Counselling Male Military Personnel and Veterans: Addressing Challenges and Enhancing Engagement

Duncan Shields and Marvin Westwood

Introduction

One of the gifts of feminist research and practice has been the insistence that the mental health field recognize intersections of gender, diagnosis and clinical interventions. Yet while the key role of gender socialization in women's experience and recovery from mental health challenges such as trauma has been extensively studied, relatively little attention has been paid to the influence of gender socialization in male's mental health experiences, and on the experiences of male veterans specifically (Braswell and Kushner 2012; Brooks 2010; Fox and Pease 2012; Jordan 2004; Shields et al. 2017). Despite this lack of attention, historically, hyper-masculine gender norms have been explicitly used by the military to socialize soldiers into an idealized culture of "warrior masculinity," presenting the soldier as the ideal of the strong and stoic male (Barrett 1996; Fox and Pease 2012; Hinojosa 2010; Keats 2010; Keegan 1994). Against the backdrop of these military masculine norms, veterans may remain silent about their service-related stress injuries and other life or mental health challenges lest they be shamed (Shields 2016).

D. Shields (✉) · M. Westwood
University of British Columbia, Vancouver, BC, Canada

M. Westwood
e-mail: Marvin.westwood@ubc.ca

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Therapists are in an ideal position to help veteran clients rewrite the rules of masculinity to recognize the battle for the heart and mind as valid, courageous and a sign of strength. Doing so restores dignity to the individual, is an act of social justice, and brings to light inherent capacities and convictions that enhance veterans' ability to resolve the difficulties they face. A culturally safe, gender-informed approach to veterans' counselling can contribute to more accessible, relevant and effective services (individual and group) that respect veterans' existing courageous and agentic helping and healing efforts.

Military Masculinity

Various researchers have noted that in military training, a particular type of "traditional" masculine gender role is extended or emphasized in a hypermasculine military cultural norm in order to prepare soldiers for combat and inculcate values of selfless sacrifice for the group (Brooks 2010; Fox and Pease 2012; Hale 2012; Higate 2000, 2001; Morgan 1994; Westwood et al. 2012). The historical emphasis of the military on this subtype of masculine ideals underscores the adaptive and functional nature of these norms within certain contexts. The masculine gender precept requiring soldiers to confront particular aspects of human biology and suppress them, to override and disregard biological signals to run in fear or to cry out in grief or pain, is amplified in military enculturation to help soldiers continue to act and survive in battle (Basham 2008; Fowler 2010; Mejia 2005). This pressure and expectation that military personnel be able to detach from emotional and physiological response, and continue to push on and fight, is captured and reinforced in often repeated infantry credos such as "suck it up and soldier on."

This kind of message captures the drive to minimize emotions that could damage morale, and also underpins a "robust pride in ship, regiment, or squadron" (Higate 2001). As shared narratives, they contribute to a sense of "masculine unity" that is a "cementing principle," and prerequisite to belonging, in military life (Harrison 2003, p. 75). Gabriel (1988) noting this link between stoicism, agency and belonging, catalogued the desired outcome of military training as a high standard of self-discipline and emotional control; a valued group identity; and the development of a strong "warrior" persona that is aggressive, dominant, and risk-taking, and that precludes experience or expression of "weakness." Military training emphasizes domination over one's body and the external world, a neglect of physical needs and health, limited emotional expression, and allegiance to and self-sacrifice for one's

buddies (Brooks 2010; Higate 2006; Keegan 1994; Shields 2016). Selfless sacrifice, perhaps, represents the ultimate expression of belonging, teamwork, and agentic stoicism—the ability to override the needs of the body and the self, even into death, in service of mission and team.

Such masculine ideologies play a central role in military training and culture, tending to transcend the diversity of military life, and set standards of accepted behavior across service types for both men and women. The centrality of this gender messaging to the military identity, however, has important implications for veterans' and serving military members' experience of mental health challenges, on stigma and on the meanings given to contact with mental health professionals and systems of care (Brooks 2010; Shields 2016). Paradoxically, identification with hyper-masculine ideals may not only contribute to soldiers' strength and bond, but also create vulnerability to shame in the face of overwhelming experiences, or mental health or physical health challenges (Gabriel 1988).

