Understanding Cultural Humility Through the Lens of a Military Culture

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Abstract: The author's background for over the past 20 years has been working with the military veteran population and active duty military members in the Veterans Administration (VA). Her practice has comprised many components of VA health care, including medical and behavioral health. Regardless of which facet of care her practice has led her to, one element has always been the driving focus for her to convey to those who do not primarily work with veterans—the understanding and recognition of veterans and military members as a separate cultural identity. This narrative seeks to create a space for exploration and understanding of the differences between civilian cultures and military cultures by utilizing a cultural humility framework. The author's overall aim is to inform and recognize military cultural differences through the lens of a shared, collectivistic, and militaristic cultural enmeshment, thus increasing present cultural competency and linguistic knowledge beyond categorical denotations and moving toward continued cultural learning and true expression that lead to deeper implications. Providers' perceptions of their own cultural humility play a vital role in understanding and treating military members. It is in the understanding of military structure, language, commitment to their unit, service to their country, and how military members embrace honor and service, that true cultural humility begins to form (Tschaepe, 2018). The author believes it is vital that the military populations are recognized not only for their specialized services in protecting their country, but also for their unique and distinct culture that comprises the United States military community.

***Keywords*:** military culture, cultural humility, civilian culture, cultural identity

My background for over the past 20 years has been working with our military veteran population and active duty military members in the Veterans Administration (VA). My practice has comprised many components of VA health care, including medical and behavioral health. Regardless of which facet of care my practice has led me to, one element has always been the driving focus for me to convey to those who do not primarily work with veterans the understanding and recognition of veterans and military members as a separate cultural identity.

Early in my career, I found the military philosophy to be markedly separate and distinct from its civilian counterpart and comprised of multiple factors and values that define how military members live their lives as part of the United States military (Cunha & Curran, 2013). Military values define how military members live their lives and include both written and unwritten principles (Cunha & Curran, 2013). These principles include concepts such as unit cohesion through the success of the unit, the desire to never break trust among fellow members, the promise to never leave a man on the battlefield (this extends to all walks of life, such as never leaving your buddy at a bar), and control over emotions (Cunha & Curran, 2013). I was faced with the tenacity of military protocol, which promotes strong character, morale, and welfare of the military unit. This tenacity transcends military language through the use of terminology that

protects the military member's psyche, but to those outside of this military culture, language can easily be taken out of context (Cunha & Curran, 2013). From my experiences, I found there needs to be a narrative that utilizes a cultural humility framework to create a space for exploration and understanding of the differences between civilian cultures and military cultures. My overall aim is to inform and recognize military cultural differences through the lens of a shared, collectivistic, and militaristic cultural enmeshment, thus increasing present cultural competency and linguistic knowledge beyond categorical denotations and moving toward continued cultural learning and true expression that lead to deeper implications.

A brief understanding of VA medical and health care policies from which the VA operates is critical to understanding military populations and receipt of health care services. I quickly learned the military community is much different from civilian communities regarding how they provide care for discharged military personnel harmed either physically or mentally while fulfilling active duty requirements. When military personnel transition from active duty to inactive duty, members may become eligible for benefits that civilian populations may not necessarily understand, which can inadvertently create areas of marginalization. In his discussion of a strengths-based approach to health care, Saleebey (2002) indicated that "it is becoming increasingly clear that emotions have a profound effect on wellness and health" (p. 15).

Disability ratings and service connections are two terms that help define the medical and behavioral health care that military members and veterans are given throughout their mission and upon mission completion (Budahn, 2011). Service connection is a rating that determines the percentage of monies or services given to the veteran, which is evaluated by and based on the veteran's disability or health impairments (Budahn, 2011). Service connection is a classification rating system in which compensation and benefits are determined. Each tier and class bring with them the definition and types of services and needs for which veterans will be eligible and treated within the VA health care system (Budahn, 2011). A Class IV rating is considered one of the highest eligibility and reimbursed categories a veteran can receive from injuries and disabilities incurred through service to the United States (Budahn, 2011).

