Military Culture and Cultural Competence in Public Health: U.S. Veterans and SARS-CoV-2 Vaccine Uptake

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Abstract

As part of the U.S. effort to encourage vaccination for SARS-CoV-2, scholars have emphasized the importance of culture and identity in vaccine uptake decisions. The culture and identity of military service are poorly understood in the context of understanding Veterans’ acceptance of COVID-19 vaccines. In analyzing data from semi-structured interviews with Veterans in homeless transitional housing, this article examines their willingness to get vaccinated for COVID-19. Themes invoking military culture included (a) mandatory vaccinations in the military; (b) cynicism and mistrust toward the government; and (c) trust of and reliance on Veteran peers with shared military culture in decision-making. To further understand how military culture influences vaccine uptake and explore avenues for building culturally competent, trust-based health care interventions with Veterans, a previously published case study of Veterans volunteering in Team Rubicon (TR) disaster relief is examined. Veteran participants in TR described the experience of being in a Veteran-centric organization as an empathetic context wherein they were

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able to: (a) address their reintegration struggles; (b) gain a new appreciation of their Veteran status; and (c) connect with trusted peers. Given TR’s credibility, Veteran-serving health care organizations could collaborate with Veteran-led organizations to expand shared efforts to address Veterans’ distrust of government-promoted vaccines.

Keywords
Veterans, COVID-19 vaccination, military culture, public health, cultural competence, vaccine uptake, pandemic response

Introduction and Background
The U.S. public health system strongly encourages vaccination for SARS-CoV-2, the virus that causes COVID-19, as an important tool in stemming the tide of adverse impacts of this public health emergency. As part of this effort, advocates and scholars alike have emphasized concerns that historical oppression and marginalization by the medical system and government may influence how Black, Hispanic, and Indigenous populations perceive and respond to the public health system’s recommendation to get vaccinated (Schoch-Spana et al., 2021). Understanding these historical reasons behind such vaccine reluctance is vital to an equitable public health response to COVID-19 because Black, Hispanic, and Indigenous populations face a disproportionate burden of SARS-CoV-2 infection and death (M. A. Garcia et al., 2020; Labgold et al., 2021; Webb Hooper et al., 2020). Cultural competence, the ability to respect communities’ historical reasons for distrust and skepticism, is vital to an equitable public health crisis communications strategy promoting vaccination (Lofaro & Sapat, 2022). An equity-focused approach to public health efforts to engage with communities of color and other subpopulations around vaccine uptake requires an empathetic approach. Such an approach involves public acknowledgment of historical abuse and other reasons for distrust of health care systems, such as ongoing health disparities (Schoch-Spana et al., 2021).

U.S. military Veterans also face a disproportionately greater disease burden from COVID-19 due to existing health factors (Cardemil et al., 2021). They are also a group that has had a complex relationship with the U.S. government and have experienced health care inequities in the form of slow government responses to health conditions related to military service (Elwy et al., 2021; Hobbs, 2008; Jasuja et al., 2021; Rein, 2021). Their views toward COVID-19 vaccination are not well understood, even if they have similar vaccination rates to the U.S. population, and the factors that shape their
vaccination decisions are even more poorly understood (Elwy et al., 2021; Jasuja et al., 2021; Rein, 2021). Within the public health community, understanding of military culture and Veteran culture, and their impact on Veterans’ perception of vaccines and public health, is limited. Public health campaigns rarely incorporate principles of military-informed care into their engagement or messaging practices (Borah et al., 2021; Franco et al., 2021; Hobbs, 2008). While the public health field has made significant efforts to recognize the histories of racial and ethnic communities’ distrust in their efforts, Veteran engagement has not been a significant feature of the U.S. public health system’s efforts to build trust with marginalized subgroups. Prior studies on Veterans’ uptake of COVID-19 vaccines have not examined Veterans’ military culture as a factor (Der-Martirosian, 2013; Elwy et al., 2021; Jasuja et al., 2021). Efforts to vaccinate Veterans in pockets of vaccine-hesitant areas find that, for some Veterans, refusing a vaccine is a form of individual resistance to governmental power stemming from their feelings of betrayal (Rein, 2021). The complex historical relationship between Veterans and the U.S. government, particularly regarding questions of institutional power and bodily autonomy, is likely to shape their response.

This article examines the attitudes and beliefs of Veterans enrolled in U.S. Department of Veterans Affairs (VA) homeless programs about COVID-19 vaccines and their decisions regarding vaccinations. It seeks to understand how military culture and Veterans’ group identities influence their responses to recommended COVID-19 vaccination. We seek to understand how aspects of their identity, as resistive to institutional power, impact their interpretations of such health interventions. Analyzing data from interviews with Veterans enrolled in VA-funded homeless transitional housing, we explore their responses to COVID-19 vaccines. We unravel how military culture shapes Veterans’ worldviews and how these sociocultural dimensions are reflected in their responses to COVID-19 vaccines. We analyze these Veterans’ responses to vaccines and health behavior recommendations in the context of navigating their bodily autonomy, and ultimately, as forms of resistance to institutional power.

