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Veteran Evolution: What Makes a Veteran

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Abstract

American Veterans currently represent a poorly understood, underrepresented segment of the population. While cultural competence is critical to the practices of psychotherapy and clinical research (Cameron, 2023), numerous divergent strategies for defining Veteran investigational cohorts can be found, at times including participants that are still actively serving or their dependents (Delgado et al., 2021). Simultaneously, our Veterans have been shown to be at a greater risk for a range of biopsychosocial challenges than normed civilians (Grossbard et al., 2013). This study sought to identify the culturally preferred strategy of self-identification of US Veterans. It has been hypothesized that the preferred self-identification of Veterans is "Veteran" while the Service Members identify with the branch of service. 325 participants were selected at random from an archival dataset of 655 respondents who were asked their preferred method of self-identification. The study population was inclusive of 94 Service Members and 231 Veterans. The responses indicate that membership in both Service Member and Veteran groups is exclusive, with 100% of Veterans preferring to identify as a Veteran and 100% of Service Members identifying with the branch of service.

Keywords

Veteran, Military, Culture, PTSD, VA

1. Introduction

Both fiction and popular media from diverse cultures at varying points throughout history are rich with references that the individual who left for military service is not the same one that eventually returned. Current scientific literature reflects the prevalence of biopsychosocial disparities between Veterans and their civilian counterparts in the United States (Crytzer, 2019; Gobin et al., 2018; Soberay et al., 2018; Thomas et al., 2017; Trivedi et al., 2015), lending support to this assertion. The processes of change experienced by an individual as they progress from civilian to active duty, and then to Veteran status have not

been well described or modeled, and even the definition of a Veteran appears as inconsistent in the literature, with investigational groups defined by a participation in Veterans Administration (VA) healthcare system (Tran et al., 2016), deployment history (Myers et al., 2019), exposure to combat (Steenkamp et al., 2011). Cheney et al. (2018) identified a concern of being misunderstood or pathologized as one of the prominent barriers that prevent Veterans from accessing VA resources, reinforcing the argument that the lack of a consensus approach may be contributing to be challenges experienced by this population. The aim of this quantitative investigation is to elucidate the preferred Veteran cultural self-identity and to identify the relationship between Military (active duty) and Veteran cultures.

In the United States, conscription ended in 1973 and while many of today's Veterans volunteered to serve, some were not given a choice. It also seems important to recognize that the population of the mainland US has not experienced a foreign invasion since 1846, at least in part due to the strength of the national Armed Forces. Arguably, the social promise of resources and services to ameliorate the consequences of acculturation, struggles, injuries, and sacrifices of the warriors have not been fulfilled by the civilian communities that continue to enjoy the security provided by the Military, with returning warriors facing disproportionate barriers to education, employment, physical and mental wellness, and stigmatization. Not only is this situation representative of a grave social injustice, it can also be interpreted as mismanagement of finite public funds, with the Fiscal Year 2022 VA budget reported at $269.9 billion (The White House, 2021). The human cost of often educated, trained, capable, high-achieving, individuals suffering with no known resolution, however, is far more severe and tragic

When compared to their normed civilian counterparts, Veterans have been shown to be at a greater risk of suicidality (Jamieson et al., 2020b), problematic substance use (Hunsaker & Bush, 2018), pathological gambling (Levy & Tracy, 2018), and a range of psychological and medical diagnoses despite the presence of protective factors (Grossbard et al., 2013). Additionally, Veterans have also been reported as struggling in academic (Norman et al., 2015) and vocational (Brown & Bruce, 2016) settings. No consensus currently exists as to the causes of these disparities, and the research attempts to investigate this phenomenon have utilized different definitions as to what constitutes Veteran status or identity. Consequently, Veterans have been shown to underutilize the services available, including VA services, intended specifically for this population (Brown & Bruce, 2016; Cheney et al., 2018). While cultural competency in behavioral health setting is advised (Tanielian et al., 2014), varying definitions of what constitutes a Veteran are utilized, at times overlapping with those describing active-duty members (Delgado et al., 2021; Elnitsky et al., 2017; Kip et al., 2015).

Statement of the Problem

Less than 10% of the US population currently serve, or have ever served, in the Armed Forces, down from approximately 20% in 1980 (Schaeffer, 2021). The

concerns regarding, and the experiences of, Veterans not being understood by the civilian clinicians tasked with their care and lacking the contextual appreciation of their experiences are well-documented (Cheney et al., 2018; Randles & Finnegan, 2021). This study has identified 3 distinct investigational cohorts and two working definitions for term "Veteran" which may be contributing to the clinical misunderstandings between the providers and the consumers. It seems impossible to address the disparities of outcomes experienced by this population without defining what it means to be a Veteran. Further, given the impact of culturally sensitive provision of healthcare services to the outcomes, the culturally preferred self-identify of this community needs to be understood.

The purpose of the study was to elucidate the preferred cultural self-identification of the Veteran population through a quantitative analysis of unprocessed responses to a community survey. Further, the study sought to differentiate between Military and Veteran cultures with the ultimate goal of identifying potential pathways of improving the quality of biopsychosocial outcomes of the Veteran population in behavioral health settings.

2. Review of Related Literature

Approximately 18 million Americans are Veterans (US Census Bureau, 2020) and some have participated in historical events as diverse as World War II, Cold War, Korean War, Viet Nam War, NATO interventions, conflicts in Iraq and Afghanistan, and the War on Terror. Consequently, these individuals vary in age from 18 to over 100 (Schaeffer, 2021). Further, the Veteran community includes individuals representing varying genders, races, ethnicities, religions, sexual orientations and identities, and socioeconomic classes. Some of these individuals participated or witnessed combat, while others did not. The challenges of adequately modeling such a diverse population in research cannot be understated.

Simultaneously, the problems of poor modeling and heterogenous investigational grouping may be contributing to the challenges experienced by Veterans and the biopsychosocial discrepancies between Veterans and their civilian peers reported in the literature. Significant efforts to incorporate cultural sensitivity have been invested in the formulation of the current iteration of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in the recognition that divergent cultural norms and expressions of distress can impact and influence diagnostic formulation (Bredström, 2019), further highlighting the importance of the recognition of cultural norms to prevent misdiagnosing. Further, ineffective research modeling has been shown to contribute to generalized hierarchies, relationship types, and attributes of the populations studied (Rosenthal et al., 2020). The intent of this literature review is to present the current approaches to the thematic grouping of Veterans during research endeavors, discuss the potential shortcomings that can present from the current strategies of reporting Veteran issues/concerns, and explore the potential for the current modeling to result in the biopsychosocial inequities experienced by the Veterans as compared to their civilian peers.

2.1. Grouping by the Participation with VA

With VA Healthcare system functioning to serve US Veterans, a significant source of research findings has been published modeling Veterans as those who participate in VA services. This section will focus on the discussion of research articles that report on Veteran healthcare and therapeutic outcomes in which the investigational Veteran cohort was defined by the involvement of the participants based on their engagement with the VA Healthcare system.

An investigation of archival VA Healthcare data from April 2010 through March 2011 lead to the analysis of 4,461,208 clinical cases (Trivedi et al., 2015). The investigators concluded that US Veterans exhibit a greater prevalence of mental health disorders and co-occurrence of disorders as compared to published population norms. The authors acknowledged that the utilization of the ICD-9, as opposed to the DSM diagnostic system may have led to a reduced sensitivity in diagnosing behavioral health conditions and that both the chronicity and the severity of the psychiatric diagnoses could not be established in the course of the investigation. Two potential sources of error can be seen in the interpretation of the data from this study. Most significantly as it relates to this research, only 5.9% of Veterans have been shown to rely solely on VA Healthcare, with the majority, instead, having either private or Center for Medicare/Medicaid Services (CMS) insurance coverage and access to care to civilian healthcare systems (Weissman et al., 2019). Further, the individuals that have served in the Armed Forces and received a less-than-honorable discharge may not be eligible for VA benefits despite meeting the Griffith et al. (2020) definition of Veteran status. It can be argued, therefore, that the investigational cohort utilized is not representative of the Veteran population at large.

The second potential source of error is evident in the lack of precision in the discussion of behavioral health diagnoses. Terms like "depression" and "anxiety" are used without delineating whether they describe symptomology/presentation or a defined disorder, and no effort can be seen to differentiate between problematic substance use as a symptom/consequence of a mental health condition or a co-occurring substance use disorder. Given the known association between stress, mental health concerns, difficulties in family systems and increased substance use (Caravaca-Sánchez et al., 2021), a risk of over-representation of the prevalence of mental health disorders and dual diagnoses in the Veteran population cannot be ruled out. Simultaneously, however, it seems important to note that the Veterans that died between 04/2010 and 03/2011 were excluded from the study without evidence of screening as to whether the death was caused by natural causes, medical conditions, accidents, or suicides, which risks underrepresenting the biopsychosocial challenges experienced by this population.

The Million Veteran Program is a research effort initiated in 2009 with a goal of better understanding the relationship between genomics and pathogenesis with 397,104 Veterans participating (Gaziano et al., 2016). To be included into the study an individual had to receive some of their healthcare from VA facilities and be able to provide informed consent. This methodology is potentially prob-

lematic in that 3.9% of Veterans have no healthcare coverage (Weissman et al., 2019) and would be excluded from participating. Additionally, most of the included participants are in the 50 - 69 age range, while only 32.2% of US Veterans are aged 45 - 64, and while younger age within the Veteran communities has been shown to not be a predictor of chronic health concerns (Weissman et al., 2019). Again, service members that have received a less-than-honorable discharge status while meeting the Griffith et al. (2020) definition of Veteran status are categorically excluded from participating in the Million Veteran Program.

An investigation of barriers that impede Veterans from seeking healthcare interventions was carried out by Cheney et al. (2018). All of the participants in the investigation were consumers of VA services and diagnosed with at least one mental health condition, while the investigation itself was carried out at VA facilities. This investigational grouping appears as problematic as only those Veterans who were able to overcome the barriers researched were included, while the narratives of those who receive their care from a different healthcare system and those who were not able to overcome the challenges reported, remained untold. Further, conducting the investigation at VA facilities risks significant bias in that the participants may feel pressured to minimize the negative feedback so as to not jeopardize their access to care, or overexpress positive feedback as an expression of the appreciation for the care provided.

The PTSD Checklist Civilian Version (PCL-C) designed for, and normed on, civilian populations, was utilized to screen for PTSD symptomology in an effort to identify Veteran-specific feedback, despite the availability of the PCL-M (PTSD: National Center for PTSD Home, n.d.), potentially leading to either false positive or false negative diagnoses. Further, PCL assessment was already out-of-date by 2018, having been replaced with the PCL-5 (PTSD: National Center for PTSD Home, n.d.), adding to the potential of a misdiagnosis. This investigation was also limited in that the small sample size of the participants (n = 80) resided in one of three non-representative regions: Maine, Arkansas, and Northern California, communities with very different regulatory environments, demographic distributions, population densities, weather patterns, and transportation systems. It remains wholly plausible that the outcomes reported are not representative of the greater Veteran population.

The thematic grouping of Veterans in research efforts appears as significantly problematic. Both over- and under-representation of the challenges or the symptomology cannot be ruled out when this modeling strategy is employed. With the majority of US Veterans shown not being engaged with VA services, this grouping attempt can lead to both stigmatizing exaggerations of symptomology or barriers to the connection to resources through the minimization of the challenges experienced by US Veterans.