Any physical or mental complications incurred while the soldier was serving a military tour potentiates the need for a disability rating. Disability allotments to the discharged veteran can occur through a monthly compensation check and can be as minimum as 0% service connection (health care eligibility but no monthly check) to 100% service connection, which can pay a disabled veteran a monthly tax-free salary (Budahn, 2011). Along with a monthly income, veterans become eligible for medical care and prescriptions with zero co-pays, eye exams, dental benefits (for some), and housing reimbursements for handicap accessibility, along with many other eligibilities (Budahn, 2011).

I was proud to be a part of the Veterans Health Administration (VHA), one of the largest integrated health care systems that serves over nine million veterans enrolled in their system (U.S. Department of Veterans Affairs, n.d.). However, not all military populations are treated at VHA facilities (U.S. Department of Veterans Affairs, n.d.). For many health care providers who, like me, are civilians without any prior experience with military service members, immersion in

this culture adds a layer of complexity in a population very different from a civilian population (Goff, Crow, Reisbig, & Hamilton, 2007). Military populations comprise approximately seven percent of the total population, with close to 93 percent of the military population being part of a multigenerational military family (Atuel & Castro, 2018). Although there is recognition and appreciation for the job military members perform, I find there is a gap between civilian populations and military populations, which creates a lack of cultural awareness about military members as a distinct minority and culture (Atuel & Castro, 2018). For example, when active duty military members or veterans seek any type of health care service, the military member will test the trustworthiness of the provider (Atuel & Castro, 2018). Service members will ask questions relating to trust through questions such as, "Have you served?" or "Are you a veteran?" (Atuel & Castro, 2018, p. 75). Cultural humility within the military health care field recognizes power imbalances and the need for reflection (Foronda et al., 2018). If I, as a health care provider, am not culturally aware of military culture, the dialogue of understanding disintegrates, ending any possibility of a therapeutic alignment with the member (Tschaepe, 2018).

Military culture can be defined as an active process of constructing shared meaning and is represented through shared ideas, beliefs, attitudes, teamwork, trust, uniformity, anonymity, and an environment that acknowledges that the unit's goals are always placed ahead of an individual member's goals (Foronda et al., 2018). My experience found that the military culture and collectivistic framework was entrenched in each member as part of a cohesive whole. Within military communities, military life provides a structured lifestyle through rules, guidelines, and expectations that frame members' adherence to core values determined via the branch of service (Cunha & Curran, 2013). In comparison, my civilian culture is more individualistic with codes of conduct set by Western standards. Cunha & Curran (2013) describe the differences between civilian and military cultures using a job frame of reference. In military communities, a military member's job becomes their identity among their peers, their units, and their military branch—it is who they are. In civilian cultures, jobs are what people do to earn money and are not necessarily attached to their identity. Missions within military cultures in comparison to civilian cultures come with expectations of high performance and dependency on the unit for survival, and any absence from your job could endanger your unit's safety or have far deeper implications (Blazer, 2007; Koenig, 2007; Peteet, 2007).

With my behavioral health background, and from working with the returning veterans, I see military members often viewing society differently upon returning home. This view can manifest and create personal conflict for the veteran as well as his or her family, friends, and caregivers. I find behavioral health providers, as well as medical providers, need to be aware of these views by using cultural humility to benefit both the military members and their families. Cultural competency/awareness are terms that are frequently used in the health care field and encompass definitions that include concepts such as minority group knowledge and self-awareness of our own attitudes and feelings (Foronda et al., 2018).

