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Facilitating culture-centered communication between health care providers and veterans transitioning from military deployment to civilian life

Christopher J. Koenig [a,b,d,*], Shira Maguen [a,c], Jose D. Monroy [a,e], Lindsay Mayott [a,d], Karen H. Seal [a,c,d]

[a] San Francisco Veterans Administration Medical Center, San Francisco, USA
[b] Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco, San Francisco, USA
[c] Department of Psychiatry, University of California, San Francisco, San Francisco, USA
[d] Department of Medicine, University of California, San Francisco, San Francisco, USA
[e] Department of Psychology, San Francisco State University, San Francisco, USA

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ABSTRACT

Objective: To describe returning veterans' transition experience from military to civilian life and to educate health care providers about culture-centered communication that promotes readjustment to civilian life.

Methods: Qualitative, in-depth, semi-structured interviews with 17 male and 14 female Iraq and Afghanistan veterans were audio recorded, transcribed verbatim, and analyzed using Grounded Practical Theory.

Results: Veterans described disorientation when returning to civilian life after deployment. Veterans' experiences resulted from an underlying tension between military and civilian identities consistent with *reverse culture shock*. Participants described challenges and strategies for managing readjustment stress across three domains: intrapersonal, professional/educational, and interpersonal.

Conclusions: To provide patient-centered care to returning Iraq and Afghanistan veterans, health care providers must be attuned to medical, psychological, and social challenges of the readjustment experience, including *reverse culture shock*. Culture-centered communication may help veterans integrate positive aspects of military and civilian identities, which may promote full reintegration into civilian life.

Practice implications: Health care providers may promote culture-centered interactions by asking veterans to reflect about their readjustment experiences. By actively eliciting challenges and helping veterans' to identify possible solutions, health care providers may help veterans integrate military and civilian identities through an increased therapeutic alliance and social support throughout the readjustment process.

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1. Introduction

Approximately 2.4 million United States military personnel have been deployed to Iraq and Afghanistan since September 11, 2001. Military deployment and combat has historically shown to result in medical [1–4], psychological [5–8], and social problems [9–13], all of which affect veterans' post-deployment health across the life course [13–16].

Prior research on reintegration among Iraq and Afghanistan veterans has focused primarily on the physical and psychosocial problems that arise in the process of re-adjustment, but only a handful of previous studies focus on the *cultural* aspects of reintegration, such as the differences between military and civilian social environments [17–20]. Faulkner and McGaw [21] propose a comprehensive model of reentry for Vietnam era veterans using a three stage model: disengagement from military life; re-entry into the world of the civilian after deployment; and, full reintegration into civilian life. We build on this idealized temporal progression

* Corresponding author at: Department of Medicine, San Francisco Veterans Administration Medical Center, 4150 Clement Street, 111-A1, San Francisco, CA 94121, USA. Tel.: +1 415 221 4810x6419; fax: +1 415 379 5573.
E-mail address: Christopher.Koenig@va.gov (C.J. Koenig).

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by focusing the experiences of Iraq and Afghanistan veterans as they re-enter civilian life, but before they fully reintegrate into civilian life. We investigate reintegration as a complex social and temporal process [14,22].

Culture is commonly defined as the shared values, perspectives, and routine, but taken-for-granted, practices within a community [23,24]. Culture shapes heath and healthcare in diverse populations and communities as well as the course and outcomes of various diseases and illness conditions [25,26]. Military veterans have been widely studied as a community with a distinct and recognizable culture resulting from participation in both civilian and military contexts [20,27–29], but whose health has been shown to be particularly vulnerable due to deployment experiences [30–32]. Basic military training impacts individual development through acculturation into military culture, which affects the individual's sense of self or identity. However, upon returning home veterans receive limited or no similar training to acculturate back to civilian life [33,34]. As a result, many returning Iraq and Afghanistan veterans face challenges reintegrating into civil society, including identity conflict, alienation, depression, anxiety, and interpersonal difficulties [20,35–38]. Drawing from the literature on educational and cross-cultural transition [39–41], Westwood et al. characterize *reverse culture shock* as a type of stress associated with "unanticipated adjustment difficulties and unmet expectations by...following a re-entry experience" [33]. While reverse culture shock has been documented in veterans historically [10,21,42,43], few empirical studies use this construct to contextualize post-deployment problems such as physical chronic pain; psychological feelings of helplessness, irritability, and moral contamination; and social problems of isolation [20,22,33,44].