Thus, we introduce the need for culturally competent health care practice informed by the culture and history of the Veterans’ military experience as a more empathetic approach in efforts to promote vaccination. An empathetic approach to community engagement is foundational to person-centered interventions that recognize the need for trust-building within populations such as Veterans. Such approaches are the underpinning of humanistic psychology, which emphasizes supporting autonomous decision-making and encourages gaining the buy-in of self-directed individuals (Joseph & Murphy, 2013; McLeod, 2019; Quinn, 2013).
Finally, we examine the implications for public health practice. In July 2021, the VA found that 10% of its enrolled Veterans (600,000 Veterans) indicated that they did not intend to get the COVID-19 vaccine (Slack, 2021), suggesting a need for more effective engagement with them to promote vaccine uptake. As of August 2021, 60% of Veterans participating in VA homeless transitional housing nationwide had received at least one vaccine dose, while 40% remained unvaccinated (Balut et al., 2021). In contrast, 79% of the U.S. population has received at least one vaccine dose, while 67% had received two doses. While these Veterans who are residing in VA-funded housing may be getting vaccinated in numbers comparable to the U.S. general population, vaccine hesitancy is significant in this population, highlighting the value of understanding whether factors related to military culture may be impacting their decisions. As Veterans transition from military to civilian roles, they often navigate their social identities based on their membership in various social groups (Thompson et al., 2017). Amid this post-military transition, some Veterans may find greater trust and affinity in groups that possess understanding and empathy for military culture than groups lacking that cultural awareness. One clear example is Team Rubicon (TR), whose credibility stems from its recreating of military culture in ways Veterans have autonomy over and from its status as a Veteran-run organization (Kranke et al., 2016). Depending on the cohort, some Veterans, such as Vietnam-era Veterans (Heslin et al., 2013), post-9/11 Veterans who comprise many TR participants (Kranke et al., 2016), or Veterans experiencing homelessness (Gin, Balut, & Dobalian, 2022), distrust government institutions due to their own and peers’ experiences and maybe consequently cynical and resistant to government public health campaigns that are overly coercive and not sufficiently respectful of their autonomy and their military experiences.

The Veteran Experience—What the Literature Tells Us

Military identity and its general influence on the behaviors and perspectives of former service members remain opaque to civilians, including many health care system providers (Borah et al., 2021). “Military culture,” consisting of “the values, traditions, norms, and perceptions that govern how members of the armed forces think, communicate, and interact with one another and civilians” (Coll et al., 2011, p. 489), is a distinct subculture within American civilian society that continues to be significant for some Veterans after separating from the military (Exum et al., 2011; Meyer et al., 2022; Weiss & Coll, 2011; Wool, 2015). For example, military culture may shape their willingness to
engage with services such as mental health care, due to concerns about the stigma of “weakness” going against military values of toughness (Castro et al., 2015; Weiss & Coll, 2011).

Becoming a Veteran involves joining the military, serving, and transitioning from the military into civilian life. This process of socialization may hold insight into how belonging to this cultural subgroup “matters” when it comes to how Veterans perceive and respond to information and health recommendations. We build on the work of Coll et al. (2011), and additional literature regarding the unique, experience-based mindset of former members of the U.S. military. Becoming a “Veteran” can be broken down into four processes. These are not intended to include all psychological processes involved with joining the U.S. military, which are complex and diverse, nor are they intended to be generalizable to all Veterans.

**Entering the Military: A New Relationship With the Government**

First, giving up one’s existing civilian identity and joining the military involves entering a long-term, complex relationship with the government (Hobbs, 2008; Jasuja et al., 2021; Rein, 2021) and accepting the U.S. government’s authority over oneself and one’s own body. In some cases, this involves forgoing bodily autonomy and informed consent over medical and other decisions. In particular, military members are not afforded the same option of informed consent that civilians enjoy, as established in the United States through the 1979 Belmont Report, over their acceptance of investigational drugs and vaccines (Black, 2007; Rettig, 1999; U.S. Government Accountability Office [GAO], 2002):

> A service member “freely agrees when joining the military to relinquish autonomy” to the interests of the unit or mission. Furthermore, they are aware “as they approach actual fighting, their autonomy dramatically decreases.” (Rettig, 1999: p. 50)

Individual informed consent was not required in the military’s anthrax vaccination program (Black, 2007; GAO, 2002) during post-9/11 military campaigns in Iraq and Afghanistan nor for investigational drugs such as pyridostigmine bromide and botulinum toxin administered during the 1991 Gulf War in Iraq (Rettig, 1999). Military service also includes the historical legacy of exposures to environmental hazards for which compensation for service-connected disability was previously denied by the U.S. government. Currently, the VA is studying the long-term health effects of such exposures as Agent Orange in Vietnam, and respiratory illnesses from burn pits while
serving in Iraq and Afghanistan (U.S. Department of Veterans Affairs, 2022), and has subsequently recognized the health effects of these exposures as service-connected disabilities. As of April 2022, respiratory illnesses connected to exposure to airborne hazards in burn pits in the Middle East were eligible for presumed service-connected disabilities (U.S. Department of Veterans Affairs, 2022).

**Acculturation: Adopting Military Cultural Values as One’s Own**

Second, joining the military, individuals often take on a new identity (Coll et al., 2011, p. 489). Military cultural values such as “service, competence, sacrifice, mission, and collectivism” (Meyer et al., 2022) are deeply ingrained within the identity of military members. Military members forgo privileges taken for granted by most U.S. civilians, subsuming their individual autonomy to an institutional authority, whose structure of rewards and punishments is designed to foster conformity and collectivism. For example, despite military policy ostensibly allowing lesbian and gay service members to openly serve, previous research (McNamara et al., 2021) has suggested that these individuals may distrust the policy and still feel pressured to hide their sexual orientation due to their perception that military culture implicitly does not allow such differences and they could be punished as a result. Military culture has also been found to be at odds with non-normative gender and sexuality identities (Meyer et al., 2022).

