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PTSD and IPV: Pre- and Post- 9/11 War Veterans' Risks for Perpetrating Violence

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TABLE OF CONTENTS

INTRODUCTION

About 1 in 4 women and 1 in 10 men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime (Centers for Disease Control and Prevention, 2018). Not only are these experiences detrimental to the victims themselves, but also to society as a whole. One recent study estimates that the per-victim lifetime cost of intimate partner violence (IPV) is approximately $103,767 per female victim and $23,414 per male victim, and includes such things as medical costs, lost worker productivity and criminal justice activities. It is further estimated that various government sources pay an estimated $1.3 trillion (37%) of these lifetime economic burdens (Peterson et al., 2018). One large risk factor for perpetrating IPV is post-traumatic stress disorder (PTSD). Past research demonstrates that about 8 million people experience PTSD every year (U.S Department of Veteran Affairs, 2019). This disorder causes people to have flashbacks of trauma they experienced in the past, which can cause people to lash out, relive traumatic experiences and have excessive arousal. Since people with PTSD experience these things, people with this disorder are more likely to engage in intimate partner violence compared to people without PTSD (Teten, et al., 2010). Flashbacks of trauma may cause someone to get scared, not know where they are, and hurt someone they love because they cannot determine what is real and what is a memory. These negative consequences can have life-altering impacts and could be prevented if therapeutic resources were sought and made more readily available.

Military veterans tend to suffer from PTSD due to their experiences during war such as seeing others get injured, getting injured themselves, and being separated from family and friends for a prolonged period of time. Since military veterans are more likely to have PTSD compared to the general public (Teten, et al., 2010), they are also more likely to perpetrate

intimate partner violence. Prior research also indicates that post-9/11 war veterans are actually struggling more with trauma, PTSD, readjusting to civilian life via employment and social engagement, and finding help for mental and physical health ailments after their time at war, compared to pre-9/11 veterans (PEW Research Center, 2019). Since post-9/11 veterans are struggling more with these things, their risk for intimate partner violence perpetration may be even greater.

The heightened risk of post-9/11 veterans perpetrating IPV is magnified by a sense of hypermasculinity, which is seen as a negative phenomenon in society today because it over-exaggerates traditional gender role stereotypes. This sense of hypermasculinity may prevent veterans from getting help with trauma or PTSD because they do not want to be perceived as weak or effeminate for needing such help. This only further compounds the already present difficulty that service availability may be limited for some veteran populations. Just as important, hypermasculinity is found to be a key predictor of intimate partner violence (Oringher & Samuelson, 2011), not only because it causes men to believe they are weak for seeking help for problems that may lead them to be violent toward intimate partners, but also because men showing dominance and aggression is consistent with societal definitions of acceptable masculine behaviors.

Throughout this thesis, past research will be outlined regarding the relationship between PTSD and IPV among war veterans. This research will display why people with PTSD from war are more likely to perpetrate intimate partner violence than are civilians. Then, I will present more evidence as to why veterans post-9/11 veterans may be more likely to perpetrate intimate partner violence than pre-9/11 veterans. Post-9/11 veterans are less likely to get help for their mental health problems, leading them to face a host of life difficulties including

disconnectedness from family and friends, unemployment, and substance abuse problems, all of which are also precursors to the perpetration of intimate partner violence. Research also indicates that the general public was more engaged with current events and news pertaining to wars and other government issues in the pre-9/11 era. In turn, this helped veterans receive more respect for serving our country than they do today; and more directly relevant to the topic of this thesis, provided for the recognition that veterans may need assistance in a variety of domains to successfully readjust to civilian life after returning home. Today, people pay less attention to what is going on with war largely because the country has been at war for so long. In turn, this can result in a lack of awareness about the problems post-9/11 veterans are likely to face and a corresponding lack of service availability for their various needs.

In order to rectify some of these issues, I will first use prior research to assess what programs currently exist to address the issues of PTSD and IPV among war veterans, and whether these programs address those needs that are either specific to or may be more common among post-9/11 veterans. Using various government resources and reports, including the Veterans Affair's website, I will then assess average wait times for the provision of mental health services for veterans, under the acknowledgement that service availability may be an issue among certain populations and in certain geographic areas. I will conclude this section of my thesis by suggesting what specific program aspects are best incorporated into treatments and therapies for PTSD and IPV among war veterans to help reduce the frequency of these problems, as well as suggest ways to increase service availability among those demographic populations or geographic areas that may be suffering the most.

While ensuring that effective treatment programs are utilized and that such programs are readily available for those who wish to access them is a necessary first step in combatting IPV

perpetration among war veterans, a second step is helping to ensure that veterans who need such services are willing to seek them. As such, another way intimate partner violence rates could be reduced among war veterans is if the sense of hypermasculinity in society today is reduced. This could lessen rates of IPV because not only is hypermasculinity in itself a consistent predictor of men perpetrating violence against their female partners, but male war veterans may also not feel weak for seeking help for mental disorders if help-seeking is no longer perceived as an unmanly behavior. To this end, I will also conclude my thesis by assessing what programs, if any, currently exist in the military or in society more broadly (i.e., school systems, workplaces, etc.) to reduce hypermasculine ideologies and behaviors; what particular aspects of these programs are found to be most effective; and suggest ways that such programs might become more widespread throughout society in the future.

REVIEW OF THE LITERATURE

Intimate Partner Violence and PTSD

Intimate partner violence is abusive behavior, violent or nonviolent, committed against persons by their current or former spouses, boyfriends, or girlfriends (Rennison & Welchans, 2000). In its most serious forms, this type of violence tends to be perpetrated by males more than females. About 22% of violence against women is due to intimate partner violence (Rennison & Welchans, 2000). Intimate partner violence can be caused by a number of factors like demographic characteristics, relationship statuses, and mental health problems. For example, people with substance abuse problems, people of color facing issues of racism and discrimination, unemployed people, poor people, and men with varying levels of family instability tend to perpetrate violence more often than others, likely due to increased stress in their lives (Erlinder, 1983).

Prior research indicates that stress is a leading cause of perpetrating intimate partner violence (IPV). For instance, according to family violence theory, IPV is rooted in the everyday stresses of family life that produce conflict that may or may not escalate to violence. Whether this conflict escalates to violence, in turn, is often dependent on whether individuals possess the skills to resolve such conflict in healthy non-violent ways, as well as whether these same individuals are already overburdened or stressed by things independent of the specific conflict situation in the intimate relationship that preceded the violent act (Straus, Gelles, & Steinmetz, 1980; Straus & Smith, 1990). This theory, in turn, can help to explain why post-traumatic stress disorder (PTSD) is one of the leading factors causing people to perpetrate intimate partner violence (Teten et al., 2010; Iverson, Gradus, Resick, Suvak, Smith, & Monson, 2011).

According to the National Institute of Mental Health (2019), PTSD is a disorder that develops in some people who have experienced a shocking, scary or dangerous event. Rather than recover from initial negative symptoms due to trauma over time, people with PTSD continue to experience stress and fear long after the traumatic event they experienced is over. In particular, PTSD causes people to experience flashbacks of the trauma they have experienced. Unable to distinguish between what is real and what is just a past experience they are reliving, they may lash out in fear or anger and hurt someone they love.

War Veterans, PTSD, and IPV

Military veterans tend to be among the population who is most likely to experience PTSD (Trevillion, Williamson, Thandi, Borschmann, Oram, & Howard, 2015). Since military veterans experience things that most people do not have to face, like the death of others and being away from home, they are more likely to be exposed to trauma from their experiences. Research finds that 11-20 out of every 100 veterans were diagnosed with PTSD after war (U.S.

Department of Veterans Affairs, 2019). In turn, due to these higher rates of PTSD, veterans may face an increased likelihood of perpetrating violence against their intimate partners. As support for this potential conclusion, Clark and Messer (2006) note that among the many national surveys of the U.S. general population on IPV, findings of past-year prevalence rates indicate that anywhere from 0.5 to 11.6 percent of Americans have experienced IPV in the past year. Conversely, in looking at studies of IPV prevalence among active-duty military families, past-year prevalence rates have been as high as 29-32%. Relatedly, a study comparing 33,762 married active-duty U.S. Army respondents across 38 Army installations with data from 3,044 married civilians participating in the National Family Violence Survey found that even when overall experiences of husband-to-wife spousal aggression reports did not differ between Army and civilian samples, reports of severe physical aggression were significantly higher in the Army sample than the civilian sample (at 2.5% vs. 0.7%, respectively) (Heyman & Neidig, 1999).

Looking at war veterans in particular then, in analyzing the relationship between PTSD and IPV perpetration, past research has found that demographic characteristics, other mental health problems, and substance use are factors that can compound the effects of PTSD symptomatology on IPV perpetration. For instance, in a study of 810 substance using veterans entering VA mental health treatment, it was found that being male and of a lower socioeconomic status made veterans more likely to perpetrate intimate partner violence (Buchholz, Bohnert, Sripada, Rauch, Epstein-Ngo, & Chermack, 2011). Veterans of lower socioeconomic status can face stressors due to a lack of money, like food shortages and missed bill payments, that increase their risk of lashing out and perpetrating violence. In this same study it was also found that veterans with probable depression and PTSD are more likely to perpetrate intimate partner violence than those who have PTSD alone (Buchholz, et. al., 2011), as these additional mental

health issues can cloud veterans' judgement and make it hard for them to know right from wrong. Similarly, in a study of 449 male post-Gulf War and post-9/11 military veterans, 11.8% had been diagnosed with PTSD, 13.7% with depression, and 13.2% with a panic or anxiety disorder; and those with co-occurring disorders were significantly more likely to perpetrate IPV (Cancio & Altal, 2019). Finally, substance use can also increase a veteran's likelihood of perpetrating intimate partner violence, where prior research (Buchholz, 2011) has found that marijuana use, heavy drinking, and cocaine use are all associated with higher rates of intimate partner violence. These factors, along with PTSD, can increase the likelihood that veterans will perpetrate intimate partner violence; and, importantly, it is not uncommon for veterans to experience these co-occurring issues due to the intrapersonal, interpersonal and societal challenges they often face upon returning home post-deployment. For example, in a study of 94 male Afghanistan, Iraq and Vietnam war veterans, approximately 66% were diagnosed with PTSD, 59% with depression, and 51% with a substance use disorder (Teten et al., 2010).

Pre-9/11 vs. Post-9/11 Veterans

Military veterans are more likely to have PTSD, increasing their likelihood of perpetrating violence; but for some veterans compared to others, the risk for engaging in IPV perpetration can be higher depending on where and when they served and their different combat experiences (Cancio & Altal, 2019). For instance, frontline soldiers may have more severe PTSD from witnessing someone being killed than someone who works as a military nurse, who will still experience trauma due to treating wounded soldiers; but may not experience trauma as bad as the frontline soldiers. Following this line of thought, recent studies suggest that post-9/11 veterans may face a greater risk of experiencing PTSD, which may put them at a higher risk for perpetrating violence against others. For example, a 2019 study of 797 pre-9/11 and 487 post-

9/11 veterans found that post-9/11 veterans were more likely to see combat while enlisted in the military, including having direct exposure to hostile fire or coming under some other type of enemy attack. Compared to pre-9/11 veterans, post-9/11 veterans were also more likely to have served with someone who was seriously injured or killed in combat. In turn, a greater proportion of post-9/11 veterans believe they have suffered or continue to suffer from PTSD as a result of their experiences in the military, compared to pre-9/11 veterans (Pew Research Center, 2019).