Abject Identity: Mental Health and the Fall from Masculine Grace

Military enculturation and training, by continually referencing or invoking the accepted gendered norm, establishes itself as an accepted "timeless truth" for its own members. What is acceptable is further defined by all of the behaviors that are "repudiated" or considered unacceptable and looked down upon by the group (Butler 2006). Military training, in emphasizing and exaggerating masculine norms, invokes both masculine ideals and abjections in order to define military cultural norms and define who belongs and who does not (Fox and Pease 2012). "Belonging" is not an automatic process, but rather is dependent upon acceptable masculine performance and ongoing conformity to others' expectations and their approval (Whitehead and Barrett 2001). The centrality of performance testing in the military, and the need to "measure up," heightens this dependence on the esteem and estimation of others (Barrett 1996).

This dependence on the validation and acceptance of others is by no means unique to military expressions of masculinity. For example, White (1997) observed that manhood generally does not appear to be self-reliant and autonomous; it depends chronically on the estimation of others, and is vulnerable to attack by ridicule, shaming, subordination and the "dishonor" of being seen as feminine. This ever-present existence of the spectre of failed masculinity results in what Pascoe (2012) refers to as "compulsive" masculinity, in

which role compliance must be continually proven, abject identity defended against, and success never attainable in any permanent way. The nature of manhood then appears to be "precarious," as masculine status is hard won and easily lost (Vandello and Bosson 2013). The struggle and conflict of manhood is not just about achieving the ideals, but also struggling against an ever-present threat of falling into the abject identity of failed masculinity.

During initial enculturation into military service and continuing throughout service, conformity to acceptable military masculine norms is policed, both internally by the individual, and in social interactions that establish hierarchies of status and power. This process creates and reaffirms a "threatening spectre" of failed gender, which must be continually guarded against. From early training, recruits who cannot keep up with others or who exhibit sensitivity to the harsh demands, environments or treatment are subjected to a variety of shaming, gendered insults such as faggot, pussy, or wimp (Fox and Pease 2012).

Against this backdrop of masculine military norms, reinforced in recruitment and training, veterans who experience lingering effects of trauma or other mental health challenges, or who fail to uphold or perform within the accepted norms, may begin to narrate their symptoms and any mental health diagnosis as "failure" or weakness—a fall from masculine grace (Pascoe 2012; Shields et al. 2017). Previously granted membership among "warriors," those considered the military masculine ideal, these veterans may experience their mental health challenges as a collapse "from hero to zero," into the abject identity of "unfit," "disordered," and "abnormal." Symptoms of mental health challenges signal vulnerability, attract stigma, and directly threaten masculine ideals (Oliffe and Phillips 2008).

For men who comply with these military masculine ideals, the presence of "clinically significant distress or impairment in social, occupational, or other important areas of functioning," characteristic of most diagnostic categories (American Psychiatric Association 2013), confronts the individual with evidence of the loss of mastery over one's body and experiences—a source and reason for shame. A dominant cultural model of self-reliant masculinity complicates the experience of mental health issues and may serve as an oppressive force that marginalizes and stigmatizes veterans who experience distress.

Military training that links identity and belonging to agency and stoicism may inadvertently precipitate veterans' thwarted sense of belonging and a sense of burdensomeness to their team or community. These two states, along with the comfort with lethality gained from the nature of military work, make up the three essential conditions for suicidality identified in Joiner's (2005) interpersonal theory of suicide. Under these conditions,

suicide may present as the last and final act available to demonstrate personal agency—a self-sacrificing solution that may seem honorable in the face of the perception that one has failed as a soldier and become a burden to one's family and peers (Shields 2016).

Thus, the very qualities that are highly valued within the military context, and which may aid in the performance of tasks in times of conflict, may exacerbate and exaggerate emotional, behavioral, and relational difficulties after deployment. The need to maintain the appearance of stoic competence makes it more difficult for these clients to admit they have problems, seek professional help, or have faith in the efficacy of treatment (Brooks 2010; Jakupcak et al. 2014; Yousaf et al. 2015). A diagnosis, and the gendered stigma it brings, may itself become a central barrier to treatment access and engagement. The resulting "code of silent stoicism" isolates military personnel during times of distress and, paradoxically, perpetuates a myth that real soldiers neither ask for nor need help.

A Clash of Cultures: Therapeutic Versus Military Culture

Perhaps not surprisingly, numerous studies and surveys show that clients with high conformity to masculine gender norms such as these are less likely to seek counselling, and/or drop out early. Some researchers have suggested that this is partly due to a conflict between masculine and therapeutic norms (Addis and Mahalik 2003; Brooks 2010; Englar-Carlson and Stevens 2006; Owen et al. 2010). For instance, Brooks (2010) argues that traditional male socialization predisposes these clients to hide private experience, maintain personal control, appear stoic, present the self as invincible, and value action over introspection. In contrast to these norms, traditional counselling approaches tend to favor clients who self-disclose, relinquish control, recognize and express emotion, introspect, experience vulnerability, and admit failure and/or ignorance.

