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Moving from a Losing Disease Model to a Winning Wellness Model in Military Mental Health

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The ever-evolving nature of warfare, driven by factors such as large-scale combat operations, rapid technological advancements, and the prevalence of irregular warfare, present profound implications for soldier mental readiness and resilience. The situation the military is facing after two decades of war is complex, involving compounding layers of cultural tradition, rapidly evolving global variables, deep relational wounds, and most importantly, its people.[1] From our foxhole, there is no question that the Army is currently losing the war related to mental health readiness.

In February 2019, more than fifty-six thousand soldiers, equivalent to thirteen brigade combat teams, were nondeployable, with more than twenty-one thousand on temporary profiles.[2] "Behavioral health conditions—such as posttraumatic stress disorder, depression, and anxiety—are the second most common medical reason for nondeployability in the U.S. Army."[3] "Between 2011 and 2022, the [Department of Defense (DOD)] identified 5,997 service members who died by suicide in both Active and Reserve Components."[4] Additionally, the troops at the most risk for taking their own lives are the ones whose jobs expose them to the most danger. Of the forty-two enlisted military jobs performed by troops, the top three with the highest suicide rates are ordnance disposal; infantry; and missile guidance, control and checkout.[5] For the security and safety of our Nation, the Army must shift its focus to a proactive mindset as it relates to mental health and wellness.

> The question "What is wrong with people?" has guided the thinking of many psychologists and dominated countless scientific studies during the 20th century. It is hard to deny that it is an important question. In our attempts to answer the question, we have gained insight into many illnesses and have developed effective treatments for a wide range of problems. However, focusing on disease and deficit has limited our understanding and knowledgebase to pathology, and consequently, we have devoted relatively little attention to factors that make life worth living.[6]

Focusing on what is wrong with an individual is what the field of psychology considers a weakness focus.[7] This view places direct attention on negative aspects of an individual. A focus on this as an illness is also referred to as the disease model, which has shaped the very foundation of America's medical system. Although the disease model has been adopted by many researchers and practitioners, there are several important misconceptions that are often overlooked. The Positive Psychology Program asserts that there are five myths associated with the disease model: (1) fixing what is wrong leads to well-being, (2) effective coping is reflected by a reduction in negative states, (3) correcting weakness creates optimal performance, (4) weaknesses deserve more attention because strengths will take care of themselves, and (5) a deficit focus can help in preventing problems.[8] In contrast to the disease model, positive psychology can be described "as a field dedicated to the study, development, and application of positive interventions that are aimed at increasing well-being through factors under voluntary control."[9] The field of positive psychology has produced countless studies that have uncovered actions and interventions that significantly improve well-being.[10]

What is the difference between health and wellness? Health can be generally defined as the state of freedom from illness or injury. The World Health Organization defines wellness as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."[11] Additionally, wellness is "a conscious, self-directed, and evolving process of achieving full potential."[12] When examining the concept of wellness, it is also important to note that wellness is a process, a commitment, and a proactive way of life; and it must be integrated. So, why should the military care so much about wellness? The Suicide Prevention Report Independent Review Committee (SPRIRC) found that feelings of well-being can protect against severe emotional distress in the face of a stressor and reduce suicide risk in military personnel.[13]

The increasingly fast-paced and competitive nature of large-scale combat operations demands military personnel maintain readiness (wellness) and resiliency in the face of stressful environments.[14] Soldiers must possess the skills to maintain the optimal cognitive and physical performance necessary for success on a battlefield occupied with peer competitors. Military resiliency has been defined as "the capacity to overcome the negative effects or setbacks and associated stress on military performance and combat effectiveness."[15] Monica Ruiz-Casares et al. argue that resilience is "a dynamic process involving the interaction between risk

and compensatory factors across a lifespan."[16] There is no question that the soldier of the future must possess resilience to be successful. We are living in a time where we "can no longer take for granted the 'hardiness' of past generations" as the biopsychosocial challenges of the current digital generation emerge.[17] During these unprecedented times, "building and instilling resilience (nurture) in the recruits we get (nature) is not so much a question" of can we, as it is a requirement.[18]

