Bulletproofing the Psyche: Mindfulness Interventions in the Training Environment to Improve Resilience in the Military and Veteran Communities

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Abstract: While clinical health services exist for service members with existing mental health conditions like posttraumatic stress, they are not stemming the rising tide of service suicides. A new approach to mental health intervention and suicide prevention in military-connected personnel is required, one that speaks to the participatory, hard-working ethos of military culture. Social work and health promotion professionals working to prevent and treat mental health problems like depression and stress injuries must understand the confluence of warrior culture and mental health issues in the veteran community. While the research literature does not yet address this confluence issue directly, programs exist that provide guidance, and a mindfulness-based training protocol may provide the answer. The purpose of this review is to provide programming recommendations based on a review of successful exemplars in treatment settings, the limited evaluation of best practices currently available when working with this priority population in prevention settings, and a cultural analysis of the military veteran community.

Keywords: Veterans, depression, mental health, resilience, mindfulness, warrior culture

In 2011, the number of suicide deaths among active duty military personnel eclipsed the number of combat deaths. In contrast, before the wars in Iraq and Afghanistan, the incidence of suicide in active duty US service members was consistently 25% lower than in the civilian population (US Department of Veterans Affairs, 2014). Understanding the mental health problems facing American military veterans requires reviewing both the issue of depression and stress injury as well as the culture of the military population.

Depression in veterans can be categorized as both diagnosed and undiagnosed. Stress and anxiety are symptoms of depression, and depressive conditions are closely related to trauma and stress-related disorders like Posttraumatic Stress (PTS); the two often co-occur (American Psychiatric Association, 2013). Diagnosed depression is subject to semantic debate in the military community, and symptom overlap between depressive conditions and stress injuries often leads to misdiagnosis or confusion about co-occurring conditions (US Department of Veterans Affairs, 2014). Professionals discussing the same stress injury symptoms may refer to PTS or the less-popular Posttraumatic Stress Disorder (PTSD), stress reaction, battle fatigue, operational stress, or shell shock (Hoge & Castro, 2012). These trauma and stress disorder diagnoses are often accompanied by symptoms of depression in varying degrees of severity, and this co-occurrence may or may not be understood, recognized, and diagnosed (American Psychiatric Association, 2013; Hoge & Castro, 2012).

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Over 19 million people in the United States are reportedly diagnosed with depression, while others suffer without diagnosis (Hendricks Thomas, 2015). The Department of Defense and the Veterans Health Administration have made combatting depression a major priority, specifically because it is a known predictor of suicide (Bossarte, 2013). Careful study of suicide risk in the military population compared to the general population shows that suicide risk is almost four times higher among young veterans than their non-serving peers, a difference made more statistically significant when analysis controls for age and time in service (Bossarte, 2013). Internationally, numbers indicate the same. A British study of recent combat veterans found the risk of suicide to be 2-3 times higher for military members than the general population, with the year immediately following discharge being a particularly risky time (Ilgen et al., 2012).

Social workers, health promoters, and psychologists need to advocate for new treatment protocols and a paradigm shift to sharpen focus on prevention in order to change these numbers (Spelman, Hunt, Seal, & Burgo-Black, 2012). While clinical health services exist for service members with existing mental health conditions like PTS, they are not stemming the rising tide of service suicides. A new approach is required, one that shifts the focus towards training and prevention and speaks to the participatory, hard-working ethos of military culture (Libby, Corey, & Desai, 2012).

A research basis exists for mindfulness-based training protocols grounded in resiliency theory. Studying resilience involves identifying the protective personality traits and behaviors that promote growth and looking for practical ways that programming can strengthen and encourage such traits (Richardson, 2002). Original research on resiliency theory came out of the fields of social work and social psychology, but unlike more problem-oriented theories, it came about after inquiry into characteristics demonstrated by survivors of trauma. Researchers first began by asking the question of why some survivors fared better after difficulty than others who experienced the same events. Based on three decades of research on children labeled "at-risk," Werner and Smith (1982) found that 36% of those children were thriving and achieving success in school, professions, and relationships. They self-reported high levels of happiness and quality of life among other similar qualities and personality indicators, and Werner codified these as resilient traits. Children who tested as socially responsible, adaptable, tolerant, and achievement-oriented seemed to thrive, especially if they also had excellent communication skills and high self-esteem (Werner & Smith, 1982).

