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"Keep Your Chin Up": Treating Male Veterans With Posttraumatic Stress Disorder From an Integrative Feminist Theoretical Perspective

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There continues to be increasing evidence of the prevalence and growing impact of posttraumatic stress disorder (PTSD) among United States male veterans, as well as pressing concerns related to treatment engagement in mental health services for these individuals. As researchers have advocated for modifications to treatment approaches in the provision of mental health services among this unique population due to issues of traditional masculinity and mental health stigma, integration of feminist theoretical frameworks and therapy interventions are proposed as an avenue to aid in treatment engagement and, ultimately, connection to evidence-based treatments, such as cognitive processing therapy for PTSD. Specific feminist theoretical foundations and interventions will be explored, along with some case composites, to provide evidence of the utility of feminist therapy as an integration tool in trauma treatment.

Keywords: male veterans, PTSD, feminist therapy, military socialization

The prevalence of PTSD is considerably higher among U.S. veterans (21%) than the general population (Cohen et al., 2010; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). PTSD is associated with a range of psychological distress and higher rates of psychiatric comorbidity, with over 80% of individuals carrying comorbid diagnoses (Brady, Killeen, Brewerton, & Lucerini, 2000; Schindel-Allon, Aderka, Shahar, Stein, & Gilboa-Schechtman, 2010). Within the veteran population, the most common comorbid diagnosis associated with PTSD is major depressive disorder (MDD), with 30–50% of veterans suffering from both PTSD and MDD (Campbell et al., 2007). Veterans with PTSD and MDD exhibit higher rates of disability, increased severity of symptoms, are younger, and more likely to report active thoughts of suicide (Campbell et al., 2007). PTSD itself is also associated with increased suicidal ideation, attempts, and completed suicide (Bruce, 2010; Jakupcak et al., 2009). Findings from a recent study of returning veterans who were screened positive (high risk) for PTSD or another mental disorder indicated that only 23–41% sought mental health care (Hoge et al., 2004). As 22 veterans die by suicide every day, the importance of and connection to appropriate mental health treatment is particularly indicated (Kemp & Bossarte, 2012).

A paradoxical fact exists in depression literature where men are diagnosed with depression at half of the rate of women, and yet commit suicide significantly more often (Möller-Leimkühler, 2002; Weissman & Klerman, 1977). The underdiagnosis and undertreatment of depression in men is associated with masculine gender role socialization, which reduces help-seeking behavior (Emslie, Ridge, Ziebland, & Hunt, 2006) and obscures the expression of depressed mood in many men (Cochran & Rabinowitz, 2003). The depressive experience has been discussed as "incompatible" with masculinity, as the overt emotions (e.g., crying), sense of powerlessness, and vulnerability that often accompany a depressive experience are stereotypically "feminine" traits

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(Warren, 1983). Consequently, men often deny depression and manage negative affect through expressing anger as opposed to sadness, withdrawing from interpersonal support, and increasing substance use (Cochran & Rabinowitz, 2003; Courtenay, 2000). This is particularly troubling for veterans suffering from comorbid diagnoses, since depressive symptoms are theorized to play an active role in the development and course of PTSD (Schindel-Allon et al., 2010).

Men who enlist in the service are prone to adhere to the more extreme forms of gender socialization (Jakupcak, Osborne, Michael, Cook, & McFall 2006), which has been associated with decreased likelihood to seek treatment (Addis & Mahalik, 2003; Brooks, 2005). While in the military, men are thought to undergo a "secondary socialization" process that promotes, tests, and celebrates traditional masculinity (Arkin & Dobrofsky, 1978; Fox & Pease, 2012). In order to prepare for combat, men are challenged with the ultimate test of "manhood" and identity, where they are conditioned to ignore distress signals, control emotions, and run toward danger (Mejía, 2005). The fear, hyperarousal, and re-experiencing symptoms that accompany trauma challenge this identity. Postdeployment, experiencing symptoms of trauma can be seen as a "failure" in masculinity, vitiating their sense of self and ability (Fox & Pease, 2012). We posit that engaging in evidenced based psychotherapies for PTSD, which are frequently offered to veterans, also challenges traditional gender and military socialization processes, and can be aversive for male veterans, leading to avoidance of such treatments. Below we detail the state of mental health treatment for PTSD in the Department of Veterans Affairs (VA), historic and current challenges to PTSD treatment, and introduce a rationale for psychotherapy integration of feminist therapy.

