2019

Mindfulness, meaning-making, and resilience among recently returned veterans: development of a workshop and preliminary manual

Joshua Buch

Recommended Citation

Pepperdine University

Graduate School of Education and Psychology

MINDFULNESS, MEANING-MAKING, AND RESILIENCE AMONG RECENTLY

RETURNED VETERANS: DEVELOPMENT OF A WORKSHOP AND PRELIMINARY

MANUAL

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Joshua Buch

August, 2019

Shelly P. Harrell, Ph.D. - Dissertation Chairperson

This clinical dissertation, written by

Joshua Buch

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Shelly P. Harrell, Ph.D., Chairperson

Sharon Birman, Psy.D.

Aaron Aviera, Ph.D.

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DEDICATION

"This is what should be done by one who is skilled in goodness
And who knows the path of peace:
Let them be able and upright, straightforward and gentle in speech,
Humble and not conceited, contented and easily satisfied.
Unburdened with duties and frugal in their ways.
Peaceful and calm, and wise and skillful,
not proud and demanding in nature.

Let them not do the slightest thing that the wise would later reprove.
They should wish:

 In gladness and in safety
 May all beings be at ease.
 Whatever living beings there may be,
 Whether they are weak or strong, omitting none,
 The great or the mighty, medium, short or small,
 The seen and the unseen,
 Those living near and far away,
 Those born and to-be-born,
 May all beings be at ease!
 Let none deceive another, or despise any being in any state,
 Let none through anger or ill-will wish harm upon another.

Even as a mother protects with her life her child, her only child,
So with a boundless heart should one cherish all living beings,
Radiating kindness over the entire world,
Spreading upwards to the skies, and downwards to the depths,
Outwards and unbounded, freed from hatred and ill-will.

Whether standing or walking, seated or lying down,
Free from drowsiness, one should sustain this recollection."

- Metta Sutta

This work is dedicated to all beings. May it reduce suffering even just slightly.

ACKNOWLEDGMENTS

EDUCATION

Pepperdine University, Graduate School of Education and Psychology *(APA Accredited Program)*
Los Angeles, California
Doctor of Psychology in Clinical Psychology   Expected June 2019

> **Dissertation Title:** *Mindfulness, meaning-making, and resilience among returned Veterans: Development of a workshop and preliminary manual.*
>
> **Committee Members:** Shelly Harrell, Ph.D., Sharon Birman, PsyD., Aaron Aviera, Ph.D.
> **Dissertation Status:** Passed Preliminary Oral Examination October 2, 2017
>
> **Clinical Competence Examination:** Passed May 23, 2017

California State University
Northridge, California
Masters of Arts in Clinical Psychology
May 2014

> **Thesis Title:** *The Relationship between mindfulness, anxiety and depression in long-term twelve-step program participants.*
> **Committee Members:** Dee Shepherd-Look, Ph.D., Andrew Ainsworth, Ph.D., Matthew Brensilver, Ph.D.

California State University
Northridge, California
Bachelors of Arts in Psychology
May 2012

CLINICAL / MENTAL HEALTH EXPERIENCE

Psychology Pre-doctoral Intern
Veterans Affairs Loma Linda Health Care System, Loma Linda, CA
Primary Rotation - Dual Diagnosis Intensive Outpatient Program (August 2018 – January 2019)
Clinical Supervisor – Scott Wenger, Psy.D

- Provide evidence-based individual and group psychotherapy for Veterans with substance use disorders and psychiatric comorbidities.
- Provide individual psychotherapy to address symptoms of substance use disorders, depression, anxiety, posttraumatic stress, personality disorders, and issues of gender identity.
- Facilitated weekly mindfulness meditation group.
- Facilitated motivational interviewing groups to evaluate and bolster readiness for treatment.
- Facilitated long-term process groups.
- Co-facilitated weekly harm-reduction groups.
- Co-facilitated weekly CBT for depression group.

- Supervised practicum student and engaged in weekly supervision of supervision.

Evidence-Based Practices Clinic (August 2018-August 2019)
Clinical Supervisors – Jason Goldstein, Ph.D and Kendra Tracy, Ph.D
- Deliver course of Cognitive Processing Therapy.
- Provide weekly individual Acceptance and Commitment Therapy.
- Participate in weekly group supervision.

Long-term Psychotherapy Clinic (August 2018-August 2019)
Clinical Supervisors – Bryan Goudelock, Ph.D and Scott Wenger, Psy.D
- Provide individual, long-term psychodynamic psychotherapy to a Veteran with severe personality pathology.
- Participate in weekly group supervision.
- Regular discussion of articles related to interpersonal neurobiology and relational/psychodynamic theory.

Assessment Clinic (August 2018-August 2019)
Clinical Supervisor – Tyson Chung, Ph.D
- Participate in weekly group supervision.
- Present case conceptualization of assessment case.
- Didactics on assessment instruments (e.g. PAI, MCMI, MMPI-2, Rorschach).

Psychology Pre-Intern (September 2017-June 2018)
West Los Angeles Veterans Affairs Health Care Center, Westwood, CA
Cognitive Behavior Therapy for Psychosis Clinic
Clinical Supervisors – Najwa Culver, PhD. and Susanna Friedlander, PhD
- Provide adjunctive evidence-based individual psychotherapy, including the utilization of CBT for Psychosis and ACT to Veterans with persistent psychotic symptoms despite psychopharmacological intervention.
- Facilitated CBT group on inpatient psychiatry unit.
- Facilitated ACT group on inpatient psychiatry unit.
- Provided consultation to interdisciplinary medical team.
- Utilize CPRS to access Veteran medical records and write psychotherapy progress notes.
- Engage in weekly didactics
- Engage in weekly individual and group supervision which includes case formulation and review of audio-recorded sessions.
- Common co-morbidities include: mood disorders, anxiety disorders, substance use disorders, social skills deficits.

Psychology Extern (September 2016-present)
Rancho Los Amigos National Rehabilitation Hospital, Downey, CA
Clinical Supervisors – Serina Hoover, Psy.D and Rajarathnam Sainath, Psy.D
- Provided psychological services for patients undergoing acute inpatient rehabilitation for catastrophic injuries.
- Provided consultation to interdisciplinary medical team.
- Conducted intake evaluations for inpatients with spinal cord injuries and/or traumatic brain injuries.

- Provided evidence-based, supportive psychotherapy for inpatients with spinal cord injuries and/or traumatic brain injuries to facilitate adjustment, medical compliance, and engagement in rehabilitation.
- Co-treated with physical and occupational therapists.
- Administered cognitive screeners.
- Administered neuropsychology assessments (e.g. RBANS, NCSE, Trail Making Test, MS Aphasia, etc.)
- Engaged in weekly interdisciplinary medical team meetings.
- Provided consultation for interdisciplinary team.
- Facilitated classes on adjustment to spinal cord injury.
- Participated in weekly didactics.
- Conducted case presentations of patients.
- Wrote diagnostic intake reports and psychotherapy notes.
- Common pre-morbid psychological conditions included substance use disorders, personality disorders, psychotic disorders, mood and anxiety disorders.

Psychology Extern (September 2015-July 2017)
Union Rescue Mission, Pepperdine Counseling Center, Los Angeles, CA
Clinical Supervisor – Dr. Aaron Aviera, Ph.D.
Provided short and long-term psychotherapy with culturally diverse clients who are in a residential homelessness and substance abuse recovery program located in downtown's "Skid Row" area.
- Conducted psychodiagnostic intake evaluations and developed treatment plans in collaboration with clients.
- Provided evidence-informed individual psychotherapy on a weekly and/or bi-weekly basis.
- Co-facilitated a weekly mindfulness meditation group.
- Wrote diagnostic intake reports.
- Wrote weekly psychotherapy notes.
- Consulted with on-site Psychiatric Mental Health Nurse Practitioner (DNP) regarding psychotropic medication.
- Engaged in weekly individual, group, and peer supervision which includes case presentation and review of audio-recorded sessions.
- Common presenting problems included: Substance use disorders, trauma/stress disorders, mood disorders, psychotic disorders, personality disorders, cognitive disorders, anger management, and anxiety disorders.

In-Home Outreach Counselor (2014-2015)
Family Preservation, Strength United (formerly Valley Trauma Center), Northridge, CA
Supervisor – Clovis Emblen, MFT
- Provided ongoing, weekly counseling and therapy for families with open Department of Children and Family Services cases due to domestic violence, sexual abuse, substance abuse, or neglect.
- Wrote weekly and monthly reports based on therapeutic sessions.
- Engaged in multidisciplinary case planning.
- Engaged in weekly supervision.

- Participated in continuing education of evidence-based practices, including Trauma Focused – CBT, Trauma-Focused CBT with Childhood Traumatic Grief, and Cognitive Processing Therapy.

Assistant Clinician (2012 to 2014)
Assessment Clinic, California State University, Northridge
Supervisor – Dr. Gary Katz, Ph.D.
- Administered and scored cognitive and achievement assessments (e.g. WISC-IV, WAIS-IV, WJ-ACH III) to children, young adults, and adults with cognitive impairments, learning disabilities, and giftedness.
- Wrote reports based on medical, developmental and academic history and current assessments.

<div align="center">RESEARCH & SCHOLARSHIP</div>

Conference Presentations

Skulstad, H., **Buch**, J. (January, 2017). Contemplative Practices for Resilience: Attention Regulation, Meditation and Mindfulness. In S. P. Harrell (Chair) *Getting some R&R: The "Resilience and Reconnection" Group Intervention as a Positive Psychology Approach to Stress Management.* Symposium presented at the Western Positive Psychology Association, Claremont, CA.

Harrell, S., Styles, J., Skulstad, H., Rumburg, T., Rowland, L., **Buch**, J., Alnatour, R. (January, 2017). *Allies, Awareness and Action: Three pillars of resilience as a culturally-adaptive model for positive psychological interventions.* Poster session presented at the Western Positive Psychology Association, Claremont, CA.

Buch, J., Ainsworth, A., & Shepherd-Look, D. (November, 2014) *The relationship between mindfulness, anxiety and depression in long-term Twelve-Step program participants.* Poster session accepted at the annual Southern California Public Health conference.

Buch, J., Seegan, P., & Plunkett, S. W. (2013, October). *Parenting-child conflict, meeting parents' expectations, internal cognitions, and Latino emerging adults' depression.* Poster session presented at the Society for the Study of Emerging Adulthood, Chicago, IL.

Petrospour, S., Picanso, J., **Buch**, J., & Plunkett, S. W. (2013, October). *The relative importance of family qualities in relation to Latino emerging adult's mental health.* Poster session presented at the Society for the Study of Emerging Adulthood, Chicago, IL.

Buch, J., Rozner, L., Morales, J., Gardner, C., & Hopkins, J. (December, 2011). *Effects of brief mindfulness practice on heart rate and subjective anxiety.* Poster session presented at the annual PSI CHI Research Competition, California State University Northridge.

Research Assistant (2016-present)
Harrell Research Lab, Psychology Department, Pepperdine University, Los Angeles, CA

Supervisor – Dr. Shelly P. Harrell, Ph.D.
- Assisted with research that focused on the relationship between meditation practices and resilience.
- Conducted literature review on military culture for Continuing Education program for psychologists.
- Participated in the development of a stress management/resilience group intervention.

Research Assistant (2012 - 2014)
Adolescent and Adult Adjustment Lab, Psychology Department, CSUN, Northridge, CA
Supervisor – Dr. Scott Plunkett, Ph.D.
- Assisted with research that focused on the relationship between family characteristics and the mental health of adolescents and emerging adults
- Coded, entered, and verified self-report, survey data
- Wrote and edited SPSS syntax
- Conducted literature reviews on the GAD-7 (generalized anxiety disorder scale) and family dynamics (e.g., cohesion, flexibility, time, hardiness)

<div align="center">

TEACHING EXPERIENCE
</div>

Doctoral Peer Supervisor
Pepperdine Community Counseling Center – Los Angeles, CA (September 2017 – June 2018)
Supervisor: Aaron Aviera, Ph.D.
- Hand-selected to provide individual peer supervisor to beginning and intermediate doctoral-level psychology trainees offering psychological treatment at the Union Rescue Mission, Pepperdine Counseling Center.
- Provide one hour of supervision to each trainee weekly, utilizing a competency-based consultation approach, including comprehensive feedback on intake reports, case notes, and audiotaped therapy sessions.
- Collaboratively develop training goals with consultees for the year related to diagnosis, conceptualization, treatment intervention, crisis management, and legal/ethical issues.
- Discuss a variety of issues with trainees, including documentation, professional development, maintaining appropriate boundaries, managing countertransference, and therapeutic techniques.
- Attend weekly supervision-of-supervision and didactics of supervision theory to enhance competencies.

Graduate Pedagogical Assistant (Fall 2013)
Undergraduate Pedagogical Assistant (Fall 2011)
Psychology Department, CSUN, Northridge, CA
- Assisted with *PSY 610a: Advanced Child Psychopathology*, *PSY 625a: Advanced Child Psychological Assessment,* and *PSY 460: Counseling and Interviewing*
- Assisted students with assignments and in-class activities
- Proctored exams and graded assignments
- Held office hours
- Used "Moodle" (i.e., online course management system) to enter grades and attendance

Invited Lectures

Buch, J. (2016, September). *The clinical utility of mindfulness*. Guest lecture presented for PSY 704: Cognitive and Affective Basis of Behavior, Pepperdine University.

Buch, J. (2016, May) *Utilizing mindfulness practices with people experiencing homelessness.* Guest Presentation at Union Rescue Mission, Los Angeles, CA.

Buch, J. (2013, April). *Mindfulness in counseling and psychotherapy*. Guest lecture presented for PSY 460: Counseling and Interviewing, CSUN.

PROFESSIONAL AFFILIATIONS

American Psychological Association (Division 19 – Military Psychology)
Psi Chi International Honor Society

ADDITIONAL TRAININGS/CERTIFICATIONS

Three-day Training in Cognitive Processing Therapy — (2018)
VA Loma Linda Healthcare System, Loma Linda, CA

Working with Gender and Sexual Minority (GSM) Veterans — (2017)
West Los Angeles Veterans Affairs Health Care Center, Westwood, CA

Beyond Sensitivity: Integrating Culture and Context in the Psychological Care of Veterans. — (2016)
West Los Angeles Veterans Affairs Health Care Center, Westwood, CA

On-line Training Course for Trauma-Focused Cognitive-Behavioral Therapy — (2016)
Medical University of Southern Carolina

On-line Training Course for Cognitive Processing Therapy — (2015)
Medical University of Southern Carolina

On-line Training Course for Trauma-Focused CBT with Childhood Traumatic Grief — (2015)
Medical University of Southern Carolina

Human Participants Protection Education for Research Teams — (2013)
National Institutes of Health

ABSTRACT

Many military veterans experience a variety of mental health problems. Some are combat-related, others psychosocial, and yet others related to a loss of meaning and purpose in their lives when they shed their military lifestyle and identity. The purpose of this study was to design an intervention for recently returned veterans which would concurrently target the most common debilitating mental health and adjustment problems. Literature was extensively reviewed, as were related and empirically established interventions. A mindfulness and meaning-focused half-day workshop was then created. Additionally, a manual was developed to help licensed mental health professionals who work with veterans implement the mindfulness and meaning-focused intervention. This manual was reviewed by three evaluators: a U.S. veteran of recent wars, a mindfulness meditation expert, and a psychologist who has spent his entire career within the Veterans Health Administration. They all evaluated the manual based on ease and understandability for a facilitator, as well as fidelity to theory, and utility for actual veterans. Their feedback was incorporated into future directions of the workshop and manual, which included more explicitly incorporating emotion regulation strategies, being more intentional with ancillary activities (e.g. breaks), and lengthening the program over time in order to better establish group alliance and bonding. Implications for research and practice are discussed.

Chapter I: Introduction and Literature Review

Introduction

There is significant incidence of psychopathology directly and indirectly related to war (Litz & Orsillo, 2003). As the United States has been involved in multiple wars for well over a decade, there are many service members still enlisted in the military or those who have been recently discharged (i.e., new veterans) who will incur psychopathology. As the U.S. remains involved in military conflict, we continue to have people who have yet to be exposed to the potentially traumatic conditions of combat. In order to promote psychological health in the face of intense stress for such individuals, there are been various efforts made to develop and research interventions which promote resilience (e.g., Harrell, 2016; Stanley, 2014).

This project aimed to develop a program designed by synergizing various resilience-promoting theories and interventions in order to create a post-deployment, half-day-long, debriefing workshop. This is meant to prevent latent, war-related psychopathology from developing to the end of aiding veterans in continuing to live positive lives of success and well-being, along with helping continuing service members to have more productive and conscientious subsequent deployments.

Veteran mental health. Being exposed to combat can elicit various stress reactions such as withdrawal, paranoia, anxiety, and interpersonal problems (Litz & Orsillo, 2003), with 25%-56% of VA-utilizing combat veterans reported difficulty in social functioning, productivity, and community involvement (Sayer et al., 2010). Consequently, military personal who have experienced combat-related stressors are at high risk for developing anxiety disorders, substance use disorders, depression, and posttraumatic stress disorder, along with impairments in social, occupational, and physical functioning (Hoge, Auchterlonic, & Milliken, 2006). Indeed, among

Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF; Afghanistan)/Operation New Dawn (OND) veterans, 23% report symptoms of PTSD (Fulton et al., 2015).

While suicide rates of veterans do not appear to be statistically significant from the general U.S. population (Kang & Bullman, 2008), the estimated rate of 20 veteran suicides per day (Veterans Health Administration, 2016) has galvanized the Department of Defense and the Department of Veterans affairs to make suicide prevention a priority (Veterans Affairs & Department of Defense, 2013). Importantly, service members returning from OEF and OIF are increasingly dying by suicide (Katz, McCarthy, Ignacio, & Kemp, 2012). It appears that subgroups who have other mental illness and/or exposure to trauma during their service are at particular risk of suicide (Kang & Bullman, 2008). Indeed, veterans with PTSD experience higher rates of suicide ideation and behavior than veterans without PTSD, even when controlling for age, depression and substance abuse (Calabrese et al., 2011; Jakupcak et al., 2009).

In a study of suicide and PTSD in the veteran population, Legarreta et al. (2015) found that suicidal ideation and attempts predicted meeting criteria for PTSD. Further, after controlling for subjects with traumatic brain injury, those who reported suicide attempts more often endorsed the following PTSD symptoms: avoidance of thoughts and feelings (Cluster C in the DSM-5), persistent negative beliefs, diminished interest, feelings of detachment from others, and the inability to remember an important aspect of their trauma (Cluster D in the DSM-5). Notably, 78.8% of these subjects reported having experienced a TBI, 51.5% reported having a diagnosed major depressive disorder at some point in their life, and 46.6% reported having a substance use disorder. A meta-analysis of deployment-related predictors with suicide-related outcomes found that killing, and exposure to death and atrocities had the largest effect in predicting suicide-related behaviors (Bryan et al., 2015).

In a sample of non-veteran patients with PTSD, Tarrier and Gregg (2004) found that 8.3% reported experiencing suicidal ideation, 8.5% reported definite plans associated with suicide, and another 9.6% reported a suicide attempt. In a community sample of people with PTSD, avoidance, re-experiencing, and numbing symptoms were correlated with suicide behaviors (Panagioti, Gooding, Taylor, & Tarrier, 2013).

Morally injurious experiences are defined as witnessing, committing, or being the victim of an act that violates moral beliefs/values. Of 122 active duty personnel seeking PTSD treatment, 12% divulged they had committed a morally injurious act while 22% stated witnessing or being the victim of such an act was the most traumatic experience for them (Stein et al., 2012). While often not morally injurious, taking a life in combat has been demonstrated to increase the risk for PTSD, depression, and suicidality (Maguen et al., 2009) while committing acts of abusive violence as well, which are much more likely to be subjectively experienced as morally injurious acts do as well (Currier, Holland, Jones, & Shea, 2014).

PTSD symptoms in Vietnam Era combat veterans was associated with higher intimate partner violence (Orcutt, King, & King, 2003). Moreover, high levels of perceived threat were also directly and indirectly (via PTSD pathways) associated with intimate partner violence, which is consistent with findings (Holtzworth-Munroe & Hutchinson, 1993) demonstrating that male perpetrators of intimate partner violence experience higher degrees of hostile intentions from their partner. This may suggest a PTSD-influenced dysfunction of empathic discernment, which creates a higher degree of perception of antagonistic intentions in other people, leading to higher levels of violence. Aside from higher levels of violence, the ability to connect well to loved ones may be interrupted in veterans with symptoms of post-traumatic stress; isolation and loneliness partially explained the relationship between higher levels of PTSD symptoms and

marital adjustment (Itzhaky, Stein, Levin, & Solomon, 2017). This suggests that despite being in a relationship, veterans with PTSD symptoms may find it difficult to connect with their loved ones and may feel lonely despite physical proximity to a spouse.

The psychological consequences of war and trauma have been found to impede marital relationships (Nelson Goff, Crow, Reisbig, & Hamilton, 2007; Taft, Watkins, Stafford, Street, & Monson, 2011). While marriage is usually a protective factor against loneliness, veterans may have difficulty sharing their war-related experiences with their loved ones and consequently feel disconnected from them (Stein & Tuval-Mashiach, 2015). This may partially explain why many studies continually suggest that loneliness is a feature of being a veteran, years after one transition into civilian life (Kuwert, Knaevelsrud, & Pietrzak, 2014).

Bullman, Schneiderman, and Bossarte (2018) found that veterans who had been active duty had a 56% increased risk of suicide while reserve and National Guard veterans had a 29% increased risk as compared to the US civilian population. The authors suggest this difference may be linked to potentially age-related lower levels of social integration, employment, and marriage in the active duty group, as being married, having a family, and being employed have been found to lower the risk of suicide (Blakely, Collings, & Atkinson, 2003; Kposowa, 2000; Thoresen, Mehlum, Røysamb, & Tønnessen, 2006). Supporting this is the fact that Reserve/National Guard veterans have been less reliant on the military for both social and economic support, thereby making a transition into full civilian life less disruptive. As such, veterans who were active duty have a larger task of re-establishing or creating social networks, and discovering means of employment, as their entire lives were subsumed by the military for the duration of their service. This also suggests a potential need to psychologically digest and make meaning of an entire encapsulated era of a veteran's military experience if they were active

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duty. Additionally, aid with meaning in life and civilian identity appears to be a more important factor for those veterans who were active duty.

Two thirds of veterans who participated in writing about reintegration difficulties wrote about identity adjustment. The five components of identity adjustment difficulty were (a) feeling like one does not belong in civilian society, (b) missing the military's culture and structured lifestyle, (c) holding negative views of civilian society, (d) feeling left behind compared to civilian counterparts due to military service, and (e) having difficulty finding meaning in the civilian world (Orazem et al., 2017). Many veterans noted that in contrast to the sense of responsibility in protecting one's comrades or subordinates from harm, the responsibilities inherent in civilian life seem unimportant and thus nearly meaningless and dissatisfying (Orazem et al., 2017). While all of these themes underlie a sense of disconnection from the civilian world, many veterans believed they could be understood by fellow veterans.