2.2. Grouping by the Participation in Campaigns/Operations

Another common approach to the thematic grouping of Veterans in research

endeavors is to categorize the participants by participation in a specific deployment, campaign, or military operation. Doing so allows for the recruitment of individuals that are of similar ages and with a greater degree of shared experiences. This section will focus on the analysis of the published studies in which Veteran healthcare and therapeutic outcomes are discussed based on this grouping strategy.

An investigation of the perceptions of academic challenges of Veterans who are students and their barriers to the completion of academic goals was conducted by Norman et al. (2015). The investigational cohort on which the findings were presented consisted of 31 Veterans that have participated in Operation Enduring Freedom (OEF/Global War on Terrorism 10/07/01-12/31/2014) and/or Operation Iraqi Freedom (OIF/US-Iraq conflict 03/20/2003-12/15/2011). While this investigational grouping makes initial sense in that similarly aged Veterans at similar stages of professional and educational development are represented, both the title and the body of the discussion of the study strongly indicate that the data reported is representative of the greater Veteran population. This implication is open to debate and criticism in that the two military operations do not even completely represent the Veterans that have participated in US-Afghanistan and US-Iraq conflicts, with Kabul falling to the Taliban on live television in late 2021, and US troops projected to remain active in Iraq for the foreseeable future (Myers, 2022). With the sample size of 31 participants, it can be argued that the data presented does not adequately represent the sub-population of Veterans that have participated in OEF/OIF and is even less representative of the challenges experienced by the US Veterans.

The prevalence of psychopathologies and hypersexual behaviors in Veterans with and without alcohol use disorders was investigated by Moisson et al. (2019). The researchers clarified in the body of the text that the investigation was more specifically focused on post 9/11 Veterans, while the title of the study can be described as misleading in the generalization to the greater Veteran community. Even the clarification that only post 9/11 Veterans are evaluated can be criticized as misleading in that only participants of OEF, Operation New Dawn (OND), and OIF were recruited and their contemporaries who served in different assignments at the same time and members of the Coast Guard serving at the same time were wholly excluded.

This critical nuance was not easy to elucidate with the recruitment methodology not defined but cited in the body of the article, requiring a review of previous publications by this research team to analyze. Further, sexual addiction has been purposefully excluded as a diagnostic entity from both medical and behavioral diagnostic manuals (Petry et al., 2018) and the entire concept of hypersexuality remains controversial (Walton et al., 2017). Additionally, with the recognition that cultural norms and taboos have powerful influences on the expression of sexuality (Espinosa-Hernández et al., 2020), the problematic modeling of the Veterans in this article has an increased potential for stigmatizing and pa-

thologizing this population.

Investigational grouping of Veterans by their participation in military campaigns and engagements offers a benefit of the creation of study groups inclusive of individuals of relatively similar ages and experiences. Reporting the findings from those research efforts, however, does not necessarily generalize to the Veteran population at large. A careful attention to the use of language and terminology in the bodies of the discussion and titles of the articles is warranted in an effort to reduce pathologizing and stigmatizing this diverse culture.

2.3. Grouping by the Participation in the Armed Forces

Another grouping strategy for defining the Veteran investigational cohort seen in the published literature involves screening for previous participation in the Armed Forces. The following section will explore the potential benefits and concerns that may arise from this modeling approach.

A retrospective analysis of the Center for Disease Control and Prevention (CDC) was performed to clarify the relationship between Veteran status, gender, and quality of health indicators among young US adults (Grossbard et al., 2013). The researchers determined the Veteran status of the respondents based on the answer to the screening question "have you ever served in the Armed Forces, either in the regular military or in a National Guard or military reserve unit." The civilian cohort investigated was defined as those who have "never served in the Military" and the veteran cohort was defined as "those who have previously served in the armed forces, but not in the last 12 months". Consequently, 161 respondents, 20% of non-civilian participants, were excluded from the Veteran investigational group. The 12-month consideration was justified by the authors as "the time frame for measures of health access and utilization". In the context of the biopsychosocial challenges that are seen during the transition from Armed Forces to Veteran (Flack & Kite, 2021), however, the exclusion of the Veterans that are experiencing that transition, carries a risk of under-reporting the struggles that Veterans may be experiencing.

An effort to determine the quality of healthcare resources and interventions for Veterans residing in California was performed, leading to a report that 75% of respondents did not receive minimally adequate treatment (Tran et al., 2016). Respondents that endorsed having served in the US Armed Forces for at least 1 year constituted the Veteran cohort. This modeling strategy is open to criticism in that both active Armed Forces members and Veterans could potentially be represented. Whether the healthcare needs and utilization of active Armed Forces members and Veterans are alike or distinct, remains to be shown. Further, Veterans that have transitioned after less than one year of service, whether due to an injury or a discharge, were excluded, contributing to another possible source of under-representing the experiences of US Veterans that reside in California.

A comparison between civilian and Veteran suicide trends was performed utilizing 116,515 cases of completed suicides collected by the National Violent

Death Reporting System (Horwitz et al., 2019). Veteran identity was defined by the research team by the inclusion of the record that the suicide was carried out by an individual that was "ever a member of the Armed Forces". Again, the researchers risk conflating Service Members with Veterans. Further only firearm and hanging/suffocation suicides for male Veterans were counted, ignoring overdose, jumping, and motor vehicle collision methods. The reporting of the use of firearms as "characteristic of Veteran suicide" (Horwitz et al., 2019) is, therefore, open to criticism for significant mismodeling concerns.

Fogle et al. (2020) attempted to investigate the prevalence of mental health concerns and the resilience against the onset of symptomology when stressors are present within US Veteran communities. The Veteran investigational group was defined by those who affirmed "current or past active military service". This cohort explicitly included active-duty Armed Forces members and could have excluded or discouraged the participation of Reservists and Guards. As such, it remains suspect that the reported findings adequately describe the challenges and the resilience of US Veterans.

It cannot be denied that Veterans have a prior history of participation in the Armed Forces. Using the history of participation in the Armed Forces to define a Veteran investigational group without further context, however, remains problematic. Conflating active duty with Veteran status ignores the challenges, and sequelae, faced by the individuals during the transition to a civilian setting (Flack & Kite, 2021) that Armed Forces members have not yet experienced. It remains plausible that this modeling strategy as it has been reported in literature does not adequately demonstrate the relationship between the Veteran status and the variables studied.

2.4. Other Strategies for the Modeling of Veterans

To further cloud the interpretation of the reporting on Veteran phenomena in the scientific literature, other modeling strategies have also been employed. This section will be concerned with articles that model Veterans by definitions other than the participation in the VA healthcare system, participation in military operations, or history of service in the Armed Forces. With appropriate modeling described as the foundation of psychological research (Oswald, 2020), these, less common, strategies warrant an exploration.

Kip et al. (2015) investigated the therapeutic outcomes of accelerated resolution therapy (ART) when treating PTSD in civilian and military adults. The authors made no distinction between active Armed Forces members and Veterans in comparison to the civilian cohort. The inclusion into the military investigational group was based on the evaluation of the reported traumatic events as "military service related" (Kip et al., 2015) by the research team. The parameters as to what constitutes a military service-related traumatic event was not defined or disclosed. This is significantly problematic as the interpretation of the participant's feedback could easily be misinterpreted with many clinicians lacking contextual knowledge of military service and cultural sensitivity (Varpio et al.,

2018).

A meta-analysis of 19 studies funded by the Military Suicide Research Consortium (MSRC) in an effort to clarify the relationship between suicidal ideation, insomnia, and traumatic brain injuries in active duty Service Members, Veterans, and civilians (Soberay et al., 2018). The definition of Veteran, for the inclusion into the study, was not disclosed and could not be identified upon a thorough search through Google Scholar and PubMed databases and currently available MSRC publications. The researchers clarified that the same definition was established by the MSRC for all of the 19 studies reviewed, but the defining parameters used to determine Veteran status remain unknown.

Studies that feature unclear or subjective modeling strategies can potentially lead to misleading conclusions. Further, they may be included in subsequent meta-analyses, further distorting the findings. From a cross-cultural perspective, the risk of either pathologizing or minimizing culturally normative behaviors and presentations from poor thematic modeling cannot be ignored (Boer et al., 2018).

2.5. Concerns and Challenges with the Current Modeling of Veterans in Literature

Appropriate thematic modeling is an integral consideration of empirical research (Oswald, 2020). If the investigational groups are not representative of the population researched, the conclusions are not likely to be valid or helpful. Further, the low-validity conclusions drawn from the studies with problematic modeling of the participants can become amplified through the subsequent inclusion into meta-analyses, further obscuring the fund of knowledge regarding the phenomena studied. The following section will feature an exploration of some of the potential shortcomings of the current modeling strategies of Veterans in scientific studies.

2.6. American Psychological Association

The American Psychological Association (APA) is the dominant scientific and professional organization representing the practice of psychology in the US (American Psychological Association, n.d.). The organization defines the Scope of Practice and Professional Responsibilities and the Code of Ethics for psychologists, accredits educational institutions and internship settings, advises/lobbies the legislators, as well as promotes and sponsors research studies (American Psychological Association, n.d.). Further, APA Division 19: Society for Military Psychology is focused specifically on the psychological implications of military service. Given the influence of the APA on the scientific practices of psychology, the methodology of modeling Veterans by the APA will be explored.

The APA Multicultural Guidelines direct psychologists to utilize culturally adaptive and appropriate assessment, intervention, teaching, supervision, consultation, and research. Despite this guidance, however, no distinction between Military and Veteran cultures or cultural identities can be identified in the APA

publications. In a course of an APA-supported investigation of the perceptions of institutional betrayal, for example, the terms "military members" and "veterans" were routinely used interchangeably (Andresen et al., 2019). The same conflation of military and Veteran identities can also be seen in the APA and VA-endorsed treatment manuals for PTSD (Moore & Penk, 2019). Further, an APA-supported investigation into military sexual trauma defined Veterans as those overseen by the Department of Defense (Blais et al., 2018), which, instead, describes active-duty Service Members.

Despite its commitment to culturally sensitive and appropriate utilization of psychological principles and techniques, the APA continues to struggle to effectively thematically model Veterans in scientific investigations and clinical literature. This may represent another example of a lack of an understanding of the Veteran culture and/or identity and another potential example of the marginalization of Veterans by civilian institutions.

2.7. Veteran Administration Healthcare

To a less informed civilian, the VA Healthcare system can be reasonably associated with the provision of healthcare services to US Veterans. It is, therefore, not surprising that investigators often report on Veteran healthcare outcomes or phenomena based on investigational groups that define a Veteran as someone who receives healthcare services from the VA. While specific articles and their conclusions were scrutinized above, this section will explore broader issues and challenges with the investigational grouping of Veterans based on their participation in VA services.