Beyond experiences of PTSD specifically, post-9/11 veterans also report having more difficulty adjusting to civilian life than pre-9/11 veterans (at 44% versus 25%, respectively) (Pew Research Center, 2012). This includes having more negative physical and mental health experiences following their deployment, experiencing a weakening of their religious faith, having more difficulty paying bills, feeling disconnected from family and friends, and having difficulty dealing with the lack of structure in civilian life (Pew Research Center, 2019). And, while these experiences may not be related to PTSD specifically, as noted previously, family violence theory (Straus, Gelles, & Steinmetz, 1980; Straus & Smith, 1990) indicates that people who are overwhelmed or burdened by a number of life stressors are more likely to resort to violence when conflict arises in their intimate relationships. Similarly, and as also previously noted, veterans with co-occurring issues are more likely to perpetrate IPV; and recent research (Cancio & Altal, 2019) indicates that post-9/11 veterans, compared to post-Gulf War veterans specifically, experience higher rates of PTSD, depression, panic and anxiety disorders, as well as have higher rates of alcohol, marijuana, non-prescribed prescription drugs and cocaine use.

Finally, pre-9/11 veterans tend to be more accepted and respected by society, and people are more willing to recognize their needs for help based on their combat experiences in wars from decades past, compared to post-9/11 veterans. This is largely because people in society

today do not pay as much attention to war going on around them. This inattention toward war in the Middle East compared to past wars is largely because of how long the war in the Middle East has lasted, in addition to the United States not instituting a military draft in recent decades. According to the Pew Research Center (2019), only a quarter of the public states that they follow news on wars closely, and half the public says wars have made little difference in their lives. This is compared to public involvement during the Vietnam War, which entailed thousands of protests involving millions of Americans over the course of a full decade, many who were jailed, injured and even lost their lives as a result of protesting the war (Zunes & Laird, 2010).

Coming home from war can be difficult and veterans need help in order to be integrated back into society. In order to try to help these veterans, programs and services need to be made available to help with things like mental health problems and getting an education or employment after serving. However, post-9/11 veterans may also feel more ashamed to receive help from people today due to judgements from others. In particular, due to increasingly stereotypical gender roles in modern-day society, many people think that men should be tough and emotionless, causing veterans to not want to seek out help or supportive services.

Hypermasculinity

Hypermasculinity can be defined as the "exhibition of stereotypic gendered displays of power and consequent suppression of signs of vulnerability" (Spencer, Fegley, Harpalani, & Seaton, 2004). Stereotypic gender roles for men in particular include that they are independent, aggressive, dominant and forceful, compared to stereotypic gender roles for women, which include being affectionate, gentle, compassionate and sensitive to the needs of others (Auster & Ohm, 2000). In turn, in societies where gendered stereotypes of masculinity and femininity are highly present, men who are emotional and behave in ways socially constructed as feminine may

be judged negatively in society and perceived as weak (Jewkes et al., 2014). Moreover, with regard to hypermasculinity, Mosher and Sirkin (1984) suggest that macho personality is identifiable along three characteristics, including a view of violence as manly, the perception of danger as exciting, and callousness toward women. In combination, these three characteristics also serve to increase the risk of violence toward women.

Prior research has found that men who strongly adhere to stereotypical gender roles tend to be more aggressive than those who do not (Anderson & Umberson, 2001; Murnen, Wright, & Kaluzny, 2002; Reidy, Shirk, Sloan, & Zeichner, 2009). Moreover, stereotypical gender roles pertaining to aggressive and violent behavior allow men to justify such behaviors toward others. As one example, after conducting in-depth interviews with 33 domestically violent heterosexual men, Anderson & Umberson (2001) found that participants described their own violence as rational, effective and natural; but if their female partners ever behaved violently, their actions were described as hysterical, trivial and ineffectual. Similarly, Reidy and colleagues (2009) found that while hypermasculine men were more violent in general, they were especially likely to be more aggressive toward females who did not abide by their supposed gender roles. This finding is in line with much earlier studies (e.g., Dobash & Dobash, 1979) on IPV which indicated that some of the most prevalent reasons for men abusing their wives was the wife questioning their performance in economic matters or the wife failing to adequately perform cleaning and cooking duties. Finally, it is also important to note that notions of hypermasculinity may increase the risk of violence among particular groups of men more than others. As one example, Levitt, Swanger and Butler (2008) found that men of lower socioeconomic status cannot as easily fulfill their gender roles of leader and economic provider, in turn increasing their risk to become violent compared to middle- and upper-class men. Thus, if society constantly

accepts men for being violent through statements like “boys will be boys” or emphasizes men’s power over women in both private and public domains, men who stick to stereotypical gender roles in society will be more likely to perpetrate intimate partner violence.

In addition to hypermasculinity increasing the risk for IPV perpetration, fears of being emasculated may also prevent war veterans from trying to obtain help for their PTSD (Caddick, Smith, & Phoenix, 2015; Green, Emslie, O’Neill, Hunt, & Walker, 2010). For example, through participant observation of a veterans’ surfing charity, veterans in the surfing group shared stories with researchers about how they would have “psychological meltdowns” when trying to ask for help for their PTSD, fearing they would be perceived as weak for needing help for their problems. Also, veterans in this surfing charity would come in with such masculine notions from combat, such as being strong, self-reliant, and displaying stoicism in the face of hardship, that they would deny having PTSD (Caddick, Smith, & Phoenix, 2015). Thus, veterans who believed having PTSD would be costly to their masculinity and identity as a combat veteran would ignore their symptoms and “man-up and get on with it.” In turn, if people do not get help for disorders like PTSD, this will only further increase their risk for becoming violent, due to PTSD being a primary risk factor for perpetrating intimate partner violence.

Finally, hypermasculine ideologies may be particularly significant for post-9/11 war veterans in reducing their likelihood of help-seeking behavior, compared to pre-9/11 veterans. As noted by Spencer and colleagues (2004) in their study of hypermasculinity among urban adolescent males, the presentation of masculinity has likely become more significant in the U.S. since the 1980s. More specifically, rising levels of poverty and the crime and violence that followed throughout the 1990s in many major American cities due to the loss of manufacturing industries left many Americans increasingly concerned about their personal safety and overall

well-being. And, in response to these chronic concerns and fears, many individuals coped by adopting psychological postures that diminished their possibility of being victimized. For males, especially those in impoverished high-crime communities, such postures often included maladaptive and hypermasculine behaviors (Spencer et al., 2004). Bringing this all together then, considering that many of our post-9/11 veterans enlisted in the military in the early-mid 2000s, they were also growing up during the 1980s and 1990s, the same time period when this sense of hypermasculinity was increasing in the United States. This is opposed to pre-9/11 veterans who were not only raised and socialized pre-1980s but may have even served in the military prior to this time period.

Sociodemographic Factors

There are multiple sociodemographic factors that play a role in the risk for intimate partner violence and should be considered in addition to PTSD symptomatology and notions of hypermasculinity if we are to reduce the prevalence of IPV among war veterans. Age, gender, socioeconomic status, employment status, and race are all demographic risk factors for predicting intimate partner violence (Capaldi, Knoble, Shortt, & Kim, 2012; Kaufman-Parks, DeMaris, Giordano, Manning, & Longmore, 2016). In particular, prior research has found that the risk for IPV exposure declines with age and that men are more likely to perpetrate intimate partner violence, at least that which is more violent or extreme in nature, similar to studies among men and women on crime and violence more generally. Unemployed and lower income people are also more likely to engage in IPV than are employed and middle- to upper-class people; and being a member of a racial-ethnic minority group increases the likelihood for people to engage in IPV (Capaldi et al., 2012). Risk factors of social class and race-ethnicity are in turn consistent with family violence theory, as poverty is a primary source of stress and arguments in

many intimate relationships (Copp, Giordano, Manning, & Longmore, 2016) and race-ethnicity is highly tied to social class here in the United States. Finally, characteristics of individuals' intimate relationships are important to consider, where prior research indicates that people in relationships of longer duration are more likely to report experiences of IPV, as are people in married or cohabiting versus dating relationships (Kaufman-Parks et al., 2016).

Theoretical Framework

As previously discussed, family violence theory tells us that IPV is a result of stresses in everyday life that escalate to conflict; and such escalation is especially likely to occur among those people who are already overburdened or stressed by things outside the specific family conflict situation that precipitated them perpetrating violence. As such, finding ways to reduce the stresses in veterans' lives is key to reducing their risk of perpetrating IPV. One part of this is addressing their experiences with PTSD. Another component to this that may be just as important though is addressing the lack of connection they feel to their family and friends, as well as the various employment barriers and financial challenges they may face upon returning home from war (Pew Research Center, 2012). Addressing these other post-war challenges is also consistent with social bond theory, developed by criminologist Travis Hirschi. Hirschi states that people are less likely to perpetrate violence if they have a social bond to society (Lackey & Williams, 1995). The social bond, in turn, is composed of four different components according to Hirschi. These include being personally attached to others and concerned about their needs; being committed to conventional lines of action, such as completing an education and obtaining legitimate employment; being involved in society through social network ties and extracurricular activities; and believing in the morals and values of society. Thus, someone who has a strong social bond to society would be less likely to break the norms of society because they want to be

a good citizen and not risk losing their attachment to others, the job they have attained, or the social networks they are involved in. However, those who do not have a strong social bond to society would be more likely to break social norms and participate in criminal behavior, as they have little to risk losing in doing so (Hirschi, 1998). As such, ensuring that war veterans have access to education, employment, and social networks (Capaldi et al., 2012), as well as attachments to others as they are adjusting to civilian life is essential in reducing their risk of intimate partner violence.

Related to issues of IPV specifically, past research utilizing social bond theory has found that having a strong social bond with another person can reduce the chances of perpetrating violence in general, as well as against that individual specifically to whom the person is bonded (Kar & O'Leary, 2013). In particular, in their report on primary prevention strategies for intimate partner violence, Smithey and Straus (2004) review findings from multiple previous studies, indicating that the applicability of the social bond in explaining IPV has strong empirical support; and that attachment to others may be one of the most effective deterrents for crime in general spousal abuse in particular. Relatedly, emotional intimacy can also have an effect on the likelihood of perpetrating intimate partner violence. In a study of 110 male veterans in a pre-deployment marital relationship or a relationship lasting at least six months in length, researchers found that those individuals who have stronger feelings for their loved ones are less likely to perpetrate violence against their partner than those who do not have as strong of feelings (Kar O'Leary, 2013). Such feelings were assessed by asking participants if their partner listened to them when they needed someone to talk to or if they can state their feelings without the other person getting defensive, among other questions. Thus, knowing that people with stronger and more genuine relationships will be less likely to perpetrate violence against their loved ones

draws greater attention to the importance of ensuring that veterans have strong attachments to others while they transition to civilian life post military-service.