In a study (Schonfeld et al., 2015) investigating adjustment to university life for service members and veterans, 28% reported difficulties adjusting. Among those finding it difficult to adjust to university life, there were significantly higher levels of PTSD, depression, and other mental health disorders (though, interestingly, not substance use). In a study of 628 students who were service members or veterans, 34.6% had severe anxiety, 23.7% severe depression, and 45.6% experienced significant symptoms of posttraumatic stress disorder (PTSD), and 46% had suicidal thoughts (20% reported having a plan). Over 98% of the participants were part of OIF/OEF/OND and 58% had been exposed to combat during a deployment.

Another significant problem amongst OIF/OEF/OND veterans are traumatic brain injuries (TBI), often related to exposure to improvised explosive devices (IEDs) and improved military armor technology which decreases the likelihood of death after such an exposure.   A

landmark study of 613,391 OIF/OEF/OND Veterans (Cifu et al., 2013) found that 9.6% of them received a TBI diagnosis within the three years of the study (2009, 10, and 11). Of those diagnosed, most had a mild TBI. TBI's have been positively correlated with suicidal ideation, attempts, and death by suicide in veterans (Brenner, Homaifar, Adler, Wolfman, & Kemp, 2009; Gradus et al., 2015; Gutierrez, Brenner, & Huggins, 2008). Interestingly, there is evidence that this increased risk of death by suicide is mediated by increased rates of anger, which then lead to depression; researchers have inferred that anger and depression are important therapeutic targets for veterans diagnosed with a TBI (Stanley, Joiner, & Bryan, 2017).

Lippa et al. (2015) revealed that of 225 veterans diagnosed with a military-related mild TBI, over 90% had a psychiatric or behavioral condition, with nearly half experiencing three or more conditions. Within this group, there were four main psychiatric presentations which emerged: (a) depression, PTSD, and military TBI, referred to as "deployment trauma factor" (pg. 25) (b) pain and sleep problems (c) non-PTSD anxiety disorders and (d) substance abuse or dependence. The "deployment trauma factor," (pg. 25) which is comprised of depression, PTSD, and military-related mild TBI appears to be an especially debilitating cluster with high levels of disability. Aside from this, the study indicates OEF/OIF/OND veterans typically present with multiple comorbid, interacting psychiatric diagnoses which call for integrated treatment interventions rather than isolating specific diagnoses for treatment (Lippa et al., 2015).

Of the OEF and OIF veterans assessed by the Pew Research Center, 44% reported readjustment difficulties, 48% reported strains on family life, 47% reported outburst of anger, and 32% reported occasional loss of interest in daily activities (Pew Research Center, 2011). Specifically, the readjustment difficulties that returning service members report are related to re-acclimating to home life, reconnecting with family, going back to school, and becoming

employed (Institute of Medicine, 2013). When service members return home to their partners, they must renegotiate roles, adjust to newfound proximity, and regulate the various effects of deployment on the relationship (Erbes, Polusny, MacDermid, & Compton, 2008; Faber, Willerton, Clymer, MacDermid, & Weiss, 2008). Indeed, soldiers who have recently returned from war are at high risk of being physically aggressive in their intimate partners (Milliken et al., 2007). While the impact of deployment on mental health varies across individuals (Hoge, Auchterlonic, & Milliken, 2006; King, King, Vogt, Knight, & Samper, 2006), many people experience worsening impairment upon returning from a deployment (Marx, Doron-Lamarca, Proctor, & Vasterling, 2009; Vasterling et al., 2006). In a VA sample of 754 OEF/OIF/OND veterans, 96% expressed interest in readjustment services (Sayer et al., 2010).

Preparation for military stress. Many months prior to overseas deployment, service members receive various types of training to prepare them for the specific types of missions they will encounter. This includes operational skills, additional physical training, as well as training related to stress management (Robson & Manacapilli, 2014). One form of this is stress-inoculation training, an adaptation of Meichenbaum's (1985) set of principals which are meant to educate about stress, control the stress response, and practicing skills under stressful conditions. In the military, such stress inoculation training is meant to habituate service members to various stressors they will likely encounter, such as live fire, explosions, darkness, confusion, and "downed" team-mates, all while attempting to execute specific tasks over time (Robson & Manacapilli, 2014). This exposure is meant to decrease stress during the real operations and increase one's confidence in the face of stress (Dienstbier, 1989; Meichenbaum, 1985), yet many people experience decreases in cognitive functioning and greater emotional disturbances during

this time period (Bolton, Litz, Britt, Adler, & Roemer, 2001; MacDonald, Chamberlain, Long, Pereira-Laird, & Mirfin, 1998; Maguen et al., 2008; see also Stanley & Jha, 2009).

Relationship between anxiety, depression, PTSD, suicide, and substance use.
Various addiction studies demonstrate that people with histories of anxiety and/or depression are at greater risk for developing substance use disorders (SUDs; Boschloo et al., 2011; Goodwin & Stein, 2013; Mohammadi, Aghajani, & Zehtabvar, 2011; Suttajit, Kittirattanapaiboon, Junsirimongkol, Likhitsathian, & Srisurapanont, 2012). Additionally, studies show that having an active substance use disorder increases the likeliness of developing an anxiety and/or depressive disorder (Boschloo et al., 2011; Goodwin & Stein, 2013).

In 2004, The National Epidemiologic Survey on Alcohol and Related Conditions (Grant, et al., 2004) concluded that "substance use disorders and mood and anxiety disorders that develop independently of intoxication and withdrawal are among the most prevalent psychiatric disorders in the United States" (pg. 107). NESARC-gathered survey data on 43,000 respondents using a structured diagnostic interview in order to better understand the relationship between SUDS, anxiety disorders and mood disorders. Respondents who had sought help for any substance use disorder, 60.31% and 42.63% had a comorbid mood disorder or anxiety disorder, respectively. Respondents who indicated they had obtained help for their alcohol use disorder in the past 12 months, 40.69% and 33.38% had a comorbid mood disorder or anxiety disorder, respectively.

In 2011, Netherlands Study of Depression and Anxiety (NESDA; Boschloo et al., 2011), half of participants with alcohol use disorder and a comorbid depressive disorder reported they had developed their alcohol use disorder subsequent to their depression. In 71.4% of people with comorbid alcohol use disorder and an anxiety disorder, the anxiety disorder was

primary. Comorbid alcohol use disorder was secondary 83.9% of the time for people with

concomitant depressive and anxiety disorders. Goodwin and Stein (2013) found that in their US-

based community sample (n = 5,788) that for 50% of social phobia, 40% of post-traumatic stress

disorder, and 30% of generalized anxiety disorder, the anxiety disorders were primary to

substance use disorders. Additionally, lifetime prevalence of PTSD strongly predicted lifetime

substance use disorders (Goodwin & Stein, 2013). Regardless of chronicity, it is clear that the

relationship between substance use disorders, depressive disorders and stress/anxiety disorders is

reciprocal, complicated, and interconnected.

In an epidemiological study of mental health diagnoses of 289,328 OIF and/or OEF

veterans who use Veteran's Affairs health care from 2002-08 (Seal et al., 2009), 36.9% had a

mental health diagnosis by the study's end. When mental health problems which did not confer

a diagnosis were included, 42.7% of the subjects met criteria. The majority had comorbid

diagnoses. The two most common diagnoses were PTSD at 21.8%, and depression at 17.4%.

Approximately 7.1% were diagnoses with an alcohol use disorder and 3% with a substance use

disorder. The youngest active duty veterans (aged 16-24 years) were twice as likely to develop a

PTSD diagnosis, twice as likely to develop an alcohol use disorder diagnosis, and at 5-fold risk

for a substance use disorder diagnosis than active duty OIF/OEF veterans over age 40.

Moreover, PTSD has been observed to emerge up to 20 years after combat exposure (Solomon &

Mikulincer, 2006), suggesting that lifetime prevalence of psychopathology amongst veterans

from OIF or OEF will continue to be revealed.

Shalev, Bonne, and Eth (1996) hypothesize that the reason PTSD treatment has met with

limited long-term success and rare complete remission rates is because comorbidity of

depression, anxiety, SUDS. Recent literature has suggested that there are transdiagnotic factors

such as factors of emotion regulation which simultaneously underlie depression, anxiety, SUDS, and PTSD (Bardeen, Kumpula, & Orcutt, 2013; Wirtz, Hofmann, Riper, & Berking, 2014).

"Emotion regulation consists of the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions…" (Thompson, 1994, p. 27). The inability to regulate one's emotions creates a greater likeliness of developing a habit of experiential avoidance to cope with persistent unpleasant emotions (Gratz & Roemer, 2004). Low emotion regulation and more specifically habitual use of experiential avoidance (a strategy implicated in maladaptive emotion regulation) have been posited as, and more recently supported to be a unifying function and/or cause of diverse symptom presentations (i.e. syndromes/disorders) and maladaptive behaviors (Gratz & Roemer, 2004; Gross & Munoz, 1995; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; Kingston, Clarke, & Remington, 2010; Mennin, Heimberg, Turk, & Fresco, 2002).

Experiential avoidance is when a person attempts to escape, avoid, or modify experiences such as thoughts, memories, emotions or bodily sensations (Hayes et al., 1996). This is an emotion regulation strategy which is negatively reinforcing; unpleasant emotional experiences are subjectively reduced in the moment, which increases the use of specific avoidance behaviors. While, experiential avoidance is a strategy to regulate emotion, it is maladaptive because as Hayes et al. (1996) theorizes, experiential avoidance precludes one from making positive and necessary changes. This is a dominant reason experiential avoidance may lead to psychopathology; instead of intentionally changing important areas of their lives, people avoid uncomfortable experiences through thought suppression, emotion suppression, (Shahar & Herr, 2011) or through more explicitly destructive behaviors such as substance use (Hayes et al., 1996), which all function as experiential avoidance.

Experiential avoidance is highly correlated with low emotion regulation and in particular having a wide array of emotion regulation strategies, as well as emotional nonacceptance (Gratz et al., 2007; Gratz & Roemer, 2004). This appears to be true for veterans as well; OIF/EOF/OND veterans with PTSD reported more expressive suppression (i.e. the inhibiting emotionally expressive behavior once an emotion is present) and overall emotion regulation difficulties than trauma-exposed veterans who never developed PTSD (Sippel, Roy, Southwick, & Fichtenholtz, 2016). This is theorized to be because emotional and expressive suppression prevent emotional processing of traumatic incidents (Clohessy & Ehlers, 1999) and is associated with increased frequency of unpleasant intrusive memories (Roemer & Borkovec, 1994). This may offer explanation regarding why many stress or anxiety disorders develop secondary to SUDS (Goodwin & Stein, 2013); the person is in a state of such regular experiential avoidance, they are unable to process emotions and/or stress adequately, be exposed to difficult internal and/or external stimuli, or engage in helpful solutions. This, in turn, may lead to the development of unprocessed and disordered stress and anxiety.

An intensive multi-week-long treatment for Vietnam-era combat veterans with PTSD demonstrated that when emotion regulation is an explicit target for treatment, even at the negligence of traditional PTSD treatment (i.e. exposure, cognitive processing, etc.), symptoms of PTSD improve (Price, Monson, Callahan, & Rodriguez, 2006). Further, when these veterans had improvements in emotion regulation, there was an associated decrease in depressive symptoms. Consistent with this, both low emotional regulation and high use of experiential avoidance are predictive of symptoms of depression (Bardeen, Fergus, & Orcutt, 2013; Vujanovic, Zvolensky, & Bernstein, 2008). In a study of 94 fully detoxified veterans with substance use disorder histories, those with more symptoms of depression were more likely to avoid negative emotions

(Forsyth, Parker, & Finlay, 2003). In a study of male soldiers who had recently returned from Iraq, experiential avoidance was associated with poor relationship adjustment and increases in both perpetrating and being the victim of physical aggression (Reddy, Meis, Erbes, Polusny, & Compton, 2011).

As relationship difficulties, intimate partner violence, depression, substance abuse, and PTSD are all considerable problems which service members and veterans face, interventions which promote emotion regulation and undermine habitual experiential avoidance may be of particular benefit to post-deployment service members and veterans.

Mindfulness

Mindfulness has been defined as "the nonjudgmental observation of the ongoing stream of internal and external stimuli as they arise" (Baer, 2017, pg. 125). Mindfulness has similarly been defined as "bare attention", where one is simply alert to one's experience without secondary processing about the present experience (Gunaratana, 2002; Nyaniponika, 1972). Theoretically, this means that a highly mindful person is not ruminating, worrying, judging, comparing, or avoiding, but simply being open, observant, aware, and accepting of reality as it occurs (Brown & Ryan, 2003; Teasdale, 1999).

In general, mindfulness is incompatible with experiential avoidance because of the way which mindfulness brings us into direct contact with our experience. In mindfulness meditation, for instance, a person repetitively brings their attention back to their present moment experience with an attitude of openness, regardless of what emotions may be present (Gunaratana, 2002). The person is exposed to varying emotional valences simply by being aware of their own experience and is trained to be in varying states of acceptance despite unpleasant (or pleasant) thoughts and emotions (Kabat-Zinn, 1990a; Linehan, 1994).

In a model of the relationship between mindfulness, executive functioning and emotion regulation, Teper, Segal and Inzclicht (2013) acknowledge that mindfulness promotes both greater awareness and acceptance. Accordingly, the awareness that is refined through meditation practice enhances attention to and recognition of subtle cues (e.g. increased heart rate) that indicate nascent emotions. Before these nascent emotions become full-blown emotional reactions via secondary elaboration, mindful acceptance can be employed to fully prevent or mitigate this effect. In addition, if awareness was not so great as to detect said subtle cues, and an emotional reaction occurs (as in the case of a novice, or someone with only moderate, rather than high mindfulness), acceptance may be employed as something akin to reappraisal of our relationship to the emotions/thoughts. This, in turn, stops the process which may turn into over engaging with and overelaborating on emotional stimuli; rumination and/or worry. Early detection of emotion or subtle cues which indicate emotion is advantageous because once a nonconscious appraisal takes place, it is likely that further appraisals will have a similar trajectory (Bargh & Williams, 2007). So then, awareness at subtle and inchoate stages of emotion allows for early acceptance and subsequent adaptive behavior (cognitive or otherwise) before said emotion fully activates and becomes maladaptive behavior (which may lead to exacerbation of problems and/or emotions) - as in the case of substance abuse (i.e., experiential avoidance; Hayes et al., 1996; Teper et al., 2013).

The research described above suggests that mindfulness might be used as an overarching treatment in people whose emotion dysregulation and/or experiential avoidance are etiologically linked to their psychopathology. If this were true, one would see a reduction in symptoms associated with depression and anxiety, and reduction in self-reported depression and anxiety. This is supported in the findings of one study conducted with a sample of people

seeking treatment for mood and anxiety disorders (Desrosiers, Vine, Klemanski, & Nolen-Hoeksema, 2013). In this study, worry mediated the relationship between low mindfulness and anxiety, and rumination mediated the relationship between low mindfulness and depression. This demonstrates that in both cases, being overly engaged in cognitions in a repetitive way is reduced when levels of mindfulness are increased via mindfulness training (Desrosiers, Vine, Klemanski, Nolen-Hoeksema, 2013).

Review of mindfulness interventions. There are four main mindfulness-based interventions, two of which are meditation based and two of which are based significantly less in actual meditation practice. Mindfulness-based Stress Reduction (MBSR; Kabat- Zinn, 1990a) was the first standardized application of mindfulness, created by Jon Kabat-Zinn in order to treat patients with chronic pain. This program is an 8-week, intensive training consisting of approximately two hours per week of face-to-face mindfulness instruction and training. Participants are also instructed to practice mindfulness meditation and other mindful activities at home. Further, participants are encouraged to attend day-long mindfulness meditation retreat. The premise is that intensive and consistent training in mindfulness will help patients become less reactive and judgmental (i.e. upset) regarding their experience of physical pain and will consequently have less emotional pain and stress in relation to somatic symptoms.

Mindfulness-based Cognitive Therapy (MBCT; Teasedale, 2004) is a group intervention which was developed to prevent relapse for people with a remitted depressive disorder. It is a manualized treatment, which incorporates components of cognitive therapy (CT) into mindfulness training. The purpose of MBCT is to help participants notice thoughts simply as mental events, rather than as claims about reality which must be engaged with. This is considerably different from standard CT which aims to help one evaluate the rationality of the

thoughts themselves and to develop alternative thoughts. MBCT, instead, helps one develop a different relationship with thoughts and emotions which functions by negating the association between negative automatic thoughts and dysphoria.

A non-meditation-based modality which focuses heavily on mindfulness is Dialectical Behavior Therapy (DBT; Linehan, 1993). While initially developed for chronic suicidality and self-injurious behaviors, DBT is now being used across disorders when underlying the symptom presentations is emotion regulation difficulties. DBT uses Zen philosophy and practices in combination with traditional CBT to concurrently promote acceptance of difficult experiences and behavior change strategies. These are viewed as having a reciprocal relationship; if someone behaves reactively during intense emotional experiences, said behaviors are likely to produce consequences which lead to greater emotional distress (e.g. lashing out at a loved one, who in turn becomes distant, leading to fewer reinforcing experiences of affection and closeness, which thereby increases loneliness, guilt, and frustration.) Mindfulness is used as a means to notice what is happening internal and externally, as well as learn to accept it. This improves someone's subjective experience in the moment but also helps prevent reactive behavior which may worsen any given situation.

Acceptance and Commitment Therapy (ACT; Hayes, McCurry, Afari, & Wilson, 1993) is the other, along with DBT, psychotherapy modality which focuses heavily on mindfulness without engaging in formal meditation practices. ACT posits psychological distress is created by a cycle of avoidance of negative thoughts and emotions, which often paradoxically proliferates distressing thoughts and emotions, leading to further distress, reactivity, and difficulty consistently engaging in valued behaviors. ACT, then, focuses on creating greater psychological flexibility by teaching and practices various components which comprise mindfulness (e.g.

cognitive defusion, acceptance, presence, etc.) while helping people recognize their values and ways to engage in valued behavior.

Mindfulness and military service. Due to its beneficial effects, various studies have been conducted researching mindfulness in military and veteran populations. Additionally, as research has demonstrated that mindfulness is correlated with and predictive of positive benefits in this population, some have created mindfulness interventions specifically with military culture in mind.

A mindfulness protocol made explicitly for pre-deployment military personal has been created by Stanley & Jha (2009) and has been titled Mindfulness-based Mind Fitness Training (MMFT). MMFT combines elements of mindfulness training, sensorimotor regulation (Ogden, Minton, & Pain, 2006), Somatic Experiencing (Levine, 1997), and the Trauma Resilience Model (Leitch, 2007; Leitch, Vanslyke, & Allen, 2009). In this protocol, mindfulness applications for the operational environment and information about stress, trauma and resilience are taught in didactic form. Despite the inclusion of relevant didactics, the program emphasizes mindfulness instructions, mindfulness-based exercises, and a discussion about how the topic at hand applied to specific examples of operational effectiveness.

According to Stanley (2014), there are at least three factors unique to the pre-deployment military setting which make an adapted MT training relevant. First, given then context of military training, MT would need to be incorporated into a unit's organizational setting and ongoing training. This means that the MT should address the fact that personnel in different positions in the command hierarchy will participate in the training together. Second, resistance to the MT may emerge due to the troops not necessarily deciding to participate on their own accord. Given this fact, materials which build motivation for participation both in class and

outside of class should be readily incorporated into the training. These would include more didactics which make MT more explicitly related and accessible to actual military missions. In this case, this means psychoeducation on stress, resilience, and operational applications. And third, given the assumption of prolonged and acute stress during stress inoculation training and future deployments, stress resilience and performance enhancement, rather than just stress reduction, are explicit goals of MMFT.

After agreeing to participate in the training, many of the participants endorsed symptoms of PTSD, which was unknown to the program developers beforehand. Many admitted to withholding this information during military-administered assessments, which highlights how powerful stigma surrounding mental health still is in the military. This gives further credence to Stanley's decision to include framing the utility of mindfulness in terms of operational performance and unit cohesion (which also relate to one another) rather than as a mental health treatment.

Three experiments utilizing MMFT have been conducted using pre-deployment military personal. A detachment of 34 U.S. Marine reservists were the subjects in the initial trial (Stanley, Schaldach, Kiyonaga, & Jha, 2011). Qualitatively, individual Marines described better concentration, the ability to stay with difficult experiences, improved identification and acceptance of emotions, greater calm, improved relationships outside of the military, and even using the tools to work with difficult emotions and behaviors that resulted from previous deployments. As a group, improved team communications and unit cohesion was noted by leader and members. Importantly, leaders spoke about improved leadership ability which was the result of a greater awareness of their own and others emotions (empathy) which helped them become more receptive, rather than defensive, when given feedback from subordinates. The

greater awareness also leads to better understanding of specific strengths and weaknesses of individual members, which lead to improved task delegation and more cooperative team behavior. They also reported that as a group, they faced stressful and chaotic experiences with more effectiveness

An experimental study (Johnson et al., 2014) of eight Marine infantry platoons ($N = 281$) randomly assigned to training as usual or MMFT showed that Marines who received mindfulness training demonstrated improved stress recovery. Specifically, improvements in stress recovery were in the form of heart rate and breathing rate recovery, as well as peripheral biomarkers before, during, and after a stressful training session. Further, neuroimaging results from another study using a civilian population supported the hypothesis that MT led to better integration of information about one's internal physiological state and a consequentially improved somatic stress response (Tang et al., 2007).

In an experiment of mindfulness training on working memory capacity and affective experience which compared two military cohorts with a civilian cohort, it was noted that working memory capacity decreased over time for the military cohorts but not for civilians (Jha, Stanley, Wong, & Gelfand, 2010). This would indicate that higher stress depleted working memory capacity. In the military cohort that received mindfulness training, those with low amounts of time practicing mindfulness experienced degradation of working memory capacity, while those with high amounts of time practicing mindfulness experienced an increase in working memory capacity. Additionally, higher mindfulness training practice correlated to lower levels of negative affect and higher levels of positive affect. This would suggest that satisfactory mindfulness practice may mitigate functional impairments related to high-stress situations in the military.

Mindfulness and veterans. Within the VA, providers are increasingly using acceptance-based treatments to address chronic symptoms of depression, PTSD, and pain (Lang et. al., 2012). King et. al (2013) found MBCT significantly decreased PTSD symptoms for veterans compared to those in usual care group treatments. In a randomized control trial implementing an 8-week, primarily telephone-delivered mindfulness intervention, veterans had significant reductions in PTSD symptoms vs. the control group who received psychoeducation (Niles et al., 2011).