**Military Deployment (or Service Without Deployment): Forming Lifelong Bonds of Trust**

Third, combat-related deployment forms powerful, lifelong bonds of brotherhood and effects drastic psychological changes, many life-transforming (Castro et al., 2015). For some, deployment combines the stress of being in a foreign land for “endless hours in a miserable work environment” with occasional moments of existential “terror and destruction of human life” (Coll et al., 2011, p. 491). The intensity of the experience and the bonds forged therein further reinforce the perception of necessary sacrifice and trusting only others who share this culture. These conditions can cause Veterans to continue having mistrust toward those who are not in-group members, a form of psychological hypervigilance wherein they adopt the narrative that “if you’ve never been there, you wouldn’t understand” (H. A. Garcia, 2017). Even many Veterans who have never experienced foreign deployment in a theater of war go through this inculcation into the military culture and
establish strong cohesive bonds with other team members, making these military-forged relationships highly salient (Coll et al., 2011). Long after separation, these bonds can continue to be meaningful, as Veterans often evaluate the trustworthiness of information and people through the lens of shared Veteran identity; that is, they may view information from fellow Veterans with greater trust than information from non-Veterans (Alenkin, 2015).

Separation and Navigating Culture and Identity Transition

Fourth, military separation is often accompanied by a sense of disillusionment. Some Veterans return with a loss of trust in the U.S. government (Coll et al., 2011, p. 488). After being psychologically embedded within the military culture for years, separation typically engenders a type of “culture shock” and disorientation (Coll et al., 2011, p. 488). “No one leaves unchanged” is often the description given to the experience of separation after military service. After the socialization and experience of military service, fully transitioning to being a civilian may be very challenging, if not impossible for some Veterans.

Separation confers on Veterans a level of autonomy they gave up when they joined the military; upon separating Veterans are now free to make many decisions over their body, including health care choices as well as food, hairstyle, and daily attire. However, this can also be overwhelming and for some feel like a letdown. The disillusionment and loss of raison d’etre may cause Veterans to question their own self-worth and feel that they are simultaneously isolated and only able to connect with others who share their military identity. Veterans transitioning from military to civilian roles must negotiate their social identity based on their membership in various social groups and the value that they attach to those memberships (Thompson et al., 2017). For some, the process can involve difficulties in negotiating between their perceived military versus civilian group allegiances, leading to isolation and mental health challenges (Castro et al., 2015; Coll et al., 2011; Kranke et al., 2016), as has been established in interviews with Veteran volunteers active in Team Rubicon (Kranke et al., 2016). Veterans struggling with such reintegration challenges are particularly distrustful of public health initiatives wherein the voices of Veterans are largely absent (Franco et al., 2021) due to gaps between military and civilian experiences that exacerbate Veterans’ perception of a divide that can only often be bridged by Veteran peers (Hobbs, 2008). For some Veterans, mistrust of civilians, whom they perceive to be incapable of comprehending the scale of their sacrifice and lacking similar loyalty and commitment, remains after separation (H. A. Garcia, 2017).
Additional detail on the separation process, as discussed by Veterans participating in TR (Kranke et al., 2016), is provided in the discussion section.

**Veteran’s Military Culture, Health Decision-Making, and the COVID-19 Vaccine**

This article focuses on Veterans’ military culture to identify how the lived experience of being acculturated into the military, followed by separation, leads some group members to view themselves as separate and apart from mainstream U.S. society, with their own unique subculture. For some members, this status permeates many aspects of their lives, especially their relationship with and perception of the U.S. government and government health care such as the VA. The effects of Veteran experiences and culture on their health decision-making have been established in existing literature, particularly in work in the field of Veteran mental health (Borah et al., 2021; Coll et al., 2011; Hobbs, 2008). In examining the impact of this subculture on Veterans’ narratives around their COVID-19 vaccine decisions, we argue that a more empathetic, culturally competent approach to engaging with this group would be more effective in building trust, both for the COVID pandemic and for future health campaigns and health emergencies.

Past research has identified differences in health-seeking behavior among Veterans, which may suggest attitudinal factors affecting their decisions. Borah et al. (2021) identify some possible adverse consequences of communication breakdowns that may result from Veterans encountering health care that is not informed by military culture. When some Veterans feel that their concerns are not adequately heard or addressed, they may agree to comply with provider recommendations and then later fail to follow through due to their conditioning of obedience to authority although they may not buy into recommended health behaviors (Borah et al., 2021). Heslin et al. (2013) found that Veterans’ levels of trust in local health departments were markedly different from those of non-Veterans, especially among Vietnam-era Veterans expressing cynicism toward the government. Kranke et al. (2016) suggest that shared cultural values of self-reliance or “a bootstrap mentality” instilled during military service can hinder their willingness to seek or accept recommended mental health services. Mental health providers are therefore advised to better have cultural competence in military culture to better empathize with Veterans and thus “get through to them” more effectively within the therapeutic relationship (Borah et al., 2021; Castro et al., 2015; Coll et al., 2011; Meyer et al., 2022). However, this body of work does not fully speak to how Veterans’ military culture might shape perceptions toward COVID-19 vaccination.
In this article, we argue that the role of Veteran culture has been neglected in both research on Veterans’ vaccine behavior and efforts to encourage vaccine uptake among Veterans. Using data from interviews with Veterans in VA homeless programs, this article seeks to better understand how Veterans, especially those who have experienced challenges with maintaining stable housing, respond to, and interpret the COVID-19 vaccines. It aims to thoroughly unpack the role of Veteran experience and culture in an effort to better understand how campaigns to encourage vaccine uptake can gain greater credibility within the Veteran population.

