

The American Institute of Stress

COMBAT STRESS

Harnessing Post-Traumatic Stress for Service Members, Veterans, and First Responders

Volume 8 Number 3

Fall 2019



Fort Hood Massacre Tenth Anniversary

Nothing has changed: Still Workplace Violence AND the Escalating Epidemic of Veteran Suicides.





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AIS provides a diverse and inclusive environment that fosters intellectual discovery, creates and transmits innovative knowledge, improves human health, and provides leadership to the world on stress related topics.

COMBAT STRESS

We value opinions of our readers.

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Combat Stress magazine is written with our military Service Members, Veterans, first responders, and their families in mind. We want all of our members and guests to find contentment in their lives by learning about stress management and finding what works best for each of them. Stress is unavoidable and comes in many shapes and sizes. It can even be considered a part of who we are. Being in a state of peaceful happiness may seem like a lofty goal but harnessing your stress in a positive way makes it obtainable. Serving in the military or being a police officer, firefighter or paramedic brings unique challenges and some extraordinarily bad days. The American Institute of Stress is dedicated to helping you, our Heroes and their families, cope with and heal your mind and body from the stress associated with your careers and sacrifices.

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The American Institute of Stress is a 501c3 non-profit organization, headquartered in Weatherford, Texas. We serve the global community through both online and in-person programs and classes. The Institute is dedicated to advancing understanding of the role of stress in health and illness, the nature and importance of mind/body relationships and how to use our vast innate potential for self-healing. Our paramount goal at the AIS is to provide a clearinghouse of stress related information to the general public, physicians, health professionals and lay individuals interested in exploring the multitudinous and varied effects of stress on our health and quality of life.

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Editor's Message

By Kathy Platoni, Psy.D., DAIPM, FAIS
COL (RET), U.S. Army, COL, Ohio Military Reserve/State Defense Forces



Our fall issue pays tribute to the countless victims of the Fort Hood Massacre on the **tenth anniversary of this national tragedy. It is devoted to the memory of the 13 lives so unnecessarily lost and the 33 Soldiers wounded, during the largest massacre on any military installation in the history of our nation. MAJ (RET) Alan Hopewell, with the assistance of LTC (RET) Michael Adams** in reviewing the facts and providing the many details of

the bona fide truth, have just composed one of the most compelling articles ever written about the massacre for this issue, chronicling the horrific events of that tragic day and taking the reader directly to the scene of this national tragedy. To further expose our readers to the travesties of justice surrounding this tragedy, our editor has included the latest of many letters to the President of the United States, requesting that the Fort Hood Massacre be reclassified as an act of domestic terrorism. This story will continue to unfold for decades to come, as the countless hidden truths are revealed.

In this very same endeavor, the catastrophic mass shooting that occurred on 4 August 2019 and that remains frozen in time for the entire Dayton, Ohio community, is recounted in photographs from the presidential visit in the days following to honor the heroes, the guardian angels of public safety of the **Dayton Police Department**.

This issue is also dedicated to the profoundly significant topic of Veteran suicides, which is likely to dominate many of our issues to come. Our greatest *Combat Stress* Magazine supporter and marketer to the masses, **Veteran Roland Van Deusen**, has generously included his North Country Public Radio interview to expose the magnitude, breadth and depth of the epidemic of Veteran suicides that has become a deadly plague upon this nation. In this endeavor,

Reverend John Thurman has expounded further on this exceedingly necessary topic to instruct our readers about suicide prevention and the role for which each of us must be far more responsible.

Also featured in our fall issue are a host of **notable and renowned authors** from many walks of the Veteran, Service Member, and mental health communities. Among them is returning Canadian author, **Dr. Louise Gaston**, who has contributed in enormous ways to the one-size-does-not-fit-all community of clinicians who believe and who practice that with respect to any psychological or mental health interventions, treatment absolutely must be tailored to the patient/client and not to just any government-imposed evidence-based practice paradigms and protocols.

Another national figure, **COL (RET) D.J. Reyes**, has very graciously contributed a most inspirational piece regarding his national movement for the establishment of Veterans Treatment Courts and Veteran mentorship initiatives so that no Veteran is left behind. His model for VTC's has taken hold, now reaching the eyes and ears of our elected officials and none too soon. According to COL Reyes, legislation was just passed in the House of Representatives last month to essentially federalize funding and policy in all 50 states for those Veterans who find themselves

involved in the criminal justice system, oftentimes because of service-connected or psychological conditions or disorders. The very bottom line is that VTC's are saving the very lives of Veterans.

Vietnam Veteran Charlie Grantham, has motivated thousands in his charge through his nationally recognized wellness movement and expertise within the healing arts. Accompany him on his hero's journey for an in depth and delightful immersion into finding and sustaining balance and harmony.

One of our newest members of our **Combat Stress Board**, **Dr. Josh Briley**, has just recently discovered the tremendous and unlimited virtues of cranial electrotherapy stimulation. His ability to put his newfound knowledge into words is purely brilliant and insightful, with tremendous utility for all of our clinicians trained to use the Alpha-Stim AID for the treatment of anxiety, insomnia, depression, pain, and PTSD.



Lastly and not at all least of all, **PsyberGuide Project Manager Martha Neary**, will both instruct and delight in her step-by-step approach to managing stress with the use of apps.

