a sibling and a child of veterans, and one had a service member cousin with whom she was very close. Of these 16 immediate family (or very close) veterans, 6% had never deployed overseas, 37.5% had deployed once, 19% had deployed twice, and 19% had deployed three or more times; in the remaining three cases (19%) the respondent was unsure or did not answer. Branches of service included Army (12.5%), Army National Guard (12.5%), Army Reserve (6%), Marine Corps (12.5%), Navy (12.5%), Navy Reserve (6%), and Air Force (19%); in three cases (19%) the family member was not sure or did not answer. Eight (50%) of the immediate family members had served in OIF/OEF/OND, but service in Vietnam, World War II, Korea, and peacetime were also represented. Half of the sample also reported additional veterans/service members among their extended families (range = 1 to 6), including grandparents, uncles, cousins, and in-laws. One male and one female in the family group spontaneously disclosed that they were veterans themselves.

Instrument

A semistructured interview guide was developed to elicit feedback on the health and mental health care experiences of veterans and their perceptions of needs and gaps in care in both veteran-specific locations and community/general practice settings. Questions related to gender were added to the female veteran interview guide. In each group, participants were informed that the investigators were “interested in learning about your health care experiences—both the good ones and the ones that fell short of your needs or expectations.” Participants were also queried about advice they might share with a fellow veteran (or family member) about obtaining health care, as well as what training social workers and nurses should receive to be more effective in working with this population.

Procedures

Each group lasted approximately 90 minutes and began with an overview and explanation of the purpose of the study. The groups were audio-recorded, and verbal assent for the recording was provided by all participants. Resource sheets, including information about local mental health providers and veteran-specific services, were provided to all participants. Each focus group was facilitated by two research team members, at least one of whom was a veteran (or military family member in the family group). Gender-specific facilitators were used for the male and female veterans groups. An additional team member served as notetaker in each group. The groups were held on different evenings in a private conference room at a local veteran-serving organization.

Data Analysis

Qualitative descriptive content analysis (Sandelowski, 2000) was used to analyze data, following transcription and verification. This method of analysis is appropriate when there has been little previous work in an area and the phenomena under investigation are complex (Elo & Kyngäs, 2008). Two researchers (BKL and MAM), working independently, conducted line-by-line coding to identify important concepts in the data. Related codes were grouped into categories that contributed to answering the research questions. The two researchers then met to compare findings and assess code congruence. Differences were resolved through discussion and by returning to the transcripts. This analytic strategy encouraged a shared, cross-disciplinary (nursing and social work) consensus understanding of the categories being developed. Following the development of an initial set of categories and supporting quotes, we presented findings to other research team members who had been present for the focus groups or had read the transcripts. Categories were further refined and characterized based on feedback from research team members and additional close readings of the transcripts.

RESULTS

A total of 10 themes describing veteran perceptions and experiences were identified (see Table 1 for all themes): four related to highly valued and unsatisfactory interactions with providers and six related to health care systems. Although participants were asked to discuss their health care experiences in the both the VA system and other private health care settings, participants spoke almost exclusively about their experiences within the VA system (although not necessarily the local VA). Four additional themes related to suggestions for training future practitioners.

Provider-Level Themes for Veterans and Military Family Members

A number of aspects of face-to-face interactions with individual providers were important to participants and seemed to contribute appreciably to their perception of the quality of the health care they had received. The four themes identified at this level captured elements of the practitioners’ professional approach to the veteran.

The importance of respect for personhood. Focus group members universally wanted care that was characterized by respect for personhood—specifically the belief that veterans were deserving of care that recognized them as...
Individuals with a unique (military) identity, life history, and experience, and worthy of respect no matter who they were or how successfully they had managed their lives thus far. Participants indicated that respect was manifested by those providers—nurses, physicians, social workers, or others—who treated their patients with compassion, listened to their concerns, and appeared competent and interested in helping them recover. One female veteran noted, “One doctor . . . was amazing. . . . I talked to him once, and he listened and he provided feedback like he was absorbing what I was saying and validating it. He was just great.”

Negation or minimization of concerns. Some interactions, however, left participants feeling that they were not listened to or that providers viewed their concerns as unimportant or unfounded. One male veteran reported:

I tore my rotator cuff in the Marine Corps, and when I went to do the disability claim, I ended up saying, “Forget it.” I went down to the doctor; they scanned my arm and looked at it. They said, “You have scar tissue. We don’t think you tore it . . . it’s not a tear. Drink some water.” And they prescribed me Motrin.