Treatment of PTSD in the VA System

The VA has put considerable emphasis in the last few years on strengthening the provision of mental health services to meet treatment needs for veterans who exhibit symptoms of PTSD (Seal et al., 2010). Within the VA system, veterans are treated for PTSD primarily through two evidenced based treatments (EBTs): cognitive processing therapy (CPT) and prolonged exposure (PE). These treatments are empirically proven to reduce PTSD symptoms (Foa, Hembree, & Rothbaum, 2007; Monson et al., 2006) and involve weekly sessions delivered through specialty PTSD clinics by EBT-certified providers. Both CPT and PE involve elements of imaginal and/or behavioral exposure by requiring veterans to encounter and work through traumatic experiences in written statements, recording and listening to a verbal account of an event, and/or gradually facing feared stimuli in order to adequately process trauma and reduce associated symptoms. Despite the proven efficacy of these treatments, some veterans remain reluctant to seek treatment in specialty (i.e., PTSD) clinics.

Due to historic challenges with access to specialty clinics, a recent initiative has been developed in the VA to increase the mental health capacity and timeliness of connection to mental health treatments (Seal et al., 2010). Despite this, only one-third of veterans who have been diagnosed with PTSD follow-up with care in PTSD specialty mental health clinics. Reports indicate that 86% of these individuals do attend at least one follow-up primary care visit in the year after a PTSD diagnosis, suggesting that veterans may be more easily reached in primary care settings. Since veterans are less likely to attend follow-up appointments in specialty PTSD clinics, researchers have suggested integrating PTSD treatments into primary care clinics to improve access to care (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009).

Of additional concern in being referred to specialty mental health services are the negative associations with having/being treated for PTSD observed in veterans. Male Operation Enduring Freedom/Operation Iraqi Freedom veterans drop out of treatment twice as much as female or Vietnam War veterans, and have higher rates of no-show and missed appointments (Erbes, Curry, & Leskela, 2009; Garcia, Kelley, Rentz, & Lee, 2011). Research suggests that in younger civilian males higher rates of dropout are associated with negative treatment beliefs, emotional restriction, and adherence to masculine norms (Garcia et al., 2011). In addition, veterans express concern with increased stigma, negative beliefs about health care, fear of negative career consequences, and decreased

perceptions of unit support if treatment is sought (Hoge et al., 2004; Ouimette et al., 2011; Pietrzak et al., 2009; Stecker, Fortney, Hamilton, & Ajzen, 2007). Furthermore, studies have linked a sense of embarrassment, concern about perceived weakness, pride in self-reliance, and challenges to masculinity as deterrents to treatment engagement in veterans (Hoge et al., 2004; Lorber & Garcia, 2010; Nash, Silva, & Litz, 2009).

In the VA system, primary care psychologists are well-versed in motivational interviewing (MI) practices (Miller & Rollnick, 2013), which is a method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (Miller & Rollnick, 2013). Similar principles are employed by PTSD providers to enhance motivation when veterans present for trauma-focused treatment with reservations (Murphy, Thompson, Murray, Rainey, & Uddo, 2009). Researchers have advocated for the importance of alterations to interventions, such as integrating MI, in order to adequately treat male veterans who are reticent to engage in PTSD treatment (Lorber & Garcia, 2010; Mahalik, Good, & Englar-Carlson, 2003). Being referred to a specialty clinic for exposure-based therapy likely activates anxiety of the unknown and underlying conflicts surrounding a PTSD diagnosis and gender roles in male veterans, fueling ambivalence and making these motivational sessions more complex. We propose that integrating feminist-driven principles and intervention techniques into this stage of the process will provide a platform to address these issues and resolve ambivalence, enhancing motivation to follow-up with treatment. This is in agreement with recent research calling for more gender sensitive interventions in order to improve treatment adherence in male veterans, such as through reconstructing masculinity (Fox & Pease, 2012; Caddick, Smith, & Phoenix, 2015; Emslie et al., 2006). This is particularly relevant to psychologists in primary care settings where initial contact with veterans and referrals to specialty clinics are made.

Rationale of Feminist Therapy Integration

Feminist-driven approaches to psychotherapy challenge traditional conceptualizations of "mental disorders" and the power differential inherent to the process of psychotherapy. Feminists approach psychotherapy emphasizing egalitarianism and collaboration in efforts to empower the client to change. Additionally, feminists depathologize mental illness by viewing symptoms as socially and politically constructed (Enns, 2004; Worell & Remer, 2003). Integrating feminist-driven principles and practices into evidence-based trauma treatment, initially as an engagement technique and then throughout treatment, would allow for shifts in both conceptualization and therapeutic stance offering promising therapeutic benefits to veterans.