I personally wish to thank our authors for their magnificent contributions and our *Combat Stress* staff for their patience and very hard

labor to create what we believe to be a wonderful publication that has something for everyone, whether Service Member, Veteran, first responder, and/or the clinicians who treat these populations

Please disseminate and pass along our magazine to your colleagues, your co-workers, your fellow clinicians, Veterans, Service Members, and first responders. We are so very proud of our publication and given the significance of the topics covered, we would very much appreciate your assistance in promoting the messages we seek to circulate. We thank you for your willingness to do so.

The Fort Hood Massacre: Survivors' Story and the Hidden Truths

By C. Alan Hopewell, MP, PhD, ABPP, MAJ (RET) and Michael L. Adams, PhD, LTC (RET)

9/11

Those two numbers now continue to strike terror into the hearts of many Americans and are a chilling reminder to all. 9/11... 2606 people murdered in cold blood in the attack on the World Trade Towers. 125 were killed at the Pentagon, with the nose of that aircraft coming to rest only a few score yards short of smashing into the office of a Texas A&M classmate of MAJ Hopewell's. 265 more

were killed in a remote field in Pennsylvania and in the air itself, after the Capitol Building target of Flight 93 was thwarted, the remainder of this count being murdered aboard the other three aircraft. It was 2001. America was at war. Even radicals of extreme political views knew this and acknowledged this.

Soon after, recruiting for the Armed Forces reached an all time high, and our forces were taking the fight into Afghanistan. Somewhat amazing, however, is that a large number of these "recruits" were NOT young 20 year olds volunteering for the Infantry, but included a large number of military Veterans with prior service who were more than willing to serve their nation again in time of war. Another factor is that this War on Terror was to prove different in three critical ways. First, the "terrorist" nature of this war made it an asymmetrical one, such as had never before been seen or had not been seen since the Vietnam War. This was a war fought against opponents who wore no uniform, where age old secular and religious conflicts and animosities were often entangled with one another, and where dedicated war fighters often blended in with our citizenry (Nidal Hasan, the Boston bombers, etc.). Secondly, this would be a war of increasingly technical nature, with highly educated and technically skilled military personnel needed much more so than simple "bullet catching grunts." And thirdly, the use of

improvised explosive devices (IEDs) would result in higher casualty rates from traumatic brain injuries and devastating amputations, far more than all prior wars.

As a result, a very great many Veterans with prior service or even retired Veterans volunteered to return to active duty to join the War on Terror. Many of these had specialty knowledge and/ or specialty medical skills along with a great deal of military experience, making their knowledge and wisdom therefore invaluable. LTC Michael Adams and MAJ C. Alan Hopewell were two such Veterans.

As a background to the Nidal Hasan terror attack, both LTC Michael Adams and MAJ C. Alan Hopewell were highly experienced and seasoned Army Officers, both of whom had been assigned to the Army's MEDCOM for years during their prior service. LTC Adams had been trained at William Beaumont Army Medical Center at Fort Bliss, Texas or Dwight David Eisenhower Army Medical Center at Fort Gordon, Georgia and was an extremely well respected and seasoned clinical psychologist. Much of the respect for LTC Adams came from his prior experience as an Army psychologist, but also as a highly decorated Vietnam War Veteran, who knew the nature of post-traumatic stress disorder (PTSD) first hand in a way in which few current Army officers can. MAJ Hopewell had been one of the very first clinical neuropsychologists ever to serve in the



Memorial to the fallen, The Fort Hood Massacre, Killeen, TX.

Armed Forces, and had previously directed the Neuropsychological Laboratories at Fort Jackson, South Carolina, Landstuhl Army Regional Hospital in Germany, and Brooke Army Medical Center at Fort Sam Houston, Texas, before completing over 20 years of Army reserve duty. It turned out that MAJ Hopewell was destined to be the last Army psychologist to serve in Operation Iraqi Freedom, as by the time he left Iraq in May of 2008, Air Force and Navy psychologists were filling all combat stress slots, along with Army Social Work Officers. By this time, every available Army psychologist had been deployed, some more than once.

As the brain injury expert for the Army, MAJ/Dr. Hopewell also directed the largest outpatient psychiatric clinic in the world - the Resilience and Restoration Center at the Carl R. Darnall Army Medical Center, located at Fort Hood, Texas. While screening more than 7,000 Soldiers for brain injuries, he had also founded the Traumatic Brain Injury (TBI) Clinic under the guidance of Hospital Commander, BG Loree Sutton. LTC/Dr. Adams also had moved from his position as Director of Behavioral Health for the hospital to direct the new Triage Center of the Resilience and Restoration Center. With the help of the Deputy Commander of Clinical Services for Darnall AMC, MAJ Hopewell and the initial TBI team completed the justification matrix, which requested and then secured \$1.7 million dollars from the Office of the Surgeon General for the development of a formal treatment team.