Two studies by Kearney and colleagues assessed the effects of a full course of MBSR in veterans. The first was a non-controlled trial where veterans undergoing other mental health treatment participated in MBSR as an adjunct and found PTSD symptoms, depression, and quality of life improved (Kearney, McDermott, Malte, Martinez, & Simpson, 2012). The second study was a small, randomized control trial comparing the effects of treatment as usual plus MBSR versus treatment as usual. Initially, there were no initial significant differences in PTSD symptoms between the groups. However, a post-hoc analysis found that there was a subset of veterans who received MBSR in addition to treatment as usual had significant improvements in quality of life and PTSD symptoms at a 4-month follow-up in greater proportion than the control group (Kearney et al., 2013).

Researchers conducting another randomized clinical trial demonstrated that veterans with PTSD who underwent a course of MBSR experienced greater reductions in PTSD symptoms at a 2-month follow-up than those who underwent supportive group therapy (Polusny et al., 2015). This research was more recently extended by Stephenson, Simpson, Martinez, & Kearney (2017), who looked at associations between the five facets of mindfulness (Baer, Smith, & Allen, 2004) and reduction in PTSD symptoms. They found that Acting with Awareness and Non-

Reactivity were the two facets of mindfulness which were most strongly and reliably associated with improvement of PTSD symptoms.

Resilience, Meaning-Making and Posttraumatic Growth

Resilience is defined as a relatively positive psychological conclusion despite experience of stressful circumstances (Rutter, 2006). People who are highly resilient become functional individuals (or maintain functionality) rather than succumb to this stress (Rutter, 2006). Zautra, Arewasikporn, & Davis (2010) define resilience as adaptive responses to adversity. They provide a framework for such a large construct, suggesting resilience has three components: recovery to baseline after a significant stressor; sustainability, that is continuing to be able to meet values and goals despite stressors (Zautra, 2009); and growth, the ability to make meaning from and grow from stress, thereby elevating one's baseline level of resilience. Therefore, resilience has become an overarching construct that has multiple contributing factors, many of which are targeted directly and indirectly (e.g., Harrell, 2016), particularly in the case of acute and chronic stress (Dunkel Schetter & Dolbier, 2011).

A study by McAndrew et al. (2017) demonstrated that unit cohesion in OIF/OEF military personal was associated with a reduction in avoidant coping styles and consequently led to higher resilience after a deployment. Less avoidant coping was directly related, in this study, to fewer post-deployment mental health problems but this depended on strong unit cohesion. This suggests that both unit cohesion and low avoidant coping are factors of positive resilience.

Positive emotions are a significant component of resilience, as they help buffer against the exhaustion of emotional resources in the face of stress (Tugade, Frederickson, & Barrett, 2004). In a recent study of 2157 U.S. veterans as part of the National Health and Resilience in Veterans Study (Isaacs et al., 2017), analysis revealed that the most modifiable resilience factors

which prevented mental health problems despite high trauma-exposure, were gratitude, emotional stability, a sense of purpose, and altruism.

A concept related to resilience is posttraumatic growth (PTG), which is positive growth and meaning-making despite adversity or trauma (Tedeschi & Calhoun, 1996). To be sure, this is akin to the growth aspect of Zautra et al. (2010) definition of resilience. According to the Posttraumatic Growth Inventory, there are five dimensions of PTG: Appreciation of life, relating to others, new possibilities, personal strength, and spiritual change (Tedeschi & Calhoun, 1996). What is interesting is that despite their seeming correlation, resilience and PTG are discrete ideas. In fact, one study demonstrated that highly resilient people are unlikely to demonstrate posttraumatic growth (Levine, Laufer, Stein, Hamama-Raz, & Solomon, 2009). This is seemingly because a highly resilient person may not experience a highly stressful event as traumatic, thereby precluding the shattering of assumptions, reappraisal and new meaning which defines PTG. So, in one scenario a high-stress event occurs, the resilient person will either (a) not experience it as trauma or return to baseline rapidly as in the case of high minimal impact resilience; (b) experience the event as being intensely incongruent to one's worldview, thereby requiring one's worldview to shift in order to accommodate and assimilate this new information. Tedeschi and Kilmer (2005) suggest that "people who display resilience have adjusted successfully despite adversity, whereas person who experience PTG are transformed by their struggles with adversity" (p. 223).

If an event is experienced as traumatic, it requires someone to make new meaning through the reconciliation of their old assumptions and new experiences (Park, 2010). Recent empirical research suggests the onset and course of PTSD is hypothesized to be mediated by how well one integrates the traumatic experience into their preexisting worldview or how well one

develops a new worldview which allows for the traumatic experience (Park et al., 2008; Park, 2010).

In Maguen, Vogt, King, King, and Litz's (2006) research on Gulf War I veterans, perceived threat to life predicted a greater appreciation for life. WWII and Korean veterans believed their war experiences helped them cope with adversity better, increase self-discipline, and have a broader life perspective, with greater combat exposure associated with the perception of more growth (Aldwin, Levenson, & Spiro, 1994). One surprising study, conducted nearly 40 years ago, found that over 90% of Vietnam ex-POWs perceived themselves to have a greater understanding of themselves and others, and a clearer concept of life's priorities as a result of their traumatic experience (Sledge, Boydstun, & Rabe, 1980). Another Vietnam ex-POW study showed that factors of post-traumatic growth, particularly appreciation of life and personal strength, were positively correlated with duration of captivity and optimism (Feder et al., 2008). Due to these and other examples, "meaning in life may be an important treatment concern for veterans with PTSD symptoms" (Owens, Steger, Whitesell, & Herrera, 2009).

Indeed, even when depression and history of suicide were controlled for, life meaning was significantly associated with suicidal ideation (Braden, Overholser, Fisher, & Ridley, 2015). This suggests, as the authors state, "life meaning may be an important, previously ignored indicator of suicide risk" (pg. 24). For veterans, sense of meaning was associated with lower rates of depression (Blackburn & Owens, 2015), which is of particular import considering the most at risk group of VA-treated veterans are those experiencing depression, with rates of deaths by suicide being seven to eight times higher than the normal population (Zivin et al., 2007). From a community sample of Vietnam veterans, those who felt a loss of meaning were more

likely to pursue mental health services in the VHA even many years after transitioning into civilian life (Fontana & Rosenheck, 2005).

Conversely, greater exposure to morally injurious experiences was associated with less meaning made of veteran's stressful experiences, which was then associated with higher PTSD, depression, and suicidality (Currier, Holland, & Malott, 2015). It is possible that finding meaning in morally injurious experiences is particularly difficult, highlighting the need for veterans who had such experiences (either as victim, witness, or perpetrator) to find meaning in other experiences and the aided reconstruction of non-military identities (Currier, Holland, & Malott, 2015).

A chilling complication is that identification of at-risk veterans by VA providers is inconsistent, even if the veterans had been in contact with providers prior to their death. An investigation about VA healthcare utilization and suicide found that nearly all veterans enrolled in VA healthcare who died by suicide saw a VA provider in the year before their death, and nearly half had contact with a provider in the month leading up to their death (Britton et al., 2012). While suicidal ideation was the strongest predictor of veteran suicide if completed one week after provider contact, it was only documented in 18% of suicides that happened one week after contact with a provider (Britton et al., 2012). This highlights the need for prophylactic care which might assume a veteran will experience various difficulties as they transition into civilian life, some of which may aid in the development or bolstering of significant mental health problems.

Mindfulness to meaning. The Mindfulness to Meaning theory (Garland, Farb, Goldin & Fredrickson, 2015) suggests theorizes that mindfulness practices, especially in combination with positive experiences, do not just foster relaxation, acceptance, and positive emotion regulation,

but also facilitate meaning-making despite stressful experiences. According to Garland et al. (2015), this happens first by decentering (being able to observe thoughts and physical sensations) which reduces narrow and oft-upsetting thinking to include a broader awareness of context. This in turn leads to positive reappraisal. When attention is more broadly oriented, and it notices something, it tends to elaborate on that thing, especially if encouraged; this creates more of an inclination to attend to positive stimuli (Koivisto & Revonsuo, 2007). Theoretically, one's ability to savor positive experiences, such as the consequential emotions for an adverse experience being reappraised, leads to an amplified positive experience to (Garland et al., 2010; Garland et al., 2015). By being able to notice the transitory nature of both positive and negative phenomena, tolerate distressing sensations, decentering, reappraising situations in a meaningful way, savoring pleasant experiences, etc., a person is able to have their adverse experiences assimilated into a broader and more complex, positive and accepting system of meaning (Garland et al., 2015).

Writing interventions. People with traumatic histories may be more willing to disclose their trauma stories through written form than through immediate discussion with another person (Slatcher & Pennebaker, 2006). A meta-analysis of writing interventions revealed greater psychological well-being for those who engaged in expressive writing than controls who did not (Smyth, 1998). Mindfulness appears to make the effect of expressive writing greater, as those with higher mindfulness appear to have greater physical and psychological benefits than those with lower mindfulness (Poon & Danoff-Burg, 2011). One study found that writing about perceived benefits of a trauma without writing too deeply about the traumatic event itself increases one's ability to find meaning in an event and is linked to positive physical and psychological outcomes (King & Miner, 2000). In addition, a small study demonstrated that

self-expressive writing may improve emotional expression and self-awareness in veterans with PTSD (Nevinski, 2013).

Harrell's resilience & reconnection stress management group. A highly adaptable model which targets resilience through a variety of means, methods, and activities is the Resilience and Reconnection (R&R) Stress Management group intervention currently in development (Harrell, 2015; Skulstad & Buch, 2017). This model emphasizes the activation of contemplative, communal and empowerment processes (aka Awareness, Allies, and Action) in the development of group interventions across diverse cultures and contexts. These are conceptualized as three pillars that support resilience. The intervention model operationalizes wellness-promoting transactions that are identified in Person-Environment-and-Culture-Emergence (PEaCE) meta-theory (Harrell, 2015). PEaCE theory is a highly integrative way of conceptualizing wellness and resilience and its manifestation as the R&R model emphasizes "cultivating, enhancing, and sustaining strengths and ways-of-being that promote culturally-syntonic stress resilience" (Harrell, 2016, pg. 26). Therefore, this theory and adaptive model can be used to guide the development of group-based resilience interventions informed by an understanding of the specific needs and culture of the target population. Military culture is very influential and serves as a primary identity group for many members. Thus, development of an intervention that considers the needs and culture of the military is important. The intervention created for this project focuses on strengthening the resilience pillar of awareness with an emphasis on the contemplative processes of mindfulness practice and reflective writing.

Synthesis and implications for future directions. Through the Walter Reed Army Institute of Research, the United States military has responded to the plethora of war-related psychopathology by creating a protocol titled "Battlemind Training" (Castro, Hoge, & Cox,

2006) The program is comprised of various skills which promote resilience and help a service

member transition out of a deployment to the end of mitigating possible mental health and

behavioral problems. Battlemind training helps prepare the service member transition home

through strengths-based exercises, team-based exercises, and re-framing important combat skills

which can be problematic if not adapted to home. Difficult experiences (e.g. fear during combat,

social and emotional problems upon returning home, etc.) are normalized and room is created for

discussion of these oft-ignored topics.

When 2,297 U.S. soldiers were given early interventions following a year-long

deployment to Iraq, Battlemind debriefing and group trainings consistently led to better mental

health outcomes than the standard stress-education (Adler, Bliese, McGurk, Hoge, & Castro,

2009). Use of a Battlemind module 3-6 months after returning from combat led to self-report of

improved adjustment to home-life, reduced posttraumatic stress symptoms, and greater life

satisfaction. Importantly, it improved attitudes about mental health service stigma immediately

after it's delivery, though these improved attitudes were perishable at 6-month followup (Casto,

Adler, McGurk, & Bliese, 2012). Apart from service members involved in combat, there are

Battlemind modules for military leaders and for military family-members.

While Battlemind training is an incredibly useful resource, its effect-sizes are small

(Adler, Castro, & McGurk, 2009) and while it focuses on much-needed directive suggestions for

how to act and think about concrete situations that are likely to occur, it does not directly

promote mindfulness, reflection, cognitive flexibility, and self-awareness which then may lead to

posttraumatic growth and subsequent improved resilience.   And as Orazem et al. (2017)

concluded, "identity adjustment is a critical yet understudied aspect of veteran reintegration into

community life following combat deployment" (pg. 4) which Battlemind and other post-

deployment interventions do not directly consider.   Given the five themes of post-military identity disruption (Orazem et al., 2017), it may be important to consider how to help veterans feel like they belong in civilian society; develop a similarly structured lifestyle within a post-military life and/or learn how to become comfortable with a less structured lifestyle; find empathy and positive qualities of civilian society; discover how military experience helped them grow, learn, and mature; and find meaning in life outside of the military.

While the proposed workshop is considered a standalone intervention, it can also be considered a way to extend Stanley's work on MMFT and Kabat-Zinn's MBSR by integrating an explicit focus on meaning-making and variables related to post-traumatic growth in an effort to strengthen the prophylactic and reparative effects of the group mindfulness intervention. This intervention is being developed for post-deployment Veterans as a means to introduce them to mindfulness practice, as well as facilitate meaning and post traumatic growth. However, this intervention can be used for Veterans with previous mindfulness training (e.g. MMFT or MBSR). It is hoped that introducing more reflective discussion within the group will also increase the level of group cohesion, thereby elevating the levels of resilience-enhancing social support as a separate therapeutic factor. Given that mindfulness reduced levels of loneliness (Creswell et al., 2012) it is hoped that a group mindfulness intervention will have an increased effect of helping veterans experience less loneliness and increase connection with others. Based on the literature reviewed, it is hypothesized that introducing meaning and growth-focused reflection will have a synergistic effect with the strong mindfulness and stress resilience protocol described. This will potentially have the effect of promoting meaning-making of past traumatic experiences and encourage growth for anticipated future traumatic experiences, thereby facilitating posttraumatic growth and future resilience. In this way, the intervention can have a

two-fold effect: (a) to promote resilience to stress, thereby reducing the likelihood that an acutely stressful experience will actually be traumatic (i.e. standard MMFT) and (b) provide a reflective context for meaning-making if an experience overcomes one's resilience threshold a is by definition traumatic, to the end of posttraumatic growth.

As Tedechi and Moore (2016) note in their workbook for posttraumatic growth, PTG is "a pathway to resilience" (pg. 14). The growth that is possible following a trauma can change one's worldview enough to be able to integrate future potential traumatic injuries in a way characterized by resilience; that is, a normal return to baseline without the need to alter one's worldview. Resilience can also prevent an acutely stressful experience from being experienced as traumatic in the first place.

If an event is experienced as traumatic, it requires someone to make new meaning through the reconciliation of their old assumptions and new experiences (Park, 2010). The onset and course of PTSD is partially mediated by how well one integrates the traumatic experience into their preexisting worldview or how well one develops a new worldview which allows for the traumatic experience (Park et al., 2008; Park, 2010). This information informs some of the basis of cognitive processing therapy (CPT; Resick & Schnicke, 1993), one of the frontline treatments for posttraumatic stress disorder which also attempts to undermine avoidance to facilitate the emotional processing of trauma. An integration of the literature suggests that nonavoidance, cognitive flexibility and adequate meaning-making appear to be the recipe for preventing trauma (i.e., resilience) or healing and growing from it when it occurs (i.e. post-traumatic growth; Garland et al., 2015; Park et al., 2008; Park, 2010; Resick & Schnicke, 1993).

A meta-analysis on the way mindfulness interventions bestow posttraumatic growth in participants in medical traumas (98.6% were cancer-related), suggest that mindfulness has a

small but positive effect on posttraumatic growth in-and-of-itself (Shiyko, Hallinan, & Naito, 2017). Specifically, domains of posttraumatic growth such as improvements in relating to others, appreciation for life, and spirituality were the most noticeably impacted by mindfulness training. The addition of reflections meant to elicit posttraumatic growth may broadens one's worldview in order to accommodate reality by means of cognitive flexibility and reflection, and consequently create future resilience while processing and learning from present trauma.

Thus, the specific research objectives for this project include: a comprehensive review of the literature, familiarization with currently used resources, the development of a curriculum and manual, and a preliminary evaluation of the manual.

Chapter II: Methodology

Given the need for expanded and improved methods to address, prevent, and treat psychopathology in recently returned Veterans, this dissertation study aims to develop a half-day debriefing group for recently transitioned veterans who experienced combat. This is meant for service members who have undergone previous mindfulness training, such as Mindfulness-based Mind Fitness (MMFT; Stanley & Jha, 2009) training or Mindfulness-Based Stress Reduction (MBSR, Kabat-Zinn, 1990a) or as a meaning-focused introduction to mindfulness practice. This intervention will serve as a means to introduce or reorient Veterans to mindful ways of being and to encourage meaning-making and growth.

The research conducted utilized a program development methodology to create a brief program aimed at helping recently returned Veterans transition back into civilian. The first phase of the program development included an extensive review of the existing literature, including empirical and experimental research on mindfulness, stress, resilience, psychopathology, meaning-making, posttraumatic growth, veterans, and the military. Further, the literature review also included interventions which utilize mindfulness, meaning-making, and posttraumatic growth. This review of empirical research and existing interventions informed the synergistic creation of a mindfulness, meaning-making, and posttraumatic growth post-deployment debriefing workshop for active-duty service members.

The second phase of the study involved a review of existing treatments which promote resilience, mindfulness, or meaning-making/PTG. Any interventions which include these variables for either veterans or active-duty service members were given special attention in order to inform the development of specific workshop components and helped clarify the need for culturally-specific considerations or adaptation recommendations. In addition, blogs and

podcasts targeting the adjustment of service members were reviewed in order to integrate current military themes and concerns into the content of the workshop. The third phase of the study included an integration of the previous phases and the development of the debriefing workshop. The fourth and final phase of the study included an evaluation of the workshops curriculum by a panel consisting of three individuals: one veteran with a history of combat deployment(s), a mental health profession with expertise in veteran populations, as well as an advanced mindfulness instructor.

This half-day long (6 hour) debriefing workshop includes the following components: psychoeducation, mindfulness meditation, improving emotional and somatic awareness through skill-building exercises, military-themed cross-cultural reflections which implicitly or explicitly emphasizes mindfulness and acceptance, and explicit meaning-focused writing and/or discussion which are meant to elicit posttraumatic growth, adjustment, and meaning-making. The intervention itself was heavily informed by Mindfulness-based Mind Fitness Training (MMFT), Tedeshi and Calhoun's work on posttraumatic growth, and the Mindfulness-to-Meaning model. Further, the format of the workshop utilized structural components from Harrell's Resilience & Reconnection (R&R) Stress Management group intervention. Despite the breadth of the R&R model and its design as a 10-session group intervention which targets many Optimal Health and Wellness Themes (OHWTs), mindfulness and meaning-making are deeply imbued within the entirety of the model and are thus easily drawn from various portions of the extensive intervention.

Along with improving stress-related physiology as well as somatic and emotional awareness, the ability to meaningfully reflect on their identity as veterans and their experiences for the sake of flexibly incorporating stressful/traumatic experiencing into their worldview (i.e.

assimilation and accommodation) is an overt goal of the intervention. By utilizing personal reflections, participants may be able to understand themselves and their experiences in a way which helps them move forward with their lives with increased resilience. While a half-day workshop may have limitations with respect to long-term changes, the literature suggests that ongoing mindfulness practice has benefits which increase over time (Lee et al., 2015; Shoham, Goldstein, Oren, Spivak, & Bernstein, 2017), which will be an explicit recommendation of the workshop.

Development of the Curriculum for Workshop

  Phase one: Review of the literature and existing resources. Data was gathered from a variety of sources to inform the review of the literature. Internet databases including PsychINFO, PsychARTICLES, Wiley Online Library, Google Scholar were used to gather scientific journal articles, reviews and critiques of journal articles, and books. The primary focus of the literature review was the interrelationship between mindfulness, meaning-making, and psychopathology, as well as the specific cultural needs of veterans. The following keywords were used in various combinations to elicit the greatest possible number of relevant articles with which to gather data: mindfulness, meditation, contemplative practice, writing interventions, meaning making, veterans, addiction, suicide, substance use disorders, ptsd, depression, experiential avoidance, acceptance, emotion regulation, resilience, meaning-making, post-traumatic growth, stress, stress management, and military. The purpose of this literature review was to twofold: (a) understand the stress management, resilience, and post-deployment needs for the Veteran population and (b) inform the development of a mindfulness-based, meaning-focused intervention.

Phase two: Identification of relevant intervention components from existing programs. A review of existing similar programs was conducted in order to identify relevant components to include and/or modify for this specific population. Emphases was on interventions meant to bolster resilience, promote posttraumatic growth, or develop mindfulness among Veterans. Identified interventions and programs which were reviewed include Harrell's R&R model (2016), Mindfulness-based Mind Fitness Training (Stanley & Jha, 2009), Battlemind Psychological debriefing (Adler, Castro, & McGurk, 2009), Tedeschi and Calhoun's interventions for posttraumatic growth, as well as group-based mindfulness interventions in day-long or retreat formats.

Phase three: Data integration and workshop development. After a comprehensive review of relevant literature and existing interventions was completed, the workshop was developed. This was done by synthesizing the literature in such a way as to inform the development of a new protocol. A curriculum was developed based on need and utility. The duration of different portions of the intervention were carefully considered, specifically, meditation sessions are at least 15 minutes in length in order to ensure positive effects (Arch & Craske, 2006).

The workshop is presented as a reintegration session for those who underwent pre-deployment mindfulness training (e.g. such as MMFT) or Veterans new to mindfulness. The preliminary structure of the workshop is organized into the following sections: (a) Introduction– facilitating awareness of the purpose of the intervention and outlining goals; (b) Psychoeducation – reorienting and/or teaching the group about mindfulness as a concept, along with a culturally congruent cued discussion if its benefits (e.g., action despite discomfort, acceptance of reality, focus, etc.); (c) Practice – guided sitting meditation, walking meditation, then loosely guided

sitting meditation (d) Internalizing Reflections – Speaking and writing on various reflections which may facilitate meaning-making and post-traumatic growth; and (e) Closing – Participants are given written mindfulness instructions and examples of multiple mindful activities along with questions to consider going forward.

