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No Man Left Behind: Effectively Engaging Male Military Veterans in Counseling

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Abstract

Ex-military men have emerged as a vulnerable subgroup for mental illness amid long-standing trends signaling men's reticence to seek professional help. Less explored is how men engage or disengage when they actually *do* enter helping programs. Contrasting decades of quantitative research pairing masculine ideology with low help seeking (i.e., describing the problem), this article draws on qualitative data to distill factors that help men become engaged and committed to counseling (i.e., identifying solutions). Shared is an evaluation of a treatment program with high success rates and virtually no dropouts—a unique occurrence in men's counseling. Enhanced Critical Incident Technique data suggest that helping men feel competent and free from judgment in the company of down-to-earth peers and genuine practitioners are instrumental in helping men draw benefit from counseling. While appealing to male gender roles may be critical in recruiting men to counseling, men can transition to embrace virtues (i.e., that might be shared by men and women alike) and universal human needs as counseling progresses.

Keywords

veterans, military, masculinities, men's health, men's counseling, help seeking, gender role, engagement, client centered, critical incident, qualitative, psychotherapy, group therapy, Veterans Transition Program, trauma

Introduction

Men are reticent to seek help (Addis & Mahalik, 2003; Mahalik & Rochlen, 2006; Mansfield, Addis, & Courtenay, 2005), particularly in terms of mental health services (Englar-Carlson, 2006; Westwood & Black, 2012). Military men may be even more reticent given their vulnerability for mental illness (Gadermann et al., 2012), avoidant behaviors, and conditioned self-reliance (Braswell & Kushner, 2012).

While discourse has tended to explain such long-standing trends epidemiologically (e.g., by referencing suicide rates; Jakupcak et al., 2009), little attention has been given to upstream prevention strategies. Given disastrous outcomes, such as men's higher depression with comorbid substance abuse (Fava et al., 1996), higher incarceration rates (2.7% vs. 0.5% of U.S. population; Bonczar, 2003), and completed suicide rates 4 to 15 times that of women (Moscicki, 1997), it is critical to identify means of engaging men in helping programs in a preventative manner.

The need for preventative research extends to military veterans, within whom prevalent major depressive disorder is roughly double that of the overall U.S. population (12% of those currently deployed and 13.1% of those previously deployed vs. 6.9% of U.S. adults; Gadermann et al., 2012;). Furthermore, U.S. military suicide rates are increasing yearly, topping 21.7 per 100,000 soldiers in 2009 (Braswell & Kushner, 2012). Braswell and Kushner (2012) argue that exposure to hypermasculinized military culture drives high suicides as occupational stress (e.g., depression and trauma symptoms) co-occurs with pressures to be strong and self-reliant.

The current article distills factors of veterans' engagement in a group-based counseling program, considering key ingredients of men's mental health enhancement. A secondary focus of the article is checking how the program influenced levels of gender role socialization. First, it is helpful to situate men and veterans in the context of help seeking and therapeutic engagement.

Military veterans often strongly endorse traditional masculine ideologies (Hinojosa, 2010). While these can be positive (e.g., helping others), they often create pressures

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such as avoiding vulnerability. Pleck's (1995) *gender role strain paradigm* illustrates how male socialization can be at odds with accepting psychological distress or relying on others (e.g., I am weak if I can't handle my shit) which is linked to poor health outcomes such as depression (Oliffe & Phillips, 2008).

Reticent help seeking paired with gender role strain of course occurs in civilian men as well. For instance, despite the high treatability of mental health conditions such as depression, men more often suffer in silence (Addis & Mahalik, 2003; Corrigan & Watson, 2007). In the United States, women comprise two thirds of mental health clients (Hoover, Bedi, & Beall, 2012). In the United Kingdom, women comprise 29% compared with 17% of men (Singleton & Lewis, 2003). Men also tend to drop out of helping programs more often than women (Powell, 2006), with particularly high attrition for that of military men (up to 26.5%; D. M. Sloan, Feinstein, Gallagher, Beck, & Keane, 2013).

Men's reticent engagement may be due in part to counseling training models' common use of a "feminine nurturance model" (Westwood & Black, 2012) centered on corrective and empathic emotional support that may clash with socialized masculinities. This is thought to create a double bind when men require help yet feel shame for receiving it (Englar-Carlson, 2006). Furthermore, men must quickly learn to communicate emotionally. This may seem foreign and alienating, triggering feelings of incompetence (Powell, 2006).

Awareness that approaches to counseling are often ineffective with men helped prompt the measurement of masculine ideology (e.g., the Male Role Norms Inventory–Revised, Levant et al., 2007), linking to negative health outcomes (Mansfield et al., 2005). Discourse like Levant's (1996) "New Psychology of Men" called for a "new masculinity" wherein men step outside of traditional gender roles. While well intentioned, this implied that *men* change to match counseling rather than practitioners working to meet the needs of men. Kiselica and Englar-Carlson (2010) termed this a "deficit model" since male socialization is viewed negatively. Instead, they focused on positive aspects of traditional masculinity (e.g., *male self-resilience* and *the worker/provider tradition of men*) so that counselors can effectively work with men's strengths to build a relationship and deepen therapy.

There is a growing discourse centered on men's needs (Good & Brooks, 2005; Pollack & Levant, 1998). For instance, Englar-Carlson (2006) stresses avoiding labels and stereotypes, while Lynch and Kilmartin (1999) suggest speaking with men how they speak (e.g., refer to events vs. feelings at first). Kiselica (2008) breaks norms by having a meal or throwing a ball with a client, while Powell (2006)) argues that men engage best in gender-specific groups.

