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Metacognitive Therapy as an Acceptability Bridge for Military Mental Health: A Prevention-Oriented Framework

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ABSTRACT

Military psychological support systems provide multiple pathways to care; however, a stable use gap persists at subclinical levels where performance is at risk but specialty thresholds are not met. This study proposes a performance-congruent, metacognitively framed approach that targets information-processing patterns—perseveration, threat monitoring, and inflexible control—rather than disorder labels. Grounded in the self-regulatory executive function (S-REF) model and metacognitive therapy (MCT), this paper argues that brief, skill-based elements can be embedded within existing training without creating diagnostic pathways. The proposal emphasizes two levels of prevention. At the universal level, concise literacy on the cognitive–attentional syndrome and micropractice of attentional shifting and detached responding can be delivered in short blocks and reinforced through task-tied prompts. At the selective/indicated level, S-REF-informed formulation, disengagement practice, and metacognitive belief testing are applied in small-group labs or brief individual sessions to reduce cognitive–attentional loops that degrade daily performance. Design principles include role-congruent framing, minimal transaction costs, clarity of confidentiality, modularity, and contextualization to mission tasks. This paper outlines boundary conditions and pragmatic evaluation directions, acknowledging that uptake will vary with culture and tempo and that some presentations require case-formulated protocols beyond preventive microdrills. If implemented with these constraints—short, embedded, S-REF-consistent, and paired with clear referral options—metacognitively framed elements offer a feasible route to narrowing the acceptability gap for subclinical personnel while complementing existing clinical services.

Keywords: Attentional control, detached mindfulness, metacognitive therapy, military, prevention, S-REF.

ÖZ

Askeri Ruh Sağlığında Kabul Edilebilirlik Köprüsü Olarak Metakognitif Terapi: Önlemeye Yönelik Bir Çerçeve

Askeri psikolojik destek sistemleri bakıma erişim için birden çok yol sunar; ancak performansın risk altında olduğu fakat uzman hizmet eşiklerinin karşılanmadığı subklinik düzeylerde istikrarlı bir yararlanma açığı sürmektedir. Bu makale, bozukluk etiketleri yerine yineleme (perseverasyon), tehdit izleme ve esnek olmayan kontrol gibi bilgi işleme örüntülerini hedefleyen, metakognitif çerçeveli ve performansla uyumlu bir yaklaşım önermektedir. Öz Düzenleyici Yürütücü İşlev (S-REF) modeli ve metakognitif terapiye dayalı olarak, kısa ve beceri odaklı unsurların tanısal bir yol oluşturulmadan mevcut eğitimlerin içine gömülebileceğini savunur. Öneri iki önleme düzeyini vurgulamaktadır. Evrensel düzeyde, bilişsel-dikkatsel sendrom hakkında kısa bir okuryazarlık ile dikkat kaydırma ve ayrışmış tepki verme (detached responding) mikro uygulamaları kısa bloklar halinde sunulabilir ve göreve bağlı ipuçlarıyla pekiştirilebilir. Seçici/gösterilmiş düzeyde, küçük grup çalışmaları veya kısa

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bire bir oturumlar; günlük performansı bozan bilişsel-dikkatsel döngüleri azaltmak için S-REF temelli formülasyon, ayrışma (disengagement) uygulaması ve metakognitif inanç testini kullanır. Tasarım ilkeleri; rolle uyumlu çerçeveleme, asgari işlem maliyeti, gizlilik konusunda açıklık, modülerlik ve görev/mission görevlerine göre bağlamsallaştırmayı içerir. Ayrıca, benimsenmenin kültür ve tempo ile değişeceğini ve bazı başvuruların önleyici mikro alıştırmaların ötesinde olguya göre formüle edilmiş protokoller gerektireceğini kabul ederek, sınır koşullarını ve pragmatik değerlendirme yönlerini ortaya koyar. Bu sınırlılıklar altında -kısa, gömülü, S-REF ile tutarlı ve açık sevk seçenekleriyle eşleştirilmiş biçimde- uygulandığında, metakognitif çerçeveli unsurlar mevcut klinik hizmetleri tamamlayarak subklinik personel için kabul edilebilirlik açığını daraltmada uygulanabilir bir yol sunar.

Anahtar Kelimeler: Dikkat kontrolü, tarafsız farkındalık, metabilişsel terapi, askeriye, önleme, öz düzenleyici yürütücü işlev modeli.

