

Military cultural competence in the context of cognitive behavioural therapy

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Abstract. Current work in multicultural competency has emphasized factors such as race and ethnicity, age, disability status, socioeconomic status, sexual orientation and gender. For those clinicians who work with military and veteran populations, grounding in military cultural competence is also critical as a prerequisite for providing quality care. We believe that engaging these populations from a specifically cognitive behavioural orientation allows bridging of cultural gaps and that there is a natural alignment between cognitive behavioural therapy (CBT) and many aspects of warrior culture. This paper outlines several factors related to the values of military culture and strategies of the CBT therapist to better understand and use these values effectively in clinical practice, including lessons learned from an intensive outpatient program providing speciality care to veterans and military service members.

Key words: military culture, CBT, veterans, training

Introduction

Providing high-quality clinical care across cultural groups requires that providers possess cultural competence. The American Psychological Association's multicultural guidelines suggest that all psychologists should have self-awareness of their own cultural contexts across multiple systems (i.e. across smaller communities and larger cultural contexts), the ability to reflect on cultural differences between themselves and their clients, and an attitude that supports culturally appropriate care (American Psychological Association, 2017b). Current work in multicultural competency has emphasized factors such as race and ethnicity, age, disability status, socioeconomic status, sexual orientation and gender (e.g. Hays, 2001), with relatively less emphasis on competency in military culture. This is surprising given that the military is a distinct culture, and one that represents a large and under-served population (Hall, 2011; Moore, 2011; Reger *et al.*, 2008). For military-affiliated individuals who identify with this culture, the experience of consulting a mental health provider who lacks grounding in military culture may be frustrating, alienating, and likely to dissuade the individual from

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continuing to seek help (Tanielian *et al.*, 2014). One study found that veterans who report higher levels of military identity report higher levels of psychological distress (Lancaster and Hart, 2015), indicating that those in most need of psychological services may also need care that is culturally competent.

Without culturally competent care, veterans and service members may perceive a poor fit between ‘warrior culture’ and the world of mental health treatment in general (Bryan and Morrow, 2011). Examples of this supposed poor fit are the tendency of mental health providers to use a deficit model (e.g. with focus on symptoms and/or disorders) by default, encourage emotional vulnerability, and assume an intrinsically individualistic orientation most Western mental health providers explicitly or implicitly favour (Sue and Sue, 2003). Unfortunately, research highlights that service members and veterans harbour negative views of mental health services and providers (Kulesza *et al.*, 2015) and that this population does not access mental health care at a rate equal to their apparent need (Tanielian *et al.*, 2014). However, approaching warrior mental health from a specifically cognitive behavioural orientation can allow bridging of cultural gaps. We argue that military culturally competent delivery of cognitive behavioural therapy (CBT) is complementary of many aspects of warrior culture. This paper outlines several factors related to the values of military culture and strategies of the CBT therapist to better understand and use these values for treatment success. We conclude with a description of a program specifically designed to deliver CBT to warriors within a military culturally competent framework, including discussion of lessons learned in clinical practice with this population.

Cognitive behavioural therapy

First, CBT refers to a class of interventions which posit that psychiatric disorders are maintained by modifiable cognitive and behavioural factors. Early models of CBT focused more directly on challenging maladaptive thoughts (e.g. Beck, 1970), whereas contemporary models blend emotion-focused, behavioural and cognitive techniques (Hofmann, 2011). Specific treatment procedures may differ for specific mental health problems, but CBT, in essence, is an evidence-based, time-limited intervention focusing on changing thoughts and behaviours.

CBT typically begins with case conceptualization in how a client’s thoughts, underlying beliefs and behaviours may be maintaining their emotional distress. Case conceptualization also includes functional analyses of problematic behaviours with consideration to the antecedents and consequences of behaviour. Therapists provide psychoeducation into how the client’s thoughts, beliefs and behaviours are likely contributing to their distress. Then, therapists apply evidence-based techniques to modify these factors within an over-arching frame of short-term, problem-focused treatment. The goal of CBT is to assist individuals with reducing their distress and impairment so that they can improve their ability to live according to their personal values (Twohig and Crosby, 2008).