Cultural humility is a lifelong immersion in a bi-directional commitment to self-reflection and self-critique focused on the process of mutually re-addressing and re-defining imbalances of power dynamics when interacting cross-culturally (Foronda et al., 2018). American culture

constructs fit this definition through a popular cultural lens that binds masses of diverse people in an amalgamated identity—viewing conglomerates of people through a lens of similar customs, beliefs, and social norms (McAdams, 2014). However, it is erroneous to amalgamate military service members and veterans into the construct of American culture (McAdams, 2014). I can attest that the attention to cultural awareness and diversity without the inclusion of cultural humility when working with military personnel brings into question common understandings of social constructs and clinical terminology used in civilian populations and the relatability of that terminology to military personnel (Hinojosa & Hinojosa, 2011; Oztürk, Bozkurt, Durmus, Deveci, & Sengezer, 2006).

In a military cultural setting, military personnel reflect the social constructs and governing bodies that define and make up a militaristic hierarchy and the creed of a Warriors Ethos (Hinojosa & Hinojosa, 2011; Oztürk et al., 2006). Lack of military cultural knowledge can lead to viewing variables about military culture as superordinate, leading to interpretation of cultural-, racial-, or ethnic-group variances as minority-group deficits or majority-group strengths independent of embedded social, organizational, and pedagogical processes which negate the institutional context and function of cultural and historical circumstance (Brannan, Esler, & Anders Strindberg, 2001; Merlan, 2005). I find that the lack of military cultural humility and awareness creates areas of miscommunication when using common terminology to describe behavioral characteristics of military members, affecting understanding for both the military member and the provider with the potential to miss critical or necessary information (Goff et al., 2007; Hoge, Auchterlonie, & Milliken, 2006; Knox, 2017).

Examining a cultural humility framework within military populations extends understanding of culture when compared to cultural competence. Cultural humility incorporates a lifelong commitment to self-evaluation and critical reflection of our knowledge and to recognizing power imbalances (Foronda et al., 2018). Cultural humility commits to continual learning in a world that has power imbalances (Foronda et al., 2018). For example, from my experience working with veterans, the sustained presence of American military personnel over the past decade in Iraq and Afghanistan has created an atmosphere of persistent high risk, increased potential for mental health challenges, and increased exposure to missed communication encounters due to not understanding military culture (Currie, Day, & Kelloway, 2011).

In some ways, modern war can be considered a condition of captivity, as military service members describe their experiences of active duty as being *always on* and the recognition that they are not free to quit and return home (Adler, Huffman, Bliese, & Castro, 2005; Hutchinson & Banks-Williams, 2006; Reeves, Parker, & Konkle-Parker, 2005). Their mission requires a continued presence of military personnel in Iraq and Afghanistan, which is a 24-hour continuous danger zone with no front line that separates troops from the enemy (Hoge et al., 2006). Warfare tactics have shifted and become more ambiguous and intangible. Blurred boundaries between war and safety make it impossible to separate innocent civilians and enemies (Hoge et al., 2006). These blurred boundaries shift the conventional way of conceptualizing war from the perspective of the location of the enemy or targets in a latitudinal and longitudinal perspective, but this shift doesn't always equate and match with how the provider views war (Ettlinger & Bosco, 2004). Loss of a clear demarcated front line, terrorist networks, and the expansion of the war challenge

military perceptions of sense of place and sense of time during military missions, thus increasing reliance and adherence to strict military protocols within military culture (Currie et al., 2011; Ettlinger & Bosco, 2004). Military culture and training design protect military members from, mitigate, and lessen the effects of war by fostering interdependence, teamwork, a greater bond, and greater trust with fellow military members (King, King, Gudanowski, & Vreven, 1995). By using a cultural humility framework in recognizing this culture, I am constantly aware of an ever-evolving and ever-changing lens through which I provide care.

I have learned that military culture, when viewed through its own cultural humility lens, can assist in the greater understanding of primary factors, many of which are based in military experience that aids practitioners in having real conversations with military members (Helmer et al., 2007; Resnik, Gray, & Borgia, 2011). Military philosophy differs from civilian philosophy in relation to how service members make decisions, whether in combat or not; how they overcome adversity and challenges; and how they conduct themselves (Cunha & Curran, 2013). What must not be forgotten when working toward a cultural humility framework in understanding military populations—one that I continually strive for—is the notion that behaviors, attitudes, emotions, and actions of military personnel all serve within a symbiotic relationship to protect military units (Hoge & Castro, 2012). We as practitioners and civilian providers must recognize our responsibility and therapeutic obligation to meet military members where they are within their military culture.