INTRODUCTION

Armed forces continue to report substantial mental health burdens, including patterns that do not meet diagnostic thresholds yet impair readiness, operational performance, and interpersonal functioning (Hoge et al., 2004). Most services appropriately prioritize clinical treatment for diagnosed disorders, but this focus can leave a large middle range of personnel without timely, acceptable options. Mild-to-moderate strain may persist for months, eroding sleep, concentration, decision quality, and social functioning while remaining outside referral criteria or being normalized as "part of the job." A prevention gap follows: organizations need early, low-burden support that complements clinical services rather than competing with them and can be embedded in routine settings.

Acceptability is the central constraint. Even when services are available, personnel may avoid formal pathways because they expect career harm, confidentiality risks, or social judgment. These pressures reflect local incentives, unit norms, and the opportunity costs of seeking help under operational tempo. Therefore, a prevention-oriented design needs to ask not only what is effective but also what can be adopted, practiced repeatedly, and sustained in environments where strain is generated.

Stigma-reduction efforts are ethically and clinically justified. Service members frequently report perceived career harm, confidentiality concerns, and practical barriers as reasons for avoiding formal mental health care in military settings (Hoge et al., 2004). Negative attitudes about treatment and stigma-related concerns are also linked to lower use of services (Kim et al., 2011). The literature further describes stigma as a persistent barrier to help-seeking (Sharp et al., 2015). Beliefs about readiness and self-reliance can make diagnostic treatment pathways feel incongruent with the role of some personnel (Greene-Shortridge et al., 2007). Beliefs about mental health care can function as an additional barrier to military personnel and veterans' use of services (Vogt, 2011). This review argues that prevention-oriented and role-congruent routes can complement stigma reduction by reducing the need to adopt diagnostic labels or enter formal clinical pathways at an early stage.

The proposed route frames mental health as adaptive information processing under operational demands. This emphasis follows an information-processing account of emotional disorder in which sustained internal threat focus and perseverative thinking maintain distress (Wells & Matthews, 1996). Instead of beginning with diagnostic categories, the framing begins with processes that personnel already recognize as performance-relevant: attention allocation, threat monitoring, worry and rumination, sleep-related arousal, and flexibility of coping choices. Psychological support can then be offered as skills training in processing style—how attention is directed, how internal experiences are related to, and how coping routines are selected and revised—using neutral, non-diagnostic language that preserves the individual's professional self-concept.

Metacognitive therapy (MCT) is a brief, evidence-based approach designed to reduce persistent distress by changing how people relate to their internal experiences and how they allocate attention (Wells, 2009). It is grounded in the self-regulating executive function (S-REF) model and targets the cognitive attentional syndrome (CAS): a pattern of worry/rumination, threat monitoring, and maladaptive coping strategies that maintain distress (Wells & Matthews, 1996). The MCT logic can be adapted for prevention by focusing on proximal process targets and using non-diagnostic language while remaining consistent with evidence-based psychological principles.

Accordingly, this review proposes an MCT-informed framework for military psychological support across primary and secondary prevention. This paper (i) summarizes the practical barriers that shape utilization and acceptability, (ii) outlines the S-REF/MCT constructs most relevant to military contexts, and (iii) presents an implementation blueprint with evaluation anchors that can be integrated into existing support systems. The aim of this study is not to medicalize transient strain but to provide structured support for regulating attention and processing routines that otherwise accumulate into persistent impairment. In doing so, the paper offers a bridge between clinical evidence and real-world delivery constraints in military organizations.

The remainder of this paper reviews the current landscape and barriers in military psychological services, summarizes the S-REF/MCT model and relevant evidence, and proposes a high-level implementation design for prevention-focused delivery. This study concludes with limitations and priorities for future work.

Current Landscape and Barriers in Psychological Services for Military Personnel

Service Pathways and Their Utilization

Most military organizations maintain tiered psychological support spanning unit-level and peer support, primary care, and specialist mental health pathways; however, service use is often lower than predicted. In the United Kingdom, for example, a systematic review of veteran help-seeking identified barriers such as military cultural norms (e.g., stoicism and self-reliance), stigma, and practical difficulties in navigating or accessing services (Randles & Finnegan, 2022). This mismatch between need and uptake is particularly relevant for prevention-oriented approaches like MCT because subclinical difficulties can persist without crossing thresholds that trigger formal referral.