CURRENT INVESTIGATION

Many factors can increase the likelihood for people to perpetrate violence against others. In addition to sociodemographic differences in the prevalence of IPV, prior research indicates that PTSD is one of the leading risk factors for perpetrating intimate partner violence; and this is a disorder that is particularly common among those who have served in the military. However, military veterans also face differing levels of PTSD and thus different risks for perpetrating intimate partner violence, often dependent on where and when they served. For example, pre-9/11 war veterans may be less likely to perpetrate violence due to the greater help they received when they returned home and the greater support they faced while at war. This is compared to post-9/11 veterans, who did not gain as much respect for their service, did not receive the same help others did in the past when returning from war, and had more difficulty adjusting to civilian life post-military service. Adding to these issues, we also know that hypermasculinity is a key predictor of IPV perpetration. Hypermasculinity is also an ideology that is likely to be more present among post-9/11 than pre-9/11 veterans based on the social and historical contexts of American society during the 1980s and 1990s.

Thus, in order to prevent intimate partner violence among post-9/11 veterans, two actions must be taken. First, we need to ensure that resources are made available to veterans as they return to and continue to adjust to civilian life. Importantly, these resources should address any and all needs of the veteran, including but not limited to counseling and other mental health services for veterans dealing with PTSD and related issues; educational opportunities, job training programs and employment and financial assistance; and group-based, couples-based or

family counseling services to build greater attachments to loved ones and build stronger social network ties within veterans' communities. Two, we need to ensure that veterans feel comfortable seeking out assistance and/or accepting such assistance when it is offered to them. This will mean finding ways to combat maladaptive emotional and behavioral patterns associated with hypermasculinity that exist among veterans specifically and society in general.

METHODOLOGY

As prior research has demonstrated, PTSD is one of the leading risk factors for perpetrating intimate partner violence (Buchholz et. al., 2011), military veterans are one of the largest populations who experience PTSD, due to their experiences during combat, causing them to be more likely to perpetrate intimate partner violence than the general public (Trevillion et. al., 2015). In order to figure out successful ways to lessen the amount of PTSD and decrease intimate partner violence experienced by war veterans, I will first conduct a systematic review of journal articles and government reports published in the last 25 years assessing policies and programs that have been implemented to treat PTSD and reduce experiences of intimate partner violence among war veterans. This systematic review will entail identifying all relevant studies pertaining to my topic of interest, and assessing the various programs and policies discussed or analyzed within each article or report to see which have been most successful. In this assessment, I will look for any patterns across the various programs and policies on what has and has not worked in helping war veterans deal with PTSD and intimate partner violence perpetration, particularly among post-9/11 veterans. Similarly, I will identify reasons for differences in results across studies, such as whether some policies or programs have been more beneficial in helping veterans with singularly-diagnosed versus co-occurring mental health disorders, or whether these programs take a centralized versus more multi-faceted approach in combatting either PTSD or

IPV. Finally, I will cite any limitations of current knowledge in this field. This research will allow me to devise several policy or program recommendations in order to lessen PTSD and IPV among veterans. Specific services which are already provided to some veterans, such as treating illness and injury with medications, preventing current and future health problems through individual, couples, and family counseling, improving veterans' ability to function and readjust to civilian life via education and employment services and financial assistance, and enhancing their quality of life with peer support groups will be studied in order to figure out which approaches are most successful.

After identifying the programs and services that are most successful in helping to combat IPV and PTSD among post-9/11 veterans, I will then conduct a second systematic review on any programs that have been developed within society more broadly, such as in our country's primary and secondary educational systems, or toward military personnel specifically on combatting hypermasculinity. This is important as even if effective programs are available to war veterans to help them deal with issues of PTSD and violence within their intimate relationships, they must first be willing to seek out such programs and services; and a sense of hypermasculinity may prevent men, particularly those raised during or after the 1980s (Spencer et al., 2004) and serving in wars post-9/11, from doing so (Green et al., 2010). Hypermasculinity is likewise a key predictor of perpetrating intimate partner violence (e.g., Anderson & Umberson, 2001). As noted within the first systematic review procedures previously outlined, this systematic review of hypermasculinity prevention or intervention programs will entail identifying all peer-reviewed academic journal articles, government reports and any other reputable sources that discuss programs geared toward reducing hypermasculinity, at least in its more negative forms. As more attention has only been brought to hypermasculinity in recent

years, it is likely not as many programs exist dealing with this issue as is the case with PTSD and IPV. As such, I will also need to assess what programs might be extrapolated to work successfully among military personnel and war veterans, if any, or whether such programs are best geared toward society more generally in order to help boys and young men combat hypermasculinity before entering military life. Finally, I will also assess whether hypermasculinity in its more positive forms might be used to compel men to seek treatment for PTSD and issues of intimate partner violence, as some research suggests that men might be more willing to seek such help if they perceive ignoring or running away from their personal troubles as being less masculine (Caddick et al., 2015). Once these assessments have been made, I will conclude with my own program or policy recommendations for combatting more negative forms of hypermasculinity among war veterans specifically or in society more generally.

One last barrier stands in the way of post-9/11 veterans receiving the proper treatment and services for their PTSD and violent tendencies; and this is ensuring that all veterans who seek out such services have access to them and receive such services in a timely manner. Research finds that it often takes veterans several weeks, if not longer, to get the mental health assistance they need, although approximately $9.4 billion goes into funding veteran's mental health programs (Shane, 2019). For instance, the Veteran Health Administration recommends that all veterans are provided with outpatient mental health services within 30 days of consultation for an appointment. Yet, some state analyses have found that over three-quarters of appointments are delayed beyond the 30-day recommendation, with some new patients waiting as long as 286 days for their initial appointment (Department of Veterans Affairs, 2019). Thus, in addition to ensuring that good programs exist, and veterans are willing to seek out such services, we also need to ensure these programs are readily available to them with the resources to help

them get better. As such, for this final policy recommendation section of my thesis, I will access the Veterans Affairs' website and various government reports to examine the average wait times veterans are experiencing across the country in accessing needed mental health services, the various potential reasons for any unreasonable days, and potential solutions to help reduce these wait times where possible.

RESULTS

PTSD Program Systematic Review

Table 1 presents the results of the first systematic review guiding this study: an analysis of PTSD programs for veterans. To conduct this review, two databases were searched; these databases were Google Scholar and Assumption University's EBSCO search engine. In order to be included in this systematic review, the article or report must have been published within the last 25 years. Additionally, the article or report must outline a program in which veterans were actually enrolled; in other words, the article could not simply detail a needs-assessment or outline a program that was in the planning and development stages. Further, the article or report needed to provide adequate detail on program length, participant selection, elements of treatment, and treatment effects; completion rates were also preferred but not required. With these inclusion criteria in place, a total of 17 programs were included for assessment in this systematic review.

Evaluations of program success were based primarily on reductions in PTSD-symptomatology. However, programs were also considered successful if they led to decreases in such things as depressive symptoms and substance abuse; or led to increases in family and interpersonal functioning and overall quality of life scores. Program completion was also considered in the assessment of success. High program dropout rates may indicate that programs

are too cumbersome for veterans to complete, or they may also indicate that veterans chose to withdraw prior to program completion as they did not perceive the program was beneficial to them in its earlier stages.

Of the 17 programs reviewed, eight indicated moderate-large statistically significant effects on PTSD-symptomatology, six had modest effects, and three had small or no effects. Examining similarities in those programs that were most successful in reducing PTSD symptoms among veterans, all but one focused on cognitive behavioral and/or trauma exposure therapies in either an individual and/or group setting. The one exception to this was a multifamily educational group therapy program (Fischer, Sherman, Han, & Owen, 2013). Most of these programs also involved significant levels of contact between veterans and clinicians. Successful programs ranged in length from three weeks to nine months. However, shorter programs required more intense interaction within the program. For instance, the three-week trauma exposure therapy program reviewed by Biedel and colleagues (Biedel, Frueh, Neer, & Lejuez, 2017) was an intensive outpatient program, requiring participants to reside in a hotel together and attend 29 sessions within those three weeks. Conversely, the longest of the programs, the multifamily educational group therapy program (Fischer et al., 2013) required the most contact sessions, at over 60 sessions for veterans and their families over a nine-month period. The remaining six of the most successful programs lasted between 6-18 weeks and required, on average, 12-36 therapy sessions.

While reducing PTSD symptomatology was the primary goal of these programs, veterans attending the most successful programs also saw reduction in brain trauma and depressive symptoms, substance abuse, anxiety and psychological distress. Those in the multifamily educational group therapy program also had significant improvements in the understanding of

and coping with their PTSD and reported better relationship functioning. Yet, and importantly, the most successful programs only allowed for treatment of certain co-occurring issues. More specifically, while one program did focus on the simultaneous treatment of PTSD and substance abuse (Cook, Walsher, Kane, Ruzek, & Woodey, 2006), four of these programs excluded veterans if they were active substance users and four had exclusion criteria for veterans with severe mental health issues, including evidencing psychotic behavior, being diagnosed with antisocial personality or dissociative identity disorders, or having suicidal or homicidal ideation.

Turning then to program completion rates, 15 of the 17 programs reported completion rates. Of these 15, completion rates ranged from 38% to 97% with a mean of 78% and median of 84%. Thus, from a program completion standpoint, programs were considered successful if they fell above the mean completion rate of 78%. Six of the eight programs that were most successful in reducing PTSD symptoms met this rate of completion success. However, and importantly, the two programs that did not meet this completion rate (Brady, Dansky, Back, Foa, & Carroll, 2001; Cook et al., 2006) had very small participant samples, at 39 and 25, respectively. As such, it did not take many participants to withdraw from the treatment program for these two programs to show lower than desired completion rates. Finally, an additional three programs ranked high in completion but had only modest success rates for reducing PTSD symptoms among participants. Treatment protocols for these programs included trauma exposure therapy (Schnur et al., 2003), cognitive behavioral therapy (Bolton, Lambert, Wolf, Raja, Varra, & Fisher, 2004) and group yoga (Carter et al., 2013).

IPV Program Systematic Review

Table 2 presents the results of the second systematic review of this study, which is an analysis of IPV programs for veterans. For this review, two databases were searched; these

databases were Google Scholar and Assumption University's EBSCO search engine. For articles or sources to be included in this systematic review they must have been published in the last 25 years. Also, the article must outline a program which veterans were actually enrolled in to evaluate the program's effectiveness. The article could not outline a program that was in planning. For the article to be included, it also needed to report adequate information about program length, participant selection, elements of treatment, and treatment effects. Completion rates of the program was another factor which was preferred but not required. After reviewing all potential empirical articles on IPV programs for veterans in the last 25 years, a total of 6 were included in this systematic review.

