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Culturally Informed Interventions for Military, Veteran and Emergency Service Personnel: The Importance of Group Structure, Lived Experience Facilitators, and Recovery-Oriented Content

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Cover Page Footnote

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Abstract

There is little available research on what constitutes a culturally informed program to treat mental health conditions among military, veteran, and emergency services personnel. The current study presents the qualitative participant evaluations of a modified group Skills Training in Affective and Interpersonal Regulation (STAIR) program. Participants were grouped with either lived-experience facilitators or non-lived-experience clinicians for the program, and 93 textual responses to a series of qualitative questions were analyzed. The findings suggest strong support for the postulated three primary components of a culturally informed program: a group structure; facilitation by peers with lived experience; and functional, skills-based, and recovery-oriented content.

There has been increasing interest over the last decade in the cultural competence of clinicians who manage military and veteran personnel. Military and veteran personnel form a distinct subset of society that is shaped by members' service experiences, including training and deployment experiences, norms, traditions, and values (Atuel & Castro, 2018). The high rates of mental health conditions among active and veteran military personnel have received significant attention in Australia (Van Hooff et al., 2018) as well as the United States, and commonly reported conditions include post-traumatic stress disorder (PTSD), depression, anxiety, and substance abuse, among others (Hoge et al., 2004). Physical symptoms and conditions such as chronic pain are also more prevalent among military and veteran personnel compared to civilians (Graham, K., 2019), and they have been reported to have major impacts on individuals' quality of life and mental health (Ahmadian et al., 2019).

Current clinical practice guidelines for the prevention and treatment of PTSD recommend both individual trauma-focused psychotherapies and pharmacotherapy for service members and veterans (Hamblen et al., 2019; Ostacher & Cifu, 2019). Most of these guidelines, however, are based on results from randomized control trials with moderate to large sample sizes investigating reductions in PTSD symptom severity as the primary outcome of interest, with psychological and pharmacological treatment as the target interventions. In contrast, there is less focus on and promotion of other, adjunctive interventions that can assist in the reduction of PTSD symptom severity but do not fit the criteria above. These include generalized "recovery-oriented" interventions for mental health and well-being, mind–body interventions, physical therapies, other psychotherapies, and psychosocial interventions. Another range of interventions and programs targets the issues that arise during specific stages of military members' careers (i.e., the transition into civilian life). Unfortunately, there are also concerns about the efficacy of the mainstream care and interventions that are frequently offered (and promoted) to military personnel and veterans. Problems may arise from a one-size-fits-all approach to treatment that doesn't necessarily work for all (Steenkamp & Litz, 2014). In particular, the evidence-based treatments recommended by PTSD guidelines (Steenkamp et al., 2015; Steenkamp et al., 2020) have had relatively poor clinical outcomes, particularly over the long term for these populations. Researchers have also argued that treatments should be formulated to address the different stages of PTSD and their associated physical and psychiatric comorbidities (McFarlane et al., 2017).

Lack of clinician cultural competence is considered to add to the barriers that service members and veterans face in accessing and remaining engaged with care, especially mental health services (Atuel & Castro, 2018). For these reasons, many clinicians with service experience

have promoted the need for, and elements of, cultural competence among clinicians in the American and Australian contexts (Atuel & Castro, 2018; Burek, 2018; Coll et al., 2011; Gayton & Kehoe, 2016; Lane & Wallace, 2020). These calls to action also raise the question, however, of what a culturally informed program or intervention for the treatment of mental health conditions among service members and veterans might look like in terms of its structure, format, and content.

Several recent peer-led, community-based interventions have shown promising results in reducing mental health symptoms among military veterans. Examples of such programs include Buddy-to-Buddy, a peer support program for U.S. National Guard and reserve service members (Greden et al., 2010), and the Team Red, White & Blue community-based model for developing positive social networks to enhance outcomes in military veterans reintegrating into civilian life (Angel et al., 2018). Another study examined the relationship between peer support, self-efficacy, and PTSD symptoms in combat veterans after an intensive weekend program run by the community support group Vets4Vets (MacEachron & Gustavsson, 2012). A range of peer outdoor support therapy (POST) programs have also been evaluated, and all of these programs indicate some beneficial outcomes for PTSD despite being nonclinical interventions (Bird, 2014).

These programs share several common features: They are based on a group structure; they do not involve individual one-on-one therapy from a clinician to a patient; they include peers with lived experiences of military culture and/or mental health conditions; and they emphasize psychosocial functioning from within a recovery-oriented framework rather than just "treatment." These factors are all worth examining in detail in terms of how they relate to military culture and therefore why they should be considered essential for culturally informed practice.

Group Structure

There are a number of elements of group programs that are reminiscent of military culture. In fact it was John Rickman and Wilfred Bion, both British Army psychiatrists during World War II, who originally pioneered the therapeutic community model that is considered today to be the forebearer of group programs (Mills & Harrison, 2007). Bion himself was a highly decorated World War I veteran who had fought in the tank corps, which gave him particular insights into the dynamics of teams (Gooch, 1998). Rickman and Bion's therapeutic communities minimized patient–practitioner hierarchical differences, creating a culture of inquiry that promoted self-investigation and awareness. They also created a culture of mutual support, whereby all members within the community united to support themselves and others within those communities (Mills & Harrison, 2007). Rap groups played a critical role in early self-generated support efforts for U.S. Vietnam war veterans and led to the emergence of counseling services, in which veterans played a key role in providing support, as an alternative to formal therapy (Egendorf, 1975; Shatan, 1973).