Career, Confidentiality, and Stigma

Military organizations must balance a legitimate interest in deployability and risk management with the expectation of privacy. In practice, this balance is experienced through documentation requirements, fit-for-duty decision points, and the perceived permeability of medical information across the chain of command. Even when formal policies support confidentiality, personnel may anticipate career costs or unwanted visibility and therefore delay engagement until impairment is difficult to conceal or thresholds for referral are crossed (Bogaers et al., 2020).

Stigma-reduction initiatives remain ethically and clinically important but may be insufficient when avoidance is anchored in soldier identity and professional values, such as reliability, self-control, and readiness (Greene-Shortridge et al., 2007). Stigma has also been consistently described as a barrier to seeking care among personnel with mental health problems (Sharp et al., 2015). If support is framed primarily through psychiatric labels, some personnel may interpret help-seeking as adopting a "patient" role that conflicts with that identity. Therefore, this review emphasizes an additional route that can be offered in parallel: skills training framed as performance-sustaining mental readiness, with clear pathways for referral when impairment or risk is detected.

Subclinical Presentations and the Gaps in Prevention

Subclinical patterns, such as worry, sleep disruption, irritability, and attentional drift, can significantly degrade coordination and decision quality while remaining below diagnostic thresholds. Because these difficulties are often interpreted as "normal stress" or a personal discipline issue, they may persist for months without triggering formal pathways. Therefore, prevention-oriented support is most valuable when it is low-burden, available early, and aligned with how personnel make sense of strain in daily work.

Capacity versus Acceptability: A Practical Distinction

From a systems perspective, mild-to-moderate difficulties can remain untreated because the pathway is difficult to access or does not fit the user's situation. A patient-centered access framework highlights how approachability, acceptability, and appropriateness emerge at the service design and population needs interface (Levesque et al., 2013). Implementation outcomes such as reach, acceptability, fidelity, and sustainability should be tracked alongside clinical outcomes for prevention-oriented delivery so that scale-up decisions are based on both effectiveness and feasibility (Proctor et al., 2011).

Decision Dynamics under Operational Constraints

Barriers are not solely attitudinal; help-seeking unfolds as a behavioral chain. Personnel repeatedly decide whether to notice a problem, whether to name it a support issue, who to approach, and how much to disclose. Each step is shaped by immediate contingencies (time pressure, peer norms) and anticipated consequences (career impact, visibility) (Hoge et al., 2004). The availability of low-stakes entry points and trusted intermediaries can alter these choices by lowering the initial engagement cost (Bogaers et al., 2020). This decision structure implies that prevention delivery should minimize high-cost thresholds and offer practice-based skill modules that can be accessed without committing to a clinical identity.

These barriers point to the need for brief, low-disclosure interventions that target processing style (e.g., attention allocation and responses to internal events) and can be

practiced without adopting a clinical identity. The next section introduces the S-REF model and MCT as a candidate framework for this purpose.

S-REF and MCT: Theory, Evidence, and Military Fit

S-REF/CAS: Core Constructs

The S-REF model explains how patterns of appraisal, attention, and coping can maintain emotional disorder. In this account, executive control processes shape how attention is allocated (for example, toward threat signals or internal states) and how coping strategies are selected. When coping is dominated by negative thinking and monitoring, distress can persist even when external stressors remain (Wells & Matthews, 1994, 1996).

Metacognitive Beliefs and CAS Loop

Metacognitive beliefs organize and sustain the CAS within the S-REF model. Positive metacognitive beliefs (e.g., "worry keeps me prepared") can legitimize perseveration under uncertainty, whereas negative beliefs (e.g., "once it starts, I cannot stop" or "my worry is dangerous") increase perceived threat and urgency, further fueling monitoring and rumination (Wells & Matthews, 1996). These belief patterns are measurable and have been operationalized in instruments such as the MCQ-30 (Wells & Cartwright-Hatton, 2004).

Methods of MCT: Attentional Control and Detached Mindfulness

MCT translates the S-REF principles into procedures that target metacognitive beliefs and attentional control. Rather than restructuring the content of thoughts, MCT aims to reduce the CAS by changing the thinking style and its relationship to internal events (Wells, 2009). In practice, this involves testing beliefs about the usefulness and uncontrollability of worry/rumination, reducing threat monitoring, and restoring flexible control over attentional placement (Wells & Matthews, 1996).