According to the US government publications, approximately one-half of the VA annual budget is allocated to fixed costs such as payroll, facilities maintenance and operations, etc. In 2022, this translates to an annual allocation for healthcare expenses of $134.95 b (The White House, 2021). If the VA was the sole provider of healthcare to US Veterans only $7497 would be available for the treatment costs per person per year, on average. With US healthcare spending averaging $12,530 per person (National Health Expenditure Data: Historical, 2020), the funding is obviously inadequate and is helpful in highlighting that the VA is not equipped to be the primary source of healthcare services for US Veterans. Further, only 5.7% of Veterans rely exclusively on VA for their healthcare needs, with another 5.7% supplementing MediCare coverage with VA benefits, 2.1% having private, CMS, and VA insurances; and 1.9% having both private and VA coverage (Weissman et al., 2019). In all, approximately 15% of US Veterans receive any of their healthcare services at the VA. Further nuance can be found in that 6.33 m patients/clients were treated by VA providers in 2019, nearly double the number reported by Weissman et al. (2019) which balloons the average cost of care to $25,000 per recipient, double that of the US average.

Although inefficient use of resources cannot yet be ruled out, this cost of care can potentially be explained by the population receiving healthcare from the VA

being older and/or less healthy with at least some family members/dependents of the Veterans also receiving VA services. While family members, dependents, and surviving spouses of Veterans are generally ineligible for VA benefits, they do qualify in some specific cases (Health Care for Veterans: Answers to Frequently Asked Questions, 2020). With 85% of US Veterans never seen in VA facilities and the remaining 15% seeming as older and more seriously ill, the reporting of research findings based on investigational cohorts defined by their engagement with the VA system without a clear caveat that only a small sub-population of the community is represented while civilians may also be included, appears as wholly inappropriate.

Approximately 13% of the US population hold an advanced degree (US Census Bureau, 2019) that is most often required to become a licensed behavioral health clinician. Simultaneously, less than 10% of the population are Veterans (Schaeffer, 2021). It is not surprising that the overlap of those demographic variables consists of a small number of clinicians with first-hand experience of Military or Veteran cultures. Despite its target population consisting primarily of Veterans, this scarcity of contextual knowledge remains significant at the VA, staffed mostly by civilian employees (Shulkin, 2016). It is therefore not surprising that even those Veterans who are receiving treatment from VA facilities report concerns of being misunderstood and stigmatized (Cheney et al., 2018). These reported concerns are strongly reminiscent of other current and historical instances of social rejection and marginalization.

From a regulatory perspective, VA Healthcare is a discretionary program with both the enrollment in, and the provision of, services contingent on available appropriations (Health Care for Veterans: Answers to Frequently Asked Questions, 2020), which vary with budget cycles. It can be argued, therefore, that the VA defines which Veterans qualify for benefits, rather than offering a definition for what makes a Veteran. To enroll in the offered benefits, an individual has to have the awareness of the administrative steps involved, inclusion/exclusion criteria, and the ability to navigate the application process. It seems important to note that some exceptions to the posted guidelines exist, with Veterans that have received a dishonorable discharge status seen with some frequency in clinical settings (Cameron & Ginzburg, 2019) despite the policy stating their ineligibility (Health Care for Veterans: Answers to Frequently Asked Questions, 2020).

The population of Veterans receiving healthcare services from VA providers does not appear to be consistent over time, while the services offered are also contingent on budget availability and political forces. It is also important to recognize that the VA system is one of the largest destinations for interns, with thousands of student-clinicians trained every year (US Department of Veteran's Affairs, n.d.), contributing to the high turnover and understaffing concerns reported (Office of the Inspector General, 2018). Further, healthcare outcomes have been shown to vary significantly between different VA facilities (Anhang Price et al., 2018), additionally compounding the complications of the investigational grouping of Veterans by their participation in the VA system in research.

2.8. Grouping by the Participation in Military Operations

It does not appear as controversial that those who have participated in military operations and have retired from the Armed Forces are Veterans. Grouping Veterans based on their participation in specific operations offers the benefit that the cohort will represent individuals of similar ages and experiences and may reveal the consequences of the participation in those historical events. Whether the findings from those research efforts generalize to the greater Veteran population, remains to be seen.

American Armed Forces are stationed on bases around the world and have been designed to be able to participate in combat against peer opponents simultaneously in multiple theaters of operation (Edelman & Roughead, 2018). It, therefore, makes sense that only a portion of the Armed Forces are involved in any individual mission, while the remainder maintains mission readiness on other assignments. Further, only 10% of active-duty Service Members are combat troops with 90% serving in a support capacity (Bartell, 2021). Research grouping of Veterans as those who have participated in military operations is, therefore, misleading in that only a small, and not necessarily a representative, sample of the participants of similar ages and experiences are represented.

The US Coast Guard consists of nearly 100,000 active-duty, reserve, and ancillary Service Members, while the number of its Veterans is an order of magnitude higher (The Unique Role of the US Coast Guard, 2021). The service has defined law enforcement and military roles and is mandated to operate under the Department of the Navy during wartime (United States Code, 2011). The transfer of Coast Guard command authority only took place once, during WWI, in which 9000 guardsmen participated (United States Coast Guard (USCG) Historian's Office, n.d.), with Coast Guard Squadron One also participating in a combat role during the Vietnam War (Thiesen, 2021).

While one of the smaller of the Armed Services branches, the Coast Guard is also one of the most active, with over 30,000 interdictions and 15,000 Search-and-rescue missions completed in 2019 (US Coast Guard, n.d.). At least in part due to the changes in regulatory and reporting structures, the casualty estimates of the Coast Guard vary and are sometimes combined with those of the Navy (Congressional Research Service, 2020), while the prevalence of injuries is controversial with the link of exposure to approximately 70 chemicals to degenerative conditions continuing to be researched (Rusiecki et al., 2017). With the last official combat mission participation of the Coast Guard completed in 1970, research efforts that define Veteran status by the participation in a military operation explicitly exclude nearly all of the retirees from the Coast Guard enrolling, despite their undeniable participation in overall national military and security activities and regulatory definition as US Veterans.

While investigational cohorts that define a Veteran status by participation in military operations may be useful for investigations regarding the exposures, and their sequelae, during those events, they do not appear to be representative of

the greater Veteran community. Additional care in interpreting the results of these research publications is, therefore, warranted.

2.9. Veteran Evolution

It seems indisputable that all Veterans enlisted to serve in the Armed Forces and have transitioned back to a civilian setting. The following section will feature an exploration of literature findings that describe the impact of the events that constitute the Veteran evolution from a civilian, to a Service Member, and upon the transition back to a civilian environment.

The Western culture is significantly individualistic (Tse et al., 2022). Conversely, the military is significantly collectivistic: the number of individuals killed, or wounded, is far secondary to mission success. Even an amateur historian might describe D-Day as a major tactical and strategic victories for the Allied Powers, while some research may be required before recognizing that, by some estimates, the amphibious assault resulted in 10,000 lives lost, double that of the defenders (Napier, 2015). All military service begins with Basic Training, where recruits are "re-socialized to meet the demands of military service" (Britt et al., 2006). Basic Training includes both physical and psychological conditioning techniques to train the recruits to conform to the military norms, function as a team, carry out orders, face mortal danger, and kill opponents in battle (Grossman, 2014).

Compared to their civilian counterparts, military recruits do not have the freedom to quit their job with their individuality also suppressed through mandated standardization of personal appearance, denial of privacy, and the prohibition of the use of first names (Britt et al., 2006). Further, units, regiments, or entire army groups have been ordered into sacrificial rear guard or spoiling actions to permit the withdrawal or consolidation of other formations, so that they may continue the fight elsewhere, throughout history (Adam, 2005; Burrell, 2011; Hall, 2010).

To qualify for the highest military award, the Medal of Honor, an individual must be distinguished by gallantry and intrepidity at the risk to their life (United States Department of Defense, 1996). From a Western, Judeo-Christian, perspective this normalization of self-sacrifice can be described as a sin against God, as seen in Jeremiah 29:11: "'For only I know the plans I have for you,' declares the Lord, 'plans to prosper you and not to harm you, plans to give you hope and a future'" (Hendrickson Publishers, 2004). The acculturative stress, as an individual rectifies divergent cultural norms, has been linked to numerous physical and emotional health concerns (Ahn et al., 2020; Cheung et al., 2020; Simmons & Limbers, 2018; Sirin et al., 2019), and is subsequently repeated when the same individual transitions away from active military service and back to an individualistic community. A research approach that does not consider this two-step acculturation process, therefore, risks the mis-modeling of a Veteran experience.

A typical person in the US is expected to relocate approximately 11 times in their lifetime (US Census Bureau, 2021). Conversely, military members and their

families are faced with relocation, at times to other countries or continents, every 2 - 3 years and it is not unusual for the children of Service Members to have relocated 9 times between kindergarten and high school graduation (DeSimone, 2018). While this mobility offers Service Members, and their families, increased exposure to more communities, points of view, and experiences, it also comes with the cost of consistently being "the new kid on the block". The impact of this impermanence is poorly understood and may be contributing to the biopsychosocial disparities reported between the family members of Service Members and their civilian counterparts (Ormeno et al., 2020). The psychological burden that may arise from the awareness that their participation in Armed Forces may be negatively impacting their families and children is difficult to imagine. Further, upon completion of the military service, the family may be left with few social connections in their community of residence, perpetuating further stressors as the Service Members transition to Veteran status.

The Napoleonic era of warfighting employed line formation tactics to concentrate and maximize the effectiveness of firepower, demanding that troops march and charge shoulder-to-shoulder under fire (Adam, 2005). Modern warriors remain subject to sleep deprivation, supply scarcity, physical exhaustion, moral injuries, and the stress of combat. One of the protective factors against these stressors is described by the Service Members as "esprit de corps" (De Miranda, 2020; Salzer, 2015): an intense bond of comradery, mutual loyalty and "we-feeling" that is often more powerful than the bond the recruits were familiar with in a civilian setting (Dornbusch, 1955). It would therefore appear, that the Veterans are distinct from Service Members through the disruption of this coping strategy through interpersonal cohesion, as those who served together may now be scattered through civilian communities nationwide. Indeed, the transition from Active Duty to Veteran status is documented to be a tumultuous process that impacts the individual's physical and behavioral health (Flack & Kite, 2021). This warrants a consideration to distinguish between active-duty Service Members and Veterans in research efforts.

While different branches of services vary from each other in what skills are emphasized during recruit training, the same foundational skills are taught to all recruits within the same branch, regardless of whether the Service Member will serve in combat or support capacity (Britt et al., 2006). The training is inclusive of firearm competence, preparedness to assault or defend a position, handling of explosives, and practicing hand-to-hand combat (School of Infantry, n.d.). While the oxidative stress responses of martial artists during their preparations for simulated/athletic combat have been demonstrated (Santos et al., 2014), no similar research with military recruits, training for actual mortal combat, could be found in PubMed and Google Scholar databases. It seems reasonable to extrapolate that the biochemical events and corresponding epigenetic mechanisms would be more pronounced in the latter in response to greater intensity and chronicity of the exposure to life-threatening situations and themes. This consideration offers one possible explanation for the health disparities seen be-

tween Veterans and their civilian peers.

"Birds of a feather flock together", is an old English proverb that ascribes cohesion to similarities. With the advances in neuroimaging technologies and techniques, the neurological activity during social comparisons to self has been demonstrated (Moore et al., 2013), offering support to the idiom. Conversely, observable differences have served as fodder for social rejection, discrimination, and marginalization. It is, therefore, not surprising that evidence of social rejection between the civilian and Veteran communities can also be found. It seems important to recognize that the prevalence of depressive conditions of Black and Hispanic Veterans is consistently reported as lesser than that of White Veterans (Liu et al., 2019), while the opposite is true for civilians (Dunlop et al., 2003). This could be explained by the historical prevalence of marginalization directed at the communities of color contributing to the development of coping strategies to mitigate the impact of discrimination, leaving White Veterans, that are less likely to have this experience, less adapted to cope with social rejection.