Researchers reported findings that were both practically and statistically significant regarding individuals' ability to self-correct, demonstrate confidence, and exude sociability. These resilient characteristics helped them to thrive despite dire circumstances and trauma histories (Heavy Runner & Marshall, 2003). Key identifiable traits make a person resilient (Hendricks Thomas, 2015; Richardson, Neiger, Jensen, & Kumpfer, 1990). Researchers interested in psychological and social determinants of health picked up the concept of resilience and have gradually extended its use from the domain of mental health to health in general. Early work on resilience was concerned with the individual, but more recently researchers have become interested in resilience as a feature of whole communities. Resilient traits can be taught, but this does not happen in a vacuum. Cultural analysis to ensure applicability is vital. Third wave Resiliency Theory works to apply

questions of environment and culture to any study of individual resilient traits, with the goal being more effective cultivation of those traits by focusing on building them within supportive communities invested in doing the same (Fletcher & Sarkar, 2013; Richardson, 2002). The dialogue surrounding resilience is well-suited to training of the military population.

Training protocols differ from treatment prescriptions and address the problem preventively, without the same stigma barriers. These protocols would be best implemented in participatory fashion in the training environment, rather than in treatment settings. Veterans often reject patient identities, which creates a major barrier to mental health care with this population (Hendricks Thomas, 2015). To combat suicide rates and promote military and veteran mental health, a new approach is required, one that embraces peer education and speaks to a competitive and individualistic military culture (Kobau et al., 2011; Seaward, 2004).

Within the military community, much of the issue lies neither in lack of screening for depressive disorders, nor in the medical care available to service members suffering from depression. Rather, the challenge is getting veterans to avail themselves of treatment services (Currier, Holland, & Allen, 2012; Elnitsky et al., 2013; Koo & Maguen, 2014). In one post-deployment study, 42% of screened reserve and National Guard soldiers answered questions in such a way that they were flagged as being in need of evaluations and possible treatment (Greden, et al., 2010). However, only half of those soldiers referred sought treatment. Only 30% of those that sought treatment followed the basic program through the full eight sessions (Greden, et al., 2010). Part of the issue is the stated disconnect combat veterans feel from civilians, even civilian mental health professionals who treat the military population (Malmin, 2013). Service members and veterans often feel they are wasting their time dealing with people who cannot relate to their perspective and may actually feel more comfortable in the war zone (Hoge, 2010).

Warrior subculture tends to promote the belief that acknowledging emotional pain is synonymous with weakness and specifically, that asking for help for emotional distress or problems is unacceptable (Malmin, 2013). Depressed veterans face inexorable stigma when it comes to care-seeking for a possible or confirmed condition because of the normative values held within the warrior subculture. Culture is an important factor that shapes individual behavior through customized sets of attitudes, beliefs, and values shared by a large population (Shiraev & Levy, 2010). One's surrounding social norms play a vital role in shaping the attitudes and beliefs commonly used to delineate and define culture. In insular and intense communities, normative values can become highly prescriptive and are enforced in a myriad of intangible ways. Emotional norms become disciplinary tools, rendered more effective in communities with high levels of adherence to hierarchy (Ahmed, 2010). Especially in military communities that promote competitive individualism, this allows the expectations of others to weigh heavily on warriors' shoulders. The result of such a firmly entrenched value system is shame associated with patient identity and mental health conditions. According to social worker and grounded theory researcher Dr. Brené Brown (2012), warrior culture is opposed to vulnerability and sees outreach as weakness. Yet, vulnerability is in fact critical to healing and self-knowledge (Brown, 2012).