The modes of psychotherapy integration that are explored within this article follow predominantly a technical eclecticism and a common factors approach. According to Strieker and Gold (1996), from a technical eclecticism approach, techniques and interventions from more than one form of psychotherapeutic system can be utilized both systematically and sequentially. Target problems or concerns are identified (as well as the relationships between problems) and cognitive, affective, and specific interpersonal characteristics of the patient are taken into consideration as specific interventions are chosen based on the clinical needs of each patient (Strieker & Gold, 1996). This approach allows freedom to understand the specific clinical needs of each patient and match the therapeutic interventions accordingly. Relatedly, from a common factors approach, the specific effective aspects of different therapies are used integratively so that the patient can be exposed to a combination of therapeutic factors, which will best treat the unique needs of the patient (Strieker & Gold, 1996). The integration of feminist therapeutic approaches with evidence-based cognitive-behavioral approaches in the treatment of PTSD allows patients to benefit from interventions that both of these types of therapies uniquely bring to the therapeutic relationship. Additionally, both of these therapies have common factors, which means that these factors can be used in a manner that utilizes the most advantageous aspects of both therapies.

Psychotherapy integration also allows the opportunity for therapeutic creativity or experimentation (Norcross & Newman, 1992) to best meet the intricacies of each patient, as well as capitalize on the strength of universal psychological components leading to less dead-ends in very complex cases (Bergin, 1968; Goldfried, Pachankis, & Bell, 2005). As Wachtel (1977) has also advocated, the

convergence of procedures from more than one theoretical orientation is likely to enhance the effectiveness of intervention attempts. Below we expand on the methods in which feminist therapy integration can be engaged in and provide specific feminist concepts that we feel heighten the likelihood of treatment engagement by male veterans for the treatment of PTSD.

Egalitarianism to Enhance Trust

Feminist approaches emphasize empowerment, equality, and collaboration between the client and therapist. To start, the principles of feminist therapy include the ideal that the client is viewed as their own best expert on their experience and that the client is competent, strong, and capable of change and growth (Enns, 2004; Kashak, 1992). Additionally, feminist principles advocate for an egalitarian relationship with clients, which can help demystify the therapeutic experience and break down the inherent power differential in the client-therapist relationship (Enns, 2004; Kashak, 1992; Worell & Remer, 2003). This perspective is particularly salient for veterans since they often report distrust for mental health professionals (Hoge et al., 2004). The feminist egalitarian relationship allows space for the veteran to be seen as the "expert" on his experience and educate the therapist, increasing both feelings of self-control and the feeling of being "understood" in therapy.

Collaboration to Reduce Vulnerability

Feminist principles advocate for the development of goals collaboratively in the therapeutic experience and fully informing clients about the therapeutic process (Enns, 2004). Collaboration and transparency can be crucial in addressing cognitive dissonance and enhancing veterans' treatment engagement. Specifically, male veterans have been taught to maintain emotional control and be strong, but are also being asked to engage in a therapeutic experience in which they may feel disempowered or vulnerable. Engaging with the client from a collaborative perspective can reduce felt vulnerability and increase empowerment (Enns, 2004).

Recognizing Socialization and Societal Influences on Identity

Feminist approaches view identity as diverse, multifaceted, and developed through the interconnections of multiple societal and interpersonal systems (Enns, 2004; Worell & Remer, 2003). These goals and frameworks are useful when considering the identity of male veterans, including the intensity of masculinity socialization, which must be explored and understood in order to adequately conceptualize what it means for a veteran to seek mental health treatment. Feminist practice goals also encompass helping clients examine how their perception of gender-appropriate behavior is influenced by gender role expectations and the resultant impact on mental health (Enns, 2004; West & Zimmerman, 1987).

The Environmental Context: Viewing "Pathology" Through an Alternative Lens

The feminist approach of interpreting personal problems in the context of how people have been impacted by their environments may be especially beneficial in treating male veterans with PTSD. We have frequently found that male veterans are hesitant to engage in mental health services because they do not want to be deemed "weak" due to masculinity socialization as well as the effects of stigma. The feminist approach of reframing symptoms as responses to environmental factors and methods of coping can create more normalization for veterans and decrease the likelihood of internalizing or blaming themselves for their problems (Greenspan, 1993). In fact, goals of feminist practice include the use of therapy as an agent for change by increasing insight into how emotional pain, life circumstances, and mental health symptoms are interconnected (Enns, 2004). In adjusting self-conceptualization, this feminist framework can help create emotional distance from a stigmatized viewpoint of being "crazy," creating more space for self-efficacy, empowerment, and the belief in personal change, which also facilitates treatment engagement.

Therapeutic Goals

Long-term goals of feminist-oriented trauma treatment are also in congruence with evidence-based treatment for trauma (CPT and PE). Once a therapeutic alliance has been established and

specific trauma-focused treatment has begun, intervention focuses on the following: creation of a safe environment that will support the survivor's treatment, exploration of the interaction of trauma and masculinity, reduction of negative impact of the traumatic event and a return to pretrauma level of functioning, development of positive coping skills, assistance in retelling of the traumatic event without being overwhelmed by distressing emotions, elimination of behaviors that maintain avoidance, promotion of healing and acceptance of the event, and the instillation of hope, resilience, and transcendence (Foa, Hembree, & Rothbaum, 2007; Mejía, 2005; Resick, Manson, & Chard, 2008). Since there is notable relatedness between the therapeutic goals of both feminist-oriented trauma treatment and evidence-based trauma treatment we believe there is a strong argument for utilizing feminist therapy integratively with evidence-based trauma treatment, which also adds an additional depth to treatment that evidence-based trauma treatment alone does not entail.