Another example of potential marginalization of Veterans can be seen in the report of Veteran employees of the VA, where they are statistically a minority, as endorsing a worse quality of health as compared to the civilian employees (Schult et al., 2019). Given the emotional and the psychosocial responses to being told that one is at risk of psychosis (Woodberry et al., 2021), it seems easy to appreciate how the health of a "broken Vet" can be negatively impacted at an organization striving to serve other "broken Vets". With this consideration in mind, poor thematic modeling of Veterans in research efforts can be seen as further evidence of the social rejection of the Veterans by the, largely civilian, research community.

Research findings suggest that Veterans may be distinct both from their civilian peers and from Active Duty Service Members. Failing to adequately describe the investigational groups when studying Veteran phenomenon, therefore, may contribute to the social rejection of the Veterans by the civilian communities and the exacerbation of the biopsychosocial discrepancies between Veterans and their civilian counterparts.

2.10. Reported Challenges of Veterans

While the methodologies of Veteran-related research efforts have been criticized throughout this chapter, it remains important to review the difficulties and challenges that Veterans are reported to experience. The following discussion will be less concerned with whether or not the research findings are representative of the Veteran community-at-large, focusing instead on the range of difficulties experienced by the members of that community.

2.10.1. Findings Regarding the Behavioral Health of Veterans

In order to join the military, a prospective recruit has to meet physical, medical, moral, and educational standards (USAGov, 2021). Further physical conditioning, medical care, vocational training, and social support are provided to those

who join. Resources, such as the GI Bill, also become available to Service Members. These protective factors can be reasonably expected to improve the psychological functioning of individuals as they transition to Veteran status. Simultaneously, however, these individuals are also faced with significant stressors and challenges. The psychological well-being of Veterans will be explored in this section.

Motor Vehicle Collisions (MVCs) contribute greatly to adult mortality and morbidity and can theoretically happen to any driver or passenger. Nonetheless, Veterans have been shown to be at a greater risk of experiencing a MVC as compared to their civilian peers (Bullman et al., 2017; Huseth-Zosel & Hammer, 2018). The MVC risk was also shown to not be significantly different between combat-deployed and non-combat Veterans, implying a lack of contribution to the MVC risk of an individual due to combat exposure. With some of the more prevalent risks for a MVC described as distracted driving, impaired driving, and aggressive driving (Biever et al., 2019), the increased MVA risk among the Veterans may be indicative of mental health concerns with distractibility, dissociation, problematic substance use, and aggression/reactivity seen in multiple DSM diagnoses. Indeed, US Veterans have been shown to exhibit greater dissociative symptomology (Herzog et al., 2020), dysphoric arousal, described as sleep disturbances and inattention, aggression/hostility, and greater prevalence of SUDs as compared to civilian peers (Fogle et al., 2020), contributing to their MVC risk.

The prevalence of SUDs among Veterans as compared to civilians remains controversial. The reports of increased rates of these disorders in Veteran populations are common (Campbell et al., 2018; Fogle et al., 2020; Hunsaker & Bush, 2018) while reports to the contrary can also be found (Horwitz et al., 2019). This may be partially attributable to the number of Service Members dishonorably discharged for conduct attributable to SUDs, making them ineligible for Veteran status by the regulatory definition (Collins, 2022). This consideration would also suggest that the actual prevalence of SUDs among Veterans may be higher than currently reported. It is also important to note that Veterans are also reported to be at a greater risk of behavioral addictions such as gambling (Cowlishaw et al., 2020; Levy & Tracy, 2018; Stefanovics et al., 2017) and hypersexuality (Moisson et al., 2019) further supporting the premise that Veterans may be at a disproportionate risk for addictive disorders.

Moral injury (MI), a violation of an individual's moral or ethical standards (Jamieson et al., 2020a), is described as a psychiatric syndrome among military personnel that exhibit symptoms of PTSD (Koenig & Al-Zaben, 2020). While not exclusive to those who served in the Armed Forces (Rowlands, 2021; Williamson et al., 2020), it is easy to appreciate that, in free societies, Service Members may be ordered to perform actions that go against their belief systems more frequently than civilians. Indeed, 40% of Veterans report having experienced a morally injurious experience with 14.6% of Veterans diagnosed with psychogenic non-epileptic seizures meeting the criteria for MI (LaFrance et al., 2020). Fur-

ther, Veterans also report experiencing spiritual and moral distress more commonly than their civilian peers (Rogers, 2020). The risk of experiencing a MI is reported to increase with exposure to combat situations and is closely linked to suicidality risk among returning Veterans (Jamieson et al., 2020a). While the academic debate as to whether or not MI qualifies as a distinct diagnostic entity or a sub-type of PTSD is continuing (Fani et al., 2021), as an increased prevalence of this condition in frontline healthcare workers during the COVID-19 pandemic has been observed, this phenomenon has been known to clinicians involved in the treatment of Veterans for much longer (Giwa et al., 2021).

In the US, Veterans die by suicide at a higher rate as compared to civilians (Ammerman & Reger, 2020). Further, female Veterans have been reported to experience suicidal ideation at double the rate of male Veterans (Hoffmire et al., 2021) and to employ more lethal suicidality methods as compared to female civilians. Similarly, transgender Veterans are twice as likely as cisgender veterans to complete a suicide (Tucker, 2019). Taken in total, these findings are strongly indicative that the suicidality risk of US Veterans is significantly disproportionate to that of civilians, representing a dire mental health concern need of this population.

In developed countries, individuals who are experiencing medical or behavioral symptomology can reasonably expect to receive treatment that improves their functioning. US Veterans, however, have been reported to experience worse outcomes from "manualized" front-line PTSD interventions as compared to civilian peers, while also exhibiting higher treatment drop-out (Straud et al., 2019). The drop-out rates from Veteran-centered PTSD treatment programs are reported to be as high as 44% with only 38.9% of Veterans experiencing positive treatment outcomes (Doran et al., 2021). Considering that the completion of PTSD treatment programs is positively correlated to social and vocational health of US Veterans (Stevenson et al., 2021), this high failure rate of the available treatment methods can lead to profoundly negative downstream effects. Qualitative analysis of Veteran-reported barriers to the completion of the therapeutic regimen is significant for themes of fears of being judged or misunderstood by the clinician, an expectation of the symptomology to worsen, access limited to short-term temporary programs, and lack of transportation resources (Doran et al., 2021). Again, an appearance of social rejection and perceived stigmatization of the Veteran clients by the civilian clinicians is evident.

Veterans have been shown to be at an elevated risk for behavioral health concerns despite the protective factors offered through the participation in the Armed Forces. While stress and trauma-related disorders are closely associated with Veteran wellness, cultural sensitivity and the contextual knowledge of Veteran evolution are advised in clinical settings.

2.10.2. Vocational/Financial Difficulties Experienced by Veterans

Educational and career training opportunities are some of the more advertised benefits of joining the Armed Forces (USAGov, 2021). It would seem reasonable

to expect, therefore, that Veterans would enjoy vocational and financial advantages over their civilian peers. The following section will focus on the review of research findings regarding Veteran's vocational and financial needs and wellness.

Participation in the Uniformed Services offers a pathway to college education to some individuals who would otherwise not have the resources to do so. Nonetheless, Veterans working toward a college degree continue to experience difficulties fitting in. Dyar (2019) reported that Veterans struggle to adapt from a structured military environment to a more permissive campus life. It seems important to note that the study population consisted of student-clinicians working toward a degree and licensure in Nursing, hardly low intensity, high-spontaneity, or permissive programs. While some of the Veteran student-clinicians studying Nursing may benefit from healthcare-related training they received during their Service, they remain "disadvantaged by MI and spiritual distress" (Wynn, 2020), as compared to their civilian peers. A theme of social exclusion of Veterans by civilians is again evident in the descriptions of Veterans in Nursing programs as hesitant to ask clarifying questions and keeping to themselves in class (Elliott et al., 2019).

It is not surprising that Veterans with healthcare accommodation needs face additional challenges in academic and vocational training environments. The fears and concerns of Veterans engaged in VA educational programs and Vocational Rehabilitation are reported to include: a lack of accommodation of health problems, concerns regarding a loss of benefits, and a lack of accommodation for Veterans that are nontraditional students (Shepherd-Banigan et al., 2021). The latter report is supported by the observation that the APA does not accredit any online instructional programs (Levy & Ellison, 2022), precluding non-traditional graduates from many career opportunities, including those at the VA (Cardoos, 2021; Clark et al., 2018). The barriers facing Veterans in less specialized training and re-training settings are reasonably likely to be even more significant.

Compared to demographically normed civilian participants, US Veterans have been shown to be less likely to be self-employed or be employed in the private sector (Winters, 2018). Government employment helps to make up for the lack of opportunities in the private sector for Veterans that do not have a disability rating, who are 15 times more likely to be employed in the public sector. The likelihood of both government and private sector employment reduces with an increased disability rating. It is curious to note that the private sector is the least likely setting for Veteran employment (Winters, 2018), further reminiscent of the social rejection of Veterans by civilian employers.

Some wounds are harder to heal than others, while trauma exposure can profoundly impact the level of functioning of an individual. A study of trauma exposure of female Veterans involving 369 respondents revealed that 47.5% of the participants were unemployed (Sienkiewicz et al., 2020), while the overall US unemployment rate was reported as 3.9% (U.S. Bureau of Labor Statistics, n.d.).

Military trauma, which was not precisely defined, military sexual trauma, and adult sexual trauma were most closely associated with unemployment status (Sienkiewicz et al., 2020). These findings may be indicative of the vocational difficulties experienced by the Veterans, despite a strong labor market.

Successful employment after completion of a Vocational Rehabilitation is strongly correlated to reduced mental health symptomology in the Veteran population (Abraham et al., 2021). Simultaneously, however, the positions most commonly sought and successfully secured through the Vocational Rehabilitation are at an urgent risk of being lost due to automation (Tsai et al., 2021). Of the hiring managers surveyed, 40% endorsed a viewpoint that automation will have a negative impact on job opportunities for Veterans. Taken together, these findings suggest that the emotional and occupational functioning of Veterans is anticipated to decline. Further, only 15% of the hiring managers support the premise that new jobs will be made available to Veterans as technology advances (Tsai et al., 2021). It is also interesting to observe that the jobs most commonly secured through Vocational Rehabilitation are in housekeeping/janitorial, administrative and clerical, food service, and warehouse positions (Tsai et al., 2021) hardly the high tech/high paying positions advertised as a benefit of military service.

It may be a somber realization that thousands of individuals residing in the wealthiest country in the world are unable to afford basic housing. An investigation into nearly half a century of data identified Veteran status as a very significant predictor of homelessness risk (Giano et al., 2019). Other risk factors identified included substance use disorders, mental health disorders, and family instability, all of which are also overrepresented in the Veteran population, as contributing to the risk of homelessness. While the lack of housing security is reflective of financial health, experiencing homelessness is strongly negatively correlated to physical health and an increased risk of a fatal opioid overdose (Soncrant et al., 2021).