Modern-day group intervention programs for veterans and emergency service personnel have a similar ethos. They offer a format and structure that reflect normal service culture, defined by such tenets as a team-oriented approach to problem resolution. Such group interventions involve several people gathering together on a regular basis and engaging in the social connectedness that is essential to service life. These meetings offer opportunities to normalize stress and distress, and they challenge perceived stigmas about having mental health conditions and engaging with services for help with those problems. Through their provision of mutual support and understanding, group interactions help to validate participants' traumatic experiences and therefore reduce potential shame (Schwartze et al., 2019), just as happens in a normal service environment. Working as a part of a team and sharing a sense of loyalty, pride, camaraderie, and brotherhood are fundamental aspects of service and hence are often lost upon transition out of service (Burek, 2018). Group interventions' potential to restore these feelings might help explain the popularity of the format among veterans.

Peer Support

The desire for community explains why many service members naturally gravitate toward others who have shared experiences, values, norms, attitudes, beliefs, and expectations of behavior, both during service and beyond, when creating psychosocial bonds (Lifton, 1976). This affinity for others who have the same "lived experience" also helps explain the attraction and power of peer-driven programs for veterans and the benefits that culturally specific group programs can offer. Typical veteran attitudes include beliefs such as "If you haven't been there, you don't get

it," "We believe in taking care of our own," and "Other veterans can be trusted." In contrast, many veterans mistrust mainstream clinical services and clinicians (Blank, 1982; Greden et al., 2010). As such, military personnel are used to relying on peers for support, consider them more trustworthy than other authority figures, and identify with leaders with similar experiences to model adaptive growth and change (Hundt et al., 2015). Peer support programs therefore meet an inherent need of service personnel.

They are also becoming increasingly popular because they can improve outcomes in inpatient programs, as evidenced by their formal introduction in the U.S. Veterans Affairs medical system (Jain et al., 2016). Additionally, when employed in a paraprofessional role, veterans themselves can augment existing services in low-resource communities (Jain, 2010). Finally, programs led by peers with lived experiences of both service culture and recovery from mental health conditions can augment and cement the group bonding and cohesion process because they mimic the general training and occupational format of service life—that of a leader with more experience and knowledge who serves as a role model, instructor, and guide for a group of others, within a task or purpose-oriented frame.

Recovery-Oriented Content

Recovery is defined in this context as "gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self" (Australian Government Department of Health, 2010). This definition of recovery fits well with the positive attributes of military culture, values, beliefs, norms, and behaviors. The concepts of self-efficacy, striving for excellence, and high-performance standards, all of which are facets of recovery, are also essential to military identity (Burek, 2018). Finally, the three characteristics (or values) of "integrity," "team worker," and "good judgment" were all ranked significantly above random assignment in Gayton and Kehoe's (2016) work with Australian Army Special Forces soldiers. These characteristics seem to drive recovery-oriented behaviors—as also seen in the work of Dabovich et al. (2019) on values and identity redevelopment during rehabilitation and transition—hence the popularity of a recovery-oriented approach with military and veteran personnel.

Another aspect of military culture is the concept that performance of one's task and mission is central to a positive sense of self (Lane & Wallace, 2020). A task- or mission-oriented approach allows for sublimation of distress, especially emotional distress, and therefore becomes an effective coping mechanism: Individuals derive a sense of purpose from their vocational tasks that allows them to push through their distress. Unfortunately, service members and veterans lose these adaptive coping mechanisms as their cognitive and motor functions decline due to mental health injuries. The reality of these functional losses represents a direct challenge to the positive self-concept characteristics described above; the individual loses the ability to demonstrate high performance, is no longer a part of a team, and may have been discharged from the military as unfit for service. However, the drive for individual improvements in effective functioning and positive identity improvements through teamwork can therefore also be used as components of a culturally appropriate, recovery-oriented program.

Functional losses often include difficulties with emotional regulation (ER), which are commonly seen in service members and veterans. Stanley and Larsen (2019) described how the typical military attitude to emotional distress is to "suck it up" and "drive through," which ends up resulting in emotional suppression and therefore further distress and disability. They argue that high accumulated chronic stress loads from occupational, operational, and organizational factors of service increase ER challenges and maladaptive coping mechanisms, therefore increasing the risk of psychological distress and suicidality among both service members and veterans. Considering these risk factors in combination with personal societal stigmas against mental health diagnoses and treatment, which are linked to treatment avoidance and poor adherence (Vogt, 2011), it is not surprising that there are such high rates of mental health morbidity within this population.

