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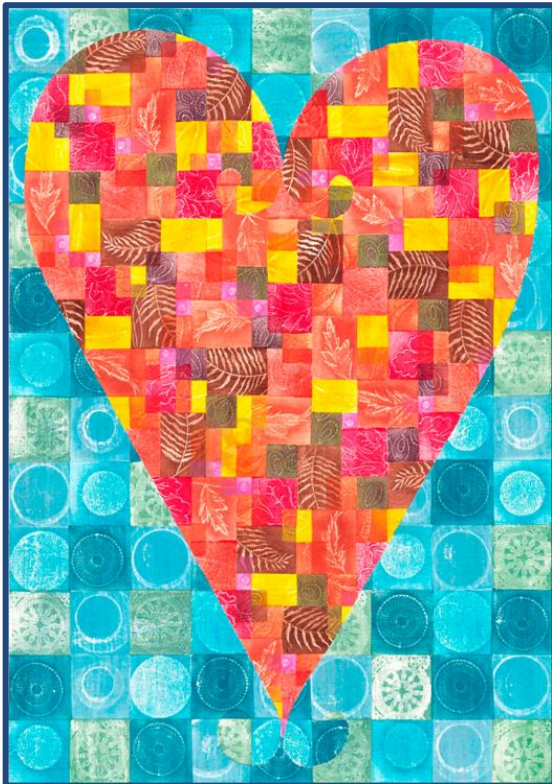
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Teaching Mindfulness to Veterans: A Resource



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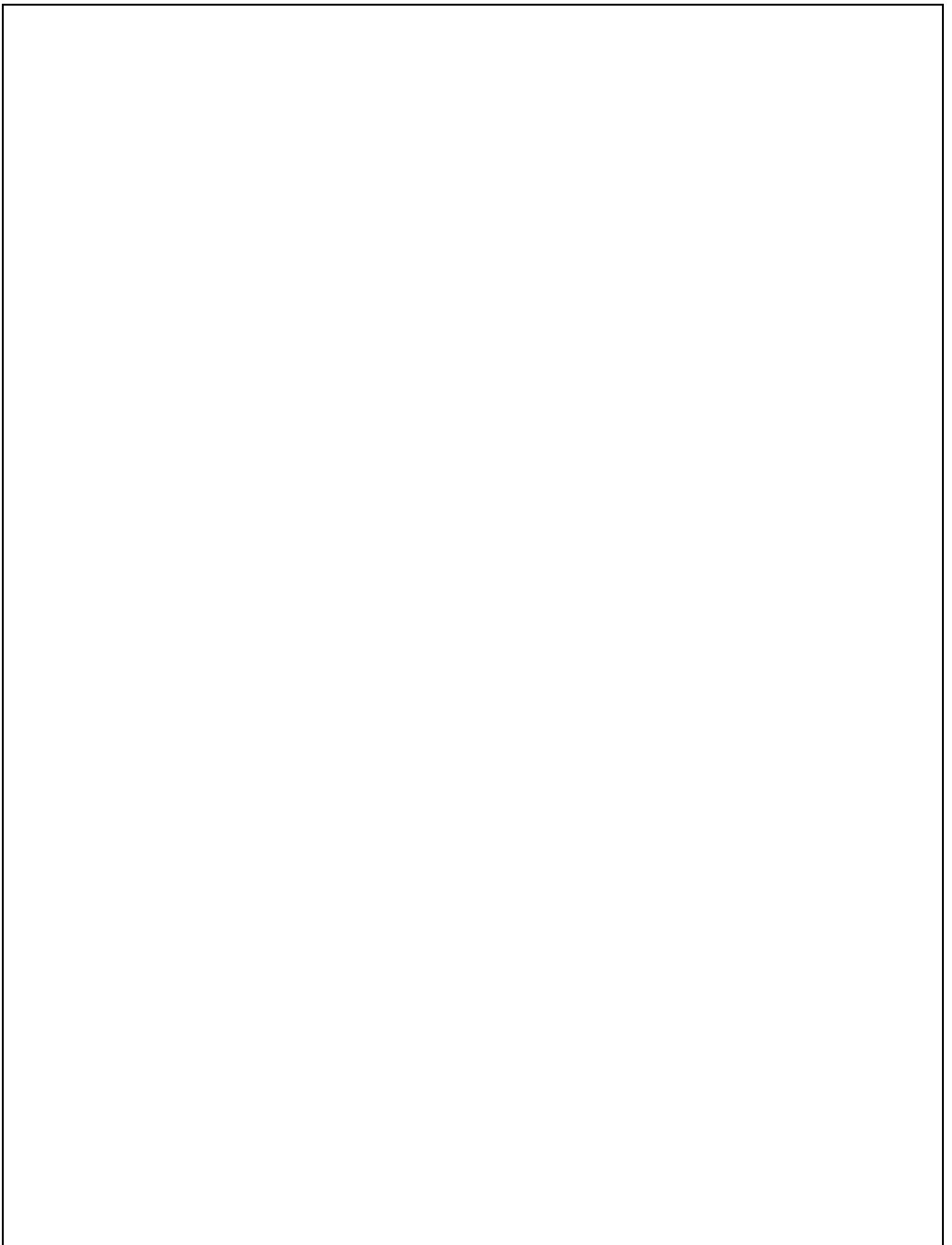


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Introduction and Purpose

The goal of these materials is to provide mindfulness teachers with an additional resource for teaching groups of Veterans. The comments, reflections and occasional recommendations in this document were influenced and informed by the key voices in this endeavor - the voices of Veterans themselves. Of note, although we sometimes refer to Mindfulness-Based Stress Reduction (MBSR) in this document, (which is the 8-week program used to teach mindfulness in our setting), our intention is to provide observations and suggestions that more generally apply to teaching mindfulness to Veterans in a group format. It is our hope that the quotes, reflections, observations, suggestions and educational materials will prove helpful to others as they teach mindfulness to those whose burden of suffering is often quite large – our nation’s Veterans.

As part of the process of developing this resource, we interviewed many Veterans who had completed MBSR, as well as Veterans who were referred to MBSR but either dropped out or declined to participate. We used qualitative research methodology to understand their experience and identify themes that emerged that we hope will be beneficial for other mindfulness teachers who currently work with Veterans or who plan to do so in the future. We also include the reflections of teachers who have extensive experience teaching mindfulness to Veterans, so that they could share examples of their approach to teaching mindfulness when working with this population. Hence, this guide reflects the combined perspectives of Veterans and mindfulness teachers who have a great deal of experience working with Veterans. These reflections and examples range from practical logistical considerations to suggested approaches to group dynamics to observations about teaching specific mindfulness practices. Lastly, we have included supplemental education materials on conditions commonly borne by Veterans - chronic pain, PTSD, and depression, to help educate teachers about ways these clinical conditions may be positively impacted by mindfulness. It is our hope that this resource will foster a better understanding by mindfulness teachers of issues often faced by Veterans, which will in turn help them to skillfully respond to their needs.

Part I: The Veterans

Chapter 1: What are the Veterans Bringing with Them?

"I was a long time in the military training, and my mind is very rigid, very tight... Memories of the Afghanistan war, human relationship issues I'm going through. I'm easily angry, pissed off... I was trained as killing machine, so it's easy to get pissed off without any delay or patience"

"I had problems dealing with the public and not having anger problems."

"I have irritable bowel syndrome and that's created my stress, so... my doctor uses the Mindful-Stress reducing classes for a lot of his patients and he's seen some results in reducing the level of stress"

"My hope was if I could fix my sleep, manage my pain and fatigue, that would maybe help with the cognitive issues that I sometimes – well, not sometimes – that I have."

Reflections and observations:

Many Veterans bring a variety of chronic medical conditions as well as the life stress associated with dealing with these conditions to their mindfulness course. Some Veterans are dealing with the physiological symptoms of stress. Chronic pain is a major issue for many Veterans. Others are looking for help dealing with their PTSD from combat, sexual assault, or childhood trauma. They may have difficulty regulating their emotions, such as anxiety or anger. Many Veterans express a desire to find a way to deal with their anger, in some cases knowing that failure to do so could lead them back to jail or to the end of their marriage. Others live such isolated lives that the idea of being in a group is overwhelming to them. In addition, some are struggling with social stress caused by poverty, homelessness, and other such difficulties.

"Well I didn't want to fly off the handle at anyone because right now I'm pretty edgy... How to control my emotions better... How to deal with other things that are coming up along with dealing with what I am dealing with now."

In our experience, the majority of Veterans who seek out MBSR are older (in their forties, fifties, or sixties). Many are Vietnam Veterans who have lived with chronic problems for decades, who may come to the mindfulness group feeling as though it is a last shot at gaining some control over their lives. These older Veterans also seem prepared to work with an acceptance-basedⁱ approach such

ⁱ To be clear, acceptance-based approaches do not advocate acquiescence, giving up, or resignation of any kind. These interventions encourage acceptance of things that *as they are*, but do not assume that is how things will always be. Acceptance empowers the person to skillfully choose how to respond to the reality of their experience, rather than resisting it.



as mindfulness, having experienced firsthand the limitations of attempts to suppress or avoid chronic symptoms, coupled with the realization that personal growth and healing are often slow processes that require some effort. At our facility we have had some younger Iraq or Afghanistan Veterans sign up for the class.ⁱⁱ Anecdotally, there is some concern that Iraq and Afghanistan Veterans may drop out at a higher rate, similar to what has been shown for other interventions for OIF/OEF Veterans.²

Overall, we have found it critical to remember that the Veterans in the room are often extraordinarily strong and resilient. As an example, one of our past students was a paraplegic who was in constant pain but nevertheless attended every class. During the movement exercises, he would spend his time in sitting meditation. Even with his significant physical limitation, he found that the class helped him immensely and the other members of the group were moved and inspired by his tenacity. Thus, we have found that regardless of the level of physical ability, Veterans can take part in a mindfulness program. 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.

Recommendations:

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. The educational materials provided in this and subsequent chapters are intended to allow mindfulness teachers to deepen their understanding of the burden of illness often borne by Veterans, and to provide supplementary educational materials on chronic pain, depression and PTSD. It is our hope that a conceptual understanding of how mindfulness may mitigate the suffering caused by these common conditions will allow mindfulness teachers to better respond to the needs of group members.

When developing eligibility criteria for participation in a general mindfulness group (i.e., a mindfulness group that is not focused on treating a specific diagnosis or condition), we suggest a policy of broad inclusiveness. There is growing evidence that mindfulness interventions provide benefit across multiple conditions and specialties, which includes aspects of both physical and mental health. Because it is common for Veterans to present with a wide range of overlapping physical and mental health concerns, mindfulness programs with broad eligibility criteria are likely to be more attuned to the needs of

ⁱⁱ However, for MBSR the question of adherence rates for OIF/OEF Veterans has received very little study, which limits our ability to draw conclusions about the acceptability of MBSR for this population. Among the Veterans we interviewed for this resource, few were from the OIF/OEF periods of service. This is an important area for future study.

Veterans who seek health care at VA facilities. We feel that a policy of broad inclusiveness is a patient-centered approach, and consistent with the original model of MBSR.

Specifically, we suggest accepting all Veterans who have a desire to participate in a mindfulness group after attending an orientation session (see chapter 22), and who do not have one of the following exclusion criteria noted in the medical record:

- Current psychotic disorder
- Poorly controlled bipolar disorder with mania
- Borderline or antisocial personality disorder
- Substance use disorder or alcohol use that poses a safety concern 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.

Although we recognize that learning mindfulness could potentially benefit Veterans with some of these exclusion criteria, they are recommended because of concerns that some conditions could disrupt the group process, or would require closer safety monitoring than is possible in a large group setting.

For providers who refer patients to a mindfulness group, it is important to remember that there is no need to convince your patient to enroll. We suggest simply providing strong encouragement for the Veteran to attend an informational session/orientation, so that he or she can decide whether participating in the group is a good fit.

We recommend providing an orientation session for Veterans who either self-refer or who are referred by a provider to a mindfulness group. We have found that an effective orientation process is essential to help Veterans decide whether the program is right for them. Our impression is that this also helps to reduce attrition rates by providing a pre-screening mechanism to select Veterans who are more likely to attend the group; this allows for more efficient use of resources. An orientation process assures that Veterans who attend the first class session understand what the program entails, which minimizes the potential for surprises that could lead to drop-outs. For suggestions about how to conduct an orientation session, see Chapter 22.

Context:

Most Veterans who participate in mindfulness groups have overlapping chronic physical and mental health conditions. Large numbers of returning war Veterans meet criteria for at least one mental health condition, and a high proportion of Veterans who receive care at VA facilities have chronic pain, as well as other chronic medical problems.

We have witnessed firsthand the high frequency of co-occurring physical and mental health conditions among Veterans in our MBSR groups. In a study³ of 92 Veterans who participated in MBSR groups at our facility, nearly *three-quarters* met symptom-based criteria for PTSD at baseline and a third had a PTSD diagnosis in their medical record. Furthermore, 59% had a depressive disorder, 17% had an anxiety disorder other than PTSD, and 20% had a substance use disorder. Equal proportions of the group (8%) had a bipolar disorder or ADD/ADHD. In addition to psychiatric problems, many participants also had medical problems; 67% had a chronic pain condition and 45% had two or more pain conditions. The next most prevalent medical conditions were gastrointestinal disorders (40% of the participants), hypertension (26%), sleep disorders (24%), and diabetes (11%)

“My doctor, she brought it up, ‘cause I was having a lot of pain with my knees and everything, and my back, so she told me to try these classes.”

while 6% had asthma and 3% had chronic fatigue syndrome. (For a summary of these findings, see the figure on the next page.) These high rates of psychiatric and medical problems in Veterans participating in MBSR at the VA are important for future MBSR teachers to bear in mind while working with this population.

I. Chronic Pain

Chronic physical pain conditions are very common among Veterans, affecting up to half of Veterans receiving VA health care.⁴⁻⁶ These physical pain syndromes commonly co-occur with PTSD. In a national study of all Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans using VA outpatient care, Veterans with PTSD had more diagnosed medical conditions than those without a mental health diagnosis.⁷ Another national study of OIF/OEF Veterans enrolled in VA care found an overlapping “triad” of pain, PTSD, and depression.⁶ Among OIF/OEF Veterans receiving VA polytrauma care in one study, 42% were simultaneously diagnosed with PTSD, chronic pain, and persistent postconcussive symptoms.⁸

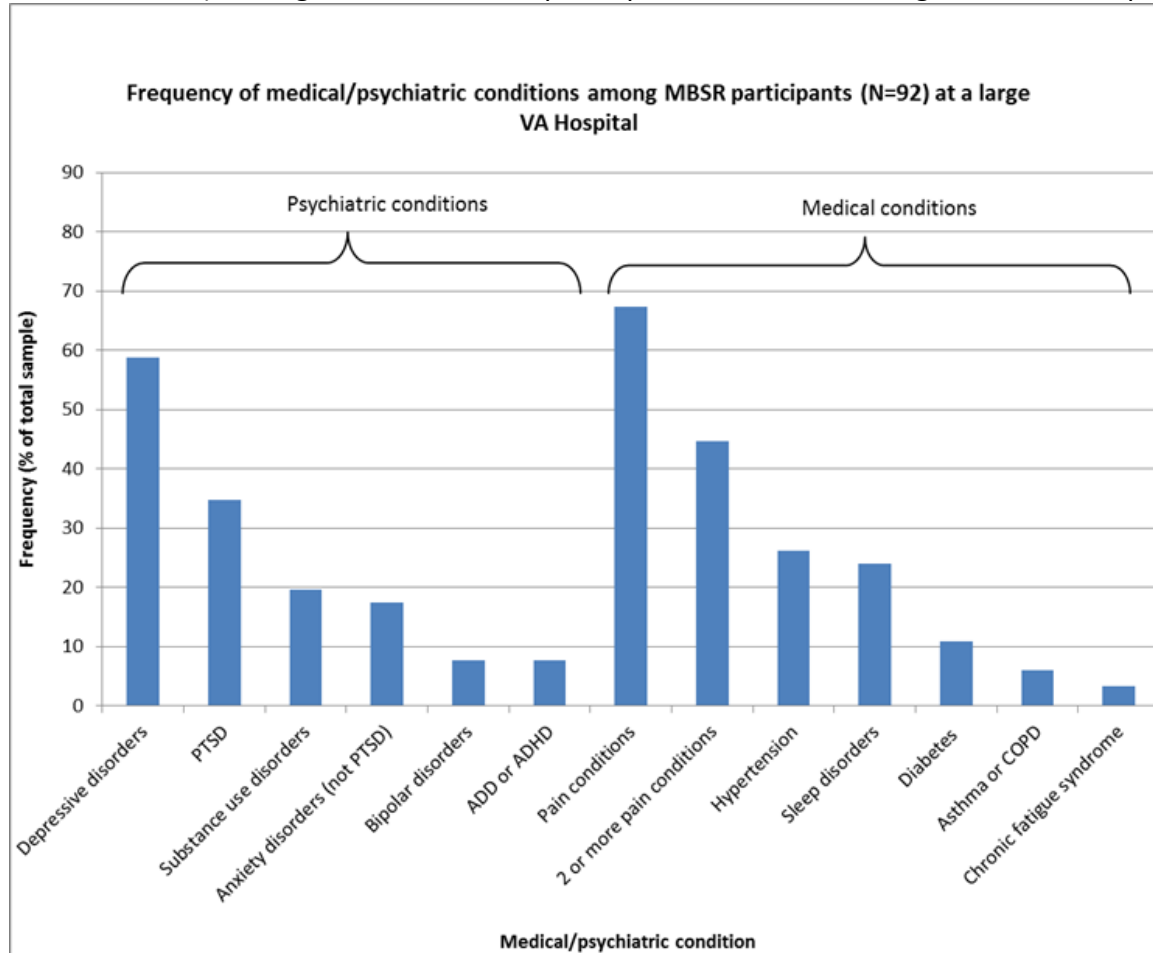
“I was hoping it would stop the nightmares. Also to give me peace of mind. I got a sleeping disorder and I take all types of pain pills.”

One possible explanation is that PTSD may influence pain symptoms through depression and anxiety sensitivity.⁹ The combination of overlapping physical and mental health conditions can present significant difficulties for Veterans seeking to regain a sense of health and wellbeing. Many Veterans seek out a mindfulness program as a means of working with these conditions, and accumulating evidence indicates that mindfulness is in fact an intervention that provides benefit across multiple

domains of health. Increasing evidence suggests that as many as half of Veterans seen in VA primary care settings report using integrative medicine modalities to address a variety of issues¹⁰ and that many do so to limit their use of medications and to ensure that their social and spiritual needs are addressed.¹¹ For more information on the phenomenon of chronic

pain and how mindfulness may be helpful to Veterans struggling with it, the reader is referred to Chapter 14.

Figure 1. Prevalence of medical and psychiatric conditions (as assessed by review of the medical record) among 92 Veterans who participated in MBSR at a large urban VA hospital³



II. Posttraumatic Stress Disorder (PTSD)

A large study of returning OIF/OEF Veterans showed that 25% promptly received a mental health diagnosis when they accessed VA health care, and that more than half of those who received a mental health diagnosis were diagnosed with two or more distinct mental health conditions.¹² In the aforementioned study, PTSD was the most common mental health diagnosis code, affecting 13% of Veterans. This is similar to the findings of other studies, estimated conservatively as PTSD rates of 10% for Gulf War I Veterans¹³ and 8.5% of female and 15.2% of male

"...something to help me make proper decisions when I'm dealing with a stressful situation and when the depression kicks in, to make just smarter choices rather than picking up the bottle again, because that's been my escape in the past and obviously it doesn't work."

Vietnam Veterans.¹⁴ PTSD prevalence rates vary widely depending on the criteria used,¹⁵ with other studies estimating the rates of PTSD among OIF/OEF Veterans to be as high as 20% to 30%.¹⁶⁻²⁰ PTSD frequently occurs with other mental health disorders, in particular depression. For instance, a 20-year study of Gulf War Veterans found that PTSD was more likely to occur in conjunction with depression and anxiety, than alone.²¹ For more information on PTSD and how MBSR may be helpful in addressing it, please refer to Chapter 15.

III. Depression

Depression is common among Veterans – up to 15% of Veterans meet full criteria for depression and as many as a third of Veterans have clinically significant depressive symptoms.²² Beyond the painful nature of the disorder itself, depression is associated with disability, reduced functioning, lower quality of life, and higher risk of co-occurring pain, anxiety, and substance-use disorders.²² Thus the burden of depression goes far beyond “depressed mood.” It also places Veterans at higher risk of suicide.²² Given the complex nature of depression, holistic approaches may be uniquely suited to address certain aspects of the disorder. There is promising evidence for the use of mindfulness-based interventions for preventing depressive relapse among patients who have a history of depression,^{23, 24} although there is limited evidence for the use of mindfulness-based interventions for active depression; more research is needed in this area.²⁵ For more information on depression and how mindfulness plays a role, see Chapter 16.

Suggestions for further reading:

Department of Veterans Affairs & Department of Defense. (2010). VA/DoD clinical practice guidelines for management of opioid therapy for chronic pain.

http://www.healthquality.va.gov/guidelines/Pain/cot/COT_312_Full-er.pdf

Department of Veterans Affairs & Department of Defense. (2009). VA/DoD clinical practice guidelines for management of major depressive disorder (MDD).