The growing obesity rate has been a much-discussed topic in the US. Simultaneously, up to 20% - 22.5% of US veterans experience food insecurity (Cypel et al., 2020; Pooler et al., 2021). The risk of hunger is not limited to the homeless veterans, or those struggling with mental health conditions, with 39% of veterans experiencing food insecurity being housed and 53% endorsing a lack of psychosocial diagnoses (Pooler et al., 2021). This lack of nutritional security appears as very telling of the financial health of US Veterans.

US Veterans have been shown to experience disproportional challenges in educational and vocational domains. While an increasing number of Veterans are participating in educational and re-educational programs, the careers most commonly offered upon completion offer limited resource security and are in danger of being lost altogether. Numerous barriers faced by the Veterans in educational and occupational settings are evident. This may serve as a warning sign that the well-being of Veterans may decline in the near future.

2.10.3. Social Functioning of US Veterans

Military recrement is open to individuals between 17 and 39, although the upper age limit varies by the service branch (USAGov, 2021). Consequently, the enlisting individuals have had a relatively lengthy period of time during which their social functioning was influenced and shaped by their families, culture, and community of origin. A review of the literature comparing the level of functioning of Veterans and their civilian counterparts in social and relational domains will be conducted in the following section.

One of the fascinating aspects of human sexuality is that it is both deeply personal and inherently interpersonal. The right to sexual pleasure is listed as one of the eleven core principles in the World Health Organizations Declaration of Sexual Rights and is also described as fundamental to Human Rights (Aksakal, 2013). It is, therefore, deeply disturbing that the unique experiences of female Veterans disproportionately contribute to sexual dysfunction, dissatisfaction, and a decreased quality of life (Rosebrock & Carroll, 2017). While nearly 70% of female Veterans reported having experienced a military sexual trauma (Braun et al., 2021), general military trauma and the stress experienced by the Service Members are correlated to the disturbance of sexual functioning of female Veterans (Rosebrock & Carroll, 2017). Further, both male and female Veterans have been shown to be at an elevated risk for hypersexual behaviors (Moisson et al., 2019), which can be accompanied by negative relational, legal, and healthcare consequences. This coincides with the reporting of Veterans as being at a disproportionately elevated risk of STIs (Petersen & Jhala, 2021; Wilkinson et al., 2021). Tragically, nearly half of all Veterans endorse experiencing some sexual dysfunction (Shepardson et al., 2021).

The emotional health of Veterans can also impact their family and relational functioning. Common difficulties experienced by the Veterans within their family systems include disagreements regarding family responsibilities, relational discord, and the children seeming as afraid of the returning Veterans (Lawrence & Matthieu, 2017). Further, from the Veterans referred for a behavioral evaluation 78% have reported relational conflict and 60% reported some form of domestic abuse (Lawrence & Matthieu, 2017). With more male, as opposed to female Veterans, these rates appear as significantly disproportionate when compared to the IPV rates in the civilian communities, where 3.4% - 20% of males are estimated to have experienced domestic abuse (Kolbe & Büttner, 2020). It is, therefore, not surprising that Veterans are reported to experience higher divorce and marital separations rates when compared to their civilian peers (Shea et al., 2021).

Participation in, and the subsequent transition away from, military service has been shown to have a significant risk of a negative impact on family and social functioning. Unfortunately, the social support systems that can mitigate relational difficulties for many individuals can also be strained through relocations and social rejection experienced by the Veterans. While the participation in the

Armed Forces is associated with many protective factors, the Veterans have also been shown to experience disruptions of emotional, vocational/financial, and relational health parameters that are disproportional to their civilian peers.

2.11. Theoretical Framework

Drs. George Engel and Jon Romano are credited with the introduction of the Biopsychosocial Model (Engel, 1977). The theory is significant for the description of the interplay between biological influences, psychological events, and social forces as contributing to either wellness or symptomology. This approach is recommended for investigation of complex bio-medical phenomena and is clinically utilized in medical, behavioral, and allied health professions (Epstein & Borrell-Carrio, 2005; Wade & Halligan, 2017). While the current approaches to the modeling of Veterans in research has been shown to be problematic, the biopsychosocial theory appears as the best-suited theoretical lens for Veteran-centered research. The process of a civilian becoming a Veteran through the biopsychosocial perspective, will be explored next.

This model can be described both as a philosophical approach to clinical care and as a practical clinical modality. Significantly, the biopsychosocial model is focused on the sum of the client's subjective experiences as a significant contribution to both wellness and diagnostic formulation (Epstein & Borrell-Carrio, 2005). It has been employed in both research and clinical interventions for a range of physiological and behavioral conditions. The biopsychosocial model is widely used in the empirical evaluations of complex medical phenomena and is the theoretical basis for the World Health Organization's Internal Classification of Functioning (Wade & Halligan, 2017). Further, the model has been utilized specifically to demonstrate correlations between social biases and healthcare outcomes (Brondolo et al., 2017).

The biopsychosocial model has been revised and updated through meta-analysis spanning 40 years of published literature (Bolton & Gillett, 2019). The biological, psychological, and sociological development of an individual are now modeled as being directly impacted by behaviors, beliefs, attitudes, values, which can subsequently either predispose or serve as a protective factor for a broad range of medical and psychological conditions. As such, the biopsychosocial models appears as the most appropriate approach for the investigation of Veteran identification strategies.

2.12. Summary

2.12.1. The Biology of Becoming a Veteran

It can be difficult to appreciate how the participation in the Armed forces and the transition back to the civilian communities impact the physiological functioning of the individuals involved. Despite the popular superhero movies, it doesn't seem as likely that the recruits are mutated into super soldiers. Nonetheless, Veterans have been shown to experience disproportional physiological challenges as compared to their civilian counterparts. The following section will

include a review of some of the biological considerations impacting those who participate in, and transition from, military service.

Obesity represents a significant concern for much of the developed world with more than half of the US population described as obese (De Lorenzo et al., 2020). In order to join the military, however, a minimum standard of physical fitness is required, while the minimally acceptable fitness standard is further increased for the Service Members and is checked annually (Eligibility and Requirements, 2022). It seems fair to conclude that recruits and Service Members dedicate a greater portion of their time to physical conditioning as compared to civilians, which represents a strong protective consideration against multiple healthcare conditions. Simultaneously, however, the increased physical activity can contribute to an increase in wear-and-tear degeneration, physical injuries, etc., that can impact negatively impact health in older age.

In popular culture, it's been said that "time and tides wait for no man". It can, therefore, be surprising that Veterans have been shown to exhibit a faster rate of cellular aging as compared to their civilian peers (Howard et al., 2021). While the biochemical implications of telomere shortening remain controversial and poorly understood, the participation in Armed Forces and transitioning back to civilian communities is accompanied by measurable alterations in biological functioning.

The nature of warfighting is inherently dangerous, while the training and the preparation for the participation in military activities can also expose an individual to hazards not present in their communities. The prevalence of cancers and dementias attributable to agent orange exposure of Viet Nam War Veterans is continuing to be investigated (Martinez et al., 2021), for example. Similarly, the exposure to burn pits and petrochemicals are being investigated for links to sleep and breathing difficulties experienced by the Veterans of the last two decades of conflicts (Powell et al., 2020). In both cases, most of the contemporary civilian peers were protected from the exposure to these potentially injurious substances by a diverse array of federal, state, and local laws and regulations.

Participation in the Armed Forces can significantly impact the physical health of those who have served. Both positive and negative influences on long-term healthcare can be found due to the participation in the military services that impact Veterans disproportionately, as compared to their civilian peers. The lack of awareness of the biological stressors, and their sequelae, experienced by the Veterans, therefore, risks significant mis-modeling of the Veteran experience.

2.12.2. Psychological Considerations for Becoming a Veteran

An argument can be made that psychological processes, in any given person, are taking place at all times. Indeed, perception, attention, concentration, memory/learning, communication, and awareness are not unique to any individual, culture, or group. Nonetheless, some of the psychological considerations that are unique to Veterans will be explored next.

The modeling of PTSD has evolved from the "shell shock" of Freudian times

to the modern DSM5 diagnosis. One of the contributing factors to this greater understanding of PTSD is the modeling of how the perception of generalized unsafety undermines "safety signals" and predisposes an individual to develop stress-related symptomology (Huskey et al., 2022). It seems easy to appreciate that recruits and Service Members are exposed to a high frequency and intensity messaging that mortal combat is normative.

While many civilians are dedicated to preserving life, military recruits are trained to kill so that they, and their buddies, are not killed (Dornbusch, 1955). Similarly, civilians have been awarded damages in legal proceedings for psychological injuries suffered after being pepper sprayed for illegally encircling Law Enforcement Officers (Memmott, 2011), while Marine recruits train for chemical warfare inside a tear gas chamber and report the experience as "confidence-boosting" (Flanagon, 2019). Live fire drills, military history, and the Memorial Day holiday, can all serve as powerful reminders that both causing and avoiding death is an occupational focus within the military and can also contribute to the perception of generalized unsafety.

The biopsychosocial theory is also useful in demonstrating the distinctions between Service Members and Veterans in the cognitive domain. The process of transitioning from active duty to Veteran status has been shown to be frequently accompanied by a disturbance in the individual's sense of self and purpose (Flack & Kite, 2021; Inoue et al., 2021). This intrapsychic struggle is closely correlated to depressive and stress-related symptomology (Frankl, 2018) that is over-represented in the Veteran communities.

Differentiating between correlation and causation in social sciences can be difficult. Nonetheless, both unique intrapsychic conflicts and over-representation of behavioral health diagnoses can be found within the Veteran communities. This can be taken to indicate that the psychological/cognitive domains warrant careful attention in Veteran-related research.

2.12.3. Veteran Evolution: Social Domain

"The Charge of the Light Brigade", is a poem written by Alfred, Lord Tennyson in 1854 about a misguided, valorous, and suicidally ineffective cavalry engagement during the Battle of Balaclava, famously featuring the passage: "Theirs not to make reply, Theirs not to reason why, Theirs but to do and die" (charge of the light brigade, 2006). The sentiment expressed stands in stark contrast to the ideas of individual liberty, self-determination, and rationalism of the Enlightenment Age (Sato et al., 2012) and, nonetheless, has been embraced by military cultures resulting in the modern "ours is not to reason why, ours is but to do and die" proverb. The following is an exploration of the changes experienced by an individual as they progress from individualistic civilian cultures to collectivistic Military culture, and then return to individualistic civilian communities.

College campuses project an aura of academic freedom where any topic may be open to a scholarly debate. They can also be seen as explicit examples of the rejection of the Military and Veteran cultures by the dominant civilian cultures

through the picketing of recruiter offices and the description of the US Military as "anti-gay" (Yeaw, 2005). A greater prevalence of LGBTQ individuals identify with the Veteran community as compared to the general population (Wolfe et al., 2023) on the other hand, suggesting a greater acceptance of LGBTQ individuals by the military and Veteran communities. Further, any internet search for derogatory terms to describe a Service Member or a Veteran is guaranteed to result in a multitude of results that are not appropriate to repeat in academic writing. Protests during Veteran recognition events such as Fleet Week and air shows have become routine in many communities (James, 2018), serving as another example of an apparent social rejection by civilian communities.