Method

The current study focuses on military veterans who completed the Veterans Transition Program (VTP)—an intervention that incorporates much of what the current literature indicates is effective with men. The VTP is a 10-day residential group-based program in which veterans participate in group building, guided autobiography (see Shaw & Westwood, 2002), action-based processing of traumatic life events (see Westwood & Wilensky, 2005), and goal setting. Participants complete the program after finishing the 10 days, typically demonstrating high levels of engagement and reduced stigmatizing attitudes toward mental health conditions (Westwood, McLean, Cave, Borgen, & Slakov, 2010).

The VTP model of "soldiers helping soldiers," as well as including two paraprofessionals (former graduates) on each program is thought to create a veteran-friendly space with a reduced sense of clinical hierarchy. For example, on arrival participants often limit talking with clinical leaders, instead speaking with a paraprofessional who may normalize their anxieties (e.g., "I bet you're scared shitless. Sometimes I think for me coming here was harder than getting shot at"). A recent VTP study reported a zero percent rate of attrition in 56 veterans who entered the program (Westwood et al., in press). The program allows one of the most reluctant subpopulations to demonstrate high levels of commitment, engagement, and improvement, indicating a valuable opportunity to look closely at what works for men.

This study identified factors associated with military veterans' therapeutic engagement by examining the perspective of VTP graduates. A qualitative methodology was chosen based on the study's research goal, that is, investigating what helps men's therapeutic engagement. Thus, the Critical Incident Technique (CIT; Butterfield, Borgen, Amundson, & Maglio, 2005; Flanagan, 1954) was used to examine what aspects of the VTP helped or hindered its success. More accurately, this article used the *enhanced* CIT (ECIT; Butterfield et al., 2005), which is more rigorous in its credibility checks, contextual grounding prior to interviews, and the inclusion of "wish list" (WL) items concerning elements that would have been helpful if they had been available.

Procedures

All VTP participants consented to be contacted following VTP graduation for research purposes. With Behavioural Research Ethics Board approval from the University of British Columbia, 10 individuals who had completed the program in the previous 12 months were invited to participate. Seven of these men agreed, ultimately participating in the study. Volunteers were then informally interviewed

for about 10 minutes regarding their level of therapeutic engagement during the program. Each participant indicated that during the program they had felt (a) safe and included throughout VTP sessions, (b) a genuine sense of wanting to be there, and (c) motivated to contribute throughout the sessions, all indications of therapeutic engagement. Also, three VTP facilitators from the participants' programs were asked if their experiences of these graduates matched participants' reports.

A secondary focus of the article was to check how the program influenced gender role socialization, as measured by the *Male Roles Norms Inventory–Revised* (MRNI-R; Levant et al., 2007). The general masculine ideology index (e.g., a general measure of male gender role endorsement) of the 53-item MRNI-R assessed participants' indicated agreement or disagreement with statements about male socialization (e.g., "A man should be allowed to openly show affection for another man") using a 7-point Likert-type scale (i.e., 1 = *strongly disagree*; 7 = *strongly agree*).

This questionnaire was administered by a visiting research assistant on the morning of the first day of the 10-day program prior to any therapeutic intervention. Participants were walked through the informed consent procedure and supervised as they completed the MRNI-R. The MRNI-R was then administered immediately after the closing of the 10th and final day of the program following a review of informed consent by a research assistant.

Enhanced Critical Incident Technique

The seven recent VTP graduates (i.e., within 1 year) mentioned above met inclusion criteria and were interviewed twice (Butterfield, Borgen, Maglio, & Amundson, 2009). Five were interviewed via phone call and two in person. The first interview was the critical incident (CI) component and was divided into (a) contextual questions to ground participants in the study's purpose (i.e., to investigate what helped and hindered therapeutic engagement); (b) helping incidents; (c) hindering incidents; (d) WL items (i.e., what was missing that would have further helped their engagement); and (e) demographic information. Participants were asked both for CIs and the personal meaning each incident had along with specific examples.

An interview protocol aided consistency across each session. The second interview involved follow-up questions and is further explained in the Data Analysis section. Participants were given code numbers to maintain anonymity. All interviews were digitally recorded and transcribed by an independent research assistant. Exhaustion (i.e., redundancy of categories) occurred after six interviews which was checked by conducting a seventh interview.

Data Analysis

Each transcribed interview was loaded into the qualitative research program HyperRESEARCH, which was used to color-code helping and hindering CIs as well as WL items. Each incident had three components: (a) the incident itself and its meaning to the participant, (b) how it affected their experience in the therapeutic setting, and (c) an example of how this took place. In five instances across three participants, the interview did not provide a specific example to support an incident and so the participant was contacted for clarification.

Next, categories of CIs and WL items were created (Butterfield et al., 2009; Flanagan, 1954) with the goal of identifying practical "male friendly" interventions. Electronic text documents were created for each participant, within which CIs and WL items were inductively organized into categories by examining similarities and differences. This process was repeated with each transcript until no new categories emerged. This was aided by logging the emergence of new categories.

Credibility/Trustworthiness Checks. The study used nine ECIT credibility checks to support the trustworthiness of the findings: (a) audio recording the interviews; (b) interview protocol fidelity that involved having every third recorded interview and transcript (i.e., the third and sixth interview) reviewed by an ECIT expert; (c) independent extraction of CIs in which an independent researcher reviewed two random transcripts and using the same coding scheme, extracted helping and hindering CIs as well as WL items, which resulted in first, an 86% agreement rate and then, a 100% rate of agreement; (d) calculating participation rates (i.e., percentage of total sample who responded to a given category), with a goal of having a 25% minimum of participants represented in all categories (Borgen & Amundson, 1984); (e) categorization of incidents by an independent researcher who placed 25% of all incidents (chosen randomly) into established categories, which resulted in 100% match rate; (f) cross-checking by participants, which resulted in high levels of agreement for both incidents and categories; (g) expert opinions, where categories were submitted to two men's health professionals who agreed that the categories were both relevant and useful in regard to men's therapeutic engagement and provided feedback that fine-tuned one category description; and (h) theoretical agreement, which was assessed by first reflecting on the primary assumption of this study. That is, that men are often reticent to engage in helping programs. Reviewing the literature, this is well-supported (Addis & Mahalik, 2003; Kiselica & Englar-Carlson, 2010; Mahalik & Rochlen, 2006). The second step was to reference emergent categories through a literature search. While all categories

Table 1. Critical Incident and Wish List Items.