<http://www.healthquality.va.gov/guidelines/MH/mdd/MDDFULL053013.pdf>

Department of Veterans Affairs & Department of Defense. (2010). VA/DoD clinical practice guidelines for management of post-traumatic stress.

http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL-201011612.pdf

Chapter 2: Why Mindfulness?

"I think ultimately I was looking to gain some insight and peace on the suffering that I endure from PTSD. I mean ultimately that was the goal. I've been moderately successful managing pain through meditation on my own so I hoped maybe to get a better tool to do that with. But really the primary reason for going was because PTSD...the feeling of remorse, kind of depression, sadness... guilt, that's the key word. Guilt. And just kind of a purposeless existence, really, from somebody that was pretty motivated before."

"I wanted to learn more about meditation... I'm trying to meditate, do yoga, anything to relax or help the depression out, so that's what I really want to do."

"I think just through the group process, being able to be less timid in terms of social interaction. You just get to share more of yourself, be vulnerable and all that kind of stuff."

Reflections and observations:

In our experience, Veterans seek out a mindfulness program for numerous reasons. Some come to class desperate to get off their medications or at least minimize the number of medications they take. Some want an alternative to medications because they are concerned about side-effects or becoming addicted. Others are interested in mind-body approaches because they understand the link between their stress and pain. They may have never tried meditation before and are open to anything that can help them, or they may have pursued integrative medicine approaches in the past and found them beneficial. Most Veterans continue to pursue other treatment modalities (e.g., medication management, psychotherapy) while they take part in the mindfulness group and see the course as a complement to their other treatments. In addition, some Veterans may be looking for help with social isolation and desire a group format. Some wish to learn to deal with problems more independently. Others seek insight about their suffering related to PTSD. Importantly,

"I was curious about the mind's stressing, because I'm seeing a psychiatrist for depression, so I was kind of interested, it was kind of in my mind, trying to help myself out."

many Veterans come to the mindfulness group with the sense that they have tried everything else, and as a result, they are remarkably open to trying this program. They tend to be willing to jump in with both feet, although we witness and invite a healthy amount of skepticism.

Many Veterans articulate their reasons for participating in the mindfulness group when they initially enter the program; others are less clear about their motivation for participating at the outset but become more clear over time. Of





note, it is not uncommon for Veterans to share with our teachers at some point in the class that they feel that the mindfulness group is one of the most helpful programs they have encountered at the VA, or indeed anywhere.

Recommendations:

Frame participation in a mindfulness group as a complement to, rather than replacement of, usual care. In our setting, when introducing mindfulness in the first session, as well as in the orientation session, we emphasize that mindfulness practice should not necessarily be viewed as a substitute for usual care; we encourage participants to discuss how mindfulness practice fits in with their overall treatment plan with their health care providers.

Ask Veterans to articulate the real reasons behind their enrollment. In the first class, some teachers lead a guided meditation that asks Veterans to inquire about why they came to the class, and then to reflect more deeply as to why they really came. This can be a deep and insightful process. It is fascinating to hear the reasons people give in the first class as to why they are there, and then at the end of the class series when they share what they learned from the program.

Context:

Recently, the VA has begun to emphasize a shift toward patient-centered, integrative treatment approaches that include an emphasis on self-care in addition to professional care.^{26, 27} This framework can be schematically depicted as the ‘Components of Health and Well-Being,’ which center around the patient’s mindful awareness (see Figure 2 below).¹ The perspective of such patient-centered approaches is that many individuals prefer – and benefit from - integrative treatments that attempt to address the whole person, rather than focusing entirely on symptoms of a specific disorder or illness. Mindfulness is taught from a whole-person perspective, and the VA has placed mindful awareness at the center of its working definition of health and wellbeing.

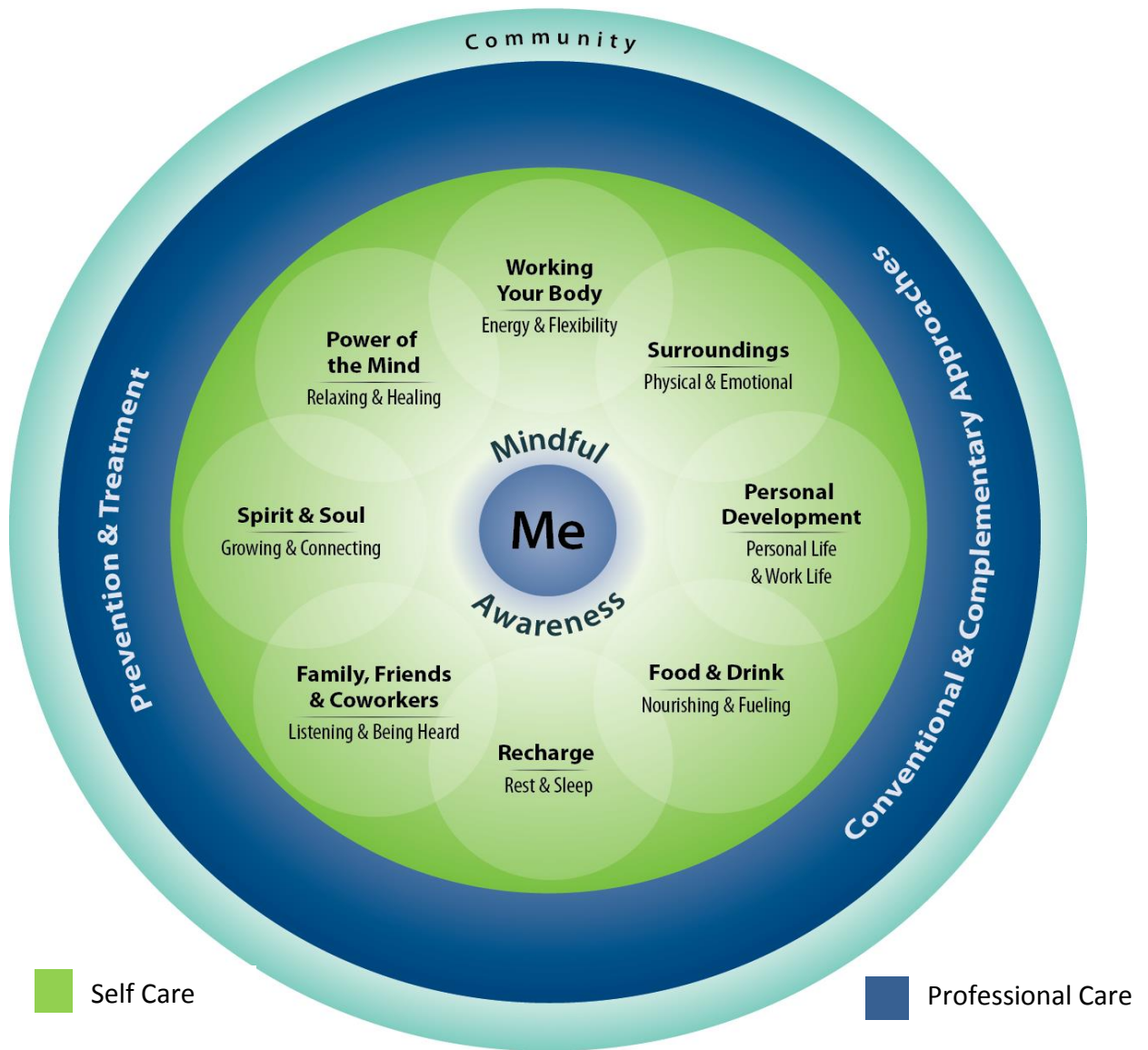
Studies show that Veterans are very receptive to Integrative Medicine / Complementary and Alternative Medicine (CAM) approaches to the management of chronic conditions such as pain and PTSD. A large study of Veterans with chronic pain found that 82% had used at least one CAM modality in the past, and nearly all (99%) were open to trying CAM

“I said okay, I’ll try that because any time I have pain, I’d rather try something without drugs...so this was a better way to do it.”

“My pain is way out of control. No I don’t take pain meds, I refuse to. I very seldom take that stuff because it’s just not good for your body.”

for pain.²⁸ A survey of VA PTSD treatment programs found that 96% reported using at least one CAM modality, demonstrating the widespread use of CAM in the VA for PTSD.²⁹ Many Veterans turn to CAM modalities because they address their whole person, rather than just their illness.¹¹ In particular, they report dissatisfaction with the reliance of conventional care on prescription medications and the lack of a holistic, integrative perspective.¹¹ Mindfulness interventions would typically be classified as integrative medicine or CAM interventions.

Figure 2. Components of Health & Well-Being¹



Part II: Group Dynamics

Chapter 3: Building a Container of Trust - Guidelines for Participation

"I think in the very beginning, um, just letting people know: if you can only do it for a minute, do it for one minute. Because when you first come in, there's the expectation of, 'This is what we want you to do.' When you really read the expectations, it's like an hour, here and there. It's kind of like that concept I had to learn about exercise: 30 minutes a day. Well, I can't do 30 minutes a day all at one time, so learning that I could break it down in five-minute increments and work my way up; i.e., 'Hey, if you can only do five minutes for the whole day, at least it's five minutes.' Which is better than not doing it. Maybe saying, 'This is the end goal; but the reality is, we know this is a change, and we know it's hard to implement these things. So, just dedicate at least five minutes every day to starting to do these practices.' And I think that would help people that are kind of anal about doing everything they're supposed to do when they read the directions, and give them that kind of 'Phew, okay.'

"And for the instructors that is something to look into - to not allow people to come who are chronically late to classes and be disruptive. And as a matter of fact, I left that day, and I said 'Oh, no' when I felt the anger coming. I recognized it, I said 'No, I'm not going to stay here and give away all of this stuff I have learned over these last 8 sessions,' I had never seen that lady and the man before, the two late people. I think that is something that basically shouldn't have happened."

"The other thing about meditation and yoga... is that you are helping yourself. Okay so whereas therapy you have somebody there who is guiding you and trying to help you and you're trying to tell your story help others, in this environment with meditation and yoga, you're helping yourself. So he explained at the very beginning how we are not here to give each other advice..."

Reflections and Observations:

When establishing a mindfulness group, it is important that group members feel there is enough openness to allow their voice and other voices to be heard, and to feel that their questions, comments and observations are held by the group in a way that is supportive and non-judgmental. At the same time, there also needs to be enough structure to keep individuals or the group from going off topic, or from shifting into a mode of advice-giving or fixing. In this and the following sections, we attempt to share examples and approaches that help to establish the group as a container of trust – as well as quotes from Veterans who describe times when the group went off track. It is our hope that these examples will prove helpful to teachers of groups of Veterans.

As described below, a careful review of the guidelines for participation (listed below) in the first class session helps to set up expectations for the group related to attendance, participation, sharing and confidentiality, and interacting with other group members.





The Rules of Engagement. Perhaps a shorter, pithier version of the approach to building a container of trust are expressed in a saying used by one of our MBSR teachers. As originally described by Parker Palmer, the Rules of Engagement can be distilled as:

“No Fixing,
No Advising,
No Saving,
No Setting Anybody Straight.”

Recommendations:

Late arrivals to class. When introducing the Guidelines for Participation,ⁱⁱⁱ we suggest that if people must be late (due to other obligations, or unforeseen circumstances such as travel), that they as quietly and unobtrusively as possible enter the group. During the course of MBSR, we sometimes suggest to people that when others arrive late, this provides an opportunity to bring awareness to their own reaction patterns. Do they experience judgment? Curiosity? Compassion? What arises? In this way we attempt to weave the inevitability of some people arriving late into the theme of the classes.

Class attendance. In order to promote accountability, when Veterans know that they will miss a week, we ask that they mark this beforehand on the attendance sheet as an ‘informed absence; I.A.’ We advise teachers to reinforce the expectation (also outlined during orientation) that the more one puts into the class, the more one will get out of it. In particular, we encourage participants to make the first class which lays the groundwork for the series, and advise people who have to miss classes (especially the first two) to consider passing on this series and signing up at another time.

When discussing homework, we recommend that teachers frame the reading in *Full Catastrophe Living* as supplemental and optional, whereas doing the meditation practices is the primary homework. Although we acknowledge that reading about mindfulness is often helpful, we have found that for many people it takes a significant amount of time to complete the recommended reading. For this reason, we frame the book as an additional resource, which they can continue to utilize weeks or months after finishing the program. In addition, for Veterans with specific clinical issues, such as chronic pain, we often suggest that they read the pertinent book chapters in *Full Catastrophe Living*.

ⁱⁱⁱ The guidelines for participation provided in these materials were adapted from guidelines originally provided by the Osher Center for Integrative Medicine, University of California, San Francisco and the Center for Mindfulness in Medicine, Health Care, and Society, University of Massachusetts Medical School

Guidelines for Participation

1. **Please be on time.** We will cover a lot in our time together and you may miss something important to you if you are late. On the other hand, if you cannot avoid being late, please be sure to come in quietly anyway. It is better to be late than miss a session.
2. **Do the homework.** Set aside 30-45 min each day for your formal practice, even if it means 30-45 min less sleep. Many people find that 45 min of meditation can result in benefits that go beyond those derived from sleep.
3. **Maintain confidentiality.** Keep what is discussed by others in the group absolutely confidential. You are free to discuss your own experience with others outside of class.
4. **Be supportive, but do not try to fix others.** The greatest support for this practice is a safe environment. We support each other by simply listening and not offering advice nor trying to solve each other's problems. The most transformative learning happens when we each arrive at our own realizations in our own time. We will try to create an environment where each person can begin to see beyond all the "shoulds and should-nots" to what is actually true for them in each moment.
5. **Focus on the present moment, not past or future experiences.** Use "I" language to talk about what is going on in your body and mind and remain present-centered. For instance, "I notice thoughts of leaving class because of the tightness in my chest right now;" "I feel like I can't breathe." We will refrain from storytelling, or getting too far into the past and future (such as "I hope my leg pain doesn't get worse" or "when I was young, I had a leg injury that was worse than this"). Instead, consider what you are experiencing *here-and-now*: e.g., "right now, I notice tingling and burning in my legs." The most important aspect of this class is your experience in this moment.
6. **Communicate your concerns.** Please let the teacher know if you are having any difficulties. You may do so in the group or speak privately with the teacher. Time to talk before or after class, or on the telephone will be available.
7. **Be respectful of the group process.** If you will be absent or must leave early from a class, please notify the instructor or program coordinator beforehand.
8. **Plan to turn off your cell phone during class.** Since this class is about establishing and sustaining attentional focus, cellphones, texting, and email can be very disruptive, especially during periods of guided mindfulness practices. You are invited to see this class as your own personal time, a kind of mini-retreat within your day. Please make sure that you have made any essential calls, texts, or emails before class has begun.
9. **Do not bring visitors.** No one is to bring spouses or friends to any of the classes who has not been enrolled in the class from the beginning.

Some examples used by mindfulness teachers to illustrate these points:

Use the analogy of going to the gym because we have decided we want to be stronger. “If we wanted to gain physical strength, we wouldn’t expect that working out would produce this change in two or three weeks; it would naturally take much longer for us to gain strength. In this way, attending the mindfulness group is similar to going to the gym. In order to build any kind of strength or capacity, it will take some time – at least several weeks.” In this way, we advise participants to let go of short-term expectations and commit to at least eight weeks of practice before checking in on their progress.

Suggest to participants that they consider the mindfulness group as “basic training” for their minds, bodies, and emotions. “The extent to which you commit to the training, putting forward your best effort, is the extent to which you will find benefit from the course. You have all been through basic training in the military. Now we have the opportunity for basic training that can heal and bring peace.”

Invite participants to think of this class as a laboratory for their minds and bodies. “We will experiment with mindfulness and our basic experience. Nothing that happens in this lab is wrong or a mistake. It adds to our knowledge and understanding of ourselves and the world around us. Let’s see what happens in our daily lives and relationships when we become more mindful.”

It may help to explain to participants that when people come and go a lot in the series, it is difficult for the group to maintain cohesion and for the instructor to maintain a solid container of trust, safety, and flow. For instance, one of our teachers once had a participant who had so many appointments booked on the same day that the only time he could eat lunch was during the mindfulness group. The first couple of classes he was crunching on chips during meditation. From the negative response of his fellow classmates and a conversation with him, he came to realize he just was packing too many things into his schedule and he should take it at another time.

Balancing guidelines with acceptance that people are doing their best. At the same time, even as teachers encourage people to be on time, set aside time each day, and set up a schedule to allow for their best success, they should also remember to set it up to “do the best they can.” In our society, there is an epidemic of people feeling like they are not doing enough and they are not good enough. So while teachers need to encourage people that there is a certain amount of discipline needed within the class structure, they should also model and teach loving-kindness when talking about doing one’s best and not beating oneself up if one doesn’t do what the book says.

Chapter 4: Motivation, Support, Learning Opportunities

"It is helpful to have other people that you know are in the same boat as you; you know they're struggling and they made it to class and they're doing the work, even though it's not easy. So it makes it easier to be there and do it, because you've got the support."

"... one particular conversation that happened when one of the gentlemen in the class constantly complained about his back and his pain, constantly, constantly. I got really irritated with his constant complaining. Then all of a sudden, it just dawned on me that that's how I sound to my wife! I actually told the group, because of the gentleman's continuing conversation about his pain, it made me relook,- it made me look at how I come across and how I communicate my issues of pain around my family. I made a conscious decision, and the group actually applauded it, I made a conscious decision that I was going to be careful about what I say around my wife because it affects her."

"In the last two weeks, I've talked to almost half my class because they knew I was in the hospital. They just came out of the woodwork when they found out I was in the hospital, they're everywhere, so I thank God that they are still there for me. Everybody's like, 'You can do it Mike, come on,' everybody knows."

"It was actually wonderful to sit there and share parts of myself with people and to have them share themselves with me and have people share things that I understood; you know, that made me feel like I wasn't crazy, that I wasn't alone, that I was being understood out there with the way I was feeling. It made it a lot easier for me to relax and to let my guard down, which if you have ever tried to speak to people and say something about yourself, it's very hard to talk about yourself. You don't really want to open up and say the truth about yourself. It got to be very, very easy to open up and tell the truth about yourself. It was a wonderful experience."

Reflections and observations:

Although the group format can present numerous challenges (see chapters 5-9), it also affords opportunities for growth. Many Veterans find that the group provides motivation and support to practice, both inside and outside the classroom. For example, the group often fosters a sense of accountability to complete the homework despite difficulties. In addition, in the group format Veterans are encouraged to notice their own reaction patterns while listening to others, which can lead to insight, growth, and change. Sharing in the group can also be therapeutic for many Veterans, especially in the presence of individuals who are similarly dealing with physical and/or emotional pain. Relating to others in the group on the basis of a shared struggle can help support practice. Some Veterans are surprised at the level of openness of other group members, and enjoy the chance to share their views as well as learn from one another's experiences. The group becomes more unified and cohesive over the course of the eight weeks, as members form bonds with one another and the teacher and engage more fully with the practices.

"At that level of feeling each other's pain and hearing yourself and being seen, healing happens."



Recommendations:

Invite participants to view their reactions to others as learning opportunities.

The unique challenges of working in a group can also be keys to growth when worked with. For instance, rather than becoming lost in judgments about others, or pushing away feelings of annoyance or irritation, encourage participants to turn their awareness to these internal experiences as objective, passing events worthy of interest and understanding. It may also be useful to ask participants to note if they experience similar reactions to people when they are outside of class. If so, why not use the experience in MBSR as an opportunity to work with these reaction patterns? The teacher can facilitate this process by modelling interest and curiosity about these reaction patterns, e.g. “How great it is that you are noticing that annoyance is coming up for you. Are you able to stay with this and be curious about it?” In this way, each experience is framed as an opportunity to work with reactive or resistant habit patterns. 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.

“I think I made more of a conscious effort to do it and get it done because I knew I had not only an obligation to myself, but to my classmates and to the instructors, of doing the workbook, doing the meditations, to stay involved and engaged in that. It was a little bit more purposeful.”

Remind participants that learning mindfulness may paradoxically increase their stress initially. We like to use the Jon Kabat-Zinn quote from *Full Catastrophe Living*, “...it can be stressful to take the Stress Reduction program (page 2).”³⁰ Participants may enter the class expecting their stress to go down right away. In fact, this is not the case; MBSR asks participants to notice whatever arises during class sessions and homework practice – including painful sensations, thoughts, and emotions. In this way they are asked to greet with friendliness and nonjudgmental attention what they usually react to and resist. Reminding participants that MBSR may be challenging in a number of ways – from getting to the class, to finding time to practice, to listening to other group members – can help them re-adjust their expectations and prepare them for the challenges and opportunities ahead. This is especially important because among Veterans, we have found that dealing with difficult group dynamics can be particularly stressful; this may actually increase their stress in the short-term.

Chapter 5: Over-Sharing and Maintaining Control

"[Our instructor] was very welcoming, very open...she is very good about maintaining the length of the class and keeping everyone focused and on topic without going off on a rabbit trail too much. Very helpful...leading the class discussions, being respectful of everyone's opinions, and setting a good tone for the overall class."

"I come to my meditation and mindfulness instruction through a Buddhist background and I've seen their instructors be very good at holding people accountable. They start going off and it's, 'Hey, come back.' And so what I kind of noticed is, there was a deference allowed by the instructor to the experience of the vet that was in the class. Which was nice, you know; it's nice to hear 'Thank you for your service.' Great. But there also needs to be an accountability, and I think a vet may be more comfortable holding other vets accountable and getting them back on task and dealing with the blustery-ness of people who have been in charge of other people their entire life."