Upon returning from his Operation Iraqi Freedom (OIF) tour, MAJ Hopewell was formally designated to be the Officer-in-Charge (OIC) of the Traumatic Brain Injury Clinic, which then moved to the new buildings and offices he had

secured. Although later news reports would almost exclusively focus on the Soldier Readiness Program (SRP,) in reality, the site on Battalion Avenue consisted of a complex of five buildings in total. Two buildings served as the Soldier Readiness Program and the Post-Deployment Health (PDHRA) sites; the former to prepare Soldiers for deployment and the latter to screen them upon return. The other three buildings were all "owned" by MAJ Hopewell as the OIC of the Brain Injury Building, to include the Rehabilitation Building, and the ANAM building for automated cognitive testing. It was in this setting that LTC Adams, OIC of the Triage Clinic for the Resilience and Restoration Center, and MAJ Hopewell were performing their usual duties on 5 November 2009.

The sun was shining brightly over the medical processing complex "quad" through the cool fall air that is so typical of Texas "football weather." Two officers were stationed at opposite ends of the approximately 75 yard long "quad." They acknowledged each other across what normally was a quiet stretch of lawn that was gradually being landscaped with grass, and which typically bustled with Soldiers and a few Army civilians processing the hundreds of Soldiers daily who were undergoing the medical testing and treatment that they supervised. However, this was not the normal acknowledgement of their usual friendly wave, which often include their third Officer-in-Charge, the senior nurse in charge of the Soldier Readiness (SRP) site. Both officers were stunned. One was transfixed; splattered in blood with a wounded terrorist brandishing both a Belgian FN-57 and a .357 magnum at his feet. Surrounded by wounded Soldiers and armed security officers, he was

the Officer-in-Charge (OIC) of the PDHRA (Post-Deployment Health Reassessment Program). For his actions in confronting Hasan directly, he was later awarded the Army's highest medal for noncombatant heroism, the Soldier's Medal. The other OIC was wearing his Kevlar helmet, having giving his body armor to a female civilian, and was directing a SWAT team in securing one of the buildings at the other end of the quad. This was the Officer-in-Charge of three of the five buildings in the complex, the Traumatic Brain Injury (TBI) Clinic, MAJ Steven J. Richter being in charge of (Post-Deployment Health Reassessment Program) and MAJ Leslie Parish, in charge of the SRP site.



The Fort Hood Massacre just after the shooting.

Between the two officers lay a field of bodies and blood, a swarm of "walking wounded" and frantic first responders helping the dying and injured, along with spent magazines and shattered windows. Then, when no one thought anything more unbelievable could occur, an even more implausible event took place. Several security officers ran from the west end of the quad and the PDHRA building through the bodies laying on the ground, through the first responders, and through the arriving media crews. They excitedly accosted the Major in the Kevlar helmet. Thrusting an official Department of the Army identification "CAC" card into his face, they began to yell:

"This guy is a psychiatrist! The PDHRA staff

told us he works for you. Is he your employee?"

MAJ Hopewell, the senior Officer in the complex and OIC of the TBI complex, was then the Officer who formally identified Hasan, who was lying near a telephone pole at the West end of the PDHRA building.

The "employee" in question was Nidal Malik

Hasan, now known to be a follower and devotee of Anwar al-Awlaki, the high ranking jihadist killed in Yemen, who also specialized in radicalizing English speaking terrorists. Hasan was not only a devotee of this terrorist, he would later openly write a letter joining the ISIS Caliphate in the Middle East,

which burned captives alive in cages and raped kidnapped Yazidi women, whom they sold as sex slaves. As a uniformed Army Officer and while attending medical school at the Uniformed Services University of the Health Sciences (USUHS) at U.S. taxpayer expense, Hasan had been a devotee at the Dar al-Hijrah Mosque in the Falls Church area of Virginia. Two of the September 11th hijackers (Nawaf al-Hazmi and Hani Hanjour) also attended this mosque. Additionally, Ahmed Omar Abu Ali (who was later convicted of providing material support to al-Qaeda and a conspiracy to assassinate President George W. Bush) attended this very same mosque. Anwar al-Awlaki was the mosque's

imam at the time. After fleeing the United States, Awlaki received as many as 20 e-mail messages from Hasan inquiring about jihad, also expressing a desire to meet him in Islam paradise as a martyr. Soon after the attack, Anwar al-Awlaki praised Hasan for the shooting, and encouraged other Muslims serving in the military to "follow in the footsteps of men like Nidal."

The Major in Kevlar being questioned was assigned to the Darnall Army Medical Center's Department of Medicine and directed the Traumatic Brain Injury (TBI) Clinic in the SRP (Soldier Readiness Processing) /TBI Complex. Major C. Alan Hopewell had just returned from a ten month deployment to Iraq, in which he had served as the Theater Consultant for TBI.

In addition to this, by virtue of additional degrees and training, he was the only clinical psychologist authorized to prescribe medications in the combat theater. He had just been awarded the Bronze Star Medal for both his work as TBI Consultant in the combat theater, as

well as writing over 2,000 prescriptions in Iraqi territory, ranging from Balad in the North to the infamous Mamadiyah in the South, where he himself had been involved in combat when the Sadar City Rebellion began. Ironically, Major Hopewell had prior first hand experience with terrorism since during his first active tour of duty in the late 1970s and early 1980s. He had been integrally involved in the Iranian hostage and



Baader-Meinhof terror events as the Chief of Psychology at Landstuhl Army Medical Center in Germany.