Unit cohesion, considered necessary for survival during military conflicts, is a cultural element not frequently embedded in a civilian provider when considering military members' challenges (Hinojosa & Hinojosa, 2011). Traumatic events and circumstances experienced by military units serve to bind and tie military service members together (Hinojosa & Hinojosa, 2011). These bonds created among fellow military members and units are defined by military members as surrogate families; these cultural bonds develop during war or adversity and can increase transitional stress on a military member's reintegration process into civilian life (Chappelle & Lumley, 2006; Figley, 2005; Hoge, Terhakopian, Castro, Messer, & Engel, 2007; Solomon & Mikulincer, 2006; Taft, Schumm, Panuzio, & Proctor, 2008). I have come to learn and understand that at discharge from being an active military member, demobilization serves as a prelude to a break-up of the military member's family, ultimately ending the camaraderie and intimacy of shared war experiences (Atuel & Castro, 2018; Hinojosa & Hinojosa, 2011).

I continually examine militaristic phenomena through a cultural humility framework, which includes associating culture within military structure development and involves the exploration of many domains (such as ethnicity, occupation, gender role, spirituality, and social and peer negotiations) through the lens of military collective processes of individual and group categorization and re-categorization of group membership (Oyserman, Coon, & Kemmelmeier, 2002). Military members' cultural identity process begins with their military branch, rank, job title, and duty. Race, ethnicity, or other parameters traditionally used to separate and define civilian populations are not at the core of a military troop and unit (Oyserman et al., 2002). Understanding military culture and the therapeutic processes when working within this culture when military cultural humility has not been taken into consideration can compromise services and impede the therapeutic relationship (Bowling & Sherman, 2008; Goff et al., 2007). For

example, when I work with military members, it is important to understand military organizational structure and hierarchies of power (Hoge & Castro, 2012). Military culture in comparison to civilian cultures lies within power structures according to rank and job title (Hoge & Castro, 2012). Military members follow a hierarchy of authority with the military command recognized as the decision makers. In military culture, the commanding officer of the service member stays involved in their lives on and off duty (Cunha & Curran, 2013). Medication choices, treatment choices, and intervention modalities must be cleared and understood through the member's chain of command. Military members are never off duty. They can be called to action at a moment's notice with the expectation of continual mission readiness (Atuel & Castro, 2018). It is imperative that I always recognize the cultural organizational frame in which the military member functions. Without military cultural awareness, I can unknowingly create areas of misperception when using common civilian terminology to describe behavioral characteristics, such as mission readiness, and I could jeopardize the military member's ability to serve if treatment modalities do not follow military protocols (Goff et al., 2007; Hoge et al., 2006; Knox, Conwell, & Caine, 2004). This misperception in terminology can potentiate critical outcomes, especially if mission readiness is viewed as less important by the provider (Goff et al., 2007; Knox et al., 2004; Spelman, Hunt, Seal, & Burgo-Black, 2012).

Mission readiness is a military cultural norm that continuously ties service members to a military identity, thus usurping other cultural constructs, such as race, religion, or gender (Bowling & Sherman, 2008). Conformity to the military structure and an organizational cultural group, plus a military identity embedded within the military organizational culture and a military chain of command, are the cultural cornerstones for military members (Atuel & Castro, 2018).