Brooks (2010, p. 34) contends that, "While the creation and the development of the psychotherapy establishment has been historically dominated by men, it has largely failed to develop models of therapy that are more harmonious with unique masculine ways of experiencing emotional pain and coping with distress." Within the military masculine culture, there exists a stigma associated with seeking mental health care and therefore both male and female military personnel are discouraged, sometimes actively, from doing so. Many may also fear that seeking help is "career suicide" if they are

no longer seen as "fighting fit" (Linford 2013). This cultural backdrop may exacerbate fear of stigmatization with regards to help-seeking, particularly in the early stages of contact with the mental health system. This suggests that the relatively unstudied clinical feature of shame in men's mental health concerns is a particularly powerful, preoccupying, and overwhelming source of emotional conflict and a barrier to service uptake.

Traditional methods of therapy have often failed to attract or interest these clients, and caution needs to be exercised to ensure that the client is not blamed for this failure (Brooks 2010). For feminist researchers, the development of new understandings of femininity have been a central feature of responses to women traumatized by rape, abuse, and domestic violence. There, a rich research literature demonstrates the importance of social constructions of gender on both women's experience of trauma and in developing gender-sensitive approaches to respond to it (Burstow 2003; Butler 2006; Harvey et al. 2000; Herman 1997). The colonization of male veterans' experience of their mental health challenges with military masculine role norms, and the problems that ensue, shows a parallel need for such scholarship and a change to our approach.

In the face of these larger hyper-masculine sociocultural contexts and pressures, how do we successfully engage veterans and leverage the strengths and values inherent in their worldview in the service of therapy? If, for example, PTSD disrupts the ability of the individual to form safe social attachments (Herman 1997), and masculine socialization may engender shame reactions that exacerbate a shift toward isolation (Brooks 2010), how do male veterans negotiate culturally safe spaces to form therapeutic alliances or other relationships where they can renegotiate overly constrictive and self-defeating masculine role expectations? In the following sections, we will explore avenues for culturally appropriate approaches that can help veterans form safe social bonds, take control, and engage more actively in therapy.

Reframing Therapy

Making counselling "culturally safe" for military clients calls for clinicians to be able to acknowledge, respect, and value differences that arise from traditional masculine gender roles and military cultural norms—to become culturally competent. In order to work effectively and ethically with this population, careful attention needs to be paid to the attitudes and therapeutic structural barriers that can make it difficult for this population to begin counselling and to benefit from it.

Essential to any satisfactory therapeutic outcome is the formation of a "Helping Alliance" that begins with meeting the client where they are. This way of looking at counselling encourages the clinician, regardless of his or her own cultural background and gender roles, to communicate and practice in ways that respect and take into account the cultural, political, linguistic and spiritual realities of the people with whom they are working (Brown 2008). It also behooves the counsellor to not only meet the military client on their own terms, but also to be sensitive to frame the work to be done together within the context of the clients existing values and belief systems.

Military social norms and values can be readily leveraged as assets to enhance engagement and propel the process of change. Soldiers are explicitly taught particular values in their training and are expected to live up to them in everything they do. Counselling can be consciously retooled to leverage these values. Some of these explicit values adapted from military training include:

Courage: Military personnel must face fear, danger or adversity. This is a matter of enduring physical and emotional duress and at times risking personal safety. Courage may also be required in the long, slow process of continuing to "do the right thing," even if taking those actions are not popular with others. (Sample questions: Tell me about a time when you had to act and complete a task despite fear, danger or adversity? How does your current situation call for courage from you? What does it mean to face and actively struggle with these problems with all of your courage?). Expressing feelings can be redefined as "courageous," the "hard thing to do," as "men's work." Paradoxically, the very expression of emotional life that was previously stigmatized becomes reconstrued as a form of agency—the hero's path. In courageous and bold self-assertion against the judgment of others, therapy can assist in the building of a parallel meaning structure in which the strongest men are able to feel and speak their truths (Michaels 2011). "Only the toughest belong here. We're in a battle. That battle is not done alone. You never go to battle alone."