The military no longer has the luxury to blame the currently "weak" generation for our Army's shortcomings in recruitment and lowering of standards. The Army must find a way, like the many generations before us, to transform civilians into the soldiers our Nation's security demands. In these unparalleled times, the nature versus nurture debate has outlasted its usefulness.[19] Charles Darwin and Leon Megginson established "that the species that is best able to adapt to a changing environment is the species that will prevail, not [necessarily] the strongest nor most intellectual."[20] The future armies that will prevail are those comprised of resilient individuals who can overcome challenges while performing with "greater agility, tenacity, survivability, and lethality."[21] Resilience is a multifaceted capacity for which there is no singular approach; therefore, a hybrid tactic may be superior.[22] To build resilient soldiers, the Army must be all in on "locally, coordinated, multidisciplinary, multifaceted 'Human Performance' programs that are well resourced and founded" in collaboration between practitioners and researchers.[23] Our soldiers' readiness and resilience (totality of wellness) will define the security of our Nation, and therefore we must build on what we get.

The eight dimensions of wellness align directly with the Holistic Health and Fitness (H2F) program and encompass emotional, physical, financial, intellectual, occupational, environmental, social, and spiritual realms. Field Manual (FM) 7-22, *Holistic Health and Fitness*, outlines five overarching domains of readiness to include physical, nutritional, mental, spiritual, and sleep readiness.[24] The purpose of this document is to establish the Army's doctrine for the readiness (wellness) training of soldiers.[25] According to Thomas Brading, H2F's design aims to diminish injuries and equip soldiers for contemporary warfare.[26] Thus far, the program's success is undeniable, with troops in H2F-resourced units seeing 52 percent fewer musculoskeletal injuries than those in non-H2F units.[27] "Early data gathered from the [H2F program] has shown more than a one-third reduction in [completed] suicides among soldiers in units that have incorporated the program," coupled with a more than one-third increase in suicides among brigades in the sample that did not have the program.[28] Furthermore, H2F units had a 49 percent lower incidence of behavioral health referrals and 492 fewer behavioral health profiles.[29]

With successful data behind them, the Army plans to distribute H2F across the force by 2030, but is that enough, or could we do better? To accomplish the H2F mission, doctrine

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further "directs leaders and Soldiers to use unit-level [U.S. Army Forces Command (FORSCOM)] experts, facilities, and equipment to develop physical and non-physical components of Soldier readiness" and proactive health.[30] FM 7-22 establishes the personnel assigned to H2F include physical therapist, occupational therapist, registered dietitian, strength and endurance coach, athletic trainer, and holistic health and fitness coach.[31] The only vague mention of mental health professionals is "unit medical and installation personnel to develop and coordinate performance readiness."[32] We would argue that this is where the H2F program has missed the mark in relation to the mental domain of readiness and lethality. To be "all in" on the mental readiness of the force, the Army must strategically and systematically assign uniformed personnel to address proactive mental health prevention. The data is promising and with continued evolution, involvement, and dedication of resources, the Army may be able to turn the tide. Todd South asserts that if H2F was fielded across the entire force, with similar improvement rates in injuries and mental health, "readiness and cost savings would be significant."[33] "It would theoretically give [FORSCOM] a 90% deployable force."[34] This additionally equates to a "$1.4–$1.6 billion cost savings on retraining."[35]

In the realm of mental health, two of the largest threats to medical readiness are suicidal ideations and death by suicide. The SPRIRC report "emphasized that effectively preventing and responding to suicide will require a multifactorial approach, as deaths by suicide among service members are complex; thus, simple or singular strategies will not work."[36] Researchers are now asserting that although a "cause-and-effect approach is sufficient to solve many conventional problems, it is ill-suited for 'wicked problems' like suicide."[37] "To address a wicked problems [*sic*] like suicide, the DoD must reduce its reliance on solutions-oriented thinking and adopt process-oriented thinking instead."[38] The SPRIRC offers three must haves to achieve process-oriented thinking: (1) multiple strategies are needed, no one thing; (2) a strategy that prevents suicide in one instance may have little effect or make things worse under other conditions, no one-size-fits-all; and (3) even when a strategy works, different strategies will be needed in the future, it is an ever-evolving fight.[39]

> The issue of mental health and suicide involves simultaneous and rapidly emerging variables. To address the underlying root causes, the military must work outside its comfort zone and get into the dirty, messy work of repairing human relationships.