Program success was evaluated based on reductions in IPV perpetration among veterans. Programs were also deemed successful if they led to increases in relationship satisfaction, family cohesion, family expression, marital satisfaction, and decreases in PTSD symptomology. Program completion rates were another factor considered when measuring the success of IPV programs. High program dropout rates may indicate that the program required too much commitment for the veterans, or veterans chose to drop out before completing the entire program due to something like perceived lack of effectiveness.

Of the 6 programs reviewed, four had moderate-high statistically significant effects on IPV perpetration rates among veterans and two had moderate effects. When examining the similarities between the most successful (i.e., moderate-high effects) programs, three of the four used cognitive-behavioral therapy methods. The one program that did not use this method (Brewster, 2002) relied on marital therapy, anger management training, individual therapy, conflict containment programs, communications skills training, alcohol therapy, or group therapy, depending on the specific veteran's needs. Successful programs varied in length from 10

weeks to 11.5 months. The shortest program required weekly sessions for 10 weeks (Taft, Creech, Gallagher, MacDonald, Murphy, & Monson, 2016), and required participants to engage in the Strength at Home program, a cognitive-behavioral trauma-informed intimate partner violence prevention intervention. The longest of the programs was a cognitive behavioral therapy program (Gerlock, 2004) which had the participants engage in a four-week orientation, twenty-six weekly rehabilitation sessions, and six-monthly meetings of maintenance after the primary sessions. This program required the most contact sessions out of all the IPV programs. One of the programs with higher success did not detail program length or number of sessions (Brewster, 2002). This is likely because the program was a referral program that referred veterans to a multitude of different services depending on the individual needs the veteran presented with. The remaining successful program was a 12-week program which required weekly meetings for the veterans to participate in (Creech, Benzer, Ebalu, Murphy, & Taft, 2018).

Reducing IPV among veterans in relationships was the primary goal of these programs; however, the most successful programs also saw reductions in PTSD symptomology. The veterans in the individual service referral programs also saw decreases in family conflict and child abuse, along with increases in family cohesion, family expression, and marital satisfaction. Although most of the moderate-high success programs did not exclude veterans for having other issues along with recent IPV perpetration, one program excluded veterans who had severe reading difficulties, severe organicity or active psychosis, prominent suicidal ideation, or alcohol/drug dependence (Taft et al., 2016); while another program excluded those with active substance dependence, uncontrolled bipolar and psychotic disorder, or severe cognitive impairment (Berke, MacDonald, Poole, Portnoy, McSheffrey, Creech, & Taft, 2017) .

Turning to the completion rates of the programs, all six programs provided information on this topic, with completion rates ranging from 37%-82% with a mean of 52.6% and a median of 48%. Therefore, according to this criterion, programs were considered successful if they fell above the mean completion rate of 52%. Half the programs had completion rates above 52%; although, notably only the Strength at Home Couples treatment group in the study by Taft and colleagues (2016) met this benchmark, while the comparison treatment group (Supportive Prevention group) did not. The Strength at Home Couples program was also the only program in this systematic review to have both a high completion rate and moderate-high success rates in reducing IPV among program participants. The other two programs with high completion rates, at 67% and 82%, were categorized as having moderate results in lessening the amount of IPV in veterans' relationships. These programs had treatment methods of couple-based therapy, which included communication skills and cognitive behavioral therapies (Nowlan, Georgia, & Doss, 2017), and trauma-informed cognitive-behavioral group treatment (Berke et al., 2017). Interestingly, of the three programs with high completion rates, two had rather strict inclusion criteria as to who was eligible for program enrollment (Berke et al., 2017; Taft et al. 2016), while the third enrolled the oldest average participant at average age 50 (Nowlan et al., 2017). Thus, while strict inclusion criteria may not be necessary for program success, it may help ensure better program participation and completion rates.

Finally, it is important to note that only six studies including empirical results on programs catering to the intervention of IPV perpetration among war veterans specifically were identified within the last 25 years. This lack of evidence in the empirical literature leads to two potential conclusions. One, while IPV prevention programs are plentiful in society overall, programs catering specifically to war veterans may still be relatively rare. Two, if such programs

are not uncommon for war veterans, there is a lack of empirical analyses evaluating whether these programs are truly effective and to what extent they prevent future IPV perpetration among program participants.

Hypermasculinity Program Systematic Review

Table 3 presents results from the third systematic review of this study, which is an analysis of programs to combat negative forms of hypermasculinity that may contribute to the perpetration of IPV or prevent men from seeking help when dealing with PTSD or violent impulses. For this review, Google Scholar and Assumption University's EBSCO search engine were used to find resources published on hypermasculinity programs within the last 25 years. Unlike other programs reviewed in this thesis, the only inclusion criteria for hypermasculinity programs were that the programs were actually in existence and had male participants enrolled. Since the development of programs of this kind are relatively rare, there were not many sources which included veterans as part of the program and thus veteran-specific enrollment was not an inclusion criterion. For the article to be included in the review, it also had to provide adequate information about participant selection and elements of treatment. Likewise, while the systematic review table for hypermasculinity programs was constructed to include information similar to the PTSD and IPV programs previously reviewed, not all the information for the table was presented in the articles; again, because the development of these programs and corresponding evaluation of these programs is so new. After reviewing all potential articles on programs to combat negative forms of hypermasculinity in the last 25 years, a total of eight sources were included in this systemic review.

Program success was evaluated based on changing views of hypermasculinity in males. Programs were also considered successful if they improved males' relationships with others,

boosted males' self-esteem, and allowed the men in the program to have a better sense of identity. Only two of the eight sources provided information about program completion (Peacock & Levack, 2004; Raymond, 2005). They both had moderate completion rates at 66% and 77%, leading to the potential conclusion that these programs were most likely reasonable to complete and were not inconvenient to access.

Of the eight programs reviewed, five of them had moderate-high success rates. The remaining programs did not provide information on success rates. When comparing the successful programs, all of them used focus groups or workshops as their methods of promoting a better understanding of masculinity. Successful programs varied in length from five days to 22 weeks. The shortest program was the Men as Partners Program in South Africa (Peacock & Levack, 2004), which allowed men to participate in workshops aimed at reducing gender-based violence and to promote men's constructive role in sexual and reproductive health. The longest program is the Men of Strength Club (Men of Strength Club, 2020), which is a program for middle school and college boys focused on promoting an understanding of masculinity contributing to violence. The other two successful programs that provided information about program length lasted for 8 weeks (Liddell & Kurpius, 2014) and 6 weeks (Raymond, 2005), respectively.

These sources did not provide information based on veterans, but instead focused on boys and men as a whole. This makes it more difficult to assess how these programs might benefit veterans in helping them to overcome violent urges or seek help for their PTSD. More research has to be done on this topic, but the programs I researched did demonstrate that encouraging men to open their mind to different definitions of masculinity can have positive effects on their relationships and how they view the world around them.

Service Accessibility Assessment

The U.S. Department of Veteran Affairs has on their website a search engine where veterans can go to find both mental and physical health services in their area. It allows them to search by state of residence, identifying facilities within a 50-mile radius, whether those facilities are accepting new patients, and what the average wait time is for new patients seeking service. As such, I performed a state-by-state analysis of mental health facilities accepting new patients. Table 4 presents these results, including the total number of mental health providers for veterans within a 50-mile radius of the center of each state, the number and percentage of providers not accepting new patients out of the total number of providers, and the range and average wait times for each state among those providers who were accepting new patients. The final row of the table then presents these total averages across the United States as a whole.

As can be seen within the table, the total number of mental health providers in each state ranged from a low of 2 to a high of 64, with an average of 20 providers within a 50-mile radius of the state center across the country. Of these, the percentages not accepting new patients ranged from a low of 0 to a high of 62.5, with an average of 25% of providers in each state not accepting new patients across the country. Finally, the average wait time for new mental health patients among those providers accepting new patients ranged from a low of 3.5 days to a high of 27 days, with an average of 9 days throughout the United States. However, an analysis of ranges also indicated that one provider had a wait time of 97 days for new patients, while a total of 16 states had providers where maximum wait times exceeded one month for a new patient mental health appointment.

POLICY RECOMMENDATIONS

PTSD Programs for Veterans

The following suggestions should be considered by policymakers and military officials when trying to combat PTSD among war veterans. The suggestions are based on results from the systematic review and a review of other relevant sources. According to these sources, the best methods for combatting PTSD in war veterans are cognitive-behavioral therapy and exposure therapy (Beidel et al., 2017; Brady et al., 2001; Chard, Schumm, McIlvain, Bailey, & Parkinson, 2011). Exposure therapy is a psychotherapy which involves repeated real, visualized, or simulated exposure to or confrontation with a feared situation or object or traumatizing event (APA, 2017). This could be used to combat PTSD because repeatedly exposing a traumatic event to a veteran can help them habituate with the event, causing them to find it less traumatizing. Cognitive-behavioral therapy could also be used to lessen PTSD being experienced by war veterans. Veterans' negative thoughts about a situation could be altered, helping them experience less flashbacks and trauma. Instead of having negative thoughts about their life or experiences, their thoughts could be challenged in order for veterans to have a more positive outlook on life or to learn how to associate current life experiences with past positive events, rather than false or inappropriate associations with past trauma. Therefore, I would recommend any programs targeted to reduce PTSD symptomatology among veterans to incorporate these specific types of therapy since they have been found to be among the most successful based on this systematic review.

Results indicated that most of the successful PTSD programs not only lessened the amount of PTSD symptomology, but also addressed other co-occurring issues. Some of these co-occurring issues included brain trauma and depressive symptoms, substance abuse, anxiety and psychological distress (Cook et al., 2006; Fischer et al., 2013; Yoder, Tuerk, Price, Grubaugh,

Strachan, Myrick, & Acierno, 2012). In order to successfully lessen PTSD symptomology, it is important to focus on other issues that a veteran could be facing. As noted by McGovern and colleagues (2009), PTSD and substance abuse in particular are often co-occurring issues among individuals seeking treatment. This is because alcohol and drug use are common coping methods used to deal with the associated trauma symptomatology and flashbacks experienced by PTSD sufferers. However, research finds that patients are less likely to forego substance use while dealing with active PTSD symptomatology. Meanwhile, treating PTSD is simultaneously difficult to do among individuals whose cognitive and emotional abilities are impaired due to active substance use. Thus, addressing both of these issues simultaneously may provide the most significant long-term results. This same study likewise found that cognitive behavioral therapies (CBT) may be the most effective therapeutic approach in dealing with this particular dual diagnosis (McGovern, Lambert-Harris, Acquilano, Xie, Alterman, & Weiss, 2009). Finally, and related, research has also found that progress in psychotherapy for PTSD can be significantly hampered by cognitive deficits, whereas neurocognitive treatment efforts for traumatic brain injuries can be far less effective due to psychiatric illnesses such as PTSD (Cole, Muir, Gans, Shin, D'Esposito, Harel, & Schembri, 2015). Therefore, on top of exposure therapy and CBT, PTSD programs developed and recommended by policymakers and military officials should focus on other inter- and intra-personal problems going on in a veteran's life, as well as additional illnesses veterans may be suffering from. Importantly, and particularly in an outpatient setting, some veterans may still have to be excluded from treatment for their own safety and the safety of others, particularly in cases where veterans evidence psychotic behavior or present with suicidal or homicidal ideation (e.g., Biedel et al., 2017; Monson et al., 2006). Yet, in cases where

co-occurring issues do not present a significant level of threat, treatment efforts should be designed to be as inclusive as possible to the differing needs veterans present.