Similarly, the experience of not feeling listened to by providers also applied to choices about or the need for treatment. For example, one female veteran remarked, “I’ve told them that acupuncture helps more than anything else, but they just want to throw drugs at me.”

At the least, these interactions felt disrespectful. In some cases, though, veterans felt that they were seen as malingerers or freeloaders who were wasting the providers’ time. Such invalidating health care interactions were quite common, and they are concerning because they can erode trust in both the providers and the system.

One female veteran captured the essence of this issue of respect by noting, “They don’t get that when we say there’s something wrong, we’re serious; we don’t complain about little things.” Her sentiment further suggests that these responses may feel particularly inappropriate and unfair given the military ethos to be strong and stoical, and that providers, particularly those working in the VA system, should know that.

Lack of follow-through. Still other participants expressed frustration with providers for a lack of follow-through and knowledge about how the VA system works. One veteran remarked:

[Y]ou have to have a paper script to get your pain meds renewed, and [the physician] forgets to fill out the script. So then she’s gone; . . . for, like, four weeks. . . . They kept telling me, “She didn’t write your paper script. We can’t do anything about it without a paper script.”

This apparently accidental oversight left the participant in needless pain and feeling frustrated and angry.

The value of open information sharing. This theme emerged consistently across groups, and it suggests that direct, instructive communication from practitioners is highly valued. One male veteran said, “Tell me the truth, and tell me what you’re going to do. Tell me how we’re going to work this out. Then I know what to expect, because I have the information and I can process that.”

However, at times, participants perceived that providers had little interest in engaging with them to help them understand their condition. One male veteran described the following interaction with a provider that left him feeling both frustrated and frightened:

I had some tests run. The results came back; I come in to hear the results and she just glazed over the test. I wasn’t satisfied. I said, “Listen, you really need to give me a more in-depth explanation.” So she glazed over them again.

System-Level Themes for Veterans and Military Family Members

Group participants also noted a number of features of the healthcare system that they either appreciated or found to be of concern. In this sample, most of these experiences where described in the context of a VA system, however some appear to be applicable to healthcare settings in general.

The value of accessible and sustained care. Several participants described how much they appreciated quick access to VA treatment services when the need arose. One veteran remarked:

Within ten days from walking in the first time, I was in [a VA hospital] getting help for my PTSD [posttraumatic stress disorder]. Within two months after I started individual therapy, my counselor had me connected with another service office and started a PTSD claim.
Participants also valued the ongoing care and aftercare provided by the VA. For some this involved receiving follow-up phone calls and being allowed to stay longer in the hospital when needed. One female veteran recounted:

The care I was given while I was at the VA was phenomen- nal . . . The staff was just excellent as far as caring and following up on me. Even after I had been released, the follow-up calls that I got were phenomenal.

Another male veteran described VA procedures with similar enthusiasm:

They bring you in; they take care of the problem. If you’re not ready to go home, then you stay; or if you are ready to go home and you’re not physically healed enough or they haven’t quite figured out everything that’s wrong, they’re not letting you go. They’re going to request that you stay until they do get the problem taken care of.

Yet in addition to these highly positive experiences at the VA, several group members noted some problematic features, including a system that is overburdened, inflexible, and difficult to navigate, concerns about records management, and assumptions that devalue servicewomen.

An overburdened system. From the perspective of veterans, large caseloads make providers too busy to spend enough time with their patients. One veteran remarked: “She was just so focused on just getting me in and getting me out, which I understand . . . but she doesn’t really know me, and I was trying to tell her certain things that would better help her help me.” Family members affirmed the perception that the VA is overburdened. One explained:

So there are people who may be suicidal, who may have TBIs [traumatic brain injuries], or comorbid disorders, who aren’t able to get services because the doors are full, the beds are full, the social workers are full. Everyone is full, so where do they go?

An unresponsive and inflexible system. Participants also reported that VA procedures and rules can make it slow to respond and rigid. Several observed that it can take three months for a change in provider to be honored and that long wait times for specialty care are not unusual. One female veteran remarked, “If you find that you can’t make an appointment for even a really good reason, too bad. Now you have to wait for the next month; they won’t reschedule you.” Although participants acknowledged that this policy is in place to prevent wasting resources, it seemed to frustrate participants who viewed themselves as genuinely invested in their own recovery.

Frustrations were also voiced about the requirement that the origin of a health condition must have demonstrably occurred during service. One family member explained: “That stuff makes me so mad, and it all comes down to what you can prove happened during your service.” The same participant went on to say:

This [health problem] didn’t happen until this year, so none of that stuff is documented in his Reserve medical records in [the] two years he was home. Because of that, it’s going to be hell to try to get him covered under the system.