The freedom of speech and to petition the government for a redress of grievances is a right enshrined in the First Amendment to the US Constitution. This right is much less clear for the Service Members, sworn to protect and uphold the Constitution, with contemptuous and/or disloyal speech regulated by the Uniform Code of Military Justice (Watch What You Say—Don't Violate UCMJ, 2007). Disclosures to the press, both when carried out in- and out-of uniform are also regulated by the UCMJ. This discrepancy in the application of laws between Service Members and civilians has been codified as precedent in the Supreme Court case Orloff v. Willoughby, 345 U.S. 83 (1953), in which the Court said: "the military constitutes a specialized community governed by a separate discipline from that of a civilian" (Military Speech, n.d.).

The unequal application of laws has also been addressed at the Federal Circuit Court level in Parker v. Levy 417 U.S. 733,758 (1974) in which the Court ruled: "The fundamental necessity of obedience, and the consequent necessity for the imposition of discipline, may render permissible within the military that which would be constitutionally impermissible outside it" (Military Speech, n.d.). Multiple other limitations on constitutional protections of freedoms of religion, press, and from discrimination, can also be found in case law history. While these regulations are limited to Service Members, it is easy to appreciate how the fears regarding the loss of benefits may intimidate Veterans that lack a legal degree from participating in constitutionally protected activities, possibly more so in the context of a nebulous distinction between the Military and Veteran cultures.

Upon a careful review, US Veterans appear to be faced with challenges that are unique for both civilians and Service Members across biopsychosocial domains. The bidirectional interplay between biological, psychological, and social considerations that are common in the Veteran communities may be contributing to the biopsychosocial functioning discrepancies between Veterans and their civilian peers.

3. Methodology

Most of the American population has never served in the Armed Forces (Schaeffer, 2021), contributing to the lack of contextual understanding of the Veteran experience. This gap of knowledge may be magnified by the classified nature of many military activities and possible social rejection of the Veterans by

civilian communities. Divergent strategies for the modeling of the Veteran experience have been identified, while Veterans are reported to experience biopsychosocial challenges disproportionately as compared to US civilians (Bullman et al., 2017; Fogle et al., 2020; Herzog et al., 2020; Huseth-Zosel & Hammer, 2018). The heterogenous thematic grouping of Veterans in research efforts may be compounding, not resolving, the gaps of empirical knowledge about the Veteran experience and healthcare needs/outcomes. While cultural competency and culturally-sensitive provision of therapeutic services are recommended by the relevant disciplinary bodies, no working definition for a Veteran, or a distinction from the Military culture, can be found. This research will elucidate the culturally preferred self-identification of US Veterans and will attempt to differentiate between Military and Veteran cultures.

3.1. Research Method

Observational, passive research design, also referred to as passive research design will be utilized in this study. This approach is reliant on the utilization of quantitative analysis of collected survey data to better understand individual or group perspectives as they relate to a particular construct or topic of interest (Tobi & Kampen, 2017). Survey research design allows for a greater understanding of general trends in a population of interest through a quantitative analysis of similarity or divergence of responses of the participants to the questions posed (Rahi, 2017).

This study will utilize an unprocessed, archival survey data set from an online/social media-based survey of the Veteran and Military cultures by Anchor Therapy Clinic in Sacramento, California under the title "Healing our Heroes". The survey asked the participants to self-report their knowledge of Veteran and military-related topics, anonymized demographics, and preferred self-identification in an effort to better understand the impact of a therapeutic interventions specifically designed for the Veteran culture (Cameron & Ginzburg, 2019).

3.2. Participants

The participants in this study self-reported previous or current participation in the Armed Forces. From the regulatory perspective, Service Members are defined as participating in the Armed Forces in either active-duty, national guard, or reserve capacity, while Veterans are defined as former participants in the Armed Forces (50 U.S.C. 3911, 2016). The inclusion into this study required membership in one or more of those groups. A priori power analysis utilizing G * Power 3 was conducted to test the mean difference between two dependent means for a two-tailed test, a moderate effect size (d = 0.20), with an alpha of 0.05 (Kang, 2021). Results indicated that power of 0.95 requires a 272-participant population size.

The participants were be drawn at random from an archival and unprocessed survey data set consisting of 655 voluntary responses collected by Anchor Ther-

apy Clinic in Sacramento, CA from military and Veteran populations that met the inclusion criteria (Anchor Therapy Clinic, 2022). Respondents that endorse either current or former membership in the Army, Navy, Air Force, Marine Corps, Coast Guard, or Space Force are included in this study. A Service Member is operationally defined as a status variable by membership in the Army, Navy, Air Force, Marine Corps, Navy, Coast Guard, or Space Force serving on Active Duty, in a Reserve component or a National Guard component. A Veteran is operationally defined as a status variable by former membership in the Army, Navy, Air Force, Marine Corps, Navy, Coast Guard, or Space Force serving on Active Duty, in a Reserve component or a National Guard component possessing a DD 214 (Cameron, 2023). Respondents that endorsed no prior military service history, former service history without having discharge documents, or did not complete the survey are excluded from this study. A random sample of 325 participants meeting the inclusion criteria for this study will be drawn from the 655-respondent data set.

3.3. Instrumentation

This research will utilize an unprocessed archival data set and not require other survey instrumentation. The original data collection was conducted by Anchor Therapy Clinic as part of its "Healing our Heroes" therapeutic program (Cameron & Ginzburg, 2019). The contextual information contained in the "Healing our Heroes" program (Cameron & Ginzburg, 2019) has been validated through the use of Military Knowledge Assessment and was formulated from primary military training publications that are universal across the service branches. In response to the question regarding the preferred method of self-identifying the following response options were possible: Service Member, Former Service Member, Soldier, Airman, Marine, Space Force, Sailor, Coast Guardsman, Veteran, Army Veteran, Navy Veteran, Marine Veteran, Air Force Veteran, Space Force Veteran, Coast Guard Veteran, Other, with as blank prompt. The demographic questions and those gauging the common military knowledge, such as "Do you have a DD214", were multiple-choice. The latter was used to gauge the respondent's knowledge of basic military constructs and the possible authenticity of the responses: individuals who reported former membership in the Armed Forces, but not possessing DD214 (discharge documentation).

Reliability analysis was performed on the scale revealing the survey to accomplish the desired reliability of alpha = 0.962. All items appeared as important for retention with a decrease of alpha upon deletions. The 325 participants were randomly selected from the overall 655 participant data set. Survey respondents were predominantly male (n = 132, 76.74%) with mean age of 42.6 years, resembling other Veteran-based research studies (Gaziano et al., 2016; Horwitz et al., 2019).

This research will only utilize archival, unprocessed data voluntarily provided for Healing our Heroes program of Anchor Therapy Clinic. The authorization of use of archival data has been approved by the governing Board of Directors

(Anchor Therapy Clinic, 2022). No personally identifiable information was gathered, and the participants will not be reachable for follow-up contact. The variable studied is the preferred self-identification of Veterans and Service Members with demographic data only used in supporting/ancillary analytical statistics and screenings for confounding findings (Gaziano et al., 2016).

3.4. Data Analysis

Anchor Therapy Clinic has authorized the use of and will provide a dataset of 655 anonymized survey responses gathered from Military and Veteran communities in 2019 (Anchor Therapy Clinic, 2022). The data will be screened for meeting of the inclusion criteria. A minimum sample of 272 responses was shown to be required to achieve a moderate effect size (d = 0.20), based on a power analysis to test the mean difference between two dependent means, utilizing a two-tailed test. This data will need to be scrubbed to determine data that meet the inclusion criteria for this research. Based on the power analysis to test the mean difference between two dependent means for a two-tailed test to achieve a moderate effect size (d = 0.20), a minimum of 272 participants is required (Faul, Erdfelder, Lang, & Buchner, 2007).

The data analysis will be conducted through the use of the IBM Statistical Package for Social Sciences (SPSS) to identify trends and tendencies of the participant responses. Participant demographic variables will be analyzed for central tendencies and the distribution of participants analysis. With culturally preferred self-identification represented as nominal data, a Chi-square test of independence will be performed. The differences between the groups will be scrutinized utilizing a paired-sample t-test.

The initial dataset will be reviewed for the inclusion of the participants into the study. 325 responses meeting the inclusion criteria will be randomly selected from the dataset to comprise the study population. Service Members are operationally defined as self-reported membership in the Army, Navy, Air Force, Marine Corps, Navy, Coast Guard, or Space Force serving on Active Duty, in a Reserve component or a National Guard component. A Veteran is operationally defined as a status variable by self-reported former membership in the Army, Navy, Air Force, Marine Corps, Navy, Coast Guard, or Space Force serving on Active Duty, in a Reserve component or a National Guard component possessing a DD 214. The mean difference between these groups will be analyzed using a paired-sample t-test.

3.4.1. Reliability and Validity

Cronbach's α coefficient is used to measure the internal consistency of a measure or a scale, with 0.80 or greater coefficient considered to have strong reliability (Rönkkö & Cho, 2020). The archival dataset used in this research has been analyzed by the Military Knowledge Assessment and Cronbach's α coefficient demonstrated the survey to reach acceptable reliability at $\alpha = 0.962$. All items appeared as worthy of retention with a decrease of α if eliminated.

Internal validity will be increased by randomly assigning the survey respondents into the research population. Confounding data will be screened for, as described in the data analysis plan. Regression concerns are not applicable, with each participant responding to the survey only once. Similarly, History, Maturation, and Attrition are not concerns for this research design. External validity is maintained through random participant recruitment with no incentivization to participate or provide disingenuous feedback. The study population directly represents the population of interest, minimizing potential generalization concerns. Statistical conclusion validity is maintained through power analysis. Construct validity is controlled by the researcher possessing contextual knowledge and cultural competence regarding the population studied.

3.4.2. Bias

Bias in clinical research can be most broadly classified into three categories: selection, information, and confounding (Stenson & Kepler, 2019). This study seems to minimize selection bias through the use of randomized participants that provided feedback voluntarily and a lack of an incentive to participate or provide disingenuous information. The data is de-identified and the dataset used belongs to a non-profit third-party clinic, limiting the potential of informational bias. Confounding bias is limited by the study design and the use of nominal data.

4. Results

The goals of this study have included: clarification the preferred method of self-identification of US Veterans, differentiation between the Military and Veteran cultures, and an analysis of how appropriately Veterans have been modeled in research efforts and therapeutic literature. The participants in the study comprised current and former military Service Members who were asked to select their preferred method of self-identification. The specific research questions addressed by this study were: What is the culturally preferred Veteran self-identification; are Military and Veteran cultures distinct; are Veterans currently well modeled and described in therapeutic and research literature? The hypothesis of this study is that the preferred self-identification of US Veterans is that of a "Veteran", while the preferred self-identification of active-duty Armed Forces members is in alignment with the branch of service; that Veteran and Military cultures are distinct.

This research utilized a quasi-experimental study design and an unprocessed, archival, anonymized data set comprising responses to a survey collected by Anchor Therapy Clinic in Sacramento California. The survey respondents identified their country residence as US, Canada, and the United Kingdom, with the respondents outside the US not included into the study population. In addition to demographics, the survey asked the participants if they are current or former member of the military and their preferred self-identification method.