The military must resist the common urge to apply quick-win solutions to demonstrate progress on this complex issue. The issue of mental health and suicide involves simultaneous and rapidly emerging variables. To address the underlying root causes, the military must work outside its comfort zone and get into the dirty, messy work of repairing human relationships. Wicked problems challenge our deepest held beliefs and assertions while calling upon us to lean in and discover new conventions within our organizations.[40]

Overall, the SPRIRC proposes a public health approach to suicide prevention:

1. Strengthen economic impacts—*prevention*.
2. Create protective environments—*prevention*.
3. Improve access and delivery of interventions—*prevention/treatment*.
4. Promote healthy connections—*prevention*.
5. Teach coping and problem-solving skills—*prevention*.
6. Identify and support those at risk—*prevention/treatment*.
7. Decease risk by lessening harms and preventing future risk—*treatment/prevention*.[41]

Utilizing a public health approach, along with viewing suicide as a wicked problem, served as the foundation of the 2022 SPRIRC findings, which are organized around the four pillars for the *National Strategy for Suicide Prevention* adopted by the DOD in 2015:

1. **Healthy and empowered individuals, families, and communities.** This pillar is focused on creating environments that promote well-being with

the core assumption that suicide can be prevented when communities collaborate and coordinate activities. *Actions are preventative in nature.*

2. **Clinical and community preventative services.** This pillar is focused on the availability of support services and systems to assist in solving challenges prior to them rising to a medical need for treatment/intervention. *Actions are preventative in nature.*
3. **Treatment and support services.** This pillar is focused on the availability of evidenced-based healthcare. The assumption here is that suicide can be prevented when people are able to quickly receive effective and early interventions/treatments. The current behavioral health system is overwhelmed, underresourced, and not meeting this need. At every installation visited by the SPRIRC, at least one-third of the assigned behavioral health positions were unfilled; in some locations, more than half of the behavioral health positions were unfilled. *Actions are treatment oriented.*
4. **Surveillance, research, and evaluation.** This pillar is focused on the importance of continual efforts to collect and analyze data to inform future decision-making. *Actions are preventative in nature.*[42]

To have a fighting chance to turn the tide in the military's fight against the crisis of mental illness, the Army must employ evidenced-informed prevention practices rather than relying solely on treatment tactics. The historically accepted concept of treat as the need arises has done nothing but overwhelm the current military healthcare system. While the military seems to be dabbling in physical health prevention practices (with the H2F program), the military mental healthcare system continues to chase its tail, tirelessly putting out fires after the point of injury. While the Army will never be able to prevent all injury, increasing focus and efforts in the realm of wellness have proven to lessen the burden on healthcare systems. Evidence demonstrates that prevention programs that yield even small changes in prevalence risk factors related to chronic disease are likely to lead to significant reduction in the burden of chronic disease for communities, individuals, and the healthcare system.[43]

We have laid out the data behind the need to shift to a wellness and prevention mindset, but the question that remains is how do we apply this knowledge in an impactful and actionable manner that will produce sustainable programs resulting in increased mental health readiness (wellness) across the force? In response to this inquiry, the SPRIRC offers the following charge:

> Many SPRIRC recommendations are similar or even duplicative of recommendations made previously by multiple other independent reviewers. To that end, one conclusion of the SPRIRC is that persistently elevated suicide rates in the DoD result in no small part to the DoD's limited responsiveness to multiple recommendations that have been repeatedly raised by independent reviewers and its own experts.[44]

The estimated cost of the SPRIRC for "the Department of Defense is approximately $2,412,000 in Fiscal Years 2022-2023. This includes $978,000 in expenses and $1,434,000 in DoD labor."[45] Imagine what type of programs the DOD could implement with this money rather than conducting yet another study to sit on the shelf and collect dust. Knowledge is power only if we translate this knowledge to actionable practices with proven results.

Proposed Actions

We propose the following actions be considered in transforming to a winning, wellness model for military mental health.