Family members also expressed similar dissatisfaction with the regulation that a veteran must sign up for care within five years of separating from the service.

Difficulties in navigating the system. Some participants described challenges in determining the kind of care they needed and how to access it. One veteran remarked, “If you don’t have that roadmap in front of you, you’re screwed.” Another summarized his feelings following his attempts to access care: “Where I’ve ended up through the whole process for the last three years is just being confused, not knowing what’s going on, not having nobody else to talk to.”

In response to frustrations with the VA health care system, some veterans developed workarounds to achieve their objectives. Some veterans described increasing the effort and/or skill they applied to get their needs met within the system. Others spoke about the value of formal advocacy services (although not all were aware of the existence of such helpers). Alternatively, some veterans chose to supplement the services of the VA health care system, in some cases by paying privately for care outside the system, and others maintained a “shadow chart” and advised others to maintain their own copies of all documents. Unfortunately, some veterans responded to their frustrations by opting out of the VA or any health care system. One male veteran remarked, “I have personally given up on the VA . . . . I just try to self-medicate myself. If I’m sick, I take care of myself.” Another reflected on his unmet needs for guidance: “I was just a young kid, really confused, didn’t know where to go . . . . They really didn’t point me in the right direction. I’m like, ‘Screw this.’”

Poor records management. Participants also reported that medical record keeping at the VA is problematic. Many participants reported errors in their records or that records had been lost. One veteran remarked:

I’m not saying once in a while. I’m saying every single [expletive] time they will lose your file . . . . I had mine mailed from Kansas straight to [a particular VA] to the records room, and they lost it. So make sure you have your own copy of your entire file, and when you give it to them, give them a copy of your copy. Do not let go of your copy.

Participants particularly emphasized the importance of monitoring their medical records for accuracy and comprehensiveness. As one female veteran commented, “They’ll say one thing while they’re sitting there talking to you, but
what’s being put in your records is something totally different.” This issue is of critical concern, because the extant medical record dictates the care and services that will be provided. Some family members were also frustrated with the lack of integration between military service and VA record keeping.

**Assumptions that devalue female veterans.** An important theme raised by female veterans was their perception that the VA system is not particularly welcoming to them and that their contributions felt devalued because they were women. Several indicated that providers (and administrative staff) assumed that they were wives of veterans rather than veterans themselves. These women reported that they expected their service and contributions to be recognized.

Female veterans also reported that some providers assume that their presenting concern is related to military sexual trauma (MST), notwithstanding their other health care needs. One female veteran remarked, “MST needs to be addressed definitely, because it’s rampant in the military, but that’s not the only thing that we’re concerned about.” A female family member participant, who was also a veteran, explained: “I go to the VA and want the medical services. I want medical services for other things, other than the military sexual trauma.”

**Training Needs Identified by Veterans and Military Family Members**

In many cases, veterans and military family members translated their needs and concerns into concrete recommendations for the training of health professionals and students. Participants identified four general areas in which they believed practitioner training would be particularly helpful: military culture, veteran-specific health problems, strategies to empower and support veterans, and the needs of military families. Many of these recommendations echo and even amplify the sentiments raised in previous sections.

**Understanding military culture.** Participants in every focus group emphasized that the military constitutes a unique subculture and that awareness of and sensitivity to that culture was nonnegotiable in becoming an effective care provider. One family member described how essential it is that students and health care professionals know how to engage veterans: “Vets are a whole different population within themselves. If you say the wrong thing... you can... forget it. They will not be back; they will just walk out.” In addition, practitioners need to learn basic elements of the culture, including roles, ranks, and terminology within the military. As one male veteran commented, “They need to learn to speak our language.”

Another family member explained that training in military culture is important not only to understanding and helping veterans but also to understanding the families of service members. She said, “They need to understand military culture, and that validation... is the validation for those spouses who are left behind.” Similarly, understanding the impact of the deployment cycle, and of multiple deployments, on “not just the soldier but every member of the family” is essential. In many ways, military/veteran cultural competence appeared to be directly linked by participants to conveying respect for the veteran’s personhood.

**Veteran-specific medical and psychological issues.** Both veterans and family members also suggested that students be trained thoroughly in the problems that occur commonly in veterans, including health problems caused by Agent Orange or chemicals used in day-to-day activities, TBI, PTSD, substance use, depression, and comorbidities.