  Phase four: Workshop evaluation. Consultation and literature review preceded the curriculum development. After this was completed, all sources of data were integrated into a curriculum. Approval from the dissertation chair was then obtained and the fourth phase commenced. This phase included an evaluation by three individuals with expertise or personal experience in relevant areas. The first evaluator was a veteran whose primary duties in the military included combat. This veteran is also a licensed Marriage and Family Therapist who is currently a psychology post-doctoral fellow at a VA, and who has some experience implementing mindfulness interventions with veterans. That the designated veteran evaluator is also a psychologist is considered a confound and limitation of the study, however, the opportunity to have such a evaluator who had multiple perspectives provided a unique perspective such that the benefits outweighed the limitation. The second is an expert mindfulness instructor who has ten years of experience teaching meditation multiple time per week at a Buddhist meditation center, including dozens of half-day, daylong, and multi-day-long mindfulness meditation; she underwent a four-year training to become a Buddhist meditation instructor through a Spirit Rock Meditation center affiliate. The third evaluator is a psychologist with over thirty years of experience working with veterans in the VA system; he too has some experience teaching mindfulness to veterans, specifically, participating in one mindfulness group on a PTSD clinical team. The focus of the evaluation was on applicability, ease of access for a new facilitator, understandability of content, and effectiveness.

Inclusion criteria for evaluators. The criteria for the mental health professional who has experience working with relevant populations included: (a) be a practicing licensed psychologist, and (b) have a minimum of 5 years of experience working with recently deployed and/or returning military personnel and/or veterans (i.e., deployed and/or returned within the last year). The inclusion criteria for the mindfulness instructor was a minimum of 10 years as a mindfulness instructor with priority given to anyone with specific experience working with veteran and/or military populations (though this was not required). The inclusion criteria for the individual with military combat experience was having at least two combat deployments.

Recruitment strategies and procedures. All three individuals were found through the author's professional network. The author sent interested persons an email (Appendix A) to describe the workshop and basis for its development. Persons who agreed and appeared to meet criteria for a specific role (e.g. expert mindfulness instructor) were sent an informed consent (Appendix B) and questionnaire to assess whether or not they meet the inclusion criteria (Appendices C, D, or E). After the informed consent and screening questionnaire were received, evaluators were e-mailed the evaluation questionnaire (Appendix F) and returned all completed materials through e-mail.

Analysis of evaluation. After receiving the manual evaluations, the researcher reviewed their responses in order to identify common themes that emerges which may be valuable in enhancing the workshop content and intervention procedures. These themes and recommendations are explored in the Discussion chapter. This information may help identify strengths and limitations of the workshop, inform suggestions for improving the workshop, as well as reveal needs for future research.

Chapter III: Results

This chapter will provide a description of the content and development of the workshop, *Mindfulness and Re-Discovering Purpose,* and a summary of the evaluation results. First, the process of developing the workshop, which targets veterans who have recently returned from combat, will be discussed. Second, the organization and content of the workshop manual (see Appendix G – Manual) will be presented. Third, the comments and recommendations from all three evaluators will be detailed and examined.

Brief Overview of Manual Development

The initial phase of manual development was a literature review related to veteran mental health and adjustment, resilience, emotion regulation, meaning-making, and mindfulness to the end of more clearly understanding the mental health needs of recently returned veterans. Special attention was paid to previous clinical research with the military and veteran population, specifically regarding meaning-making and mindfulness practices. Additionally, time was spent listening to podcasts and reading memoirs about war, veteran culture, and mindfulness in order to incorporate diverse sources that could enrich the content of the manual.

Literature review. There is significant incidence of psychopathology directly and indirectly related to war (Litz & Orsillo, 2003). As the United States has been involved in multiple wars for well over a decade, there are many service members still enlisted in the military or those who have been recently discharged (i.e., new veterans) who will incur psychopathology. As the U.S. remains involved in military conflict, we continue to have people who have yet to be exposed to the potentially traumatic conditions of combat.

In an epidemiological study of mental health diagnoses of 289,328 OIF and/or OEF veterans who use Veteran's Affairs health care from 2002-08 (Seal et al., 2009), 36.9% had a

mental health diagnosis by the study's end. When mental health problems which did not confer a diagnosis were included, 42.7% of the subjects met criteria. The majority had comorbid diagnoses. The two most common diagnoses were PTSD at 21.8%, and depression at 17.4%. Approximately 7.1% were diagnosed with an alcohol use disorder and 3% with a substance use disorder.

Together, these studies highlight the need for an intervention for recently returning veterans which attempts to simultaneously target the most common problems for reintegrating veterans; navigating changing identities, making meaning, benefiting from meaningful connections, and learning how to undermine transdiagnostic symptoms which are related to, or even exacerbate, anxiety, depression, substance abuse, and PTSD.

Mindfulness is a trainable state which targets several factors which underlie multiple mental health problems veterans most commonly experience by reducing frequency of and relationship to rumination, worry, and avoidance which are hallmarks of depression, anxiety, SUDs, and PTSD. Simultaneously, mindfulness increases openness, awareness, and acceptance of reality as it occurs (Brown & Ryan, 2003; Hayes et al., 1996; Kabat-Zinn, 1990a; Linehan, 1994; Teasdale, 1999; Teper et al., 2013). Previous efforts to incorporate mindfulness training into the training of military service-members have yielded promising results, both in the increase of operational success and in prophylaxis of mental health problems associated with deployment (Jha, Stanley, Kiyonaga, Wong, & Gelfand, 2010; Johnson et al., 2014; Stanley et al., 2009; Stanley, Schaldach, Kiyonaga, & Jha, 2011).

Additionally, mindfulness-based practices have been gaining traction within the VA for a myriad of chronic symptoms, including pain, depression, and PTSD (Lang et al., 2012). Recently, many researchers have found that a variety of implementations of mindfulness (e.g.

MBSR, MBCT, alternatively delivered mindfulness, etc.) help reduce the symptoms of depression, PTSD, and improve the quality of life for veterans (Kearney et al., 2013; Kearney et al., 2012; Niles et al., 2011; Polusny et al., 2015; Stephenson et al., 2017).

Orazem et al. (2017) found that two thirds of veterans who participated in writing about reintegration difficulties wrote about identity adjustment. Many veterans noted that in contrast to the sense of responsibility in protecting one's comrades or subordinates from harm, the responsibilities inherent in civilian life seem unimportant and thus nearly meaningless and dissatisfying (Orazem et al., 2017). While all of these themes underlie a sense of disconnection from the civilian world, many veterans believed they could be understood by fellow veterans.

The Mindfulness to Meaning theory (Garland et al., 2015) suggests that mindfulness practices facilitate meaning-making despite stressful experiences. Given that life meaning was negatively associated with suicidal ideation (Braden, Overholser, Fisher, & Ridley, 2015) and that scientists have acknowledged "meaning in life may be an important treatment concern for veterans" (Owens et al., 2009, p. 654), interventions which explicitly focus on the derivation of purpose and meaning are important.

Overall, the literature suggested a need for an intervention which targets several common symptoms and underlying mechanisms which contribute to mental health problems in recently returning veterans while increasing purpose, meaning, and connection to others. Given the centrality of mindfulness in these endeavors and its burgeoning utilization within the VA, a decision was made to create a mindfulness-based group intervention which utilizes mindfulness in-and-of itself, it's theoretical aid in meaning-making, and the addition of meaning and purpose-focused reflections, all while attempting to utilize trauma-sensitive and culturally adapted language for veterans.

Integration of data and manual content. The literature review and information amassed via listening to the voices of veterans through diverse mediums was utilized both to derive empirical rationale for the development of workshop content and processes, as well as in ways as congruent with veteran culture as possible. The result of this is the manual called, *Mindfulness and Re-Discovering Purpose: a manual for a half-day workshop* (referred to as "the manual"). Efforts were made to remain grounded in the scientific literature while bearing in mind the veteran experience to create a responsive and useful manual to guide a half-day intensive mindfulness workshop for veterans.

Specifically, this 36-page manual was created for use within a Veterans Administration setting, by licensed mental health practitioners who have enough training and experience with veterans to be aware of common issues veterans experience. Moreover, while this manual provides several scripts to use if someone is less familiar with mindfulness practices, there is an explicit recommendation that the provider be well-versed in mindfulness practices.

The manual is comprised of the rationale for the program, clinical caveats regarding mindfulness practices for those with PTSD, recommended exclusionary criteria, and concrete suggestions for the group (e.g. size, setup, materials, logistics). Next, a section by section outline is provided, with user-friendly scripts, needed materials, participant guidelines, and links to videos. Guidelines for facilitating a therapeutic group experience for veterans is provided. Additionally, handouts for veterans are provided, specifically for the meaning and purpose-focused reflective writing, as well as additional resources available nationwide and/or at the specific VA they frequent.

A Section-by-Section Overview of the Manual

Section one of the workshop helps teach and/or reorient participants to mindfulness as a concept and practice. Additionally, the idea that mindfulness practices are congruent with military culture and identity is presented. An overview of the workshop is then presented along with guidelines, rules, and consideration for the group. The facilitator will begin with introductions and each participant will say their name and if they choose, rank, and role in the military. This is because such pieces of personal information are often essential to veteran identity. Additionally, it will help build group cohesion as each member will have a basic understanding of the trials, stresses, and dangers possibly encountered by other participants.

The second section of the workshop is initially didactic, with a presentation on the relationship between stress, traumatic injuries, basic physiology, meaning-making, posttraumatic growth, and resilience. Education and normalization are the explicit goals of this section. Mindfulness as a concept and practice is explained, and culturally congruent language is used to help demonstrate its benefits and rationale. These examples focus on processing trauma (cognitively and somatically), maintaining focus despite stress, action despite discomfort, accepting unpleasant thoughts and feelings, and interpersonal awareness and cohesion (e.g. good leadership).

The third section consists of three periods of meditation. The first is a guided sitting meditation with emphasis on somatic and proprioceptive awareness using the breath as the main object of meditation. The second is an expansion of the first, using the rest of the body and proprioceptive awareness to further anchor into the present moment; language congruent with Somatic Experiencing (Levine, 1997) was utilized to implicitly embed respective components into the second mindfulness practice. The third includes instructions for walking meditation in

order to strengthen concentrated/gathered awareness of a the present-time experience despite the introduction of potentially distracting stimuli (i.e. the visual field, objects in the room, other people, etc.).

This section will focus on what it means to be part of a warrior/military culture, be a person returning to civilian life or preparing for further deployment. Positive military values such as honor, courage, loyalty, integrity, commitment, along with lesser known military virtues such as peacefulness and restraint will be woven into the structure of the reflection. After this, participants will be invited to consider the way that stressful experiences in the military and/or traumatic injuries impacted the way they viewed themselves, others, and the world. They will be provided a quiet space wherein they will continue to write about and/or discuss in group various questions which are designed to encourage meaning-focused reflection and consequential posttraumatic growth and resilience (e.g. 'who do I want to be moving forward?'). This section ends with a final guided sitting meditation which will include instructions on developing awareness of thoughts and decentering.

The end of the workshop includes more resources for mindfulness meditation, including those created by the Veteran's Health Administration. Additional resources for veterans are included, such as the VA Veteran's Crisis Line, and a template for individual providers to add resources specific to their VA.

Summary of the Evaluation Results

Overall, the average of the evaluators' responses on the six Likert-scale items (e.g., scale of one to five, one being "Strongly Disagree" and five being "Strongly Agree") on the evaluation questionnaire was 4.44. The average of the veteran evaluator's responses was 3.6, the average of the psychologist evaluator's responses was 5, while the average of the mindfulness expert

evaluator's responses was 4.6. Table 1 presents the average ratings for all evaluators on each of the six Likert-scale items. All items were all rated between 3 and 5 by the evaluators, indicating moderate to highly positive evaluation of each area assessed. Overall, the psychologist rated the workshop manual most highly, followed by the mindfulness instructor, with the veteran providing the lowest ratings.
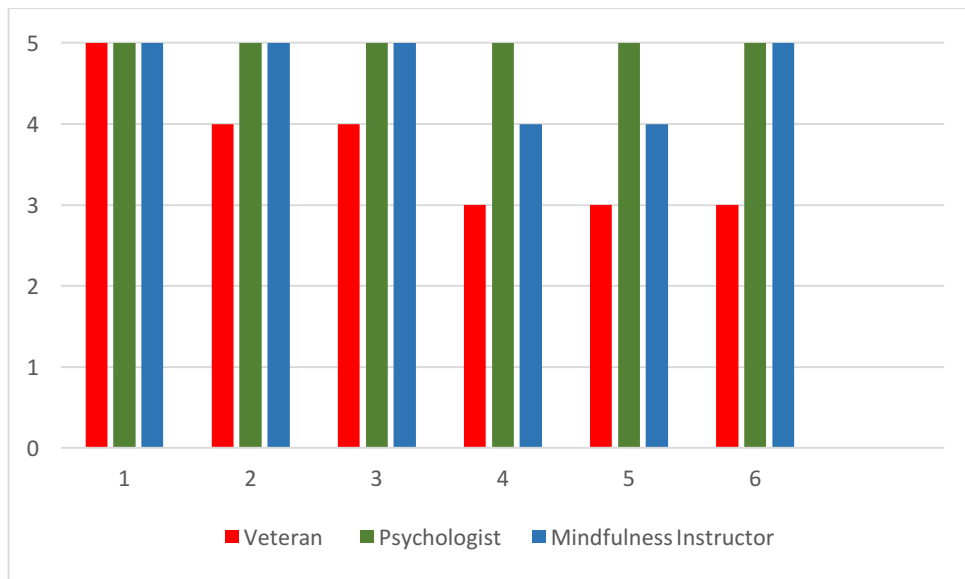
Figure 1. Evaluators' responses to six Likert-scale items.

Table 1

Evaluator Ratings of the Workshop Curriculum

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Item	Psychologist	Mindfulness Instructor	Veteran	Mean
Easy to Understand	5.00	5.00	5.00	5.00
Well Organized	5.00	5.00	4.00	4.75
Addresses Objective	5.00	5.00	4.00	4.75
Appropriate Activities	5.00	4.00	3.00	4.00
Helpful for Demographic	5.00	4.00	3.00	4.00
Engaging	5.00	5.00	3.00	4.25

_____

With respect to the open-ended items, there were noteworthy disagreements in the strengths and weaknesses of the curriculum. For instance, the veteran evaluator, in his response to Item Eleven stated "the program is trying to fit 4 weeks of work into one day" and "there is too much information for a half-day seminar if the veteran is expected to continue practicing at home" on Item Eight. In contrast, the mindfulness expert stated in Item Seven that she believed the manual is "really explicit in its intentions and aware of the limitations of a half-day workshop…It offers a variety of tools that the veterans can take with them." Further differences in opinion have to do with the specific needs of veterans, particularly around attending to PTSD and grounding exercises; the psychologist evaluator wrote "extra care was taken to address the

needs of veterans who may be exhibiting symptoms consistent with diagnoses of PTSD or Anxiety disorders, e.g., how to use 'grounding' and other adaptations," on Item Seven. However, the veteran evaluator stated, "there is no mention of what to do if a veteran dissociates" and continued in Item Nine that the manual needs to address "…how to ground yourself."

Workshop evaluation: identified weaknesses. While all evaluators agreed that mindfulness practices as a whole offer significant benefit to veterans, each offered suggestions for improvements surrounding wording, logistics, and instructions, though nearly all gave positive written feedback on the clarity and good organization of the manual. For instance, it was noted by the mindfulness expert evaluator that there are not built-in breaks and when there should be silence or breaks in silence. Another set of suggestions came from both the psychologist and mindfulness expert evaluators related to the walking meditation; the psychologist noted that veterans could walk in circles if need-be whereas the mindfulness evaluator expressed some hesitancy about the length of the walking meditation as well as believing more instructions were necessary for this meditation (e.g. what to do with one's hands, speed, paying attention to others' walking pace, etc.). The veteran evaluator believed a significant improvement would be focusing more on discussing pain and what it means to observe pain non-judgmentally rather than ignore pain, which he stated was what veterans were trained to do in the military. He also expressed a desire for more clarity around rules for the content of speech (e.g. trauma narratives, "war stories," etc.) given some veterans may have PTSD and could be triggered by such speech.

Other feedback regarding the weaknesses of the workshop provided by the veteran evaluator was that there is not adequate time for the group to bond and develop subsequent trust. This lack of trust due to the workshop only being a half-day rather than several weeks is

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hypothesized to lead to a notable lack of sharing and dialogue, particularly around the meaning-focused reflections and discussion.

Workshop evaluation: identified strengths. Strengths of the study include first and foremost, that mindfulness was viewed by all three evaluators as an effective way to address stress for veterans. They all agreed that the manual was well-organized, easy to understand, and detailed enough to implement in a standardized way. Two evaluators believed the manual did well in addressing specific and common needs of veterans, specifically regarding mental health problems common to veterans, the language of the manual, and the specific mindfulness practices employed by the workshop. Evaluators believed the program offers several tools which veterans can continue to practice for improved outcomes over time.

Despite critical feedback, both the veteran evaluator, who is a psychologist completing his post-doctoral residency at a VA and the psychologist evaluator expressed hope that this workshop would be implemented within the VA. The psychologist evaluator expressed gratitude at being asked to read the manual and went on to state in an e-mail correspondence, "Thanks for asking me to review it, I learned – and re-learned – a lot about Mindfulness and how we can best teach it to Vets!"

Table 2

Evaluator Comments on Workshop Strengths

Evaluators' Responses to Item Seven

In your opinion, what are the strengths of this workshop?

Evaluator	Comments

Veteran I think that mindfulness can be effective at addressing stress and could be useful for

returning veterans. I think that the manual is easy to read and provides scripts that would allow

it to be implemented in a standardized way.

Psychologist Extra care was taken to address the needs of Veterans who may be exhibiting

symptoms consistent with diagnoses of PTSD or Anxiety disorders, e.g., how to use 'grounding'

and other adaptations.

Mindfulness Instructor It's really explicit in its intentions and aware of the limitations of a

half-day workshop. It's a good introduction to mindfulness in a way that is specific to the

population it serves. It offers a variety of tools that the veterans can take with them.

Table 3

Evaluator Comments on Workshop Weaknesses

Evaluators' Responses to Item Eight

In your opinion, what are the weaknesses of the workshop?

Evaluator	Comments

Veteran There is too much information for a half day seminar if the veteran is expected to continue practicing at home. Additionally, there are several points where a question is asked but no response is allowed and then other places when responses are expected with the same wording. There is no mention of what to do if a veteran dissociates during a practice.

Psychologist As with any clinical intervention, future work might expand upon this content (e.g., using other Mindfulness exercises) or address special needs of some Veterans (e.g., Veterans with Serious Mental Impairments).

Mindfulness Instructor I don't see any real weakness in the material or how it is laid out. The only concern is that the facilitators be skilled enough to deal with the population and to handle anything that might arise during the sessions. The instructions speak to these contingencies very well.

Table 4

Evaluator Comments on Overall Improvement of Workshop

Evaluators' Responses to Item Nine

Do you have any suggestions for improving the curriculum?

Evaluator   Comments

Veteran Address that dissociation is possible when practicing mindfulness and how to ground

yourself. Consider a longer period of time to present the topic and a way to get additional

practice or assistance at home (e.g. videos, audio, VA apps).

Psychologist   None.

Mindfulness Instructor At the outset it's helpful to go over the logistics of the day and that

there will be smoke and bathroom breaks, etc. (Intro p7)

When setting the guidelines for the day it's also helpful to ask if the facilitator has left

anything out.

Are the breaks in silence? (p14)

Table 5

Evaluator Comments on Improvements for Demographic

Evaluators' Responses to Item Ten

In terms of delivering this workshop to the military population, what improvements would you make?

Evaluator   Comments

Veteran Since this protocol is targeting a group that has likely been exposed to trauma, there

needs to be class expectations and guidelines at the beginning of what can be discussed and

what cannot be. Scripts need to be worded in a way to let participants know when an answer

is expected and when a nod is expected.

Psychologist None.

Mindfulness Instructor Nothing comes to mind.

Table 6

Evaluator Comments on Improvement of Mindfulness

Evaluators' Responses to Item Eleven

In terms of explicit mindfulness practices, what improvements would you make?

Evaluator   Comments

Veteran If the format is going to remain the same, I would make the mindfulness practices

exact replicas of practices that are available online. I would also spend more time discussing

pain since military culture is often to ignore pain and focus on other sensations. The group

will likely need more time and explanation around what it means to feel pain and how to do so

in a non-judgmental way.

Psychologist Suggestions have already been provided to the developer of this Curriculum

(e.g., minor changes in wording).

Mindfulness Instructor It's also good to remind the participants that they cannot do the

mindfulness practice wrong; they can't make a mistake.

25 minutes seems a little long for a first walking meditation, but it may be fine. It's also good

to remind them not to pay attention to how quickly or slowly others are walking. There is no

right or wrong speed. And they may speed up or slow down during the time. It can be helpful

to make suggestions on what to do with their hands. Anything that takes worry out of the

practice is helpful.

Table 7

Evaluator Comments on Improvements of Meaning-Focused Exercises

Evaluators' Responses to Item Eleven

In terms of other contemplative, meaning-making exercises (e.g. writing, reflections, etc.), what improvements would you make?

Evaluator	Comments

Veteran The program is trying to fit 4 weeks of work into one day. There is no time built in for group rapport, yet you are asking them to share about the difficulty of deployment, the sensations of trauma without sharing about trauma, and you are wanting them to share their experience with meditation without knowing anyone else in the room. Without room for bonding, meditation without knowing anyone else in the room, and without the ability to trust, this is going to be a half day lecture on mindfulness with examples and not something beneficial to veterans.

Psychologist I don't know that these constitute 'improvements', but there are a nearly infinite variety of Mindfulness-based therapy exercises which could be incorporated or adapted for use with Veteran groups, along with specific therapies (e.g., ACT for Veterans with PTSD).

Chapter IV: Discussion

The current project involved the creation of a mindfulness and meaning-focused intervention and manual designed to aid licensed mental health professionals working within the VA system to implement a half-day workshop for veterans. Three qualified evaluators completed ratings of the curriculum and provided additional feedback on open-ended items, including strengths, weakness, and suggestions for improving the curriculum.

Development and Content of the Workshop Curriculum

The *Mindfulness and Re-Discovering Purpose* workshop curriculum was developed after a comprehensive review of relevant literature, as well as immersion in related media sources such as podcasts and blogs. This program was designed by synergizing various resilience-promoting theories and interventions in order to create a post-deployment, half-day-long, debriefing workshop. This is meant to contribute to the prevention of latent, war-related psychopathology from developing to the end of aiding veterans in continuing to live positive lives of success and well-being. While a theme associated with veteran mental health is disconnection from others, many veterans have reported they could be understood by fellow veterans (Burlingame, MacKenzie, & Strauss, 2003), which was one rationale for establishing this intervention in a group format. Additionally, findings that veterans in therapy groups believe connection to each other was one of the most important therapeutic factors (Holmes & Kivlighan, 2000) helped solidify the decision to use a group format.