Bridging CBT to military culture

There are numerous aspects of military culture and values that are well-aligned with established CBT practices. In this section we will explore these in greater detail (see [Table 1](#) for list of examples). Many individuals presenting for psychotherapy for the first time,

Table 1. Alignment of common military values with CBT practices

Military culture and values	CBT practices
Emphasis on daily structure	Agenda-setting
Prioritization of mission success	Explicit goals for treatment
Adherence to chain of command	Directive stance of therapist
Need for personal responsibility	Clear expectations between therapist and patient
Development of strengths	Focus on skills training
Inclination towards action	Emphasis on behaviour change

regardless of their background or cultural context, may not know what to expect, and may base their ideas of mental health treatment on media representations of therapy which are often exaggerated and/or inaccurate (Gabbard and Gabbard, 1999). Certain standard CBT practices, for example the setting of agendas and the explicit development of treatment goals, may be at odds with the expectations of those who present for treatment wanting a more open-ended or unstructured experience. However, for the warrior, who is accustomed to the structure and predictability of everyday military life and a solution-focused mentality, this over-arching imposition of structure at the level of each treatment session and of the entire treatment course mirrors the military's prioritization of mission success. A CBT therapist ideally is communicating clearly to the patient from the outset what treatment will entail, what will be expected of the patient, the desired outcome, and how the therapist expects these actions will bring about that outcome.

The emphasis on specific treatment outcomes is another way in which a CBT therapist may easily work with, and not against, warrior culture and values. As suggested by many, warrior culture is collectivistic in contrast with the more individualistic perspective endemic to most of Western society and by extension to most mental health providers (Sue and Sue, 2003). For the warrior, one's individual goals are difficult to separate from that of the unit as it pursues its given mission, whereas as therapists we are tasked with thinking about how to best serve the individual's needs. A hallmark of CBT is a detailed discussion early in treatment of specific goals towards which to work; of course the details of these goals may be infinite but at a broad level frequently emphasize behaviour change, improvement in interpersonal functioning, and/or reduction in negative affect. It can always be useful to explore with a patient *why* they desire these outcomes (i.e. their values) and *how* doing so will benefit him or her (i.e. valued living). In the case where one is treating a warrior, the patient may be inclined to think primarily about how these changes will positively affect his or her family, or possibly the success of those he or she works with, rather than how they may affect solely him- or herself. By highlighting these as reasons to motivate the patient for change, the therapist is effectively harnessing rather than being hindered by the issue of collectivistic versus individualistic orientation.

The culture of the military relies on a rigid authoritarian ranking structure in which the chain of command must be observed at all times. Some have suggested that, in context of mental health treatment of a warrior, the therapist inadvertently assumes the role of superior with the patient as subordinate (Reger *et al.*, 2008). For most therapists trained in contemporary US settings, this is not the preferred dynamic; indeed, we are taught to make efforts to *reduce* the power differential between therapist and patient in order to build rapport and increase the

likelihood of open communication. Therapists would prefer to think that they are working *with* their patients and supporting their patients' efforts towards change. It can certainly be a struggle to work productively in the enterprise of psychotherapy when a patient regards the therapist more as he or she would a commanding officer to whom he or she must answer. This is as true among CBT therapists as it is among the larger population of mental health providers. However, the therapeutic relationship observed in CBT takes a relatively more directive stance than is found in other modalities (seen, for example, in the practice of assigning between-session work and holding patients accountable to complete it). Expectations of the patient and the therapist are communicated clearly and explicitly, and the patient's inability to meet expectations are identified and discussed promptly. In this way, again, certain aspects of warrior culture – in this case, personal responsibility and willingness to take direction – are honoured by the therapist in context of the therapeutic process. (Of course, it is critical for the therapist to still highlight the ways in which he or she is *not* equivalent to a commanding officer; first and foremost the patient's right to confidentiality in a private mental health setting must be clearly articulated.)