Reflections and observations:

Veterans appreciate the chance to share their experiences about the practices and learn from one another's perspectives; indeed, this can be healing. But they regard this kind of sharing as fundamentally different from the discussion being sidetracked and dominated by a few group members. Many are bothered when particular group members share if it steers the conversation to issues they consider off-topic or inappropriate for a mindfulness group.



Recommendations:

The challenges of the group format underscore the need for teachers to be mindful about guiding and balancing group discussions with Veterans. Holding the group accountable is encouraged and providing clear structure is helpful in this regard. Additionally, having some knowledge of Veteran culture can enable facilitators to foster the needed accountability and structure. The following are a few recommendations for maintaining control of the group:

In session one, describe how this group differs from other groups Veterans might have taken part in in the past.

The way that we approach this is to acknowledge that the format of many groups is to discuss and process what has happened to them up to this point in their lives, that *this is often valuable, and this is not the purpose of this group.* Instead the format of MBSR discussions is to discuss their experiences while practicing mindfulness. To make the point more strongly, some instructors clearly state that “this not group psychotherapy, nor a support group (though people are generally supportive of one another) – it is a mental training, and everyone is training together.”

Explicitly describing the approach taken in a mindfulness group and contrast it to other support-oriented groups seems to help keep the group on track.

Framing this at the outset of the course – i.e., that this isn’t a class about sharing our life stories but instead is focused on working in the here and now – may come as a surprise and possibly a relief to some people. It can help establish a “container” where participants understand that while they may hear some of other’s stories, they don’t have to take them on because this work is based on the premise that we all have the capacity and wisdom to work with the issues in our lives and we are here together to discover those strengths and abilities within ourselves.

“I think she was very good as far as commanding the room. She was a central portion of it. Like I said, her voice is absolutely wonderful, so she did a wonderful job of directing the class. She was great.”

“There was a Vietnam vet who had taken the class two or three times. And had a self-described power control problem. He had to be in control. He had to tell people what to do. And he gave a disclaimer that, obviously this is something he’s working on, and his disclaimer at the beginning of group, ‘I do this, I apologize,’ and then he continued to do it. And the disclaimer’s great, it’s great you understand, it doesn’t make it okay. And I think somebody who’d have been more comfortable in that role would have been able to say that.”

“[The instructor] was open, she was informative. She was really patient and able to steer people if they started to go off on their own little tangent, able to let them feel comfortable saying what they needed to, but at the same time, not take over class. I think the balance was really great.”

Lay out the Guidelines for Group Participation.

In the first class session, we review the guidelines for participation (see Chapter 3). We ask all participants to abide by these guidelines, which include ‘Do Not Try to Fix Others.’ It is helpful to emphasize this point in the first session, and to point out that this means no giving of advice. If at times later in MBSR this seems to occur, it may be helpful to remind participants of

these guidelines. This can be a simple ‘let’s make sure not to fix others’ or could include recognition that ‘the advice seems to be coming from care and concern AND each person

will benefit from finding their own path in their own time so it's best to avoid giving one another advice.'

Utilize skillful redirecting when necessary. The instructor needs to have techniques at hand to cut people off in a dignified manner if it seems appropriate, to politely redirect and use skillful inquiry. Simple phrases of bringing people back, if they become tangential, might include interjections or questions by the instructor such as, "Can you bring it back to the exercise we're discussing?", "I need to ask you to come back to the topic at hand", or "I need to ask you to pause." **Don't be afraid to be direct.** We have heard repeatedly from Veterans that they appreciate directness and clarity from the instructor.

Interrupt when needed: At the beginning of class, it is helpful to tell the group that there may be times when the instructor will need to interrupt the conversation. For example, if people are "in their story," the instructor may invite them to become more present with their bodies and what they are experiencing in the moment. Or, due to time constraints and an effort to adhere to the curriculum, the instructor may need to stop a conversation and move on. Saying this at the outset helps mitigate hurt feelings later on.

Frame participation in the group as an opportunity to practice mindful listening. Invite participants to engage in the practice of active listening as a form of mindfulness meditation. Instructors may prompt participants to notice what comes up for them as they

listen; i.e., are they really listening, are they in their own thoughts, what are they feeling about what's being said, what thoughts and emotions are coming up, etc..

"He had a calming demeanor and was very good at explaining things and helping people understand and acknowledging people that asked questions that would be covered later on. He would say, "You've raised a really good point and I don't want to address that right now, simply because we are going to be talking about it in the next session, and this session builds onto the next. - which was a fair statement."

Suggest doing the opposite of your usual tendency to share or remain silent.

If a participant knows that he or she tends to speak more often and easily jump in, we invite him or her to notice that impulse and instead experiment with not speaking and see what comes up. When some group members dominate the class discussions, it may be helpful to introduce the next

"Apparently these Veterans have nothing better to do and want to talk about Vietnam. I left the military 20 years ago, I was in Desert Storm, I left Desert Storm behind, I do not care to listen to stories about Vietnam while I'm in a meditation class. It was literally ridiculous and a complete waste of time. He [instructor] couldn't control it. ... So that's why I quit... I'm not there to get over the military, I'm over there to get over my back pain... You've got some hard core Veterans in there. You've got to be a very strong instructor to say, 'Listen, this is what we do: bottom line, we need to stop..'... if there was a stronger able-minded person to say 'OK, let's move on now,' whereas he just was not able to do that at all."

discussion section with the suggestion to “take this opportunity to do the opposite of your usual habit. If it is your natural tendency to talk and share, then perhaps this would be an opportunity to sit with that impulse and instead cultivate listening to others. If it is your tendency to be quiet and not to talk, then perhaps you can take this opportunity to speak.”

Chapter 6: Anxiety about Sharing

"It was really cool to see three students that usually don't talk actually speak up. And they shared some really great insights, and I know it's a non-judging, and it wasn't a judgment, it was a validation, an affirmation – 'Don't be quiet; you've got stuff to share.' And I noticed that after that, those people (except one) started to speak up – they started to speak up more. It wasn't by any stretch of the imagination a lot, but for them it was more. So that was really cool because it showed that they were using their practice and they were also starting to come out of their shell a little bit. Or feel more comfortable talking about their experiences. Because they realized that their experiences could benefit others."

"I think some of them are so angry and/or anxious that they weren't really listening or tying in where I felt like I was willing to tie right in... I was willing to do it. And I think some of the other participants were not so much. One man, one woman particularly, maybe a couple of the women that were uncomfortable then."

"There's a lot of anxiety in those rooms."

Reflections and observations:

Sharing in a group can be an anxiety-provoking experience. For some Veterans, this anxiety subsides over the course of the group. For others, it remains a challenge, motivating them to stay very quiet even though they are experiencing difficulties. In general, Veterans seem to appreciate the chance to share their experiences with meditation and hear others share.



Recommendations:

Invite participants that do not share frequently, to try to share more. Instructors can invite people who aren't comfortable speaking to notice this tendency and maybe work with getting out of their comfort zones in the safety of this group. It is helpful to frame the group sharing process by saying that because of our familial or cultural backgrounds it might be more or less easy to share, but in this group what you have to say is valuable and you never have to speak if you don't want to - but there is a space for you to be heard.

Remind participants that every voice is valuable. Often, people come to mindfulness groups with either great ease or great difficulty openly sharing in a group, and it helps to frame the class by

"If there was any other challenging part, it was we went around the room and actually had to talk. That is a challenge to me. I'm always concerned on what I'm going to say and how I'm going to come across..."

acknowledging that, because of our life history, sometimes we might feel that what we have to say is not valuable. It may help to tell people that in this class, everyone's voices and experiences are valued and there is a place here for them to be heard. This often is met with almost a sigh of relief.

Some instructors encourage participants to share by first giving permission not to speak, then inviting them to speak – for example “the only thing you really have to do is to do the mindfulness practices in your life...but it might enhance your experience a lot if you do speak up sometimes and share what you are learning or what you are having trouble with.”

Use “Microphone Practice”: Given that in most groups there are those who like to speak and those who don't, one way of encouraging participation by all group members is to suggest that they use the “sharing time” as an opportunity to do “microphone practice” – if they are the kind of person who likes to talk, to watch that need and see what it would feel like to hold back. What do they notice? Conversely, with people who don't easily speak in groups, it may help to frame this as an opportunity to practice taking risks and to “take their place.” This practice often creates even more safety for those more reticent to share, to share.

“There were some people in there with really bad issues that were staying quiet while all this other talking was going on.”

Chapter 7: Women-Only Groups

"The level of estrogen and male hormones were balanced, and so it's like an AA meeting; it's a better balance, it's more real." (from a female who completed MBSR)

"I do feel that a women's group is something that should be offered. Um, just because the whole point is to reduce stress and pain and whatnot, putting women that have military sexual trauma and other types of things, I definitely see how that might feel very unsafe to them, because you're closing your eyes – you're vulnerable during that time." (from a female who completed MBSR)

"I am more of a female-to-female... if a bunch of us are coming from the Women's Trauma Center, why can't we create one inside the Women's Trauma Center rather than outside? I noticed when I was female to female, it was a lot easier for me to deal with my rapes because that's where I was able to deal with my rapes better." (from a female who completed MBSR)

Reflections and observations:

Some female Veterans feel strongly that a women's-only group should be offered. They find it difficult to open up and feel comfortable in a room with males, especially if they have experienced military sexual trauma. Participation in a mindfulness group invites vulnerability, and while some discomfort is natural and encouraged, there is a point at which it is too difficult to practice. Discomfort with males in the room has prompted some female Veterans with PTSD to drop out of MBSR. Of note, this represent a conflict with mixed-gender groups, not with mindfulness practice itself. However, this sentiment is not universal; some women do not have an issue participating in a group with men. In addition, male Veterans express that they appreciate the female perspective in group discussions.

However, some female veterans with histories of MST may use the experience of a mixed group to help them heal from a fear of men. The following story comes from one of our MBSR instructors, about a female participant with MST:

"I went to a group physical therapy at the swimming pool and men actually touching me. I can't do that. I'm not there for people to touch. I'm there to get better. That's the end of all my group classes, I will not take another group class. Sorry, I can't do it." (from a female who declined to participate in MBSR)

"From the beginning of class she was able to tell the group about her assault. Over the course of the class, she asked if she could sit close to me and be close to me when we did mindful movement, especially lying on the floor. I would check in with her at the end of every class. In this way she was fully supported and by the end of



the class some men in the class expressed appreciation for her being there and she actually thanked them for being there to support her healing process.”

Recommendations:

When mixed gender groups are offered, make it clear in the orientation process that there will be both men and women in the group. In this way, women Veterans can make an informed decision about whether they are ready to participate in a MBSR group with men.

“I knew about one guy and some things that he had done, was doing, and two people I just didn't feel safe with in there... because I had such issues with certain people and one of them couldn't sit still, I would turn around and he kept staring at me, I was not comfortable. So I was like, okay, it was hard for me.” (from a female who dropped out of MBSR)

When possible, we also recommend offering women-only mindfulness groups to better serve the needs of women Veterans. Although women with histories of interpersonal trauma might benefit from participation in a mixed gender group (which would provide opportunities to approach their discomfort, fear, or anxiety with mindful awareness), this should be pursued *only if they are open to it and feel prepared to take this step.* It is not necessary for patients to confront their most difficult sources of stress at the outset. We think that offering mindfulness in a women-only format could eliminate this potential deal-breaking barrier without loss of essential growth opportunities.

For women-only mindfulness groups, we recommend female instructors.

Context:

Military sexual trauma (MST) occurs at alarming rates – as many as 20% - 40% of women Veterans report MST, as do 1% - 5% of male Veterans.³¹⁻³⁶ The Department of Veterans Affairs defines military sexual trauma as sexual assault or harassment that occurs during military service; this includes any sexual activity which a service member is pressured or forced into against his or her will. MST is a potent risk factor for developing PTSD – women Veterans with MST have higher rates of PTSD than those with trauma histories other than sexual assault.^{31, 34} Indeed, one study found that women Veterans with MST were *nine times more likely to have PTSD* than those without MST histories.³⁷ In addition, MST places women Veterans at higher risk

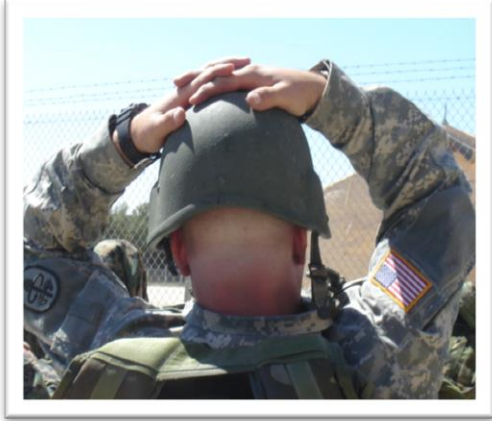
“I really like the co-ed type of thing because you get the point of view from a woman's eyes and a point of view from the man's eyes. To me, women are more sensitive so they come up with better things than men, so it was great to participate with women.” (from a male who completed MBSR)

of depression, substance use disorders, and poorer health status, including chronic health problems, pain, and reduced quality of life.^{32, 34, 38} Combined with the fact that the number of women Veterans is steadily growing, these figures highlight the fact that women Veterans' unique needs must be taken into account in healthcare interventions and VA settings.³⁹ Although some women with MST and PTSD are willing to participate in mixed gender MBSR groups, some women Veterans with a history of MST and/or PTSD do not wish to participate in a group with males.

Suggestions for further reading:

Department of Veterans Affairs. (2014). Military sexual trauma.
<http://www.mentalhealth.va.gov/msthome.asp>

Chapter 8: Observations on How Veterans Relate to One Another



"The nature of the class tended to become less of an issue for me, because we were all able to find a commonality amongst ourselves and why we were there...initially it was kind of difficult just being in a mix of people you're not sure about, you didn't really have much knowledge of them, but I think as the core group...you kind of develop a rapport with them so that it made the in-class exercises easier to do, a little bit more comfortable to do."

"I was being understood out there with the way I was feeling. It made it a lot easier for me to relax and to let my guard down. If you have ever tried to speak to people and say something about yourself, it's very hard to talk about yourself. You don't really want to open up and say the truth about yourself. It got to be very, very easy to open up and tell the truth about yourself. It was a wonderful experience."

"I think they should be knowing this by now, Vietnam was a lot different than Desert Storm, Iraq was a lot different than Desert Storm, and I'm considered very young... I do not in any way shape

or form – other than the fact that I've been to a war – I do not relate with a 60 year-old Vietnam Veteran. It was a completely different era, a completely different time, and a completely different mind frame that what we went into Desert Storm with. And ours was all voluntary; huge difference, you got a lot of mad 60 year-olds out there"

"It's just that combat Veterans relate to combat Veterans. They also relate to other people but they're hungry to relate to combat Veterans and it's only because it was such a distorted situation to be in. A lot of people that were in combat did not really know the name of the people that were next to them unless it was their front man or back man... Vietnam Veterans are extremely hungry to relate to other Veterans. Not tell their stories, just to be next to them so it's kind of being able to relate to and then you have people that were not in combat, they are not respected by people that were in combat. They have that undercurrent going on"

"It is helpful to have other people that you know are in the same boat as you. You know they're struggling and they made it to class, and they're doing the work, even though it's not easy. So it makes it easier to be there and do it, because you've got the support."

"One of the reasons that I joined the group was I was hoping to get in contact with vets from my generation, or my war. I was looking for that connection as well."



Reflections and observations:

Veterans may relate to one another based on period of service. In other words, some Vietnam Veterans relate better to one another than to younger Gulf War, OIF/OEF Veterans, and vice versa. Thus, a preponderance of older Veterans can make the group experience challenging for younger Veterans, particularly if the conversations go off track. Some participants are not interested in hearing about others' war experiences, because that is not the reason why they came to MBSR. When members over-share about their military service or the effects it had on them,

"When I talk to other members of the class, we should share experiences and then it would reinforce that I'm on the right track and that I'm not crazy here. That helped."

"It was actually wonderful to sit there and share parts of myself with people and have them share themselves with me, and have people share things that I understood – you know, that didn't make me feel like I was crazy – that I wasn't alone, that I was being understood out there with the way I was feeling."

it can seem off-topic to other Veterans, especially if they are from different eras or periods of service. The combination of over-sharing and lack of redirection by the facilitator can sometimes prompt Veterans to drop out.

Nevertheless, one of the unique aspects of the classes with Veterans, as compared to teaching mindfulness in other settings, is that there is a common bond among all Vets when they walk in the room, regardless of age or era. The group process is always one of formation and maturation, but the power of starting from a base of an important mutually shared experience can

foster group cohesiveness and deep bonding. Veterans also relate to one another in terms of shared struggle with ongoing clinical challenges, such as being in the group to help with pain.

The mindfulness instructors have noticed time and again how grateful Veterans are to find they are not alone. Many feel so isolated in their experience that the shared understanding encountered in group participation can be powerfully healing.

Recommendations:

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.

Interviewer: *What is the most important thing you learned about yourself in the MBSR class?*

Veteran: *I'm not alone.*

Part III: Reflections on teaching specific mindfulness practices

Chapter 9: The Body Scan

"I do that basically especially at night, my final set of the night because my feet are usually the most irritated part of my physical being by the end of the day. I have severe neuropathic pain in both feet along with numbness, tingling, sharp pain, so I kind of start with getting my feet in order and how they feel and letting go of that and then I just move on, it's a very simple process. I automatically focus on my feet because they hurt the worst and once they settle down everything else settles down behind them and the next thing I know I'm waking up."

"It kind of just makes me stop and be aware where I'm at in the present moment. Sometimes, I don't think I'm holding the stress or the stressors that are around me and how my body reacts to those, so it just kind of makes me stop and say, okay I hurt because I'm holding stress here or just kind of lets me recognize it, try to release it, and then just go on and kind of help me deal with the moment."

"So that's a difficult task. Really, I don't like to talk about it because I have not been able to get it down. I just haven't been able to get it down. It's hard for me. I think it's more because I'm not understanding the whole concept of it... Sometimes it's like I can't understand why they're doing it and why I'm going to scan, what the purpose is really and how it's going to help me. Sometimes I get lost in that and I'm not able to focus on anything else. I'm not able to move on."

"I didn't like doing the body scans 'cause it brought attention to my pain...And I spend more of my time trying not to focus on my pain. And it was like, 'Okay, you're asking me to focus on my pain, and that makes no sense to me'... we're supposed to resist the pain, that's what we're taught: resist the pain, not to approach and accept it."

Reflections and observations:

Veterans have diverse reactions to the body scan practice. Some enjoy it and find it helpful. They find that greater body awareness, while difficult, is ultimately beneficial for managing their symptoms. Many also use it for falling asleep at night. Others dislike it, finding it difficult to understand why they would bring awareness to their body which is causing them pain.



Recommendations:

Recognize that this can be uncomfortable and very new to people. It may be helpful to make very clear that the scan can be uncomfortable for some people and that this is part of the process of looking at what is really happening in our minds and bodies. We have spent many years getting to the place we are in now, so it will take effort to find a new way. It can be frightening to go into the places in our body where we have been hurt or held pain. Invite people to simply try the best they can to stay with the voice and see what happens.

Clearly explain the rationale for increased awareness of bodily sensations, including pain. This is important for engagement because the practice can be very difficult for Veterans dealing with chronic pain conditions. Additional information on working with Veterans with chronic pain can be found in the chapter on chronic pain.

Acknowledge personal limits and encourage people to do the best they can. Room needs to be left for people with severe PTSD or chronic pain to shorten the body scan if they do not feel they can participate otherwise. This can be negotiated privately with individual participants who seem to be deeply struggling with a sustained body scan, and can also be included as part of general instructions. When Veterans experience difficulty practicing the body scan, we advise explaining that even practicing it for only a few minutes initially can be better than not doing it at all, and it can be built upon each day.

For Veterans with physical limitations, provide the option of engaging in the body scan while sitting in a chair. For some Veterans, lying in a recumbent position can be particularly painful, due to back problems or other physical conditions. For this reason, we suggest offering the option to engage in the body scan while sitting in a chair, if needed. Adaptations can be made while lying down as well, such as bending the knees, using a bolster under the knees, or lying in an “astronaut pose” with calves up on the seat of a chair.

Chapter 10: Sitting Meditation (or Breathing Meditation)

“When I find myself...when I’m walking along or driving along, and I find I’m not breathing, at that point I am so tense and so stressed, that a deep breath brings me back or slows me down...and I need to get control... I understand now that my breathing is part of the process of me getting control or taking control back. So, it’s directly connected to how I see myself handling a particular situation or how I’m engaged. I know when I...can get so engaged that I will stop breathing, and that’s when anger and irritation comes on.”

“I’m able to deal with it a whole lot better using my mind or using breathing to help control a bad situation. Normally I would just fly off the handle, say anything, but stopping, taking time to breathe,

and do a little thinking, I can resolve getting into an argument over whatever was said, so I just deal with it differently instead of just jumping right off chewing your head off.”

“I was getting leg spasms really bad... So I took the three deep breaths, and immediately I wanted to say, ‘Just don’t think about it.’ It’s like before I did the deep breaths: ‘Don’t think about the pain, just put it away, drive on, focus on something else.’ But I took the three deep breaths, and I was able to assess that, ‘My body is telling me that I’m fatiguing and that it is in pain and that it needs me to manage that pain.’ And so I took my pain medication, which then made everything a lot better.”