Mechanisms of Change and Micro-Intervention

MCT procedures are supported by a structured, time-limited dialogue that targets metacognitive beliefs that sustain the CAS. The facilitator helps personnel test positive beliefs about worry and rumination (e.g., "it keeps me prepared") and negative beliefs about uncontrollability or danger (e.g., "once it starts, I cannot stop"). The aim is to reduce perseveration and threat monitoring by shifting to deliberate attentional control and detached mindfulness rather than to disputing the content of thoughts (Wells, 2009). This logic can be expressed as short prompts and brief practice in prevention-oriented delivery: notice the trigger, label the process, redirect attention, and postpone extended worry or rumination.

Evidence Base and Military Fit

Controlled trials and meta-analyses have suggested that MCT produces large reductions in anxiety and depressive symptoms across disorders (Normann & Morina, 2018). A review of recent advances similarly concludes that MCT compares well with other evidence-supported approaches in the current literature (McEvoy, 2019). Randomized evidence is available for generalized anxiety disorder (van der Heiden et al., 2012) and post-traumatic stress disorder (Wells & Colbear, 2012).

Component research also aligns with the S-REF emphasis on attentional control. A laboratory-based study reported that the attention training technique (ATT) reduced self-focused attention and anxiety outcomes (Fergus et al., 2014). A randomized trial comparing ATT with an alternative compassion-focused intervention also reported symptom improvements in a sample of students (Haukaas et al., 2018).

Military operations routinely involve sleep restriction, sustained vigilance, uncertainty, and acute stressors that degrade attention and executive control—capabilities required for situational awareness and rapid decision-making (Belenky et al., 2003). Field research shows that overnight military training with sleep loss can impair sustained alertness and monitoring on tasks relevant to safety-critical work (Passi et al., 2022). Laboratory protocols of simulated military operational stress produce measurable declines in serving personnel's tactical adaptive decision-making and vigilance (Sekel et al., 2023). Rapid reviews further emphasize the need to monitor and protect the cognitive function of warfighters in high-stress environments to preserve mission-critical information processing (Main et al., 2023).

Concepts such as cognitive resilience and cognitive readiness are increasingly used to describe the demands of information processing in modern operations. A recent review synthesized evidence and mechanisms for military personnel's cognitive resilience to psychological stress and highlighted modifiable targets for training and prevention (Flood et al., 2022). A theoretical model of military cognitive readiness distinguishes readiness demands at operational and strategic levels and supports the development of measurement for complex decision contexts (Grier, 2012). The U.S. Army doctrine also embeds cognitive performance and mental readiness within broader readiness systems (Department of the Army, 2020). Supporting materials for Holistic Health and Fitness describe unit-level mental readiness coaching and structured skills practice as part of performance optimization (Department of the Army, 2023).

These military findings are compatible with the S-REF account of how prolonged threat monitoring and perseverative thinking

Table 1. The core elements of an MCT-informed prevention program for primary and secondary prevention

Element	Primary prevention (universal)	Secondary prevention (selective or indicated)	Process target (S-REF/CAS)
Information-processing primer	10–15 min module in routine training; non-diagnostic language; links to readiness.	Brief recap at entry: tailored examples based on role demands.	Normalizes attention limits and introduces CAS as a maintainable loop.
CAS recognition and labeling	Simple checklist: worry/rumination, threat monitoring, and unhelpful coping; taught as performance drains.	Individual or small-group mapping of CAS patterns and triggers.	Improves perseveration detection and monitoring under load.
Attention flexibility practice	1–3 min drills (ATT-style shifting) embedded in a warm-up or debrief; repeated weekly.	Guided practice with feedback and troubleshooting barriers to practice.	Deliberate attentional control is restored and internal threat focus is reduced.
Detached responding skills	Short prompts: notice–label–redirect; postpone extended worry/rumination.	Structured experiments on uncontrollability/usefulness beliefs and individualized DM practice.	Weakens the metacognitive drivers of perseveration and monitoring.
Cues and habit support	Unit-level cues (brief audio/text prompts) during routine windows (opt-in).	Personalized cues linked to high-demand periods and relapse prevention plan.	Increases repetition and generalization without additional disclosure.
Low-burden indicators	Weekly self-rating: time spent worrying/ruminating, perceived attentional control, and sleep quality.	Same indicators + brief functional check (concentration lapses and decision delays).	Tracks proximal change and supports iterative adjustment.
Escalation pathway	Clear clinical pathway signposting; safety exceptions stated up front.	Rapid referral when impairment/risk is detected and warm handoff procedures.	Preserves ethical boundaries and prevents misclassification of clinical need.