In addition to common CBT processes involved in bridging cultural gaps, the *content* of common CBT interventions also is worth exploration. As mentioned above, the landscape of mental health treatment is likely to focus on deficits rather than strengths, in stark contrast with warrior culture's championing of strength (Bryan and Morrow, 2011). To be sure, the roots of CBT are in symptom reduction (Hofmann *et al.*, 2012). Yet, CBT is often framed by the therapist as a set of *skills* that the patient may strengthen through systematic practice. As a parallel, in the military certain skills are taught at a fundamental level and rehearsed repeatedly throughout one's career (e.g. preparation for reacting to a vehicle rollover or to indirect fire), for purposes of training individuals to respond effectively when needed. Furthermore, although CBT was developed to address psychopathology, at present there is wide-ranging agreement that many common CBT skills are components of healthy social and emotional development that might prevent psychopathology (Taylor *et al.*, 2017). Thus CBT may naturally be framed with an eye towards developing strengths rather than fixing deficits.

Possibly the most frequently cited discrepancy between warrior culture and mental health culture is the emphasis placed by the latter on emotional vulnerability, which can be seen as contrary to the clearly articulated values of the military. These values encompass over-arching themes of duty, integrity, ethics, honour, courage and loyalty (Department of Defense, n.d.). In contrast with the importance placed on emotional openness and expression in a therapeutic context, stoicism is highly reinforced in the military context. As mentioned by others (Bryan and Morrow, 2011), it is crucial that a therapist treating a warrior be able to recognize the function of this stoicism: safety of the unit and the mission, most particularly in the immediate context of combat operations. For that matter, other characteristics that may appear undesirable or pathological in context of the therapy room are highly adaptive in combat theatre, prime examples being hypervigilance and the ability to 'turn off' one's emotions – to remain calm in the presence of danger. For a significant portion of the warrior's life, these trauma-related symptoms identified by clinical science (King *et al.*, 1998) are actually occupational skills.

For the therapist treating a warrior who is highly avoidant of displaying emotional vulnerability (i.e. 'numbing'), an effort should be made to explore the positive aspects of those cultural values that have historically kept the warrior safe – even if those same values may be hurdles in the patient's being able to benefit fully from therapy. With regard to CBT

practice specifically, a way to address the patient's avoidance of emotional expression is to keep the primary focus on behaviour. Behavioural interventions, specifically those based on principles of exposure, stimulus control and/or behavioural activation, are a natural fit with the warrior culture's inclination towards *action*. In our treatment setting, which primarily implements exposure-based interventions, we have been struck by how many of our patients conjure metaphors likening an assigned exposure to a dreaded but critical chore required of them as service members (physical training being the most commonly cited). Not infrequently our patients will greet the assignment of a behavioural intervention with a mixture of anxiety and excitement, and will recall instances from their service history in which they were asked to rise to the occasion.

Military culture and case conceptualization

Often, CBT is criticized for being too rigid (House and Loewenthal, 2008). Particular critics might attest that manualized treatments do not account for individualized conceptualization and treatment, consequently influencing patient care (Sanders, 2010). Cognitive behavioural therapists may be trained to adherence in manualized treatments, but flexibility guided by case conceptualization is key for high-quality CBT (see Abramowitz, 2006; Kendall and Beidas, 2007). A thorough conceptualization that accounts for a client's individual and cultural experiences allows understanding of the patient's schemas, or lenses through which he or she interprets the world. Furthermore, functional analysis is essential in any treatment that relies on behavioural principles. Well-constructed treatment manuals allow therapists to engage in functional analysis in order to apply the principles of a treatment in the case of a wide array of specific client factors (Addis *et al.*, 2006). The factors that influence the patient's behaviour are related to the patient's unique learning histories, including learning that took place within a cultural context. These lived experiences influence his or her assumptions, rules and beliefs which act to guide how that person interacts with the self, the world, and others.