Reflections and observations:

Many Veterans adopt a regular practice of sitting or breathing meditation after completing a mindfulness course. They find it helpful in coping with pain and stress, and often report that the breathing meditation helps them to step out of reaction patterns, which allows for sounder judgment and greater self-control. Learning how to change their response to a situation by breathing, rather than reacting, has been beneficial for many. They can deal with difficult interpersonal situations and life stressors better when they are able to breathe. Many find breathing meditation to be a more accessible practice than the body scan when they are in pain. Indeed, for some it becomes a regular part of their daily routine. Veterans report practicing breathing in many settings, including commuting. In MBSR for Veterans, we teach breathing meditation while seated in chairs; only rarely do Veterans opt to sit on cushions on the floor. When needed, participants are free to adapt the seated posture further, with the addition of cushions, or to practice breathing meditation while recumbent, in order to accommodate pain or disability.





However, many participants also report that they find the sitting meditation to be more difficult than the movement practices. Sitting is a more concentrated encounter with racing or painful thoughts, and difficult emotions like restlessness, anxiety, panic, or boredom, which can be more easily held at bay for many people during the movement practices. In this sense, staying with the sitting practice builds the “mindfulness muscle,” and grows our ability to be with what is uncomfortable or unpleasant in a less reactive way. Our approach is generally to acknowledge that sitting practice can be difficult, but that it is intended to serve a useful purpose, and to provide kind encouragement for continued practice. We often encourage Veterans to adopt a courageous attitude of moving into difficulty, and to bring an attitude of strength and kindness to this endeavor. However, as with all the practices, we often include in the general instructions encouragement to trust their intrinsic wisdom if they feel it is truly necessary for them to disengage or adopt a different form of practice – while balancing this with the knowledge that it is often necessary to lean into difficulty if we are to grow. In addition, this can be a useful point for the mindfulness teacher to provide instruction about working with judgment. This can take the form of asking Veterans to notice whether judgment arises – either as a comparison to others in the room or to an internalized standard. If that is the case, we invite Veterans to view this as an opportunity to work with this aspect of experience – to notice judgment - and then to continue practicing with kindness and steadfastness as best they can.

“I have a hard time doing the seated meditation, but if I can cross my legs on a cushion my posture is much better, it’s a better meditation. The seated ones, the injuries hurt sitting. That’s probably one of the things that hurts the most. But it doesn’t hurt in a cross-legged position.”

Recommendations:

Invite participants to notice their reactions, favorable or unfavorable, to the practices without judgment. Participants will tend to decide what they like and don’t like among the practices, much as we all are prone to have preferences to most things in our lives; e.g., “I hate the body scan” or “The body scan doesn’t work for me because I always fall asleep” or “I really love the breathing meditation.” However, it is important for the instructor to keep supporting all the

“So that one was a little bit easier; that one I didn’t feel the body pains as much because that was more of breathing and the sitting versus, let’s focus on our bodies. That I enjoyed a little bit more.”

practices so that participants continue to challenge their learning edges and to provide a practical support for seeing reaction patterns in their lives. To this end, consider telling Veterans that the sense of “this is no good” or “I can’t do this” is a common feeling in early mindfulness practice, but that this voice may be the body or mind resisting some hard, growth-inducing work that can be done. We encourage Veterans to adopt an attitude of kindness and curiosity when aversions to specific practices arise. In this way they are encouraged to view each practice as an opportunity to learn more about themselves – including how they deal with situations that are uncomfortable or don’t meet with their preferences. What is it about a specific practice that they find difficult? If there are ideas that they cannot do this, are those ideas true? Can they experiment with approaching each practice with openness and a beginner’s mind, knowing that no two practice sessions are the same? As described above in the reflections and observations section, encouragement to move into difficulty with curiosity, openness and an eye toward deeper understanding is balanced with instructions to give oneself permission to pull back or opt out if needed – and to do so without judgment.

Provide encouragement for staying with the practice, even when it is difficult. It can be helpful to tell participants how courageous they are for taking on this practice, expressing gratitude for their presence and honoring their willingness to be with themselves as honestly and directly as they are. One instructor sometimes tells the group that when she looks out across a room of people in silence and stillness, she thinks it is one of the most courageous things we can do - although it may look easy. Participants may be encouraged by hearing about their teachers’ own early meditation experience – if they hated sitting still, how hard it was, how they just wanted the leader to ring the bell, how they struggled with self-criticism – and what kept drawing them back to the practice. It can be helpful to acknowledge that it is so much easier to get up and seek pleasure or avoidance, and that it takes real courage to just stay, stay, stay.

Chapter 11: Mindful Movement – Yoga and Qi Gong

“The more I keep my body flexible, the less pain I have. And so I won’t have to take pain medication. So I like doing the yoga.”

“And it’s not the hard yoga that I used to do, so that’s the reason why I like this yoga here, because the ones I’m accustomed of doing, I’m in these exercise programs with the military... they’re too hard on my joints in going down and getting into those deep, deep poses. So I just really like this yoga here because it does not tax my joints. And I’m not in any competition with anybody else”

“It was helpful to have the instructor do the Qi Gong, because I thought that if there might have been a DVD along with the Qi Gong exercises at

home it would have been helpful. Whereas actually seeing her do it, it was easier to see and follow her doing those exercises as opposed to trying to read how to do them just in the material, so that was helpful.”

“Sometimes, the physical exercises were difficult because I have balance issues; but I also have fatigue issues, and sometimes my legs weren’t real happy so I wanted to be down on the floor or whatnot. And it didn’t feel like we were given a lot of good instruction on modified poses. What if you have somebody that can’t stand for long periods; how can they benefit from a balance exercise in a sitting position? ‘Cause there are ways to do it.”

Reflections and observations:

Many Veterans enjoy yoga and Qi Gong. Although Qi Gong is not part of the formal MBSR curriculum, some of our MBSR teachers substitute Qi Gong for yoga as a mindful movement practice, and our impression is that this is perfectly acceptable. Indeed, Qi Gong often is reported by participants to be their favorite practice. Mindful movement practices seem to be particularly helpful for pain relief, and *with appropriate modifications* are not too difficult for most Veterans with physical limitations. ***Of note, when teaching MBSR, we significantly simplify the yoga sequence proposed in the original MBSR curriculum, due to the physical limitations of many Veterans.*** The simplified yoga sequence and Qi Gong practice both appear to be accessible and acceptable to Veterans dealing with chronic pain. Engaging in these movement meditations also appears to serve the purpose of demonstrating for some Veterans that they are capable of more movement than they previously thought. This can be an empowering realization, with positive short- and long-term consequences. Some Veterans continue to practice yoga and Qi Gong formally and informally after MBSR. A few report finding yoga difficult, but many are able to modify the movements to accommodate their limitations.

Several Veterans have suggested that more visual guides for Qi Gong (e.g., a video of the movements) would help with at-home practice. Although a favorite among participants, Qi Gong seems to be more difficult for people to learn and remember.



Recommendations:

When yoga is taught, a more simplified yoga sequence than originally used in the MBSR curriculum is recommended for groups of Veterans.

Chair yoga, which utilizes a chair as a prop during the practice of yoga, also represents a viable option for working with groups of Veterans; if the mindfulness instructor is qualified to teach chair yoga we suggest this as a viable option.

"I would just put my relaxation on and then I try to do the yoga part of it and the different stretches and that. I don't cross my feet, I don't cross my legs, I kind of just sit there. I do it kind of differently to accommodate me."

Give Veterans options and modifications when doing yoga, including the option to 'opt out'.

Many will try to do the exercises, but some may refuse many exercises due to their "limitations." Working with these limitations – working directly with the challenges in the body and mind and "seeing what happens" – can be very powerful. It may be supportive to gently urge participants to give it their best or perhaps to participate in only small movements (e.g. raising and lowering arms) if they have significant physical limitations.

Work to create effective visual aids for Qi Gong. For instance, providing a video that demonstrates the Qi Gong movements could support participants in their home practice.

"I really like the Qi Gong because with my fibromyalgia and my fatigue, sometimes it's really hard to do anything. And I used to do triathlons. So going from a very endurance-intensive sport to hardly being able to move sometimes is very psychologically difficult. And the Qi Gong is movements that you can make no matter what. Even if I'm having fatigue issues, there's nothing saying I can't sit down and do some of the arm movements, to get some of that movement going"



Chapter 12: Walking Meditation

"Typically we are going from point A to point B on a constant basis, and the walking meditation gave us the opportunity to slow down to be in the moment, to not have an end goal to reach. That was a different aspect for me. I'm used to going from here to there and getting things done; whereas being in that moment and just taking time to focus on the steps, the movement, your breathing, was very different. That stands out to me."

"[When] you're actually doing it, you start to realize that meditation is not something you necessarily do when sitting down or laying down. It can be just a part of your life, you know, a way of being... I think walking meditation is kind of an intro to the realization that you can have that presence, that presence when you're doing the body scan, you can have that all the time when you're talking to people, when you're moving through the world."

Reflections and observations:

The practice of walking meditation seems more helpful for some Veterans than others. Those who find it helpful enjoy the opportunity to slow down and be in the moment while doing something simple, repetitive and familiar. For this reason, many Veterans are able to incorporate walking meditation into everyday activities. For some, walking meditation can be initially uncomfortable but grows easier over time. However, other Veterans find this practice to be challenging due to physical disabilities and balance problems. For these Veterans, sitting meditation may be a more viable option. From a logistical perspective, walking meditation requires rooms of ample size.

"I don't really like the walking meditation. Your balance, if you kind of focus on something, being still is a lot better for me. I walk and think all the time, you know it's not like meditation, and so I don't think I was really good at it."



Recommendations:

Consider introducing the walking meditation earlier in the program. Two of our teachers find it helpful to introduce it earlier in the program, by the fourth or fifth class. Incorporating it earlier rather than later gives Veterans more options for their practice.

Give Veterans the option to 'opt out' of walking meditation, if physical limitations make this practice difficult or not possible. If Veterans decide to opt out of walking meditation, sitting meditation or body scan meditation can be substituted. As described

above under sitting meditation, this can also be a useful opportunity to notice the comparing mind and judgment.

"The first time was a bit weird, but then afterwards everything was okay. It took a little getting used to it. I still had to deal with my mind... I would be doing meditation, but my mind is still going on, still thinking stuff."

Chapter 13: Loving-Kindness Meditation

"I felt odd in doing it... It's just a practice of something that we don't normally do for ourselves, so I was kind of uncomfortable telling myself that I'm okay with where I'm at in this stage of myself, my being or my situation. That's kind of what was uncomfortable to me."

"It will exponentially help them as far as opening the heart, removing obstacles to the heart.... Loving kindness brings in the love, hard core... when you do loving kindness, you're working directly with light. You're consciously bringing love into the situation."

"It was very good. It was the high point... It connects to the heart, I don't know how to put it in words. That's where the healing happens."

"It was different. I think you have to have love in everything that you deal with. It's freeing your mind, well it was freeing my mind. It helped me be able to make it through that day better, even though I was facing a whole bunch of adversity."

Reflections and observations:

Loving-Kindness meditation is briefly introduced in MBSR during the all-day Saturday session. In our experience, it has mixed reactions among Veterans. Some find it very enjoyable, liberating, and healing. They see it as having a positive impact on themselves, others, and society in general. For some, it helps them feel greater kindness and love towards themselves as well as others. On the other hand, some Veterans find it challenging and uncomfortable. Many Veterans with PTSD develop beliefs about self, others and the world in general that can lead to added suffering, as well as feelings of shame and guilt. In our experience, these limiting beliefs come readily to the surface during LKM practice. This can provide a valuable opportunity to bring awareness to these beliefs with an attitude of kindness and curiosity. In PTSD, there can be ideas and feelings that they are 'damaged goods,' or that they are weak, vulnerable, inadequate or disgusting in some way. LKM emphasizes the cultivation of goodwill toward oneself, which helps to repair these tendencies toward shame. In addition, many people with chronic PTSD develop a decreased ability to feel emotions of any type, especially those involving intimacy or affection. This can present as feelings of chronic alienation and deadness. The cultivation of positive emotions through LKM may be particularly helpful for these numbing and constrictive symptoms characteristic of chronic PTSD.



Recommendations:

We think it is helpful to introduce Loving-Kindness Meditation in a mindfulness class series. We have found many Veterans with PTSD, as well as other chronic conditions, find the practice helpful, and preliminary research suggests a benefit.

When introducing Loving-Kindness Meditation, we encourage Veterans to set aside preconceptions and just go with the practice. It is often helpful to include in the instructions to LKM a description that “if while practicing you don’t necessarily notice positive emotions, that is fine – you are not doing the practice wrong. In Loving-Kindness Meditation practice, we encourage you to ‘just do it’ and then to notice whatever arises with an attitude of kindness and friendliness.”

Mindfulness instructors should understand that barriers to openheartedness will often come to the surface during Loving-Kindness Meditation practice when teaching Veterans, and that this is not a problem. This seems particularly true for Veterans with PTSD. When repeating LKM phrases, the practice is to notice whatever thoughts, emotions and feelings arise. This might include limiting beliefs, painful emotions, or feelings of reluctance, hesitation, or even aversion to self or others. In LKM, the practice is to greet these experiences with kindness, to notice them without judgment, and eventually to return to the LKM phrases and the breath without self-criticism. It is worth emphasizing that not only is it not a problem that difficult thoughts and feelings often arise during Loving-Kindness Meditation practice – it can be considered an expected/desired part of the process. From a therapeutic perspective, an enhanced ability to notice difficult thoughts and emotions, and to regard them with kindness, openness and curiosity, is thought to promote therapeutic change. This can include constructive cognitive and behavioral change, enhanced self-compassion as well as other capacities; these capacities are theorized to contribute to an enhanced capacity to navigate life’s challenges.⁴⁰⁻⁴²

“For me, it’s basically checking in with myself and saying I’m blessed, I’m beautiful, I’m happy, and today is a great day. Or, you know, I thank the Lord for waking me up and that I have the activities of my limb, and even if I have a pain, I said, I thank you for the pain, because I have one of my senses: I can feel... And then basically checking in with me, and telling me all the nice things I can find to say about myself. You know, you’re beautiful, you’re a queen, and basically, that’s what I go by... Because there are days where it’s really hard living in this body, because of the pain.”

When teaching loving-kindness meditation practice, it may be helpful to encourage Veterans to bring kindness and compassion to their reactions as best they can. Here, one might note that it may be difficult to interrupt old thought patterns in the moment while saying the phrases and that eventually coming to see them as old thought patterns is a

compassionate act in and of itself. Reminding Veterans that they can cultivate kindness and compassion for themselves in the face of self-criticism can be a useful support.

When teaching Loving-Kindness Meditation, some teachers find it helpful to include “all the men and women on active duty” in the LKM practice. For some Veterans, this can provide an accessible category to help them experience goodwill and openheartedness for others. Typically in Loving-Kindness Meditation practice, participants are invited to extend loving-kindness to a benefactor, themselves, a beloved friend, a neutral person, a difficult person, groups (e.g. men and women, Veterans and non-Veterans), and eventually to All Beings. Particularly for participants who have been struggling with the other categories (e.g. a benefactor, neutral person, self), extending loving-kindness toward active duty service members as part of the Groups practice or All Beings practice may facilitate more natural feelings of connection and openheartedness. For example, “Now include all the men and women on active duty for our country, particularly those who serve in foreign lands. May you be safe and protected. May you be physically healthy and strong. May you be truly happy and know peace. And may you come home.”

Suggestions for further reading:

Salzberg, Sharon. (2004). *Loving-Kindness Meditation*. Sounds True, Inc.

Chodron, Pema. (2012). *Awakening Love: Teachings and Practices to Cultivate a Limitless Heart*. [CD].

Kearney, D. J., Malte, C. A., McManus, C., Martinez, M. E., Felleman, B., & Simpson, T. L. (2013). Loving-Kindness Meditation for Posttraumatic Stress Disorder: A Pilot Study. *Journal of traumatic stress, 26*(4), 426-434.

Kearney DJ, McManus C, Malte C, Martinez M, Felleman B, Simpson TL. “Loving-Kindness Meditation and the broaden-and-build theory of positive emotions among veterans with posttraumatic stress disorder.” *Medical Care*; 2014; 51: S32-S38.

Fredrickson BL, Cohn MA, Coffey KA, et al. Open hearts build lives: Positive emotions, induced through loving-kindness meditation, build consequential personal resources. *Journal of Personality and Social Psychology* 2008;95:1045-1062.

‘Healing a Soldier’s Heart’ is a 30-minute documentary film that follows five Veterans with PTSD as they progress through a Loving-Kindness Meditation program.

<http://www.seattlechannel.org/videos/video.asp?ID=3171005>

Part IV: Reflections on Working with Veterans' Challenges

Chapter 14: Reflections on working with Veterans' challenges – Chronic Pain

"Something's broken and we don't have the technology to fix it, so the way to deal with it, is to mentally understand that it's still going to be there but you can focus on something else, and the pain it might be there but you can work with it."

"It's given me a different relationship in terms of pain. I'm able to see it in a different light that pushing through and dragging on is not always the right answer, and you have to spend a little time thinking about your pain to be able to actually

manage it. Which was the opposite of the way my brain was working on it."

"It was kind of hard to sit through an entire class with all the pain I was in, but I was able to put the pain aside and gather something even though I was in a great deal of pain... added to my dilemma in a good way instead of a negative way... the yoga, meditation, breathing, all that helped. It makes me feel a little bit better because it's saying I can do stuff even though I'm still in all this pain."

Reflections and observations:

Many Veterans find MBSR beneficial for their pain and would recommend the program to others for pain management. Veterans with chronic pain report that most of the practices are useful for pain, including the body scan, yoga, Qi Gong, and breathing. For many Veterans, MBSR was beneficial for pain because it helped them relate to pain differently and work with the presence of pain. MBSR does not appear to be too difficult for Veterans in chronic pain. While it can be very challenging for Veterans with chronic pain to sit through the class, pain does not appear to be a barrier to completion of MBSR.

"A Veteran seeking help managing pain who's thinking about that program, I would definitely recommend it to them."



Recommendations:

Include instructions for working with physical pain in each of the meditation practices. In MBSR, each meditation practice (i.e., body scan meditation, sitting meditation, mindful movement, loving-kindness meditation) is led on multiple occasions over the course of the program. We suggest that on at least one occasion for each of the meditation practices taught, that instructors include specific instructions for working with chronic physical pain.

Adjust the mindful movement practices to accommodate pain. Anticipate that pain could be a barrier for the movement practices and prepare ways to assist Veterans who are having difficulty. Helping them modify exercises makes them more accessible and fosters continued practice.

Manage expectations about “getting rid of the pain.” In working with chronic pain and mindfulness, it is important to talk about the realities of pain reduction and to manage expectations. Sometimes people will come to MBSR because they heard it could “get rid of their pain.” These are often the people who are most disappointed. Emphasize that it’s not about the pain per se, but our relationship to it.

Encourage Veterans to notice pain as a ‘sensation’ during mindfulness practice. The word "pain" often has alarming connotations whereas the word "sensation" tends to be benign. This small shift can help Veterans reappraise pain as less threatening, which can be a useful initial step.

Introduce the equation: Pain = Sensation + Your Reaction to the Sensation. Veterans can observe the sensation of pain and their physical, cognitive, and emotional reactions to pain. What is happening to their breathing? Are their muscles tense or relaxed? What story do they tell themselves about the sensation? Encourage them to observe the story without identifying with the story. Emotions can be observed without being swept away by the emotion. Veterans discover for themselves how some cognitions and emotions escalate pain while others de-escalate pain.

Some experienced mindfulness teachers take a systematic approach to working with pain in meditation practice. Initially, a person is asked to notice the tendency to want to move or shift in an attempt to minimize pain in meditation practice. And if participants move or shift during practice in response to pain, they are asked to move or shift with full awareness. A person is then asked to turn towards the pain, to investigate with openness and curiosity the actual sensations, to stay with the sensation “as best we can in that moment.” In this way they are asked to be open to the moment-to-moment sensations of pain. This requires kindness and self-compassion. An emphasis in the instructions on kindness, as well as permission to “just do your best” can be a helpful way of conveying the need for kindheartedness when approaching pain. It is often helpful to ask participants to breathe into the area of pain or to ‘aerate’ the pain – which helps them to stay with and investigate the moment-to-moment experience of the body. One other beneficial aide can be to ask participants if they see the pain as solid and fixed and therefore stuck and firm, like a board. If they experience pain in this way, they can be asked to breathe into and through the area of painful sensations. It can be helpful in this process

“This meditation brings it specifically for pain management, but unfortunately you focus on your pain; but the awareness of your pain will help you focus on how to heal it, how to make your body work with it.”

to imagine it as more porous - more like a sponge than a rock. This slight shift in perception can be very helpful to some people.

When providing education about the neuroscience of chronic pain in group discussions, consider using the analogy that chronic pain is like a faulty fire alarm system.