Mainstream mental health treatment programs may further aggravate these problems. As described earlier, traditional interventions have been criticized because they are generally administered on an individual basis (one-on-one with a therapist and client) and provided within an institutionalized framework that defines clinicians as "experts" who deliver "treatment" to patients because they have a "disorder" (Lifton, 1976). This medical model disempowers

consumers, ignores their cultural context, and has the disheartening effect of dismissing any of the consumers' strengths (Brende, 1981). In effect, mainstream services reinforce a negative sense of self-identity by reaffirming individuals' lack of functional capacity and minimizing their sense of efficacy except within a narrow focus of trauma-focused psychotherapy. Indeed, Steenkamp et al. (2020) argued that trauma-focused psychotherapies may have low success and high dropout rates because veterans with PTSD typically struggle to cope with the prescribed, emotionally demanding therapies. This is not surprising given the difficulties with ER described by Stanley and Larsen (2019), but it should also be recognized that veterans and service members are engaging in these therapies without the support of their peers and without any leveraging of the inherent strengths and capabilities they developed during their service careers. In contrast, the adjunctive interventions that seem to be increasing in popularity among veterans do not have the same hierarchical structures, do not pathologize psychological distress, and focus on leveraging the strengths and positive characteristics of the veterans themselves to move them toward functional recovery. In other words, as stated earlier, these therapies have several key components: They involve peers; are goal-oriented toward functional improvement (recovery); and leverage the values, norms, and conditioned behaviors expected by military and veteran personnel.

A Potential Culturally Informed Model of Intervention

The discussion above suggests that a culturally informed intervention for active military personnel, veterans, and other service personnel should have three main factors: It should be group-based, with minimal hierarchy; it should be delivered and facilitated by leaders with lived experience ; and it should have functional, recovery-oriented content. This model also implies that "treatment" for psychological disorders should have a staged approach, depending on the severity of participants' symptoms and functional disability (McFarlane et al., 2017). This staged approach should also include a primary skills-based stabilization stage, preferably including an ER component, prior to active treatment. It is at this early intervention point that culturally specific interventions are considered to be most relevant, achievable, and effective.

The Skills Training in Affective and Interpersonal Regulation (STAIR) program by Cloitre et al. (2002) was originally developed to target ER among individuals with complex PTSD. STAIR is a manualized, skills-based program designed to educate individuals with PTSD on the personal impacts of trauma, and it uses various psychological tools (primarily dialectical behavior therapy) to help participants develop the skills they need to improve their own ER capability and the quality of their interpersonal relationships. It has primarily been used in the context of sexual trauma, with the psychoeducation and skill phase being followed by a narrative exposure therapy phase (a form of trauma-focused psychotherapy treatment), and it has been shown to improve both distress symptoms and functional outcomes in participants (Cloitre et al., 2014; Cloitre et al., 2016). STAIR has also been adapted to a group format (Cloitre et al., 2015), which has the added benefit of maximizing social support (Charuvastra & Cloitre, 2008). As such, group STAIR provides the perfect platform for creating a culturally relevant intervention delivered by peers whose lived experiences could help model functional recovery.

Finally, programs that deliver skills-based, function-oriented content with the goal of improving ER, social supports, and interpersonal relationships are also likely to appeal to the service member and veteran audience because they align with their predisposition to want to perform and succeed at given tasks within a recovery-oriented framework.

Summary and Current Research Project

While there is growing interest in the cultural competence of clinicians working with service members and veterans, there is little published research on what constitutes a culturally informed structure, format, and content for an intervention for mental health conditions among this population group. The purpose of this paper is therefore to examine the participants' perspectives of a culturally informed and modified pilot STAIR program. This intervention was informed by the three key principles that we have so far discussed: It was conducted in a group format, the content of the program was functional and recovery-oriented, and it was delivered by facilitators with lived military and mental health experience.

Methods

This study is part of a larger mixed-methods effectiveness trial of a group STAIR program conducted with current and veteran military and emergency service personnel in Australia. This larger, modified group STAIR evaluation consisted of a range of common mental health inventories and open-ended questions in the form of a written survey. It was approved by the Australian Departments of Defence and Veterans' Affairs Human Research Ethics Committee (DDVA 030-18) and the University of Adelaide Human Research Ethics Committee (H-2018-114) and was conducted as a real-world effectiveness trial over a 24-month period.

Participants

The sample evaluated in this paper was restricted to participants' responses to the four open-ended questions at the end of the survey. Responses were collected from the 93 participants who completed the entire program. All participants were current or former military or emergency service personnel who were experiencing difficulties with their mental health. Participants were excluded if they had active psychosis or suicidal ideation with a plan to carry out self-harm. Emergency services personnel were actively recruited to the project because they have similar cultural norms, attitudes, beliefs, and behaviors to military personnel. In addition, in Australia they have similarly high rates of mental health conditions but much more limited access to care, especially culturally informed care (Harman, 2019).

Procedure

Participants for this study were referred into the modified group STAIR program by their community care clinicians, but they also continued to receive care as normal from their clinicians during the program. Psychometric evaluations (not reported in detail here) and qualitative evaluations were administered at four time points: (1) immediately before the program, (2) immediately at the end of the program (3 months), then at 6 months (3) and at 12 months (4) following commencement of the program. The qualitative data reported in this paper were collected from the immediate post program survey. The project procedures were approved through the Australian Departments of Defence and Veterans' Affairs (DDVA) and University of Adelaide (UA) human research ethics committees.