Our veteran and active duty service members are routinely challenged by having to delicately balance both military and civilian aspects of their lives while remaining true to their own identities and cultural values. However, our nation's warriors are diverse in gender, sex, sexual orientation, religion, spirituality, race, ethnicity and socioeconomic status; all of which affect how they move about in their communities, families, the world, and the military. In addition, there exist distinct subcultures within the larger military associated with factors such as branch of service (as described above), active duty versus selected reserves, enlisted personnel versus officers, era of service, and military occupational speciality (for example, combat medics). When working with this population, an understanding of antecedents to or consequences of maladaptive behaviour requires an understanding of the sociocultural context of those behaviours (Hayes and Toarmino, 1995). For example, a client who is still an active-duty commanding officer may avoid expressions of emotion in group therapy due to different behavioural contingencies than a lower-ranking Vietnam veteran. To provide CBT according to evidence-based principles, adaptations should be based on idiosyncratic client factors including, for veterans, an understanding of military culture.

As mental health professionals, it is our responsibility to work alongside our patients in order to understand the intersectionality inherent in their lives (American Psychological Association, 2017a). The cognitive behavioural conceptualization allows the intersectionality of an individual's identities to be discussed and explored with the goal of establishing how

their cognitive schemas were developed and how they are manifesting in their current lives. As the therapeutic relationship is embedded within the social context, not only does this allow space to explore the client's cultural and socioeconomic context but create change in how the individual responds to this context (La Roche and Maxie, 2003).

An important dimension that transcends all contexts, identities and relationships is the client's experience of power that further influences their schemas. Warriors are faced with power structures in both their civilian and military lives that affect their experience of privilege or lack thereof. The patient-centred nature of CBT allows for the therapeutic relationship to be adjusted individually based on the patient's experience of power and the clinical relevance.

In practice: the Emory Healthcare Veterans Program

Implementing CBT in a program specific to warriors has allowed the Emory Healthcare Veterans Program (EHVP) to gather a number of lessons learned in providing military culturally competent care. EHVP is one of four academic medical centers (including Rush University Medical Center, UCLA Health, and the Massachusetts General Hospital) that form the Warrior Care Network, a partnership funded by the Wounded Warrior Project with the aim of providing evidence-based treatment and conducting research to advance clinical practices for post-9/11 warriors suffering the invisible wounds of war [including post-traumatic stress disorder (PTSD), traumatic brain injury (TBI) and other forms of psychiatric illness]. Warriors accepted into EHVP receive comprehensive, multidisciplinary care via traditional outpatient psychotherapy or an innovative 2- or 3-week intensive outpatient program (IOP) consisting of daily individual psychotherapy, daily group psychotherapy (including group-based *in vivo* exposure therapy, if indicated), and adjunctive programming such as motivational wellness coaching. Program development has been shaped through an iterative process guided by continuous collection of outcome data and client feedback.

The structure, format and content of the IOP has been designed to ensure culturally competent practice and improve warrior engagement in treatment. In order to ensure cultural competence in all aspects of program administration, all staff, regardless of clinical, research or administrative role, complete 10 hours of training in military culture, warrior values and the impact of deployment on service members. The EHVP also employs warriors as both clinicians and staff members; civilian providers are encouraged to consult with warrior team members regarding military culture as needed, and warrior team members are encouraged and empowered to express concerns regarding any aspect of the program that may be incompatible with the values of its patient population as well as provide guidance and suggestions for program development. Additionally, warrior patients are greeted by warrior staff members as their first contacts at the beginning of the IOP, who conduct a program orientation and review of behavioral expectations. In orientation, warrior patients are encouraged by warrior staff to go 'all in' during treatment, and success in treatment is framed in terms of willingness to actively confront and address clinical concerns. Behavioural expectations for program participation, and consequences of failure to adhere to program expectations, are made explicit at the outset of care. Patient time is heavily structured and accounted for, and warrior patients are provided with printed itineraries outlining times and locations for all elements of the program.