One essential capacity is recognizing and providing care related to trauma. Traumatic experiences are inherent in military service, yet without comprehensive training the psychological fallout of such events may be misunderstood and misattributed. One family member observed, “Those boys who try to cover up all that PTSD... use substances to cover up those feelings.” One veteran also remarked, “How many of your symptoms of PTSD does everyone else look at and say, ‘He’s just an asshole?’”

Participants also advised that providers cultivate attitudes of respect, empathy, and trust toward veteran clients, and interact with them skillfully, with positive regard, and with a willingness to listen. Indeed, one male veteran acknowledged that basic clinical skills training is important because those seeking care are not always at their best:

Sensitivity is big, but I think coupled with the sensitivity is the ability to deal with difficult clients... A lot of the times in the VA system, people aren’t prepared to deal with you. Whatever the difficulty... knowing how to deescalate the situation, we need that [from providers].

**Empowerment and support.** Health care providers are ideally positioned to help veterans both through enabling their constructive efforts and by providing instrumental support. One participant emphasized the importance of providers’ capacity to facilitate empowerment for their veteran clients and families by challenging themselves:

How are we giving them [veterans] the tangible tools that they can take to empower themselves to take care of themselves? How are we teaching them how to take care of themselves and deal with [the fact that] now they’re a different self?

In addition, given the complexity of the VA health care system, participants felt that professionals should learn to support and assist veterans and their family members in navigating that system and avoiding potential barriers to care. One female veteran saw the need for people that can step in and help patients to access services more efficiently and work through the system, not the
frustration. It’s bad enough that you’re going through any type of medical issues in itself, and then add to that the red tape that you might have to go through on top of it.

Participants who had used a designated advocate found that to be very helpful. One male veteran commented: “Out of luck I found an advocate; I didn’t even know what an advocate was.”

Needs of families. Almost completely missing from the broad system of care for service members and veterans, as reported by family members, was any recognition of the needs of family members related to deployment. Members of this group spoke eloquently about the needs of family for counseling that anticipated the challenges during this period. They described how deployment irrevocably changes the person who experiences it, even if the damage is invisible, and how completely unprepared family members felt. As voiced by the wife of a veteran:

These guys and these women that are coming back from the war zone, they walk out your door—and I can vouch for this—they walk out that door and you never see that person again. I don’t care if they come home with all their limbs; you will never see that individual again. That’s always true.

Family members felt that counseling was needed to prepare family members for all stages of deployment, including the challenges that may be involved in the service member’s return. They wanted help, for example, in preparing children and understanding their needs, and to deal with their own diverse and difficult emotional responses, including feelings of guilt and powerlessness. Family members described a culture of silence among service members about what they had felt and experienced during deployment, leaving the family member feeling helpless to understand and offer support. As one wife of a veteran told us, “My brother-in-law who went into Baghdad, what he saw and what he had to do, he doesn’t even talk about it,” not even to his brother, who was also in the military.

Participants in the family member group felt generally isolated and unsupported, reporting that within their communities and employment settings there was little understanding of the challenges of having a spouse or child deployed. They wished the military would create a “network of support.” As voiced by one wife, “Having that support is huge. That’s a really critical piece.” Family members wanted guidance and skills to manage their own distress as well as to learn to be an effective advocate for the returning soldier related to getting his or her health care needs met.

DISCUSSION

In this study, veterans and military family members were asked to share their perceptions of health care provision and the subject matter that should be included in health care provider training. Qualitative content analysis identified a number of positive and negative responses related to interactions with providers and with the health care system. Although we queried participants about their experiences across health care settings, discussions within the focus groups repeatedly narrowed to reports of experiences within the VA.

Veterans and military family members greatly appreciated providers who were attentive. However, they also reported some problematic interactions characterized by what they perceived as a lack of respect for the veteran’s personhood, negation or minimization of concerns, and challenges in follow-through and clear communication. Taken together, these themes indicate a need for developing military/veteran cultural competency among providers so that interactions may be more respectful and responsive to veterans’ healthcare needs.

Cultural competency, in general, refers to mastery of knowledge, skills, and related resources pertaining to the needs of individuals, families, and communities within their cultural context (Lum, 2005); it also includes an understanding of the cultural relativity of behavior and beliefs and an awareness of one’s own values, prejudices, and beliefs and how they may impede understanding (Winkelman, 2005). At a minimum, military/veteran cultural competence could include education about the general characteristics of military life (such as branches, ranks, terminology, and military culture). However, our findings would suggest that, for those who deliver services to veterans and their families, other essential elements of military/veteran cultural competence would include knowledge of the values and ideals to which members of the Armed Forces subscribe and their implications for reintegration, postservice adjustment, and health care utilization; an understanding of the stressors that military life places on individuals, families, and communities; monitoring clients for problems that may be specific to military populations; and acknowledgment of and respect for the discipline and sacrifice required of those who have served and of their families. In many ways, military/veteran cultural competence appeared to be linked by participants to the communication of respect for the veteran’s personhood and service. In addition, one may wonder whether compassion fatigue (Bride & Figley, 2009) among providers may contribute to inattentive or insensitive interactions.