	Helping critical incidents (*N* = 50)			Hindering critical incidents (*N* = 11)			Wish list items (*N* = 5)		
	Participants (*N* = 7)		Incidents	Participants (*N* = 7)		Incidents	Participants (*N* = 3)		Incidents
Category	*n*	%	*n*	*n*	%	*n*	*n*	%	*n*
Establishment of Safety	7	100	12	—	—	—	—	—	—
No Longer Alone	6	86	11	—	—	—	—	—	—
Affection From Members and Leaders	6	86	6	—	—	—	—	—	—
Effectiveness of Leaders	5	71	9	—	—	—	—	—	—
Collaboration and Team Orientation	4	57	6	—	—	—	—	—	—
Knowledge of Program Competence	2	29	3	—	—	—	—	—	—
Spartan Practicality	2	29	3	—	—	—	—	—	—
Detracting Group Members	—	—	—	6	86	7	—	—	—
Overworking	—	—	—	3	43	4	—	—	—
Additional Integrative Work	—	—	—	—	—	—	3	43	5

were supported (e.g., Englar-Carlson, 2006; Kiselica & Englar-Carlson, 2010), surprisingly certain incidents were not reflected in the literature (see Discussion for details). All credibility checks considered, it was concluded that the data are sound.

Results

Participants were seven Caucasian men whose ages ranged from 28 to 60 years ($M = 47.71$ years). Six participants (86%) were born in Canada, while one was born in Germany. Four participants (57%) had undergraduate degrees, one (14%) had a high school diploma with some postsecondary education, one had a high school diploma, and one had two master's degrees. Four participants (57%) were married, two (28%) divorced, and one (14%) single. Years of service ranged from 6 to 32, though most served more than 20 ($M = 21.57$ years).

Before completing the VTP, men scored $M = 3.16$ ($SD = 0.79$) on the MRNI-R, which assessed traditional male gender role endorsement—essentially the same as Levant et al.'s (2007) normative sample ($M = 3.14$, $SD = 0.21$). Notably, after completing the program, scores dropped slightly to a mean of 2.93 ($SD = 0.63$). This apparent overall decrease is misleading, however, as individually two participants decreased, two increased, and two did not change. This subtle and inconsistent change is mentioned briefly in Discussion.

The primary focus of this study was the qualitative ECIT component. CIs were tallied to calculate how often a given incident was referred to by participants. A total of 66 CIs comprising helping ($N = 50$), hindering ($N = 11$), and WL items ($N = 5$) emerged regarding men's therapeutic engagement (see Table 1, for a summary). All categories had participation rates above 25%. Results below comprise 10 categories: 7 helping, 2 hindering, and 1 WL category. The top five helping categories (including subcategories) are discussed. From these, three main principles emerge and are elaborated within Discussion. All the hindering and WL categories are discussed. Categories are contextualized by participant quotes.

Helping Critical Incident Categories (N = 50)

Establishment of Safety (12 incidents, 100% participation) pertained to group rules, guidelines, physical location, atmosphere, and the feeling that it was safe to disclose experiences, vulnerabilities, and personal truths in group. With safe conditions, participants expressed feelings of belonging, being respected, trust, and protection from judgment. Two participants discussed lovingness within the men's group—a surprising finding given traditional male avoidance of the "L-word" (Levant et al., 2007). Incident count and participation rate suggests that this was the most important category of helping factors in therapeutic engagement. Following are several examples:

> The guy wouldn't hesitate to say it because this whole atmosphere of comfort and non-judgment told him that it didn't matter what he said, we still loved him, we still supported him, giving him all of the support that [he] would probably need down the road sometime. (Participant 3)

> Just in conversation with people in general, their biggest fear is judgment. Period. And to have that explicitly talked about, even in the veterans circle, the judgment, to just have that absent is key. (Participant 2)

> I'm sorry, but I can't keep a stiff upper lip forever. Maybe some people can, but count me out. [Interviewer: Right, maybe you got a sense that you didn't have to at this program?] No, not at all. The worst thing I remember was

> wearing our masks when we got there. We eventually got beyond that and learned about each other really intimately on the emotional level. (Participant 1)

Two subcategories characterized special instances of what contributed to participant safety. *Crawl, Walk, Run (3 incidents, 43% participation)* suggested that men felt relieved to find out that when the program became difficult or "went deep" they would not be left behind. Similar to the broad safety category, this helped participants engage in the process and feel they belong. An example of how this pacing affected a member is:

> We were taking the time to do each piece, there was no rush through it. . . . If it took extra time then it took extra time, so those are the things that really made me believe right off the bat that, "OK, this is a legitimate program." This isn't just cookie cutter shit . . . the guys are getting the time they need. It seemed to be really focused towards the vets versus focused towards the clock. (Participant 6)

The Company of Men (2 incidents, 29% participation) meant safety to engage unguardedly as a result of a male group. That this was mentioned very little contrasts the theoretical emphasis on the value of men's groups (Powell, 2006). It may be the case that this was supported on such an implicit level that participants did not consciously experience it. One example:

> You place a female in that room and just the basic instinctive dynamics would change. [It] would have shut down aspects of what they had to say or how they felt about things. One of the big bonding things was, "Fuck I feel the same way. I've had the same experience." And if I didn't hear that out loud, which you wouldn't have in front of a woman . . . I would not have connected with that person. If I'm not connecting with that person I'm not connecting with that group. (Participant 5)

No Longer Alone (11 incidents, 86% participation) was the second most common category based on number of incidents and representative participation. It pertained to the sense of finally being understood, being heard and seen, and feeling normal within group. The men at times sighed with relief while recanting when they suddenly realized their commonalities with others. Below are two examples:

> Everyone in the group was able to reflect on the story that was told and say, "Your story was impactful on me because I had a similar experience when such and such a thing happened to me." We said, "Wow we had the same childhood." That's a positive thing. Even if your childhood was horrible, suddenly you're in a room with four or five different guys saying, "Hey man, I'm just like you," or "You're just like me." That goes a long way towards not feeling so alone anymore. (Participant 4)

> The personal things they had to deal with. Not sleeping, the anger, the different things they described . . . over the last year or the last decades. How it's changed their lives. The core issues are very similar. So right away that created for me an understanding, "Hey I get that," "Fuck, I thought I was the only guy that would do that." I'm an oddball in any group but I felt, "OK, I'm not an oddball in this group." (Participant 5)

Shared Military Background (4 incidents, 57% participant) was a subcategory that accounted for members sharing an "effortless understanding." This involved shared military jargon, but more important, that the feelings associated with military experiences could be shared among the group in a way the men had become exhausted trying to explain to others. One example:

> The fact that everyone there has a common denominator of the military is also another factor. There's no having to explain the chain in command or the feelings that go with it. (Participant 5)

Affection from Members and Leaders (6 incidents, 86% participation) pertained to being valued or cared for by others who communicated this through words and actions. It seemed to have a ripple effect as men felt cared for and spontaneously communicated affection toward others. Participants communicated caring, such as in the examples below, through a theme of fatherhood and becoming angry on another man's behalf:

> It was the sharing and the non-program sharing, just as human beings. We actually bought into it quite quickly. I kept calling [Participant 2] son and he kept calling me dad. A bit of a joke. We were able to talk about things very easily and we still do. (Participant 1)

> I got to really understand how I viewed myself as that of being a monster because of the things I had to do. Coming into this, feeling that I didn't deserve to be here. To be told (by another member), "You deserve to be here. It's *bullshit* that you don't think you deserve to be here. I'm angry that you feel that way" is a big deal. It's huge. So to be told that . . . is really the beginning of self-compassion. (Participant 2)

Effectiveness of Leaders (9 incidents, 71% participation) involved how participants bought in after seeing the leaders adequately carry out their roles, convey themselves respectably, and respond to challenges. For two participants, it was particularly important that leaders respected their competence without pitying or looking down on them. In the third example, a participant appreciated that the leaders presented the treatment straightforwardly:

> It didn't feel like I was going to talk to doctors. It wasn't like I was being pitied. Or just, "Ohhh, we need to help you

> because there's something wrong with you" [patronizing tone]. If there was any of that I would have shut off. I didn't want to be "helped." They talk to you like you're a person. Your input is valued and given airtime. (Participant 2)

> Sometimes we have a problem explaining ourselves and it can be a little bit frustrating. They would understand the feelings you were projecting. The leaders knew the right questions in order to bring it out appropriately. (Participant 3)

> They presented fairly complex perspectives and issues in a very simplistic, easy, straightforward way. We'd ask, "Guys what does that mean?" and they could define it as opposed to some people, when you call them on a word, lack the ability to define it. Sort of like how Stephen Hawking understands complex concepts so well that he can easily make others understand. (Participant 5)

Genuineness of the Leaders (3 incidents, 29% participation) was a subcategory marking special type of leader effectiveness. In this case, men placed high value on the human aspect of the leaders not "hiding behind" the role of a therapist:

> When I met them at the VTP . . . I didn't see psychologists or whatever sort of title they would have had. I saw them as people. The entire notion of airy-fairy just isn't there. There's no question about what the intention is. They communicated no ulterior motive. For me to go to speak to somebody about these things is a really fucking big deal. (Participant 2)

> Do the helping interview with me for more than five minutes and I'm going to shut off. I prefer we discuss and if you think, "Wow, that's fucking weird," I expect you to tell me that sounds weird and then we'll go in that direction. I'm very direct. I like to be dealt with directly and I don't like being shined. (Participant 5)

Collaboration and Team Orientation (6 incidents, 57% participation) involved comfort, familiarity, and engagement connected to the roles and responsibilities of working as a group. Also important was men simply being with men, modeling of others, and recognizing that this was a collaborative process where their input was valued. An example:

> It's just the boys back together again, it's not going to be complicated, and it's not going to be difficult. Any team based fire fighters, COPs, anything along those lines where you're always working in a team with a bunch of guys it seems like a pretty simple move. The relative simplicity made it easy for me. (Participant 7)

Feeling Valued Within Group (3 incidents, 43%) and *Giving to Receive (2 incidents, 29% participation)* emerged as subcategories. The former refers to a sense of feeling one's input was respected and critical group progress. The latter involves awareness that one makes gains in proportion to how much they give and that if one does not contribute, others may get stuck. Here are some supporting quotations from the former and latter, respectively:

> I have to commit otherwise they're not going to commit. That kept me going. I wanted them to know that I was committed to them as much as they were committed to me and that goes back to the way that the program is structured. We're all here to do our own work but at the same time we are here to support and help each other. I formed some strong attachments and I want to see them be successful. (Participant 4)

> Somebody always takes the lead in sharing something really personal or sacred about their injury and their youth. Somebody takes the lead and then sets the standard and then everyone tends to follow suit. (Participant 6)

Hindering CI (N = *11) and WL Item Categories* (N = *5)*

There were relatively few cited hindering CIs and WL items. In the case of factors that hindered men's therapeutic engagement, two categories formed.