We have reviewed some of the guiding principles, goals and practices of feminist theoretical foundations to provide a case for the utility of this frame of thought for treating male veterans with PTSD. The following sections will provide greater detail about integrating feminist therapeutic process and interventions with evidence-based trauma treatments. In our own work, we have found these feminist interventions particularly salient in treating male veterans who present with PTSD. Lastly, case composites will be included to give a voice to how feminist process and interventions may be utilized.

Integrating Principles Into Practice

Gender Role Analysis and Social (and Military) Role Analysis

Gender- and/or social-role analyses can be utilized to heighten a veteran's insight in to how societal gender role or social-role related expectations impact psychological well-being (Kashak, 1992; Sturdivant, 1980). A gender role analysis typically includes exploration of gender in connection to family dynamics, life stage, cultural/ethnic background, personal values, and environment (Brown, 1990). During these exercises, it is important to explore expectations associated with gender- and/or social-roles, the way that messages and behaviors are reinforced or punished, the rewards and costs for either gender- or social-role conformity or nonconformity, and any experiences of oppression or victimization (Brown, 1990; Enns, 2004). For veterans, we also encourage providers to use a "military role analysis" in the same manner. This analysis can raise discussion of internalized standards which may create experiences of self-loathing, failure, and guilt if the client does not feel in congruence with those standards (i.e., standards of military training). Similarly, this provides an opportunity to explore additional gender role conflicts that emerge in seeking treatment, where men feel a sense of failure to meet masculine gender role rules, which can create psychological distress (O'Neil, Good, & Holmes, 1995).

Addressing Stigma in the Military (Prior to Discussing PTSD)

As part of the feminist process, it is important to engage male veterans in dialogue that explores what it means for them to have and experience PTSD. Frequently, this dialogue will engender shame around the notion of having a "mental health problem," instigating feelings of low self-worth and self-blame that as soldiers they have faced experiences of trauma and have not been able to "man up," or "get over it," as they have been taught emotional suppression in their military training (Lorber & Garcia, 2010; Nash et al., 2009; U.S. Department of Army, 1994). For therapists, a significant challenge in treatment engagement is helping a veteran confront the perception that they might have a "mental health problem," which is in direct contrast to ideals of hypermasculinity, emotional control, and unrelenting strength (Lorber & Garcia, 2010; Mahalik, Good, & Englar-Carlson, 2003).

A Feminist-Based Conceptualization of "PTSD"

It is instrumental in feminist psychotherapies to address the notion of "pathology" as a socialization process at treatment outset. This is directly applicable to the PTSD diagnostic criteria of experiencing a "stressor" (Criterion A) and "emotional avoidance" (Criterion C) (American Psychiatric Association, 2013). Specifically,

veterans have often been placed in war zone environments and exposed to injury, life-threatening events, and death. In addition, gender and/or military socialization processes have encouraged veterans to dismiss, constrict, and disengage from emotional experience in order to perform duties effectively (Mahalik et al., 2003; Nash et al., 2009). Consequently, soldiers are exposed to inherently traumatic environments, trained to ignore or redirect their normal emotional response, and then deemed to have a "disorder." Considering PTSD's environmental and societal influences may reduce the tendency for veterans to shame themselves for being "sick," and also provides an avenue for exploring the emotional and physiological consequences of excessive emotional avoidance (Karlin et al., 2010).

Survivorship

In the process of engaging veterans in dialogue about what it means to have PTSD and helping them redefine this for themselves it may be helpful to talk about their experience in terms of survival. To expand, facilitation of conversations around the idea that symptoms are by-products of the mind's ability to persevere and survive extreme distress creates psychological space for veterans to reframe their symptoms as the body's attempt at adaptation to traumatic events that their mind previously had no cognitive categorization for, hence, these symptoms are resultant adaptations that were necessary to survive the traumatic event. This ideal may also resonate with military training due to the fact that veterans are frequently taught methods of survival.