The Program

The modified group STAIR program by Cloitre et al. (2015) consisted of once-weekly 90-minute sessions, which were run as closed groups over the course of 12 weeks in 2018 and 2019. Six sessions covered emotional regulation, and six sessions covered interpersonal relationships. The group STAIR program was modified by the author (a clinician with 30 years' Army experience as an enlisted soldier, medical doctor, and psychiatrist) to make it more culturally specific and relevant to military, veteran, and emergency service personnel. Modifications included using appropriate language and providing detailed psychoeducation on the impacts of service and culture on identity, behaviors, patterns of maladaptive coping mechanisms, and relationships.

The program was delivered through two separate Australian nongovernmental community service organizations. These were The Road Home (TRH), a leading South Australian veteran and emergency services charity in Adelaide, South Australia, and Mates4Mates (M4M), another ex-service organization with Family Recovery Centres in Hobart, Brisbane, and Townsville. The TRH groups (n = 62) consisted of a mix of active military, veteran, police, and fire brigade personnel, and they were led by the primary author with an ex-policeman and a current military peer as cofacilitators. The M4M groups (n = 31) only had military and veteran participants and were led by clinical psychologists with no lived military experience.

Participant Mental Health Status

All participants completed a baseline battery of self-report mental health questionnaires prior to commencement of the STAIR program in order to provide initial measures of mental health symptoms and prior trauma history. These included the Kessler 10 (K10), a 10-item screening measure of psychological distress (Kessler et al., 2002); the seven-item Generalized Anxiety Disorder (GAD-7) scale to screen for anxiety symptoms (Spitzer et al., 2006); the nine-item Patient Health Questionnaire (PHQ-9) to screen for depressive symptoms (Kroenke et al., 2001); the 20-item PTSD Checklist for *DSM-5* (PCL-5) to screen for PTSD symptoms (Wortmann et al., 2016); the Dimensions of Anger Reactions (DAR-5) scale, a five-item screening measure to assess anger frequency, intensity, and duration and anger's perceived negative impact on social relationships (Forbes et al., 2004); and four items

to examine suicidal ideation, plans, and behavior adapted from the Australian National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2007). The Lifetime Exposure to Traumatic Events scale was taken from the CIDI V3 (Haro et al., 2006). The 28 questions covered a range of potentially traumatic events and were endorsed by either "yes" or "no" answers from participants. The total number of times that participants were exposed to each of the 28 traumatic events was also obtained.

Qualitative Component

Qualitative data was obtained from written responses to the following questions:

1. In what way do you feel the clinician who facilitated your STAIR Program helped you understand yourself and some of the problems you might have experienced?

2. Were you able to relate to the facilitator? If so, what made this possible, and why?

3. Do you think it's worthwhile training people to be Counsellors to help their Peers? If yes, then why?

4. What do you think the main potential benefits of having Peer Counsellors are?

The data analysis process used qualitative content analysis (Drisko, 2015) to derive common descriptive themes from the written responses to the four separate review questions. For the purpose of this paper, responses were coded for three themes. These themes represent the three factors suggested earlier to be implicit in the development of a culturally informed intervention for military personnel, veterans, and emergency service workers: group structure, lived experience peer support, and recovery-oriented content. Identified subthemes will also be discussed and illustrated by the inclusion of direct quotes from participants.

Results

Demographics

Ninety-three of the 130 participants who enrolled in the study between January 2018 and December 2019 completed the qualitative measures and hence were included in the sample for the current study. Of those 93 participants, 83% were current or ex-serving Australian Defence Force members, and 17% were current or ex-serving Australian emergency services personnel. Table 1 provides detailed demographic and occupational information for this sample.

The total number of times each participant reported exposure to a different traumatic event and the proportion of the sample exposed to each type of traumatic event are summarized in Figures 1 and 2. The figures show that the occupational and lifetime risk of exposure to traumatic events is high among military and emergency services personnel, with the mean level of exposure being six separate events. When looking at the specific types of trauma, 70% of participants endorsed witnessing death, 45% of participants reported witnessing the death of someone they were close to, and 40% reported being in combat.

Table 1. Participant Occupational Demographics

Demographics	No. of participants	
	(N=93)	%
Gender		
Male	79	85
Female	14	15
Age		
Range (22–73)	SD=11.82	M=46
Currently working	**50**	**54**
Emergency services	14	15
Defence	19	20
Health and community services	8	9
Other	9	10
Retired	**43**	**46**
Emergency services	8	9
Defence	35	38

Mental Health

Baseline scores on each of the mental health measures according to the standard scoring bands are provided in Table 2. Overall, 30% of participants scored in the severe range for anxiety, with 36% scoring greater than 50 on the PCL-5 and 30% scoring above