According to the results section of this particular systematic review, six of the eight successful PTSD programs met the mean completion rate of 78%. The fact that the majority of successful programs in this specific review (at 75%) had such high completion rates is encouraging. Yet, we must keep in mind that in order for veterans to complete programs, they have to be easily accessible. As such, all VA hospitals should be required to provide psychotherapy for veterans experiencing PTSD (Finley, 2013). If there are programs to combat PTSD at every VA hospital, it gives veterans a variety of locations where they can participate in a program. Moreover, and reiterating what was previously stated, veterans need to be encouraged to continue treatment through supportive services dealing with co-occurring issues so that they do not become discouraged when PTSD treatment efforts alone may not yield positive results in other life domains. In order to do this, society needs to support a positive culture of healing so all VA hospitals will want to provide recovery-oriented services at all locations (Finley, 2013).

Related to accessibility issues, another factor that needs to be considered in order to get veterans with PTSD the help they need is race and/or ethnicity. For instance, prior research has demonstrated that while ethnicity may not play a role in access to PTSD programs, race does, particularly in the types of treatment offered for PTSD sufferers (Spoont, Hodges, Murdoch, & Nugent, 2009). The researchers found that African Americans and Latinos were less likely to have access to medication for PTSD than whites; on the other hand, African Americans were more likely to receive counseling than whites. Treatment of PTSD should not be segregated by race. Everyone should have equal access to treatment. As such, I recommend that VA hospitals provide everyone the same access to different treatment methods. In order to do this, every VA

hospital should conduct annual evaluations of veterans seeking treatment, including the types of treatment and services they have requested or been referred to, and what treatment and services they ultimately received. Key to these evaluations will be recording veterans' demographic data to include not only issues of race and ethnicity, but also age, biological sex, social class, and any other factor that may influence treatment disparities. Once these evaluations are performed, service providers and VA hospital administrators should work together to craft solutions geared toward reducing or eliminating these disparities based on empirical evidence of where these disparities are occurring and why they might exist.

In summary, I recommend that veterans' hospitals provide cognitive-behavioral therapy and exposure therapy as primary treatment modalities for PTSD; keep focused on accessibility and equitability of programs and services, particularly among different demographic populations; and include programs that offer solutions to multiple personal problems in addition to PTSD, like substance abuse and traumatic brain injury. I have done a lot of research on PTSD program evaluations which have been published in the last 25 years. However, there is always more research to be uncovered; and other recommendations could be made if different methods are proven to be successful.

IPV Programs for Veterans

In trying to better intervene upon IPV that is occurring in war veterans' relationships, policymakers and military officials should consider the following suggestions, based on both results included in this systematic review of IPV programs and based on a review of other relevant studies pertaining to war veterans' IPV experiences. According to the results presented here, one of the best methods for combatting intimate partner violence is cognitive-behavioral therapy (Creech et al., 2018; Gerlock, 2004; Taft et al., 2016). Cognitive-behavioral therapy

(CBT) is a type of psychotherapy in which negative patterns of thought about the self and the world are challenged in order to alter unwanted behavior patterns or treat mood disorders. In specific regard to IPV perpetration, CBT has been used as a treatment approach for male batterers more broadly since the 1980s. In this context, it relies on the premise that IPV perpetrators' attitudes and cognitive processing styles are important correlates, if not determinants, of IPV; and include such things as hostile attitudes toward women, positive beliefs about the acceptability of violence to obtain power and coerce others, and a biased style of interpreting the social world. Thus, if these negative attitudes can be successfully challenged within a treatment setting, IPV perpetration should be reduced (Eckhardt & Schram, 2009). The results of this systematic review illustrate that CBT is thus successful in not only reducing IPV perpetration among male batterers more generally, but also among war veterans specifically. As such, I would recommend this type of therapy be incorporated into any treatment program for veterans seeking to combat intimate partner violence.

Some of the more successful programs assessed in this review also sought to address other issues veterans were struggling with both personally and in their intimate relationships, with specific focuses on reducing PTSD symptomatology and increasing relationship satisfaction, to help reduce IPV. Such a multi-focused approach is supported by prior survey research of veterans, whereby increased PTSD symptomatology and decreased emotional intimacy with partners were strongly correlated with IPV perpetration experiences (Kar & O'Leary, 2013). Thus, in order to lessen the amount of IPV being perpetrated by veterans, it is important to note other factors that may play a role in them becoming violent. Thus, in addition to incorporating CBT approaches in treatment efforts, if IPV prevention and intervention programs were able to simultaneously address other problems veterans are dealing with

personally and in their intimate relationships, this could lead to a decrease in the rates of their violence.

As noted in the results section of this systematic review, programs were either highly successful with relatively low completion rates or only moderately successful with moderate-high completion rates. Yet, it is important for veterans to complete intimate partner violence programs in their entirety to obtain the best results (Gerlock, 2004). As such, in addition to focusing on the specific treatment protocols implemented in IPV programs, policymakers and military personnel should also seek to find ways to better ensure veterans who need such programs successfully complete them.

One reason veterans may fail to complete such programs, especially ones that are longer in duration, may be due to relocation for a job or family. Therefore, I would recommend that VA hospitals make programs widely accessible throughout the country to a wide range of veterans. For example, the same program could be offered at all or most VA hospitals nationwide so that veterans could continue participating in the program despite any needed relocations. Prior research also indicates that male batterers are less likely to complete IPV intervention programs when they are less educated, unemployed, dealing with substance abuse and not court-ordered to attend the program (Daly, Power, & Gondolf, 2001). As such, VA hospitals should work with veterans to address these co-occurring issues, particularly in regard to their education and employment statuses. This will not only help to address the issue of program completion but will also increase veterans' bonds to society. Following the basic premise of social bond theory, as noted in the literature review of this thesis, the strengthening of veterans' social bonds will in turn further reduce their likelihood to perpetrate IPV even without an intervention specific to IPV. Meanwhile, the IPV intervention program in which veterans are enrolled may try to

simultaneously address veterans' IPV perpetration and substance abuse through CBT and other treatment approaches. CBT has been found to be successful in reducing substance abuse (McHugh, Hearon, & Otto, 2010); and a dual focus on both IPV and substance abuse would not only increase program completion, but also lead to more success in reducing rates of IPV, as noted elsewhere in this review. Finally, given that court-mandates are key predictors of program completion, military policymakers and local officials at VA hospitals may consider incentivizing program completion through such things as tying the receipt of various military benefits to veterans' completion of IPV programs where necessary.

After all my research, I believe veterans should have greater accessibility to longer duration programs; programs should focus on multiple problems veterans face both inter- and intra- personally in order to combat intimate partner violence; cognitive-behavioral therapy should be used as part of the program; and steps should be taken to better ensure program completion. Although I did a lot of research on the topic, I did only find 6 sources which included empirical evidence on programs that were successful in lessening the amount of intimate partner violence being experienced in veterans' relationships. There is still a great deal of research to be done on this topic in order to confidently recommend programs that would be most beneficial for veterans dealing with IPV.

Hypermasculinity Programs for Civilian, Active Duty and Veteran Men

After a review of the existing research, the following suggestions should be considered by policymakers and military officials when trying to engage veterans in a better understanding of masculinity. According to these sources, the best method for engaging men in transforming their definition of masculinity is group-based sessions and workshops (Liddell & Kurpius, 2014; Men of Strength Club, 2020; Namy et. al., 2015; Peacock & Levack, 2004; Raymond, 2005).

Engaging men in a group atmosphere allows them to better understand the perspective and lives of others, and recognize that everyone need not, or potentially even should not, fit the mold of hypermasculinity often conveyed in American culture. Likewise, because men may fear others' reactions if they are to express fewer masculine beliefs and behaviors, having support of other men as they try to break down the hypermasculine barriers society has imposed on them is particularly important. Similarly, hypermasculinity programs geared toward veterans may also consider workshops to be an effective approach. Several of the programs with older, college-age participants (e.g., Richmond College, 2020; Topou, 2020) incorporate this type of programming with male college students in order to reduce such things as violence and sexual assault on their campuses. The benefit of workshop-based programming is that speakers and topics can be crafted to the specific participants enrolled in the program. As such, local VA hospitals could consider hosting workshops on combatting hypermasculinity led by other veterans or active-duty military who could speak to the traditionally hypermasculine nature of military culture and how breaking down such a culture could actually be beneficial to the military given the higher rates of violence experienced by members within its ranks.

Masculinity is an important concept in the treatment of veterans because it can affect how often men will be willing to seek or receive help. Veterans have a sense of traditional masculinity, making them believe men should not express emotion and that seeking help for things like mental illnesses makes them look weak (Lorber & Garcia, 2010). If people can highlight the importance of understanding masculinity as part of the therapy process for veterans receiving help for mental disorders, it may make the veterans more likely to get the help they need. Masculinity could be used in a positive light to encourage men to have better

understandings of masculinity, making them more accepting of themselves and other men who want to seek out help for their struggles (Caddick, Smith & Phoenix, 2015).

Enacting hypermasculinity programs among veterans may be difficult, as the very hypermasculine beliefs these programs try to break down prevent veterans from enrolling in them for help to begin with. As such, based on previous research, I believe it would be of most benefit for boys to go through hypermasculinity programs at a young age in order to try to combat stereotypes around what a man should be before they firmly take hold in adolescent and young adult life, and before military service becomes a potential reality for them in the future . If everyone was taught from a young age that it was okay to get help and be emotional as a man, it may reduce the potential shame veterans may feel for getting help with PTSD or IPV later in life. Much more research must be done on this topic in order to more accurately assess what would be the best method for combatting PTSD and IPV based on notions of hypermasculinity among the veteran population specifically. However, based on my knowledge of the sparse research that does exist on the topic, I would recommend hypermasculinity programs with group and workshop-based methods, emphasizing the importance of understanding masculinity, and teaching how the expression of emotion and help-seeking behavior does not define someone's manliness or lack thereof.