Program Recommendations

Resilient Trait Cultivation Through Mindfulness

Mindfulness interventions teach participants unique methods for improving their own ability to regulate their nervous system and calm the body's fear receptors (Nassif, Norris, Gomez, Karch, & Chapman, 2013). The term has become in vogue, and many branded phrases are used to describe the sorts of mindfulness interventions used to treat patients (Meredith et al., 2011). Typically, such interventions involve still, seated meditation, physical movements of varying difficulty levels, and instructional seminars on individual peace, spirituality, and stress management (Hendricks, Turner, & Hunt, 2014; Seaward, 2004). Interventions using mindfulness have met with tremendous success and have been used to improve mental health outcomes in a variety of populations (van der Kolk, 2014).

Timing and Framing

Rather than operating from a paradigm of post-incident therapeutic intervention, social workers and health programmers who wish to maximize efficacy within the confines of warrior culture must alter the conversation to one of preparation and training pre-incident. Training in mindfulness focuses on building agency and resilience and can ameliorate the problem of stresses due to deployment both before and after the tour (Ryan, 2012). Creating a climate of peer-led training at both the unit and individual levels will reduce overall stigma against self-care practices because everyone participates, the program is led by trusted informants, and no one has to take on a patient role to participate. To train is to actively participate, and this is a wellness concept with which service members are already familiar. Framing mindfulness training as a way to bulletproof your brain renders palatable a training opportunity designed to create more effective warriors with mental endurance; framing this as promotion of combat fitness, resilience, and mental endurance makes it accessible to the military population (Ryan, 2012). Creating training protocols that emphasize connection and compassion over disassociation is important to maximize success (US Department of Veterans Affairs, 2014).

By establishing mental fitness as another component of optimal combat readiness, we establish mindfulness training as a crucial component of mission preparedness and remove the stigma of mindfulness treatments for post-deployment troops who may be struggling with stress illnesses of varying degrees. The message can become directive. Just as service members learn mission essential skills and train their bodies for arduous combat, we must adopt practices designed to train and promote a healthy mind. Turning to notions of empowered self-care, health promoters can modify stress management therapies to help them resonate with the military community.

Protocols

Stress injury can certainly be a result of a one-time traumatic experience, but it can also be a result of chronically elevated hormone levels that cause the nervous system to remain constantly on alert. Anyone subjected to recurring threats of death over time is at risk of developing issues because their stress response will be continually active. This

abnormal stress reactivity and chronic stress response elevation becomes a stress injury, or PTS in clinical circles. A fight or flight impulse that never goes away can wreak havoc on the human body.

The research basis for specific somatic treatment protocols exists (van der Kolk, 2014). Mindfulness interventions have been highlighted in community setting studies as effective in reducing stress and anxiety (Stevens, 2012) and in individual case studies looking at mindfulness and mood recovery (Jouper & Johansson, 2012). The Department of Defense has demonstrated the validity of yoga in Wounded Warrior recovery programs and is slowly expanding research partnerships with universities like the Uniformed Services University of Health Sciences and Johns Hopkins. Studies on one particular yoga *nidra* protocol (called iRest) at Walter Reed yielded positive qualitative feedback and resulted in a 3-week version being included in the treatment program at the deployment clinic (Hoge et al., 2008). In San Francisco, a qualitative study of 16 veterans with diagnosed PTSD completing an iRest course yielded positive findings (Stankovic, 2011).

Research from a team at the Mind Fitness Training Institute led to the development of mindfulness protocols in response to stress case studies conducted at the University of Pennsylvania. The research team found demonstrable changes to deployed service members' stress reactivity even when removed from the combat environment (Jha & Kiyanoga, 2010). Using a case study approach, the team studied long-term cognitive changes in Marines post-deployment, looking at how stress reactions either enabled or impaired mission effectiveness. They found that in Iraq, the intensity made sense because the fast-moving landscape of the contemporary combat environment trains service members to respond quickly and to spend most of their time in elevated states of alertness. Those states persisted up to two months after soldiers returned home. The team found the Marines struggling with focus, anxiety, and emotional outbursts (Jha & Kiyanoga, 2010).