Hasan was MAJ Hopewell's colleague, but not his employee, as he was rather the "employee" of the Chief of Behavioral Health, since he was assigned to the Department of Behavioral Health (BH) as a junior, fledgling psychiatrist. Fresh from his training, which had taken him an inordinately long time to complete as a very poor student, Hasan had never before seen "real" patients at a "warrior/ deployment" Army post, had never had a full caseload of deploying Soldiers, and had never deployed himself. This was his first job. It was later determined that what time he did spend

seeing patients, he had spent trying to coerce them into relating information about their tours of duty in a way which would implicate them as possible war criminals, then attempting to turn them over to the Judge Advocate Corps (JAG) as war criminals. It was later determined

that he had tried to do this with a number of MAJ Hopewell's patients, never communicating any of this to MAJ Hopewell. Indeed, MAJ Hopewell had worked with Hasan, evaluating patients who had recently been med evacuated back in to Darnall Hospital (CRDMAC) from both Iraq and Afghanistan. MAJ Hopewell had repeatedly tried to teach Hasan about the TBI Clinic and ways in which he could improve referrals and

communication with outpatient psychiatry (which MAJ Hopewell had previously directed himself). Hasan had rebuffed all such overtures and had shown no interest in working with his colleagues. For the past two years, MAJ Hopewell had also personally taught the TBI block of information to all deploying Combat Stress personnel. He

had just the day before taught this information to the 1098th and 467th Reserve Combat Stress Medical Companies, one of which Hasan was to have been assigned for his deployment. (Our editor, COL Platoni, who had been assigned to the 467th MED

DET {Combat Stress Control}, never knew that she was assigned to be Hasan's supervisor until she arrived at FOB Wilson in Afghanistan, 30 days after the Fort Hood Massacre. Per the reports of others, she was at the top of his hit list, though she had never laid eyes upon the shooter.) Hasan had not shown up for the required training. The next day, 5 November, MAJ Hopewell and the Hospital Commander both personally looked for Hasan at the annual Behavioral Health luncheon, which all CRDAMC mental health professionals were expected to attend. MAJ Hopewell wanted to make arrangements for Hasan to make up his missed training, but he was nowhere to be found.

Instead, Hasan had spent the morning giving

away many of his possessions, and had dressed in Arab garb, apparently to get breakfast and coffee. Then, finally donning his required military uniform, he was found at the credentialing office of the hospital at 1000 hours on business related to his credentialing for his upcoming deployment. He engaged in small talk with a senior Lieutenant

Colonel Psychologist (LTC Adams,) who was also there on business, and who saw nothing amiss at that moment. LTC Adams asked Hasan what he was doing at the Credentialing Office and was told he was there because he was deploying. Hasan seemed perfectly calm. Hasan then told LTC Adams that

he was going upstairs to the fifth floor of the hospital, the headquarters for psychiatrists and the Behavioral Health Department, and where both he and the Department Chief's offices were located. He stated that he was looking for the Department Chief, but did not specify a reason. The Department Chief, a Lieutenant Colonel psychiatrist, was Hasan's real "employer," his rater for his Officer Evaluation Reports. He had repeatedly informed Hasan that he was scheduled to deploy with the 467th Combat Stress Control Detachment to Afghanistan. The Department Chief repeatedly sent Hasan to the SRP site, as he refused to complete simple paperwork properly. This brought him to the attention of the SRP OIC. This senior nurse, a



The Fort Hood Massacre, 5 November 2009 - Shock and Horror.

field grade officer entrusted with the direction of the SRP site, had had to meet personally with Hasan two or three times in attempts to force him to complete the uncomplicated processing adequately. Later, this SRP OIC was one of the military Officers Hasan tried to kill, along with MAJ Hopewell.

At 1200 hours (noon), the Behavioral Health Department sponsored its annual luncheon, attended by scores of social workers, counselors, technicians, staff, and the few psychologists and psychiatrists then assigned to Fort Hood. As the new psychiatrist just transferred from Walter Reed Army Medical Center, Hasan was expected to attend, but

his absence was visibly noted, as his absence from the training activities of the 467th Combat Stress Control Detachment. Even the hospital Commander stopped by to meet all the staff and for an informal review of the departmental activities. Hasan, however, was evidently too busy with other activities to be at his assigned duty station and to be meeting the Hospital Commander. At about 1:15 pm he parked his car in the lot behind the SRP/TBI complex, close to MAJ Hopewell's car, which was later shot up by Hasan during the massacre. The video later presented at his Article 32 hearing¹ shows him apparently first "casing" the TBI main building, the associated rehabilitation building, which

was being outfitted at that time, and the brain function computer testing building. The latter was the ANAM building, standing for "automated neuropsychological assessment metrics". All Soldiers received a battery of mental tests prior to deployment in this program, and Hasan himself should also have been tested there. Instead, Hasan removed a Belgian FN Five-seven

semi-automatic pistol, a .357 magnum, and a large number of both 20 and 30 round magazines from his car. (Note: at that time there were no 30 round magazines for the FN pistol. Hasan had purchased extension kits and assembled the longer magazines at sometime prior to this day.) He then walked



Pallbearers carrying the casket of the Fort Hood Massacre fallen for transport to Dover AFB Mortuary.

to the SRP building, entered, and at about 1:30 pm jumped onto a table, yelled "Allahu Akbar," and began to shoot. The Soldiers were densely packed and unarmed, some with ACU blouses removed as they were undergoing medical tests and vaccinations. An investigator later testified that 146 spent shell casings were recovered inside the building. Another 68 casings were collected outside and around the TBI buildings, for a total of 214 rounds fired. Hasan had his pockets full of pistol magazines, and when the shooting ended, he was still carrying 177 rounds of unfired ammunition in his pockets. Thirty people were wounded, and 14 killed – 12 Soldiers, one civilian and one an unborn baby.