When explaining pain sensitization, some mindfulness teachers find it useful to ask participants to use the analogy that the neural pathways involved in pain perception are similar to the fire alarm system in the building. “Usually it would take a hot fire to trigger the alarm, however if the wiring were faulty, the alarm could be triggered by normal temperatures. Sometimes it can be helpful to look at pain this way. In chronic pain, nerves are sensitive and can be activated with normal movement. When this occurs, pain can result not from tissue damage but from abnormal activity of central nervous system neurons.” It can also be helpful to emphasize that the nervous system is always in a state of change, i.e. that nerve sensitivity is reversible through practices that calm the nervous system.

Suggest that Veterans with chronic pain read the chapters on working with pain in Full Catastrophe Living. In general, throughout the MBSR course, we frame reading sections of *Full Catastrophe Living* as *suggested supplemental reading*, rather than required homework. Veterans are encouraged to read if they are interested and have time after doing their daily mindfulness practice. For Veterans with chronic pain, we have found that reading the relevant sections in *Full Catastrophe Living* helps them to better understand the rationale for and application of the practices.

Include supplemental materials in class materials (e.g., in the participant workbook) related to chronic pain. An example of a patient handout on working with chronic pain through mindfulness practice is provided in the appendix.

Context:

Chronic pain among Veterans.

Among Veterans, pain is one of the most common reasons for seeking care. More than 50% of male VA patients in primary care report chronic pain, and rates may be even higher among female Veterans.⁴³ Chronic pain may also be compounded with other life problems, including comorbid medical, psychological, and social difficulties (such as disability, mental health problems, substance use, and poverty).⁴³ In our experience, many Veterans enter MBSR with the goal of reducing use of pain medications or learning strategies to enhance their quality of life despite ongoing pain.

The evidence indicates that participation in a mindfulness program is associated with improved pain perception,⁴⁴ reduced pain intensity,⁴⁴⁻⁴⁶ better coping with pain,⁴⁴ reduced symptom severity,⁴⁷ and reduced depressive and anxiety symptoms.⁴⁴⁻⁴⁶ In addition, mindfulness was associated with greater pain tolerance and acceptance, as well as greater physical well-being, reduced stress and improved quality of life.⁴⁴⁻⁴⁶ Mindfulness-

based interventions appear to be acceptable for chronic pain patients,⁴⁴⁻⁴⁶ and may be a comparable alternative to other treatments.⁴⁶

A BRIEF PRIMER ON CHRONIC PAIN AND THE ROLE OF MINDFULNESS

Chronic pain: Definition and mechanisms

The International Association for the Study of Pain defines pain as an unpleasant sensory and emotional experience associated with actual or potential tissue damage.⁴⁸ Acute pain is a warning signal of injury, disease or threat to the body and this usually resolves as the underlying cause is addressed or the tissue heals.

Pain is defined as chronic when it persists longer than three months. In the case of chronic pain, the expected time required for tissue healing has passed, yet the experience of pain persists. A key concept is that in chronic pain conditions, central nervous system changes occur that can contribute to ongoing pain generation. Central nervous system changes include a prolonged hypersensitivity of neurons in the spinal cord dorsal horn, as well as select brainstem and brain areas; these changes can result in increased neuronal responsiveness to previously innocuous stimuli.^{49, 50} Under these conditions, pain is no longer coupled to the presence, intensity, or duration of peripheral stimuli. Normal movement can result in the experience of pain, not because of tissue damage, but because of easily activated neurons in central nervous system pain pathways. In addition, a contributing factor to sensitization of nociceptive spinal neurons is prolonged use of opioid medications.⁵¹ Another contributing factor is that in chronic pain there is greater activation of brain areas involved in arousal, emotions and memory occurs,⁵²⁻⁵⁴ which can further contribute to the level of distress experienced.

The central nervous system is neuroplastic – i.e., it is in a constant state of change. These maladaptive changes observed in chronic pain conditions are reversible with successful treatment.^{55, 56}

Stress and chronic pain

The intensity or aversive quality of a stressor can either inhibit or amplify pain. In some situations, an acute, highly intense stressor can result in reduced pain intensity. Termed “stress-induced analgesia,” this experience was first described by Henry Beecher, M.D., a military anesthesiologist, who collected data on pain complaints of severely wounded soldiers during World War II.⁵⁷ Two thirds of the men with extensive injuries complained of little or no pain.

More commonly, when dealing with chronic pain in the clinical setting, stress tends to worsen clinical pain conditions.⁵⁸⁻⁶⁰ Evidence from laboratory research with rodents suggests that exposure to repeated stress produces heightened pain sensitivity, termed “stress-induced hyperalgesia.”⁶¹⁻⁶³ Neurobiological changes in both peripheral and central nervous system contribute to this increased pain sensitivity.⁶¹⁻⁶³

Trauma and chronic pain

Traumatic experiences can include physical injuries that result in chronic pain. In addition, the experience of trauma can contribute to sustaining chronic pain. Factors that contribute to trauma and chronic pain co-morbidity include attention and reasoning biases, anxiety sensitivity, reminders of the trauma, avoidant coping, depression and reduced activity levels.⁶⁴

Individuals with a history of abusive childhoods are at an increased risk of chronic pain in adulthood relative to individuals not reporting childhood abuse.⁶⁵ Childhood stress gives rise to excessive threat vigilance, a mistrust of others, poor social relationship and unhealthy life choices.⁶⁶ This combination is theorized to foster stress-related nervous system changes, which confer an increased vulnerability to developing a chronic pain condition.

The biopsychosocial model of illness and chronic pain.

When working with patients with chronic pain, it is helpful to have an understanding of the biopsychosocial model of illness. The biopsychosocial model suggests that biological, psychological (including thoughts, emotions and behaviors), and social factors each exert an influence on the disease process, and each must be addressed for optimal disease management. Mindfulness has been studied due to its potential to result in constructive changes in thoughts, emotions and behaviors,⁶⁷ which may in turn positively influence the chronic pain experience.

How does mindfulness influence the experience of chronic pain?

Mindful awareness, with its emphasis on non-judgmental awareness of sensations, thoughts and emotions, offers a unique approach to modulation of nociceptive processing. This awareness provides a first step in the self-regulation of automatic, unconscious habit patterns that can escalate pain, suffering, and disability.

Uncoupling of the sensory and affective components of pain. Jon Kabat-Zinn theorized that mindfulness might influence chronic pain by teaching individuals to differentiate between the emotional and physical components of pain.⁶⁸ In turn, this would facilitate greater understanding of the emotional component, making them more skillful in responding to their pain. In mindfulness training individuals are taught to distinguish emotions from the painful sensation itself, which is postulated to lead to 'uncoupling' of the sensory and affective components of pain.⁶⁸

Cognitive and emotional change can influence the experience of chronic pain. Pain can negatively impact emotions and cognitive function.⁶⁹ Conversely, negative emotional state can lead to increased pain, while positive emotional state can reduce pain. Also, cognitive states such as memory and attention (for instance, whether pain is being

remembered or focused on) can either increase or decrease pain. Because mindfulness favorably influences emotions and cognitions, it may favorably impact chronic pain.⁶⁹

Changes in pain appraisal. Meditation affects how pain is evaluated and anticipated. Research has found that meditation is associated with reduced anticipation and negative evaluation of pain, both of which are implicated in chronic pain. Also, meditation experience has been found to be correlated with pain unpleasantness, in that more experienced meditators rate painful stimulation as less unpleasant.

Reductions in catastrophizing. Pain may be chronically maintained when it is interpreted as threatening (also known as pain catastrophizing), leading to fear of future pain.⁷⁰ This fear prompts hypersensitivity to and avoidance of pain sensations, which encourages further disuse of the painful area, depression, and disability. Paradoxically in this context pain can increase, and a vicious cycle may be established.⁷⁰ The role of mindfulness in this process was shown in a study that found that mindfulness moderated the relationship between pain intensity and pain catastrophizing in chronic pain patients.⁷¹ That is, whether pain intensity was high or low, the level of mindfulness determined the degree to which pain was catastrophized. This finding suggests that mindfulness, which fosters an open, curious, and nonjudgmental attitude toward experience, may reduce the likelihood of interpreting pain fearfully. Less fear and avoidance, in turn, will encourage greater use and recovery.

Enhanced Body Awareness. Body awareness is the outcome a dynamic process that includes somatosensory neural activity, cognitive appraisal and a person's attitudes and beliefs.⁷² The close observation of internal stimuli in mindfulness practice, involving observing, sustained attention and non-judging of experience, is thought to enhance body awareness.^{72, 73} For individuals with chronic pain, enhanced body awareness is a necessary step in controlling muscle tension, which can escalate in reaction to pain. In addition, improved body awareness may lead to enhanced self-care such as more appropriate pacing of activities and adjustments in posture and body position, which can prevent additional pain and tension.⁷⁴

Suggestions for further reading:

Woolf CJ. Central sensitization: implications for the diagnosis and treatment of pain. *Pain*. 2011;152(3 Suppl):S2-15.

Apkarian AV, Hashmi JA, Balili MN. Pain and the brain: Specificity and plasticity of the brain in clinical chronic pain. *Pain* 2011;11:S49-S64.

Veehof MM, Oskam MJ, Schreurs KMG, et al. Acceptance-based interventions for the treatment of chronic pain: A systematic review and meta-analysis. *Pain* 2011;152:533-542.

Reiner K, Tibi L, Lipsitz JD. Do Mindfulness-Based Interventions Reduce Pain Intensity? A Critical Review of the Literature. *Pain Medicine* 2013;14:230-242.

Kabat-Zinn J. An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: theoretical considerations and preliminary results. *General Hospital Psychiatry* 1982;4:33-47.

Lakhan SE, Schofield KL. Mindfulness-based therapies in the treatment of somatization disorders: a systematic review and meta-analysis. *PLoS One* 2013;8:e71834.

Chapter 15: Reflections on working with Veterans' challenges – Posttraumatic Stress Disorder (PTSD)

"It's really good for PTSD and calming me down, keeping my stress levels down, helping me isolate my stressors... and just overall it's really good for my PTSD. Working with it, I seem to be able to work with my stressors, identify and alleviate the stress."

"A key to helping me come to grips with PTSD is being able to forgive myself, have compassion for myself and then for others that I was active with, signed the orders, putting me where I was when I was doing – and a nation at large, you know. I'm bitter about a country that can celebrate what I did, I'm not proud of it. So I want to be able to feel that compassion, because I can intellectualize it, I can rationalize it, I've got a good grasp on that in theory. But to be able to experience that is where I'm lacking."

"I just was tired of worrying, you worry so much about so many things, and you're powerless. And all people tell you is just don't worry, but they don't tell you how not to worry, you know? And I wanted to know how not to worry. How do you do it? What do you do instead? And the class taught me some things to do instead. And that was it."

"I can't believe how MBSR turned me into this person I was before my PTSD just went through the roof from my military sexual trauma accounts. It turned me around into this person I never thought I could be... I'm slowly becoming this happy-go-lucky, calm person that I used to be before my rapes happened. I can actually talk about some of my rape accounts now."

Reflections and observations:

Some Veterans come to a mindfulness group seeking an additional option for managing their PTSD. In addition to PTSD symptom reduction, they may be seeking an approach that will lead to greater inner peace, self-acceptance, self-awareness, and forgiveness. For other Veterans, PTSD can be a barrier to enrollment; for instance, hyperarousal and avoidance, which are cardinal manifestations of PTSD, may lead them to decline participation in a group. However, PTSD does not appear to be a barrier to participation in a mindfulness group for many Veterans with PTSD.

Of note, the MBSR curriculum does not explicitly address PTSD, and some Veterans have requested that the teachers more directly relate the material taught to clinical manifestations of PTSD. Other Veterans have reported that participation in MBSR (without specific teaching about PTSD) does help their PTSD by offering tools to cope with stress and anxiety.

"It's just sort of, it's made me more open to people, I think, you know. 'Cause I have PTSD, and my relationships have been kind of scattered and not the healthiest."

Some Veterans also find that participation in a mindfulness group has helped improve their relationships, which can be severely strained in PTSD. Notably, we have not found that Veterans with PTSD report that the





practices taught in MBSR are too difficult for a person with PTSD. Given the high prevalence of PTSD among Veterans, we think that some familiarity with how mindfulness practices relate to manifestations of PTSD would be helpful to mindfulness teachers who work with Veterans.

Recommendations:

We suggest that mindfulness teachers have a basic familiarity with the clinical manifestations of PTSD. Some knowledge of PTSD may help mindfulness teachers to better understand the experiences of Veterans in the room. Of note, we do not suggest that mindfulness teachers attempt to frame class discussions around PTSD or to use the clinical language of PTSD symptomatology. Rather, we suggest keeping the focus on learning mindfulness. When experiences are shared that may be related to PTSD, such as hypervigilance or feelings of avoidance, we suggest using everyday language work with these experiences – for example, by noticing thoughts, feelings and bodily sensations. In fact, in our experience working with Veterans with PTSD, the term “PTSD” is very rarely mentioned by instructors. However, having some background knowledge of manifestations of PTSD by the instructor is likely to be helpful.

“The focus of the group is not PTSD as a clearly defined focus, and I get it. ...it was primarily focused on chronic injuries... I wouldn't say that the group leader was really versed in being able to address PTSD issues”

For example, simply understanding that for Veterans with PTSD, there may be avoidance tendencies - which can make participation (or sharing) in a group challenging, can help the instructor to better facilitate group discussions. Awareness that there may be different issues behind such reluctance can also be helpful, including anxiety about being judged by others, concern about not being able to control one's anger responses, and feeling that one's experiences or perspectives are so extreme as to not be understandable by others. Encouragement to share, while acknowledging that being open in this way may go against deeply ingrained tendencies, can sometimes help people to engage. An invitation to share can be made while still offering the option to 'opt out' if needed (along with encouragement to practice opting out without judgment). Framing participation (or just showing up to class) as an act of courageousness can also be helpful.

For other Veterans with PTSD, emotional numbing may occur as a consequence of longstanding PTSD; an appreciation of this tendency may lead instructors to give clear instructions about sensing feelings in mindfulness practice. For some Veterans, describing the fact that emotional numbing can occur following trauma - then discussing how mindfulness leads to an enhanced ability to experience emotion - can help them to understand the rationale for the practice, which can in turn serve as a motivating factor for continued practice. Encouraging Veterans to experiment with the naming and noting practice (of feelings) can be a useful tool. Instructors should recognize that prevalent

emotions among individuals with PTSD can include pervasive feelings of shame and guilt. When these emotions are experienced, Veterans are encouraged to hold these feelings with kindness and self-compassion, which in turn is reflected by the instructor.

Hypervigilance and exaggerated reactivity may also be evident in certain situations. For example, as related by one instructor, when a behavioral emergency was called out over the VA public address system, many Veterans were triggered. During class, the instructor guided the participants to notice the experience in their minds and bodies with mindful awareness. In this way it was used as a learning experience. We have also found that some Veterans experience discomfort when sitting with their back toward the door, or when others walk behind them. Some report keeping their guard up and feeling uncomfortable opening up to strangers. Instructors may give suggestions on how to work with these feelings: for instance, by noticing them come and go, along with urges to react to them (e.g., the urge to leave the class).

Of note, we have not shortened or modified the MBSR meditation practices due to the high prevalence of PTSD among Veterans in our mindfulness courses. However, we do provide instructions in MBSR classes at our site that include wording to suggest a balance between wise effort and safety; participants are encouraged to trust their intrinsic wisdom and sometimes pause, stop meditation practice, or pull back in their effort if it feels wise, and to do so without judgment.

"It's a good meditation technique for centering myself...it's really good for PTSD and calming me down, keeping my stress levels down, helping me isolate my stressors."

We routinely ask Veterans with PTSD to meditate with their eyes closed; this does not appear to be a problem. Early in the class series many instructors will mention that if Veterans prefer to meditate with eyes open, it is perfectly acceptable, and that in fact, some meditation traditions teach this form of practice. However, despite this invitation to practice with eyes open if needed, we find that nearly all Veterans, including those with PTSD, choose to practice meditation with eyes closed.

What follows is a brief introduction to PTSD and how mindfulness might play a role in supporting mitigation of some of the symptoms that most profoundly affect Veterans' quality of life. Of note, although there are plausible psychological processes through which mindfulness practice might influence PTSD symptomatology, scientific research in this area

"Speaking of PTSD, most of the guys wind up being reclusive. So that comes with the territory, being reclusive, and it has to do with having a lot of feeling inside that feels kind of scary, because if you let yourself into that feeling you're not sure what you would do..."

...[since taking the class] I take more risks. I inserted myself in two back to back concerts of about 2500 people, which normally I wouldn't do, I don't put myself in crowds. So I did that, and I stayed for the whole thing."

is limited. These comments, which are derived from the clinical approach taken in MBSR classes, remain speculative.

Context:

PTSD among Veterans.

Posttraumatic stress disorder (PTSD) is one of the most common mental health conditions diagnosed among military Veterans.^{75, 76} Prior research indicates that 10-15% of Vietnam veterans meet criteria for PTSD at some point in their lives,⁷⁷ and that a similar percentage of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) Veterans¹² and Gulf War I Veterans¹³ are affected. PTSD often results in severe reductions in quality of life,⁷⁸ with the largest effects seen in the domains of mental health and social functioning.⁷⁹ In addition to the hallmark clinical symptoms, PTSD often disrupts interpersonal relationships, reduces the ability to work, and increases the risk of mood disorders,^{80, 81} alcohol/substance abuse disorders⁸⁰ and suicidality.⁸² Importantly, a significant proportion of PTSD among Veterans is not combat-related; many who serve in the military have experienced other forms of trauma, including sexual trauma, which occurs at worrisome rates.^{83, 84} Without effective treatment, many people with PTSD will experience distressing symptoms for many years across the lifespan.⁸⁵

"I would suggest any veteran to take the class, especially the ones suffering from PTSD because it's just another tool to help fight PTSD."

At this time we do not consider participation in MBSR to be a primary treatment package for PTSD. In our setting, some Veterans who have already participated in empirically supported PTSD treatments choose to participate in MBSR as way of working with persistent difficulties, such as a loss of meaning, feelings of disconnection and alienation, or disrupted interpersonal relationships. Other Veterans may not feel ready to participate in an empirically supported PTSD treatment and may choose MBSR as an initial step toward working with the consequences of trauma. Of note, we have found that MBSR appears safe and generally acceptable to Veterans with PTSD.

Recently, mindfulness interventions have received preliminary study for PTSD, with some suggestion of benefit.^{3, 86-88} A before-and-after trial of 92 Veterans who participated in MBSR as an adjunct to other ongoing treatment found significant improvements in PTSD, depression, and quality of life over time.³ However, in a small randomized pilot study (N=47) of Veterans with PTSD, which compared MBSR to usual care, PTSD symptoms were not significantly reduced, although there was evidence of improved functionality and reduced depressive symptoms among completers.⁸⁹ In addition, a greater proportion of participants assigned to MBSR had reliable change in both PTSD symptoms and quality of life, suggesting that a subset derive clinical benefit for PTSD symptoms.⁸⁹ Another trial compared an eight-week mindfulness telehealth intervention to psychoeducation for PTSD among combat Veterans, and showed reductions in PTSD symptoms compared to psychoeducation, but the improvement in PTSD symptoms waned at follow-up.⁸⁶ In addition, a non-randomized trial compared mindfulness based-cognitive therapy (MBCT) to

treatment-as-usual among combat Veterans and found that MBCT participants had greater reductions in PTSD symptom scores.⁸⁷ Additional trials are needed, and are ongoing.

A BRIEF PRIMER ON PTSD AND THE POTENTIAL ROLE OF MINDFULNESS

What is PTSD?

Briefly, the DSM-V diagnostic criteria for PTSD include the following:⁹⁰

- History of exposure to a traumatic event
- Intrusive, re-experiencing symptoms
- Avoidance of trauma reminders
- Negative changes in cognitions and mood
- Changes in arousal and reactivity

The symptoms must have lasted longer than one month, cause significant functional impairment or distress, and not be due to substance use or a co-occurring medical condition.⁹⁰

How might mindfulness influence the experience of PTSD?

Potential for reductions in avoidance. Avoidance of trauma-related reminders is a major symptom and cause of PTSD.⁹⁰

Individuals with PTSD avoid external cues (places, people, situations) as well as internal cues (thoughts, emotions, sensations, memories) associated with the trauma. Avoidance of emotions is termed emotional numbing. While avoidance is meant to reduce short-term anxiety, it paradoxically maintains the disorder in the long run by preventing emotional processing.