Emotional reactivity is a hallmark symptom of a stress injury and can cause a vicious cycle of problems for sufferers as they create rifts in their support relationships (Hoge & Castro, 2012). Jha discovered that the reason for such reactivity is that long-term stress injury decreases working memory capacity (Jha & Kiyanoga, 2010). This higher-level brain function emotionally regulates humans, allowing for bonding and social interaction. Working memory capacity also makes advanced, intellectual activities possible. Losing working memory capacity can cause a host of emotional and behavioral problems and result in major issues with attention, focus, and regulation of responses. In studies, deployment adversely impacted the working memory capacity of study participants (Jha & Kiyanoga, 2010; Vasterling et al., 2006).

Interestingly, high stress reactivity, naturally-occurring adaptation though it may be, hinders the ability of service members to perform complex missions and interact with foreign nationals. The modern battlefield involves interaction with civilians and allies as a matter of course (Hoge, 2010). Becoming overly reactive as a response to environment hinders that mission. For example, soldiers who screened positive for mental health problems were three times more likely to report having engaged in unethical behavior while deployed (Jha, Stanley, Kiyanoga, Wong, & Gelfand, 2010). Behaviors ranged from unnecessary property damage to noncombatant injury or harm, all diametrically opposed

to the United States' mission of winning hearts and minds. Improving stress regulation allowed study participants to bond and interact with one another socially and made advanced, intellectual activities and focus possible (Jha et al., 2010).

The Mind-Fitness Training Institute team conducted a specific study on a company of Marines during pre-deployment work-ups, seeking to answer the question of whether a mindfulness-based behavioral health intervention could improve the resilience of Marine Corps reservists preparing for a tour in Iraq. Employing a mixed-methods approach to the instrumental case study, the researchers studied one unit of 34 reservists. In addition to the normal training required before heading overseas, these reservists underwent a carefully tailored yoga and mindfulness program designed to improve their ability to manage both chronic and acute traumatic stress (Teng et al., 2013). Study results were statistically significant, as participants demonstrated that adherence to intervention protocol for 15 minutes each day exponentially improved their working memory capacity (Teng et al., 2013).

Other researchers have followed the path of the Mind-Fitness team and attempted to validate specific interventions for the military community incorporating mindfulness practices. A 2011 RAND analysis commissioned by the Office of the Secretary of Defense conducted a systematic evaluation of existing programs in different branches of service. A noted finding of the study was that few programs currently being delivered in piecemeal fashion have any formal evaluation plan in place, though almost all those interviewed saw the need for longitudinal studies to determine the effectiveness of their programs (Foran, Adler, McGurk, & Bliese, 2012; Teng, et al., 2013).

Peer Leadership

Because of military culture insularity and lack of communication between bureaucratic treatment agencies, programs that seek to collaborate, bridge gaps, and use peer leadership meet with real success (Greden et al., 2010). Understanding culture and delivering a product specifically targeted to the military is important; allowing for participatory implementation of a given program is vital. In the military community, the best program implementation cases are found within participatory research frameworks. Warrior subculture creates a powerful mandate for peer-to-peer outreach. Any message aimed at decreasing stigma must come from members of the community in order to be deemed credible. Recall that a major symptom of separating service members, especially after a combat deployment, is a feeling of disconnect from civilians (Hoge, 2010). Because warrior cultures have their own temperaments, they are typically exclusive and mistrustful of outsiders with different life experiences (Malmin, 2013).