**Approach and Method**

This article presents data and findings from a study focused on vaccination attitudes among Veterans enrolled in VA homeless transitional housing. This study was reviewed and approved by the Institutional Review Board at the VA Greater Los Angeles Health Care System. Data were drawn from semi-structured telephone interviews conducted between January and April 2021 with 20 Veterans residing in the VA’s Grant and Per Diem (GPD) program, which funds nonprofit organizations providing transitional housing to Veterans experiencing homelessness. Only Veterans participating in VA GPD programs were eligible to be recruited for this study. Interviews were also conducted with staff leaders at seven GPD organizations and VA staff members who assisted with recruitment by inviting Veteran residents to sign up to participate in the study. Further details regarding the recruitment methods, interview guide, and data collection and analyses are available elsewhere (Gin, Balut, & Dobalian, 2022).

Digital audio recordings were transcribed verbatim, and transcripts were analyzed thematically. Themes were reported based on substantive significance (Patton, 2002, 2014), or how the themes inform the existing literature. As there is a paucity of research on homeless Veterans’ vaccine attitudes, we first conducted open coding to identify emerging themes. Data corresponding to these themes were sorted by shared content using the “sort and sift method” (Maietta et al., 2021) pulling together interview passages with shared meaning and adopting a phenomenological approach to interpreting Veterans’ narratives regarding their life experiences. We coded Veterans’ reactions to questions regarding their willingness to get vaccinated; the codes reported in this article regarding veterans’ military identities were emergent codes identified through inductive coding, allowing patterns in the codes to emerge. Two researchers coded a single interview to cross-check for interrater reliability. Researchers then coded the remaining interviews independently and reviewed coded text, using the constant comparative method (Boeije, 2002), to sort the
codes by shared findings (e.g., “mandatory military vaccines” and “distrust of government.”). The resulting group codes were compared, contrasted, and sorted into themes. When differences in the analysis occurred, the individuals on the research team provided justification for their coding scheme, and the theme was adjusted so that it encompassed the additional components identified. From this, a master codebook was created and used for the analysis of the final interviews.

To ensure that our interpretation and understanding of Veterans’ lived reality accurately represents Veterans’ perspectives, we solicited input from a VA Veteran Peer Specialist to help in triangulating our findings and contextualizing our data. This Veteran, who is identified in the acknowledgements, served in the U.S. Marine Corps from 1997 to 2001. Peer Specialists are Veterans “with mental health experience—actively engaged in his or her own recovery—trained and certified to help other Veterans” (U.S. Department of Veterans Affairs, 2018). As important allies for Veterans, they bring the added advantage of familiarity with the experiences of other Veterans, as well as their own.

We also examine our identities in the research process: two authors identify as “military-connected”; by military-connected, we mean having a service member or veteran that is a close family relation. None of the authors has personally served in the U.S. military. However, all four authors have over a decade of experience each working on Veterans’ issues in both our research and practice, and we are all committed to understanding the lived realities of Veterans, particularly those who experience challenges in their return to civilian life. In conducting and interpreting interviews, the authors sought to present empathetic understandings of Veterans’ experiential realities from their vantage points and perspectives (Meyer et al., 2022), in keeping with phenomenological research and practice traditions in qualitative research methods and humanistic psychology, respectively.

**Findings and Analysis**

All 20 Veterans interviewed were living in VA GPD facilities, were male, and were between 29 and 65 years old, with most in their 40s and 50s. Eleven were White, five were people of color, representing Black, Native American, Hispanic, and Biracial identities, and four declined to state their racial/ethnic group. Veterans were not asked any questions about the military, their service, nor their identities as Veterans. Rather, these topics emerged as they shared their stories. Veteran culture themes were spontaneously mentioned by 11 of 20 Veterans, alluding to its salience.
Three themes emerged: (1) mandatory military vaccination and bodily autonomy; (2) distrust and cynicism toward the government; and (3) reliance on Veteran peers in vaccine decisions.

**Mandatory Military Vaccination and Bodily Autonomy**

Veterans who served in the post-9/11 conflicts mentioned mandatory vaccines such as the anthrax vaccination program and the influenza vaccines. One Veteran, who was eager to get the COVID vaccine, rationalized it in terms that mirrored his military thinking:

> when somebody offers me a vaccine, I’m like all right I’ll get it. I’m prepared. . . I’m used to being a guinea pig. I was in the Army active for three and a half years, and then I did nine and a half years total, the reserve and active. . . You know people sticking needles in me, telling me, all right you need to take this, and I’m like okay. (MA4)

His willingness to accept vaccines was partly based on his experience with mandatory vaccines in the military, that is, desensitization. However, his narrative is also tinged with cynicism, conveying skepticism about complying with taking medicine that he barely understands and portraying himself as a passive subject, complying with having needles stuck into him. His perception of the experimental aspects of the anthrax vaccine that he received continues:

> Basically, what they did is they gave everybody this vaccine to test it out. Because that’s what they do. They give it to prisoners and military members to see what exactly is gonna happen over a period of time because they’re government property. (MA4)

Veterans’ quotes about mandatory vaccination in the military involved processing what it means to receive these vaccines then, and the implications of getting the COVID-19 vaccine now. Another post 9/11 era Veteran explains his views on getting vaccines:

> every Veteran I’ve talked to about this is, the way in which the military treats vaccines is you get desensitized to the idea of the government putting things in your body. I’ve had anthrax, Hep A, Hep B. . .—things I can’t even pronounce, pumped into me. And I’m still alive. I just don’t worry about vaccines. Nor does any Veteran, that I know. (IA1)
Rather than “taking medicines,” which would involve active participation, he emphasizes that he cannot even pronounce the names of the medicines that are being “pumped into” his body. His cynicism about the passive nature of his identity when getting vaccines underscores the lack of informed consent involved. This example frames the vaccination process in terms that evoke a lack of free agency and choice in vaccination and would be considered an example of obedience without evidence of buy-in (Borah et al., 2021).