Mindfulness interventions foster acceptance rather than suppression or avoidance of one's experiences, including difficult experiences,⁹¹ and there is some evidence that mindfulness interventions reduce avoidance symptoms of PTSD.^{92 87} Specifically, King and colleagues reported that change in PTSD symptomatology over the course of mindfulness-based cognitive therapy was driven by a reduction in emotional numbing.⁸⁷

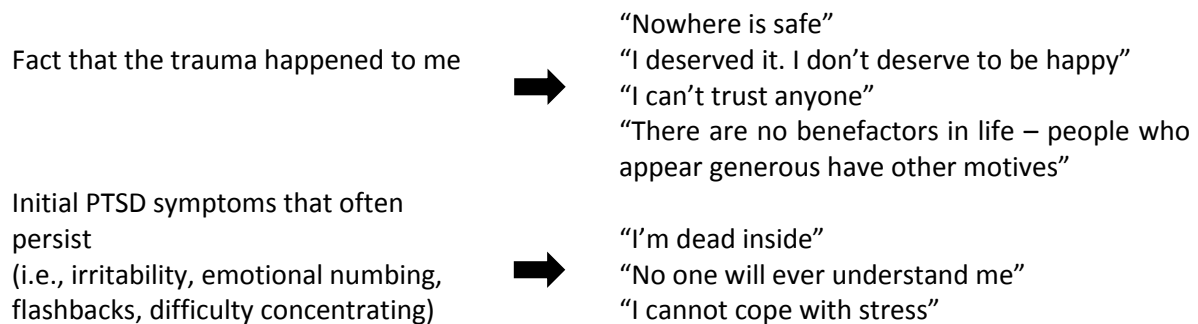
The following are some examples of avoidant behaviors seen in PTSD:

<i>Cognitive avoidance</i>	
	<ul style="list-style-type: none"> • Try not to think about the trauma • Occupy mind at all times
<i>Emotional avoidance</i>	
	<ul style="list-style-type: none"> • Control feelings, numb emotions • Avoid anything that could cause feelings (positive or negative)
<i>Behavioral avoidance</i>	
	<ul style="list-style-type: none"> • Drink alcohol, take drugs • Avoid place where event occurred • Avoid wearing similar clothes • Avoid crowded places • Avoid other people, looking at others • Avoid anything that could be potentially stressful

Adapted from Ehlers, A. & Clark, D.M.. A cognitive model of posttraumatic stress disorder. Behaviour Research and Therapy 38 (2000) 319-345.

Potential for changes in the relationship to post-traumatic cognitions and beliefs. A fundamental capacity developed by mindfulness practice is the ability to step back from one’s thoughts, emotions, and sensations, and view them from a distance.⁹³ One of the core features of PTSD involves negative changes in thoughts and mood. Following trauma, many people develop beliefs about self, others and the world in general that can lead to added suffering. Mindfulness may help individuals step back from thoughts, seeing them as temporary events in their mind and not as reflections of themselves.⁹⁴ Theoretically, this may result in reduced distress from and reactivity to thoughts and beliefs that develop after trauma.

Common beliefs and attitudes following a traumatic event can include:



Other people's reactions after trauma



"They think I am too weak to cope"
"I need to appear strong"
"They think what happened was my fault"
"They just want me to get over it"

Other consequences of trauma
(physical, social)



"My body is ruined"
"I will never be able to lead a normal life again"
"I am unable to feel close to anyone"
"I cannot love others again"
"I'm unlovable"
"I'm damaged, broken"

Adapted from Ehlers, A. & Clark, D.M.. A cognitive model of posttraumatic stress disorder. Behaviour Research and Therapy 38 (2000) 319-345.

Potential for reductions in hyperarousal / hypervigilance.

Hypervigilance is a core symptom of PTSD.⁵ Hypervigilance is defined as excessive processing of threat-related information in the environment.⁹⁵ Individuals with PTSD tend to be hyperaware of and sensitive to threatening cues, with a threshold for threat is much lower, such that cues that are non-threatening are perceived as dangerous.⁹⁵ Threat-related information is more likely to be processed, maintaining the disorder in a feedback loop, while non-threatening information is less likely to be processed. Mindfulness may teach individuals to broaden their attention to diverse aspects of their experience, and to bring non-reactive stance to distressing aspects of experience. Because mindfulness fosters the ability to sustain attention to distressing thoughts and emotions, mindfulness has been theorized to represent a form of exposure therapy.⁹³ Interventional studies demonstrate that mindfulness interventions reduce physiological arousal and reactivity to stress,⁹⁶ and in a study of childhood sexual abuse survivors hyper-arousal significantly decreased following participation in MBSR.⁹² In a before-and-after study of MBSR for Veterans, all PTSD symptom clusters decreased significantly over time, but hyperarousal exhibited the largest change.³ Correlational studies also suggest a relationship between mindfulness and hypervigilance (or hyperarousal).^{97, 98}

"MBSR helps the brain kind of slow down, like when a PTSD or anxiety attack, or civilians call it an anxiety attack, us veterans call it PTSD, when they arise it actually slowed my brain down to where I'm just like, "Okay, this is the here and now, let's get through the situation," breathing techniques in and out,...."

Suggestions for further reading:

Kearney DJ, McDermott K, Malte CA, et al. Association of Participation in a Mindfulness Program with Measures of PTSD, Depression and Quality of Life in a Veteran Sample. *Journal of Clinical Psychology* 2012;68:101-116.

King AP, Erickson TM, Giardino ND, et al. A pilot study of group mindfulness-based cognitive therapy (MBCT) for combat veterans with posttraumatic stress disorder (PTSD). *Depress Anxiety* 2013;30:638-45.

Kearney DJ, McDermott K, Malte C, et al. Effects of Participation in a Mindfulness Program for Veterans with Posttraumatic Stress Disorder (PTSD): A Randomized Controlled Pilot Study. *Journal of Clinical Psychology* 2012;69:14-27.

Niles BL, Klunk-Gillis J, Rynkala DJ, et al. Comparing mindfulness and psychoeducation treatments for combat-related PTSD using a telehealth approach. *Psychological Trauma: Theory, Research, Practice, and Policy* 2012;4:538-547.

Chapter 16: Reflections on working with Veterans' challenges – Depression

"I wanted to learn more about meditation, exercising or trying get some more tools that I can relate to so it would help me out. I'm trying to meditate, do yoga, anything to relax or help the depression out, so that's what I really want to do."

"Well we had talked about my depression for some time and we had tried different things. I was not happy with side effects...she suggested I had a suitable personality to be in a class like this that

would help me, and I had to trust somebody so I trusted her."

"Something to help me make proper decisions when I'm dealing with a stressful situation, and when the depression kicks in to make just smarter choices rather than picking up the bottle again, because that's been my escape in the past and obviously it doesn't work."

Reflections and observations:

Some Veterans come to MBSR seeking help with their depression; our research indicates that Veterans have significant levels of depressive symptoms when entering MBSR, which improves significantly over time.^{3, 89, 99} The finding of improvements in depression is consistent with multiple prior studies of mindfulness-based interventions in a variety of settings. However, in our qualitative work, however, few have commented on the impact of MBSR on depression in particular. Also, individuals with depression may tend to be withdrawn during class discussions, so it is easy to miss chances to help them apply mindfulness to the challenges associated with depression. Given the high prevalence of depression among Veterans, we feel that a working knowledge of how mindfulness skills relate to depression would be helpful for mindfulness teachers.



Recommendations:

Acknowledge that Veterans may be experiencing very difficult emotional states. When discussing awareness of emotions, it can be helpful for the instructor to name and give examples of emotional experiences, including sadness and depression.

Instructors should at some point in the class series explain the relationship between mindfulness, rumination, self-compassion and depressive moods. Many Veterans seem to appreciate assistance by the instructor in making the link between rumination, depression, and mindfulness. It may be most helpful to introduce the concept of rumination early in the class series, to notice the problem-solving tendency inherent in rumination, and contrast this 'doing mode' to the 'being mode' fostered by mindfulness practice.

We suggest that mindfulness teachers read the professional manual ‘Mindfulness-Based Cognitive Therapy for Depression,’ by Segal, Williams and Teasdale (MBCT), which skillfully elucidates these concepts. We have found that MBSR teachers can readily insert education about depressive mechanisms into their classes, and that many Veterans express understanding and appreciation of this material. Of course, undergoing facilitator training in MBCT would be an additional, valuable option.

We recommend excluding Veterans with suicidal ideation with intent, unless there is the ability to closely monitor these Veterans. For Veterans who do not pose a safety concern, we recommend including them in a general mindfulness group. There is accumulating evidence that mindfulness-based interventions are helpful for individuals with significant depressive symptoms.¹⁰⁰ At our site, in one study the mean PHQ-9 depression score of Veterans entering MBSR was 14.7, indicating moderate to moderately severe depression; these depressive symptoms decreased over the course of participation in a mindfulness group.³

Inclusion of patients with active suicidal ideation may be more appropriate when the groups are led by mental health clinicians, and when each patient is engaged in another form of mental health care; there is evidence that this approach is safe and beneficial to Veterans with suicidal ideations.⁹⁹

Follow up with students who appear to be in acute suffering. If an instructor recognizes that a participant appears depressed, the instructor may check-in with the Veteran after class. The instructor may urge them to have contact with their providers for additional support. Early on in the class series (as well as in the orientation session) it is helpful to encourage Veterans to utilize their existing resources (e.g. therapists, other groups) for support in processing issues that may arise.

Context:

Depression among Veterans.

A survey of Veterans using VHA services showed a prevalence of significant depressive symptoms of 31%.¹⁰¹ There is good evidence that mindfulness-based interventions result in improvement in depressive symptoms.^{94, 100, 102} A summary of multiple trials, most with pre-post designs, showed significant reductions in depressive symptoms for people with chronic medical conditions who participate in MBSR or Mindfulness-Based Cognitive Therapy (MBCT), with large effect sizes.¹⁰⁰

There is strong evidence to support the effect of MBCT on preventing relapse of major depression, as described below.^{23, 94, 103, 104} There is also growing evidence to support effectiveness of mindfulness-based interventions for treatment of active depression.^{94, 100, 102}

A BRIEF PRIMER ON DEPRESSION AND THE ROLE OF MINDFULNESS

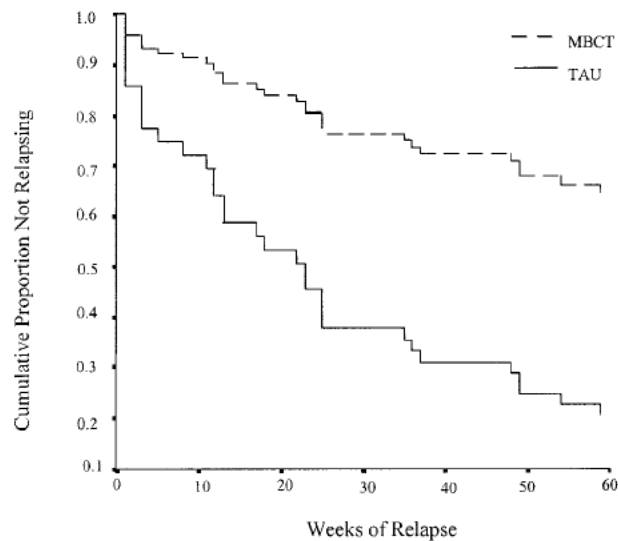
What is depression?

In brief, major depression is characterized by depressed mood and/or reduced interest and enjoyment in activities, and may also include changes in weight, sleep, and psychomotor function; fatigue; reduced concentration; and suicidal ideation.¹⁰⁵ These symptoms must be significantly distressing or impairing, and be present nearly every day in the past two weeks. They cannot be not due to substance use or a medical condition, and are distinct from grief following a loss.

How does mindfulness influence depression?

Participation in Mindfulness-Based Cognitive Therapy (MBCT) reduces by half the rate of major depressive relapse,^{23, 103, 104, 106} and is as effective as maintenance antidepressants in preventing relapse.¹⁰⁷ Mindfulness-Based Cognitive Therapy (MBCT) was adapted from MBSR for the purpose of preventing relapse of depression for individuals with three or more prior episodes of major depression. MBCT includes elements of cognitive behavioral therapy and includes teaching about key factors involved in relapse of major depression. MBCT and MBSR are very similar, and although prevention of depressive relapse has been most clearly demonstrated for Mindfulness-Based Cognitive Therapy (MBCT), it seems likely that MBSR too can influence depressive relapse, although this remains unstudied. The comments below are intended to provide a brief overview of some of the concepts involved in prevention of relapse of major depression by mindfulness-based interventions. Those interested in learning more are encouraged to read the MBCT professional manual and possibly participate in MBCT professional training.

Teasdale et al. randomized recovered recurrently depressed patients to MBCT or treatment-as-usual (TAU).²³ Over a year of follow-up, MBCT almost halved the risk of depressive relapse or recurrence among patients with 3 or more previous depressive episodes (77% of the sample) compared with treatment-as-usual. These findings were replicated in a study by Ma and Teasdale, who randomized recurrently depressed patients to TAU or TAU plus MBCT.¹⁰⁴ Among patients with at least three previous depression episodes, MBCT reduced the rate of relapse from 78% of the TAU participants to 36% of the MBCT participants:



The above findings were confirmed by a meta-analysis of six rigorously designed studies involving a total of 593 participants, which showed that MBCT achieved a relative risk reduction of 34% for relapse of depression as compared to treatment as usual or placebo controls.¹⁰⁶

It has also been shown that participation in MBCT also allows people with a history of major depression to successfully discontinue antidepressants.^{106, 107} In a well-designed trial, MBCT was compared to maintenance antidepressants for individuals with a history of major depression. Over 15 months follow-up, 75% of those randomized to MBCT were able to discontinue antidepressant medications.¹⁰⁷ MBCT also was also more effective than the maintenance antidepressant medication group in reducing depressive symptoms and improving quality of life.

How does mindfulness reduce the rate of depressive relapse?

Reduced rumination. A key factor in relapse of major depression is rumination, defined as passively and repetitively focusing one's attention on negative emotions, with intrusive, distressing thoughts about negative events.¹⁰⁸ Mindfulness interrupts the cycle of rumination by fostering decentering, which can be defined as the ability to observe one's thoughts and feelings as temporary, objective events in the mind, as opposed to reflections of the self that are necessarily true. Mindfulness meditation practice develops the skill of 'letting go' of ruminative cycles of thought, which are regarded from a decentered perspective.

Cultivation of the "being mode" rather than the "doing mode." While in the doing mode, one contrasts what is desired with what is actually present, and tries to resolve the inconsistency through problem-solving.⁹⁴ While this can be helpful when there are clear action steps available, it is more problematic in cases of things that are more difficult to change; for instance, the nature of one's internal experience.⁹⁴ A focus on problem-solving in these situations can increase suffering and perpetuate depression.⁹⁴ In contrast, being

mode allows one to notice and accept the present moment experience without evaluating and judging it against what is desired. Mindfulness practice fosters the ‘being mode.’ It can be helpful for instructors to incorporate language around the ‘being mode’ in meditation instructions or in-class discussions.

Enhanced meta-cognitive awareness. Metacognitive awareness refers to the capacity to recognize depressive thinking in a broader field of awareness, i.e. to recognize thoughts as passing events without becoming attached to or identified with these thoughts, and without pushing them away or suppressing them. In mindfulness practice, participants are encouraged to see ‘thoughts as thoughts’ which come and go. This opens the opportunity for attention to be directed at other aspects of one’s experience – to process positive or neutral stimuli (e.g., the breath) – rather than fixating exclusively on negative aspects of one’s experience.¹⁰⁹ The mere act of sitting in an upright posture and paying attention to the breath can shift one’s focus away from the all-consuming problem and allows for greater perspective to be taken,¹⁰⁹ which makes depressive symptoms less likely.

Enhanced self-compassion: In a study comparing MBCT to maintenance antidepressants, it was shown that individuals who developed greater self-compassion had an ‘uncoupling’ of the relationship between depressive styles of thinking and symptoms of depression.¹¹⁰ In other words, dysfunctional thinking styles weren’t necessarily reduced, but for people who developed self-compassion during MBCT, there was a change in the *relationship* between cognitive reactivity (beliefs, assumptions and rules thought to be dysfunctional that are usually associated with depressive style thinking) and depressive symptoms. These findings suggest that although negative patterns of thinking may reappear after participation in a mindfulness intervention, what matters for depressive outcome is how one responds to these negative thought patterns (i.e., with or without self-compassion).

Suggestions for further reading:

- Hofmann SG, Sawyer AT, Witt AA, Oh D. The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology*. 2010;78(2):169-183 MBCT for Depression professional manual, Segal, Williams, Teasdale
- Segal ZV, Williams JMG, Teasdale JD. Mindfulness-Based Cognitive Therapy for Depression, 2nd Edition. Guilford Press 2013.
- Williams JMG, Teasdale JD, Segal ZV. *The mindful way through depression: Freeing yourself from chronic unhappiness*: The Guilford Press; 2007.

- Teasdale JD, Segal ZV, Williams JM, Ridgeway VA, Soulsby JM, Lau MA. Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting & Clinical Psychology* 2000;68:615-23.
- Piet J, Hougaard E. The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: a systematic review and meta-analysis. *Clin Psychol Rev* 2011;31:1032-40.
- Kuyken W, Byford S, Taylor RS, Watkins E, Holden E, White K, Barrett B, Byng R, Evans A, Mullan E, Teasdale JD. Mindfulness-Based Cognitive Therapy to Prevent Relapse in Recurrent Depression. *Journal of Consulting and Clinical Psychology* 2008;76:966-978.
- Additional information on MBSR and MBCT teacher training: [Mindfulness-based Professional Training Institute \(http://mbpti.org\)](http://mbpti.org)

Part V: Comments on Practical Matters

Chapter 17: Referrals and Orientation Sessions

"She [my primary care provider] actually didn't know much about it, she had heard about it, she knew it was about meditation, which is something I'm very interested in but, basically that was it. She really didn't know much."

In response to: "Was there anything that you think would have been helpful about MBSR when you were referred?: "No, I think I was told everything I needed to know"

"I don't think it was applicable to me, because my condition wasn't in my head, and that's the way my doctor made me feel, that it was more in my head than actual physical pain... definitely the way the program is put out to the patients is a big factor. It could be put out more like this program might benefit for you to relieve some of the pain, not 'cure your pain' or treat it like it's all in your head."

"...the initial screening that I think you guys did, you cleared up any questions I had..."

"I have lung cancer, and I remember the doc saying it would be helpful to sit with a group of cancer patients. Didn't want to spend a lot of time with the other sick people saying, oh woe is me."

"I had heard about it I think on PBS, maybe a year or so ago, so I was familiar with it. ... However I will say that the initial screening that I think you guys did, you would have cleared up any questions I had anyway."

"I went to a group physical therapy at the swimming pool and men actually touching me. I can't do that. I'm not there for people to touch. I'm there to get better. That's the end of all my group classes, I will not take another group class. Sorry, I can't do it." (Female, Decliner)

Reflections and Observations

In our setting, MBSR is offered as a hospital-wide course. The vast majority of referrals come from providers in primary care and mental health, but providers in any service line can refer a Veteran. The information given to patients about the program during the referral process appears to vary significantly, and it can influence whether an individual declines to enroll, drops out, or completes the course. In our interviews with patients referred to MBSR, we discovered that some providers do not have sufficient or accurate information about mindfulness programs, or they may not know what information is most pertinent to help patients decide if they are interested in participation. On the other hand, completers of the program have reported having sufficient information about MBSR at the outset.

We feel it is critical that providers who are making the referrals clearly understand the scope of the class and that orientation sessions clearly outline the class as well, so that Veterans come into the first class with a basic idea of what they are getting into. To help providers better understand the role of a mindfulness program, as well as the information that is important to share with patients, we created and distributed informational booklets for providers and





patients; our impression is that this appears to have helped achieve better education of patients and providers.

For some Veterans, the group format is a barrier. Some people are not ready to pursue personal work in a group setting, or they simply prefer working one-on-one with a therapist. Aversion to groups can also be related to PTSD; although many Veterans with PTSD are interested in participating in a group format, others find the group format to be a deal-breaking barrier.

Spiritual or religious affiliations do not appear to be a barrier to enrollment. By and large, in our experience, Veterans do not feel there is a conflict between their religious beliefs and the Eastern roots of mindfulness meditation.

Recommendations:

We recommend that all Veterans be required to participate in an orientation session before enrolling in MBSR. Misinformation, lack of information, or feelings of ignorance going into the group can lead to dropouts, so all MBSR participants are required to attend an orientation prior to the first session. The purpose of the orientation is to provide a sense of what to expect from the mindfulness group by showing a 45-minute documentary video (see below); this helps to ensure that all participants gain a basic understanding about what participation in the program entails. During this group orientation session, Veterans are given the opportunity to ask questions about the program. Attending the orientation also gives Veterans the opportunity to cancel enrollment if it does not seem like a good fit.

During the orientation session, inform Veterans that they will not be obligated to share during mindfulness class sessions. Some people avoid group programs because they are fearful of sharing in a group setting, and we feel it is helpful to let people know ahead of time that although there is a component of group interaction and discussion, they are welcome to share as much or as little as they would like during the class. The knowledge that they won't be forced to share or divulge helps to develop a feeling of safety and trust.

"Honestly I wasn't too sure of the program and what it does. Knew that it was a mind-body wellness program but didn't know in details what the program was all about"

During the orientation session, set expectations for participation. First, encourage and advise people to attend the first class, which lays the groundwork for the series. Also, advise people who may be unable to attend the first two classes to consider passing on this series and signing up when their schedule is more conducive to participation. When people come and go a lot in the series it is difficult for the group to maintain cohesiveness, which can make it difficult to create and maintain a solid container of trust, safety and flow. The expectation should be to attend as many of the class sessions as one can, with the

understanding that effort is asked of them if they are to learn and grow. Additionally, the importance of being on time to each class must be stressed. Encourage participants ahead of time to plan ways to be on time, to set aside time each day, and set up a schedule to allow for attendance.