Commitment: Military personnel fulfill their obligations, taking pride in tackling the hard challenge and doing the tough work. They must resist the temptation to take the easy way or "shortcuts" that might undermine the integrity of the final product or outcome. (Sample questions: What is one thing you did, or were part of, that makes you proud of being in the military? What is the toughest thing you had to do while serving in the military? How did that affect you then? How does it affect you today? What commitments do you need to hold firm to now? Who are you committed to as you make changes in your life today?)

Loyalty and Selfless Service: Military personnel put the welfare of others, the nation, the military, and their team before their own. They commit to go a little further, endure a little longer, and look a little closer to see how they can add to the effort. Loyalty and service to others requires these clients to consider the impact of their behavior not only on themselves, but also on their family, their team, and their community (Sample questions: When were you expected to work for the good of the whole group regardless of the cost to you? Could you tell me about that? Who relies on you today? There are a lot of military personnel who suffer in silence and who have not been able to take the step forward to get help—If you could model something for them by how you approach your own struggles and your own counselling, what would that be?)

Integrity: Integrity calls on clients to assume accountability for their behavior and to take steps to enhance or recover personal "fitness" and well-being. Assist the client to identify what part they have played in the events that lead them to counselling and what part belongs to others, or the military. (Sample questions: What helped you in your decision to come here today? Many service members don't show up in counselling to do the work that you've stepped up to do. How do you keep connected to the integrity that you've shown in your commitment to do the work that you need to do?)

In order to demonstrate that counselling is relevant and helpful to military clients, the process can be recast so that it capitalizes on these military values and is seen as a relevant means to help clients align more closely with their own value system. It can be beneficial to help the clients see that their personal courage will be tested—counselling is not for the faint of heart. Commitment is required in the face of setbacks and they will be called on to give 110% because counselling will not be an easy way. They will be held accountable for their behavior and called upon to do and give their very best. As one military client observed, "sitting in the bar is a lot easier than being in here." Or as another described counselling, "This is a battle for the heart and mind." These core values and sensibilities can be honored and integrated into specific approaches to counselling. The following further considerations will allow counsellors to tailor their work to capitalize on, rather than work against, the dominant military culture:

1. Use a strength-based approach. For these clients to engage in therapy, clinicians needed to attend to issues of cultural "safety" and appropriateness in order for safe social bonds to develop. By first creating conditions of safety and recognizing resources and strength, the courage and capacity needed to explore vulnerability and emotional content can emerge. When a

counsellor actively seeks and acknowledges the client's strengths, the client feels respected and recognized for his or her competence. Clients need to be given the space to inform counsellors about themselves and what competencies underpin who they are or were. A counsellor needs to be aware that clients may worry or feel anxious that they will be judged or that counselling may uncover all their weaknesses. For that reason, they may work to correct this perception or clients may have difficulty dropping the "mask of competence" they have assembled to compensate for feeling out of control. It is also beneficial to explore values that are also a kind of strength.

As clinicians, we may need to more explicitly communicate our belief in our client's intrinsic strength and frame our therapeutic environment and interventions in ways that first recognize and support notions of competence and skill. It may be helpful to explicitly recast therapeutic activities within masculine role norms, or even as proof of compliance to military masculine norms. (Sample questions: What does it mean to you to be in military service? What motivated you to sign up? What is one of the things you most enjoyed, most valued? Take me through a challenging day when you were proud of how you handled yourself—What were you saying to yourself? How did you "carry" yourself physically? What did you do? This must have been difficult to come here and many don't have the strength to start this work. What do you draw on to start this work?)

2. Be goal oriented and "hit the ground running." Initially, these clients may be uncomfortable with introspective discussions and may prefer focusing on approaches that emphasize more immediate relevance and action. It is frequently beneficial to apply cognitively oriented approaches and/or self-regulation, relaxation or simple mindfulness exercises in the early stages of the work due to the concrete nature of the skills and the ability to demonstrate small gains immediately. (Sample questions: If you could take away something useful from todays meeting, what would you like to have more insight into, or new skills to start to address?)

3. Educate. Action-focused skills training or activities tap into a familiar learning style reinforced in military training and service. A counsellor can provide specific information on relevant areas of concern, such as the psychobiology of trauma, effective communication skills, specific self-regulation techniques, and other skill-based or problem-solving tools.

4. Ensure safety by augmenting their control. One military client who came for counselling was quickly tearful when he started telling his story and clearly quite embarrassed about his "breakdown." By interrupting his storytelling and teaching a self-regulation technique, he learned immediately and first hand that the consultation would give him reliable tools to stay in control.