Treatment plans at EHVP are individualized and developed in a multidisciplinary case conference based on data from comprehensive assessments, which include structured and semi-structured diagnostic interviews and well-validated self-report instruments.

Evidence-based treatments are administered based on comprehensive case formulations and in a culturally competent manner. Clinicians at EHVP specialize in cognitive behavioural approaches, with particular expertise in exposure therapies for PTSD and anxiety disorders. Consequently, the majority of warriors receiving treatment at EHVP (approximately 85%) present with a primary diagnosis of PTSD and complete prolonged exposure therapy (PE; Foa *et al.*, 2007; Yasinski *et al.*, 2017).

The exposure-based approach of PE is inherently consistent with warrior values. The primary objective of PE is to elicit recovery from trauma via emotional processing of the traumatic event and confrontation of safe but anxiety-provoking situations that have been avoided as a consequence of trauma exposure (Foa *et al.*, 2007). PE contains four core components: psychoeducation about trauma and common reactions, breathing retraining, repeated *in vivo* exposure to avoided stimuli, and repeated, prolonged revisiting of the trauma memory via imaginal exposure. As an active, highly structured and solution-focused psychotherapy that guides patients in confronting and processing difficult emotions, PE is consistent with warrior values of courage and commitment to valued action. PE has also been shown to be effectively administered within a group format (Smith *et al.*, 2015), and there are data to suggest that peer support may facilitate successful engagement in PE for military personnel and veterans (Hernandez-Tejada *et al.*, 2017).

The implementation of PE with military and veteran patients can also be facilitated by careful consideration of military cultural values in the application of the manualized components of the treatment. In the EHVP IOP, a single psychoeducation session within group format is used to deliver the contents of the first two sessions of PE: eliciting information about patient symptoms, discussing common reactions to trauma, presenting the rationale for exposure therapy, providing an overview of the treatment process, introduction of the concept of subjective units of distress, and construction of an exposure hierarchy. The communal discussion of common reactions to trauma facilitates group cohesion, aids in destigmatization of mental illness and mental health treatment, and encourages accountability of warriors to one another as goals and exposure targets are shared in front of other group members. (To protect patient privacy, group members are informed that they may also approach group leaders separately if they wish to discuss additional exposure targets or symptoms in a private setting, particularly if discussion of targets necessitates unintentional self-disclosure of trauma content.) In the second group session, the process of *in vivo* exposure is discussed, the concept of safety behaviours is introduced, and warriors complete their first exposure exercise with a clinician. Explicit discussion of safety behaviours, including the likelihood of interference with recovery and unintended consequences of use of safety behaviours such as those that characterize many hypervigilance behaviours (e.g. scanning, contingency planning, carrying a weapon), is particularly important when working with this population in light of a common shared history of training in effective responding to dangerous situations. Strategies that may aid in this discussion include: emphasizing the adaptive nature of these behaviours in dangerous contexts *vs* relatively safe contexts; framing reductions in reliance on safety behaviours in terms of increasing choice, flexibility, and accurate responding in various environments; focusing on exposure as a pathway to increasing vitality and enjoyment of life; and encouraging warriors to reflect on and articulate ways in which use of safety behaviours may be values-inconsistent.

Remaining group sessions are goal oriented and consist of a check-in regarding completion of assigned homework exposures, planning for an *in vivo* exposure to be completed during the

scheduled group time, completion of exposures (typically on one's own once understanding of the exposure process is demonstrated, in order to reduce reliance on the presence of other warriors as a safety behaviour), and returning to report on the exposure experience and plan for homework. Problem-solving for task completion is completed as a group. To encourage self-efficacy, early exposures are typically planned with considerable guidance of the group facilitators, with a graded progression towards entirely self-directed exposures as warriors progress through the program. Warriors begin the 2- or 3-week IOP on a rolling cohort basis, with new cohorts beginning each week and participating side-by-side in the same group sessions and ancillary services as warriors in earlier cohorts, who typically report and evidence improvement in PTSD symptoms by the second week of the program. This overlap in cohorts is consistent with military values related to leadership and the concept of 'leaving no man behind', facilitating motivation of the newer warriors by the senior warriors and promoting increased mastery of skills among senior warriors through the process of providing guidance and feedback to new group members.