The inclusion criteria for the study included: current or former membership

in the Armed Forces. Further, the respondents that endorsed former participation while also not having a DD214, were excluded from participating in the study, as any separation from Armed Forces would be recorded on that document. Similarly, those who reported actively serving and having a DD214 were also excluded as inauthentic. Prospective study participants were also excluded if the survey was not completed. The study population of 325 participants was randomly selected from the dataset containing 655 respondents meeting the inclusion criteria. The sample population (N = 325) included current Service Members (n = 94, 28.92%) and former Service Members (n = 231, 71.08%). Further, the participant demographics break down as follows: African American/Black (n = 26, 8.00%), Asian (n = 10, 3.08%), Hispanic/Latinx (n = 66, 20.31%), Middle Eastern (n = 4, 1.23%), Native American (n = 12, 3.69%), Pacific Islander (n = 2, 0.62%), Caucasian/White (n = 128, 39.38%), Other (n = 77, 23.69%). The mean age of participants was 37.3, and the majority of respondents identified as male (57.84%).

The primary analysis distinguished between the participants that were currently serving in the Armed Forces (n = 94) from those who were no longer serving (n = 231), at the time of their participation in the survey. The relationship between self-identification as a Service Member and the self-identification as a Veteran among the individuals currently serving in the Armed Forces was examined by a chi-square test for goodness of fit. The results demonstrated that Chi-Square value = 325, $p < 0.001$, and that results are significant $p < 0.05$.

Subsequent analysis revealed overwhelming differences in preferred self-identification between active members of the Armed Forces and Veterans. None of the respondents who endorsed active-duty status identified as a Veteran and identified solely with the branch of service. Similarly, none of the participants that endorsed having separated from the Armed Forces identified solely with the branch of service, as a current or as a former Service Member, or utilizing the "other", fill-in-the-blank option, instead reporting their preferred identification either as a "Veteran" or as a Veteran of the branch of service (Army Veteran, Navy Veteran, etc). This is strongly indicative of significant distinctions between Military and Veteran cultures.

4.1. Preferred Self-Identification of Current Service Members

None of the respondents that endorsed currently serving in the Armed Forces reported a preference for identification as a Veteran despite the freedom to do so, with 100% reporting their self-identification with the branch of service (Soldier, Airman, Marine, etc), and 0% preferring to identify as a Veteran or as a Veteran of a service branch. Consequently, chi-square test of independence revealed: Chi^2 = 325, p-value is <0.001, and the results are significant at $p < 0.05$. Among respondents actively serving, the preferred self-identification prevalence breakdown is: "Service Member" 3.19% (n = 3), Army/Soldier 40.43% (n = 38), Navy/Sailor 11.70% (n = 11), Air Force/Airman 19.15% (n = 18), Marine 5.32% (n = 5), Coast Guard 8.51% (n = 8), and Space Force 11.70 (n = 11). Interesting-

ly, the responses were highly consistent with no coding or grouping required and no "other" responses.

4.2. Preferred Self-Identification of Veterans

None of the respondents that endorsed previous participation in the Armed Forces reported a preference for identifying as a Service Member or as a Former Service Member despite the freedom to do so. Further, the "Other", fill-in-the-blank, option was never utilized. Instead, 100% of Veteran respondents reported a preference for identifying as a "Veteran" or as a "(branch of service) Veteran". It is important to recognize that both of these self-identification strategies meet both the regulatory (30 USC 101: Definitions, n.d.) and Griffith et al. (2020) definitions for the term "veteran" and message of the transition away from military service preserved. Again, the chi-square test of independence revealed: Chi^2 = 325, p-value is <0.001, and the results are significant at $p < 0.05$.

4.3. Summary

In response to a multiple choice inclusive of an open-ended, fill-in-the-blank, option regarding the preferred method of self-identification, 100% n = 94 of Service Members identified with the service branch. Similarly, 100% n = 231 of those that have separated from the Armed Forces identified as Veteran. With none of the Veteran participants having identified as a current or former Service Member, the null hypothesis H1o is rejected. Further, with 100% of the Veteran participants having reported their preferred method of self-identification as a Veteran, the H1a was accepted. Additionally with 100% of Service Members identifying with the branch of Service while 100% of Veterans instead preferring to identify as a Veteran, significant distinctions were seen between Military and Veteran self-identification strategies. The divergent modeling strategies discussed in the literature review serve as contrast against the consistency of self-identification preference of Veterans and Service Members and indicate that Veterans are poorly modeled in professional literature.

4.4. Research Questions

RQ1. What is the culturally preferred Veteran self-identification?

The literature review of this study has identified differing strategies for the grouping and modeling of Veterans. It would not be possible to evaluate whether the current modeling strategies are representative of the population investigated without a working definition of what constitutes a Veteran experience or identity.

With the recognition of the definition of culture as: "membership in a socially constructed way of living, which incorporates collective values, beliefs, norms, boundaries and lifestyles" (American Counseling Association, 2014), the survey responses to question regarding how they prefer to self-identify were posed to both current and former members of the Armed forces. Popular attitudes such

as "once a Marine, always a Marine", indicated that Veterans may continue to identify with their previous branch of service, while the prevalence of studies defining the Veteran cohort by the participation in military operations could have indicated a possibility of "Gulf Veteran", or other identification strategies.

Research Findings: It was shown that while Service Members prefer to be identified with their branch of service (Soldier, Marine, Sailor,) etc, Veterans prefer to identify either as a "Veteran". Despite the open-ended option, no "Other" responses such as "combat Veteran", "Iraq Veteran", etc., were seen.

RQ2. Are Military and Veteran cultures distinct?

Defining the Veteran investigational cohorts by a history of military service with unclear distinction between Service Members and Veterans are relatively common (Andresen et al., 2019; Grossbard et al, 2013; Horwitz et al., 2019; Tran et al., 2016; Tran et al., 2016). It is plausible that this modeling strategy is effective and appropriate if active-duty Service Members and Veterans are sufficiently homogenous in their biopsychosocial functioning to be included in the same cohort. Significant distinctions in self-identification preference between members of the military and Veterans, however, were demonstrated.

Research Findings: None of the Service Members identified as a Veteran and none of the Veterans identified as a Service Member. Despite the open-ended response option, the culturally preferred identification was strongly consistent for both groups. These are strong indications of distinctions between those currently serving in the Armed Forces and Veterans, and the membership in these cultures was shown to be mutually exclusive. The degree of the divergence warrants further research efforts, but investigational cohorts that do not differentiate between Service Members and Veterans are prone to mismodeling concerns.

RQ3. Are Veterans currently well modeled and described in therapeutic and research literature?

Four distinct grouping strategies for the modeling of Veterans in research have been identified in the course of this investigation. The currently available body of literature models the Veteran population poorly with the term "Veteran" including those whose preferred identity is that of a Service Member. Further, some veteran-centered research (Gaziano et al., 2016) has also included family members of the Veterans in reporting on the Veteran experiences and challenges.

Research Findings: This study has demonstrated a consistent preference for self-identification as a Veteran among those who have previously participated in, and have separated from, the Armed Forces. The findings indicated that 0% of Service Members identified as a Veteran, while 0% of the Veterans identified as a Service Member and that despite the freedom to do so, 0% of the Veterans reported a preference for identifying with a military operation. The results of this research indicated that Veterans are not currently well modeled in literature. A determination regarding whether the poor modeling of Veterans in research is a cause, a correlation, or a consequence of the biopsychosocial discrepancies be-

tween Veterans and their civilian contemporaries was outside the scope of this study.

5. Discussion

This quantitative study attempted to equip the field of psychology with a clearer understanding of the preferred self-identification strategy of Veterans. Four distinct research modeling strategies were identified in Chapter 2. This has resulted in culturally inappropriate definitions and assumptions as to what constitutes a Veteran identity and complicates generalizing research findings to the specific population studied (Randles & Finnegan, 2021). More specifically, the reported findings regarding Veteran phenomena are based on investigational cohorts that are inclusive of active-duty Service Members (Cheney et al., 2018), civilian dependents (Gaziano et al., 2016), and those preventing some Veterans from inclusion (Trivedi et al., 2015). With the proportion of US residents who participate, or have ever participated, in the Armed Forces declining, the operational definition of a Veteran in research efforts has often been formulated by civilians that may be lacking contextual or cultural knowledge needed for appropriate thematic grouping. Researchers and clinicians that work with this population and lack cultural competency risk over-diagnosing, misdiagnosing, stigmatizing, and placing barriers to access to resources (McCaslin et al., 2021) for an already underrepresented population. An argument can also be made that the mismodeling in research efforts has either contributed to, and/or served as an example of, a rejection of the Military and Veteran cultures by their civilian peers.

A clear operational definition of what makes a Veteran was needed to better understand both the challenges and the attributes of the individuals that have separated from serving in the Armed Forces. Further, a culturally sensitive understanding of Veteran identities, experiences, and norms may offer protection from the pathologizing of normative behaviors by civilian clinicians and researchers. Identifying the preferred strategy of self-identification by the Veterans was the main goal of this study, to prevent further projection of civilian norms on this under-represented culture.

Based on the data revealed in the course of this investigation, an argument can be made that a Veteran can be operationally defined by a former service in the Armed Forces. Further, a Military Service Member can be operationally defined by a current participation in the Armed Forces in either Active or Reserve capacity. The identification strategies of the family members from either culture, remain to be investigated.

Further goals for this study included the demonstration of dis-similarities between the active-duty Service Members and Veterans and an examination of how well Veterans are currently modeled in research and therapeutic publications. To this end, an archival, unprocessed data set collected by Anchor Therapy Clinic of Sacramento, CA, was processed by comparing the preferred self-identification strategies of Veteran and active-duty Service Members. While the discharge status and previous/current history of participation in the Armed

Forces of the respondents were not independently verified, the screening of disingenuous feedback was performed through the screener question regarding the possession of DD214.

This study was conducted through the lens of the biopsychosocial model. Credited to George Engel in 1977, the biopsychosocial model of wellness is a dimensional, multidisciplinary approach that is concerned with the interplay between the biological, social, and psychological influences faced by an individual. Significantly, this theory considers the subjective experiences of a person as critical to their functioning (Epstein & Borrell-Carillo, 2005). With Veterans shown to have experienced unique changes across the biopsychosocial domains, the biopsychosocial model was chosen as the best-suited approach for the exploration of the Veteran self-identification.

This study included a systematic review of peer-reviewed literature with an added focus on the studies published in the last five years. The relevant laws, regulatory statutes, and regulations of the Armed Forces, along with the sentiments expressed in fiction literature and news media relevant to the relationship between Veterans and their civilian peers were also reviewed.

5.1. Findings

Multiple distinct approaches to defining a Veteran were identified in the literature review. Simultaneously, Veterans have been demonstrated to experience a lack of understanding and stigmatization from their civilian contemporaries in educational, vocational, and healthcare settings (Cheney et al., 2018). The degree to which the current investigational modeling of the Veterans may be misrepresenting or misinterpreting the experiences/challenges of this population is not clear. Taken in total, this can be reasonably interpreted as a sign of social rejection of the Veterans by their civilian peers, adding importance to this investigation.