Figure 1. Frequency of Participants' Total Lifetime Exposures to Trauma

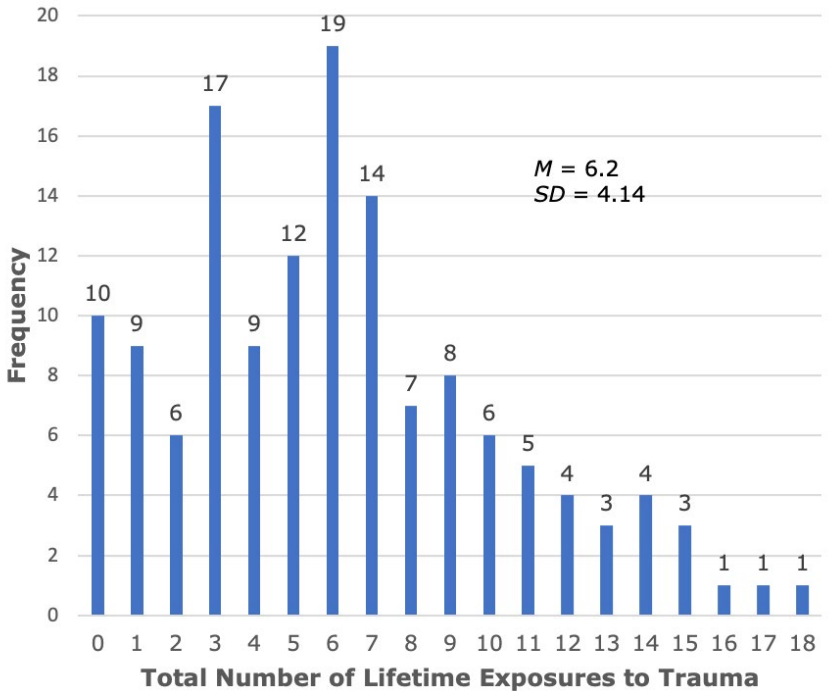
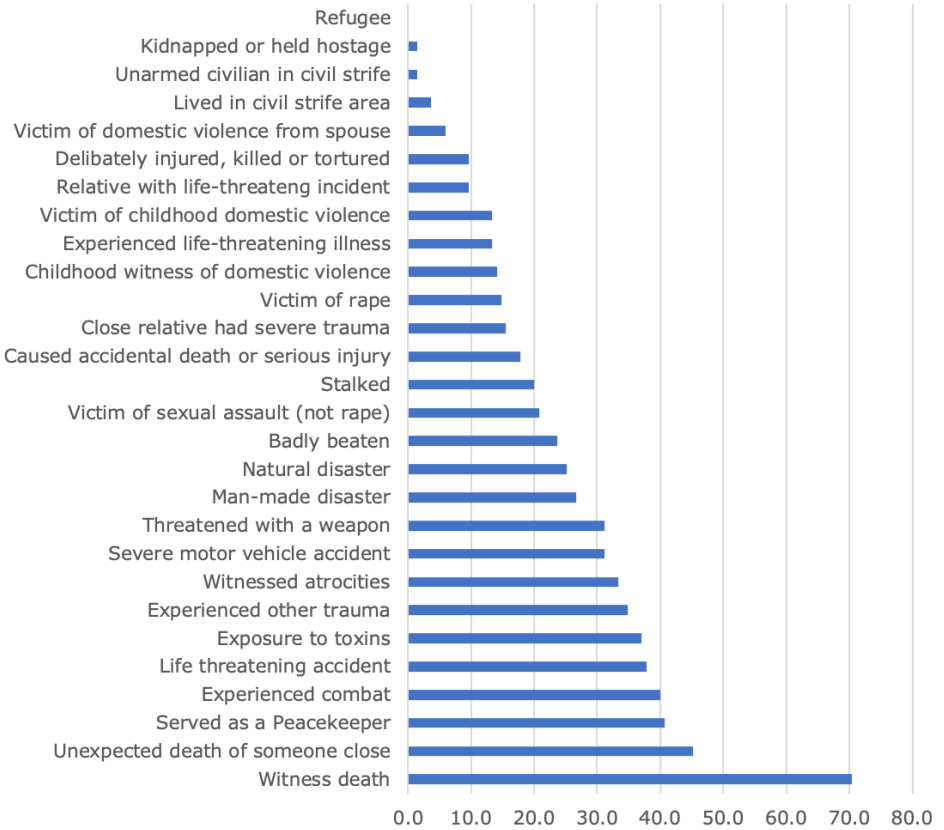


Figure 2. Percentage of Participants Who Endorsed a Specific Trauma Type



15 on the GAD-7, both of which are indicative of a probable disorder. Severe levels of psychological distress based on K10 scores were reported in 48% of the sample, 49% reported some form of suicidality (either suicidal ideation or attempt), and 49% reported problematic levels of anger (a score of 12 or greater on the DAR-5). The quantitative results of the changes in the clinical measures are not reported in this paper as they will be presented in a separate article.

Qualitative Question Results

The participants' responses were evaluated to derive their perspectives, perceptions, and opinions of the following three themes: (a) the importance of the group format; (b) peer support/lived experience; and (c) skills-based, recovery-oriented content. Direct quotes from participants that illustrate the derived themes are also included.