This prevention effort must be a U.S. Army Training and Doctrine Command (TRADOC) and FORSCOM mission that is not farmed out to U.S. Army Medical Command (MEDCOM). MEDCOM cannot meet the need for treatment, let alone the addition of prevention services. The SPRIRC found a demand-supply imbalance within military mental health that has resulted in long wait times for service members hoping to initiate behavioral healthcare and even longer gaps between scheduled appointments. Mental health appointments are considered specialty care appointments, thus the acceptable wait time for an initial appointment is twenty-eight days. However, some installations meet this expectation with a work around by utilizing "walk-in" or same-day visits. After an initial behavioral health appointment, follow-up appointments cannot be scheduled as frequently as needed. At many installations, for instance, psychotherapy appointments are available only every four to six weeks instead of every one to two weeks.[46]

At its current staffing and resourcing level, MEDCOM is failing to meet access to care and evidenced-based treatment standards; adding the additional burden of prevention efforts is unrealistic. Additionally, a strong argument can be made that this burden of treatment within MEDCOM's embedded behavioral health clinics. This would be a true distinction and shift directing MEDCOM mental health assets to own the treatment arm in its entirety and for FORSCOM BHOs to spearhead prevention efforts.

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proposed, prevention first, effort directly aligns with the Defense Health Agency "targeted care" mental health initiative by allowing FORSCOM behavioral health assets to "vector" soldiers to the right care at the right time.[47]

If we hope to change the culture, from day one, we must build our new recruits with wellness and resiliency in mind. TRADOC must have built-in psychoeducation and training with wellness and resiliency at the forefront of the curriculum. FM 7-22 upholds this value in asserting that "the fifth H2F element, leader education, describes H2F education that Soldiers receive across their career."[48] Soldiers and their leaders must understand the foundations, standards, and rationale for the H2F system from the beginning and throughout their careers. The H2F doctrine further states that holistic health and fitness should be delivered through every step of professional military education.[49]

Finally, we argue that FORSCOM is most directly impacted by readiness issues; therefore, the Army must find a way to address this issue within their own backyards. Let MEDCOM focus on the treatment aspect (post-injury). To prevail, FORSCOM must lead the charge in prevention. The question which follows is then, who is best suited to begin to address mental health prevention efforts within FORSCOM formations? We assert there is no one more qualified than active-duty behavioral health teams (consisting of two behavioral health officers [BHOs] and at least one 68X [behavioral health technician] per brigade). This argument comes with one large caveat: for such transformation to be successful, BHOs and 68Xs must strictly focus on prevention efforts within their assigned brigade and be relieved of the longstanding

This realignment additionally calls for examination of BHO manning across FORSCOM.

Prevention efforts must be evidence-informed, standardized, and fully resourced across the force with the ability for continued research and evolution. Utilize the SPRIRC and FM 7-22 as founding documents to build standardized prevention efforts.

- Create positions at corps and division levels to lead this transformation. Emphasis must be placed at the corps level to ensure compliance and traction for such a large-scale, systemic change.
- Rather than funding another research or committee inquiry, budget funding for prevention and shift active-duty mental health resources directly to FORSCOM, to begin actionable work toward prevention efforts.
- Continue funding and focus on research efforts related to psychological flexibility and resiliency.
- Research teams and assigned prevention/wellness coordinators (proposed as BHOs) must have regular collaboration.
- Wellness coordinators must work hand-in hand not only with local command but also with already-fielded H2F teams.

Systemically we must begin to incentivize wellness over sickness. In our opinion, this maybe the most difficult challenge to address. How can we further incentivize wellness?

Civilian health insurance wellness programs offer wellness newsletters, discounts on renewal premiums, wellness coaching, deposits into health savings accounts, and access to apps and wearable device programs. While studies to evaluate the use of financial incentives to change civilian employees' wellness

behaviors are inconclusive; overall, wellness programs have demonstrated a reduction in healthcare expenditure as individuals maintain their overall well-being.[50] Per the American Heart Association, "life-style elements such as healthy weight, regular physical exercise, balanced diet, not smoking, and alcohol avoidance extend lifespan more than 12 years for males and 14 years for females."[51] Additionally, these healthy life choices also "reduce the expenditure on medicines, hospitalization, and other therapies."[52] So, how do we adapt these very specific civilian practices to the military?