Veterans' Affairs Accessibility

Policymakers and military officials should consider the following suggestions, based on existing research, when trying to provide greater accessibility to veterans for mental health treatment. Whether its treatment related to PTSD or issues of aggression, veterans need better and more timely access to care, both for themselves and for their loved ones who may be equally affected by their struggles. According to research outlined herein, on average, 25% of veteran

mental health care providers in each state of the U.S. are not even accepting new patients at their mental health facilities right now. This makes it a lot more challenging for veterans seeking help to obtain the care they need and may prevent them from seeking help at all if they perceive too many barriers in the process. Similarly, since one in four providers does not have room for new patients, this may be geographically inconvenient or even impossible for some veterans due to work and family obligations or lack of reliable transportation. In order to make sure veterans get the help they need, it is important for Veterans Affairs to ensure that mental health clinics are evenly distributed across the country and that there are enough providers within each new facility so that new patients can be accepted when the need arises.

Even among those clinics who are accepting new patients, wait times pose another barrier for veterans who are trying to seek help. As shown in the Table 4, wait times can be as long as 97 days, like the maximum wait time found for clinics in New Mexico, while many other clinics have long wait times of more than one month. In turn, long wait times often results in individuals seeking mental health treatment to be less likely to show up for their appointment, less likely to stick with treatment long-term, and be more dissatisfied with their treatment (Lacy, Paulman, Reuter, & Lovejoy, 2004). This may be especially the case among male veterans, who are already concerned with issues of respect when sharing their problems with others. The high importance placed on respect in both the military and in line with notions of traditional masculinity may lead male veterans especially to perceive long wait times as disrespectful of their need for treatment. As such, lowering the amount of time veterans are waiting for an appointment could make veterans more likely to get the help they need. Finally, it is important to note that wait times for clinics could be even longer than what is officially reported, as some reports have indicated that the Department of Veterans Affairs is not always able to track wait

times accurately (Kime, 2019). This is because wait times often do not take into account the initial enrollment process for veterans to begin receiving benefits; and less accurate data collection is often present when veterans seek care at private facilities through the VA Choice Program.

Policymakers and military officials should take these problems into consideration and work to improve mental health clinics for veterans. More clinics need to be accepting of new patients; and clinics also need to be aware of their location compared to where most or all veterans reside. Moreover, in order to improve wait times, veteran administrators could make changes to start date definitions for wait-time measurements, revise current scheduler training procedures, and improve oversight through scheduler audits (Draper, 2019).

At present, many clinics provide new patients with what is called a preferred date for the patient to be seen, which can leave the patient waiting longer for an appointment than what they are initially told if there are too many patients scheduled for their preferred appointment day. However, if VA clinics changed these scheduling procedures, they could better ensure the patients would actually be seen on the date they are scheduled, which would increase the possibility of veterans getting the help they need and not foregoing treatment in cases where their preferred appointment date is rescheduled. Related, improving current scheduler training would allow for more accurate wait-time measurements as it would make it easier for schedulers to understand how long it will take for a patient to be seen. This might entail training schedulers on how long it takes for VA benefits to process so that patient appointments are scheduled at a time when benefits have a greater chance of already being secured, particularly in the case where former active-duty military are seeking treatment shortly after discharge. It may also entail further training of schedulers on how to use automated appointment systems. In 2019, most VA

clinics switched to an automated scheduling system where schedulers would provide patients with an initial appointment date based on health care provider referral on when the patient should be seen. This is in comparison to pre-2019 when schedulers had to access the veteran's medical records to see when their primary health provider wanted them to be seen and manually enter that date into the system. However, recent analyses indicate that there is still an 8% error rate between when appointments are scheduled compared to when they are recommended by health care providers based on this automated scheduling system. Importantly, this is an 18% improvement over when schedulers had to enter appointment dates manually. Yet, this 8% error rate indicates that a small proportion of veterans seeking care are still waiting for an initial appointment past the time their health care provider has recommended based on their clinically-diagnosed mental health disorders (Draper, 2019). Related, scheduler audits could improve the scheduling process as well, because an audit is an official inspection of an individual's or organization's accounts. If every scheduler had to keep track of the appointments they made and had someone looking over what they were doing, this would allow for more accurate information being given to the patient and appointment dates that are consistent with what the patient is being recommended by their primary care provider.

Once changes to start-date definitions and scheduling procedures are made, this could allow policymakers and military officials to understand the true extent of the problems with access to care insofar as extended wait times past the veteran's preferred appointment date or the date their health care provider recommends they be seen by. In turn, this could help push for legislation that would increase funding, availability and other resources in mental health clinics providing care for veterans. Finally, understanding that in some instances veterans may still need to wait several days or weeks for an initial appointment, even if access to care were to improve,

all clinics should also develop a reminder system to remind patients when their appointment date is near. This may be especially helpful for younger male veterans of color, as research tends to show that young people, men, and people of color tend to be the most likely to be no-shows for their mental health appointments (Boos, Bittner, & Kramer, 2016).

In conclusion, in order to improve accessibility in mental health programs for veterans, the wait times have to be lowered, patients need to feel respected, more clinics need to accept new patients, and a reminder system should be implemented. All of this will of course first require more accurate data collection to understand the true extent of the problem, followed by a directed increase in resources so that more clinics are available and that clinics are fully staffed with licensed professionals to deliver the mental health treatment veterans need.

CONCLUSION

In order to effectively combat intimate partner violence (IPV), it is important to focus on studying treatment options for veterans, as veterans are one of the largest populations of perpetrators (Teten et al., 2010). This is due to their experiences during combat, resulting in PTSD for many of them. PTSD can cause flashbacks, and this trauma and stress may lead PTSD sufferers to lash out violently. Relatedly, there is some research to suggest that post-9/11 veterans are more at risk of perpetrating violence than pre-9/11 veterans. This is because studies have shown that post-9/11 veterans are more likely to see combat while enlisted, increasing their risk for PTSD and subsequent violence perpetration (Pew Research Center, 2019). Moreover, post-9/11 veterans may be more likely to perpetrate intimate partner violence due to the increasing rise of hypermasculinity in the late 20th and early 21st centuries (Spencer et al., 2004). Hypermasculinity encourages men to be tough and unemotional. These notions of masculinity may not only increase the risk for violence in itself with a strong focus on toughness, but may

also reduce the chances veterans will get the help they need for their PTSD because they are ashamed to be perceived as weak. In turn, if veterans do not receive the help they need for PTSD, this only further increases their chances of experiencing other problems, like perpetrating intimate partner violence.

Given all of the aforementioned ideas, it is important to assess the best methods to provide veterans with mental health treatment in order to combat issues of PTSD and intimate partner violence. In order to do so, I conducted three different systematic reviews on what programs work best for reducing PTSD symptomology and IPV perpetration among veterans, as well as on programs geared toward reducing negative forms of negative hypermasculinity, whether among veterans or any other population of males, as these programs are considerably rarer in existence than treatment and intervention programs for PTSD and IPV. I conducted the systematic reviews through two databases, which were Google Scholar and Assumption University's EBSCO search engine. To be included in the review, the article or report also had to be published within the last 25 years. For the systematic reviews on PTSD and IPV programs, the article or report also had to outline a program in which veterans were actually enrolled. This second criterion was not necessary for the hypermasculinity program review given the scant literature that currently exists on these types of programs.

In addition to conducting these three systematic reviews, I also conducted an analysis on treatment accessibility among VA mental health providers nationwide. This is because it is also important to study whether there are any barriers in accessing help among those veterans who are comfortable enough to seek out services for their PTSD and issues with violence and aggression. For this systematic review, I used the U.S. Department of Veteran Affairs website search engine. This tool allows veterans to search state-by-state of residence, identify facilities within a 50-mile

radius, figure out if the facility is currently accepting new patients, and determine what the average wait time for a veteran seeking new services is.

Seventeen programs were reviewed for the first systematic review on PTSD treatment programs for veterans. Of the 17 programs, eight indicated moderate-large statistically significant effects on PTSD symptomology. Studies demonstrated that the most successful way to lessen PTSD is cognitive behavioral or trauma exposure therapy in a group or individual setting. Cognitive behavioral therapy is successful in combatting PTSD because it allows patients to be exposed to fears and anxieties in order to better control their emotions, thoughts, and actions when these fears or anxieties occur (e.g., Chard et al., 2011). Meanwhile, trauma exposure therapy is based on the notion that repeated exposure to past trauma will, over time, desensitize the patient so that recalling negative experiences no longer results in intense emotions or negative behaviors (e.g., Beidel et al., 2017). Meanwhile, less successful PTSD programs focused on such treatment techniques as group yoga therapy, biofeedback, group-run relaxation training, and mindfulness-based stress reduction.

The most successful PTSD programs ranged in length from three weeks to nine months. Shorter programs required more intense interaction within the program via more contact days or longer therapy sessions. The most contact sessions a program had was 60, while the remaining programs ranged from 12-36 therapy sessions. These findings indicate that successful programs must also require multiple treatment sessions and long-term contacts between the veteran patient and their clinician. Thus, based on this first systematic review, VA clinics should focus on cognitive behavioral and trauma exposure therapies as their primary treatment modalities for veterans struggling with PTSD, and ensure that treatment either last several weeks with multiple contacts per week, or one contact per week over the span of several months.

Six programs were reviewed for the second systematic review on IPV treatment and intervention among veterans. Four of the six programs had moderate-high statistically significant effects on IPV perpetration rates. Like the first systematic review on PTSD programs, this review also indicated that the most successful way of combatting IPV is through cognitive behavioral therapy. This method allows for negative thought patterns among patients concerning the appropriateness of violence and aggression or attitudes toward women to be challenged, allowing patients to see alternative behaviors that would be more appropriate to enact in various situations (e.g., Taft et al., 2016). Meanwhile, less successful IPV programs focused on couples-based therapy instead of cognitive-behavioral therapy. This is not to say that couples therapy cannot be a useful additive tool in fighting IPV in relationships. However, among male veterans in particular, cognitive behavioral therapy seems to be the best approach. Considering that many veterans may be engaging in violence due to their PTSD symptomatology, this could very well be because individual therapy is better able to serve a dual focus and reduce IPV through reducing PTSD symptoms. Finally, successful IPV programs varied in length from 10 weeks to 11.5 months, further indicating the amount of time it takes for veterans to successfully combat issues of PTSD and IPV via mental health treatment. Thus in addition to recommending cognitive behavioral therapy as the primary mode of treatment for veterans dealing with PTSD and IPV, I would recommend that policymakers and military officials pay attention to the amount of time it takes for someone to successfully overcome these issues in order to make sure veterans are receiving the best care possible.