Theme 1: Group Format

There were no specific questions that asked participants about their perceptions of the group format. However, spontaneous answers demonstrated positive regard for the format, such as "Group situation good." Most of the other relevant comments addressed the benefits of normalizing difficult experiences during service and within the treatment process, such as "Sharing learning and understanding behaviour" and "It was good to discuss other people's situations and coping mechanisms." The group format allowed for interaction and engagement, which participants appreciated. One participant noted, for example, the "opportunity to pass on knowledge and understanding, share personal experience and reflect on those." Finally, the notion of support from others within the group was very strongly identified; participants wrote, for example: "understanding of the issues each other face, mutual support" and "Good to have that peer support." It appeared that people felt they could relate to each other because of their shared experiences and shared understandings of similar problems, and they felt "more likely to open up about each other's experiences" because there was "trust" and "understanding and connection within the group." The fact that these comments came from all the participant groups suggests that incorporating emergency services personnel within the groups did not diminish the trust, rapport, and sense of connection that participants felt with each other, and these factors emerged regardless of whether or not groups had lived-experience facilitators.

Theme 2: Lived Experience

Lived experience of military/service life and mental health conditions were the most prominent themes to emerge in participant responses,

Table 2. Participant Mental Health Characteristics (N=93)

Test (range)				
K10 (0–50)	**Well**	**Mild**	**Moderate**	**Severe**
M=28.2 (SD=8.4)	16 (18%)	12 (13%)	20 (21%)	45 (48%)
GAD-7 (0–21)	**Well**	**Mild**	**Moderate**	**Severe**
M=9.9 (SD=5.9)	19 (20%)	29 (32%)	17 (18%)	28 (30%)
Suicidality	**Screen (y)**	**Ideation**	**Plan**	**Attempt**
	45 (48%)	32 (34%)	5 (34%)	2 (2%)
PHQ-9 (0–27)	**Well**	**Sub-syndromal**	**Probable disorder**	
M=12.6 (SD=6.8)	23 (25%)	51 (55%)	19 (20%)	
PCL-5 (0–80)	**Low**	**Sub-syndromal**	**Probable disorder**	
M=36.9 (SD=20.9)	35 (37%)	35 (38%)	34 (36%)	
DAR-5 (5–24)	**No disorder**	**Probable disorder**		
M = 12.2 (SD=4.7)	46 (51%)	47 (51%)		

particularly in response to Question 1. For example, the majority of the participants from the groups led by the facilitators with lived experience ($n = 62$) spontaneously mentioned the importance of shared experiences and similar personal characteristics in relation to how they related to the facilitator or how they felt the facilitator related to them. This suggests the importance of the facilitator's lived experience in developing rapport both on a personal level as well as clinically. Responses included: "Service-related background established rapport, respect and confidence to disclose vulnerable information of myself," "He was very familiar with what we were talking about and didn't have to have everything explained to him," "He was familiar with military and policing terms which is generally lacking in therapists," "Via Military speak, true understanding of why I am thinking mostly the military way," "Always made examples that were relatable," "Related well. With his background in defence it made it easier to connect with him. And somehow could read my mind," "Yes being in the ADF [Australian Defence Force] and the examples used, and the language and situations automatically built a trust and a relationship. So much respect," and finally, "As a veteran who has served and then become a psychiatrist [he] truly understands the issues facing veterans because he has lived the military life. If you don't get it you don't get it, it's not just trauma from service it's training and culture."

Shared language, culture, behavioral norms, beliefs, and attitudes were also very influential on participants' opinions of the lived-experience facilitators. The use of culturally informed language, although directly referenced by only a few participants, is likely to have influenced this as well. Participants noted, for example, that the facilitator "spoke in a manner that was so clearly understood—spoke layman's language and not a lot of confusing jargon," "Yes, down to earth, in layman's terms not medical, very approachable, understanding etc.," and "being in the ADF and the examples used and the language and situations automatically built a trust and a relationship." In contrast, none of the participants in the groups led by the facilitators without lived experience ($n = 31$) mentioned anything about lived experience or relating to the clinicians on a personal level because of their shared experiences.

Questions 3 and 4 both addressed participants' opinions and perceptions of using peers in facilitation and/or counseling roles. The dominant themes to emerge here were shared understanding, shared experiences, and therefore also a perception that peers were likely to be more effective counselors. Examples included: "Very useful to have peers that already have some rapport with personnel and can provide immediate assistance. Often means there is no barriers [stigma]," "Yes, they can relate as they have been in the same situation," and "We can all relate to each other, we have instant rapport and a level of trust, especially as peers in the military. We "get" each other." Modeling recovery was also mentioned: "Yes. 100%. Because it helps the peers to relate to personnel that have first-hand experience in what they are feeling and going through. They are not alone. Also shows them that there is light at the end of the tunnel."

Other themes to emerge in relation to the benefits of having peer counselors were equality, shared experiences, and common backgrounds and therefore more trust, rapport, and relatability between counselors and participants. These subthemes also encompassed stronger perceived psychosocial bonds between facilitators and participants as well as the benefits of normalizing difficulties and modeling recovery. Examples of these sentiments included: "Familiarity, shared experiences, shared understanding, trust, not a doctor," "They've lived your problems and can empathize," "Shared experience and understanding that others have been through it," "Relatable experiences & see people as normal," and "Like minded individuals who share a common experience of having experienced trauma, been diagnosed with it, and sought help through their relevant organisation, and the STAIR program."