The strong support in the literature provided the foundation for emphasizing mindfulness strategies in the workshop, given its established use within the VA (Kearney et al., 2013) and its efficacy with veterans (Vujanovicetal, Niles, Pietrefesa, Schmertz, & Potter, 2013; Polusny et al., 2015). Language which is somatically grounded (Levine, 1997) was incorporated into the

mindfulness exercises as such interventions are emerging as empirically-validated within the realm of PTSD treatment, including with combat veterans (Brom, et al., 2017). Given that researchers point to meaning as an important therapeutic consideration for veterans (Orazem et al., 2017) and others theorize that mindfulness can help aid in the development of meaning (Garland et al., 2015), explicit meaning-focused activities were added to the intervention in order to take advantage of the mindful and cognitively flexible mind which may create the space for greater meaning-making (Garland et al., 2015). It was hoped that this would create a stronger, highly synergistic effect of the intervention in terms of rediscovering purpose and making meaning for reintegrating veterans.

Specific mindfulness practices were chosen from VA-related sources and an attempt to further improve them by incorporating language which was somatically-based, trauma sensitive, and culturally congruent was made. Meaning and purpose-focused reflections were created by adapting questions from the meaning and posttraumatic growth literature (Tedeschi & Calhoun, 2004) to specifically engage identity and meaning problems associated with veterans (Adler, Zamorski, & Britt, 2011).

Recommendations for Future Steps in Workshop Development

Despite contradictions in the suggestions from the evaluators, a number of valuable improvements can be identified which are consistent with the literature. To begin, greater attention must be given to explicit instructions and logistics. Of note and considerable importance are more detailed instructions about what should and should not be spoken about in group (i.e. trauma narratives). Time for breaks should be more intentionally incorporated into the schedule, as should greater specificity regarding silence throughout the day, including ways to incorporate silence and mindfulness into breaks (Wolf & Serpa, 2015). For instance, it is not

uncommon for "smoking meditations" to be described at meditation retreat centers with smoking sections. Given that some veterans will take smoke breaks at designated break times, silence and mindfulness can be incorporated during these times to broaden the scope of the practice.

A particularly useful suggestion is related to the issue of chronic pain among veterans. While it was explicitly suggested in the manual that the provider be familiar with problems common to veterans, one of which is indicated to be chronic pain, more attention needs to be given to the experience of pain. This is especially true not simply because of how common chronic pain is for veterans, but also because the training service members receive about pain may contain messages that conflict with mindfulness. More specifically, for operational efficiency, service members are taught to ignore the pain and continue the mission (Willink, 2017) or to eventually correct the pain through analgesic medication, physical therapy, and surgery (Vallerand, Cosler, Henningfield, & Galassini, 2015). While these approaches are entirely useful and congruent with the Department of Veterans Affairs therapist manual for cognitive behavioral therapy for chronic pain (Murphy et al., 2014), mindfulness asks to be with and accept pain in a non-judgmental way in order to create a different relationship to residual pain.

Further, while the psychologist evaluator felt adequate time was spent attending to grounding as it was embedded within the protocol, some improvement can be made in the content. Given the potential for dissociation amongst those with PTSD, it would be beneficial to spend more time discussing grounding through non-somatic sensory experiences (e.g. naming multiple objects that are seen in the room, trying to find a pleasant sight, sound, or sensation to notice, etc.) and spend more time explaining when to use grounding. There is support in the literature for additional attention to grounding, as clinicians with expertise in dissociative PTSD

reported using frequent interventions aimed to improve awareness of emotions and somatic sensations, (Myrick, Chasson, Lanius, Leventhal, & Brand, 2015), and researchers recommend that for people who present with high levels of avoidance and dissociation, a strong emphasis on grounding techniques may be helpful to help emotion regulation (Kaur, Murphy, & Smith, 2016). Such techniques usually involve paying close attention to sensory details, such as what one sees, hears, smells, feels somatically (e.g. temperature, proprioceptive experiences, etc.), or tastes to ground one into the present moment.

Finally, alternative delivery formats should be explored in future development of the workshop. There are good reasons to implement this workshop as a multi-session group, rather than single day experience in order to promote greater bonding, trust, sharing, and lasting connections, as these qualities build over time in veterans (Thompson-Hollands et al., 2018) Given the difficult experiences many veterans have faced, the culture of being reticent to share personal thoughts and feelings, and the suggestions and desire of the program to create an open space for sharing, bonding, and comradery, it may be more beneficial to lengthen the program considerably. Other suggestions for this problem is to split the program into a once-per-week, 4-session protocol with practice assignments. This might be done in a variety of ways but given the literature on the cumulative effects of mindfulness (Ferrarelli et al., 2013; Lee et al., 2015), the need for bonding before sharing, and the feedback of the evaluators, multiple sessions may be a more effective format.

While loving-kindness meditation was considered as another type of meditation to include, at this time it does not have an evidence base for war veterans (Litz & Carney, 2018). However, it is currently being researched among the veteran population and has otherwise shown promise in clinical trials (Neff & Germer, 2013).

Further, complicated grief is an important treatment consideration for the OEF/OIF/OND population (Charney et al., 2018). Upwards of 80% of post-September 11, 2001, veterans studied have reported significant loss while 30% meet criteria for complicated grief (Charney et al., 2018). Complicated grief was associated with poorer quality of life above and beyond what can be accounted for by PTSD or depression (Charney et al., 2018). Incorporating meaning-focused reflections which may target grief should be considered.

While doing a purely mindfulness-focused workshop (with time for silence) may be beneficial in a half-day workshop, the incorporation of meaning-focused reflections and discussion requires more time. Specifically, alliance within the group needs time to develop (Burlingame et al., 2003). Many patients in group therapy believe the relationships they cultivate with other group members is even more meaningful than relationships with the facilitating therapists (Holmes & Kivlighan, 2000). Of particular note, if meaningful self-disclosures and meaning-focused discussions are part of the treatment, group relations are incredibly important (Holmes & Kivlighan, 2000). Additionally, while interpersonal difficulties are a hallmark of PTSD, one study found that veterans with PTSD with an interpersonal (i.e., violent) index trauma were able to develop group alliance levels similar to veterans with PTSD whose index trauma was not interpersonal (e.g., a serious accident; Thompson-Hollands et al., 2018). Given the centrality of re-discovering purpose and its unique contribution, creating a longer protocol that occurs over multiple sessions is much more likely to increase the level of bonding, sharing, and consequently the efficacy of the meaning-focused reflections and discussion, as well as the intervention as a whole.

Future steps would include modifying the current manual to include the above-suggestions, and then conducting a pilot program. The pilot program would include pre- and

post-measures, as well as qualitative feedback from participants to the end of refining the intervention even further. Gaining feedback from veteran participants as well as observing the protocol in process would highlight yet-to-be-discovered strengths and weaknesses which could then be improved.

Conclusion and Implications of this Study

The curriculum and manual for a half-day workshop was developed as a mindfulness and meaning-focused intervention for recently returned veterans to reduce stress, benefit mental health, and increase adjustment to civilian life. This manual was developed based on existing literature which demonstrates a need for such programs, as well as evidence suggesting the ameliorating effects of mindfulness for this population. Hopefully, such a program would be a strong foundation for future social bonding, mental health treatment, mindful living, and self-reflection. This manual was evaluated by three relevant experts; a combat veteran of recent wars, a psychologist who has spent his career within the VA helping veterans, and a mindfulness teacher with extensive training, teaching experience, and self-practice. These evaluators offered their expert opinions about the strengths and weaknesses of the program, as well as suggestions for development. All of their feedback was thoroughly reviewed, considered, and weighed in light of the literature for inclusion in future versions of the curriculum. It is hoped that this work will add a valuable intervention approach to current programs for recently returned veterans. Additional applied research studies to develop and implement similar interventions are critical to better serve the mental health and readjustment needs of recently returning military veterans in an effort to help them successfully reintegrate into civilian life.

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APPENDIX A

Summary Table of Selected Literature

APPENDIX A

Summary Table of Selected Literature

Authors	Year	Abbreviated Title	Focus (Variables, Keywords, Population, etc.	Source (Article, Chapter, Book, Presentaton, etc.)	Type (Conceptual, Review, Empirical, Biography, etc.)	Key Points
Adler	2011	The psychology of transition: Adapting to home after deployment.	Transition, military personnel, home	Book Chapter	Conceptual	The author examines the transition home for veterans after a combat deployment. She includes positive aspects of the transition process and adjustment issues which are not considered, and are thus often ignored, when diagnosing psychiatric disorders in recent service members who have experienced a combat deployment.
Bardeen, Fergus, & Orcutt	2013	Experiential Avoidance as a Moderator of the Relationship Between Anxiety Sensitivity and Perceived Stress	Anxiety, emotions, stress, experiential avoidance	Article	Empirical	Authors examined the relationship between anxiety sensitivity, experiential avoidance, and perceived stress. The findings suggest experiential avoidance moderates the relationship between anxiety sensitivity and general distress.
Brown & Ryan	2003	The Benefits of Being Present Mindfulness and Its Role in Psychological Well-Being	Psychological well-being, self-regulation, stress, Mindful Attention Awareness Scale	Article	Empirical	This paper is comprised of multiples part, including the development on an instrument and two studies with that instrument. The authors provide both the empirical and theoretical role of mindfulness in psychological well-being to the end of constructing an

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						instrument which measures mindfulness, the Mindful Attention Awareness Scale. This instrument is then used to demonstrate validity and reliability of the instrument by comparing mindfulness practitioners to non-practitioners as well as other tools used to measure effects which mindfulness is thought to produce (e.g. enhanced self-awareness). They then demonstrate that both trait and state mindfulness can predict positive emotional states and self-regulation. The next study demonstrates that mindfulness can be increased through practice in cancer patients and decreases their psychological stress over time.
Charuvastra & Cloitre	2008	Social bonds and posttraumatic stress disorder	Social bonds, posttraumatic stress disorder	Article	Conceptual Review	Authors review the literature of posttraumatic stress disorder at length, weaving together a picture which demonstrates that human-generated traumatic events (e.g. combat, sexual assault) are the most correlated to the actual development of posttraumatic stress disorder. They integrate empirical and theoretical literature on human-generated traumas, social support, developmental psychopathology, attachment theory and social neuroscience to

						demonstrate that pre-and post-trauma social support is a key factor in both developing and recovering from PTSD.
Elder, Gimbel, & Ivie	1991	Turning points in life: The case of military service and war	Perceptions of military service as life turning point, military career, combat experience	Article	Empirical	Authors investigate the perception of military service and war as life-changing experiences which produced profound shifts in outlook on life using four long-term longitudinal samples of American males born between 1904 and 1930 who served between 1940 and 1955. Generally, it was not war but military service broadly which was viewed as life-changing. Growing up in a family profoundly impacted by the Great Depression (i.e. poverty) increased the likelihood that someone viewed their military service as a deeply positive turning point, as did joining the military early (i.e. right after high school) as this afforded someone more freedom and stronger incentive in controlling their future post-military vs. people who enlisted later on and had family and/or careers disrupted by service.
Foa & Kozak	1986	Emotional Processing of Fear: Exposure to Corrective Information	Exposure to feared situation to reactive memory, emotional processing of fear structure	Article	Conceptual Review	Authors review commonalities in various psychotherapy modalities (e.g. Freudian psycho analysis, cognitive therapy, Gestalt, etc.) and arrive at the idea that

						avoidance is one of the main common factor which all therapy modalities describe as underlying psychopathology, albeit with different names. They then bring attention that in direct relation to avoidance underlying psychopathology, each psychotherapy attempts to increase exposure, albeit in different ways and by different names (e.g. "Gestalt therapists use imagery [and multiple means] to coax a person into 'the here-and-now,' while psychodynamically oriented therapists 'expose their patients to information about unconscious conflicts." They then review non-theoretical, basic scientific research which demonstrates the efficacy of exposure. After this, the authors theorize a large model of fear modification using affective science, cognitive theory, and behaviorism and describe the process of emotionally processing fear and hypothesize about other, more complicated mood states such as sadness and anger.
Fulton, et al	201 5	Prevalence of PTSD in OEF/OIF Veterans	PTSD, Prevalence, Veterans	Meta-Analysis	Empirical	Authors examine 33 studies published between 2007-2019 involving 4,945,897 OEF/OIF veterans. The estimates of the various studies vary widely, from 1.4% to

						60% due to several imprecise variables including only using data from veterans who actually use the VA services. From the meta-analysis, PTSD prevalence was newly estimated to be 23%.
Garland, Farb, Goldin, & Fredrickson	2015	Mindfulness Broadens Awareness and Builds Eudaimonic Meaning: A Process Model of Mindful Positive Emotion Regulation	Broaden-and-build, mindfulness-to-meaning theory, positive emotion	Article	Theoretical	Authors reintegrate the historical and traditional purpose of mindfulness, which is conceptually at ends with contemporary academic scholarship on mindfulness. The authors describe why historically, mindfulness was not purely dispassionate observation, as is often touted in contemporary scholarship, but a means to help facilitate eudemonic mental states. They then utilize cognitive and affective science to theorize that mindfulness actually leads to a deepened capacity for meaning-making, a greater engagement with life, and more positive emotional states. Mediating variables are described a length to elucidate the process of mindfulness-to-meaning.
Gross & Munoz	1995	Emotion regulation and mental-health	Emotion, mood, regulation, mental health, depression	Article	Conceptual	Authors define emotion regulation in multiple ways but focus on the moderating of emotions themselves. They explain how this process is functionally embedded in mental health and how

						when it is disrupted, mental health problems occur. The authors focus specifically on major depressive episodes. The focus on antecedent-focused and response-focused patterns of emotion regulation describes how pre-emotional contexts are modified to influence a subsequent emotional state and how if an emotional state is already triggered, one may regulate the emotion in a variety of ways to moderate its intensity and/or effect on one's surroundings.
Hayes, Wilson, Gifford, Follette, & Strosahl	1996	Experiential avoidance and behavioral disorders: a functional dimensional approach to diagnosis and treatment	syndromal vs functional classification strategies in psychopathology & utility & implications of functional dimensional category of experiential avoidance	Article	Conceptual	Authors justify a functional classification approach of psychopathology by demonstrating how many forms (i.e. syndromes) of psychopathology can be thought of as different unhealthy ways to avoid emotions, thoughts, memories, and other private experiences. Authors explain, through relational frame theory, how private experiences are not well-governed by intentional control and avoidance "prevents needed change," while creating unhelpful narratives and restricting one's behavioral repertoire in such a way as to strengthen psychopathology by way of negative reinforcement. Implications for

						treatment are discussed, specifically regarding mindfulness and acceptance of unpleasant private experiences as means of promoting flexibility, both behaviorally and cognitively.
Hoge, et. al.	2004	Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care	Combat duty, mental health problems, major depression, anxiety, posttraumatic stress disorder	Article	Empirical	Authors' aim was to begin to systematically address mental health problems and barriers to treatment for veterans who were part of U.S. combat infantry units. After surveying thousands of combat infantry soldiers and Marine, they discovered differences in combat exposure based on theatre (i.e. Iraq or Afghanistan), and data regarding mental health outcomes after combat exposure. 11.2-17.1 percent of subjects experienced either depression, generalized anxiety, or posttraumatic stress disorder. Amount of combat exposure was positively correlated with incidence of PTSD, in particular. Further, perception of stigma of mental health care was one of the largest barriers of care to those in need; only 23-40 percent of those with a diagnosable mental health condition, as evidenced by self-report of symptoms, actually sought mental health treatment.

Isaacs, et. al.	2015	Psychological resilience in U.S. military veterans: a 2-year, nationally representative prospective cohort study	Resilience, Posttraumatic stress disorder, Veterans, Trauma, Depression, Epidemiology	Article	Empirical	Large group of authors designed a large, longitudinal study to identify and predict resilience in U.S. veterans. They take the positive approach and notice that approximately 67.7 percent of trauma-exposed veterans are psychologically resilient, meaning they experience low distress despite high trauma exposure. Dynamic factors which reliably predicted low current distress despite high trauma exposure were higher levels of emotional stability, dispositional gratitude, purpose in life, and altruism. Other factors, such as age, race, physical health, psychiatric history, and substance abuse also predicted resilience or lack thereof, however. From a clinical perspective, dynamic factors which can be influenced were paid special attention with suggestions to create context and treatment for service-members with a high likelihood of trauma exposure and for Veterans with trauma exposure to increase gratitude, sense of purpose, and altruism as prophylactic and restorative practices.
Kabat-Zinn	1990	Full Catastrophe Living: Using the wisdom of your body and mind to face	mind, body, stress, chronic pain, illness	Book	Conceptual	In this groundbreaking text outlining Mindfulness Based Stress Reduction, the author examines

		stress, pain and illness				stress from somatic, subjective, and mental perspectives as well as outlines the eight-week training course created at the Stress Reduction Clinic at the University of Massachusetts Medical Center. Various meditation practices are offered, as well as demonstrations of how one can apply mindfulness in a variety of situations and to a variety of subjective experiences (e.g. walking around, talking to people, experience of anxiety, depression, chronic pain, etc.) The author harkens back to his Buddhist meditation roots and recommends readers engage in 45-minute meditation sessions six days a week.
King & Miner	2000	Writing about the perceived benefits of traumatic events	Trauma, visits to health care centers, college students	Article	Empirical	Authors conducted full 2x2 experiment with four possibilities for random assignment. Subjects are asked to write about either 1) the most traumatic event in their lives 2) only the positive aspects of that trauma 3) half the trauma and half the positive aspects of it or 4) mundane control topics. Those who wrote about either the most traumatic event in their lives or the positive aspects of the trauma were recorded to have fewer visits to health center, which is hypothesized to be mediated by higher

						self-regulation afforded by the writing intervention.
Linehan	1993	Cognitive–behavioral treatment for borderline personality disorder	Psychotherapy integration, behavioral therapy, Zen	Article	Conceptual	The article describes DBT, which was an integrated psychotherapy meant to borderline personality disorder. The authors describe the philosophy of DBT, which offers understanding the synthesis of biological and environmental factors in the development and maintenance of BDP. It then goes onto describe the reasoning for integrating Zen Buddhist practice into behavior therapy, name, to develop mindful acceptance and to help extinguish strongly reinforced contingencies. The authors then describe the process of holding two ostensibly contradictory treatment goals, that of change and acceptance, and how to best utilize these approaches to deal with different problems which emerge within the intensely painful and highly dysregulated subjective experience and behavioral repertoire of those experiencing BDP.
Owens, Steger, & Whitesell	2009	PTSD, guild, depression, and meaning in life among military veterans.	PTSD, guilt, depression, veterans	Article	Empirical	Authors examine the relationships between combat exposure, PTSD, depression, guilt, and meaning in life among veterans of several wars. While

						veterans of all theatres were involved in the study, Vietnam veterans were by far the most common, with 75% of participants from that era. Guilt and lower meaning in life predicted greatest PTSD severity, which possibly indicates posttraumatic growth, meaning-making and finding purpose are all processes which can ameliorate PTSD symptoms. Additionally, meaning in life and depression had a significant, negatively correlated relationship.
Park	2010	Making Sense of the Meaning Literature: An Integrative Review of Meaning Making and its effects on adjustment to stressful life events.	Meaning making, stress, coping	Article	Review	Author discusses how stressful life events challenge global meaning of belief, values and thoughts which were previously held strongly. Author notes distress stems from the appraisal of the discrepancy between global meaning and event. A subsequent meaning making process occurs to reduce discrepancy and restores a sense of global meaning (meaning made outcome). This occurs through assimilation, accommodation, and over-accommodation.
Peitrazak et. al	2009	Psychological resilience and postdeployment social support protect against traumatic stress and	Psychological resilience, postdeployment social support, traumatic stress, soldiers, operations	Article	Empirical	Authors examine the relationship between resilience, post deployment social support, PTSD, and depressive symptoms. They discovered subjects

		depressive symptoms in returning OEF/OIF soldiers				with PTSD had significantly less self-reported resilience, particularly the factors "increased personal control" and "positive acceptance of change." Further, post deployment social support was negatively associated with PTSD and depressive symptoms despite combat exposure. The authors suggest interventions which promote resilience and social support after deployments may mitigate the risk and intensity of PTSD and depression in OEF/OIF veterans.
Smyth	199 8	Written emotional expression: effect sizes, outcome types, and moderating variables.	written emotional expression & reported physical health & psychological well-being & physiological & general functioning & health behaviors, adults, meta-analysis	Article	Meta-Analysis	Author synthesizes, conceptually and statistically, the efforts of 13 studies which examine the relationships between written emotional expression and the enhancement of four health outcomes after the writing intervention: reported physical health, psychological well-being, physiological function, and general functioning. Of note, writing reduced distress in the short-term, both during and after writing, suggesting it can be a positive coping behavior which leads to longer-lasting benefits. Notably, for those writing about traumatic experiences, writing about current or recent traumas

						tended to have greater benefit than writing only about past traumas.
Southwick & Charney	2012	The science of resilience: Implications for the prevention and treatment of depression.	resilience, major depression, prevention, treatment, individual variability, stress, trauma, neurobiological risk, protective factors	Article	Conceptual	Authors explore explanations for why some people develop PTSD, other trauma-related disorders, and depression. This is in contrast to other people who develop brief symptoms which can even be quite distressing but resolve rapidly and without direct treatment. They explore several categorical variables which moderate the effects of stress in relation to the development of enduring psychological difficulties. They shed light on genetic factors, physiological factors (e.g. HPA axis), genetic factors, developmental factors such as emotion dysregulation and learned helplessness, adaptive stress responses, stress inoculation effects, and cognitive flexibility and spirituality to name a few. They describe the complex set of factors which can produce resilience, that is, the ability to recover from stress.
Teasdale	1999	Emotional processing, three modes of mind, and the prevention of relapse in depression	mindless emoting & conceptualizing/doing & mindful experiencing/doing modes of emotional processing used in cognitive therapy to relapse prevention in depression	Article	Conceptual	Author describes three modes of processing emotional material: mindless emoting, conceptualizing/doing, and mindful experiencing/being. The authors discuss

						how conceptualizing/doing may perpetuate depression by ruminative processing, whereas mindfulness experiencing facilitates pure emotional processing. Author describes how this can be used to prevent depressive relapse by teaching patients who have recovered from a depressive episode to notice and recognize the internal signatures of all three processing systems and how to engage in mindful experiencing by controlling attention in grounded, present-time experiences. This article is the basis of Mindfulness-Based Cognitive Therapy.
Tedeschi & Calhoun	1996	The posttraumatic growth inventory: measuring the positive legacy of trauma	development of Posttraumatic Growth Inventory assessment instrument, 17–25 yr old college students	Article	Empirical	Authors developed an instrument to assess posttraumatic growth, that is, positively strengthening perceptions of self, others, and the world in relation to a traumatic event that occurred. They do a comprehensive literature review which describes five components of growth after trauma. The construct of posttraumatic growth has five components: New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life. The statistics

						of the measure are discussed and the reliability and construct validity are supported. They also discuss limitations, which are essentially confounding and/or explanatory variables such as personality factors such as optimism. They further go on to compare and contrast related concepts such as resilience and hardiness.
Thompson	1994	Emotion Regulation: A theme in search of definition	Acculturation, family, and immigration	Book Chapter	Review	Discussed family separation, disruptions to family systems due to migration and negative impact on children. Author notes family motivates migration but has unforeseen negative consequences of prolonged separations, impacts on traditional family roles, cohesion, and cultural values in families. Author discussed the challenged of undocumented status including deportation and separation from children because of undocumented status. Author notes immigration can have negative impact on attachment due to the above issues.