MCT: Metacognitive therapy; S-REF: Self-regulatory executive function; CAS: Cognitive attentional syndrome.

can dominate attention under stress and reduce flexible, goal-directed control (Wells & Matthews, 1996). MCT offers a concise, process-focused route to address these loops by training attentional flexibility, changing metacognitive beliefs, and reducing extended worry and rumination. These elements can be practiced with minimal symptom-focused disclosure and without positioning personnel as patients when delivered as prevention-oriented skills training. Therefore, an MCT-informed approach is a plausible complement to existing readiness programs, while specialist clinical care remains available when diagnosable disorders and functional impairment are present.

High-Level Implementation of Primary and Secondary Prevention

Aims, Scope, and Core Principles

This section outlines a pragmatic framework for embedding S-REF/MCT-derived elements in routine activities at the primary (universal) and secondary (selective/indicated) prevention levels. This study aims to strengthen control over attentional allocation and thinking style—the core information-processing variables in S-REF (Wells & Matthews, 1996)—while avoiding the medicalization of routine strain and unnecessary movement into clinical pathways.

A shared mental health literacy module can support this aim by teaching mental health as an information-processing problem under load: how attention is captured, how internal threat signals are monitored, and how worry or rumination consumes limited control resources. This framing is consistent with the military focus on cognitive performance and readiness, where operational priorities are vigilance, fatigue management, and decision quality (Department of the Army, 2020; Main et al., 2023). Therefore, the prevention package begins with a brief information-processing primer and then provides small, repeatable cues during routine training.

Table 1 summarizes the core program elements proposed for primary and secondary prevention. The table is intended as a design aid: it specifies process targets (CAS

components), delivery formats, and low-burden indicators that can be embedded in existing training cycles without expanding clinical throughput.

Table 1 summarizes each element as a low-disclosure skills component that can be embedded in routine training. The underlying logic is to treat distress-relevant patterns as information-processing vulnerabilities under load and strengthen attention control and coping flexibility in ways that support readiness and decision quality (Department of the Army, 2020; Main et al., 2023).

The information-processing primer links mental health to operationally familiar constraints: limited attentional resources, fatigue effects, vigilance demands, and decision quality. Sleep restriction and sustained operations reliably degrade alertness and executive control (Belenky et al., 2003), and field studies have shown that night training with sleep loss can impair sustained vigilance and monitoring on safety-relevant tasks (Passi et al., 2022). In this frame, CAS labels (worry/rumination, threat monitoring, and unhelpful coping) are introduced as practical detection tools rather than diagnostic categories, especially under high workload and uncertainty, where perseveration and monitoring can compete with situational awareness and adaptive decision-making (Sekel et al., 2023).

Short attention-flexibility drills are included because attention allocation is a central operational requirement, and fatigue and operational stressors reduce sustained attention and monitoring performance (Belenky et al., 2003; Passi et al., 2022). Detached responding skills (e.g., notice–label–redirect routines and worry postponement) are framed as methods to recover goal-directed control when internal threat processing is escalated under uncertainty. This aligns with the broader emphasis on cognitive resilience and readiness as modifiable targets in military populations (Flood et al., 2022; Department of the Army, 2020).

Implementation relies on cues, habit supports, and low-burden proximal indicators to sustain repetition in real settings. When doctrine endorses mental readiness coaching and structured practice, the package can align with existing delivery roles and rhythms (Department of the Army, 2023). Finally, a clear escalation pathway protects ethical boundaries and prevents undertreatment. Given that perceived career harm and confidentiality concerns can delay engagement, escalation criteria and limits of confidentiality should be stated up front (Hoge et al., 2004; Vogt, 2011).

Interventions should be brief, repeatable, and aligned with unit rhythms to make practice routine rather than exceptional. Delivery should use neutral, non-diagnostic language and require minimal disclosure. Routine records should only capture completion and fidelity indicators, not clinical content, to prevent reclassification as medical data. The package is designed to complement, not replace, clinical pathways when higher-risk presentations are detected (Vogt, 2011).