As veterans are more willing to engage in the feminist process and accept that they might have had these reactions as a means of survival, another concept that can lead to personal change and willingness to engage in trauma treatment can be introduced-adaptation. More specifically, although symptoms were created as methods of coping and survivorship as an experience of being exposed to trauma, these same symptoms are not as functional over time and in fact contribute to personal distress because they are no longer facing the same traumatic events (Greenspan, 1993). This concept of survival and adaptation is also in accordance with other evidence-based treatments such as CPT and PE (Foa, Hembree, & Rothbaum, 2007; Resick et al., 2008); therefore, the utility of using these treatments integratively is well founded. Metaphorically, it is as if clients are still in a "fight or flight" mode when the actual danger is gone, creating distress from prolonged heightened arousal that is no longer adaptive. Additionally, there is a need for new and different skills, as well as new coping methods to face current life tasks which are not threatening. As veterans gain some of this ground, they may be more willing to think about engaging in treatment for trauma or other interventions which can facilitate personal change, create avenues for emotional expression, and help alleviate their suffering.

Viewing Identity as Multifaceted

Another cornerstone of feminist process in treating male veterans with PTSD should include exploration of veterans' multiple identities, including the impact of culture and training on identity development (Enns, 2004). It is important to engage in dialogue that can reveal the different parts of a client's identity as well as how that is connected to multiple interpersonal and societal systems. Among many male veterans, the experience of being part of the military comprises a significant portion of their identity, as it carries heightened emotional salience, self-worth, and pride. Because much of military training and culture includes ideals of strength, emotional control, and invulnerability (Eisenhart, 1975; Messerschmidt, 1993), this can cause a dilemma for veterans who are being asked to engage in mental health treatment. At the right time in the course of treatment a cost/benefit analysis may be incorporated to explore what a veteran is sacrificing (aspects of identity) in order to heal. Exploration of this dilemma respectfully while creating possible options for identity development, as well as an increase in personal empowerment, are all part of the feminist process.

Resolving Ambivalence About Military Identity

Feminist approaches allow for a dialogue that raises ambivalence about treatment to the forefront of therapy. This is done through balancing various aspects of identity and their influence on

symptom expression and/or avoidance in initial sessions. For example, this may emerge in the feminist process as a veteran examines the meaning of his identity as a soldier who is strong, in control, and able to withstand hardship which creates self-worth, while at the same time recognizing some of these military ideals have led to emotional suppression, treatment avoidance, and prolonged suffering.

As veterans start to allow themselves to create different definitions of their identity, there may be a mourning period for the loss of a central military identity. Feminist process that can empower the ability to foster ambivalence and create emotional distance from aspects of military identity that exacerbate treatment disengagement may be pivotal moments in therapeutic engagement. This can offer the veteran an opportunity to identify and maintain alternative characteristics of his military identity that remain beneficial to mental well-being, such as respect, self-discipline, responsibility, honor, and teamwork (Husted & West, 2008). It is important to note that feminist process may include dialogue around balancing affinity and a core identity as part of the military versus being "damaged" or having consequences as a result of their service (e.g., mental health issues, PTSD, injuries, medical illness, pain, traumatic brain injury, family conflict, isolation).

Emotional Expression and Reactions

Feminist therapy also calls for the importance of helping men increase their ability to disclose emotions and reactions that are frequently kept as "secrets" (Ganley, 1988). As a byproduct of the egalitarian and safe collaborative feminist therapeutic relationship, there is opportunity to be genuine in the therapeutic process through modeling the expression of appropriate emotions and reactions in order to increase a client's own ability to express emotions appropriately (Worell & Remer, 2003). Furthermore, psychoeducation and training to help cognitively reframe can be provided (on healthy emotional expression) that includes learning to accept personal feelings as valid and as a reflection of reactions to something that is real (Enns, 2004). As appropriate emotional expression is shared, feminist process can be engaged in to provide feedback to veterans regarding their emotional expression and therapist reactions, including the concept that the veteran does not appear weaker because of the expression, but rather courageous and resilient. Also, this experience helps facilitate a corrective experience. A veteran may expect to be rejected for their emotional expression in line with traditional masculinity, but experiences acceptance as emotional risk is taken, allowing the opportunity for beliefs about emotions to be challenged.

Personal Empowerment

Feminist therapy also embraces interventions aimed at personal empowerment. Feminist concepts of empowerment embodies the ideal that individuals have the ability to conceptualize themselves as active agents on their own behalf and can develop the skills and capacity for gaining some reasonable control over their lives (Enns, 2004: McWhirter, 1991). Empowerment-focused interventions could include the following: helping veterans increase their self-esteem and self-affirmation by pointing out unique contributions, strengths, and achievements; aiding in the development of a supportive network to foster self-nurturance; increasing access to problem-solving skills; empowering flexibility of gender-related behaviors, thinking, and identity; and providing opportunities to engage in social justice activities (Worell & Remer, 2003). Ideals of empowerment emphasize personal competence rather than just symptom removal, and research has provided support for the positive benefits of these interventions (Enns, 2004).