**Distrust and Cynicism Toward the Government**

Both Veterans who got the vaccine and those who refused expressed strong distrust and cynicism toward the government, but these sentiments were almost universal among vaccine refusers. The same post 9/11 era Veteran whose rationale in getting vaccinated was quoted above said elsewhere in his interview:

I don’t trust the information they give me. Because I understand their track record. And I was in the military too long to trust what anybody said to me. . . They give me a piece of information and like okay I take it at face value. And then I go, and I find out that it’s wrong, and now I’m not pleased but that’s what governments do, they lie to people to make them feel better. . . (MA4)

Despite accepting the vaccine, he expresses an unequivocal worldview of cynicism and distrust, suggesting that Veterans with such beliefs are unlikely to view government authorities as trusted information sources. He later cynically states that he does not trust the VA:

The VA was made to mend the broken toy soldiers that the military made. And for a very long time they were not good at their job. They’re getting better. The amount of care that they’re offering now because of the Gulf War and (post 9/11 era) Veterans. . . So the VA is forced to become better at their job. . . that’s why I don’t trust the VA. You know the military they give you a piece of gear and it’s made by the lowest bidder. But they’re getting better, and I know a lot of people in the system that are trying to do good. (MA4)

The reference to “broken toy soldiers” alludes to the loss of autonomy and sense of betrayal that often occurs when Veterans reflect on the experience of giving up their individual identities to join the military, only to enter the VA in need of care often perceived as substandard, bureaucratic, and insufficiently nimble and responsive to their needs (Franco et al., 2021).

The historical legacy of exposure to environmental and toxic health hazards in the military was another source of mistrust that Veterans mentioned.
A Veteran in his 50s who was opposed to vaccination mentioned that he was enrolled in a VA study on the long-term health effects of being stationed at Camp Lejeune, a Marine base where drinking water was found contaminated with toxic chemicals for more than 30 years:

So, I don’t really trust the government when it comes to saying everything is all right when it comes to medicine for patients. I’m also in the study of the Camp Lejeune. . . And they’re . . . still refusing to step up . . . and they’re not taking care of people that were exposed to it. (MA1)

He also mentioned the exposure to Agent Orange during the Vietnam War as a reason for his mistrust and cynicism toward information from government institutions about health and safety:

FDA is saying oh, they’re good, but we’ve heard those things before. With Agent Orange guys from Vietnam, you know, 50 years before the government said yeah, there was a problem, and by that time, most of those guys had died terrible deaths. (MA1)

Interestingly, although the Veteran (MA1) served a decade after the Vietnam War, the historical legacy of Agent Orange was salient to him, possibly because of his status as a Veteran enrolled in the study on long-term health effects of environmental exposure.

Another Veteran (MA4) from the post-9/11 era mentioned burn pits in the Middle East as another military environmental exposure that contributed to his cynicism and distrust of the government:

There were consequences . . . Just like the heavy metals we all ingested from the burn pits when we were deployed. Raised the rates of cancer. Stillbirth with children. (MA4)

Burn pits, Agent Orange, and Camp Lejeune are all hazardous exposures whose long-term health impacts the VA is following for possible linkages to cancer or death (U.S. Department of Veterans Affairs Public Health website, April 26, 2022). Moreover, these are all exposures for which the U.S. government significantly delayed approving the payment of service-connected disability benefits due to the lengthy scientific review needed to establish a connection between military toxic exposures and cancer diagnoses (Shane, 2021). These narratives, all of which involved the VA’s system of awarding benefits based on documented service-connected harm, undoubtedly contribute to government mistrust and cynicism among Veterans, particularly
Veterans enrolled in VA Homeless Programs who may have had the experience of having to apply for VA benefits.

Belief in government conspiracy theories related to COVID-19 and vaccines revealed another dimension of Veterans’ distrust: their relationship with government power. None of the Veterans explicitly mentioned power, but one GPD staff director and one VA provider touched on it in their discussion of Veterans’ mistrust of the VA. The GPD staff director, who was a post 9/11 era Veteran himself, noted that his generation of Veterans do not trust the VA:

> my generation of Veterans and younger have a cultural distrust of the VA. That’s something I work very hard to try and chip away at. But there’s a cultural mistrust of the VA, so they’re not going into the VA to be counted . . . Which is unfounded. But it’s perpetuated. So it’s very institutionalized among Vets that they don’t trust the VA. (NJ)

This quote suggests that many of his peer generation of Veterans refuse to go into the VA to receive services and “be counted” as an act of resistance. Refusing may be a form of asserting one’s autonomy against feeling constantly surveilled during one’s service. This suggests that Veterans experiencing homelessness who do not use the VA may be especially resistant to a government authority, and possibly vaccination, due to even higher distrust levels.