A 2010 case study highlights one Michigan pilot program's experience with buddy-to-buddy peer support programs. A team from the University of Michigan and Michigan State worked with the Army National Guard (ANG) to address the constellation of issues facing soldiers returning from a deployment to Iraq. National Guard soldiers, like all reservists, often face stresses additional to those faced by active duty troops. Reservists do not come from as insular of a military community and may lack support services in civilian community settings. Particularly because PTS symptoms are very likely to be misread as

behavioral deviance, stigma may be even more difficult to overcome in community settings removed from the active duty military component (Greden et al., 2010).

The University of Michigan researchers also understood the need for audience-centered communication and partnered with unit leadership to institute a program that was completely peer-led. This decision came out of the qualitative research they conducted in the unit prior to developing a program. Interviewees said things like, "if you haven't been there, you don't get it" and "other veterans can be trusted" (Greden, et al., 2010, p. 93). The research team considered concepts of warrior culture and sought to design a program that spoke the correct language, using an understanding of social norms to change the culture of treatment avoidance (Greden et al., 2010). The researchers trained 350 peer leaders called "Buddy Ones" by the program. One returning unit participated in the program. Preliminary results were encouraging. Ninety percent of participants understood program intent, received regular calls and contact from their buddies, and felt comfortable with their trained peer. More than 20% were referred to formal treatment by their buddy, and that percentage all affirmed using the recommended services. As a pilot study, the Michigan buddy program is light on long-range evaluation results but advances greatly the notion that attention to warrior culture, unit-specific language, peer leadership, and insider message delivery can aid in suicide prevention (Greden et al., 2010). A focus on stigma-reduction can lead to improved rates of treatment-seeking. When working within the boundaries of warrior culture and so improving treatment-seeking by reducing existing barriers is of paramount importance (Hendricks Thomas, Turner et al., 2015; Tanielan & Jaycox, 2008).

Research and program efforts in the training environment must be participatory and peer-led whenever possible (Hendricks Thomas, Plummer Taylor, Hamner, Glazer, & Kaufman, 2015). As has been demonstrated successfully in recovery communities, peer mentoring and leadership provides the interaction, camaraderie, and instructor credibility required to encourage participation in an intervention with potentially recalcitrant participants in very specific, insular, or marginalized communities (Gosan & Dustman, 2003). Mindfulness programs, with their focus on individual agency and training to control the nervous system, have unique appeal to military-connected personnel who embrace notions of agency and actively avoid patient identity (Hendricks Thomas, 2015). By promoting mental fitness training, mindfulness programs work around the boundaries erected by warrior culture. In truth, warrior culture can distort critical thinking and good judgment in cases where warriors suppress emotional pain, fail to apply sound cognitive thinking, do not acknowledge real health or wellness issues, and intentionally choose not to seek help that might remedy a mental health problem. If strength is a virtue, becoming a patient is antithetical to being virtuous (Malmin, 2013).

Conclusion

Case studies of existing programs provide the foundation upon which savvy programmers must build. Health promotion professionals working to prevent and treat mental health problems like depression and stress illness must understand the confluence of warrior culture and mental health issues in the veteran community. While the research literature does not yet address this confluence issue directly, it contains ample evidence to

support the development of a culturally-informed mindfulness training protocol. This protocol would be best implemented in participatory fashion in the training environment, rather than solely in treatment settings.

Current initiatives such as the Air Force *Resiliency Training* program, the Army's *Total Force Fitness*, and the Marine Corps' *Operational Stress Control and Readiness* program endeavor to train in the short-term and rely primarily on the classroom setting. Importantly, the training programs involve information dissemination without the inclusion of performance metrics that commanders can rely upon to track unit progress. Service members often reject patient identities, which creates a major barrier to mental healthcare in this population. To combat suicide rates and promote military and veteran mental health, a new approach is required, one that embraces peer education and speaks to the participatory, hard-working ethos of military culture. Mindfulness-based programming has the potential to meet these needs, and may provide a blueprint for success in working with the military population.

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