"MBSR would probably be a bunch of people going through overwhelming stress... I don't like show and tell, I prefer one-on-one... Maybe cathartic for some, but it's not cathartic for myself"

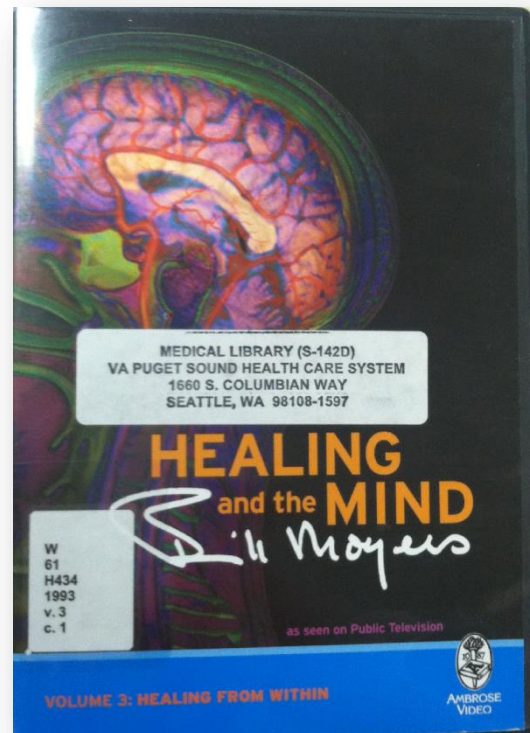
"Being in a group of people is something I don't enjoy... And being in a group of that many people is more than I can basically handle."

During the orientation session, point out that learning mindfulness is not the right fit for everyone. Although in our experience the vast majority of Veterans who are referred to MBSR and attend an orientation choose to enroll in the group, some Veterans decline enrollment. For those who decline enrollment, it is important for the person leading the orientation to acknowledge that this may not be a good fit for everyone, and perhaps even to affirm that there are many different paths that lead to learning and growth. Deferring to the patient's judgment about whether or not to participate in a program like a mindfulness group is a central aspect of patient-centered, patient-driven care.

A brief outline of an orientation session. The orientation session is critical for the success of this program, and we highly recommend it be as thorough as possible.

A sample orientation format, which follows an hour-long format, is as follows:

1. Hand out group schedules & offer informational brochures as attendees arrive.
2. Encourage Veterans to ask questions but also allow Veterans to be anonymous and quiet if they choose. We generally do not ask Veterans to introduce themselves during the orientation session; if they enroll introductions are performed in the first class session.
3. Play the Bill Moyers documentary video, "Healing and the Mind" (45 minutes; see below). We utilize this video in order to provide an accurate picture of what the class series involves.
4. Additional comments by program coordinator, opportunity for Q&A (5-10 minutes).



5. Another option for the orientation session is to deliver a brief presentation that provides an overview of the stress response, reactivity, and the role of mindfulness.

We generally have three orientations prior to the start of each mindfulness group to accommodate everyone who is interested. When possible, it is helpful for the MBSR teacher to lead the orientations, although many of our orientations have been successfully led by the program coordinator, who is familiar with the program and mindfulness practice.

“Healing and the Mind” is the name of a 5-part series, sold in a set of 3 DVDs. The segment used for the MBSR orientations is found in the first 45 minutes of Volume 3: *Healing from Within*, which follows an MBSR cohort at the University of Massachusetts Medical Center, led by Jon Kabat-Zinn. Bill Moyers interviews participants, Jon Kabat-Zinn, and a gastroenterologist, who each provide comments on the role of mindfulness practice for chronic conditions. There are discussions of the challenges and growth experienced by participants during their 8 weeks in MBSR.

How can I get the video?

The video can be purchased as a DVD, and the MBSR segment can also be found on YouTube, which can be offered as an alternative to patients who are unable to attend any of the in-person orientations. To find it, search “Healing and the Mind Bill Moyers” in the YouTube search bar, and select the University of Colorado posting (42:49 in length).

We recommend providing educational brochures about mindfulness to patients and clinicians, with the goal of reducing the likelihood that Veterans will receive inadequate or inaccurate information. Sample brochures are provided in the appendices to this document.

When mindfulness groups for Veterans are offered in VA medical centers, we recommend incorporating the mindfulness group into the consult menu in CPRS in order to provide a convenient referral mechanism for clinicians throughout the hospital. Given that clinicians who are working with patients are very busy and utilize the Computerized Patient Record System (CPRS) for each patient encounter, inclusion of a referral mechanism in the consult menu of CPRS greatly facilitates referrals to the program.

At our site, a program coordinator reviews the consults received each day from CPRS. When the consult is received, the coordinator first reviews CPRS (problem list and recent notes) for any exclusion criteria (see Chapter 1). The CPRS referral menu should also prompt the referring clinician to review the exclusion criteria to minimize the chances that an ineligible patient will be referred to the program. We accept all Veterans who have a desire to participate in MBSR after attending an orientation session, and who do not meet exclusion criteria. Although we recognize that learning mindfulness could potentially benefit Veterans with some of the exclusion criteria, these criteria were adopted because of concerns that some conditions could disrupt the group process, or would require closer safety monitoring than is possible in a large group setting.

Chapter 18: Room and Scheduling Considerations

“The classroom we used had a lot of extra stuff like a white board, additional chairs, podium, so I think if some of the items in the classroom would have been positioned differently or not there would have given us a little bit more room. I mean with the number of participants we had, it would have been easier to maneuver to do some of those, for instance floor exercises. I mean we made it work by shoving as much as we could to the side, but the room was just really crowded with additional extra items.”

“Would have loved to try to take the class if able to provide some help with child care. Distance to Seattle not a problem if I didn’t have to worry about my daughter. Trying to get back before day care closes is the issue.”

“You did hear people in the hallway sometimes running through laughing... he apologized for that it was just the location of the class room. I don’t know if there is another location here in the complex that would have been more suitable with sound proofing.”

“The place that we were doing it, we hadn’t been in the program yet for one day, and they had another program going on next door that was completely disturbing the problem. So it was a bit of a juggling act to find the space to do the thing in. Which makes people that are Veterans feel like beggars, as they already do. So there was a little bit of displacement mentally, not just physically...it may not have been noticed by most, but it was noticed by several.”

Reflections and Observations

Mindfulness groups require more space than other groups due to the moving meditation exercises (walking meditation, yoga, qi-gong, etc.) and the relatively large group size. Participants will need enough open floor space to lie down on their yoga mats with at least a foot or two between them. Classrooms where it is difficult to do the yoga or walking meditation can create barriers for Veterans.



Recommendations:

Offer a variety of times for mindfulness groups throughout the year (morning groups, afternoon groups, evening groups) to accommodate a wide range of patients’ schedules. In our experience, weekday mornings are most often the most convenient option for patients. It is important to be mindful of potential inconveniences regarding the timing. Getting to the hospital is very difficult for many Veterans, especially those who commute long distances. When deciding which 2.5-hour time frame to schedule the groups,

be aware of the bus and shuttle schedules; these may impact patients' willingness or ability to remain in group the full length of the session.

Large conference rooms, group therapy rooms, or the hospital chapel are appropriate locations for mindfulness groups. At our site, mindfulness courses are often taught in the chapel, which provides a quiet, generally interruption-free environment. A large, clearly worded sign placed on the door during class sessions can help prevent interruptions.

Location consistency matters. As much as possible, reserve the same room for every session in a class series. Although space for group events is limited at many VA medical centers, changing locations week to week can, at best, create confusion resulting in late attendance as people try to find unfamiliar rooms, and at worst, it can trigger feelings of unworthiness.

"I had a class a year ago that was in the afternoon from 12:30-3:00. We didn't realize that a number of major buses to the VA departed at 3:00 so a number of people had to leave early consistently, which was very disruptive. So consider traffic and transportation into your schedule planning." (MBSR teacher)

Chapter 19: Course and Session Length

"I really wanted the course length to be longer too, because I felt that we were really just getting to the point where the meditation portion of it was getting to stick, that we could do it per her little bell, she didn't have to coax us into it with her words, where by her bell we could just fall into it"

"At first I thought they were lengthy, but the time went by so fast because most of the time, how can

I say it, you were in a trance of floating, always trying to get in touch with yourself, your inner self, what makes you, you."

"That was a little long for me. I think 90 minutes was probably the optimal amount of time in my case. I think after about an hour and a half you start to, ya know, at least I do, start to look at your watch and it sort of becomes repetitious."

Reflections and observations:

Although MBSR classes are long (2.5 hours per session, plus a 7-hour retreat on a Saturday), in our qualitative research we found that many Veterans actually want longer class sessions and lengthier courses. Also, some Veterans would like the group to meet more frequently than once a week. In MBSR, class sessions are long because at least half of each class session is devoted to practicing meditation, with the remaining time allotted to group discussions. In general, many Veterans feel that the class and course length is sufficient, whereas others feel that 2.5 hours is too long and difficult to fit in with other appointments. Of note, in our qualitative work we found that every Veteran who attended fewer than 4 MBSR sessions said they would recommend MBSR to someone else. Similarly, most patients who declined due to lack of time and scheduling conflicts were still interested in enrolling at some point. This implies that although the time-intensive format of MBSR can present an obstacle for some Veterans, it appears valuable and attractive to most who are referred and attend an orientation session.



Recommendations:

While we recognize that mindfulness can be taught in a variety of formats and session lengths, when offering MBSR to Veterans we recommend adhering to the standard class structure and length. Although there is a trend toward providing briefer interventions in health care, as described above many Veterans appear to prefer the time-intensive structure of MBSR. The acceptability of the MBSR format is supported by evidence of high attendance rates in prior studies of MBSR among Veterans,^{3, 89, 99} as well as our ongoing qualitative research.

Chapter 20: Instructor Characteristics

(Number of instructors, instructor gender, non-Veteran instructors)

"Yeah, I think two teachers would've helped out a lot. There were a lot of people in this class though, at least 20 some people or something, so yeah I mean it's almost like a classroom, you can't help everybody, so if there was an extra individual they might be able to help out a little bit more and I think it's kind of stressful for one person, not really stressful on you, but sometimes I think he would have been better off with another person with him."

"If you have two people talking, you would lose your shift in your attention back and forth. And it's better to have one thing to focus on, one thing on breathing, one voice, one consistent voice. 'Cause then you're going to have two different voices and that sometimes to me would disrupt any type of meditation you tried to achieve."

"As far as needing any assistance or someone else to better explain things or whatever, assist with other people in the room or whatever, I don't think she needed it. I think she, as far as maybe someone else that was less informed may have needed some help, but she herself, she didn't need anyone helping her."

"I didn't really care if it was a man or woman, just as long as I am receiving the same information, so it doesn't bother me whether it is a man or a woman, as long as they help me to achieve what I'm looking for." (Male)

"There is a different way that you have to speak to Veterans. And I understand that it's a civil program they do it outside the Veterans. I think it's different when you're in the VA, you're talking to nothing but Veterans, it is different..."

"What they don't teach you is how to deal specifically with PTSD, even though it's understood that a lot of the people that are in the class are suffering from some acute problem...it seems that a person can only get that from a psychologist or a shrink, but the only kind of psychologist or shrink that you can get that from are people that actually are Veterans that have suffered the same consequences of war. Hence the problem here..."


Reflections and observations:

Number of instructors: We generally have a single instructor for MBSR classes. However, when asked, some Veterans express an interest in working with two instructors. Given the large size of the groups (typically 15-25

Veterans), a second instructor could maintain control and provide added attention to specific individuals during movement practices, in addition to bringing an additional perspective to teaching. For many people, hearing mindfulness instructions from instructors with different personalities and different teaching styles can be very helpful. Also, hearing instructions from

"For this environment, two might've been able to keep the group under control as opposed to one guy sitting up there by himself with 20 faces staring at him."





both a man and a woman can help some individuals to understand and relate to the practice. An added benefit is that a second instructor can effectively teach by modelling mindful listening and attentiveness as the other instructor teaches. However, it is important to point out that when two instructors lead the group, they must work well together as a team. In our experience, instructors are able to gauge whether their teaching style naturally complements the teaching style of another instructor, and when resources permit, we provide MBSR with two instructors. In this case, it can also provide the opportunity to serve more Veterans by offering a larger group (e.g. 20-30 Veterans).

Instructor gender: While some Veterans prefer having a female instructor, many appear to have no preference. Instructors should be aware that some Veterans, including males, may initially feel more guarded in the presence of a male instructor. As described in chapter 7, we also recognize that some women with histories of interpersonal trauma could likely benefit from opportunities to approach their discomfort, fear, anxiety, or anger in a women-only format, and in this situation a female instructor would be preferred.

Non-Veteran instructors: None of our MBSR teachers are Veterans. Because Veterans often have unique experiences and face different challenges that others may not easily comprehend, when asked, some Veterans have expressed the idea that they would be better served by working with mindfulness teachers who are also Veterans. In our research, we also found that some Veterans express the desire for mindfulness teachers who have a better understanding of Veteran culture. This was part of our motivation for providing this resource – to provide more information to teachers about the unique experience of Veterans, including sub-cultures operative within the Veteran community, in order to help them as teachers. An important qualifier is that despite the fact that our teachers are not Veterans, most participants rate them very highly on teaching ability and have found them easy to connect with. Indeed, many have expressed a strong sense of gratitude to our teachers for being there and for offering the class. Also, as further evidence that they feel they learned something of value, a high percentage of Veterans report that they would recommend the class to other Veterans. Thus, although the desire for mindfulness teachers who are Veterans is understandable, our clinical experience and research indicates that mindfulness can effectively be taught to Veterans by non-Veteran instructors.

“People teaching can’t relate to those who’ve been in war environment”

Recommendations:

A single instructor is generally sufficient for mindfulness groups, but if resources permit, two instructors can be helpful.

In general, the most effective means of connecting with the group is to keep the emphasis on learning mindfulness as the shared experience. We have found that teachers who embody sincerity, humility, authenticity, and direct experiential knowledge of mindfulness practices are readily accepted by the group. We feel that it is important for teachers to have an ongoing personal mindfulness practice, and when teaching to speak directly from (and not beyond) their own understanding. If the instructor sometimes shares his/her personal struggles or insights on the path of learning mindfulness, it can often serve as a way of framing the bond with group members as a common shared experience of learning mindfulness.

Be able to connect on a human level to diverse individuals and relate to their experiences and struggles with kindness. One of the most powerful ways of learning mindfulness can be through interacting with a teacher who embodies a mindful way of

“She was great! She was great. Loved on us. Loved on us, loved on us, loved on us. She didn’t put too many expectations on us. If you could not physically do the exercises, she would instruct you to sit in the chair and do them. She knew that people had a certain pain threshold and she really was good about making sure that you were mindful not to go over that [threshold]. She was funny. She was caring. She was great! She was great. She made it, she made that class...she made that class everything that it should be. I don’t think that she could have done anything more to make it any better.”

“I could see that she enjoyed what she was doing and she was very positive. She listened.”

“He knew the subject, obviously. He was thorough on his explanations of what he wanted us to do and how he wanted us to do it. Then just the way he talked, he had the mono voice to help you relax and instruct you to move this way or do this. You could understand him, he was very vocal. I had no problems”

“She was for real. Every now and then she would share something with us to help guide us along the way. She was relentless even though she was a very nice person she was relentless all the time. I noticed that.”

“We had several one on one talks and I just love her. I just love her. I think everybody did. I think the angry guy was the only one that had problems with her and even he gave her a hug at the end session. She was just wonderful. She knew her stuff, she really did...I don't think she did anything that was unhelpful. If you had a question on anything, if she didn't know the answer she found it for you. She made a point of calling you and telling you or bringing you the material in. She always had some wonderful poems that she would bring in for the class and read, and we always wanted to take the poems home and I still have poems. I have one of them in a frame in my office, it is just wonderful. It really helps to turn around and look at it from time to time.”

being. If the teacher naturally embodies warmth, openheartedness, curiosity, humor, and acceptance, it can help to bridge the gap between divergent life experiences and foster a strong sense of trust and connection with the teacher.

"The instructor was very good. I could tell that the reason he was doing it was because he needed to. He was a person that really needed to be doing all of the things, which made everyone in the class for sure believe that here was a person that all in his heart was teaching this so, you know. ...my experience with the instructor was very excellent."

Respectfully acknowledge the Veteran's service to the country, and, by extension, the instructor. Coupled with a sincere statement of the instructor's intention to offer this form of service to them for what they have done, this can create an environment of mutual respect that supports the class, participants and instructor.

Be mindful that many Veterans may come from a very different background from your own, which often involve very challenging socioeconomic circumstances. Awareness of the unique challenges faced by many Veterans, as well as their courageousness and resilience, is a theme throughout this resource.

As an additional recommendation, ***we advise that teachers do not ask group members what they do for a living when members are asked to introduce themselves.*** In civilian MBSR groups, this can sometimes be the routine, but many Veterans are dealing with unemployment, struggling to find work or keep a job, and some are homeless. Taking this approach can help prevent alienation. Instead, try asking them what they do *in life*, as opposed to what they do for work.

Male instructors can provide modeling of mindful self-reflection and emotionality. Many male Veterans have been taught to show limited emotion or hold the belief that emotional communication makes them appear weak. The presence of a male instructor who consistently demonstrates that one can be strong and mindful and emotional can provide powerful corrective lessons. Male instructors who effectively balance the head and heart and communicate this synergy with clear accessible language will be most effective.

"I would rather have a woman instructor. I like women instructors." (Male)

"I just happened to feel like the ultimate healing involves maternal energy." (Male)

"I don't think being a male or a woman would have any bearing on me taking it at all - it would not have had any." (Male)

[When asked if it helped to have a male or female instructor] "I can't say because I've had both. In the military I've had male instructors teach the same thing and I think that if the person is passionate enough and knows what they're doing, I don't think gender really matters." (Female)

"I prefer a woman... for me personally, I can become more vulnerable. You know, I can let my defenses down... versus with a man, I don't always feel like I want to do that." (Male)

Chapter 21: Maintaining Practice, Continued Support

"Oh yes, I'm doing the eating stuff, I'm doing the yoga part, I also do the body scan because I suffer with chronic pain and fibromyalgia, so I have to do the stretches. I have to do something that's going to really help the body with the pain and minimize the inflammation. So I have been doing them... I do it every day: I do it in the morning and I do it in the evenings."

"I went and got the Qi Gong CD set and got some other meditation stuff, because I really do want to

make it a daily practice. Because I know that it's not a cure, but it certainly makes things easier. And I'm all about making things easier at this point. So yeah, that's kind of the change that I saw: before I was just dabbling in meditation, but this helped bring it all together."

"If we could have a support network inside the VA System with MBSR... why can't we have a support group for loving-kindness or MBSR or even conjoining both into one meeting?"

Reflections and observations:

Many Veterans maintain a variety of mindfulness practices after the course. The breathing meditation appears to be maintained most often - Veterans often report incorporating it into their daily activities (on the bus, while driving, outdoors, in bed, etc.). Some also continue practicing the body scan to help them relax and fall asleep, as well as yoga to manage their pain. Spouse participation helps some Veterans to continue their practice. Several Veterans have reported engaging additional resources outside of the VA as a result of taking MBSR, including taking yoga classes or participating in other mindfulness training or retreats. Other Veterans do not maintain a practice after MBSR, whether it be due to lack of interest, perceived lack of benefit, or inability to find time.

One indicator of how well-received the program has been is the common request by Veterans to take the class a second, third, and fourth time. However, in the process of interviewing Veterans, we learned that it is common for Veterans taking the class for the first time to feel that including individuals in their group who have previously taken MBSR detracted from their experience. This finding led us to develop an alumni class series at our site for those who have previously taken MBSR. As another way of offering ongoing support, in our community there are organizations that provide opportunities for Veterans to participate in weekend mindfulness retreats at low or no cost. We have found that some Veterans appreciate the opportunity to go deeper in their practice by attending these retreats, and for this reason we inform Veterans who have completed MBSR of these opportunities.

"I found out that these people had taken the class back-to-back and they were on a third session taking the class again, and I don't think that is right...."



Recommendations:

Support Veterans to “make the practice their own” from early on in the course. It can be useful to describe MBSR as introducing a palette of mindfulness practices, with the hope that each participant will leave the course with enough facility with the practices to continue on their own after they complete the course. Veterans may have questions about how they should practice after leaving MBSR, and we suggest pointing out that there is ‘no one way to practice.’ Another possibility is to point out that given the uniqueness of each person in the room, along with unique life circumstances, we might expect each person to incorporate the practices into their life in a unique way.

Encourage Veterans to continue to use the guided meditation CDs after the course ends. Many Veterans find these guided meditations to be a readily available, accessible form of support.

Provide a list of community resources for continued mindfulness practice and learning. This is provided as an informative list, without specifically endorsing any particular resource in the community.

If resources permit, offer occasional ‘alumni’ class series for those who have completed MBSR. At our site, we offer periodic MBSR courses limited to those who have previously taken MBSR (‘alumni’ courses).

If it is not possible to offer alumni courses, we suggest creating a guideline for re-enrollment that balances availability of spots for new courses with the need for ongoing support for alumni, e.g., a Veteran could retake the course once per year. When including MBSR alumni in groups predominantly composed of individuals new to MBSR, it is also helpful to include some comments surrounding this situation in the guidelines for participation at the beginning of the class series. These comments should encourage MBSR alumni to allow space for others to learn for themselves through their own experience.

“I think it would be good to have, let's say a step two. I know people can take it repeatedly, but if you take it repeatedly coming into the same classes, it doesn't go much further than the first time around. But if there could be some kind of commitment ..to go deeper...”

Be aware that it may be hard to say goodbye.