This is important as early disclosure can be overwhelming and, if it occurs before the establishment of trust, can result in embarrassment for the client and precipitate early termination. By then using the opportunity to discuss how the body "releases" and reregulates itself through tears, the grief that tears signal can be normalized and the courage required to "let go" of tears and acknowledge hurt or loss can be acknowledged. For significantly traumatized clients, establishing grounding skills early in counselling allows them to discuss difficult trigger events without becoming hyper-aroused or dissociating.

5. Explore their issues within a structure and with pacing. Utilizing structured storytelling assignments is one example of giving the client a sense of personal control as he or she can choose what they want to and do not want to talk about. Adhering to masculine gender roles may result in a client feeling uncomfortable or incompetent in the area of emotional self-disclosure and self-reflection normally expected by the counsellor. It becomes easier to focus attention on feelings and expression of inner states once the client has first established themselves in a place of strength. It is important to create safety first, build rapport and then facilitate introspection and self-examination. Note that this is a contrast to how counsellors are normally taught to use relationship building skills emphasizing insight, emotion and self-reflection in the initial stage. A counsellor should be mindful that for many personnel who have been through military socialization, emotions may be funneled toward anger until they learn to expand their vocabulary of emotion and acquire the skills for expressing them.

6. Draw their attention to their body sensations. Use somatic awareness and physical sensations as a way to expand emotional identification and expression. Despite the fact that many clients with high masculine gender conformity have a diminished range of emotional expression and may not be able to access and describe their emotions, they still experience the physiological effects in their bodies. These clients may experience emotions as a general feeling of frustration or anger, and tension in the body. You can assist clients to expand awareness and insight by helping them identify emotional themes in their stories and begin to focus on and label body sensations. Focusing on sensations in the body helps clients identify internal states and yet does not maroon them in the unfamiliar territory of emotion where they may lack language to describe their experience.

Culturally competent counselling with military members, as in any effective counselling, begins with making a connection with the client, establishing the therapeutic alliance essential for the process of helping to begin. Without a successful interpersonal connection and a shared understanding

of how their work will be approached, the client will not feel understood, and will likely remain disengaged, and isolated with their problem. This also extends to negotiating an agreement about the nature of the issues at stake, how to address them, or establishing a shared understanding of how change occurs. It is important for the counsellor and client to agree on an approach. In military terms, this could be conceptualized as defining objectives and a plan of attack acceptable to both of them. Regardless of the cultural and gender lens of the counsellor, the clinician must provide explanations and interventions that are consistent with the client's perspective and point of view. In short, the counsellor must work collaboratively with the client to establish safety, trust and a felt sense of having some personal control so they are willing to move out of their current comfort zone and into the foreign territory of counselling. Through changes in framing, language, and metaphor, therapy can be made more "culturally appropriate" for those who conform to military masculine norms, and this may be helpful in, or indeed a prerequisite to, establishment of a helping alliance.

Working in Groups—The Veterans Transition Program (VTP)

There are opportunities and advantages for utilizing group-based counselling approaches with this particular population. The following case study, which describes working in groups, incorporates many of the cross-cultural competencies and perspective presented.

The group approach presented here draws on the inherent capabilities present in any military group and leverages the preexisting respect and trust for other military personnel in a "soldiers helping soldiers" model. When we ask soldiers, what got them through their most difficult experiences in their service, they typically say that they trust and rely on: (a) their equipment and technology; (b) their training; and (c) the soldier beside them. Counsellors can work with them in the same way by giving them the tools, the training, and the support they need.

Bringing soldiers together in a group offers an efficient mechanism to teach skills but also presents a unique opportunity for them to obtain support from the social group for which they have the most respect and with which they have the most cohesion. Validation received from a group of fellow soldiers has far more credibility than validation from a counsellor—even a counsellor within the military.

The group approach is a culturally appropriate intervention for working with soldiers for all of the reasons outlined previously. Most soldiers are group trained, group experienced, and group ready, as this is the context of their daily work and has been since day one of their military experience.

A Case for the Group: Soldiers Helping Soldiers

A number of researchers have recommended approaching the treatment of traumatized combat veterans with group approaches as the benefits are considerable (Coalson 1995; Greene et al. 2004; Ruzek et al. 2001; Shea et al. 2009; Van der Kolk 1987). Van der Kolk et al. (1996) suggested that veteran groups inherently include built-in peer input, the potential for interpersonal support, and the benefits of social regulation. They also stressed the value of the group for trauma work with veterans.