Social Action

Feminist theoretical foundations focus intently on social justice and a call for social action (Brabeck & Ting, 2000). As feminist therapy is engaged in and as it progresses, there are opportunities for specific interventions that involve clients in social action, which in itself is restorative, a healing process, increases empowerment, and ultimately facilitates social change. Feminism historically utilized a variety of methods such as consciousness-raising groups in which women, in a community, gathered to raise awareness of oppressive sociocultural structures and worked together toward social change, which was therapeutic in itself for many individuals and instrumental in change of oppressive social structures (Brodsky, 1973;

Kravetz, Marecek, & Finn, 1983; Worell & Remer, 2003). As veterans are presented with unique, socially constructed barriers to mental health treatment, client-led social action agendas directed toward groups, communities, organizations, systems, and social policy should be a major element of therapeutic intervention. Taking social action empowers clients to use their own voice and includes engagement at the macro- and meso-levels. Examples include: groups of veterans gathering together to offer mutual peer support related to their experience of trauma, stigma, and treatment, community veteran-led talks to increase awareness, lobbying for social policies that increase mental health prevention efforts and treatment options for PTSD, and/or engaging in the development of free public media aimed at breaking down the walls of silence around gender socialization, the military, trauma, and mental health. Recently, a group of veterans receiving services in the VA system engaged in such a social action initiative by sharing their personal experiences with PTSD via the Internet in order to enable national access and peer support to other veterans (U.S. Department of Veteran's Affairs, 2013). We have found that encouraging veterans to get involved in various social justice action agendas can break the oath of silence, decrease stigma, and facilitate personal and community-wide efforts in the prevention and treatment of PTSD.

Case Composites

To maintain confidentiality the following three cases are composites of typical cases that present in a primary care setting at a VA medical center. The first case is a lengthier and more extensive example of offering integrative treatment from a feminist perspective and the last two are shorter examples, which provide snapshots of specific feminist interventions that can be used as an integration/engagement technique and are particularly relevant to this paper.

Case 1

John, a 51-year-old African American man saw his primary care physician and was referred to a psychologist after reporting difficulty sleeping, irritability, and nightmares. Interestingly, per the initial interview the veteran presented with a severe case of PTSD and problem drinking; however, reported no history of treatment even though he had been out of the service for over 20 years. He also appeared very hesitant to answer questions and eager for the session to be over, stating frequently, "I'm not crazy." The veteran was provided options for a treatment referral to the clinic that treats PTSD and substance use, but he declined by stating, "I don't have that PTSD stuff . . . I told them I'm fine." John expressed significant ambivalence surrounding psychotherapy participation but was also facing an ultimatum by his wife. As a compromise, he agreed to some treatment, as long as it was in the primary care clinic. Treatment first focused on addressing the veteran's anxieties about therapy threatening his sense of masculinity through a feminist-motivational approach, with the goal of later engaging in trauma-focused treatment for PTSD.

As the veteran began to attend sessions with the psychologist, hypermasculine ideals, emotional rigidity, identity issues, and stigma related to a mental health diagnosis were apparent barriers to treatment engagement. The effects of PTSD were evident as John described drinking frequently to "take his mind off the past," getting little sleep, carrying his gun around, and having difficulty keeping a job. A feminist theoretical framework was the foundation for treatment engagement with John, including a gender- and social-role analysis, enhancement of appropriate emotional expression, facilitation of personal empowerment, and opportunities for social action.

As the gender- and social-role analysis was conducted, questions were presented that fostered dialogue, such as, "How did your family teach you to handle emotions as a boy?" and "What values did the military tell you were important?" John shared that he was told by his father many times to "man up" and could not remember ever crying after the age of eight. John paralleled this to his military experience, stating that in the service he was told to "keep his chin up" and only "weaklings" ever showed fear or cried.

Additionally, John shared a few experiences of racism that occurred while he was a young man and while in the military that had angered him, but was proud that he never let it show "it got to him." Though John had some significant PTSD symptoms he was very guarded against his experiences of trauma. After three sessions,

through motivational interviewing, John was able to weigh the cost and benefits of "keeping it all inside." He noted the detriment of emotional suppression to his marital and occupational relationships through rage and isolation. It was evident John did not want to burden others, fearing abandonment due to shame of being unable to "move past" his trauma as he became increasingly open. Pivotal moments included open and transparent communication in session, validating to John that he was not being viewed as "crazy," and reframing his symptoms in terms of survivorship and adaptation.

A major part of the therapeutic engagement included redefining what it meant to be a "man" and that emotions were a normal human experience. After initial reticence, through modeling/reflection by the therapist, John became increasingly comfortable and open to identifying emotions and how to express them in a healthier manner rather than suppress them or abuse alcohol to "numb out emotionally". As he gained more practice in therapy, he tried this emotional expression with others in his family and became increasingly empowered to express emotions that he had historically viewed as "weak." Furthermore, his problem drinking behaviors reduced as he engaged in more adaptive forms of emotional expression.