- Reduce the cost of healthy food at dining facilities and commissaries.
- Further pursue providing wearable devices as part of wellness program participation.
- Mandatory physical training will never be replaced, but what if we offered an incentive to get soldiers to utilize on-post gym facilities?
- More long-term thinking: is there a way to offer an incentive along the lines of a health savings account or discount in retiree Tricare premiums?

A research brief produced by the RAND Corporation in 2015 reviewed incentives for workplace wellness programs with the following conclusion:

> While incentives seem to be effective at increasing programs uptake, they are not a panacea. Offering a rich, well-designed program is almost as effective at boosting employee participation rates as incentivizing employees to join more-limited ones.[53]

Theoretically, all it may take to incentivize wellness is to build a state-of-the-art program, but we must have support (funding, resourcing, and allocations) from the top to do so.

In the realm of military mental health, the Army is currently losing the war on readiness. The military can either continue to blame the current generation for shortfalls or it can act in the face of adversity by executing a necessary paradigm shift to a prevention and wellness mission. The Army cannot simply sit on its hands and wait for programs such as H2F to be fielded across the force. While H2F statistics are promising, the Army cannot not ignore the need for a systemic change in how it understands and addresses readiness (wellness) as it relates to mental health. The culture must change to one where mental wellness and prevention services are seen as a sign of discipline, resulting in strength and resilience. Furthermore, to ensure the Army wins future wars, it must allow behavioral health officers to directly impact the readiness of its assigned units prior to soldiers sustaining mental injuries.

To anyone who may challenge that the military is America's fighting force and should not be in the business of people's well-being, we offer the following words: "The greatest asset of the United States Army aren't our tanks or our helicopters or our sophisticated weapon systems. They are our people. You are what make ours the best and most powerful military in the world."[54] The military institution can succeed only when its people thrive. "It is for people that warriors go to war, and for people, they return."[55] In our current climate, loyalty is won or lost in how we care for our most valuable asset: people. It is feasible to positively shift the military mental health culture while serving the mission, and we must do both.[56] Through examination of the data and wisdom of those who have come before us, we can only draw but one conclusion, we must invest in the well-being of our people, above all else. ■

Notes

1. Corie Weathers, *Military Culture Shift: The Impact of War, Money, and Generational Perspective on Morale, Retention, and Leadership* (Elva Resa Publishing, 2023), 5.
2. Thomas Brading, "Holistic Health Added to Army Fitness Doctrine," Army.mil, 30 September 2020, https://www.army.mil/article/239475/holistic_health_added_to_army_fitness_doctrine.
3. Kimberly Hepner et al., "Readiness of Soldiers and Adult Family Members Who Receive Behavioral Health Care, Identifying Promising Outcome Metrics," *RAND Health Quarterly* 9, no. 3 (2022): 19, https://www.rand.org/pubs/periodicals/health-quarterly/issues/v9/n3/19.html.
4. Office of the Under Secretary of Defense, *Report on Incidence of Military Suicides by Military Job Code: Report to the Committees on Armed Services of the Senate and the House of Representatives* (Office of the Under Secretary of Defense, July 2024), https://www.king.senate.gov/imo/media/doc/suicide_report_by_job_code_73024.pdf.
5. Ibid., 8.
6. Alicia Nortje et al., *17 Positive Psychology Exercises* (Positive Psychology Program B.V., n.d.), 4.
7. Ibid., 4.
8. Ibid., 5–8.