During the investigation of the RQ1, 0% of qualified respondents that endorsed prior participation in the Armed Forces and the possession of DD214 reported a preference for identifying in the same manner as those preferred by the current members of the Armed Forces, instead preferring to identify as a "Veteran" or as a "(branch of service) Veteran". Similarly, 0% of those endorsing currently serving in the Armed Forces reported a preference for identifying as a Veteran, or as a (branch of service) Veteran, identifying instead with the branch of service. Significantly, despite the availability to do so, 0% of the respondents reported a preference for identifying with a military operation, or any of the other thematic groupings discussed in Chapter 2, with 100% preference for identifying as a "Veteran" endorsed. The strong consistency of responses of both groups can be taken as evidence of the integration of the norms, applications of relevant laws and regulations, and ways of living into a distinct cultural identity that is strongly conserved in both investigational groups. It is also noteworthy that the cultural identity of Veterans appears as acquired, in that none of the

Veterans preferred to identify as a Veteran before transitioning away from active participation in the Armed Forces, while none of those currently serving preferred to identify as a Veteran. In response to RQ1, it was therefore concluded that the culturally preferred self-identification strategy of Veterans is as a "Veteran".

The investigation of the RQ2 revealed significant distinctions between Military and Veteran cultural identities. Membership in both was shown to be exclusive with 100% of Service Members preferring to identify with the branch of service and 100% of Veterans preferring to identify as Veterans. In the context of very strong consistency of responses, and the mutually exclusive membership in either Service Member or Veteran, it was shown that the Military and Veteran cultures are distinct. It seems important to note that the differences seen do not dictate that Military and Veteran cultures are independent of one another, merely that they are not identical. This concept will be further elaborated on in the Recommendation for Future Research section.

The investigation revealed that Veterans are modeled inconsistently and poorly in therapeutic and research literature. While cultural competency remains critical to appropriate research modeling and therapeutic outcomes (Schaeffer, 2021), research into Veteran phenomena was shown to utilize divergent thematic modeling, at times including Service Members or dependents in the "Veteran" cohort (Fogle et al., 2020; Trivedi et al., 2015). In contrast, the preferred self-identification strategy of the Veterans is strongly consistent and was shown in this study to be explicitly exclusive of Service Members. Further, it was shown that 0% of the Veteran participants prefer to identify with a military operation despite the freedom to do so. Additionally, despite the numerous modeling approaches currently used, 100% of individuals that have transitioned away from active participation in the Armed Forces were shown to prefer to self-identify as a "Veteran". Contemporary literature describes the Veterans as experiencing disparities across biopsychosocial domains and a combination of external and internalized stigmatization. It seems easy to appreciate how the reporting of negative attributions based on poor thematic modeling can be adding to the stigmatization of this culture. Specifically, defining a "Veteran" investigational cohort by a participation in a military operation was shown to be significantly prone to mismodeling concerns. The degree to which normative behaviors and attitudes may be pathologized and/or reported as a clinical concern, remains to be clarified.

5.2. Implications for Professional Practice

While it may be difficult to consider an individual that has not changed in demographic or spiritual domains and residing in their community of origin as belonging to a different culture when compared to peers that have never participated in the Armed Forces, this appears to be true for Veterans. From the biopsychosocial perspective it appears as easy to appreciate how the "re-socializing"

to function in the Armed Forces, physical and behavioral conditioning, altered family structures, unequal legal and moral standards can foster behavioral and psychosocial norms that are adaptive for the survival and success of those serving. It also seems as easy to consider how those same behaviors and psychosocial norms can be seen as maladaptive upon the return to the community of origin.

The findings indicated that clinicians treating US Veterans may benefit from the consideration that Veterans are significantly distinct from both Service Members and civilians. A consideration that the clinical presentation of a Veteran may be influenced by the experience(s) of social rejection, despite the appearance of belonging to a dominant/prevailing culture, is also recommended. Every clinician is encouraged to consider whether the biopsychosocial disparities between Veterans and their civilian peers are fueled by the characteristics of a Veteran, or by the relationship that exists between the civilian and Veteran cultures.

Clinical sensitivity to the barriers to access to resources, both objective and perceived, faced by the Veterans (Inoue et al., 2021; Newins et al., 2019; Pooler et al., 2021) can make a positive impact on the therapeutic relationship. Further, the clinical community can benefit from the consideration of the evolutionary process experienced by the Veterans as they transition from an individualistic culture of origin into a communal one, subsequently returning to an individualistic community, leading to a need to rectify divergent cultural norms in a manner analogous to multicultural stress (Scholaske et al., 2021).

The distinction between the preferred self-identification strategies of Service Members and Veterans can serve as a reminder to clinicians working with the former that the acculturation stress of the returning to the community of origin may be in their near future. Similarly, Veterans who have recently separated from active service may not be mindfully aware of the acculturation stress that they may experiencing. Techniques that employ insight building and reinforcing/broadening the coping regimen may be beneficial during these milestone events.

Careful clinical attention is warranted to prevent pathologizing normative or trained/conditioned behaviors as diagnosable mental health illnesses. Specific questions to consider asking a prospective client include, but are not limited to: are you currently, or have you previously served in the Armed Forces; can you describe your separation from the Armed Forces; what are your attitudes/beliefs about your military service or about the transition to Veteran status; what is your current level of social support; what attitudes or beliefs that were helpful during the military service are now challenging? Lastly, civilian members of clinical and research teams are encouraged to consider that the last time the US mainland witnessed the presence of foreign troops was during the Mexican American War (ABC-CLIO, 2013), with the strength of the American Armed Forces contributing to the prevention of physical, psychological, and economical injuries of warfare experienced by a large portion of the world's civilian popula-

tion.

The attitudes toward gun ownership vary in different civilian communities and organizations. The message from military training manuals, however, is that the personal firearm can be the difference between surviving and perishing (Department of the Army, 2020). It is, therefore, not surprising that the majority of the Veterans own at least one firearm and many opting to routinely "carry" (Bossarte et al., 2021). These divergent attitudes toward gun ownership can have several implications for a clinical practice. Most significantly, the fear over losing access to firearms may prevent Veterans from seeking mental health services, as it is illegal to own firearms after qualifying for many mental health diagnoses under 18 U.S.C 922(d) and a multitude of state-specific statues. Further, divergent attitudes toward gun ownership may threaten the therapeutic alliance between a clinician and a Veteran client, if not appropriately addressed. It also seems worthwhile to consider that in some cases, the increased difficulty to firearm access may increase the perceived level of threat to survival for some Veterans. Veterans are approximately twice as likely as civilians to own firearms (Carter et al., 2022; Cleveland et al., 2017) and it remains possible that gun ownership is a cultural norm as opposed to habit, hypervigilance, violent expression, etc.

Another topic of unique clinical relevance, as it relates to the Veteran culture, is that of sexuality. With Veterans shown to be at a disproportionate risk of hypersexual behaviors and sexual health and relational difficulties (Bird et al., 2021; Larsen 2019; Moisson et al., 2019), it remains plausible that cultural norms in this domain may also diverge from the dominant view in the community. From the biopsychosocial perspective it seems easy to appreciate how the stressors discussed in Chapter 2 define goals and taboos that are unique to the Veteran experience and that the behaviors that were adaptive during the military service can become maladaptive in the civilian communities. A cross-cultural approach is, therefore, advised in the treatment of Veterans with psychosexual concerns.

Approximately 3.8% of the population identifies as a member of the LGBT community and 8.2% have reported engaging in some same-sex sexual behaviors, with a further 11% reporting some attraction toward same-sex (Gates, 2021). This implies that the size of the LGBT and Veteran populations are roughly similar. Further, greater proportion of Veterans than civilians identify with the LGBT community (Wolfe et al., 2023). An argument can therefore be made that Veteran cultural considerations are as significant to represent in educational materials, graduate coursework, and clinical competence repertoire, especially in the context of historical marginalization, demographic overlap, and disproportionate suicidality rates in both communities, and that this aspiration is not yet reached.

Researchers and clinicians are encouraged to remain aware that the VA, despite being a valuable resource to many, is a setting that services a specific seg-

ment, comprising approximately 20% of the Veteran population (Weissman et al., 2019). A representative consumer of the VA services may therefore function significantly different in some biopsychosocial aspect from a representative Veteran. Further, analysis in Chapter 2 highlighted that the VA, as an organization, is underfunded for the size of the population served, with the scarcity of resources leading to barriers to access and sampling bias. On a broader level, university campuses Institutional Review, disciplinary and licensing boards are encouraged to consider Veterans as a marginalized culture that is different from that of US civilians. The community of researchers and clinicians engaged in peer review are encouraged to comment when poor thematic modeling of Veterans can be seen in the study design. Journal editors are encouraged to reject the publishing of studies in which modeling concerns can negatively impact or stigmatize Veteran participants.

In societal terms, it has not been very long since the DSM-III described homosexuality as a diagnosable mental health illness (American Psychiatric Association Staff, 1980). As the clinical practice of psychology continues to advance, Veterans deserve the understanding of the stressors; injuries, be they physical, psychological, social, or moral; barriers and rejection that many of them have experienced. It seems as critical to recognize that even the application of Constitutionally protected rights is different for military members and non-military members, as seen in Parker v. Levy (1974) and Orloff v. Willoughby (1953), adding to the distinctions between civilians, Service Members, and Veterans.

6. Conclusion

American Veterans can be described as an underrepresented and poorly understood culture that comprises approximately 8% of the population (Schaeffer, 2021). US Veterans have also been shown to experience biopsychosocial challenges (Cheney et al., 2018), face barriers to resource access (Inoue et al., 2021; Newins et al., 2019; Pooler et al., 2021), and experience negative therapeutic outcomes (Kip et al., 2015; Soberay et al., 2018), that are disproportionate when compared to normed civilians. While the culturally informed approach to psychological interventions and research efforts has been commonly advocated, no working definition for Veteran, Veteran culture, or its distinctions, has been adopted prior to this study.

This study concluded that, in research and clinical considerations, significant distinctions exist between civilians, Service Members, and Veterans in the US. Further, it concluded that Veterans are not currently well modeled in professional and scientific literature, which may contribute to, or exacerbate, the biopsychosocial disparities seen between Veterans and normed civilians (Koenig & Al-Zaben, 2020).

Literary and popular culture references describing the individual that left for military service as different from the one who returned are common. The military training manuals refer to the process of "re-socialization" during which the

recruits are trained to participate in and survive combat operations (De Miranda, 2020), which appears as only linguistically distinct from "acculturation". Indeed, new beliefs, behavioral and social norms, and applications/protections of constitutionally protected rights take place as soon as Basic Training (Research Guides: United States Army Technical Manuals: A Resource Guide and Inventory: Introduction, 2022). While these new norms are beneficial and are reinforced during the military service, they may be seen as maladaptive by civilian clinicians, peers, and family members of Veterans upon their return from service.

This study has revealed that from the perspective of the Service Members and Veterans the membership in these groups is exclusive, with 100% of Service Members opting to self-identify with the branch of service and 0% with Veteran status, while 0% of Veterans preferring to self-identify as a Service Member. The recommended operational definition of a Veteran based on these findings is: "an individual that has been discharged from service in the Armed Forces."

In a free society with a division of labor, it seems difficult to argue against the conclusion that Veterans, collectively, fulfilled their "part of the bargain". They played their part in maintaining the nation free of foreign invasion while overcoming individual and collective challenges until receiving a discharge and returning to the civilian communities. It also seems difficult to argue that insufficient medical care, disproportionate food and housing insecurities (Cypel et al., 2020; Eversole, 2021; Tran et al., 2016) are just rewards for the participation in the Armed Forces.

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Conflicts of Interest

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

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