Theme 3: Functional and Recovery-Oriented Content

Although there was not a specific question asking participants about the importance of functional and recovery-oriented content, several themes emerged in participants' responses that supported the importance of such content. For example, participants' answers to Question 1 often referred to the skills components of the content in explicit detail and described how this content benefited them in functional terms: "My understanding of emotions and relationships has improved as well as tools to deal with my anxiety," "Helped me understand my feelings are normal. Change starts with me," "ability to break complex human thoughts and emotions down via explanation so that I was able to analyse and understand/interpret them. This info could then

be used to consciously change thoughts/feelings/behaviours moving forward allowing for greater understanding of self and others and therefore opening the door to improved relationships," "Easy to apply the learning to my everyday life. Made the information very relatable and understood our lives and work," and "It was presented in a way that made it real and relevant to the context I live and work in. He helped me understand that a lot of the issues I have are normal human responses and there are ways to combat the negative ones."

Improved self-efficacy in ER, especially anger, was another strong theme to emerge in relation to content. Participants wrote, for example: "By breaking down the basic mechanics, so by getting myself to recognise my own emotions and how to regulate them. How my feelings in situations can affect my reactions to situations," "helped me gain control of my life back. Reduced anger and awareness of what's going on in my head, and how to control that," "Helped me deal with anger and dealing with situations," "I have been able to address my issues with conflict and realising that sometimes the pain of conflict is worth the conflict itself," "Gained a lot of knowledge, and understanding about feelings emotions, helped improve communication within the family home." All of these quotations imply a sense of mastery through skills acquisition, which had broader implications for participants' psychosocial well-being, functioning, and self-identity.

Discussion

This investigation aimed to explore participants' perceptions of using lived-experience facilitators to deliver a small-group, skills-based intervention to improve emotional regulation and interpersonal relationships. It was hypothesized that this intervention met the requirements to be considered a culturally informed intervention because it used a group format, was facilitated by peers with lived experience, and was composed of skills-based and recovery-oriented content. The qualitative results suggest that the participants viewed the intervention and its outcomes favorably. Participants' answers to all four questions also demonstrated positive regard for the three themes in question: the group format; lived-experience facilitators; and functional, skills-based, recovery-oriented content.

Lived Experience and Role Modeling of Functional Recovery

Question 1 was aimed at exploring how well the facilitator was able to transfer the program content to participants. Facilitators were tasked with educating participants about the degree to which their mental health conditions and functional problems are consequences of exposure to chronic stress, trauma, as well as the conditioning effects of military and other service experiences, and they were also charged with providing participants with skills to address these challenges. The skills-based content primarily targeted the ER deficits identified by Stanley and Larsen (2019). Participants' answers to Question 1 showed support for the functional ER skills obtained from the intervention, with a number of respondents reporting better perceived self-efficacy to manage themselves, their emotions, and their daily functioning. This finding is important given that the modified group STAIR content made it a psychoeducation and skills-based intervention rather than a typical "treatment" or trauma-focused psychotherapeutic intervention.

However, a striking aspect of participants' answers to Question 1 was how respondents related to and spontaneously praised the lived experiences of their facilitators in terms of making the content relatable. They also commented on how this helped them develop knowledge and understanding of their own emotions and identified their rapport with the facilitator as a large factor in how they were able to normalize and understand their experiences so they could regain functionality.

The increased rapport that developed between the participants and the lived-experience facilitators is important because this sits apart from the intervention content and has to do entirely with the frame of the intervention. Participants' responses to Questions 3 and 4 also reflected these attitudes; these questions were aimed at exploring participants' opinions of whether it is important and potentially beneficial to have peers with lived service and mental health experience in therapeutic leadership roles. Responses were overwhelmingly favorable toward this proposition. The themes of increased understanding, trust, and rapport engendered by a common language, experiences, and histories were prominent, as was the idea that the therapeutic process would be more effective if peers with lived experience more commonly facilitated them.

The concept of peers being able to normalize psychological injuries from service was also prominent, suggesting that participants had previously felt abnormal or "different" in some way because of their operational stress injuries.

Similarly, peers (similar to the lived-experience clinician facilitators) were identified as modeling and demonstrating recovery and post-traumatic growth, therefore challenging negative beliefs and stigma about both mental illness and the potential for recovery. Responses thus demonstrated the importance of lived experience within the interventional frame and a strong desire from the participants for their facilitators to have this lived experience.

The finding that peers are important in terms of culture and context for increasing positive attitudes toward engagement is consistent with previous research, especially studies examining correlates and predictors of whether veterans initiate and remain engaged in care. In a comprehensive review of these factors, Johnson and Possemato (2019) argued that positive valence of veterans' beliefs about mental health care consistently predicted more initiation and engagement in care. Hundt et al. (2015) has also supported the idea that perceived benefits from increased social support, purpose and meaning, normalization of symptoms, and actual therapeutic benefits are all factors that motivate veterans to engage in ongoing care and use skills-based interventions. Participants in the current study spontaneously recognized and favorably commented on these aspects of the program, potentially suggesting that the frame of the intervention was at least as important as the specific content.