Group counselling is an effective first-line treatment for many clients with PTSD. An encouraging, mutually supportive environment is commonly experienced as empowering for the participants (Van der Kolk 1987). Group-based therapeutic approaches offer additional therapeutic support beyond what is possible in individually oriented clinical therapies. The advantages of group-based therapies are summarized by Foa et al. (2000), Ford and Stewart (1999), Rozynko and Dondershine (1991), and Ruzek et al. (2001). In particular, the group setting serves to counteract and confront the socially avoidant and self-isolating tendencies of traumatized individuals (Fontana and Rosenheck 2001; Greene et al. 2004). Carefully planned and facilitated groups can provide a structured and safe environment for promoting self-awareness, emotional expression, and cognitive reframing to aid coping and symptom reduction.

Setting Up and Conducting the Group

The Veterans' Transition Program (VTP) focuses on: (a) creating a safe, cohesive environment where soldiers can experience mutual support, understanding from others who have "been there," and process their reactions; (b) normalizing soldiers' military experiences overseas and the difficulties with reentry back to civilian life; (c) offering critical knowledge to understand trauma and its origins, symptoms, impact on self and others along with provision of specific relational and self-regulation strategies for trauma symptom management; (d) reducing the symptoms of the operational

stress injuries arising from their military experiences; (e) teaching interpersonal communication skills to help manage difficult interactions or enhance relationships with others (e.g. spouses, friends, coworkers); (f) helping soldiers generate life goals and learn how to initiate career exploration; and (g) involving spouses and other family members in family awareness evenings.

These components of the VTP are conducted in a structured fashion in order to reduce reactivation, promote increased trust formation, and permit greater self-awareness, self-disclosure, emotional expression, and cognitive reframing. The groups involve veterans only, unlike many trauma recovery groups in which veterans are expected to join with civilians.

The group facilitation team typically consists of two professional clinicians (i.e., a combination of psychologists, counsellors and a physician with doctoral-level training in psychology) assisted by two soldiers paraprofessionally trained in basic communication, and group skills. They model caring and supportive behavior and engage in the expected behavioral outcomes of the program (Alcock et al. 2001). Veterans report that they trust others who have had similar experiences and the witnessing and validation from other soldiers is an essential component in the repair of war-related traumas.

Six to eight veterans meet for approximately 80 hours in a residential program occurring over an 8–12-week period. Consistent with military nomenclature, participants refer to the program as a "course" rather than a counselling group. The terms counselling or psychotherapy are often seen as stigmatizing to the veterans and can discourage others from joining the group. Research has demonstrated that military personnel are cautious about revealing information to others regarding a possible "weakness," such as a psychologically based injury (Rosebush 1998).

Following the first phase of establishing a solid working group, the counsellors begin to assist individuals to address symptoms and begin the work of trauma repair. This is accomplished by having the member share life-narratives through a group-based life review process (Birren and Birren 1996; Birren and Deutchman 1991). In this process participants write short autobiographical accounts on preselected themes in both civilian and military life. These stories are read aloud to the group by each participant. After each story has been read, others respond to what they have heard without making any judgment, interpretation, or giving advice. Rather, they speak about how the story affected them. The goal of this work is to simply and clearly let the speaker know that their story was heard and understood (Birren and Birren 1996; Birren and Deutchman 1991).

Participants practice identifying and disclosing the personal impact of listening to another person's story. By coaching participants to stay out of advice giving, soldiers have the opportunity to practice identifying and verbalizing personal impact, and the participants who are reading their own story to the group have the experience of being heard and understood by their peers. The facilitators are very active in this stage of the group process, modeling the communication skills and checking how feedback is received by the storyteller.

It is important to give the implicit and explicit message that disclosure of difficult personal information is respected as a sign of strength and is not seen as a signal of weakness or as a need for advice and assistance. An example of this occurs when a member is able to disclose feelings of threat or fear when under attack and with this disclosure hears from others that they too had similar feelings but were afraid to disclose those emotions until they witnessed the courage of another soldier to do so. Hearing the reactions of others to one's story can help normalize difficult feelings such as anger, guilt and shame. Sharing common military experiences in particular promotes trust and greater group cohesiveness (Corey 1990).

The use of life review is a relatively low-risk method to initiate self-disclosure as it allows individuals to engage and disclose at their own pace. This narrative method is a semi-structured, topical, group approach to the life review. Participants receive selected themes with guided-response questions so that they can write a 1.5-page story on the themes. The first one used is called the "Branching Points of One's Life" which asks participants to identify critical events across their lifespan beginning in childhood through to the present that have helped shape who they are today. This narrative process helps to highlight strengths and capabilities that have been shown to decrease depressive symptoms (Birren and Birren 1996; Birren and Deutchman 1991; De Vries et al. 1995; Rife 1998). The second life review theme targets critical events in their military service, and is used as a structured form of written, traumatic exposure, that can then provide a framework for sharing traumatic events within the group.