The power struggle aspect of Veterans’ resistance to vaccination due to distrust of the government is amplified in the following VA staff member’s discussion of why the VA homeless health clinic tells Veterans that they are not required to get vaccinated to receive care:

> when there’s not a lot of pressure to get the vaccine, like ‘if you want it we’ll give it you, if you don’t that’s fine, we’re still going to provide you services,’ kind of reassuring them of that, that takes some of the power struggle out of it. Because there’s a lot of people that think like ‘the government’s not going to force me to do anything,’ and the minute we said ‘no we’re not going to require you to get the vaccine, if you don’t get it that’s your choice, you get to make that decision,’ and so things calm down pretty quickly (ND)

The prospect of being forcibly compelled to accept medical treatment against one’s will has, for some Veterans, special meaning, and may be connected to other aspects of loss of autonomy during their service. Government entities, particularly the VA, may be viewed with suspicion by some Veterans and thus may not always be effective direct messengers. However, many Veterans who developed strong bonds with peers during their service trust their Veteran peers.
Reliance on Veteran Peers

Looking to others who are either Veterans or military-connected in making decisions about their own vaccine acceptance was mentioned by both Veterans and GPD staff interviewed. Others who share the Veteran identity tended to be trusted over health authorities or civilians. Some Veterans mentioned that talking to Veteran peers who were vaccinated helped persuade them, while one respondent noted that his GPD counselor was the son of a Vietnam Veteran and thus trusted his advice on the vaccine.

The GPD staff director, who was a post 9/11 era Veteran, noted that his generation of younger Veterans would be more likely to get vaccinated if they heard the message from other Veterans, particularly of their generation, due to their distrust of the VA:

a Veteran will always listen to another Veteran. There will always be . . . an inherent trust . . . the majority of Veterans trust each other . . . because there’s that sense of you know we have each other’s back no matter what. . . (NJ)

This quote exemplifies the rationale undergirding Veterans’ tendency to rely on peers with military backgrounds in making personal health decisions: Others with a shared identity and group membership are trusted, because of the military cultural norm that service members will always protect and look out for each other. Prior research identifies Veterans’ tendency to rely on Veteran peers in decision-making on health behaviors (Alenkin, 2015). This ability to trust other Veterans for information is especially vital for individuals who, as described, may not trust the VA as a source of health information.

Discussion and Implications

For many Veterans, the influence of military culture continues after their return to civilian life. Military culture, and the effects of military separation, shapes how many Veterans perceive and respond to COVID-19 vaccination. These data suggest that for many Veterans with high levels of mistrust, decisions regarding the uptake of COVID-19 vaccines are inextricably bound up with their complex relationship with both the U.S. government (Jasuja et al., 2021; Meyer et al., 2022; Rein, 2021) and their attitudes toward civilian life in general.

Because nearly all Veterans have experienced mandatory vaccinations in the military, the experience of joining and later separating from the military involves shifting definitions of bodily autonomy they must navigate to varying degrees. Some respondents view vaccines promoted by government health care institutions from the same perspective they may have developed
while in the military—that of a passive subject accepting that “government knows best,” while others may be determined to reclaim their autonomy by questioning or refusing vaccinations. Moreover, Veterans who have high levels of civilian mistrust and face reintegration challenges are likely to transfer that distrust to vaccination campaigns, especially if vaccines are being promoted by a government entity that has earned a reputational distrust among Veterans. This is likely true even if that entity, in the case of the VA, has improved its quality of care and responsiveness to service-connected health conditions such as posttraumatic stress disorder (PTSD) and Agent Orange, as many Veterans often rely on peers rather than official government notices in health care decision-making (Alenkin, 2015). Much of this distrust revolves around power and autonomy; hence vaccine promotion interventions that seem too “heavy-handed” to some, such as mandates, may appear coercive to Veterans. When evaluating whether to get vaccinated, Veterans often rely on peers as trusted sources to help with decisions. This group identity aspect of Veterans only trusting other Veterans derives from their military experience, where they are inculcated into a culture where trusting only in-group members becomes a survival strategy (H. A. Garcia, 2017).

A culturally competent approach to engaging with Veterans around health care questions such as COVID-19 vaccination would not only incorporate such aspects of Veteran culture but also engage Veterans in the process of creating Veteran vaccine outreach campaigns. When designing health care intervention and messaging efforts aimed at Veterans, the phrase “nothing about us without us” may be instructive, given the significant trust and culture gaps between Veterans and civilians. Public health campaigns designed without their involvement and input may not resonate, perpetuating the potential disconnect (Borah et al., 2021; Franco et al., 2021) and exacerbating prospective inequities in marginalized groups such as unhoused Veterans.

Given many Veterans’ trust barriers with civilians and government health care systems, how might a perspective informed by person-centered interventions and empathy toward the lived experiences of subpopulations suggest that outreach efforts regarding health behaviors to Veterans be designed? Team Rubicon (TR), a nonprofit disaster relief organization of 130,000 mostly Veteran members (Team Rubicon website, n.d.), offers some possible answers that point to best practices for engagement.