Recognizing these challenges, the Department of Veterans Affairs (VA) launched the Office of Patient Centered Care and Cultural Transformation (OPCCCT) to develop and evaluate new health care models that provide effective and culture-centered services for veterans. Because health disparities research that shows ethnic, linguistic, and racial minorities can be excluded from health care processes in large health care organizations [45–47], the OPCCCT mission shifts the significance of culture-centered care to include all veterans [48], as veteran-provider encounters can be intercultural due do systematic differences between civilian and military cultures as well as lay patient and professional medical cultures [49]. However, little prior research examines the relationship between communication and patient-centered care using an expanded conception of culture [11,22,33,44].

To fill this knowledge gap, we conducted a qualitative study with returning Iraq and Afghanistan veterans: (1) to describe the challenges and opportunities veterans experience when transitioning from military to civilian life; and (2) to develop a theoretical model that identifies broad cultural domains of significant for veterans' readjustment. Our overall goal was to develop a model of veteran readjustment that is of practical value to foster culturally sensitive interactions between providers and veterans after deployment.

2. Methods

We conducted in-depth semi-structured interviews with Iraq and Afghanistan combat veterans who had returned from deployment within the last two years. We purposively sampled veterans who were seen in the Integrated Care, Primary Care, or Women's clinics at the San Francisco VA Medical Center (SFVAMC) at least twice within three months between October 31, 2008 and October 31, 2010. We used administrative data to find veterans with a positive screen for at least one mental health problem, i.e., posttraumatic stress disorder (PTSD), depression, or high-risk drinking. We focused on Iraq and Afghanistan veterans because they recently returned from a warzone, have a high prevalence of mental health problems [50], and under-utilize mental health care, all of which may hamper readjustment. We over-sampled female veterans because they represent one of the fastest growing segments of veterans seeking VA services, and little is known about the unique challenges women veterans face in returning home [35,51,52]. Eligible veterans were sent an introduction letter, a study information sheet, and an opt-out postcard. If the postcard was not returned within 14 days, veterans were contacted by telephone to describe the study and to invite participation. The protocol was approved by the Committee on Human Research at the University of California, San Francisco and the Research Protection Programs at the SFVAMC and Department of Defense.

The study team developed an original semi-structured interview guide drawing on the senior author's (KHS) experience as a primary care physician caring for Iraq and Afghanistan veterans and the first author's (CJK) expertise in health services research. The interview began by describing the goal to investigate veterans' readjustment experiences. The interview guide included questions about challenges associated with readjusting to civilian life illustrated in Fig. 1. The interview guide was pilot tested over the first five interviews, and questions were subsequently prioritized to accommodate participant time constraints [53]. We used the *interview as conversation* model that emphasizes interviewing as social interaction, a technique consistent with investigating lifecourse transitions and culture [54]. During the interview, if the opportunity arose, we deviated from the interview guide to explore novel topics not originally included. For example, when recounting challenges to reintegration, participants frequently offered advice of what they had found useful or what they would have liked to have known before returning home. We speculated that advice giving may be evidence for adaptation to the challenges of homecoming as a possible indicator for posttraumatic growth and resilience [55]. As a result, we added questions to the interview guide that explicitly solicited participants' advice to learn about the range of coping strategies they employed during the readjustment period.

The first author, a medical sociologist and linguist, conducted all individual semi-structured interviews over 6 months between January and July, 2011. Interviews lasted a mean of 63 min (SD $\pm$ 0.007 min), and were conducted either by telephone (54.8%) or in person in a private interview room (45.2%) according to participant preference [56]. Participants gave informed consent prior to each interview, and received $30 in compensation for the one-time interview. Participants gave permission to audio-record interviews, which were professionally transcribed verbatim and resulted in 1156 double-spaced pages of transcripts (mean length = 37 pages; SD $\pm$ 12 pages). We imported all transcripts into ATLAS.ti (v7.1) for qualitative data management [57].

We used Grounded Practical Theory (GPT) [58], to guide the analysis. GPT employs interpretive analytic methods, such as theme-oriented discourse analysis [59,60], to theoretically reconstruct how members' language use may construct communication practices, recurrent social actions, and situated social identities. The overall goal of GPT is to use empirical evidence to develop normative theories that are practically useful. To construct our analysis, we employed the *editing approach* [53], a multi-step process that emphasizes a naïve orientation to data by focusing on what may be meaningful to participants rather than what may have been meaningful from prior research or clinical perspectives a priori. For example, when veterans described constantly scanning the environment for a possible threat, rather than using a technical term *hypervigilence*, we used a vernacular term, such as "feeling on edge". We first identified explicit interviewer questions about challenges and advice for returning home and located participants'