Once the group members have told their individual narratives they are ready to enact critical life events through the therapeutic enactment (TE) process. Therapeutic enactment is a highly structured intervention in which participants are able to externalize memories of traumatic events by enlisting other group members into the controlled, paced enactment of specific trauma events in a form of traumatic exposure work (Westwood and Wilensky 2005). The soldiers refer to this process as "dropping the baggage." Through the enactment process, group members are able to confront their

triggers, practice self-regulation skills in real time, and come to new understandings of the events that they have experienced and their reactions to those events.

To maintain a feeling of safety and in order to remain grounded through the enactment process, group members are taught emotional self-regulation skills. This prevents them from moving into hyper-activation (i.e., heightened anxiety response) or hypo-activation (i.e., decreased sympathetic nervous system responding). By attending to ways of regulating the psychological responses of the client, the counsellors work to keep them within the "window of tolerance" (Ogden and Minton 2000, p. 7). Through active expression of emotion (verbally, emotionally, and somatically) while describing the event for the group, the person doing the enactment integrates the trauma reactions into the narrative. This enables the individual to make sense of what occurred and promotes cognitive reintegration. Participants are able to successfully integrate their reactions at a thinking, feeling, and experiencing level, thereby helping to develop a story of coherence versus confusion and reactivity (Herman 1997).

The process follows a distinct number of steps. (a) In the planning phase, the counsellor and group member work together to plan a critical event to be enacted. (b) In the enactment phase, group members are asked to take on the key roles of significant others who were part of the event or act as witnesses to the enacted event. Techniques such as "doubling" and "role reversal" are used to help the soldier access and express the feelings and negative cognitions attached to the problematic event. (c) The enactment phase is completed by having members who took roles and the witnesses tell what they experienced, what they observed and how the enactment affected them personally. Completion of this process deepens trust among members and further strengthens group cohesiveness and support.

Group Case Demonstration

Greg, a 24-year-old sapper (combat engineer), begins to read his story to the group outlining a critical incident related to his combat experience. He explains that he has been having a lot of bad dreams and intrusive thoughts related to the death of his buddy Don, that occurred during his last tour in Afghanistan. He reports that he cannot sleep as he sees Don's face coming into focus in his nightmare after which he wakes up. It is clear to the team leaders that Greg's symptoms of trauma are tied to this incident as Greg has stated that it really should have been him that died and not Don. Greg had asked Don to drive that day because Greg was drinking the night before and was hung over. Don said he'd be glad to cover for his buddy and drive that day. They drove over an explosive device that struck the driver's side of the vehicle. Don was severely

injured and unable to get out of the driver's seat. Within minutes his side of the vehicle was engulfed by flames. Greg tried to pull him out, but couldn't due to the heat. He had to get out himself to save his own life.

Greg recalls that when the improvised explosive device exploded, he was initially unsure if Don was still alive. He felt he had not deserved to survive as he felt tremendous guilt in setting up the death of his mate by asking him to drive. He carried this guilt and shame for 2 years. In the group, he wanted to recreate the scenario of this explosion again. He wanted to do so in a way that could slow the events down so he could show and explain to the group what happened and how he had tried to save Don but couldn't. Following the steps of reenactment, Greg and the leader began to show the group what had happened by selecting someone to take the role of Don and someone to play Greg's part (as a double) in the reenactment of the two men in the vehicle on that day. The rest of the group witnessed what occurred that day.

After the enactment of that scene, the leaders ask Greg if he would like to talk to the soldier playing the part of his buddy Don to tell him directly what he wished he could have said at the time of attack. Most importantly Greg wanted Don to know how much he missed him, how guilty he felt about asking him to drive, and how it should really have been him that died. Greg added that he wished he could have died instead of Don and that his life is hardly worth living with the knowledge that Don would still be alive if Greg hadn't asked him to drive.

Participating in the reenactment permitted Greg to grieve and express some of the pain he had carried for 2 years. In addition, the enactment helped Greg hear from other soldiers who were the only credible people who could reassure him that what had happened was not his fault and that asking his buddy to drive was something each of them would have done or volunteered to do as a way of backing up a buddy when asked to do so. The soldier playing the role of Don said, "I knew what I was doing when I agreed to drive, I would have done the same thing as you did if the roles had been reversed. It's just the luck of the draw and we knew this was a possibility when we signed up. And Greg, there is one more thing—I need you to live and to live your life fully, otherwise it's as though two of us died that day. Can you do that?"