**Team Rubicon**

As part of the Biden Administration’s COVID-19 Community Corps, Team Rubicon (TR) launched a 2021 awareness campaign to facilitate vaccine uptake among vaccine-reluctant Veterans (Callaway, 2021; Team Rubicon,
2021; U.S. Department of Health & Human Services, 2021). As of August 2021, TR has distributed more than 1.6 vaccines to Veterans in nearly 100 cities (Slack, 2021). They use the slogan: a “call to arms-yours”—immediately invoking military identity in their vaccination push. Even before the COVID-19 pandemic, TR was well-known among Veterans because of its efforts to harness the unique skills and talents of recently separated military Veterans as disaster relief volunteers. In so doing, TR addresses the crisis of identity that many recently separated Veterans experience. TR’s founders and leaders, themselves recently separated post-9/11 era Veterans, had credibility among Veterans because they empathize with their identity and experiences. Initially founded to reduce the high prevalence of Veteran suicides, TR sought to address post-9/11 Veterans’ post-separation struggles with the feelings of loss of purpose and belonging that often drive their difficulties with reintegration and contribute to their feelings of civilian mistrust (H. A. Garcia, 2017; Kranke et al., 2016; Lawrence et al., 2019; Matthieu et al., 2018, 2021). Thus, TR embodies the very challenges of addressing Veterans’ struggles with trust by (a) enabling them to form bonds of brotherhood with Veteran peers who are both trusted and often able to relate to reintegration challenges and (b) valuing their military identity by having them apply skills learned during military service in service of a collective raison d’etre benefiting others, usually civilians—a feeling often lost during separation. A recent study on TR (Kranke et al., 2016, 2017) revealed the ways in which TR connected with Veterans’ identities and struggles with reintegration, thus addressing their mistrust and solidifying TR as a credible entity among Veterans. These interviews with Veterans illuminate how an empathetic understanding of Veterans’ institutionalized distrust and disconnect with civilian society can be applied to engagement in public health efforts such as encouraging vaccine uptake:

1. Loss of identity and sense of isolation upon military separation.

Veterans discussed how separation from the military left them feeling like the civilian life they returned to was underwhelming in comparison:

I believed we had a real purpose that was just and worth fighting for. . . Life here isn’t as compelling as life there. . . It’s hard to come home and be motivated and play the same game when the game is one-tenth of the stakes you’re used to playing (Kranke et al., 2016, p. 77)

after you’ve belonged to something as, you know, as powerful and as meaningful and respectful as the United States Marine Corps, and then you’re looking at going and getting a job at Best Buy. You know, it’s not the fact that
it’s the work at Best Buy. It’s just like that’s—that’s you now? (Kranke et al., 2016, p. 78)

These two quotes exemplify Veterans’ sense of disillusionment at the loss of purpose realized upon returning home, separating their identity from that of civilians.

2. Enabling them to form bonds of brotherhood with Veteran peers.

The disconnect and loss of identity fuels a sense of mistrust among civilians, including non-Veteran health care providers, whom they perceive as incapable of understanding the worldviews of Veterans because they have not gone through the same experiences as Veterans (Coll et al., 2011; H. A. Garcia, 2017). Given this loss of identity, some Veterans may feel disconnected from civilian friends and family and trust and relate better to Veteran peers. TR enables them to be with Veteran peers and recreate the powerful bonds of brotherhood first developed in the military (Castro et al., 2015):

it’s the interpersonal relationships that develop between us, and it’s a bond that you can’t explain unless you are a Veteran. And the trust that you know, you may not have ever met this person before, but you know he has your back. (Kranke et al., 2016, p. 78)

The trust of Veteran peers, even those they have never met, above all others, due to shared military culture of “having each other’s backs” is repeatedly invoked by both TR Veterans. This bond cannot ever be fully understood unless someone shares the Veteran identity, underscoring the level of in-group culture of trust that TR evokes while convening Veterans.

3. Re-establishing the value of military culture and identity through the application of military service skills in a collective mission to benefit others.

TR’s trust-building in Veterans goes beyond identity and emotions. Its disaster relief mission aligns with the skill set that individuals previously deployed with the U.S. military have homed in their service, enabling them to recover their sense of meaning:

a lot of us are wounded combat Vets... We have a set of skills Uncle Sam paid for and gave us that we have an obligation to give back to our community. (Kranke et al., 2016, p.78)
This empowerment narrative is core to Veterans’ identity and self-esteem. It is an important component of Veterans’ military culture, which discourages appearing weak or dependent and values collective sacrifice and contribution to the greater good (Castro et al., 2015; Coll et al., 2011; Meyer et al., 2022). The desire to identify as a contributor, not a victim, and to de-emphasize one’s sacrifice for country is part of the “combat Veteran paradox” (Castro et al., 2015). This enables Veterans to reclaim their own agency, which is essential for building trust.

4. Normalizing Veterans’ experience as a core aspect of separating from the military.

If military culture, and the process of military separation, consists of a core set of common processes that are normal and likely expected aspects of the Veteran journey, then these shared experiences, which set Veterans apart from civilians, can be transformed from distrust and cynicism into a basis for commonality. The need to normalize these aspects of Veteran identity has been discussed extensively in the military mental health literature (Castro et al., 2015; Coll et al., 2011; H. A. Garcia, 2017) and is illustrated here:

[Team Rubicon lets] “us see that . . . is a very common experience among vets. So, it’s not us. You are not individually damaged; you are reacting predictably and rationally to a set of experiences that you’ve been put in. (Kranke et al., 2016, p. 79)

Normalizing Veterans’ feelings misunderstood and disconnected from civilians upon separation (H. A. Garcia, 2017) helps Veterans address their mistrust by helping them find acceptance and reduce their self-perceived stigma (Kranke et al., 2016).