After jumping onto the table, Hasan initially sprayed bullets at Soldiers in a fanlike motion around the crowded room and then began taking aim at individual Soldiers. From the TBI building, the OIC heard a constant rate of fire, which at first, sounded much like an M16 A2 rifle. Recognizing that this was live weapons fire and knowing that there were no other weapons in the entire complex, the TBI staff followed established protocol and locked the TBI building completely down (evacuation in situ), as did the staff at ANAM. They then began attempting to call both police and Darnall Army Community Hospital.

In the SRP building itself, Captain John Gaffaney first attempted to stop Hasan by charging him, but was killed before he could reach him (He died at COL Platoni's knees in the Soldiers Dome after prolonged, failed rescue attempts by both now - MAJ Sean Gargan and COL Platoni). Civilian Army retiree Michael Cahill also tried to charge Hasan with a chair, but was shot and killed. Specialist Logan Burnett tried to stop Hasan by throwing a folding table at him, but he was shot in the left hip, fell down, and crawled to a nearby cubicle. Hasan then passed up several opportunities to shoot civilians, and instead, focused on Soldiers in uniform. He also began yelling for the Officer-in-Charge of the building by name and attempted to break into her office, ostensibly to kill her. Fortunately, she and a Soldier she was interviewing had barricaded the office door. They then smashed the only window and escaped to the rehabilitation building next door, suffering severe lacerations in the process.

Unknown to most of the TBI staff, one therapist had taken a group of Soldiers into the uncompleted rehabilitation building for a therapy session, as a group room there was

available. The building, only recently completed and until then unused, was filled with physical therapy and other equipment, much still in boxes piled up high and unpacked. The front door was not working and had to be secured by a chain and lock each night, but was propped open at the moment. It could neither be closed nor secured. TBI staff, unaware that this group had entered the building, began frantically to call emergency police and hospital services. At the same time, the SRP Officer and enlisted Soldier, bleeding profusely from cuts from the smashed window, ran into the rehabilitation building and alerted the group there. This action saved the lives of at least eight people. The SRP Officer continued on to flag down a vehicle, which took her to the Military Police Station, where she was able to alert the Fort Hood Police Department (civilian). Upon returning, the area had been sealed off and she was never allowed back into the SRP/TBI complex. She attempted to coordinate care by cell phone, as did TBI staff who had been at the hospital during the attack and were cut off from their co-workers. This brave officer was later fired from her job and lost her military retirement as a result of being accused of "running away."

As the alerted therapy group ran out an east side door, Hasan changed a magazine that he dropped in front of the building and entered the rehabilitation area. Two Soldiers who were too severely wounded to walk or run, remained trapped in the building and watched helplessly as Hasan went to the side door to fire at the fleeing group. This group included the female therapist, who appeared to be the only other civilian whom Hasan targeted after he had killed Michael Cahill. Cahill, though a Warrant Officer retiree, had been

dressed in civilian clothes and had charged him at the SRP building. The therapy group, with bullets striking the dirt next to them and with some of the group injured themselves, crossed about a 1/3 mile wide field, which separated the TBI complex from the nearest barracks, eventually reaching a road, and then finally arriving at the main hospital itself. The Soldiers who had been trapped in the rehabilitation building, later stated that Hasan left the building briefly, came back in, and at some time changed a magazine again. He eventually spotted one of the trapped patients, also dressed in civilian clothes and in a wheelchair due to the extent of his injuries, and told him something to the effect of "You're too injured already," before sparing his life and exiting the building.

At about this same time, the staff of TBI was still attempting to get emergency help on the phone. Busy signals to the calls placed to both 911 and the hospital were all that staff could hear, leading them to believe that either the phone lines were jammed or that they had possibly been cut prior to the attack. Moving away from his office, with a window directly opening into the quad, MAJ Hopewell tried to get help via a landline in a cubicle office in a back conference area. The cubicle was next to a side door, but out of the line of sight from the window in the door. Hasan next came to that side of the building, kicked and pulled on the door, and was heard to shout something like "Allah open the door" or possibly "If Allah wills the door." He then circled the building, being observed by staff from some of the windows, and kicked the front double glassed doors so hard, he left a mark at the bottom of one of the sheets of glass. The staff never knew why he did not shoot out one of these doors or enter the building to attack staff

and patients inside. They later speculated that as the glass had silver reflection lining, making it impossible to see inside the building. Since the building was locked and quiet, Hasan may have come to the conclusion that the building was unoccupied. This conclusion may also have been bolstered by the fact that the rehabilitation building was obviously not completed and was empty, except for the one group. The terrorist then left to attack the ANAM building. They had a very small staff and were there alone at the time, as no Soldiers were undergoing neuropsychological testing. They later reported much the same thing; that Hasan had circled the building, but since it was locked and nothing inside could be visualized, he seemed to think it was unoccupied as well. He then left the site of this building, seemingly to exit the complex.