For many Veterans in mindfulness groups, it may have been one of the first and most positive group experiences they have had in a long time; saying good-bye can be difficult. In the closing circles there is often sadness and loss and it is helpful to name these feelings. It can also be beneficial to provide space for group members to reflect on how they have changed – has the course has opened up unanticipated possibilities and connections? It can also be useful to call to mind any judgments that may have come up about other group members on the first day, and to notice what has changed and whether their hearts and minds have opened.

One suggestion for facilitating this process of saying goodbye is to include some form of ritual in the final session. One experienced instructor uses the approach of passing the meditation bell around the circle. Upon receiving the meditation bell, each person is asked to speak spontaneously from the heart about what the experience of taking the class has been like. After speaking, the person is then asked to ring the meditation bell, and the group is asked to listen as the sound of bell fades before the bell is passed to the next person, who in turn has the opportunity to speak. In this practice, people are also given permission to opt out, or to simply ring the bell as their form of self-expression. Another example of a shared ritual to promote processing and saying goodbye is the use of a totem (e.g. a heart-shaped rock or other symbolic object). The person who holds the totem is the person who speaks; the totem is then passed from group member to group member. In these forms of ritual, it is helpful and important for the instructor to share his/her experience along with the other participants, which can help to illustrate the shared, ongoing, open-ended experience of learning mindfulness over a lifetime.

Another suggestion to promote closure is to hand out a certificate of completion to each participant in the final class session. When presented, it is offered in recognition of their commitment and hard work. It is also described as being given with the hope that it might serve as a reminder of the practices, as well as a reminder of the positive intention they have shown for themselves through participation in the class. An example of a certificate of completion is provided in Appendix D.

Create a system for receiving feedback from participants that can be used to evaluate and improve the mindfulness program. At the final group session, we suggest providing participants with an evaluation form to gather feedback about the quality and impressions of various aspects of the mindfulness program. This evaluate form should evaluate multiple aspects of the program, including the teacher, the CDs and other teaching materials, the physical environment, as well as any perceived changes in their health or behaviors.

Appendices

- ❖ Appendix A: MBSR Informational Brochure 98
- ❖ Appendix B: Patient education materials for chronic pain..... 100
- ❖ Appendix C: Screen Shots from MBSR Referral Process 102
- ❖ Appendix D: MBSR Certificate 105



What Veterans at VA Puget Sound Are Saying About the MBSR Program:

"This class may have saved my life...I changed to a path of hope with a path to live with problems I thought were killing me."

"It is the beginning of weaning myself slowly off my pain meds. I will take the class again and be at the day retreats whenever possible - absolute priority."

"I am aware my thoughts are not me. By being more aware, mindful when small things in life might have upset me—now I see them for what they are—only momentary distractions."

"I am in more control and more self-accepting...it has vastly reduced my emotional pain."

Benefits of MBSR:

- Improved quality of life (school, job)
- Reduced tension, fear, frustration
- Better coping with life stressors
- Improved sleep
- Possible reduced need for pain medications
- Reduced risk of relapse of depression



Outside

Mindfulness-Based Stress Reduction (MBSR) Program



Cost of Participation:

If you are eligible for Travel pay for your other clinical appointments, that eligibility will apply to MBSR appointments as well. However, since MBSR operates out of a specialty clinic (Gastroenterology), there may be a \$50 co-pay per appointment. You can call the Registration & Eligibility office at 206-277-1469 to make sure your Means Test is updated and determine whether a co-payment will be required.

American Lake & Seattle

Director: David Kearney, MD
 Coordinator: Michelle Martinez

206-277-1721

www.pugetsound.va.gov/services/mindfulness.asp

Mindfulness Based Stress Reduction (MBSR)



The VA Mindfulness-Based Stress Reduction program serves as a complement to ongoing treatment for those suffering from chronic pain, stress, anxiety or depression. Many veterans with post traumatic stress disorder have also found the class to be of benefit. Veterans with severe physical limitations are also eligible.

MBSR teaches mindfulness meditation practices, which are intended to build coping skills that can reduce symptoms related to anxiety, depression, pain, and chronic stress. Participants learn how to play an active role in their own health as a result of participation in MBSR.

A growing number of scientific studies show mental and physical health benefits as a result of participation in MBSR. The program requires a **high level of participation involving 8 weekly 2.5 hour morning sessions and one day long retreat** between weeks 6 and 7.

Please check with your VA provider to determine if this program may be of benefit to you. Referrals can be made through your primary care provider, your mental health provider, or by contacting the MBSR coordinator directly at:

206-277-1721

What is MBSR?

Mindfulness-Based Stress Reduction (MBSR) is a program designed to teach a skill called *mindfulness*. MBSR teaches people practices they can use over the course of their life to reduce stress and promote health and wellness.



What is Mindfulness?

Mindfulness is a term that refers to *non-judgmental, present moment attention*. With original roots based in Eastern traditions, the introduction of MBSR to allopathic medicine in the United States first occurred in 1979, when Dr. Kabat-Zinn founded the Stress Reduction Clinic at the University of Massachusetts Medical Center. There are currently over 250 hospitals nationwide offering stress reduction programs based on mindfulness.

Mindfulness-Based Stress Reduction can help you to live more fully in the moment. Studies have shown that people who participate in MBSR develop coping skills that enhance resilience and improve quality of life. For PTSD, MBSR helps veterans to take a more active role in their own health and overcome both work and social impairment.



Chronic Pain



When tissue damage occurs, a nerve (A) carries information from the body area to the spinal cord.

The information is then passed to a spinal nerve (B) that carries the information to the brain (C).

When the information reaches the brain, a complex communication process takes place among many brain areas. These areas include those involved with body location and the quality of sensations in that area, your emotions, and your thoughts.

Based on the brain's conclusions about the incoming information, the brain sends instructions to the spinal cord. These instructions increase or decrease the activity between nerves A and B. This nerve pathway (D) acts like a volume control, increasing or decreasing pain-related signals in the spinal cord.

When an injury occurs, nerves A and B and various brain areas become sensitive and promote a healing process. The nerves easily send signals. As tissues heal, this increased sensitivity reverses. When pain lasts more than three to six months, the nerves can remain sensitive. They can activate even when the tissue has

healed. That causes you to experience pain, not because of tissue damage but because the nerves are sensitive and too easily send signals.

Also, when pain lasts more than three to six months, the brain changes. Some areas of the brain remain abnormally active. Again, this causes you to experience pain, not because of tissue damage, but because of abnormal brain activity.

If you have pain that has lasted more than three to six months, part of your healing process requires reversing your nerve sensitivity and changing your brain activation. Your nerves are always in a state of change. You can help them become less sensitive by:

- Understanding the complex factors that give rise to pain
- Calming your nervous system through relaxation and/or meditation
- Exercising in a manner that can retrain your nerves as well as muscles
- Practicing kind and supportive self-talk
- Doing activities to retrain your brain

Strategies to Manage and Relieve Pain

Stress = Situation + Your Reaction

Pain = Sensation + Your Reaction

Your reaction has three components: 1) physical reaction, 2) cognitive reaction, and 3) emotional reaction. These three areas are interconnected. You have control over them.

1. The first step to controlling your reaction to pain is to pay attention to your reaction in a skillful manner. Mindful awareness is a skillful way to pay attention.

Mindfulness is:

- Present moment
 - Stable, accepting
 - Kind, friendly
 - Open, curious
2. BREATHE. Breathe into your waistband. Use a word or phrase in concert with your breath to help you focus your mind. For example, think to yourself, “May I” on the in-breath, “be peaceful” on the out-breath.
 3. Think of your mind as a camera lens. Choose a wide angle. Imagine your mind like the sky: open, vast, expansive, and spacious. Think of the limitless ocean of love you have in your heart for your loved ones. Label the pain “sensation.” Imagine it like a cloud in the boundless sky of your mind.
 4. Talk to yourself as you would if a dear friend was in your situation and turning to you for support. Recognize the wisdom that you always carry. Turn this wisdom toward yourself.
 5. Experiment with doing routine activities in a calm, relaxed, mindful manner. For example, when washing your hands, let your mind rest in the present, breathe, relax, and feel the warm water.
 6. Take 10 minutes for relaxation exercises on a daily basis.
 7. Gradually increase your activity level. Start low and go slowly. Remember, you are helping your nerves heal. Some discomfort is normal. It is important to avoid overdoing activity that could flare your pain.
 8. Make time for pleasant activities. When you do something you enjoy, notice how this feels in your body and mind. Pay attention to the experience of the pleasant. This sets up new positive pathways in your brain that are a healing alternative to pain-generating pathways.

Providers are able to refer patients to the MBSR program by selecting it from the consults list in the Computerized Patient Record System (CPRS)

Integration of MBSR into the Electronic Medical Record Facilitates Referral

The screenshot displays the CPRS interface for a patient named LEARNEY David J. The main window shows a list of consult services under the heading "Consults". The list includes various medical services such as "LOGGING REQUESTS for Tobacco patients", "LUNG EDUCATION", "MEDICAL CLEARANCE - DEC PREOP CLINIC", "MEDICAL MDRN (Photography request)", "MENTAL HEALTH CONSULTS", "MINDFULNESS BASED STRESS REDUCTION (Mindfulness S.I. class)", "MOXI (Signal Obesity) - Contact primary care to enroll or call 47662 directly", "NON-IDENT DISORDERPS (Paternal a to Founding)", "PSYCHOPHYSIOLOGY (Imaging) (Imaging) (Imaging)", "MULTIPLE SCLEROSIS (Imaging) (Paternal consult)", "MULTIPLE SCLEROSIS CLINIC (Imaging)", "MUSCULOSKELETAL CLINIC (Paternal Care Service)", "NARCOTIC MEDICATION PLAN - (Consult no longer needed - Enter a progress note under the old NARCOTIC MEDICATION PLAN TEMPLATE)", "NEUROGENETICS", "NEUROLOGY Consults", "NEUROPSYCHOLOGICAL COGNITIVE ASSESSMENT (Imaging) SERVICE", "NEUROSURGERY (Imaging)", "NEUROSURGERY (Imaging)", "NONPHARMACOLOGIC RESTRICTED DRUG REQUESTS (Pharmacy)", "NON-RESTRICTED CARE CONSULT ORDERS", "NON-RESTRICTED CARE CONSULT ORDERS", "NUTRITION (Diet) (Imaging)", "NUTRITION INPATIENT (Diet)", "NUTRITION OUTPATIENT (Diet)", "NUTRITION SUPPORT (PARENTERAL/ENTERAL) TEAM (Diet) (Imaging)", "OCCUPATIONAL THERAPY Consults", "OIC PREOPERATIVE MEDICINE CONSULT", "OESOPHAGUS REFERRAL AND ORDERS", "ONCOLOGY", "OPHTHALMOLOGY/OPTOMETRY", and "ORAL AND MAXILLOFACIAL SURGERY consult".

Sample of a Referral to the Mindfulness-Based Stress Reduction program

MEDICAL RECORD	CONSULTATION SHEET
[REDACTED]	SERVICE CONNECTED 50% to 100% SC VETERAN OEF/OIF [REDACTED]

Consult Request: Consult

Consult No. [REDACTED]

To: MINDFULNESS-BASED STRESS REDUCTION
From: ANE S PAIN PROC PRE-POST OP1

Requested: [REDACTED]

Requesting Facility: PUGET SOUND HCS

Current Primary Care Provider: [REDACTED]
Current Primary Care Team: WH TEAM 6 *WH*

REASON FOR REQUEST: (Complaints and findings)
MINDFULNESS-BASED STRESS REDUCTION (MBSR) REFERRAL:

This program is provided as a wellness/self-care program for patients with chronic illnesses. Patient education is provided in a group format.

- * Conditions for which there is evidence to support MBSR include: chronic pain, depression, anxiety disorders, psoriasis, fibromyalgia, cancer, multiple sclerosis, eating disorders, as well as other chronic medical conditions.
- * The program is conducted over an 8-week period in a group setting.
- * Classes meet once weekly for 2.5 hours.
- * There is also a 7 hour class on a Saturday, between weeks 6 and 7, during which participants practice mindfulness meditation more intensively.
- * During the meetings, participants receive instructions in the practice of mindfulness meditation (nonjudgmental awareness), discuss stress, coping skills and previous homework assignments.
- * Movement and gentle stretching exercises are conducted in order to promote awareness of the body.

The following are EXCLUSIONARY criteria that makes patient INELIGIBLE for MBSR.

If patient meets any of these exclusionary criteria, <click> CANCEL below and DO NOT submit this consult referral.

EXCLUSIONARY CRITERIA:

AUTHOR & TITLE:

DATE:

ID #: _____ ORGANIZATION: PUGET SOUND HCS | REG #: _____ | LOC: ANE S PAIN

MEDICAL RECORD

CONSULTATION SHEET

SERVICE CONNECTED 50% to 100%
SC VETERAN
OEF/OIF

Reason For Request continued.

- ~ PATIENT HAS AN ACTIVE "POTENTIAL SUICIDE RISK" FLAG OR REPORTS SUICIDAL IDEATION WITH INTENT OR A PLAN.
- ~ PATIENT HAS ONE OR MORE OF THE FOLLOWING KNOWN DIAGNOSES:
 - ~~ Borderline personality disorder
 - ~~ Psychotic disorder (schizophrenia or other psychoses)
 - ~~ Antisocial personality disorder
- ~ PATIENT HAS POORLY CONTROLLED BIPOLAR AFFECTIVE DISORDER.
- ~ PATIENT HAS A SERVICE ANIMAL. (Service animals are not allowed in MBSR groups. Patient MAY participate IF he/she can bring a family member or friend to handle the service animal, or is able to make alternate arrangements for care and responsibility of the service animal during these class periods.)

 The patient CANNOT display significant behavior problems, e.g., threatening others, disruptiveness in groups, etc. Provider must address appropriateness for participation in this group BEFORE submitting this consult, and must document in CPRS that the patient has been assessed and found to not be a threat to self or others.

REASON FOR REQUEST:

Veteran is interested in restarting mindfulness practice to help her manage chronic pain, anxiety, and depression. She is also interested in meeting other Veterans.

REQUEST' PARTICIPATION IN MBSR AT:

Seattle Division

THE PATIENT DOES NOT MEET ANY EXCLUSIONARY CRITERIA AND IS APPROPRIATE FOR MBSR.

PROVIDER MAKING REFERRAL:
 PROVIDER PHONE NUMBER:
 PROVIDER PAGER NUMBER:

PROVISIONAL DIAG: chronic pain syndrome; MDD; PTSD

REQUESTED BY:
 Clinical Psychologist

PLACE:
 Consultant's choice

URGENCY:
 Routine

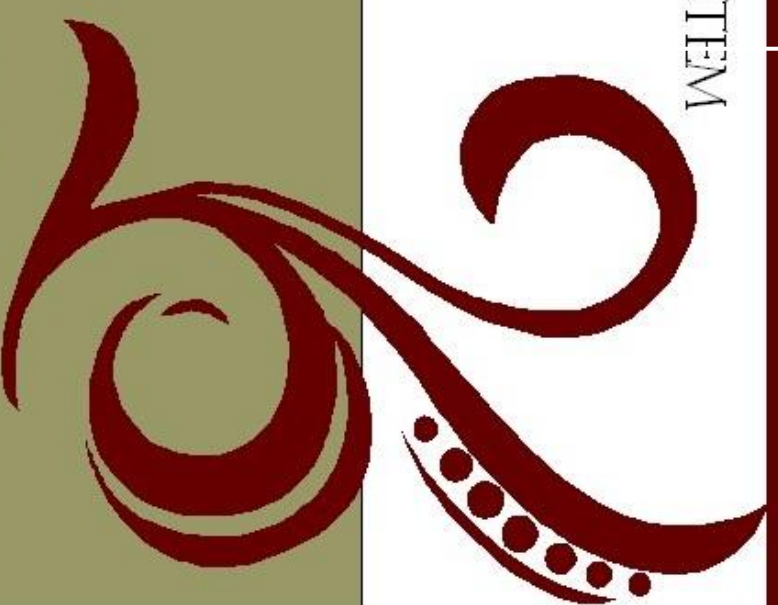
SERVICE RENDERED AS:
 Outpatient

PUBLISHED DATE:

WORKING COPY

No Consultation Results available.

VA PUGET SOUND HEALTH CARE SYSTEM
MINDFULNESS-BASED
STRESS REDUCTION



This certificate is awarded to

[FULL NAME]

[Date of final MBSR session]

in recognition of taking a step toward greater health,
by participating in the 8-week series Mindfulness-
Based Stress Reduction (MBSR)

[Name of Teacher], MBSR Instructor

About the Authors

David J. Kearney, MD is the founder and Director of the Mindfulness-Based Stress Reduction (MBSR) Program at VA Puget Sound Health Care System and a full-time staff physician. He is a Professor of Medicine at the University of Washington, in the Department of Medicine, Division of Gastroenterology. He has been teaching and researching mindfulness-based interventions for Veterans since 2007, with a focus on MBSR and Loving-Kindness Meditation. His research has studied the influence of mindfulness-based interventions on a broad range of outcomes, including symptoms of PTSD and depression, quality of life, gastrointestinal symptoms, pain, fatigue and attention/memory lapses. His work has been supported through grants from the VA Office of Patient Centered Care & Cultural Transformation and VA Clinical Sciences Research & Development.

Michelle Martinez, BA is the VA Puget Sound MBSR Program Administrator and a mindfulness research specialist. Since 2008, she has facilitated numerous MBSR and Loving Kindness Meditation groups, and assisted in the dissemination of mindfulness programs at other VA facilities. She has coordinated several mindfulness- and meditation-based intervention studies, including the qualitative interview work described in this publication. Michelle is completing her Master's in Public Health at the University of Washington.

Benjamin I. Felleman, PhD is a psychologist who is currently completing an internship at UC San Diego & VA San Diego Health Care System. He has contributed to several studies at VA Puget Sound using both qualitative and quantitative methodologies. His clinical work focuses on the implementation of mindfulness and acceptance-based interventions within integrated primary-care mental health settings.

Nicole Bernardi, BS is a Research Coordinator at VA Puget Sound Health Care System. She has been involved in two studies of PTSD, including a trial comparing loving-kindness meditation to cognitive processing therapy for Veterans with PTSD. She was involved in transcribing and coding the interviews with Veterans, as well as creating additional content for this resource.

George Sayre, PsyD received his Doctorate of Psychology with a specialization in Clinical Family Psychology from Seattle Pacific University. He works as a research investigator and qualitative resources coordinator at the Seattle & Denver HSR&D Center for Innovation for Veteran-Centered and Value-Driven Care and is an Assistant Clinical Professor at the University of Washington Department of Health. Dr. Sayre has successfully provided qualitative research expertise for multiple VA funded qualitative research projects, and guided the development of the interview and analysis protocol for the data that was collected and used from interviews with Veterans to create this resource.

Kurt Hoelting, MDiv is an author and teacher of mindfulness meditation. He received his master's degree from the Harvard Divinity School and has trained extensively as a student of Zen for thirty years. Kurt was trained in MBSR under Jon Kabat-Zinn and currently teaches MBSR at VA Puget Sound and widely throughout the Puget Sound region. In 1994, he founded Inside Passages, an organization that guides leaders of diverse professions through sea kayaking meditation retreats in the Alaska wilderness.

Carolyn McManus, PT, MS, MA is a physical therapist has been leading MBSR and Loving Kindness Meditation groups at VA Puget Sound since 2010, and at Swedish Medical Center for approximately twenty years. She holds master's degrees in physical therapy from Duke University and in psychology from Antioch University. Carolyn has an expertise in the application of mindfulness practice in the setting of chronic pain. In 2003, she published a book, *Group Wellness Programs for Chronic Pain and Disease Management*, and in 2011, she developed a new program for patients with chronic pain conditions titled "The Pain Puzzle," currently offered at Swedish Medical Center.

Lisa Hardmeyer Gray has been studying meditation for over 20 years, and has obtained MBSR Teacher Certification through the Center for Mindfulness at the University of Massachusetts. Since 2011, Lisa has been teaching MBSR to Veterans at VA Puget Sound. She also teaches MBSR throughout the Puget Sound region. Lisa is completing her Master's in Mental Health Counseling at Antioch University in Seattle, WA. She is also an award-winning documentary film maker who directed "Healing a Soldier's Heart," a film about the Loving Kindness Meditation groups at the Seattle VA medical center.

Jonas Batt, MA, LMHC holds a master's degree in Education and Mental Health Counseling and has been practicing mindfulness since 1997. He began teaching mindfulness meditation in 2001, initially as a trained yoga teacher, and has taught MBSR and Loving-Kindness Meditation to Veterans at VA Puget Sound for approximately two years. He was trained at the Center for Mindfulness at University of Massachusetts Medical School, and has studied for extended periods of time with highly experienced teachers at the Insight Meditation Society in Barre, MA. He also teaches MBSR throughout the Puget Sound region.

Tracy L. Simpson, PhD is a full-time clinical psychologist at VA Puget Sound Health Care System, and is the Director of the Mental Illness Research, Education, and Clinical Center Psychology Post-doctoral Fellowship at VA Puget Sound. She is also an Associate Professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington. Dr. Simpson has over 20 years of clinical and research experience with trauma and post-trauma sequelae. Her most recent clinical research has focused primarily on mindfulness meditation and acceptance-oriented approaches for PTSD and addictions.

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