Through these processes of creating empathetic space for Veterans to express their shared reality, TR effectively connects with their life experiences. Thus, Veterans begin forming a basis for trust, if only in other Veterans at first. TR’s focus on building these empathetic relationships lends them a degree of authenticity, cultural competence, and trust in the eyes of Veterans. Thus, organizations like TR, which are led by Veterans and focus on addressing their unique experiences and cultural perspectives, are ideal candidates to engage with Veterans on COVID-19 vaccination. In TR’s vaccine awareness campaign, they proudly display the images of men and women from iconic past trust campaigns enlisting arms of every kind: the tatted, the toned, the tanned, and the sun-deprived (www.teamrubiconusa.org), with the slogan: “Rolling up sleeves can help us defeat the virus.”
TR, as a Veteran-run organization, illustrates how entities that exemplify credibility within the Veteran community can serve as a possible approach to offer culturally competent outreach to Veterans. Veteran engagement initiatives, such as the Milwaukee VA’s Veteran-run Dryhootch initiative, can leverage the power of Veterans’ trust in their peers to offer a culturally resonant perspective on vaccination. For example, COVID-19 vaccination promotion campaigns could have Veterans, through social media and video testimony, serve as spokespeople to amplify the message of encouraging Veteran audiences to get vaccinated. As Franco et al. (2021) note, the absence of the voice of Veterans in health care initiatives is a pervasive barrier to more effective public health responses. Acknowledgment of historical and current sources of Veteran mistrust and disconnect from health care providers that do not provide military-informed care or care that is not informed by Veteran-specific health disparities is essential to pre-empting Veterans’ sense that they are either invisible or not valued. Other avenues of conveying such empathetic, culturally competent health behavior advocacy to Veterans include VA Veteran peer support specialists, non-profit housing providers such as GPD organizations, and VA health care providers who work in specialty clinics such as the Homeless Patient Aligned Care Team (Balut et al., 2021; Gin, Balut, Alenkin, & Dobalian, 2022). VA service providers who understand that there is a “power struggle” component to some Veterans’ vaccination attitudes can be helpful by enabling Veterans to feel “listened to,” as one VA provider phrased it. Given the power of those with an insiders’ perspective into Veteran experience and knowledge, Peer Specialists in the VA and other health care organizations could be specifically trained to build trust in COVID-19 vaccines. Having trained Veteran peer specialists to engage in public health outreach to other Veterans would be consonant with the promotora community health outreach worker model of non-judgmental negotiation between cultures to engage communities with health information (Deitrick et al., 2010; Lujan, 2009). Currently, Peer Specialists working with Veterans in VA homeless programs may individually opt to initiate conversations to encourage Veterans to get vaccinated, but this practice is not formally institutionalized within VA.

Limitations

This study’s understanding of the effect of Veterans’ military culture on vaccine attitudes and behavior may be limited by the fact that researchers did not initially ask Veterans about the role of military culture in their vaccination decisions. This theme was identified inductively, as more than half of the Veterans interviewed brought up their military service as a core factor in their
personal identities and their thinking about vaccines. Consequently, information about respondents’ branch of service, era, rank, and file, or prior experience with military vaccinations, which may have offered valuable insight into respondents’ military experiences, was not collected. This calls for future research to enhance understanding about how Veterans experiencing reintegration challenges view health care efforts to promote COVID-19 vaccination. Furthermore, this research was confined to a population of Veterans experiencing homelessness who are enrolled in VA housing services. Expanding such a study to other Veteran groups, including post-9/11-era Veterans—a demographic that participates in TR in significant numbers, Peer Support Specialists, or others with experience with PTSD or other mental health challenges, could possibly offer additional insight into the relationship between Veterans’ post-separation culture and COVID-19 vaccine attitudes.

Generalizability and transferability of these results are also limited. This study evaluated the perspectives of Veterans in VA-funded GPD programs, data that is triangulated through interviews with staff in these nonprofit programs. Given the trust issues inherent in this population, we cannot ascertain whether unhoused Veterans who are not participating in VA homeless programs could be persuaded by even the most culturally competent Veteran community engagement initiatives. However, GPD-enrolled Veterans had higher vaccination rates than homeless Veterans who were not enrolled in GPD housing (Balut et al., 2021) suggesting that the Veterans interviewed may be more open to vaccination than other unhoused Veterans. Furthermore, we cannot be certain whether Veterans who have other reintegration-related mental health experiences such as PTSD, would respond similarly if asked about vaccination or other recommended health behaviors. The TR case study suggests, however, that these findings may be transferable to Veteran populations with experiences other than homelessness.

Conclusion

Being a Veteran means one’s military identity never fully goes away. Veterans’ identities, defined as the ways in which those separated from military experience filter temporal experiences of the social world, are liminal. Liminal identities Veterans inhabit complicate seamless transitions to civilian life. Identity is reconstructed not as fully civilian or entirely military. This was the expressed reality for both Veterans experiencing homelessness and recently discharged post-9/11 Veterans who turned to TR for a needed sense of shared community. Shared military identity is likely to be more salient for Veterans residing in VA-funded homeless transitional housing, or who go on TR missions because these are Veterans who have chosen to recreate experiences of communal living with other Veterans.
Understanding the experience of being a Veteran underscores the importance of having trusted messengers serve as spokespersons to encourage Veterans to get vaccinated for COVID-19. While no cultural group has a single message that resonates with all members because culture is inherently diverse and diffuse, the discussion and data presented here sufficiently illustrate that Veterans have shared cultural elements stemming from common life experiences to warrant the beginning of a conversation around what a culturally competent Veteran engagement campaign would be needed to build their trust, either for the current pandemic or for a future public health emergency.

Public health institutions and others seeking to increase vaccination uptake have been criticized for approaching people with health vulnerabilities as “objects of intervention.” Such a tactic is likely to meet with resistance from Veterans who already have a cynical view toward those who treat them as passive patients without a sense of agency. Amplifying the voice of the Veteran in vaccination campaigns would enable them to retain a sense of group autonomy in this important decision. A more nuanced empathetic approach that meets Veterans where they are, without judgment, and honoring the realities of their service and reintegration efforts, is needed.

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Availability of Data and Materials
The datasets generated and/or analyzed during the current study are not publicly available. They are available from the corresponding author on reasonable request, subject to approval from the ethics committee that approved the study.

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