Hearing the input and reactions from others, conveying understanding and validation of what he felt and what he had done, gave Greg the permission he needed to complete a cognitive restructuring of his trauma narrative that let him to let go of the regret and shame that had troubled him for the past years. In addition, the other guys reminded Greg that he did the right thing by not going back into the vehicle to try to pull him out as he would have died also. A key memory also emerged during the enactment that Greg had forgotten. During the fire, ammunition had started to explode that had forced him to retreat.

In the end, Greg is invited to say goodbye to Don. He tells Don what he most valued about him and what he will carry with him in his memory. After he said all there is to say, Greg bends down to cover Don's body with a sheet. This registers an end and closure as he stands up, gives a final salute of respect to his friend, and walks away. This completes an unfinished grief reaction that has contributed to Greg's posttraumatic stress symptoms.

As part of the follow-up several months later, Greg reported that he feels lighter and that his nightmares of Don's face have stopped completely. He is pleased to add that he is sleeping through the night.

The group TE has been investigated and shown to be well suited to the treatment of combat-related traumas because it is action oriented, requires low verbal expression, involves the support of many others, provides validation and normalization from peers and has an established support group base for follow-up treatment (Black 2003; Cave 2003; Coalson 1995; Cox et al. 2014; Ragsdale et al. 1996; Westwood et al. 2002).

Having worked to confront and integrate traumatic memories, participants begin to shift their focus to their future goals and plans (family, school, work, etc.). Consolidating new learning and creating clear achievable goals and objectives for the future is part of the third phase of the VTP. This final phase could be referred to as a type of post-traumatic growth phase as described by Tadeschi and Calhoun (2004). Participants are encouraged to discuss and generate life goals including initiating possible career paths not previously considered. The group ends with members setting up a post group network of communication with one another.

Research demonstrates that there are significant gains for members who have completed the VTP, including a reduction of trauma symptoms, decreased depression and higher levels of self-esteem (Westwood et al. 2010). Once trauma-related symptoms are reduced, there is less life interference and an increased ability to respond to and plan for future life tasks within the family and at work (Westwood et al. 2010). Qualitative outcome studies reinforce the value of the group as a place where clients can be validated by others who have "been there." Member to member support strengthens clients' sense of confidence to move forward. Increased skills and knowledge about how to navigate in the civilian world allow them to be better prepared and more effective in the work world. Finally, there are considerable benefits in relationships with their spouses and children (McLean 2005).

Conclusion

Although traditional approaches to counselling have sometimes devalued or been critical of clients with high conformity to masculine gender norms, counselling can be retooled to take advantage of unique masculine language, values, and ways of experiencing emotional pain and coping with distress. Therapists are in an ideal position to help veteran clients rewrite the rules of masculinity to recognize the "battle for the heart and mind" through therapy as valid, courageous and a sign of strength. Understanding how therapy can be an asset to veterans as they seek to align their lives more closely with their own value system can contribute to more accessible, relevant and

effective services that respect veterans' existing courageous and agentic helping and healing efforts. As with all populations, the foundation for effective work with military clients is built upon the existence of high regard and profound respect for the "other."

The benefits of group work for all client groups have been addressed by several researchers (for example, Yalom 1995). Bringing military clients together to "drop baggage" is particularly appropriate given their lives are typically lived in groups and they are very accustomed to the value of helping others in their group. We invite counsellors to embrace a different approach to entering the process. We advocate adapting language and interventions so as to mirror the values which already exist in this clientele. These can be integrated into existing helping models to promote change for the military client.

While the need to maintain the appearance of stoic competence may make it more difficult for these clients to enter counselling, once engaged these clients bring a formidable work ethic and energy to the challenge. Making counselling "culturally safe" for military clients calls for clinicians to embrace the strengths inherent in traditional masculine gender roles and military cultural norms, while helping clients break free of the code of silent stoicism that isolates them when they are in pain. When empowered and equipped to escape the long tradition of masculine silence and take personal responsibility for their lives, they do not fail to engage in the work that they need to do. Given that these veterans are husbands, fathers, and sons who belong to and affect families and communities, the social costs of poor treatment access and outcomes are high. When military clients can access therapeutic modalities that allow them to heal from a position of strength, they emerge with dedication and drive to contribute back to their communities.

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