Meanwhile, MAJ Hopewell used his personal cell phone to call the personal cell of a staff member at the Resilience and Restoration (R&R) building, since no formal lines were working. This is the large, two story building, which serves as the psychiatric outpatient center for Fort Hood and is located adjacent to the main hospital. The busiest outpatient psychiatric complex in the world, the R&R center had, for years, substantially more outpatient visits per day than the Darnall Army Community Hospital Emergency Room. Since no one had yet been able to reach emergency services, the R&R staff was told specifically that no one had been able to get through by phone and that this staff was to attempt first to reach the Military Police on post. Secondly, the staff member was specifically directed to "run with her feet, NOT to try to call on the phone, to the Emergency Department, and to inform them in person

that a MASCAL (mass casualty emergency) was underway and that this was not a drill." However, instead of following the direct order given, someone at the R&R promptly locked down the building and never contacted the Emergency Department or anyone else for that matter, as far that is known. The R&R, however, which was at least two miles from the attack and never in jeopardy itself, at least was secured!

As a result, the Emergency Department remained completely unaware of the MASCAL until some of the shooting survivors literally staggered in under their own power, bleeding, into the ER. One Soldier had a buddy on each side of him, hit by bullets from Hasan. Grabbing one of these severely wounded Soldiers from the SRP site, he performed a fireman's carry and ran the two miles from the SRP/TBI complex to the Darnall Emergency Department, carrying the Soldier the entire distance. Upon arriving, staff members of the department were taking a smoke break outside, laughing at some jokes, and were completely unaware of the shooting. A few of the escaping TBI therapy group arrived about the same time, two or three having commandeered a ride from the barracks area; the rest by running. They reported the same thing: the ER staff were unaware of the MASCAL until patients actually began arriving on their doorstep. For months after this, the R&R Center, which had never even been threatened, was provided armed security. The TBI and ANAM complex, a direct target of the attack, was never provided security of any kind, as they were moved to different locations around Post. (In 2014, another mentally ill Soldier went on a shooting spree at Fort Hood, killing four people, with the shooter being headed directly toward the TBI building before being stopped

in his tracks. Once again, this building complex was completely unguarded as before. Finally, after the TBI program moved into the new NICOE building, the headquarters of the 1st CAV Division moved into these buildings. The complex now, of course, is completely guarded with weapons and concertina wire!)

By this time, MAJ Hopewell had been informed that staff had been in the rehabilitation building. The shooting also seemed to die down. He gave his body armor to his female occupational therapist and, donning his kevlar helmet, ventured outside. He found a spent magazine outside of his rehabilitation building and two patients just exiting. Both of them stated that after wandering around all the TBI/ ANAM buildings, the shooter had departed, walking toward the Southeast away from the TBI complex and toward the barracks area; the same area where he had chased the therapy group. Almost simultaneously, SWAT team members arrived in body armor, almost 40 minutes after the shooting started, not the "ten minutes" later reported by the press, which did not even report the correct location of the attack for hours. They were advised that the shooter could have doubled back and re-entered the building, as no one at that time knew where he was located. This was especially dangerous, as the rehabilitation building, with several offices tucked away in corners and filled with boxes and large crates of unpacked equipment, would have made a perfect hiding place for a shooter. The SWAT team surrounded and secured the building. Hasan's travels around the complex and the fact that he was last observed heading away from the complex in an opposite direction from where he was ultimately shot, certainly confused the situation.



Hunt



Krueger



Nemelka



Cahill



Xiong



DeCrow



Pearson



Seager



Velez



Gaffaney



Caraveo

As the Military Police were questioning TBI staff as to whether Hasan worked for them, MAJ Hopewell and a senior Physician's Assistant were also coordinating efforts to treat the wounded. A bulky "crash cart", which had been meticulously maintained in the TBI Clinic, was ironically of no use, as it could not be moved outside and over the rough ground to any effect. Ambulances were also arriving and the more seriously wounded began to be treated and evacuated to the hospital in any case. MAJ Hopewell transversed the 75 yards or so of the quad, passing by the smashed out window of the SRP building and walking through scattered clumps of first responders helping survivors. Hasan was lying on his back by the corner of the PDHRA building, and was then stabilized on a gurney for transport to an acute care setting. MAJ Hopewell then confirmed that Hasan was a psychiatrist assigned to the Behavioral Health Department and that he was supposed to be at the SRP/TBI complex for his SRP clearance and his training with the 467th MED DET (CSC). The training with

the 467th mostly occurred at a complex about 20 miles away on the northern boundary of the huge and sprawling Army post and, in any case, he had not attended any of it. Heading back to



CPT John Gaffaney, who rushed the shooter with a chair, was mortally wounded and died at COL Platoni's knees as she and MAJ Sean Gargan tried desperately to save him.

the TBI building, the dead were observed being laid side by side inside the SRP building; a row of uniformed corpses laying dead, side by side.