9. Peter L. Berridge, "From Coach to Positive Psychology Coach" (master's thesis, University of Pennsylvania, 2011), 11, http://repository.upenn.edu/mapp_capstone/19.
10. Nortje et al., *17 Positive Psychology Exercises*, 10.
11. "What Is Wellness?," Pfizer, accessed 18 December 2024, https://www.pfizer.com/health-wellness/wellness/what-is-wellness.
12. "NWI's Six Dimensions of Wellness," National Wellness Institute (NWI), accessed 18 December 2024, https://nationalwellness.org/resources/six-dimensions-of-wellness/.
13. Craig J. Bryan et al., "Happiness, Meaning in Life, and PTSD Symptoms Among National Guard Personnel: A Multilevel Analysis," *Journal of Happiness Studies* 21 (2020): 1251–64, https://doi.org/10.1007/s10902-019-00129-3.
14. Bradley C. Nindl et. al., "Perspectives on Resilience for Military Readiness and Preparedness: Report of an International Military Physiology Roundtable," *Journal of Science and Medicine in Sport* 21, no. 11 (2018): 1116–24, https://doi.org/10.1016/j.jsams.2018.05.005.
15. Ibid., 1116.
16. Monica Ruiz-Casares et al., "Cultural Roots of Well-Being and Resilience in Child Mental Health," *Handbook of Child Well-Being: Theories, Methods, and Policies in Global Perspective*, ed. Asher Ben-Arieh et al. (Springer, 2014), 2379–407, https://doi.org/10.1007/978-90-481-9063-8_9.
17. Nindl et al., "Perspectives on Resilience for Military Readiness and Preparedness," 1120.
18. Ibid.
19. Ibid., 1121.
20. Ibid., 1116.
21. Ibid.
22. Ibid., 1122.
23. Ibid., 1121.
24. Field Manual (FM) 7-22, *Holistic Health and Fitness* (U.S. Government Publishing Office, October 2020).
25. Ibid., xiii.
26. Brading, "Holistic Health Added to Army Fitness Doctrine."
27. Todd South, "Early Data Shows 37% Suicide Decrease in Units with Holistic Health," *Army Times*, 26 April 2023, https://www.armytimes.com/news/your-army/2023/04/26/early-data-shows-37-suicide-decrease-in-units-with-holistic-health/.
28. Ibid.
29. Ibid.
30. FM 7-22, *Holistic Health and Fitness*, xiii.
31. Ibid., xiv.
32. Ibid.
33. South, "Early Data Shows 37% Suicide Decrease in Units with Holistic Health."
34. Ibid.
35. Ibid.
36. Suicide Prevention and Response Independent Review Committee (SPRIRC), *Preventing Suicide in the U.S. Military: Recommendations from the Suicide Prevention and Response Independent Review Committee* (SPRIRC, 4 January 2023), 6, https://media.defense.gov/2023/Feb/24/2003167430/-1/-1/0/SPRIRC-final-report.pdf.
37. Ibid., 21.
38. Ibid., 22.
39. Ibid., 22–23.
40. Weathers, *Military Culture Shift*, 4.
41. SPRIRC, *Preventing Suicide in the U.S. Military*, 23.
42. Ibid., 23–24.
43. Paul Crosland et al., "The Value of Prevention: An Evidence Review Brokered by the Sax Institute for the Centre for Population Health," Australian Prevention Partnership Centre, 4 June 2021, https://preventioncentre.org.au/resources/the-value-of-prevention/.
44. SPRIRC, *Preventing Suicide in the U.S. Military*, 20.
45. Ibid., 1.
46. Ibid., 22.
47. Christopher McCoy, "Targeted Care Pilot Aims to Match Demand for Mental Health Care," Health.mil, 17 May 2023, https://www.health.mil/News/Dvids-Articles/2023/05/17/news444960.
48. FM 7-22, *Holistic Health and Fitness*, xv.
40. Ibid.
50. Mandyam Rangayyan Roopashree and Dixita Kapadia, "Study on Wellness Programs Offered by the Health Insurance Companies," *International Journal of Preventative Medicine and Health* 4, no. 4 (2024): 6–11, http://doi.org/10.54105/ijpmh.C1043.04040524.
51. Ibid., 8.
52. Ibid.
53. Soeren Mattke et al., "Incentives for Workplace Wellness Programs" (RAND Corporation, 11 May 2015), https://www.rand.org/pubs/research_briefs/RB9842.html.
54. David Vergun, "Austin Says 'Soldiers Army's Greatest Asset,'" Army.mil, 12 March 2013, https://www.army.mil/article/89816/austin_says_soldiers_armys_greatest_asset.
55. Weathers, *Military Culture Shift*, 10.
56. Ibid., 15.

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