Detracting Group Members (7 incidents, 86% participation) involved any way in which other group members restricted men's engagement. This most often was other men's disengagement, reflecting above how members' participation was necessary for other members to make gains. Some members also cited disingenuousness of other members as hindering. Some examples:

> I rely on my sort of intuition. How I read people and body language and that sort of thing. If I felt like [other members] were being fake I feel myself closing off. Not completely, but it's more like I've put a layer up there because *they* had a layer up. (Participant 2)

> If I've got five or six guys in a room and one guy is sort of half-hearted in it that definitely takes away from my experience. I'm not saying that he shouldn't have been there but I'm just saying it was distracting for me. It's just like, "Aw man, one guy's working his ass off and dude is just sitting in the corner." (Participant 4)

Overworking (4 incidents, 57% participation) took place when program conditions prevented gains. Note that this stands in mild contradiction to incidents in which members previously cited the "Spartan" conditions (e.g., austerity, hardwork, freedom from distraction, etc.) of the program as helpful. Some examples:

> We had some long, long days. Emotionally draining, thirteen hours, fourteen hours. And it was literally on a break I would fall back in my chair. Not so much that it was uncomfortable as it was phenomenally draining. (Participant 5)

> Sitting in chairs for eight, nine hours a day is physically very hard to do. It's painful and that does become a bit of a distraction. (Participant 6)

The WL item portion of interviews produced so few incidents it was best organized into one broad category of *Additional Integrative Work (5 incidents, 43% participation)*. Some examples:

> I would like to have seen individuals paired off one to one and telling their stories to each other first before they did an enactment. I think without the preview of the one-on-one kind of thing it took some people by shock. Then when that happens and you get that full extra openness . . . you can glimpse into the distance and see, "Ah, that's how it was. I understand a little bit better now." (Participant 3)

> For me, after the re-enactments, my re-enactment . . . was very emotional. It brought up a lot of stuff. I was very messed up. I described it as scrambled eggs brains. I felt that had [the last few days of the program] had a bit more work in there as opposed to having a large focus on administrative stuff and saying goodbye . . . it would have been more effective. I was thinking maybe if we just push a little harder, go a bit deeper. (Participant 5)

Discussion

The current article addresses a literature gap by providing strategies for preventing negative health outcomes of men's reticent help seeking and program engagement. These strategies emerged by identifying factors that helped and hindered men's therapeutic engagement in a mental health program for returning military veterans. Findings related to what helped are suggested as principles to guide programs aimed toward advancing men's mental health.

A first principle emerged from this study in observing that men's engagement was supported by a safe atmosphere with explicit rules that prohibited judgment or advice giving. Herman (1997) defines safety by (a) a sense of control through understanding symptoms and interventions, (b) trusting attachment with others, and (c) reduced alienation through interpersonal support. This definitions fits participants' experiences of the program in which they felt competent and respected with pacing that matched their individual readiness for change. This finding confirms the key ingredients of rule setting and boundary marking for effectively working with groups of men in other contexts including smoking cessation (Oliffe, Bottorff, & Sarbit, 2012) and prostate cancer (Oliffe, Gerbrandt, Bottorff, & Hislop, 2010). Similarly, men valued group structuring (e.g., taking turns with guidelines and protocol) that facilitated sharing and normalizing of feelings and presenting symptoms. Engagement was also aided by affection often marked by dramatic and courageous reframes or becoming angry on behalf of one another (e.g., "It's bullshit that you feel like a monster. That pisses me off, you belong here").

A second principle drawn from the findings is the explicit permission of other men to self-disclose as a means to ultimately self-manage one's health. Underpinning this is the group's will and collective power to traverse traditional masculine ideals that can preclude such actions. Confirmed here is emergent recognition that aligning to specific masculine ideals is neither entirely good nor bad for one's health (Oliffe, Ogrodniczuk, Bottorff, Johnson, & Hoyak, 2012; C. Sloan, Gough, & Conner, 2010). Instead, actions can and are endorsed to enable manly actions within specific communities of practice (Creighton & Oliffe, 2010).

The third principle drawn from the current study asserts the importance of skilled effective leadership and facilitation. The group leaders were frequently cited as instrumental in men's engagement, and characteristics around authenticity, competence, and straightforwardness (as distinct from coming across as traditional therapists) were among the most valued facilitator attributes. Related to this teamwork, collaboration and to-the-point "Spartan" conditions were acknowledged as key strategies underpinning the success of the program. This finding is an important reminder about the centrality of skilled leadership in establishing trust and delivering sound processes and content to make potential program benefits evident early on.

Ironically, traditional mental health care services, despite empirically based assurances about treatment efficacies, often fail to fully engage men (Johnson, Oliffe, Kelly, Galdas, & Ogrodniczuk, 2012). One interesting finding related to this emerged during interviews wherein the emphasis on factors we might associate with traditional male socialization (e.g., requiring that competence and autonomy be acknowledged, "testing" leaders with direct questions, etc.) at the outset of the program later shifted to more overall humanistic needs (e.g., feeling loved and valued, relief from unbearable feelings of aloneness, etc.). This may suggest a decrease in the masculine posturing associated with gender role strain, such as the well-cited masculine ideology that men must always remain composed and in control (David & Brannon, 1976; Pascoe, 2012).

One possibility is that as trust and safety were established, men's senses of self-worth and attachment security within the group were able to exist independent of the masculine ideology that they initially used to relate to one another. Because the gender role strain paradigm suggests that the male social process often comes at odds with men's goals of therapeutic healing (Pleck, 1995), the spontaneous freedom to express vulnerability may have been like a

"pressure release valve" for gender role strain (i.e., men escaped the double bind of seeking *and* avoiding help).