The findings from my third systematic review on 10 different hypermasculinity programs indicated that the best programs focused on creating a better understanding of hypermasculinity and the negative effects it can have on oneself or men's relationships with others. The most

successful programs used methods of focus groups or workshops to educate males about hypermasculinity (e.g., Liddell & Kurpius, 2014; Men of Strength Club, 2020). Engaging men in a group atmosphere allows them to better understand the perspective and lives of others, making it easier for them to realize not everyone fits the stereotypical hypermasculine male model (Caddick, Smith & Phoenix, 2015). Also, hypermasculinity programs in a group workshop setting allows the speaker to focus their topics of discussion toward their audience. Therefore, veterans seeking help for masculinity could have their own workshop allowing it to be geared toward their problems so they can relate to others in the group. The hypermasculinity programs reviewed also varied in length from 5 days to 22 weeks. These programs seem to be successful in a shorter amount of time than the PTSD and IPV programs. This could be due to the fact that hypermasculinity is a socially-constructed mindset or belief that may be easier to counter in a shorter timeframe, whereas PTSD is a clinical disorder that often needs professional diagnosis, clinical counseling or psychiatric medicines to treat, and which may affect sufferers emotionally, physically and physiologically. Based on this review, it is thus recommended that hypermasculinity programs using workshops and group settings alongside other mental health services be provided at VA clinics since these are the best methods of reducing negative attitudes male veterans may have about what it means to be a man, that in turn increases their chances of perpetrating violence against loved ones.

In my analysis of mental health providers at VA clinics, I found that accessibility to programs is another problem veterans face. Research shows that there is an average of 20 providers within a 50-mile radius of the state center in each state across the United States. However, these sites are not evenly distributed geographically, which may make it difficult for veterans in some areas to access help. I would recommend that there are enough mental health

facilities for veterans in each city or county of the United States based on the number of veterans who reside in that particular area in order to make it easier for veterans to get the help they need. In addition to the number and locations of VA mental health providers, wait times for initial appointments and the number of existing providers not accepting new patients were two additional issues found in my research. While there was an average wait time of only 9 days for new patients across all facilities in the United States, this number was as high as 97 days in one state and over 30 days in 16 additional states, showing again how unevenly distributed access to care is for veterans based on their geographic location. Moreover, my analysis indicated that an average of 25% of facilities across the United States were not even accepting new patients, with as many as 62.5% of providers in some states not accepting new patients. This indicates that more resources need to be funneled to VA mental health clinics nationwide so that they can employ enough providers to take on a greater number of patients and provide them with more timely care.

There were several limitations that arose from the research I conducted that are also worth noting. One problem was that the sample sizes of some of the programs were small. Small sample sizes lead to less generalizable results since the sample is not big enough to represent the entire population. For example, in the PTSD systematic review, one of the sources only had 25 participants (Cook et al., 2006), even though the program demonstrated large decreases in PTSD symptomology. This was also a problem in the IPV and hypermasculinity systematic reviews as some of those programs had as little as 22 participants. Two, some programs did not provide complete assessment information which could have been used to evaluate the programs more fully. For example, some programs did not provide enough information about the effectiveness of programs, program completion rates, or people recruited for the study. This was mostly a

problem for the hypermasculinity systematic review. For example, the Pathways for Change website did not provide any information on program length, method of delivery, rate of completion, success rate, or measurement of success. Richmond College also did not provide a lot of information for the table like program length, rate of completion, success rate, or measurement of success. Many blank spaces are left in the table where other sources did not provide all the information needed as well. Three, it is likely that my analysis on accessibility issues underestimates how problematic accessing treatment from mental health providers truly is among veterans, due to research which indicates that wait times may actually be longer than what is official recorded on the Veteran Affairs website (Kime, 2019). This is why it is imperative that schedulers are properly trained and audited on how to enter accurate data to be tracked for issues such as these, as well as to provide the veterans themselves with more accurate information on wait times for initial appointments (Draper, 2019). These limitations indicate that more research must be done on treatment and intervention approaches for male veterans suffering from PTSD and combatting issues of violence and aggression in their lives. Given that 1 in 4 women and 1 in 10 men have experienced contact sexual violence, physical violence, and/or stalking by an intimate partner during their life (Centers for Disease Control and Prevention, 2018); and that the per-victim lifetime cost of intimate partner violence is $103,767 per woman and $23,414 per man (Peterson et al., 2018), further research into how best to help one of the largest groups of IPV perpetrators is essential to help victims, perpetrators and society overall.

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APPENDIX

Table 1: Systematic Review of PTSD Programs

Study/Report Citation	Participant Info	Enrollment Method	Program Length	Services Offered	Method of Service Delivery	Rate of Completion	Success Rate	Measurement of Success
Beidel et al., 2017	N=112; 95% male; mean age 37; 67% white; 55% married	Referred but voluntary participation	3 weeks; 29 sessions	Exposure therapy; programmed practice; social and emotional rehab; social reintegration; anger management; behavioral activation	Outpatient therapy; participants stayed in same hotel	89%	High for those with severe brain trauma; 65% no longer meeting diagnostic criteria for PTSD after program completion	Lessening of symptoms of PTSD and brain trauma through clinical assessments at post-treatment, 3-month, and 6-moth follow-ups
Bolton et al., 2004	N = 105; all male, mean age- 52; varied marital and employment statuses	Voluntary referrals from other outpatient treatment centers	12 weeks	Group therapy; PTSD-educational services; stress and anger management	Weekly outpatient	87%	Modest but significant	Self-reports of psychological distress before and after treatment
Brady et al., 2001	N= 39; 32 women and 7 men; exclusion criteria included psychosis, dissociative identity disorder, dementia, illiteracy, and suicidal or homicidal ideation.	Voluntary treatment-seeking individuals; Incentive to participate was $10 gift cards given at the end of completing two consecutive therapy sessions.	16 weeks	Exposure therapy; cognitive behavioral therapy	Weekly or twice weekly 90-mintue psychotherapy sessions	38%	Significant reductions in PTSD and depressive symptoms and cocaine use	Clinician assessments administered at baseline; at weeks 4, 8, 12, and 16; and a 6-month follow-up

Carter et al., 2013	N=31 (only 16 in treatment group, 15 in control group); male; average age 58	Self-referral from patients receiving psychiatry services through phone advertisement	6 months	Group yoga; group therapy	30 hours in first month; weekly for following 5 months	88% for treatment group; 73% for control group	Moderate; significant reduction in PTSD and depressive symptoms; no effect on quality of life (e.g. physical health and social relationships) or alcohol use scores	Clinical assessments at pre-intervention, 6-weeks post-intervention, and 6-month follow up
Chard et al. 2011	N=47; all male; 80% with brain injury; mean age 35	Voluntary	7 weeks	Individual and group active-trauma therapy; cognitive behavioral enhancement group therapy	Residential treatment; 2-3 times per week and 23 hours a week of psychoeducational groups	89%	Large and significant reductions in PTSD for those with moderate/severe TBI; modest reductions in PTSD for those with mild TBI	Lessening of symptoms of PTSD and TBI; pre and posttreatment assessment
Cook et al., 2006	N=25; 72% male; mean age 50; also being treated for alcohol abuse, cocaine abuse, or heroin dependence	Voluntary self-referral from VA center	25 sessions	Substance abuse and PTSD treatment; Group treatment	Outpatient therapy	72%	High	Reduction in PTSD symptomatology and abstinence from substance use; pre and posttreatment assessment
Fischer et al., 2013	N = 100; 99% male; mean age 56; majority married	Voluntary referral through VA ; excluded those with active substance use and suicidal ideation	9 months	Problem exploration and solving within relationships, strengthening of social support networks, anger	REACH program: an outpatient multifamily group psychoeducation clinical program. Phase 1 and 2 include 4-6 weekly sessions;	95%	High	Significant improvements in PTSD understanding, PTSD coping and relationship functioning; lower levels of psychological

				management and building of communication skills.	Phase 3 is monthly sessions.			distress, anxiety and depression among veterans from baseline.
Greden et al., 2010	Returning Michigan Army national guard Iraq and Afghanistan soldiers	Voluntary partnership after contact returning home	Ongoing; as needed	Buddy-to-buddy support; one-on-one mentorship and service referral and support	Outpatient support, as needed	N/A	20-66% depending on outcome	Regular phone calls for support; referrals for concrete resources (benefits, financial or job-placement assistance) or formal treatment services
Gros et al., 2011	N = 89; 94% male; mean age 45; Iraq, Afghanistan and Vietnam veterans	Voluntary referral from local VA medical clinic	12 sessions	Telehealth and in-person exposure therapy (i.e., fear confrontation)	Outpatient individual therapy sessions	73%	Moderate; higher for in-person (30- and 16-point reductions) vs. telehealth therapy (15- and 12-point reductions)	PTSD and depression inventories
Heffner, Crean, & Kemp, 2016	N = 391; 90% male; veterans receiving PTSD treatment in 9 VA centers throughout U.S.	Voluntary enrollment through VA hospital	8 weeks	Mindfulness and mantra-based meditation program	Weekly 1.5-hour group sessions	75%	Medium effect sizes when combined with traditional PTSD therapies	Self-report PTSD symptomatology before and after program

Kearney et al., 2013	N = 92; 76% male; mean age 51; 74% PTSD at baseline; excluded if active substance use or suicidal ideation or history of personality disorders	Voluntary enrollment; referred by VA provider	8 weeks with 2- and 4-month post-program completion follow-ups	Small group mindfulness-based stress reduction program	Weekly 2.5 hour sessions with 7 hour session on Saturdays	70%	Medium effect sizes; 48% of sample had clinically significant improvements in PTSD symptoms at 6-month follow-up	Decreased scores on PTSD questionnaire between baseline and 2- and 6-month follow-ups
Monson et al., 2006	N= 60; 90% men; average age 54; exclusion criteria included current uncontrolled psychotic or bipolar disorder, substance dependence, prominent suicidal ideation, and significant cognitive impairment	Referred by VA medical center; Voluntary enrollment	6 weeks	Cognitive processing therapy	Twice a week; 12 sessions	83%	High; 40% did not meet diagnostic criteria for PTSD after program completion; 50% still met diagnostic criteria but saw changes in PTSD symptoms	Reduction in symptoms of PTSD, depression, and general anxiety were all assessed at baseline, mid-treatment, posttreatment, and 1-month post treatment
Ready et al., 2008	N = 102; all male; average age 54	Referred from VA medical center; excluded if active substance use	16-18 weeks	Group-based exposure therapy	3-hour sessions twice weekly	97%	81%	Minimum of 10-point reduction in clinician-administered PTSD scale post-treatment