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APPENDIX B

Evaluator Recruitment Email Script

APPENDIX B

Evaluator Recruitment Email Script

My name is Joshua Buch and I am a doctoral student of clinical psychology at Pepperdine University. I am contacting you to determine whether you would be willing to review a curriculum for a one-day mindfulness and meaning-focused debriefing workshop that I am developing to promote resilience and posttraumatic growth for veterans who have recently transitioned to civilian status. This workshop is a core component of my dissertation research.

I am conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The overall purpose of this research project is to develop curriculum for a one-day workshop for recently returned veterans who experienced high-stress deployment(s) and will employ mindfulness practices while providing meaning-focused reflections of their recent deployment. This is to the end of improving the stress response, easing their return from deployment, mitigating stress while making the adjustment to civilian life, and preventing nascent psychopathology from developing.

At this point in the project, I am seeking: (a) one mental health professionals with expertise in the military and/or veteran population, (b) one expert mindfulness meditation instructor, potentially with experience working with military and/or veterans, and (c) a veteran or whose primary responsibility in the military included exposure to combat to review the curriculum and respond to a brief questionnaire regarding their perceptions of the curriculum for the workshop.

If you decide to participate in this study, I will e-mail you a copy of my curriculum with an informed consent. Your input in this project will be confidential and you are under no obligation to complete the study at any time. If this is something that you are interested in doing, please reply to this email.

Thank you sincerely for taking the time to read this email and consider my request. If you have any additional questions regarding my research project, feel free to contact me, Joshua Buch, M.A., or Shelly Harrell, Ph.D. (shelly.harrell@pepperdine.edu).

Sincerely,

Joshua Buch, M.A. jbuch@pepperdine.edu

APPENDIX C

Evaluator Consent Form

APPENDIX C

Evaluator Consent Form

I authorize Joshua Buch, M.A., a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D., to include me in the research project entitled "Mindfulness and Meaning based Debriefing: A Workshop for Combat Veterans Returning to Civilian Life." I understand that my participation in this study is strictly voluntary.

I have been asked to participate in this study that will include the development of a one-day stress prevention/management workshop for veterans recently returned from deployment who are newly adjusting to civilian life. I have been asked to volunteer to participate in this study based upon my expertise as either (a) a mental health professionals with expertise in the military and/or veteran population, (b) an expert mindfulness meditation instructor, potentially with experience working with military and/or veterans, and (c) a veteran whose primary responsibility in the military included exposure to combat.

My participation in this study will last approximately 60 to 90 minutes of my time, in which I will review the written workshop's curriculum and respond to a questionnaire evaluating its design, usefulness, and effectiveness.

I understand that all information obtained in this study will be kept confidential. The Informed Consent Forms will be stored in a file separate from all other study materials. All research materials will remain in a locked file cabinet for five years, at which time the data will be destroyed. I understand that any comments submitted may be published or presented to a professional audience but that no personal identifying information will be released.

I understand that possible risks for participating in the study are minimal, but may include mild levels of boredom or fatigue during review of the curriculum and completion of the evaluation form and/or experiencing increased levels of stress as a result of considering the topic. In consideration of such factors, I have also been advised to read the manual and complete the evaluation at a time that is most convenient to me, taking breaks as necessary.

In addition, I understand that I have the right to not answer any particular question and may withdraw from the study at any time without penalty.

I understand that if I have any questions regarding the study procedures, I can contact Joshua

Buch, M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson, at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045, (310) 568-5600, to obtain answers to any of my questions.

Printed name _____

Signature _____

Date _____

APPENDIX D

Mental Health Evaluator Eligibility Form

APPENDIX D

Mental Health Evaluator Eligibility Form

1. What is the highest degree you have earned? ❑Bachelors ❑Masters ❑Doctorate

2. Do you currently hold a license to practice:

a.　　　in the state of California? ❑Yes❑No If yes, what governing body are you licensed under? ❑　California Board of Behavioral Sciences ❑　California Board of Psychology ❑　Other:

　　　_____

b.　　　in another state? ❑Yes❑No If yes:　i. What state? _____ ii. What governing body are you licensed under? _____

3. Do you have at least five (5) years of post-graduate experience working with and/or researching the military and/or veteran population, including experience with said people whose primary military duties included exposure to and/or participation in combat? ❑Yes❑No

4. Please indicate the number of years of post-graduate experience you have with the veteran or military population:

a.　　　In direct care? (i.e. psychotherapy, support groups, etc.) ____ years

b.　　　In research? ____ years

5. Do you have at least five (5) years of experience working with and/or researching:

a.　　　Mindfulness-based practices and interventions? ❑Yes❑No If yes, please describe type and duration:

　　　_____

　　　_____

_____

_____

b.   Meaning-focused based practices and interventions? ❑Yes❑No If yes, please describe type and duration:

_____
_____
_____

c.   Posttraumatic growth based practices? ❑Yes❑No If yes, please describe type and duration:

_____
_____

_____

_____

APPENDIX E

Mindfulness Instructor Evaluator Eligibility Form

APPENDIX E

Mindfulness Instructor Evaluator Eligibility Form

6. Have you been a mindfulness meditation instructor for ten (10) or more years? ◑Yes ◑No
   If yes, how many years? ____

7. What form of instruction do you provide (e.g. Mindfulness-based Stress Reduction,
   Buddhist Meditation [Theravada, Zen, Shambhala, etc.], etc.)

   a. Do you possess any form of certificate of completion of instructor training?
      ◑Yes ◑No If yes, what teacher(s) or organization(s) provided you with
      instructor training?

      _____

      _____

8. Does your meditation instruction experience include teaching in retreat format,
   specifically half-day or day-long retreats? ◑Yes ◑No If yes, please indicate how
   many half-day and/or day-long retreats you have taught

   _____

9. Do you have any experience teaching mindfulness to the military and/or veteran
   population, including experience with people whose primary military duties included
   exposure to and/or participation in combat? ◑Yes ◑No If yes, please describe

   _____

   _____

   _____

   _____

APPENDIX F

Veteran Evaluator Eligibility Form

APPENDIX F

Veteran Evaluator Eligibility Form

10. Have you served in the United States Armed Forces for four (4) or more years? ❑Yes❑No   If yes, for how many years? _____ years

    a. In which branch did/do you serve? _____

    b. What is/was your rank? _____

11. Were you deployed to combat zones? ❑Yes❑No If yes, did/do your primary duties expose you to combat (e.g. infantry, medic, combat engineer, special operator, etc.) ❑Yes❑No, if yes, please describe your primary duties during your deployment(s)_____

_____

_____

_____

_____

12. Did you participate in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), or Operation New Dawn (OND)? ❑Yes❑No, if so which one(s)?

_____

13. Do you have any direct experience with mindfulness and/or meditation-based practices? ❑Yes❑No If yes, please briefly describe_____

_____

_____

_____

APPENDIX G

Assessment of Curriculum

APPENDIX G

Assessment of Curriculum

1. The curriculum is easy to read and understand.

1	2	3	4	5

Strongly Disagree   Strongly Agree

2. The curriculum is well organized.

1	2	3	4	5

Strongly Disagree   Strongly Agree

3. The curriculum addresses the stated objective of the workshop.

1	2	3	4	5

Strongly Disagree   Strongly Agree

4. The activities are appropriate to use with veterans who recently returned from a combat deployment.

1	2	3	4	5

Strongly Disagree   Strongly Agree

5. This debriefing workshop will be helpful to service members who recently returned from a combat deployment.

1	2	3	4	5

Strongly Disagree   Strongly Agree

6. Participating veterans will likely be able to engage in this workshop.

1	2	3	4	5

Strongly Disagree   Strongly Agree

7. In your opinion, what are the strengths of this workshop?

_____
_____
_____
_____
_____

8. In your opinion, what are the weaknesses of this workshop?

_____
_____
_____
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_____
_____

9. Do you have any suggestions for improving the curriculum?

_____
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_____

10. In terms of delivering this workshop to the veteran population, what improvements would you make?

_____
_____
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11. In terms of explicit mindfulness practices, what improvements would you make?

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12. In terms of other contemplative, meaning-making exercises (e.g. writing, reflections, etc.), what improvements would you make?

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APPENDIX H

The Manual

APPENDIX H

The Manual

Mindfulness and Re-Discovering Purpose:
A manual for a half-day workshop.

Joshua Buch, M.A.

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Introduction

Welcome to "*Mindfulness and Re-Discovering Purpose*," a manual which outlines a mindfulness and meaning-focused half-day workshop meant to help veterans reintegrate into civilian life. For those who are licensed mental health professionals working in a VA setting, this manual should be useful for those interested in running a single-session, intensive group workshop for recently-returned veterans who are struggling with their post-military lives. Specifically, this workshop

teaches veterans mindfulness meditation and guides them experientially through multiple practices. It uses discussion, psychoeducation, and videos of veterans discussing their own mindfulness practices to garner rationale, hope, and motivation for workshop participants. It then utilizes carefully curated questions from the meaning and posttraumatic growth literature to help veterans skillfully (rather than morbidly) reflect on their military past, who they have become, what they value, and who they want to be moving forward. Mindfulness is utilized to help create the space for deeper answers to those questions while also being a therapeutic end in itself.

Group Rationale and Purpose

There is significant incidence of psychopathology directly and indirectly related to war (Litz & Orsillo, 2003). As the United States has been involved in multiple wars for well over a decade, there are many service members still enlisted in the military or those who have been recently discharged (i.e. new veterans) who will incur psychopathology. As the U.S. remains involved in military conflict, we continue to have people who have yet to be exposed to the potentially traumatic conditions of combat.

This program was designed by synergizing various resilience-promoting theories and interventions in order to create a post-deployment, half-day-long, debriefing workshop. This is meant to contribute to the prevention of latent, war-related psychopathology from developing to the end of aiding veterans in continuing to live positive lives of success and well-being. Some of the psychosocial risks for veterans identified in the research include the following:

(1) Among Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF; Afghanistan)/Operation New Dawn (OND) veterans, 23% report symptoms of PTSD (Fulton et al., 2015). Importantly, service members returning from OEF and OIF are increasingly dying by suicide (Katz, McCarthy, Ignacio, & Kemp, 2012).

(2) The psychological consequences of war and trauma have been found to impede marital relationships (Nelson Goff, Crow, Reisbig, & Hamilton, 2007; Taft, Watkins, Stafford, Street, & Monson, 2011). While marriage is usually a protective factor against loneliness, veterans may have difficulty sharing their war-related experiences with their loved ones and consequently feel disconnected from them (Stein & Tuval-Mashiach, 2015a).

(3) Orazem, Frazier, & Schnurr, 2017 found that two thirds of veterans who participated in writing about reintegration difficulties wrote about identity adjustment. The 5 components of identity adjustment difficulty were (a) feeling like one does not belong in civilian society, (b) missing the military's culture and structured lifestyle, (c) holding negative views of civilian society, (d) feeling left behind compared to civilian counterparts due to military service, and (e)

having difficulty finding meaning in the civilian world. Many veterans noted that in contrast to the sense of responsibility in protecting one's comrades or subordinates from harm, the responsibilities inherent in civilian life seem unimportant and thus nearly meaningless and dissatisfying (Orazem, Frazier, & Schnurr, 2017). While all of these themes underlie a sense of disconnection from the civilian world, many veterans believed they could be understood by fellow veterans.

(4) In an epidemiological study of mental health diagnoses of 289,328 OIF and/or OEF veterans who use Veteran's Affairs health care from 2002-08 (Seal, Metzler, Gima, Bertenthal, Maguen, & Marmar, 2009), 36.9% had a mental health diagnosis by the study's end. When mental health problems which did not confer a diagnosis were included, 42.7% of the subjects met criteria. The *majority* had comorbid diagnoses. The two most common diagnoses were PTSD at 21.8%, and depression at 17.4%. Approximately 7.1% were diagnosed with an alcohol use disorder and 3% with a substance use disorder.

Together, these studies highlight the need for an intervention for recently returning veterans which attempts to target the most common problems for reintegrating veterans; navigating changing identities, making meaning, and learning how to undermine transdiagnostic symptoms which are related to, or even exacerbate, anxiety, depression, substance abuse, and PTSD. Additionally, connection to each other may be an important therapeutic factor.

Clinical Caveats
With respect to utilizing mindfulness meditation with veterans, the largest randomly controlled clinical trial looking at a full course of Mindfulness-Based Stress Reduction (MBSR) for veterans with PTSD demonstrated its effectiveness and lower drop-out rates (Polusny et. al., 2015). However, according to psychologists from the VA's National Center for PTSD, anecdotal evidence and clinical wisdom suggest precaution when subjecting people with severe PTSD to long periods of silence (Vujanovicetal et. al, 2011). In fact, official MBSR training materials recommend that clients with PTSD should be screened out of MBSR if they are not in concurrent trauma-focused treatment. While these recommendations were made before the large RTC demonstrating MBSR's effectiveness for veterans with PTSD, efforts should be made to screen for veterans with more severe PTSD, particularly those exhibiting significant emotion regulation difficulties or those with high levels of re-experiencing symptoms (Vujanovicetal et. al, 2011). This can be done by administration of the PCL-9 for all interested veterans. If possible, it is recommended that for veterans with more severe PTSD, the half-day intervention described here should be imbedded as part of a larger PTSD treatment. Veterans without PTSD or with subclinical levels might engage in the intervention without concurrent additional psychological treatments. On the other hand, a large group of psychologists within the VA system note in a clinician's guide to teaching mindfulness to veterans, that "overall, we have found it critical to remember that the veterans in the room are often extraordinarily strong and

resilient…we have also found that many veterans come to the mindfulness group with very heavy mental health burdens, including significant symptoms of depression and PTSD, and are able to participate in and benefit from mindfulness (Kearney, et al., 2015, pg. 6)."

The U.S. Department of Veterans Affairs National Center for PTSD explicitly acknowledges that each research study, group, or provider must establish their own cut-off rules when screening with the PCL-9. They give a soft recommendation that in a VA mental health clinic, scores above 50 may indicate the patient should undergo explicit PTSD treatment, however they also admit "research is needed to establish optimal cut-point scores for a specific application (VA National Center for PTSD, 2012, pg. 2)." Our suggestion is based on individual providers. For instance, if this group is being provided as part of a PTSD clinic's activities by licensed mental health practitioners with extensive experience working with PTSD, a higher cut-off would likely be acceptable. In contrast, if this program is being provided through a primary care clinic, where PTSD prevalence is lower, a lower PCL-9 cut-off score should be considered (VA National Center for PTSD, 2012)

Additionally, anecdotal and common sense alterations have been suggested for those with more severe PTSD, such as breaking up longer meditation periods into two or three shorter ones, or encouraging participants to keep their eyes open with a relaxed gaze during the meditations.

Recommendations for Group Size, Setup, Materials Needed and other Logistics

While this manual offers guidelines and caveats, clinical experience is required given the likelihood that specific needs will vary from group to group and adjustments will be necessary. It is therefore of utmost importance that a licensed mental health professional with both experience teaching mindfulness meditation and working with veterans facilitates this workshop. Per *Teaching Mindfulness to Veterans: A Resource*, "When teaching mindfulness to groups of Veterans, we suggest that instructors have knowledge of the high prevalence of chronic pain, depression and PTSD among Veterans, as well as a basic understanding of how mindfulness practice may influence these conditions." (Kearney, et al., 2015, pg. 6).

<u>**Set-up and Materials.**</u>
<u>Monitor and Internet Access</u>
Because multiple short-videos will be incorporated into the workshop, make sure the group room you will be using has a monitor and internet access. It is recommended that you have each piece of media loaded on a window for easy access once it is time to view them.

<u>Room and Environment:</u>

Tables and chairs should be either facing the facilitator, oriented to the front of the room, or in a circle. It is important that if the veterans will be asked to write, they have a table in front of them or that clipboards are distributed. Importantly, given there is a **walking meditation**, there should be adequate space for veterans to each have their own walking path of approximately 15-30ft in length that will not interfere with other walking paths. Use judgement when figuring this out; if the class is near to and has easy access to an adequately sized outdoor area and weather permits, use that. If you have access to a large group room, mentally note walking paths before-hand. Most important to walking meditation is that there be adequate space without veterans crossing paths and creating traffic, as well as some semblance of privacy or space away from non-participants. For example, a well-walked hospital hallway is not a good place to practice walking meditation for this group.

<u>Timer.</u>

Make sure to have some sort of timing system. Free meditation timer apps such as Insight Timer are perfect, others prefer to have an actual bell they ring as they pay attention to the time on a watch or clock. As a last resort, a digital or kitchen timer is adequate, but they produce a sound that is often startling, so these should be avoided if possible.

<u>Additional Materials.</u> Have enough pens and handouts for every veteran. Make sure you have reviewed and adequately filled out Appendix C, a partially completed template with further resources. Resources which are national (e.g. Veteran's Crisis Line) or are freely accessible online (e.g. the Mindfulness Coach App) are already provided, however, there are empty spaces a provider should fill in which are specific to your VA (e.g. location of same-day mental health clinic or other mindfulness classes within your VA).

<u>Sample Scripts.</u>

This manual is equipped with suggested rules and guidelines for the group, psychoeducation for veterans, several mindfulness practices, and meaning-focused reflection exercises in either verbal and/or written format. Rationale and explanation is provided for each section for those who want to be more spontaneous but want to maintain fidelity to the program. However, sample scripts are provided in each section to give providers ideas or detailed and specific language to use. For provider convenience, all scripts are both indented and italicized. When there are follow-up instructions related to a specific script, the italicization is removed and the instructions are put in parentheses at the end of that section of script.

<u>Group Size and Exclusions.</u>

While mindfulness meditation can be taught in very large group, this workshop includes the possibility of writing and/or sharing. In order to give adequate time to all involved, no more than 15 veterans are suggested for each group.

The following exclusion criteria for teaching mindfulness in a group setting to veterans are suggested:
- Current psychotic disorder
- Poorly controlled bipolar disorder with mania
- Borderline, Narcissistic, or Antisocial personality disorders where interpersonal, impulse control, or emotional dysregulation symptoms are expressed in ways that would be disruptive to the group
- Substance use disorder or alcohol use that poses a safety concern, potential for group disruption, or is associated with an inability to keep appointments
- Suicide attempt or suicidal ideation with intent or plan, self-harm within the past month, or psychiatric hospitalization within past month.

For this manual, a diagnosis of **complete tetraplegia** should be considered as exclusion criteria. There are too many practices in this group which rely on observing bodily-based sensations and consequently require proprioceptive awareness. For other spinal cord injuries, a person-to-person basis should be considered; what is most important is that there are somatic sensations the veteran is able to observe, particularly surrounding the breath. For veterans who have such diagnoses which preclude their ability to engage in the following mindfulness practices, a spinal-cord injury-specific mindfulness practice may be most beneficial.

Workshop Guidelines for Facilitators

Section 1 - Welcome and Introductions
Materials Needed: Group Rules handout (Appendix A), large monitor with internet access, script for brief grounding exercise.

Begin the workshop with an introduction of the facilitators. Have a warm, welcoming attitude, and provide brief information about the purpose and focus of the group.

"Welcome everyone. Just want to make sure that everyone is here for the mindfulness group. We will be spending the next few hours together and will be finished by X o'clock. For many veterans, stress, depression, substance use problems, or even PTSD are a large part of life. Further, for many, discovering new purpose and meaning in civilian life is related to those difficulties. In this workshop, we're going to be learning and practicing mindfulness meditation, as well as doing some writing or discussion about finding meaning and purpose in life now. Everything will be guided and there will be ample time for questions after each practice session."

According to Wolf and Serpa in their *Clinician's Guide to Teaching Mindfulness*, it is important to get the class grounded and settled right after a brief welcome. Explain the use of bells/ringers ahead of time if they are used. The following is a slightly modified version of Wolf and Serpa (2015)'s suggested script for the initial grounding exercise.

"Let's actually do a short guided mindfulness exercise to get us out of our thinking minds and into the body."

"This is a short mindfulness practice that helps bring us here and now, into our bodies. It's called a Grounding Meditation." It won't be long, just 5 minutes. Finding a comfortable posture, with both feet on the floor. Allowing the eyes to close gently if that feels okay, or just lowering your gaze. Now bringing attention into the areas of contact that your feet are having with the floor. Noticing the solidity of the floor under your feet. Feeling the places where your shoes come into contact with your feet, with your toes, simply feeling your shoes, the floor, your feet, noticing what they feel like.

Pause

Now move on to where your legs and buttocks make contact with the chair, allowing the ground and the chair to support your body without you needing to do anything.

Pause

Now moving the attention to your back. Notice where your back touches the back of the chair. Try to notice the difference between where there is contact and where there isn't any.

Pause

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Now moving your attention to your hands, feeling your hands. Notice the position of your hands, what they are making contact with, possibly with your thighs and the material of your clothes, or your other hand.

Pause

Ask yourself, "How do I know I have hands without looking?" "You can just feel them. We can feel the hands from within."

Pause

Now attempt to feel your entire body sitting here, in this moment, on this chair.

Pause

And now, for the last minute or so of our short meditation, bringing the attention to the breath. Take a few comfortable breaths and really feel them. Ask yourself where you feel the breath the most or where the sensations are most pleasant. At the nostrils where the air comes in? At the back of your throat? In your chest or belly rising and falling? Using that place as the anchor for your attention, this is where you will come back to over and over whenever the mind wanders.

Now letting the breath happen, not needing to make it any other way than what it naturally does.

Pause

When you notice your attention is somewhere else, gently bring it back to the breath.

Pause

In a moment, the bell will ring and that will end our short mindfulness practice."

Then introduce and show this video, which is an official Veterans Health Association video which has a veteran describe his experience with mindfulness meditation at the VA. This video is approximately 5 minutes:

"Here is a 5-minute video of an OIF veteran discussing some of his experiences learning and practicing mindfulness through the VA."

Go around the room and give everyone the opportunity to introduce themselves and say what they want to get out of the half-day experience. Veterans will often include the branch of the military they served with and in what capacity they served as part of their introduction, this should not be encouraged or discouraged. Facilitator should go first to demonstrate brevity.