In terms of hindering CIs and WL items, most participants considered other members' disengagement, aloofness, or disingenuousness to be impediments to their own engagement. This may be the hindering CI counterpart to the helping CI experiences of members who cited that their own therapeutic gains were proportionate to how much they "gave" to others through committed and enthusiastic engagement. This supports that helping withdrawn members to engage may improve both their outcomes and those of the whole group. WL items all involved a further desire for therapeutic integration.

The transition from reticence to eagerness was the marker of change that allowed us to identify key ingredients of men's engagement. For instance:

> It's that moment of moving. . . . Like forward. You realize that these [fellow veterans] are going to take anything you say serious. If they're going to put in the effort to understand me I am going to do my best to do the same. (Participant 1)

Examples such as this support that in the right conditions, men will engage strongly in the change process. Combined with other distilled factors of engagement, this informs referrals for ongoing services as men complete our program with enthusiasm for further integration.

As Stevens (2007) had stressed, an educational component was important to the participants. A straightforward explanation of the *how* and *why* behind interventions helped address suspicions of ulterior motives and appealed to men's desires to understand the process. After all, these men wanted to learn to self-manage. They wanted to know exactly what was going on so they could match the leaders' efforts "pound-for-pound" in working toward their goals.

Other incidents that paralleled expert advice were moving beyond therapeutic conventions with activities that men may better bond over such as sharing meals, playing games, and even tasks such as moving tables (Kiselica, 2008); communicating in the same manner and at the same pace of male clients, such as avoiding emotional terms and referring to activities and events at the program's outset (Lynch & Kilmartin, 1999); clarifying through speech and action that there is no ulterior motive beyond working together to a solution (Stevens, 2007); and cultivating a physical space friendly to comradery, such as having magazines, guitars, snacks, and (a lot of) coffee around (Robertson, 2005).

Missing Categories and Implicit Incidents

While there was theoretical support for the inductively formed categories, both the literature and expert consultation revealed incidents and categories that were surprisingly absent. One example was the lack of incidents based on the physical, hands-on nature of the program (vs. a talk therapy). Action orientation as an effective means of working with male clients is popular within men's counseling literature (Good & Brooks, 2005; Kiselica & Englar-Carlson, 2010). Indeed, the VTP *is* highly action focused and parallels Powell's (2006) suggestion that men work best in groups that "do things" together with a number of integrative interventions and shared goals. It is possible that this *was* helpful to men's engagement, albeit on an implicit level that the men did not consciously think about. In a sense, this would be a strength of the program; however, it also means that we cannot overtly verify that action orientation helped engagement as it was not discussed.

Also going unmentioned in interviews was the strategic use of language. VTP facilitators rarely use words like "therapy" or "depression" and instead talk about "picking up tools," "completing a course," or "treating an injury." This male-sensitive approach to language is supported by expert theorists (e.g., Robertson, 2005). There is at least indirect evidence of this approach's effectiveness as the men were quick to use the language of "injury and repair" both during the program and interviews. Similar to action orientation, this may have been so seamlessly introduced into the program that the men were unaware the role it played in their engagement. Again, however, without being explicitly cited, we cannot consider this a helping factor for men in this study.

Implications and Knowledge Dissemination

Because men tended to cite incidents appealing to traditional masculinity that occurred at the outset (e.g., the leader presented himself as "just another guy") and then more general, universal human needs (i.e., that might be shared by men and women alike) that occurred later in the program (e.g., that other members communicated validation and affection), there are implications for men's engagement at the "front end" of helping programs. That is, the early stages of counseling may be a particularly make-or-break period for men. While this is not unique to therapeutic alliance literature (Bordin, 1994), working with traditionally socialized men still represents a minority (Hoover et al., 2012) and culturally specific interventions such as those cited in this article appear critical to reaching reticent men (Englar-Carlson, 2006; Kiselica, 2008).

A unique implication of this study is the paradox that to help men step outside of the double bind of gender role strain (i.e., men may need help, but this violates masculine principles of self-reliance; Pleck, 1995), practitioners are wise to first work within the very masculine ideology that often creates reticence. In this study's group, once trust was established and men had "picked up the tools"

of emotional exchange, the male gender role seemed to soften as the taboo of vulnerability disappeared and men expressed care and even lovingness (in their words) toward each other.

It is also important that nearly all incidents implicitly reflected group process. The constituent elements of the emerging categories formed a very group-focused framework (e.g., safety through group structure, shared experiences of a group of men, collaborative team efforts, etc.). Thus, practitioners are advised to consider the benefits of group work with men, especially in light of the growing scholarly body suggesting that men work better in a team format (Kiselica & Englar-Carlson, 2010; Maccoby, 2002). This is supported more specifically by research conducted both through in vivo observation of what works and what does not for men therapeutically (Powell, 2006) and through theoretical examination of social process in men and boys (Benenson, Apostoleris, & Parnass, 1997).

These findings are of course moot if knowledge is not effectively disseminated. Given the contemporary appeal of media campaigns like Man Therapy (2013), one must consider the drawbacks of using only traditional channels such as peer-reviewed publication. While academic papers and conferences represent one important route, they are limited to a professional audience and further yet by the popularity and affect rating of respective journals. Taking full advantage of modern social communication, we must make every effort to lobby key stakeholders both in existing programs (e.g., psychiatry, clinical and counseling psychology, etc.) and at the level of the lay public. In terms of the latter, the proliferation of YouTube channels and Twitter feeds (e.g., Men's Depression and Suicide Network, 2013) offer opportunities to make new knowledge heard by men and those in their lives across generations.