Imaginal exposures in the IOP are conducted in daily individual sessions with clinicians trained in PE and military culture. As with *in vivo* assignments, warriors are assigned daily homework and held accountable for homework completion between each session. Knowledge of warrior values can enrich the imaginal exposure process via consideration of how the treatment rationale is presented as well as enabling informed exploration and restructuring of schema. For example, it is often helpful to discuss the concept of stoicism as an adaptive behaviour in military contexts when addressing emotional processing, particularly when working with a warrior patient who may present as under-engaged in early imaginal sessions. In particular, exploring the concept of courage as being willing to experience fear and to act regardless is consistent with warrior values and can help to reframe the experience of emotional expression within the therapeutic context as a sign of strength. Likewise, awareness of military values and conventions can facilitate processing following imaginal exposure and reduce discord in the therapeutic alliance that may arise from a lack of understanding on the part of clinicians. For example, expectations about responsibility, leadership and decision-making within a military context may vary widely from those within a civilian context. Failure to understand the extent to which service members in a deployment context can and cannot take actions independent of a senior member's orders, as well as the reasons for expectations of compliance with orders and consequences of disobeying, may lead to clinicians' erroneously questioning the actions of a service member in such a way as to inadvertently reinforce negative beliefs about responsibility and guilt. To support competent treatment provision, EHVP clinicians meet periodically throughout the week to review patient progress; it is common for these discussions to include sharing of information regarding military contexts and warrior values as well as reflections on culturally competent practice.

Preliminary data suggest that this approach has been successful with regard to both symptom improvement and veteran engagement (Yasinski *et al.*, 2017). With regard to PTSD symptom reduction, baseline-completion effect sizes using the PTSD Symptom Checklist for DSM-5 (Weathers *et al.*, 2013) have been large ($n = 42$, Cohen's $d = 1.31$; Yasinski *et al.*, 2017). Anonymous feedback collected at treatment completion indicates that 84% of veteran patients believe treatment has improved their concerns and 95% of veteran patients report satisfaction with the program overall. Most strikingly, the program has seen a treatment completion rate of approximately 96%. This low drop-out rate is substantially lower than what has been shown in traditional outpatient PE, where 30% of patients drop out of

treatment (Hernandez-Tejada *et al.*, 2017). Per our observations, consideration of both the natural congruence between the values of warrior culture and PE, as well as thoughtful implementation of PE in light of specific aspects of warrior culture, has strengthened the therapeutic process and improved patient engagement.

How to improve military cultural competence

The vast majority of community-based civilian clinicians are not prepared to work with the military population (Kilpatrick *et al.*, 2011; Tanielian *et al.*, 2015). However, even those working in warrior specialty clinics such as the EVHP, who seem to be immersed in military culture, must make a concerted effort to develop their military cultural competency. The military has a long and rich history and its culture is always evolving with each new era of warriors. Therefore, all clinicians working with warriors must monitor their competence and make changes to their practice, when needed. We recommend a multi-pronged approach using didactics, consultation and self-reflection.

With respect to didactics, we recommend online tutorials as a starting point. In particular, it is very helpful to first have a sense of the organizational structure of the military and its branches, a timeline of major wars and operations, the ranking hierarchy, and its language (e.g. common acronyms and sayings). A surefire way to communicate incompetence in military culture is to be unaware of recent conflicts (e.g. Operation Iraqi Freedom and Operation Enduring Freedom) or the differences between, say, a corporal and a colonel. On the other hand, it is important to not claim expertise but rather maintain a position of a learner – asking for clarification on military culture communicates that the patient is the expert and that his or her culture is important. While many warriors enjoy teaching others about the military, they are not responsible for developing clinician competencies. We recommend free online tutorials in military culture provided by the Center for Deployment Psychology (www.deploymentpsych.org/military-culture-course-modules). Students looking for more in-depth didactics and experiential learning should consider pursuing traineeships, internships and fellowships with the Veterans Health Administration, where thousands of year-long positions are available each year to aspiring psychologists (www.psychologytraining.va.gov), social workers (www.socialwork.va.gov/education.asp), and other mental health professionals.