> *"Now let's go around the room and introduce ourselves, also saying what you might want out of the group. If you'd like to comment briefly on the video and how it relates to what you might want to get out of the group, please do. My name is _____, and I _____. (Example: "I hope that through reflection and meditations, I am a bit more aware of myself and relaxed at the end of the day.")*

Guidelines for the day:
1) Respect. *"We will not use harsh words towards others, will remain quiet and give attention when someone is speaking, and will commit to an atmosphere of community."*
2) Confidentiality. *"What we see here, what we hear here, let stay here."*
3) Compassion. *"Realize everyone here has some difficulty in their lives. It is not for us to be judge and jury regarding someone else's pains, difficulties, and afflictions. Attempt to treat everyone with some kindness."*
4) Courage. *"It is not easy to open-up and speak or even think about difficulties, confusion, or potentially horrifying experiences. A commitment to walk into this experience fully and openly requires courage."*
5) Honor. *"It is dishonorable to kick a downed person. While we may disagree with something someone might say, we are all here to improve ourselves and our lives, which is honorable. Give a small nod of acknowledgement to yourself and those around you who willingly walk into difficulty for the sake of betterment."*
6) Accountability. *"Attempt to only speak for yourself and from your own experience."*
7) Attention. *"Mindfulness is at the core of the day and in the most basic sense, this means solid attention or alertness that is relaxed and undisturbed by our mind's judgements. This is how you should attend to each activity and especially any person who is speaking. Pay respect and act with honor by giving a relaxed but clear alertness to whatever is happening in the moment."*

One VA mindfulness teacher (Kearney, et al., 2015, pg. 18) offers the following Rules of Engagement for class:
"No Fixing,
No Advising,
No Saving,
No Setting Anybody Straight."

Inquire if everyone clearly understands the guidelines for the day and if not, answer questions in the spirit of the 7 guidelines.

Section 2 - Psychoeducation
Materials Needed: Monitor with internet access

"The following video is an 11-minute TEDx Talk by Erik Younger, an OIF combat veteran diagnosed with PTSD. He speaks about some of his experiences, data on Veteran mental health, and importantly, his experience with mindfulness meditation and the ways in which it has drastically improved the quality of his life."

The purpose of this video is for veteran "buy-in" and the creation of some hope.

Play 11-minute video linked below
https://www.youtube.com/watch?v=yA1O5gmP4eg

After video, bring up image from Appendix D ("Mindful or Mind Full?"). This image is worth a thousand words. Allow them to look at the image for a few moments before saying anything. Right after the previous video, this image might be particularly meaningful. Let them look at it for 20-60 seconds before posing the following questions to the room,
"who's happier, the human or the dog? Who is more effective if something in their environment comes up, the one actually noticing what is happening, alert but calm or the one with a million things going on in his mind? Which one are you?"

Introduce need for intentional, thoughtful, mindful reintegration and the difficulty this poses for many.
Veterans often have difficulty transitioning into civilian life for a variety of reasons. When in the military, much of each day was clearly laid out and defined. One's job is pretty clear and there is a hierarchy of command; in general, people know what to do, when to do it, how it should be done, and who is in charge of whom. Civilian life is different; you decide how to spend your time and who you interact with. It is up to you to find or create work, hopefully meaningful work. In the military, there might be built-in comradery, people you see on a regular basis or even protect and rely on in combat. These bonds are sometimes incredibly solid; in civilian life, we need to create our own community and intentionally spend time with people. Community, family, friendship are not just built-in givens as they sometimes are in the military. Further, if you know you feel most comfortable around certain types of people, such as other veterans, it is only up to you to seek those people out. It won't happen for you.

The point of these *brief* questions is to engage the veterans with the content and help them resonate and connect, not to get caught up in long narratives. Attempt to hear a few difficulties but encourage brevity explicitly. For example,

> "*Does anyone relate to this? How so? Have any of you had difficulty with these things? Any nods of recognition? I know many of you have large stories and while some of you may want to tell much of them, this is not so much the purpose of today's workshop, instead attempt to say what you need and then make space for others. Please make sure to not describe any traumatic or war-related incidents, that's not what this day is for.*"

> *Additionally, sometimes service was so impactful to us but also dangerous, frightening, or there may even be terrible things we might have experienced that take a lot of time to digest. Sometimes we don't really know what to make of those experiences and cannot stop thinking about them; we can't truly digest them. But we can, we can digest the experience, learn from it, transform it so that our service experiences positively affect who we are and what we want to do in the world moving forward. But sometimes this does not happen on its own.*

The next piece of psychoeducation is discussing the relationship between stress, basic physiology, traumatic injuries and eventually meaning-making, posttraumatic growth, and resilience.

For example,

> "*We all walk around with a certain energy; relaxed, tense, alert, whatever. When something stressful happens, the body/mind has a way of dealing with this; it's called the stress response or "fight, flight, freeze." When something stressful happens, your brain realizes you need to be able to become alert, orient to the stress or potential danger, and prepare an action. This all happens instantly as part of your autonomic nervous system. Hormones are released, such as adrenaline, which makes us faster, stronger, and more alert. Once we have escaped the stress or danger through fighting it, escaping it, or waiting till it passes, our brains and bodies slowly return to normal. However, if you are under a lot of stress or danger very often, your body and brain don't fully have the time to return to baseline and also learn that keeping a heightened sense of "fight or flight" at all times is a safer way to be than relaxed and not alert to danger. This makes sense. But if you've lived this way for a long time, always alert to real danger, it is pretty hard to stop once we come back to civilian life. Loud noises are interpreted as the same as the loud noises we heard overseas which signaled real danger, even though it was just some news helicopter or car backfiring. This is called "hyper startle" or "hypervigilance" and is related to posttraumatic stress disorder. You may have learned that danger is often or even always present, which makes you feel even more stressed, understandably leading to frustration, suspiciousness, irritability, anger, and exhaustion.*

> *Does anyone relate to this? Feeling on edge, angry and irritable a lot? Frustrated with people around you, strangers, family members, whoever. Is it hard for some of you to return*

to a relaxed state after feeling stressed out? (Wait for hands or nods of resonance – if someone begins to talk, attempt to redirect or interrupt once they have adequately described how they are affected and then make a reflection such as 'it sounds like you experience what we're talking a lot' or 'it sounds like frustration and feeling stressed out might be getting in the way of your life sometimes').

Then there are the cases where there is a sense of feeling lost and without purpose after being back from deployment. For some veterans, being engaged in military combat is one of the most meaningful experiences possible. It is literally life or death and all of your actions completely matter, they all have purpose. When everything that happens has that sort of important purpose, it's difficult to come back here where every individual action might seem so much less important, less meaningful. "Who cares about x job," "my friends here don't understand what I went through, their lives are so shallow or stupid." These types of thoughts are very common and understandable after leaving an era in life where everything so very clearly always mattered. Does anyone have trouble relating to civilians, or believe there might not be a way to make civilian life interesting, enjoyable, or meaningful? (Wait for hands or nods of resonance – if someone begins to talk, attempt to redirect or interrupt once they have adequately described how they are affected and then make a reflection such as 'it sounds like you experience what we're talking about' or 'it sounds like finding purpose and enjoyment in life is difficult right now').

In either of those cases, or many others, one of the problems is that we are wrapped up in the story of the mind. Imagine you are at home watching a movie… at a certain point most people become fully engrossed in the movie and almost forget they are simply watching a two-dimensional screen made of glass, plastic, and metals. They believe, to a certain extent, what is happening in that story. They are being affected by the story, scared when something scary happens, sad when something sad happens. However, what happens if someone, fully engrossed in the movie, looks around at their friends or family, the other furniture in the room; the spell of the movie is broken. You remember that the story of the movie isn't really happening. If the movie is scary, you become less scared. The mind can cast the same spell over us as the movie, thinking all sorts of thoughts, over and over and over again about things that are no longer happening or things that haven't happened yet. And just like the movie, these stories of the past or the future really affect the way we feel, sometimes even to the point of serious depression or anxiety. In the same way we can remember the movie is just a movie by breaking our gaze from the screen, we can actually train our minds to not continuously drag us into the stories of the past or the future.

Does that resonate with anyone, having your mind constantly think about the past, over and over again or worry and maybe even get angry about a future that hasn't even happened yet?" (Wait for hands or nods of resonance – if someone begins to talk, attempt to redirect or

interrupt once they have adequately described how they are affected and then make a reflection such as 'it sounds like you experience what we're talking a about' or 'it sounds you know what it's like to get caught up in the past or the future a lot.")

Next, highlight the importance of thoughts and emotions and explain how they already have been trained in a combat-oriented mindfulness with culturally congruent examples. Then, an attempt is made to explain how mindfulness can be used to help us understand our thoughts, emotions, and actions in an attempt to process our past through accepting it (and whatever arises in the present, such as emotions connected to the past), being willing to reflect on it, discover what was learned from it and consequently how we have changed, and how to leverage changes into a healthier, more positive sense of self in the present and future.

"It is possible, though, to deeply absorb and understand how you have changed as a result of military service and to move forward in a life with an eye for finding and creating purpose. It begins with paying attention. Paying attention to our thoughts which interfere with and disrupt our path of purpose. What types of thoughts might interfere with finding purpose, connecting with others, or doing good work in life?.... Give an example.,*"I've heard some combat veterans say that the camaraderie they felt could never be replicated, which meant there was nothing for them in social situations anymore, making them feel alone and isolated or how boring doing a job might be after something as potentially intense as combat." Anyone relate or can think of other examples?*

Allow for answers.

(culturally congruent analogies which demonstrate some of the mental states that will be nurtured during the day)

During a mission or a firefight or even just a busy day when you had a lot of tasks to complete, disruptive, unbalancing thoughts can come, but you've learned how to put them aside, let them go, in order to maintain focus. This is a component of mindfulness and we can train this ability for our lives at large, not just for life or death situations. You have learned how to take action even when it's uncomfortable and your mind is screaming to stop; in part, you had to just accept unpleasantness as part of the experience in order to keep going and do the task ahead of you. Acceptance of thoughts and emotions, without getting involved, just noticing them, is another important component of mindfulness practice."

And just as you experienced the difficulty of combat and went through it by using some of these trained skills, with some different training one can move through relationships and a life that might initially seem more boring, less connected, frustrating, confusing, or aimless.

Mindfulness means paying attention to what IS with an attitude of acceptance of reality. Mindfulness notices what is happening without an attitude of fighting it, pushing it away, or trying to change it--, just allowing whatever is happening to just be what it is. Mindfulness

says "oh, that is anxiety," "oh, this is boredom," "oh, this is pleasure" without attaching good or bad, avoidance, or craving.

Some have described it as "the nonjudgmental observation of what is happening inside and outside." Being trained and practiced in this ability of mind helps separate ourselves from depressing thoughts, anxious thoughts, all of those feelings in the body and makes them more tolerable. It helps us not run from difficult sensations and emotions.

How might life be different if it was easy to tolerate really unpleasant emotions and not need to react right away to them? Has anyone gotten into trouble for believing they needed to just GET RID OF an uncomfortable emotion or impulsively acted on it immediately without reflecting first?

Let them answer and validate appropriate examples....

Examples might be getting loaded, yelling and screaming at people, becoming violent, or lying in bed because it seems too hard to do anything. Or even, trying to not think certain thoughts.
Instead, we can notice with an open, patient awareness that is willing to experience difficult things, including frustration, fear, sadness, guilt, boredom. And when we don't avoid these things, we can actually discover what needs to be changed or worked on in our lives to improve them. The way we do this is to practice paying attention to what is happening right here, right now.
Are there any questions?

Section 3 - Practice
Materials Needed: Meditation timer, and workbook or script of meditation.

Present, you-centered language.
During experiential instructions, tell the veterans what you want them to focus on during that specific meditation. For example: "Notice the sensations of your feet." Try to avoid giving instructions which make a participant think about something outside of the meditation, for example, saying "this is how you would also bring the mind back *later, when you are having dinner at home*," because it references the future, rather than the present.

Attempt to use the present participle; words ending in *–ing*. For instance, *noticing, feeling, breathing,* all representing activities currently happening. It also feels more inviting.

Generally, it is recommended that you guide a meditation with "you" rather than "we." For some, "we" can feel supportive while for many others, "we" can feel condescending. Additionally, each person's experience is different and "we" often assumes similarity. This may

needlessly have the effect of rupturing rapport, particularly if the provider is not, or has not disclosed, being a veteran.

Mindful Breaks:
It is helpful to give a few breaks throughout the day where participants can walk around, stretch, go outside, or go the bathroom for a few minutes (3-10 minutes). Encourage them to stay "mindful" throughout the break as much as possible. This means paying close attention to whatever they are doing from moment to moment. They can continue with their breath, or the sensations of stretching/walking around, or paying close attention to their immediate surroundings as if seeing these things for the first time (e.g., colors, the grass, etc.), or even doing mindful "smoking" if any of the veterans go outside to smoke a cigarette. Taking breaks may ease fidgetiness and help them practice what they have learned without having to sit still. Make sure there is a somewhat simple method of finding participants (i.e. suggesting a specific smoking section or suggesting that if they choose to walk around, they stay within a particular floor or area, etc.)

Let them know the timeframe of the meditation; for many people, not having a general sense of when the timer will go off creates an unnecessary amount of agitation-induced thoughts. Some will become anxious or uncomfortable with the prospect of 15 or 20 minutes of meditation. Remind them here that simply noticing and not reacting immediately to any little physical or emotional discomfort, such as annoyance, frustration, or fidgetiness is part of the practice which can lead to more comfort being uncomfortable.

Briefly remind them that all experiences are acceptable and that the practicing is in noticing the distracted mind, letting go of thoughts, and returning to the breath with as little self-judgement as possible.

> *"So we will start by beginning to practice focusing the mind on the here and now, what is happening in front of us and inside of us. Whatever happens is acceptable, though practicing acceptance actually requires practice! For almost all people, they will become distracted many, many times by thoughts, memories, wanting something, wondering if they're 'doing it right' or a million other things; the practice is in catching our minds distracting us, calmly accepting that fact, and returning to the breath."*

Orient them to sitting meditation practice. Discuss rationale for reducing stimuli for practice (i.e. ease of practice).
> *"Being mindful means simply being fully aware, alert, but in a relaxed, non-judgmental way. Being present, here and now, mindful throughout one's life, especially when things are difficult, is not very easy. So, we create good conditions to learn and practice in before expecting to be able to do well with the skill in the world. For instance, when you learn a new movement, strategy, or play in a sport do you attempt it for the first time ever while in a*

competition? In a competition, there are tons of things going on, it's hard to do, so first you practice the movement when nothing else is happening. A ton! Then you drill it with teammates who are sort of resisting, then with teammates who are trying hard to block you up or get around your maneuver. Then finally, once you can do the movement or play really well in those conditions, you try it out in a game. This is the same. Doing this sitting down in a room without a lot of stuff going on is where we begin our practice.

<u>Breath and bodily focused mindfulness meditation – 15 minutes</u>
"First, sit in a way that is comfortable but upright, with your feet flat on the floor. Many recommend closing the eyes, but if that feels uncomfortable for any reason, just keep your eyes open and have a relaxed gaze at the floor in front of you; really try not to look around, as that ends up being very distracting for many. Take a breath and notice what it feels like. You might notice the sensation of air coming in and out of the nose or mouth, is the air warm, cool, soft, slow? For the next breath, notice the feeling of the chest or belly expanding, the fullness it creates… as you exhale, notice it deflating, changing… just notice what this feels like…whichever was easiest for you to notice, either the wind coming in and out of the nose or mouth or your chest or belly expanding and deflating, stick to one of those sensations and keep watching the breath sensations there… keep noticing each breath in, and out.

30-60 seconds later remind them of what they are doing and normalize how quickly the mind distracts us from the task at hand.
"Most of our minds have started in with distractions, judging, thinking, planning, wondering what in the world we are doing this for… attempt to put those thoughts in the background, drop them, and re-focus on the sensations of the breath… this is how we train ourselves to stay focused, to be right here, right now, because the breath is being felt right here right now."

30-60 seconds later, remind them and normalize again. Also, emphasize that part of the task is to just notice when we become lost in thought and to return to the object of meditation several times if not continuously.
"If your mind has taken you somewhere else, as most of ours have, there is no need to get frustrated, just know this is what the mind does, it thinks thoughts. Attempt to let the stories or memories or planning or judging fade into the background, and re-focus on the breath. Part of the task is to attempt to bring yourself back to the breath when the mind distracts you."

2-3 minutes later
"Notice if there is any part of the breathing experience that is actually pleasurable; maybe it's a sense of relaxation in a part of the body or during part of the breath. Just notice and soak in that pleasure, really savor it if it's there.

2-3 minutes later, remind
"ten times, one hundred times, one thousand times, keep calmly coming back to the breath, refocusing towards the breath and away from thoughts once we've caught the mind

distracting us. If there is irritation, fidgetiness, or frustration, attempt to simply notice that and attempt to return to the breath, accepting discomfort while still feeling into the breath."

Every 2-3 minutes remind again

"over and over, come back to the sensations of the breath, letting go of the million thoughts that might be shooting around our minds, keep calmly coming back to the breath."

Once the allotted time is almost complete,

"our time is almost up… soon, a bell will sound. Try to hear the entire length of the bell's sound, really bringing our attention to the sound. See if you can notice the exact moment when the bell stops."

<u>Time for questions and answers.</u> Normalize that this is an unusual task for most people and that many people find it incredibly difficult to stay focused on their breath. Reiterate that for people with a trauma history, open-eyes with regular "regrounding" by noticing sensations of feet on the ground may be most helpful. It is absolutely acceptable to self-disclose personal "difficulty" staying with the breath. It is common at this stage for questions or statements to be related to difficulty, not doing the practice "correctly," or some other way uncertainty and frustration emerge together. Attempt to normalize and remind that the practice is NOT about stopping the mind and emotions, but to be able to catch ourselves, accept, let go, and come back to the breath.

<u>This is likely a good time for a Mindful Break (refer to pg. 13)</u>

When it time to begin, ask if people were able to be present at all during the break or if they noticed their minds wandering all over the place. Reiterate that this is a practice and that most people's minds very naturally take them into the past or future much of the time.

"Here is another very short video of another veteran's experience with mindfulness. We (I) want you to hear from other veterans and not just providers about the benefits of these practices."

Play the 1-2 minute video linked below:
https://www.youtube.com/watch?v=CdYYLcvBQRE
<u>Body Scan Meditation – 20 minutes</u>

"The next practice will help you use your body to develop more mindfulness. Our body is sensing the environment here and now and we can use that as an anchor into the present and as a way to expand our awareness beyond the breath. I will lead you in a guided mindfulness meditation practice for about 20 minutes. Notice what thoughts your mind came up with when you heard that we were going to do 20 minutes. Notice, then come back to here and now. 20 minutes happens one second at a time, so that's all you have to tolerate at any given moment.

"

Remind them here that simply noticing and not reacting immediately to any little physical or emotional discomfort, such as annoyance, frustration, or fidgetiness is part of the practice which can lead to more comfort being uncomfortable.

"Closing your eyes if that is comfortable for you, otherwise having a relaxed gaze on the floor in front of you. Take a few deep breaths in the manner you have been doing…feeling the air coming in and out of the nose or mouth, or feeling the chest or belly raise and fall. If you notice tension in the belly, try to relax it using the breath, let the breath massage away the tension.

Wait 30-60 seconds

Use the breath to anchor you right here, right now, which is the only time and place the breath is happening…Notice the feeling of your feet. Feel the ground beneath your feet. Notice what your feet feel like if they're in socks or shoes, can you feel the material against your feet? Not good or bad, just feeling what it feels like. Take a few breaths and just really notice what your feet feel like, wiggle your toes if you'd like and really notice what it feels like, the pressure of the shoes, the hardness of the ground, the wiggliness of the toes. Now take a comfortable breath and relax the feet as much as possible. Then, just notice the feet for the next minute…

In 45-60 seconds, attend to sensations of the chair

"Now moving out of the feet, notice your back or legs against the chair. Notice what it feels like, not good or bad, just noticing what it's like. Feel your weight sinking into the chair, maybe the hardness of the chair supporting your back. Hang out for a little while, noticing the sensations in the back; maybe there is some tightness, tingling, warmth, coolness, tension, pain, softness, or comfort…simply notice, dropping any judgement of discomfort being bad or comfort being good…just notice the sensations in the back. Attempt to focus on this space, the place where your body touches the chair…"

In 45-60 seconds, attend to sensations of the hands

"Now moving into the hands, try to notice what the hands feel like. Notice the contact between your hands and whatever they are touching…maybe your hands are in your lap or you're holding them. Notice what the temperature of the hands is like…warm, cool, rough, soft…notice if there are areas of your hands where the is more noticeable contact with

something else… and notice spots that aren't touching anything else. Notice if they are tensed or relaxed, take a comfortable breath and softly relax the hands."

In 45-60 seconds, remind about breath awareness

"Coming back to the breath, remembering to notice that the breath is coming in and out, pull back from the hands and spend a few breaths really noticing the sensations of the breath."

In 45-60 seconds, encourage simultaneous breath and body awareness

"Now, see if you can notice the breath while also noticing one of the other body areas like the feet… hands… or being in the chair. Rather than using your attention like a laser pointer, pull back and use it like a flashlight, broader and able to see more. And forgiving our minds when they become distracted by thought and gently returning to the breath and sensations in the body… just dropping other thoughts again and again to notice what the breath and body feel like right here, right now."

Approximately once per 2-3 minute(s) until the full 20 minutes has elapsed, remind them to calmly drop the thinking the mind distracts with and to re-focus on the sensations of the breath and body. Each reminder should bring attention to different parts of the body with a few examples of commonly present sensations (e.g. warmth, tension, relaxation, tingling, pressure from contact with another body part, etc.) Suggest a softening and relaxing of the specific area if possible, while paradoxically encouraging acceptance or tolerance of residual unpleasant sensations.

"try to notice if there is any part of the body that feels particularly nice… maybe it's free of pain, relaxed, a nice temperature… that is actually pleasurable. If there is no area that feels even slightly pleasurable, attempt to find an area that is neutral, free from pain. Stay there for a little while, maybe several breaths long and try to appreciate and notice that pleasure, really savor it if it's there."

After 1-2 minutes

"now see if you can try to spread out that feeling and bring it to other parts of the body… notice your [body part]*, notice what it feels like… is there* [name a few sensations; e.g. warmth, coolness, tension, relaxation, tingling, pressure, vibration] *or maybe other sensations there? Relax into that feeling and simply notice it for a few breaths…."*

After 30-60 seconds

"Now go back to noticing that comfortable or neutral part of the body, rest in that comfortable place, really savoring and noticing that in this part of the body, even if it's as small as a single finger, that there is some comfort, safety, and maybe even a pleasant feeling. Notice it, be with it. Like the breath, it is always with you and you can bring your attention to it anytime.

List of suggested body parts with relatively high proprioceptive salience: feet, belly, chest, hands, neck/throat, face, jaw, back, or other parts of body with physical contact (e.g. back of legs making contact with the seat of a chair). For people with a trauma history, open-eyes with regular "regrounding" by noticing sensations of feet on the ground may be most helpful.