By this time, security forces had locked down the perimeter to the SRP/TBI complex and Fort Hood itself had been sealed off. For quarantine, Soldiers, civilian staff, and many students who had been in the middle of a graduation ceremony at nearby Howze Theater, were all moved to the large Sports Dome, a part of the processing center. For hours, the few hundred

people watched as large screen televisions broadcast almost every conceivable error about the attack. The Oveta Culp Hobby building on the other side of post was continually identified as the "Soldier Readiness Center." Reports constantly mis-stated the time parameters of the shooting, leading one to believe that the

security team which stopped Hasan was almost down the street in their vehicles; armed, and ready to rush in once they were notified. The attacks on the three TBI buildings, which actually constituted 3/5ths of the complex, were never mentioned. A call from the Hospital Commander provided guidance that the senior CRDAMC Mental Health Officer on site, MAJ Hopewell, was to coordinate emergency services for the large crowd if needed. A senior social work civilian and Army Reserve Officer, herself an Iraq Veteran, had been at the graduation and by coincidence, had helped create the TBI Clinic in the first place. These two worked with Sports Dome staff to coordinate care. No one really needed emergency mental health services at that instant and what seemed to help the most was the organization of information flow and other aid such as transportation and communication with families. Most cell phone service had been shut down. The professionalism and courage of those survivors in the Sports Dome was truly awe-inspiring. Almost all the civilians had military backgrounds and their professionalism and discipline was as readily apparent, as that of the active duty and Army Reserve Soldiers who had put their lives on the line under fire.

Staff with cars behind the TBI complex had their vehicles impounded and could not retrieve them for at least 48 hours. Hasan's vehicle had been identified. For a time it was feared that his vehicle had been wired with explosives, although eventually this fear seemed to be dismissed. Some cars parked directly behind the TBI building had bullet holes or bullet ricochet damage, confirming that Hasan had been around that portion of the complex, as no round could

have been fired from the SRP building itself that would have struck these vehicles. Finally, at about 1:00 AM, staff were finally allowed to leave. Some of those with impounded vehicles had to request rides from others and arrange to stay in Killeen hotels until their cars were released to them.

After the terrorist attack, questions naturally arose as to the motives of Hasan. His radicalization could not be clearer, with him having presented written confirmation of his jihadist views to his peers at Walter Reed Army Medical Center under the guise of "research presentations," his connections and communications to Al-Awlaki, and his handing out of business cards that identified him as a "Soldier of Allah." However, naïve or misguided observers soon postulated that he was traumatized by the prospect of deployment or by the "secondary trauma" of hearing about the PTSD trauma of troops whom he was counseling, or that he was mentally unsound. First of all, every single Behavioral Health Officer at Fort Hood had deployed to a combat theater, many coming close to being killed in attacks themselves. None had refused to deploy, and all performed in their combat theaters with outstanding courage. None had returned so traumatized that they ran around shooting people, or even had trouble working. Also, every single Behavioral Health Officer at Fort Hood had already treated hundreds of combat Veterans, more than Hasan had treated in his entire brief "career." None developed any type of "secondary trauma," and if asked, all would find such an idea ridiculous. The idea that Hasan, an extremely lazy officer who, in fact, had treated very few Soldiers, compared to every other officer at the hospital who had never deployed. He had

experienced no trauma whatsoever himself, except for being told to do the job for which the citizens of the United States had trained him and paid him to do. The idea that he was traumatized was especially ludicrous. And finally, Hasan had been observed closely for years by large numbers of psychiatrists, psychologists, social workers, and counselors, the very people who are professionally trained and experienced in the identification of mental disorders. While many found him to be lazy, unprofessional, and minimally qualified, and some can be faulted for missing his radical jihadist leanings, none ever found him to be “traumatized” or to be mentally unstable, to include his face-to-face conversation with a senior colonel only three hours before his shooting spree. It was later discovered that Hasan had been taking a number of the Soldiers aside, to include TBI survivors, and attempting to have them charged with war crimes based upon their military service in the War on Terror. All such Soldiers had to be interviewed by Criminal Investigation Division staff, counseled by other mental health experts, and medical boards had to be completely re-convened, again adding to the millions of dollars of collateral and hidden damage caused by this attack.

When they resumed operations, the SRP and PDHRA teams were re-assigned to a gymnasium that had operated for the “Ironhorse” Brigade

and which was known as the Ironhorse Gym. They had previously worked out of this gym until moving into the new SRP/TBI complex, which was less than two years old; now they were crammed back in to this facility. Now cramped and flush with long lines of Soldiers, SRP at least had been provided magnetometers for metal detection and security. The TBI Clinic was moved to a set of three trailers after evicting wounded Soldiers assigned to the Warrior Transition Brigade and awaiting medical retirement from the Army. MAJ Hopewell insured that the TBI Clinic would back in business the Monday following the shooting. However, the clinic had to be set up on folding tables and desks made of wood slats placed on

the backs of chairs. Office and testing supplies had been packed into garbage bags and “organized” around the rooms. The clinic operated this way for a year, one small improvement being made when the clinic was moved to other trailers. These trailers, however, blew their fuses when more than a copy

machine was plugged in, as they were not wired for more than residential use. In order to fax or copy documents, staff often had to walk to other offices which had sufficient electrical power. For an entire year, even the hospital Public Affairs Office often could not find the clinic, much less many of the Soldiers who needed care. Scores of Soldiers therefore either never received the



care that they desperately needed, or their care was compromised. The ANAM department literally operated out of the back of trucks for months, “schlepping” the computers used for testing by pickup trucks and vans to the units being assessed prior to deployment. Finally, the ANAM department was given a dilapidated trailer with holes in the floor and staff was forced to use cardboard to create “carrels” for testing purposes. None of these programs was ever provided any security whatsoever.