With respect to consultation, we recommend starting with assessing your professional network and making mindful choices of connections to foster. If connecting with clinicians working in military or veteran contexts is not feasible, remember there are thousands of clinicians in community and university settings that have been trained by the Veterans Health Administration, the Center for Deployment Psychology, and/or PsychArmor, a training institute which offers education in military culture. One useful networking strategy is to engage with military-related special interest groups and divisions in national and international professional organizations (e.g. Association for Behavioral and Cognitive Therapies, American Psychological Association, International Society for Traumatic Stress Studies, Anxiety and Depression Association of America, and Association for Contextual Behavioral Science). For those seeking formal consultation in interventions used with warriors, there are several organizations that offer free or paid consultation. For example, the STRONG STAR Training Initiative provides 2-day workshops and 6 months of weekly consultation calls for evidence-based treatment for PTSD (www.strongstartraining.org).

Furthermore, those planning to supervise or consult others in interventions frequently used for warriors should consider developing these competencies through formal training programs such as the Emory University Prolonged Exposure Consultant Training Program (www.psychiatry.emory.edu/programs/pe_consultant_training).

Lastly, with respect to self-reflection, we recommend that clinicians periodically look inward for any biases and areas of ignorance and, when needed, resolve barriers. As stated earlier, the military has a long and rich history and no clinician has ever lived independent of the military's local and global impact. We all have biases, opinions and unique experiences regarding the armed services. As one makes a concerted effort to develop military cultural competence, one should monitor how their perspective might change. One useful strategy for self-reflection is to engage in cultural learning activities. For example, one might engage in mindful consumption of literature and film, preferably as recommended by service members and veterans within one's professional and personal networks. (As a starting point, to gain an intimate view of combat, we can recommend *What It Is Like to Go to War* by Karl Marlantes and *The Things They Carried* by Tim O'Brien.) We also recommend visiting military installations, which often include museums and visitor centres with representatives eager to share the local history. At the EHVP, some of us have participated in veteran philanthropic events and community gatherings as a way to engage with the military culture in a non-clinical setting. Whatever your strategy, repeated participation in cultural learning activities will cultivate self-reflection regarding how you understand the military and its culture. Accurate self-reflection will guide you to further developing military cultural competence.

Conclusion

As outlined above, we believe CBT complements many aspects of military culture. However, for the warrior to benefit from CBT, the clinician must be mindful in how he or she leverages the strengths and resources embedded within this distinct culture. We have provided ways in which to frame and deliver CBT with warriors and we hope our setting, the EHVP, provides an example for how military cultural competence can enhance therapeutic outcomes. Regardless of one's current level of competence, every civilian clinician can work to improve his or her familiarity and responsiveness to warrior values and experiences. Our warrior patients often remark upon the disparity between the military world and the civilian world. They are correct. The onus is on us to better understand their world.

Main points

- (1) Military cultural competence is critical to working effectively with military service members and veterans in clinical practice.
- (2) Many principles and assumptions of cognitive behavioural therapy are in natural alignment with the values and characteristics commonly associated with military culture.
- (3) Adopting a military culturally competent approach into cognitive behavioural practice is likely to promote treatment engagement and retention.

Conflicts of interest

The authors have no conflicts of interest with respect to this publication.

Ethics statement

The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as defined by the American Psychological Association. No additional ethical approval was required as no data was collected for or is reported in this manuscript.

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Recommended follow-up reading

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Learning objectives

- (1) To explain the importance of military cultural competence to successful engagement in treatment.
- (2) To describe specific examples of how cognitive behavioural therapy complements aspects of military culture and values.
- (3) To identify resources for furthering one's own grounding in military cultural competence.