"ten times, one hundred times, one thousand times, keep calmly coming back to the breath and sensations throughout the body, dropping the thoughts once we've caught the mind distracting us."

Once the allotted time is almost complete, *"our time is almost up… soon, a soft bell will sound again. Try to hear the entire length of the bell's sound. See if you can notice the exact moment when the bell stops."*

Time for questions and answers. Unrelated statements and questions (e.g. veteran telling a story) should be redirected by asking, *"is there any part of the exercise you had a question about?"* Varying levels of comfort and/or difficulty with the practice should be normalized:

"Does anyone have any questions about the practice itself? For many people, this can be extremely difficult, for some, soothing and relaxing, and honestly anything in between. For some, intense images and memories arise, for others, boredom or feeling tired. All of these experiences are allowed; the practice is to notice and accept what is there with as little judgement as possible and then attempting to come back to the sensations of the breath and body. Something that some people eventually notice is how difficult it is to even notice when they are caught up in thinking… if the thoughts they are caught up in are extremely anxiety-provoking, angering, or depressive thoughts, this can lead to hours, days, or even weeks and months of misery! And then when there isn't a "pause" between thoughts and actions, that's when a lot of people get themselves into trouble or do things they wish they hadn't. This is part of why learning how to, over and over, recognize getting caught up in thoughts and returning to the present moment by noticing the breath or body sensations is so useful."

Walking meditation – 25 minutes (if veteran is not ambulatory, have them do another body scan meditation)

"The purpose of the next exercise is to help bring this type of mindful attention when we're not just sitting around with our eyes closed. Sitting meditation is great, it's a pure form of the exercise or practice, sort of like lifting weights in a gym. It's great. But we also need to be

able to utilize that strength in the real world, with conditions that are less structured and stable than the gym. So is the case with mindfulness, developing the skill in a quiet environment is important, but so is taking that skill and developing it under slightly more distracting conditions."

Have everyone stand up and find a walking path. This should be about 15-20 steps in a straight line. It is important that participants' walking paths do not intersect one another; ideally everyone will be parallel with one another even if they start at different ends of the room/area.

With walking meditation, we attempt to simply notice the different sensations of walking which usually go under the radar. To begin, stand up straight and feel your feet on the ground. Notice the pressure where your feet touch the ground and sense that the ground is sturdy, holding you up. Of course, now everyone's eyes should be open during walking meditation, but this is really important, try not to let your eyes wander around much. Instead, have a relaxed gaze on the ground a few paces in front of you, attempt to not focus on anything in particular. Your eyes are open simply to help you walk straight, keep balance, and not bump into anything or anyone. Once again, sense into your feet. Really feel your feet on the ground, wiggle your toes around and really notice what that feels like… savor the sensation, even if it doesn't seem worth savoring. The mind-state of savoring is worth having.

Once I am done with the basic instructions, you will begin to walk. Try to notice at least four components of every step: lifting one foot; moving the foot forward; the heel being placed on the ground; the shifting of weight from the back foot to the foot which was just placed on the ground. Lift, move, place, shift. Don't walk quickly, walk at a slower than normal pace, almost as if you were leisurely walking through a beautiful area…lift the foot, move it forward, place the heel down, and shift your weight; notice these 4 components of each step. Once you get to the end of your path, stop, take a few leisurely, mindful breaths, slowly turn around, and walk back. You will go back and forth like this until the bell sounds.

Every 2-5 minutes, remind them to drop their thoughts, plans, and memories when they take over and by simply refocusing on the sensations of walking. Remind them once that anything important they have to think about will be available to them later while normalizing how often the mind naturally wanders.

Remember, anything seemingly important, thoughts that your mind doesn't want to let go of, plans, memories, resentments, anything, they will all be there for you later. For now, continue to let go of thoughts by coming back to the sensations of walking over and over and over again.

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We are training the mind and each time you realize you've lost your attention and come back, you have improved your mindfulness. Each time you're able to refocus on your breath or the sensations in your body, you have improved your mindfulness.

It's perfectly normal for the mind to wander and think thoughts, simply and calmly drop the thoughts and notice the sensations of walking.

Once the allotted time is almost complete,
"*our time is almost up…soon, a soft bell will sound. Try to hear the entire length of the bell's sound, really bringing your attention to the sound. See if you can notice the exact moment when the bell stops.*"

Time for questions and answers. Unrelated statements and questions (e.g. veteran telling a story) should be redirected by asking, *"is there any part of the exercise you had a question about?"* Varying levels of comfort and/or difficulty with the practice should be normalized.

"Does anyone have questions or statements about how that went for them? Anything I can help troubleshoot? For some people, walking meditation feels easier, whereas for others it feels more distracting. How was it for you?"

Speak to the function of walking meditation:
"Walking meditation is a transition from sitting still, often with eyes closed in meditation to being in the world attempting to be mindful in our daily lives. Walking, though a bit slowly and back and forth on a path, gets us practicing with eyes open and with some movement, which helps prepare us to continue practicing as we walk around the world in our lives."

Simply reflect statements while offering helpful suggestions for those that seem to need a bit more help or direction.

Section 4 – Internalizing Reflections
Materials Needed: Handouts (appendix B) for each veteran

Introduction
This section focuses on exploring meaning and involves posing questions to the group regarding the past and present, values, and meaning. The exercise can be completed as a journaling activity in silence with a notepad and pen. An alternative is verbal pair-sharing with both people responding to each question before moving on to the next. Allow the veterans to decide which

they would like to do. If there is a remaining person who does not want to write in silence, have them form a pair with another veteran or join a pair to create a triad. Remind veterans to attempt to continue to bring awareness to their breath and body in order to stay anchored right here, right now, rather than becoming totally wrapped up in the stories of the mind. For pair-sharing veterans, explain that even while talking and listening, they can attempt to stay mindful of the breath and body, and to the words of their partner.

Concrete guidelines for facilitation

"Next, I will hand you out some questions with space for writing. These are questions that were designed to help people think about what is purposeful and valuable to them now, to help people reflect helpfully on the past, and to consider who they are now and who they might want to be in the future. Sometimes, thinking through some of these questions can be really helpful in coming to terms with parts of the past and moving towards a better life in the future. The reason we give these questions to think about after mindfulness is that it can be incredibly helpful to let the mind quiet or settle a little bit before thinking about this stuff. Even if the mind didn't get quiet at all, you practiced observing, which will help when you try to pay attention to the answers that come up as you reflect on these questions. There will be plenty of time to answer each question, so after I read each one, take a few breaths and pause so that you are responding from the truth of your actual experience rather than reacting or just saying what you think you 'should' say. The right answers are the ones that are real for you. No one is collecting this or forcing you to read your answers, so use this space to connect with what is real and important to you"

Pass out the handout of the questions and encourage them to not skip ahead but to wait for individual questions to be read out loud by the facilitator. If they finish a question early, encourage them to simply go back to practicing mindfulness of the breath and body, and to notice what it was like to consider and respond to that question. Read one question then give five minutes for the veterans to write their answers. Let them know that no one will be seeing this or reading this but them, so they can make all of the spelling and grammar mistakes that they would like.

1) What do you realize now about life or about yourself that you never clearly realized before joining the military?
2) What things did you think you knew before that you now know with greater conviction?
3) Considering this, how might you want to live life now?
4) Are there activities and interests of yours that seem more trivial or no longer interest you? Why might this be?
5) Who does it feel important to spend quality time with?
6) For many people, being in the military *was* their identity. What other parts of our identity can you take pride or comfort in? This might be **social identities** (e.g. parent, son, brother, friend, veteran, pet owner, 12-step member, etc.), or a **work identity** (e.g. Now, I'm a plumber, martial arts teacher, cook, etc.), **identity within a hobby/passion** (e.g.

I'm a surfer, guitar player, Brazilian jiu jitsu player, volunteer, reader, writer, artist, gun-enthusiast, etc.) or **ethnic and/or religious identity** (e.g. I am a member of a certain group, culture, or religion)

7) Are there any of these which you might not currently identity with but might want to become?

Group participation: 60-90 minutes, dependent on number of participants and wordiness

Remind the group of the rules in a basic sense:

"Guidelines for the day:

1) Respect. *"We will not use harsh words towards others, will remain quiet and give attention when someone is speaking, and will commit to an atmosphere of community."*

2) Confidentiality. *"What we see here, what we hear here, let it stay it."*

3) Compassion. *"Realize everyone here has some difficulty in their lives. It is not for us to be judge and jury regarding someone else's pains, difficulties, and afflictions. Attempt to treat everyone with some kindness."*

4) Courage. *"It is not easy to open-up and speak or even think about difficulties, confusion, or potentially horrifying experiences. A commitment to walk into this experience fully and openly requires courage."*

5) Honor. *"It is dishonorable to kick a downed person. While we may disagree with something someone might say, we are all here to improve ourselves and our lives, which is honorable. Give a small nod of acknowledgement to yourself and those around you who willingly walk into difficulty for the sake of betterment."*

6) Accountability. *"Attempt to only speak for yourself and from your own experience."*

7) Attention. *"Mindfulness is at the core of the day and in the most basic sense, this means solid attention or alertness that is relaxed and undisturbed by our mind's judgements. This is how you should attend to each activity and especially any person who is speaking. Pay respect and act with honor by giving a relaxed but clear alertness to whatever is happening in the moment."*

"Can we all agree to this stuff? Mainly that what is said in here stays in here and to treat everyone with respect."

"Now I'd like to invite anyone to share any of your responses, only if you want to. Please remember that we have limited time and that there may be several people who might want to share, so maybe focus only on a few answers you might want to share."

Go through each of the 7 questions one at a time, reading the question then asking the group if anyone has an answer that they'd like to share.

Suggest that participants engage in mindful listening as another form of mindfulness practice. Instructors may prompt participants to notice what comes up for them as they listen; i.e., Are they really listening? Are they back in the "story of their mind?", what feelings emerge as they listen? Can they attempt to notice reactions, let go, and come back to the speaker's voice? Prompt the group before it begins to do this and note that in the service of both good practice and

time constraints, you will likely bring people back if they are "in the story of their minds" by asking them to stop or a question to bring the conversation back to the topic.

> *"Just like you have been giving mindful attention to your breath, body, the sensations of walking, you can also listen mindfully. When someone is talking, really attempt to stay with the sound of their voice. If you get caught up in your own thoughts, positive or negative judgements, or memories, gently bring your attention back to their voice."*

If there is remaining time from the 60-90 minutes, use it to ask members if they related to each other or identify with one another's responses. Give space/time for them to respond if appropriate.

Recommendations for group/pair discussions and sharing:
Invite participants to view their reactions to others as another thought to be mindful of and as an opportunity to learn. Working in a group often brings up reactions which can be important keys to growth. For instance, rather than becoming lost in anger-inducing judgments about others, or suppressing feelings of annoyance, frustration, or irritation until they later explode, direct participants to attempt, however difficult it is, to simply notice their thoughts and emotions and just like in the other practices, re-direct to listening to the sound of whoever is speaking. In this way, emotions are allowed, felt, and processed. It is also helpful to ask the veterans if they experience similar reactions to people when they are going about their daily lives. If they do, encourage people to use the experience in group as an opportunity to work with these thoughts and feelings. Don't get bogged down with long stories about all of the people the participant has these reactions towards, instead, redirect to the presence of emotions and utilizing mindfulness.

The teacher can facilitate this process by modelling interest and curiosity about these reaction patterns, e.g.

> *"When strong emotions come up, try to stay balanced, name them, and come back to the sound of the speaker's voice. For instance, if you're listening to someone speak and you feel agitated, notice then in your mind say "oh, this is agitation" then come back to the breath and the person's voice. It's not to say that irritation, anger, sadness, or strong emotions are*

bad at all, it's that this is a way to learn how to accept those emotions with a pause rather than a reaction that might lead to ever more anxiety, regret, anger, or sadness. Instead, having a pause and being aware of our reactions can often lead us to acting in a way that will actually be helpful, if action is required. This is hard. One of the hardest things about this practice, really. It takes time, patience, and practice. Hopefully you have a few successful experiences during this workshop, but it's really something that requires more practice and dedication for real skill to develop."

In this way, each experience is framed as an opportunity to work with the habitual reactions. If the teacher is able to model this during interactions with one or two participants, it can provide an example that is useful to others in the group. After, remind participants that they can use this in their lives when they notice strong reactions to people or situations, while also normalizing that this takes a lot of time, patience, and practice; it is highly unlikely they will be able to have resounding success with intense emotions after a single mindfulness half-day. However, encourage hope and optimism in their ability to become more skilled with practice.

Concrete suggestions:
Redirect when necessary, such as when people become tangential. Don't be afraid to be direct.
  "Let's come back to the topic."
  "Can we pause here?"

Two reflections and recommendations regarding how veterans relate to each other in group are provided verbatim from Teaching Mindfulness to Veterans (Kearney, et al., 2015):
  "Bear in mind the dialectic that veterans have many common experiences, but also many divergent ones based on when they served and other unique aspects of their military experiences. Conversations going off track make it even more important that the teacher maintain control and ensure that discussions are relevant and balanced by diverse viewpoints.

Stay tuned in not only to the person sharing, but also to how others in the room are taking it in. At times, other group members may experience painful emotions or memories while another shares a difficult story or experience, because the similarity of experiences can resonate so deeply. This is often a time to encourage participants to stay with their own experience, to touch into the felt sense of the body, and to be curious about why the discussion has brought up specific emotions within them. In the present moment, are there memories of the past? What thoughts are here now? What emotions arise? Can these experiences be held in a greater field of awareness, with kindness, curiosity and compassion? Is it possible to 'stay with' this experience, grounded in the breath and the body? In this way, the instructor can help other group members to grow in understanding as they listen to the experience of others."

Last practice

The last practice is meant to help veterans become mindful of thoughts and to be able to simply observe them. This is a modification of the ACT "Leaves on a Stream" mindfulness exercise (Harris, 2009) which has been modified and is part of the Acceptance and Commitment Therapy for PTSD: Veteran Manual (Settles, Morris, & Bratkovich, 2017, pg. 38)

Sit in a comfortable position and either close your eyes or find a spot to focus on. Now, imagine you are sitting or standing in the middle of a stream. The water is flowing away in front of you. Notice if there is any sound from the running water. Notice if there are any trees, etc. on the banks of the stream.

Now, look around and notice that there are leaves gently floating along the surface of the water. Notice that each leaf comes into your awareness and then gently floats down the stream until you can no longer see it.

For the next few minutes, take each thought that enters your mind and place it on a leaf and let it float by. Do this with each thought- pleasurable, painful, or neutral. Just notice it, place it on a leaf, and let it float by. Just observe it floating by without becoming attached.

If your thoughts momentarily stop, continue to watch the stream. Sooner or later your thoughts will start up again.

Allow the stream to flow at its own pace. Don't try to speed it up or rush your thoughts along. You are not trying to get rid of your thoughts. You are allowing them to come and go at their own pace. Some may move by quickly, others may linger. Some may come by multiple times. Just let whatever thoughts come by be there for as long as they are.

If your mind says, "This is dumb," "I'm bored" or "I'm not doing it right" place those thoughts on leaves too and let them pass.

If a difficult or painful feeling arises, simply acknowledge it. Say to yourself, "I notice myself having a feeling of boredom/impatience/frustration/anxiety." Place those thoughts on leaves and allow them to float along at their own pace.

As you do this, you may find that a thought hooks you and distracts you. This is normal. As soon as you realize you have been side-tracked, gently bring your attention back to the exercise.

You may also notice that you find yourself trying to push away a certain leaf. Again, once you notice it, gently bring your attention back to the exercise.

Continue observing your thoughts and placing them on leaves for the next few minutes

Section 5 – Closing –
Materials Needed: A handout for each Veteran (Appendix C), a timer
Closing thought activity:

Begin with a culturally relevant quotation. Give context to the quotation, demonstrating that mindfulness can be found within various philosophies, times, places, and cultures; including the warrior culture.

> *As we begin to wrap up our day together, consider this quote from Japanese samurai warrior Yamamoto Tsunetomo in his Hagakure: The Book of the Samurai written in 1716, "be true to the thought of the moment and avoid distraction. Other than continuing to exert yourself, enter into nothing else, but go to the extent of living single thought by single thought."-Yamamoto Tsunetomo (Hagakure: The Book of the Samurai)*

Now is time to let each voice in the room be heard. The direction is for each person to say something that was impactful for them in some way about the day. This might be a commitment they'd like to make based off of the meaning-focused exercises, realizing they can continue to practice mindfulness, or noticing they were not caught in anxiety. This is pretty open, but a timer should be set at no more than 2-minutes per person as a gentle reminder to wrap it up.

> *"Let's go around and each say a sentence or two about what you might remember today or something you'd like to commit to related to anything you've learned today. The timer will go off at 45 seconds as a gentle reminder to wrap up your thought."*

Giving handouts/resources:
At this point, the workshop has concluded and you should have handouts and resources prepared to give to all of the Veterans. Make sure to demonstrate appreciation for attendance, remind them or other resources at your VA, and say goodbye.

Have handouts ready for veterans with various resources, such as dates, times, and contact information of other ongoing mindfulness groups at the VA, Veterans Crisis Line, and other mental health services/walk-in groups happening at that VA. You will need to create this for yourself, as each VA has different resources and services; a template is enclosed.

Additionally, provide information about websites, apps such as the free VA-made "mindfulness coach," etc. that have guided mindfulness meditations (e.g. UCLA Mindful Awareness Research Center, UC Berkeley Mindfulness),

State that there are free guided mindfulness meditations on the UCLA Mindful Awareness Research Center.

A templated handout is provided as Appendix C. It has current information about mindfulness resources, as well as common information about the Veteran's Crisis Line. Suggestions for site-specific information is given, and blank lines are provided (e.g. Times and locations of other mindfulness groups at your specific VA, etc.)

Appendix A

Guidelines for the day:

1) Respect. *"We will not use harsh words towards others, will remain quiet and give attention when someone is speaking, and will commit to an atmosphere of community."*
2) Confidentiality. *"What we see here, what we hear here, let stay here."*
3) Compassion. *"Realize everyone here has some difficulty in their lives. It is not for us to be judge and jury regarding someone else's pains, difficulties, and afflictions. Attempt to treat everyone with some kindness."*

4) <u>Courage</u>. *"It is not easy to open-up and speak or even think about difficulties, confusion, or potentially horrifying experiences. A commitment to walk into this experience fully and openly requires courage."*

5) <u>Honor.</u> *"It is dishonorable to kick a downed person. While we may disagree with something someone might say, we are all here to improve ourselves and our lives, which is honorable. Give a small nod of acknowledgement to yourself and those around you who willingly walk into difficulty for the sake of betterment."*

6) <u>Accountability</u>. *"Attempt to only speak for yourself and from your own experience."*

7) <u>Attention.</u> *"Mindfulness is at the core of the day and in the most basic sense, this means solid attention or alertness that is relaxed and undisturbed by our mind's judgements. This is how you should attend to each activity and especially any person who is speaking. Pay respect and act with honor by giving a relaxed but clear alertness to whatever is happening in the moment."*

One VA mindfulness teacher states that the Rules of Engagement for class are
"No Fixing,
No Advising,
No Saving,
No Setting Anybody Straight."

Appendix B

Meaning and Purpose reflections

1) What do you realize now about life or about yourself that you never clearly realized before joining the military?

_____

_____

_____

_____

_____

_____

_____

2) What things did you think you knew before that you now know with greater conviction?

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3) Considering this, how might you want to live life now?

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4) Are there activities and interests of yours that seem more trivial or no longer interest you? Why might this be?

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5) Who does it feel important to spend quality time with?

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6) For many people, being in the military *was* their identity. What other parts of our identity can you take pride or comfort in? This might be **social identities** (e.g. parent, son, brother, friend, veteran, pet owner, 12-step member, etc.), or a **work identity** (e.g. Now, I'm a plumber, martial arts teacher, cook, etc.), **identity within a hobby/passion** (e.g. I'm a surfer, guitar player, Brazilian jiu jitsu player, volunteer, reader, writer, artist, gun-enthusiast, etc.) or **ethnic and/or religious identity** (e.g. I am a member of a certain group, culture, or religion)

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7) Are there any of these which you might not currently identity with but might want to become?

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Appendix C

Resources at this VA (to be added to by facilitator)
Same-day mental health services at this VA (walk-in clinics, emergency services, etc.)

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Mindfulness Groups at this VA

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Other mindfulness resources:

Apps:

-Mindfulness coach (free) – "Mindfulness Coach 2.0 was developed to help veterans, Service
members, and others learn how to practice mindfulness. The app provides a gradual, self-
guided training program designed to help you understand and adopt a simple mindfulness
practice" and many other helpful exercises. Mindfulness Coach was created by VA's
National Center for PTSD.

-Insight Timer (Free, some in-app purchases) – "The #1 free meditation app. Join millions
learning to meditate on Insight Timer to help calm the mind, reduce anxiety, manage
stress, sleep deeply and improve happiness. Guided meditations and talks led by the
world's top mindfulness experts, neuroscientists, psychologists and meditation teachers f
rom Stanford, Harvard, Dartmouth and the University of Oxford. Music tracks from
world-renowned artists."

Other

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Websites

https://www.uclahealth.org/marc/ -
UCLA Mindful Awareness Research Center has several resources including free guided
mindfulness meditations and information about meditation practice, free books and other
resources, and links to classes, retreats, workshops, and other events.

Other

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<u>Veterans Crisis Line</u>

If you're a Veteran in crisis or concerned about one, there are caring, qualified VA responders standing by to help 24 hours a day, 7 days a week.

<u>Call 1-800-273-8255 and Press 1</u>

The Veterans Crisis Line is a free, anonymous, confidential resource that's available to anyone, even if you're not registered with VA or enrolled in VA health care.

The Veterans Crisis Line is also available by text or online chat:

- <u>Chat</u>
- Text <u>838255</u>
- Support for deaf and hard of hearing: <u>1-800-799-4889</u>

Appendix D

https://cdn.shopify.com/s/files/1/1279/8659/products/poster_6cfb31e1-19a8-49cb-af66-
a0cb7d5e7879.png?v=1462974742

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http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

https://www.mirecc.va.gov/VISN16/docs/act-for-ptsd-patient-manual.pdf

APPENDIX I

IRB Approval Letter

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: January 31, 2019

Protocol Investigator Name: Joshua Buch

Protocol #: 18-02-730

Project Title: Manual for Mindfulness Group for Resilience, Meaning-Making, and Posttraumatic Growth for Recently Returned Veterans

School: Graduate School of Education and Psychology

Dear Joshua Buch:

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today January 31, 2019, and expires on January 30, 2020.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond January 30, 2020, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Mrs. Katy Carr, Assistant Provost for Research