With a developing sense of empowerment, John began to offer self-nurturance and self-affirmation acknowledging the significance of his trauma, treatment rights, and right to share his experiences in therapy, express emotions, and that he was not less "male" for being open about these things. In this phase of therapy treatment focused on John's strengths, increasing flexibility around gender-related behaviors, and the development of coping methods and problem-solving abilities to further increase self-efficacy and personal empowerment. Frequently, John was given positive feedback about each step in therapy to decrease vulnerability and increase sense of personal empowerment. Additionally, John engaged in social action interventions, which included participation in a VFW support group, allowing him to meet other veterans with similar experiences. In this experience he was able to talk about his experience with other veterans for the first time and even decided to join in a public mental health awareness campaign for veterans. Though John reported significant anxiety around this intervention, once he took that step he reported more affirmation that he was "similar to other vets." Over three months and 12 sessions, John was able to gain more trust for the therapeutic experience, expand emotional expression, and decrease his stigmatized view of himself, Ultimitely, he elected to pursue CPT to further engage in evidence-based trauma treatment.

The utility of the use of a feminist theoretical stance as an integration tool was evident as John finally engaged in CPT. Conceptualizing "problems" as tools for survival, with a destigmatizing and egalitarian approach, provided a foundation for John as he was now able to attend 12 CPT sessions. Initially, sessions focused on education about PTSD, thoughts, and emotions, as well as the cognitive theory of PTSD (Resick & Schnicke, 1993). Next, John was able to write an impact statement in which he communicated how he understood his traumatic event, why it occurred, and the impact it had on his beliefs about himself, others, and the world. This enabled John to learn how to identify automatic thoughts to improve his awareness between his thoughts and feelings, such as, "It's my fault." Feminist groundwork allowed John to continue to work toward contextualizing his experience as a response to an environmental situation and fight the instinct to self-blame. Over the next sessions of CPT John was able to engage in emotional processing of the trauma and recount his experience in order to break his cycle of avoidance and identify maladaptive core beliefs. The initial engagement through feminist techniques that fostered development of emotional expression facilitated this particular CPT intervention and John was able to build on this while engaging in emotional processing. In this case, the integration of feminist and CPT techniques provided an efficacious treatment course where John made significant progress in exposure-based techniques following his initial work addressing treatment anxieties related to masculinity.

Case 2

Frank was a 28-year-old Caucasian male who ended his tour in Iraq two years prior to coming to the primary care clinic. He presented to the clinic for a regular checkup but upon evaluation it was apparent that he was experiencing other concerns including challenges with sleeping,

being "on edge," depressed mood, anhedonia, irritability, thoughts of death, flashbacks, loss of appetite, nightmares, and feeling angry most of the time. Frank discussed difficulties with reintegrating into civilian life and no longer "fitting in" with his friends, leading him to withdraw from these relationships and isolate at home. Upon an intake by the psychologist, it was apparent that he met both criteria for PTSD and depression. Though Frank was reticent, he agreed to meet with the psychologist in the primary care clinic about his presenting challenges; however, reported "I don't think I really need therapy."

As Frank engaged in therapy in the primary care clinic it was apparent that an internalized sense of failure in response to PTSD-related symptoms (flashbacks, hyperarousal, nightmares) was driving his depression. He was skeptical of a referral to the PTSD clinic for an evidence-based treatment such as CPT or PE and reported he did not feel like "that was for him." He described oppressive and stigmatizing ruminations that he "should be able to handle it." He noted a sense of embarrassment that he could not comfortably go outside or engage in everyday activities due to being preoccupied with scanning the environment for potential threats.

The initial therapeutic challenge was to assist Frank in reconceptualizing his symptoms to decrease his internalized sense of failure and shame in hopes that this might destigmatize his process of connection to mental health treatment for PTSD and depression. During this segment of therapy it was clear that an approach that offered a feminist-based conceptualization of PTSD highlighting societal and environmental influences on symptoms and personal survivorship could offer an alternative viewpoint and decrease his pervasive shame and self-blame. This process was initiated by discussing military training and expectations in combat, along with information about trauma and adaptive and instinctive biophysiological processes that accompany life-threatening events. This decreased Frank's experience of feeling pathologized and normalized his circumstances, with the concept that he was adapting to unhealthy and life threatening environmental experiences, and shifted some responsibility onto the environmental context to his dilemma. Initially, Frank was skeptical about conceptualizing his experience of PTSD as anything other than a personal flaw; however, as discussions continued he was able to grasp that being in a war zone environment is not a "normal" human experience, and he was able to begin to reconceptualize some of his symptoms as a process of survival and adaptation. With growing understanding, Frank was increasingly open to discussing the impact of symptoms on his daily life, particularly in terms of nightmares and intrusive thoughts and his tendency to overreact to and avoid stress. Frank also acknowledged intense feelings of anxiety and fear that he was in danger again during these re-experiencing moments, which kept him in a repetitive cyclical state of "fight or flight" and essentially "survival mode." As trust, collaboration, and the egalitarian relationship deepened Frank was able to also gain understanding that this "survival mode" was persisting in his life beyond the initial threat and that it might be helpful to learn new skills and coping methods, via CPT or PE, to alleviate ongoing suffering and help him transition away from a constant state of hyperarousal or survival. This allowed Frank to accept a referral to the PTSD clinic for engagement in EBT for PTSD and depression.