The four practical principles guide the implementation. First, role congruence: language should emphasize sustaining operational performance and readiness rather than implying weakness or loss of status. Second, stepped access: entry points should allow confidential participation with clear options for escalation when risk or impairment is detected. Third, minimal disruption: delivery should be brief, modular, and compatible with training cycles. Fourth, measurement: outcomes should include both mental health indicators and operationally relevant behavioral markers (e.g., concentration lapses, decision delays, and help-seeking behavior). Perceived career harm and practical barriers to care have been repeatedly reported in combat-deployed and garrison populations (Hoge et al., 2004). Negative attitudes about treatment and stigma-related concerns are also linked to lower use of services (Kim et al., 2011). Beliefs about mental health care and role expectations can further reduce the willingness to engage with formal pathways (Vogt, 2011).

LIMITATIONS AND FUTURE DIRECTIONS

Evidence Base and Measurement Constraints

The evidence base for MCT is strongest in anxiety and depressive disorders in civilian samples, with an expanding literature in occupational settings. However, direct evidence in military populations remains limited, and heterogeneity across roles and units constrains generalizability. Aircrew, maintainers, and ground combat units differ in routines, exposure patterns, and acceptable help-seeking pathways; therefore, any claims about broad effectiveness should be treated as provisional until they are evaluated across contexts.

Although the proposed evaluation anchors are intentionally low-burden and performance-adjacent, the link between proximal change (e.g., reduced CAS-consistent worry/rumination or threat monitoring) and downstream operational outcomes is not guaranteed. Self-logged metrics (practice counts and brief ratings) are feasible at scale but vulnerable to expectancy effects and selective reporting. To strengthen inference, triangulation with independent indicators (brief behavioral tasks, supervisor-neutral performance markers, or passive usage logs with appropriate safeguards) is needed.

Implementation Risks and Ethical Safeguards

Brief skills packages are vulnerable to fidelity drift: units may compress, omit, or embellish procedures until they no longer resemble the intended intervention. To reduce this risk, delivery should be standardized (using short scripts and checklists), and facilitators should have minimal competency checks. Ethical boundaries should also be made explicit.

These modules are not a substitute for clinical assessment and treatment and should not be used as a fitness decision-making tool. Participation should be voluntary, confidentiality protections should be clear in advance, and referral routes for those who need formal care should be specified.

Evaluation, Reporting, and Scale-Up Priorities

Priority studies should test whether microinterventions reliably reduce CAS-consistent patterns (worry/rumination, threat monitoring, and unhelpful coping) under operational constraints and whether any benefits are generalizable beyond self-reporting. Designs feasible for unit settings (cluster randomization, stepped-wedge rollouts, or interrupted time series) can be used to track change over time.

Dose-response and durability also require testing. Trials should compare daily versus intermittent practice schedules, examine whether gains persist during high-demand periods, and identify the minimal effective dose.

Implementation research should proceed alongside effectiveness testing. Determinants of uptake, fidelity, and sustainment should be measured, and cultural/doctrinal adaptation (terminology, examples, and delivery roles) should be documented without diluting core mechanisms. Digital supports (e.g., brief audio prompts) may extend reach and support practice; however, they must be designed to protect confidentiality and avoid creating new monitoring pressures.

Pre-registration and transparent reporting are recommended to support cumulative learning, with a minimal data set defined in advance. Equity considerations should be explicit: access and benefit should be examined across roles and posting locations to avoid concentrating effects in already-resourced units.

CONCLUSION

Military organizations face a persistent gap between available psychological services and actual uptake when difficulties are subclinical, intermittent, or perceived as incompatible with soldier identity. Therefore, prevention-oriented support depends on acceptability and delivery constraints as much as on clinical efficacy.

This review argued that an identity-congruent frame—mental health as adaptive information processing under operational demands—can complement stigma reduction efforts by lowering disclosure and opportunity costs. S-REF and MCT provide a coherent set of constructs and procedures for targeting the CAS and maintaining metacognitive beliefs (Wells & Matthews, 1996). When translated into a prevention-oriented skills package, these elements can be delivered in ways that reduce the need for symptom-focused disclosure while maintaining clear pathways for clinical escalation when risk or impairment is detected.

The proposed blueprint emphasizes brief literacy, embedded micropractices in routine cue windows, clear ethical boundaries, and rapid pathways for referring personnel at elevated risk. The package is intended to be testable: future work should evaluate uptake, fidelity, proximal processing change, and downstream outcomes using designs that are feasible for unit settings.

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