Finally, Kumar et al. (2019) identified that peer support is also fundamentally important to the concept of global recovery in that it can help individuals with PTSD and other mental health conditions integrate their symptoms into their daily life and functioning, thereby reducing the distress they feel . This statement is effectively the definition of "recovery" used in this study and was identified as a goal for the majority of participants.

Lived Experience and the Cultural Relevance of the Group Format

Military and emergency service is largely centered around interpersonal relationships. In the context of this study, the lived experience of the facilitators helped enhance interpersonal relationships among the participants in each group. This was observed among both the emergency services and military personnel, highlighting the translatability of military experience to the first responder context. It also emphasizes how the relationships that lived-experience facilitators developed with participants were not clinician–client relationships. Nor were there power dynamics inherent to the program, which, again, is likely to have improved rapport and relatability among facilitators and participants.

Participants' interpersonal relationships were further strengthened by the group format of the intervention, with cultural service factors encouraging members of the group to rapidly come together and rely on each other for mutual support. Participants' shared behavioral norms, attitudes, and beliefs promoted positive attitudes toward each other, their facilitator, and engagement with the program content. However, the group format also mimicked participants' previous educational or training experiences; the context of the program was familiar, which again improved participants' rapport and relatability among each other and with their facilitators.

Finally, it would seem that the structure and format of the program represented the positive qualities of Rickman and Bion's earlier programs in terms of reflecting a therapeutic community with a strong alliance between facilitators and participants. This is likely why it was popular with these participants, who potentially felt isolated within the wider civilian community because their loss of employment had entailed the loss of a meaningful service community. Their losses in terms of community, role, purpose, functioning, and identity were significant, and participation in the modified STAIR groups gave them back this sense of community, a shared set of values, and a sense of mutual purpose in terms of working with other participants toward the goal of improved functioning in their daily lives.

Summary

The demographic and mental health data in tables 1 and 2 demonstrate the morbidity of mental health conditions in this population group and therefore establish the need for care. The primary themes that emerged from this study's qualitative data show strong support for the postulated factors of group-based interventions, leadership by those with lived experiences, and functional, recovery-oriented content as being culturally appropriate for a cohort of service members, veterans, and emergency services personnel. It could also be argued that it is difficult to separate these factors out because they appear to be fundamentally interdependent on each other, as demonstrated by the overlaps in participants' comments. However, more research is clearly needed to quantify what constitutes

the frame of a culturally informed or culturally appropriate intervention and to measure the nature and impact of the factors identified in this study, let alone whether all three factors are required or to what degree they are each required for such a program to be effective.

Other Community Engagement Potential

The results suggest that a culturally appropriate, skills-based, functional program delivered by peers with lived experience in a group format is highly attractive to the military, veteran, and first responder population. This raises the question of whether similar culturally unique population groups would also benefit from this approach. High-level athletes, musicians, and health care personnel are often more vocational than simply occupational populations, as they have similarly strong attachments to performance-related self-identities; hence they may be other suitable target populations for these forms of community-based, adjunctive mental health interventions. Similarly, other social or cultural groups should also be identified to determine whether the postulated factors of lived experience and group/community are transferable.

Limitations

The primary limitation of this area of investigation is the lack of recognition of the importance of interventions that deliver culturally specific structure and content to military and emergency service personnel. Results from this study provide a starting point for further explorations in the field. Limitations of this intervention evaluation include the small scale of the intervention, the limited qualitative data gained from participants, and the limited length of time of the evaluation. Quantitative data analysis demonstrating efficacy has yet to be published but would be beneficial for comparison to the more typical trauma-focused psychotherapeutic interventions. The group STAIR program had to be extensively modified to incorporate a culturally relevant structure and content, and it might therefore be more effective to develop a new program incorporating the recovery-oriented features of ER and interpersonal relationship skills alongside the necessary issues of identity, values, service history, conditioning, and transition that veterans and service personnel face. Finally, further identification of similar programs (such as the specific peer-support programs identified previously) and systematic review of their structures, modes of delivery, content, and integration into mainstream mental health services would help clarify the necessary components of a culturally informed intervention and allow for more specific interventions to be developed and evaluated.

Conclusions

This paper supports the position that context and empathy are critical to mental health interventions because treatment is not just about specific techniques. Culturally informed interventions for mental health conditions for military, veteran, and emergency services personnel are best undertaken in a group format, when delivered by facilitators with relevant lived experience, and with skills-based and recovery-oriented content. The qualitative evaluation of the modified group STAIR intervention demonstrated the inherent psychosocial benefits of group programs and showed that participants appreciated this format. Participants' strong identification of the benefits of working with others with similar lived experience reinforces the important role of cultural expertise in delivery to maximize positive regard, and therefore minimize both stigma and barriers to care. Finally, the participants' positive regard for the functional, skills-based, and recovery-oriented content, along with the ability of participants to identify and explain the perceived personal benefits of the program, also suggests that it is an effective intervention content modality.

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