Case 3

Antonio was a 44-year-old Latino male who served in Desert Storm and had a traumatic experience in which his Humvee hit a land mine and killed his best friend. Since then he had struggled with PTSD and depressive symptoms while trying to keep his personal life together. Antonio had previously been referred to a CPT treatment group twice, but dropped out after a few sessions reporting, "It was just too much." He saw his primary care doctor for a medical concern and the treating physician realized Antonio was still suffering quite extensively from ongoing PTSD symptoms, as well as depression. The primary care doctor referred him to see the psychologist there in the primary care clinic and Antonio agreed, though shared, "I've seen psychologists before and all they want to do is talk about feelings, which I'm not too keen about."

Initially, it was apparent that Antonio had experienced intensive military socialization that influenced him to believe that men and "soldiers don't feel," which had contributed to years of

keeping feelings of fear, anxiety, sadness, and depression suppressed. Due to this dynamic, it was apparent that he displayed quite a bit of anger and irritability at times throughout his life, which was a more comfortable avenue of emotional expression for Antonio than feelings of fear, anxiety, sadness, or depressed mood. Using a feminist approach, a gender role analysis was conducted to build insight into Antonio's personal challenges with expressing emotions. Antonio became aware of the socialization process that had occurred for him, which had hindered him from sharing some of his intense emotional experiences, leading to incongruent emotional expression and repression of his genuine feelings. Similarly, he was able to recognize how this repression of his emotions contributed to ongoing depression over many years, since he suffered quite frequently in silence. Antonio was also able to see how his challenges with emotional expression had impeded him from really being able to engage in the CPT groups that he had been referred to before and that he had always decided they were for "weaker men who liked to talk about feelings," which likely prolonged the impact of his PTSD symptoms over 20 years.

Though it took many months of developing a safe, therapeutic, and collaborative relationship Antonio was able to eventually disclose some of the distressing emotional experiences he had in relation to his traumatic experience in Desert Storm. In one session Antonio became tearful and reported, "I can't believe I'm sharing this secret," and reflected that he felt terrified and fearful in Desert Storm after the land mine incident and could not shake images from his mind of his friend dying in front of him. Offering validation, empathy, and normalization of such feelings due to such environmental stressors was especially helpful for increasing Antonio's capacity to share distressing feelings. Sharing literature about the stories of other men who had experienced depression and PTSD and had difficulty with emotional expression and treatment engagement also helped alleviate the pressure Antonio felt to keep his feelings inside. These early steps laid a foundation for the psychologist to provide more psychoeducation and modeling related to healthy emotional expression, including the concept that acceptance of personal feelings as valid and reflections of true personal experience empowers healing from such experiences. Antonio was able to continue to think about masculinity and strength in others ways than the ways he had been socialized to align with traditional ideals of masculinity. Additionally, this opened up a new freedom for Antonio to pursue additional treatment for his PTSD and depression, as he became increasingly accepting of the therapeutic process.

Conclusion

In conclusion, as masculinity issues, the stigma of mental illness, and other barriers continue to prevent male veterans from engagement in trauma focused treatment, feminist therapy may be a valuable integrative tool to foster increased connection to and sustained engagement in mental health services. The incorporation of feminist therapy may be specifically useful in primary care clinics since veterans may be referred to a mental health provider by their physician, whereas previously they may have been able to avoid all types of direct referrals to a traditional mental health clinic. The use of feminist therapy may also be beneficial for veterans that have dropped out of PE or CPT early, those reluctant to engage in individual trauma-focused work, and for veterans that refuse to engage in a group trauma treatment. As these frameworks are utilized, the possibilities for increased comfort with mental health services and trust in the therapeutic process may be created so that veterans can fully benefit from evidence-based treatments such as CPT and PE (Foa, Hembree, & Rothbaum, 2007; Resick et al., 2008). Furthermore, the values and concepts of feminist therapy can be incorporated in specific trauma treatments to increase continued engagement while in those specialized treatments.

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