Small sample qualitative research is not generalizable to larger groups. Thus, in working with military veterans in a group format, the goal was to examine the microcosm of effective male-counseling interventions that has been relatively unexplored in prior epidemiological research. Similarly to triangulation with different methods, it recommended that a variety of qualitative methodologies be employed to further clarify men's engagement process.

It would also be interesting to measure male ideology across a wider cohort of VTP participants, as this sample scored normatively—a surprise given that military personnel tend to score on the higher end of male socialization (Hinojosa, 2010). Our findings may be better understood in relation to gender role endorsement scores of other VTP graduates. For instance, components important to engagement for more traditionally socialized men (i.e., higher masculine ideology scores) may differ from those scoring normatively. Given that higher masculine ideology scores pair with poorer health outcomes (Mansfield et al., 2005), exploring effective engagement with an elevated scoring subset is men may be particularly helpful in guiding the practices of frontline practitioners.

In regard to the tendency for men's therapeutic needs to shift from male socialization to nongendered human needs (i.e., that might be shared by men and women alike), it is important to examine this more directly. One direction would be a mixed-methods study that pairs participants' experiences with the measurement of gender role strain (e.g., the gender role conflict scale; O'Neil, Helms, & Gable, 1986), as it is possible that dissonance has decreased as men discover a safety in conveying deeper levels of personal authenticity. In this vein, while our MRNI-R findings were inconsistent, it is important to follow-up with larger samples to help understand how and if masculine ideology is malleable in relation to counseling programs.

In conclusion, the findings drawn from the current study remind us that a range of fluid and contextual alignments to masculine ideals emerge to protect as well as risk men's mental health. Being reminded that this plurality exists within military men to influence the acceptability of treatment modalities is also timely in thoughtfully considering how we might more fully engage vulnerable subgroups of men in group-based programs.

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References

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the context of help seeking. *American Psychologist*, *58*, 5-14.

Benenson, J. F., Apostoleris, N. H., & Parnass, J. (1997). Age and sex differences in dyadic and group interaction. *Developmental Psychology*, *33*, 538-543.

Bonczar, T. P. (2003). *Prevalence of imprisonment in the U.S. population, 1974-2001*. Washington, DC: Bureau of Justice Statistics.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13-37). Oxford, England: John Wiley.

Borgen, W. A., & Amundson, N. E. (1984). *The experience of unemployment*. Scarborough, Toronto, Ontario: Nelson.

Braswell, H., & Kushner, H. I. (2012). Suicide, social integration, and masculinity in the U.S. military. *Social Science & Medicine*, *74*, 530-536. doi:10.1016/j.socscimed.2010.07.031

Butterfield, L. D., Borgen, W. A., Amundson, N. E., & Maglio, A. T. (2005). Fifty years of the critical incident technique: 1954-2004 and beyond. *Qualitative Research*, *5*, 475-497. doi:10.1177/1468794105056924

Butterfield, L. D., Borgen, W. A., Maglio, A. T., & Amundson, N. E. (2009). Using the enhanced critical incident technique in counselling psychology research. *Canadian Journal of Counselling/Revue Canadienne De Counseling*, *43*, 265-282.

Corrigan, P. W., & Watson, D. C. (2007). The stigma of psychiatric disorders and the gender, ethnicity, and education of the perceiver. *Community Mental Health Journal*, *43*, 439-458. doi:10.1007/s10597-007-9084-9

Creighton, G., & Oliffe, J. L. (2010). Theorising masculinities and men's health: A brief history with a view to practice. *Health Sociology Review*, *19*, 409-418.

David, D., & Brannon, R. (1976). *The forty-nine percent majority: The male sex role*. Reading, MA: Addison-Wesley.

Englar-Carlson, M. (2006). Masculine norms and the therapy process. In M. Englar-Carlson & M. A. Stevens (Eds.), *In the room with men: A casebook of therapeutic change* (pp. 13-47). Washington, DC: American Psychological Association. doi:10.1037/11411-002

Fava, M., Abraham, M., Alpert, J., Nierenberg, A., Pava, J., & Rosenbaum, J. (1996). Gender differences in Axis I comorbidity among depressed outpatients. *Journal of Affective Disorders*, *38*, 129-133.

Flanagan, J. C. (1954). The critical incident technique. *Psychological Bulletin*, *51*, 327-358.

Gadermann, A. M., Engel, C. C., Naifeh, J. A., Nock, M. K., Petukhova, M., Santiago, P. N., . . . Kessler, R. C. (2012). Prevalence of DSM-IV major depression among U.S. military personnel: Meta-analysis and simulation. *Military Medicine*, *177*, 47-59.

Good, G. E., & Brooks, G. R. (2005). *The new handbook of psychotherapy and counseling with men: A comprehensive guide to settings, problems, and treatment approaches*. San Francisco, CA: Jossey-Bass.

Herman, J. L. (1997). *Trauma and recovery*. New York, NY: Basic Books.

Hinojosa, R. (2010). Doing hegemony: Military, men, and constructing a hegemonic masculinity. *Journal of Men's Studies*, *18*, 179-194. doi:10.3149/jms.1802.179

Hoover, S. M., Bedi, R. P., & Beall, L. K. (2012). Frequency of scholarship on counselling males in the Canadian Journal of Counselling and Psychotherapy. *Canadian Journal of Counselling and Psychotherapy*, *46*, 292-297.

Jakupcak, M., Cook, J., Imel, Z., Fontana, A., Rosenheck, R., & McFall, M. (2009). Posttraumatic stress disorder as a risk factor for suicidal ideation in Iraq and Afghanistan war veterans. *Journal of Traumatic Stress*, *22*, 303-306.

Johnson, J. L., Oliffe, J. L., Kelly, M. T., Galdas, P. M., & Ogrodniczuk, J. S. (2012). Men's discourses of help-seeking in the context of depression. *Sociology of Health and Illness*, *34*, 345-361.