My practice of including military culture and the multidimensional aspects of formal and informal processes must include a cultural humility framework for conceptualization when working with military members (Fugas, Meliá, & Silva, 2011; Hard, Recchia, & Tversky, 2011; Hoge et al., 2006; Miller, 1999; Tschaepe, 2018). Health care providers consider normative behavior and the understanding of social norms as one of the critical aspects in the navigation of the social world (Hard et al., 2011). The construct identified and used in measuring the social world and acceptable behavior is termed social norms (Fugas et al., 2011). In a civilian world, popular culture creates the social norm. In military culture, the mental and physical health of a military member is dependent on group and normative factors of cultural safety (military social norms) (Hoge et al., 2006; Tschaepe, 2018). These factors are defined within the military context and, thus, represent a set of descriptive and injunctive values that follow military cultural norms (Fugas et al., 2011; Hoge et al., 2006). Military protective instincts designed to mitigate danger flow through a continuum of diminishing and intensifying reactions to perceived threats as the military member transitions into a civilian culture; they are not cognizant of everyday factors considered normal in a civilian world but present real threats to a military member's perception (King et al., 1995).

As an example, an active duty military member is gearing up for his fourth deployment. He comes in to see his mental health care provider or physician before meeting up with his unit and with his wife. Immediately, the health care provider starts to notice behaviors that are both subtle and elusive. The health care provider observes the simple everyday process of the military

member choosing a chair. The military member enters the examination room, immediately surveys his surroundings, and checks for exits from the room and the position of all the furniture. The significance of this illustration is paramount; the military member chooses the chair facing the door closest to the exit (Carlsten & Hunt, 2007). When the health care provider questions the military member as to why he chose that chair, he responds that it was because he could observe the door (Carlsten & Hunt, 2007). In military culture and from within a cultural humility framework, choice of chair is a protective process brought about by survival mechanisms ingrained while in a military culture (Carlsten & Hunt, 2007; Hutcheson & Adams, 2007). Conceptualization of chair choice as a protective instinct in the civilian world is irrelevant. In a military environment, failure to recognize potential threats may endanger one's life and the life of one's unit (Carlsten & Hunt, 2007; Hoge et al., 2006; Hutcheson & Adams, 2007).

Additionally, utilizing a cultural humility framework and a military cultural understanding allows the provider and the member's spouse to understand the connection of driving a vehicle in terms of a survival mechanism that is instilled during military training. I have found that in counseling military members and their partners, bringing them to a mutual understanding of how each other feels and reacts in situations such as driving a vehicle can bring greater healing within the relationship. Improvised Explosive Devices (IED) are another example of something that can trigger culturally ingrained protective instincts—and the perceived and real threat they bring to troops' lives—and this must be recognized through a cultural humility framework (Hoge et al., 2006). My example briefly illuminates the need for recognizing and defining hypervigilance through the act of driving a vehicle. A military member is driving down the street with his spouse and family. Suddenly, without warning, he is driving down the center of the road at the top speed. His spouse, who is sitting beside him, does not understand the moment and what is happening and perceives the moment from a different perspective—a civilian one. The military member's spouse immediately becomes anxious and shouts and pleads for him to pull over or slow the vehicle and go back into their lane. Her fear is coming from the perspective of an accident. The military member's fear is coming from the perspective of fear as well, but his fear is due to hypervigilance and a triggered experienced while driving. When the provider questions the service member regarding this incident, the service member reports seeing a white plastic bag float across the road (any item that appears in the visual driving field can become a life or death moment) (Atuel & Castro, 2018; Hoge et al., 2006; Hoge et al., 2007). The very mechanism that keeps the military member and his unit safe during a war is the same one that, in a civilian world, can put the military member and his family in danger.

Empowerment and recognition of power imbalances are more likely to occur when utilizing a cultural humility framework. The provider's perceptions and processing of their own cultural humility play a vital role in understanding and treating military members. True cultural humility begins to form only when the practitioner understands the following: military structure and language, service members' commitment to their unit and service to their country, and how military members embrace honor and service (Tschaepe, 2018). I believe it is vital that we recognize military populations not only for their specialized services in protecting our country, but also for the unique and distinct culture that comprises the United States military community. It is in the recognition and centralization of a cultural humility framework when working with military cultures that a positive cultural understanding can begin.

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