Reinhardt et al., 2017	N= 51 (only 26 in treatment group; 25 in control group); male; average age 46; must be a veteran and have PTSD	Monetary incentive of up to $300	10 weeks	Group yoga therapy	Twice a week	38% of treatment group; 84% control group	Small; no significant differences between those randomly assigned to treatment group compared to control group; small decreases in PTSD symptoms for those who voluntarily enrolled in treatment group compared to control group	Lessening of PTSD symptoms; assessment at baseline, questionnaires, and Clinical Self-administered PTSD Scale pre and post-treatment
Schnurr et al., 2003	N = 360 male Vietnam veterans	Voluntary enrollment through 10 VA medical centers; excluded if lifetime psychotic or severe personality disorders or current substance abuse	30 weeks	Comparison of trauma-focused vs. present-centered group therapy	1.5-2 hour weekly group sessions	90%; lower completion rates for trauma-focused group	Modest; 40% saw a clinically significant improvement in symptoms; no difference in success between trauma-focused and present-centered groups	Pre-and post-test scores on Clinician Administered PSTD scale questionnaire
Silver, Brooks, & Obenchain, 1995	N = 100; male Vietnam veterans	Inpatient VA medical center	1 year	Biofeedback and group-run relaxation training			Low; no sig. differences between relaxation and control group; biofeedback group did worse	Entry and exit scores on Problem Report Form (measures anxiety, anger, isolation, depression, flashbacks,

							than control group	intrusive thoughts, and relationship problems
Yoder et al., 2012	N = 112; 92% male; average age 41; Iraq, Afghanistan, Vietnam and Persian war veterans	Referred from VA medical center based on PTSD diagnosis	Minimum 6 weeks	Prolonged exposure therapy included exposure to trauma, self-assessments and psycho-education	Weekly 90-minute therapy sessions	84%; Iraq and Afghanistan veterans lower completion rates	High; average 20-point decrease in PTSD, average 13-point decrease in depression	Pre- and post-tests PTSD checklist and Beck Depression Inventory

Table 2: Systematic Review of IPV Programs

Study/Report Citation	Participant Info	Enrollment Method	Program Length	Services Offered	Method of Service Delivery	Rate of Completion	Success Rate	Measurement of Success
Berke et al., (2017)	N=135 (treatment and control group); all male; average age 38; 57% veterans of Iraq and Afghanistan; exclusion criteria were substance dependence, uncontrolled bipolar or psychotic disorder, or severe cognitive impairment	Clinician referrals, self-referrals, and court-referrals for at least one male-to-female act of physical IPV; Incentive of $50 for each of three assessments completed	12 weeks	Trauma-informed and cognitive-behavioral group treatment-Strength at Home Men's Program (*SAH-M*)	Weekly two-hour group sessions	82%	Moderate; treatment group had greater reductions in alexithymia than the control, Alexithymia reductions associated with reductions in psychological but not physical, IPV.	Self-reported assessments at baseline, 3-months, and 6-months of IPV perpetration (Revised Conflict Scale) and alexithymia (Toronto Alexithymia Scale)
Brewster, (2002)	N= 2,991; mostly male; average age 27; from 61 Air Force bases within the U.S. and 27 bases overseas	Voluntary; had to receive services from Air Force Family Advocacy Program		Individual service referral; varied by case, most common services included marital therapy, anger management training, individual therapy, conflict containment		48%	High; after program involvement veterans saw a decrease in family conflict and child abuse risk and an increase in family cohesion, family expression, and marital satisfaction	Pre- and post-treatment assessments as well as a 6-month follow up assessment

				programs, communication skills training, alcohol counseling, and group therapy				
Creech et al., (2018)	N= 132; male; average age 43	Voluntary	12 weeks	Cognitive-behavioral and trauma-informed group treatment	Weekly	40%	Moderate-high; significant decrease in IPV perpetration (58-78% with no IPV incidents, depending on IPV type) post-treatment 72% satisfied with program; significant reductions in PTSD symptoms; alcohol misuse was not significant	Pre- and post-treatment assessments of IPV, PTSD symptomology, and alcohol misuse; 10 question post-treatment satisfaction measure
Gerlock, (2004)	N= 62; mostly male; average age 39	Voluntary	Orientation= 4 weeks; rehabilitation= 26 weeks; maintenance= 6 months	Cognitive-behavioral therapy; four phases of program were assessment, orientation, rehabilitation, and maintenance	Orientation and rehabilitation= weekly; maintenance= monthly	37%	Program dropouts had a higher rate of repeated violence than program completers. High association between all program participants in PTSD symptomology	Pre-treatment assessment; interviews between each phase; post-treatment assessment

							and IPV perpetration.	
Nowlan, Georgia, & Doss, (2017)	N= 354; married; average age for men 50; average age for women 48	Recruited from VA medical center	9 weeks	Couple based therapy; communication skills and cognitive behavioral therapies	Orientation and weekly sessions	67%	Moderate; couples saw improvements in relationship satisfaction; reductions in IPV and psychological distress after treatment. Concluded successful in treating mild-moderate IPV but more severe IPV unknown.	Pre-treatment and 18-month follow-up assessments using Quality of Marriage Index, Conflict Tactics Scale and Brief Symptom Inventory
Taft et al., (2016)	N=138; inclusion criteria for couple were over 18 years old and cohabiting, male was a veteran; exclusion criteria were reading difficulties, severe organicity or active psychosis,	Recruited from 2 different VA hospitals; clinician referral; self-referral flyers	10 weeks	Couple based intervention; cognitive-behavioral trauma therapy; Strength at Home Couples (catered specifically to war-related traumas) vs. Supportive Prevention Groups	Weekly two-hour sessions	60% of SAH-C couples; 34% of Supportive Prevention couples	High-moderate; SAH-C couples physical violence assessed at Time 4 was half the rate of Supportive Prevention couples, Psychological violence decreased for both groups; slightly larger	Assessments completed pre-intervention, immediately following 10-week intervention, and 6- and 12-months post-intervention. Revised Conflict Tactics Scale and Multidimensional Measure of Emotional Abuse Scale for IPV; Quality of Marriage Index

	prominent suicidal ideation, alcohol/drug dependence, female using weapon for violence, or producing injury, male was fearful of female, or male was violent during past 6 months						benefits for SAH-C couples; no significant change in marital satisfaction	and Dyadic Adjustment Scale for marital satisfaction

Table 3: Systematic Review of Hypermasculinity Programs

Study/Report Citation	Participant Info	Enrollment Method	Program Length	Services Offered	Method of Service Delivery	Rate of Completion	Success Rate	Measurement of Success
Liddell & Kurpius, 2014	N=22; average age 16.5; all males	Voluntary	8 weeks	Role-playing, journaling, group discussion, and drawing	Weekly 60-90 minute sessions		Moderate; improvements in self-esteem and decreases in identity distress and relational aggression	Pre-treatment and post-treatment tests
Men of Strength Club, 2020	Middle school and high school boys	Voluntary	22-weeks	Promote an understanding of masculinity contributing to violence, expose men to better definitions of masculinity, build men's capacity to be leaders, hub for social justice			High; statistically significant changes on attitudes, feeling more responsible and connected to schools, families, and communities	
Namy, et. al., 2015	N= 48; mostly male; average age 19; youth boys and youth facilitators	Voluntary		Interview; focus-groups			High; program allowed boys personal reflection, experience-based learning, connections with youth facilitators, new peer groups, and	Data collected from interviews and focus-groups

							aspirational messaging	
Pathways For Change, 2020	Middle school, high school, and college aged males	Voluntary		Four-level social ecological model to better explain sexual violence and potential strategies for prevention				
Peacock & Levack, 2004	N= 209; mostly male; average age 33	Voluntary	5 days	Changing knowledge, attitudes, and behavior of men, mobilizing men to take action in their own communities, working with media to promote changes in social norms, and advocating for governmental commitment to promote positive male attitudes	Workshops	66%	High: knowledge increased about HIV/AIDS, positive attitude changes about sexual violence and relationships emerged, and positive behavioral shifts occurred	Interviews

Raymond, I., 2005	N=13; all male; average age 13	Enrolled in the South Australian residential care system	6 weeks	Structured lessons, action-oriented games, camps, and a presentation	Four full-day activities, two day camp, and three day camp	77%	High; boys assimilated to contents of program and improved staff-client relationships	Analysis of key performance indicators, observational data, and open interviews
Richmond College, 2020	Male college students	Voluntary		Shaping the opinion of masculinity	Richmond College Campus meetings			
Tupou, P., 2020	Male college students	Voluntary		Dudes week, men's retreat, personal development workshops, and speaker series	Travel to spread their message; 2-day retreat			

Table 4: Systematic Review of VA Mental Health Accessibility

State of Residence	Total # of VA Hospitals in 50-mile radius of state	# of VA Hospitals not Accepting New Patients	% of VA Hospitals not Accepting New Patients	Maximum Wait Time among those Accepting New Patients	Average Wait Time among those Accepting New Patients
Alabama	18	5	28%	19 days	6.5 days
Alaska	5	1	20%	9 days	6.25 days
Arizona	23	6	26%	26 days	10 days
Arkansas	20	6	30%	25 days	9.5 days
California	63	15	24%	42 days	11 days
Colorado	17	5	29%	35 days	12 days
Connecticut	9	3	33%	9 days	6.5 days
Delaware	6	3	50%	19 days	9 days
Florida	64	6	9%	41 days	8 days
Georgia	35	4	11%	44 days	12 days
Hawaii	7	1	14%	18 days	8 days
Idaho	7	1	14%	27 days	8 days
Illinois	31	8	26%	34 days	7 days
Indiana	24	3	12.5%	19 days	7.5 days
Iowa	19	4	21%	21 days	8.6 days
Kansas	18	7	39%	22 days	10 days
Kentucky	21	3	14%	13 days	4.5 days

Louisiana	18	1	5.5%	31 days	8.5 days
Maine	8	2	25%	17 days	7 days
Maryland	16	1	6.25%	24 days	9 days
Massachusetts	19	4	21%	14 days	6.5 days
Michigan	30	5	16%	40 days	10 days
Minnesota	16	4	25%	19 days	10 days
Mississippi	11	3	27%	12 days	5.25 days
Missouri	34	5	15%	38 days	8.5 days
Montana	16	7	44%	8 days	3.5 days
Nebraska	9	0	0%	42 days	13.5 days
Nevada	14	3	21%	25 days	8 days
New Hampshire	7	4	57%	6 days	4.5 days
New Jersey	16	5	31%	14 days	6.5 days
New Mexico	12	6	50%	97 days	27 days
New York	48	18	37.5%	14 days	6 days
North Carolina	26	7	27%	40 days	12.5 days
North Dakota	9	0	0%	26 days	14 days
Ohio	40	6	15%	39 days	11 days
Oklahoma	18	6	33%	25 days	9 days
Oregon	18	7	39%	13 days	6 days
Pennsylvania	42	7	17%	41 days	11 days

Rhode Island	2	1	50%	5 days	5 days
South Carolina	16	0	0%	19 days	9 days
South Dakota	9	2	22%	21 days	10 days
Tennessee	31	3	9.5%	23 days	7 days
Texas	60	6	10%	46 days	9 days
Utah	7	3	42%	14 days	9 days
Vermont	6	2	33%	15 days	8.5 days
Virginia	19	3	16%	58 days	15.5 days
Washington	13	4	31%	15 days	8 days
West Virginia	12	2	16.5%	36 days	11.5 days
Wisconsin	21	9	43%	19 days	9 days
Wyoming	8	5	62.5%	8 days	6 days
Total U.S. Averages	**20**	**4**	**25%**	**26 days**	**9 days**