A number of veterans were highly favorable about the accessible, ongoing care they had received from the VA, yet some voiced frustrations with other aspects of the health care system. These sentiments were captured in themes related to system burden, slowness and inflexibility, navigability, and problematic record keeping. Female veterans also reported experiences at the VA which seemed to convey that their service was not valued or respected (because they were women; see also Mattocks et al., 2011), and an
overemphasis among clinicians on MST, in some cases to the exclusion of other health issues. Given the VA’s increasing efforts to become more veteran centered (VA, 2009; Kuehn, 2012), and to focus on women veterans as one of its top three strategic initiatives (Hayes & Krauthamer, 2009, as cited in Washington et al., 2011), these reports are of concern.

Although the essence of many of these themes could be characteristic of any health care setting, there seemed to be a specific emphasis in the observations of group members that the VA, in particular, should be better. The root of some of these sentiments may be an implicit assumption (which may be held by some veterans and families) that, given that the VA’s explicit mission is to serve veterans, its care should be organized and implemented with the rigor and responsiveness of military systems of care. When that delivery falls short, veterans may be disappointed, confused, and frustrated, or even perceive it as disrespectful. According to a trauma-informed perspective (Harris & Fallot, 2001; Butler, Critelli, & Rinfrette, 2011), such experiences may be additionally upsetting for those with combat or MST histories if the interactions recapitulate some aspects of traumatic victimization, such as feelings of vulnerability, helplessness, and betrayal. Training providers to deliver care in a manner congruent with military values may address some of the reported sentiments.

Focus group participants also offered suggestions for improving the training of care providers. These included instruction in military/veteran culture, veteran-specific health and mental health issues, empowering and supporting veterans, and addressing the needs of military families. Although a number of the issues facing military families over the deployment cycle have been receiving increased attention by researchers (e.g., IOM, 2013; Sheppard, Malatras, & Israel, 2010; Ursano, Gabbay, & Fullerton, 2014), there appears to be a lag in translation to practice. This may be related to the recent observation that inquiring about military service is still the “unasked question” in (non-VA) clinical settings (Brown, 2012); the equivalent inquiry for family members is rarer still. Not knowing about military family status, particularly when a family member is deployed or a recently returned veteran, means that research findings will not be employed to contextualize presenting issues or inform interventions.

Several study limitations may affect the generalizability of findings. Participants were drawn from a medium-sized city in a northeastern state and recruited primarily through word-of-mouth and snowball (convenience) sampling, although we did strive to include veterans from many branches and eras of service. Given the modest sample size, findings should be interpreted and generalized with caution. In addition, many participants spoke about their experiences at VA hospitals, rather than in a range of settings, and this also limits generalizability, particularly because only a minority of veterans access VA health care services (GAO, 2011; VA, 2010). Furthermore, the present report captures only the views of consumers (veterans and military family members) but not those of providers. Focus groups comprising clinicians could shed valuable light on their perceptions of the challenges and barriers they have encountered in their efforts to deliver care to veterans and their families. Indeed, as one reviewer suggested, it would be interesting to compare the perspectives of professionals working in community-based settings with those from VA settings. Our focus groups were also conducted during a particular time period, one in which providers (including the VA) are endeavoring to adapt to changing demands, including the adjustments required to address the large influx of new veterans and of specific groups, such as female veterans or those with distinct medical needs (e.g., TBI, amputations). Some participant reports, therefore, may emphasize the issues particular to this period of transition. In addition, because more than half of the veterans in the present sample had served in earlier eras, some of their concerns and recommendations may originate in health care experiences prior to recent efforts to make service provision more veteran sensitive (VA, 2009).

Nonetheless, we believe that the findings of the present study have contemporary relevance, because they capture current perceptions of veterans and family members—perceptions that may affect future utilization. These findings also have utility in informing provider training programs and identifying additional areas for improvement in health care systems. In particular, mastery of military/veteran cultural competence among providers—a competence that involves heightened sensitivity to the experiences, perceptions, and expectations of veterans, in addition to instruction in the basic elements of the military culture—may go some distance toward making the provision of care more respectful and responsive to veterans’ and military families’ health care needs.

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**REFERENCES**