Kiselica, M. S. (2008). *Positive psychology with male clients*. Washington, DC: American Psychological Association.

Kiselica, M. S., & Englar-Carlson, M. (2010). Identifying, affirming, and building upon male strengths: The positive psychology/positive masculinity model of psychotherapy with boys and men. *Psychotherapy: Theory, Research, Practice, Training*, *47*, 276-287. doi:10.1037/a0021159

Levant, R. F. (1996). The new psychology of men. *Professional Psychology: Research and Practice*. *27*, 259-265.

Levant, R. F., Smalley, K., Aupont, M., House, A., Richmond, K., & Noronha, D. (2007). Initial validation of the Male Role Norms Inventory-Revised (MRNI-R). *Journal of Men's Studies*, *15*, 83-100. doi:10.3149/jms.1501.83

Lynch, J., & Kilmartin, C. (1999). *The pain behind the mask: Overcoming masculine depression*. Binghamton, NY: Haworth Press.

Maccoby, E. E. (2002). Gender and group process: A developmental perspective. *Current Directions in Psychological Science*, *11*, 54-58.

Mahalik, J. R., & Rochlen, A. B. (2006). Men's likely responses to clinical depression: What are they and do masculinity norms predict them? *Sex Roles*, *55*, 659-667.

Man Therapy. (2013). Retrieved from http://mantherapy.org/

Mansfield, A. K., Addis, M. E., & Courtenay, W. (2005). Measurement of men's help seeking: Development and evaluation of the Barriers to Help Seeking Scale. *Psychology of Men & Masculinity*, *6*, 95-108.

Men's Depression and Suicide Network. (2013). Retrieved from https://twitter.com/MensDSNET

Moscicki, E. (1997). Identification of suicide risk factors using epidemiologic studies. *Psychiatric Clinics of North America*, *20*, 499-517.

Oliffe, J. L., Bottorff, J. L., & Sarbit, G. (2012). Supporting fathers' efforts to be smoke-free: Program principles. *Canadian Journal of Nursing Research*, *44*(3), 64-82.

Oliffe, J. L., Gerbrandt, J., Bottorff, J. L., & Hislop, T. G. (2010). Health promotion and illness demotion at prostate cancer support groups. *Health Promotion Practice*, *11*, 562-571.

Oliffe, J. L., Ogrodniczuk, J. S., Bottorff, J. L., Johnson, J. L., & Hoyak, K. (2012). "You feel like you can't live anymore": Suicide from the perspectives of Canadian men who experience depression. *Social Science & Medicine*, *74*, 505-514.

Oliffe, J. L., & Phillips, M. J. (2008). Men, depression and masculinities: A review and recommendations. *Journal of Men's Health*, *5*, 194-202. doi:10.1016/j.jomh.2008.03.016

O'Neil, J. M., Helms, B. J., & Gable, R. K. (1986). Gender-role conflict scale: College men's fear of femininity. *Sex Roles*, *14*, 335-350.

Pascoe, C. J. (2012). *Dude you're a fag*. Berkeley: University of California Press.

Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. F. Levant & W. S. Pollack (Eds.), *A new psychology of men* (pp. 11-32). New York, NY: Basic Books.

Pollack, W. S., & Levant, R. F. (1998). *New psychotherapy for men*. Hoboken, NJ: John Wiley.

Powell, D. J. (2006). Men in groups. *Journal of Groups in Addiction & Recovery*, *1*, 95-116.

Robertson, J. M. (2005). Counseling men in college settings. In G. R. Brooks & G. E. Good (Eds.), *The new handbook of psychotherapy and counseling with men* (pp. 70-87). San Francisco, CA: Jossey-Bass.

Shaw, M. E., & Westwood, M. J. (2002). Transformation in life stories: The Canadian war veterans life review project. In J. Webster & B. Haight (Eds.), *Critical advances in reminiscence work: From theory to application* (pp. 257-274). New York, NY: Springer.

Singleton, N., & Lewis, G. (2003). *Better or worse: A longitudinal study of the mental health of adults living in private households in Great Britain*. Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4081091

Sloan, C., Gough, B., & Conner, M. (2010). Healthy masculinities? How ostensibly healthy men talk about lifestyle, health and gender. *Psychology & Health*, *25*, 783-803.

Sloan, D. M., Feinstein, B. A., Gallagher, M. W., Beck, J. G., & Keane, T. M. (2013). Efficacy of group treatment for posttraumatic stress disorder symptoms: A meta-analysis. *Psychological Trauma: Theory, Research, Practice, and Policy*, *15*, 176-183. doi:10.1037/a0026291

Stevens, M. A. (2007). *Psychotherapy with men with Mark A. Stevens, PhD*. Washington, DC: American Psychological Association. doi:10.1037/e505512006-001

Westwood, M. J., & Black, T. G. (2012). Introduction to the special issues of the Canadian Journal of Counselling and Psychotherapy. *Canadian Journal of Counselling and Psychotherapy*, *46*, 285-291.

Westwood, M. J., Cox, D. W., Hoover, S. M., Chan, E. K. H., Kivari, C. A., Dadson, M. R., & Zumbo, B. D. (in press). The clinical outcomes of a group intervention for veterans who experienced military-related trauma. *Journal of Traumatic Stress*.

Westwood, M. J., McLean, H., Cave, D., Borgen, W., & Slakov, P. (2010). Coming home: A group-based approach for assisting military veterans in transition. *Journal for Specialists in Group Work*, *35*, 44-68. doi:10.1080/01933920903466059

Westwood, M. J., & Wilensky, P. (2005). *Therapeutic enactment: Restoring vitality through trauma repair in groups*. Vancouver, British Columbia, Canada: Group Action Press.