The day following the attack, TBI and ANAM staff were given 24 hours to remove everything that they owned from the buildings. The buildings were then sealed and were not been entered by any clinical staff for more than two years. Over \$750,000 of rehabilitation equipment and office supplies for TBI were crammed and stored in a CONEX (metal storage container). Medical and TBI testing supplies could not be located for months and were often borrowed from other services. Department of the Army regulations prohibited the acceptance of supplies from outside donors, so medical vendors willing to donate much-needed supplies were prohibited from doing so. The Texas Psychological Association and other agencies willing to help were prevented from providing even the

slightest aid, as they were not “Red Cross or government-approved.” Three quarters of the TBI staff resigned almost immediately, crippling its ability to provide services to Soldiers. Eventually, only three staff remained who had been in the building at the time of the attack.

At the same time, staff received constant demands that they were to submit to mental exams to see if they had been traumatized by the attack, but almost all felt that it would have been far more helpful to have provided them resources enabling them to perform their jobs once again; treating Soldiers as only they had been trained to do. Little help for this purpose was forthcoming, and the moves and fragmentation of the clinic in different buildings made it difficult for Soldiers to seek

services and hard for the team to provide them. While most media and public attention focused on those killed and wounded in the attack, there was no appreciation whatsoever that the attack had also disrupted so many vital health care services for Fort Hood Soldiers in ways that probably and eventually totaled millions of dollars in increased expense burdens. However, in the middle of all of this, the TBI Clinic scored a second perfect score for the Joint Commission for the Accreditation of Hospitals survey. Without this accreditation, the entire clinic might have been



Susan White, RN, who saved many lives, using her underwear as a tourniquet, and COL Kathy Platoni; at the memorial service for the fallen and wounded in action, November 2009.

closed for not meeting hospital standards.

In addition to achieving perfect scores in two sequential surveys, the TBI Clinic also obtained \$2,000,000 in grants to construct replacement buildings. Since that time, MAJ Hopewell secured another \$1,000,000 for a fourth building, dedicated entirely to behavioral health, rehabilitation and research. Moving into the new buildings in October of 2010, the clinic then moved all of its equipment back into the buildings, tripled the number of Soldiers it was seeing, started research projects, had ANAM running at full capacity, and eventually added MAJ Hopewell's fourth building to the ANAM complex.

In addition, although initially awards were refused for civilian staff, MAJ Hopewell eventually succeeded in insuring that his Physician's Assistant was recognized and given a civilian award for her medical care. TBI staff therefore did eventually succeed in having most of their efforts recognized.

Although now geographically separated, the three OICs in charge of the SRP/TBI complex that terrible day still salute each other as brother/sister Army officers, continuing on with their missions to the very best of their abilities. To this day, other than the formal CID statement given, not a single government or Army official has ever asked a single question of

MAJ Hopewell about the events of 5 November 2009. One month after the shooting, MEDCOM contracted MAJ Hopewell to appoint him to the Sanity Board, to be convened with respect to the shooter. This is how out of touch the Army was the devastating impact of the Fort Hood Massacre upon the survivors and the wounded,

both physically and psychologically. Per LTC Adams, one could have glanced at Hasan and pronounced him completely sane and cleared for execution as a Jihadist. There is lots of irony there. Most of all the events and after actions were surreal. We shall always remember the very tall wall constructed to protect President Obama when he came to visit

and the government snipers on the III Corps Headquarters during the Fort Hood Massacre Memorial, several days after the mass shooting. Former President Bush never had such protection and came often to visit the wounded in Darnall Army Community Hospital. This is all very telling. Ten years after the fact, The Fort Hood Massacre remains shrouded in coverups.



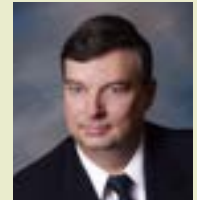
Dr. Daniel Kirsch, Col Kathy Platoni, EPI President, Tracey Kirsch, Brie Kirsch at the dedication of the Fort Hood Memorial.

References

1. Uniform Code of Military Justice - Section VII - Trial procedures. An Article 32 hearing is a proceeding under the United States Uniform Code of Military Justice, similar to that of a preliminary hearing in civilian law. Its name is derived from UCMJ section VII ("Trial Procedure") Article 32 (10 U.S.C. § 832), which mandates the hearing. Results of the Article 32 hearing determine whether the defendant proceeds to trial or if charges are to be dismissed.

ABOUT THE AUTHOR

C. Alan Hopewell, MP, PhD, ABPP, MAJ (RET) Dr. Hopewell received his formal Clinical Neuropsychological training during his residency at the University of Texas Medical Branch in Galveston in the Division of Neurosurgery as the very first neuropsychological student in Texas under Harvey Levin, PhD. He was subsequently awarded “Neuropsychologist of the Year” by the Texas Psychological Association (TPA) and was also TPA President for 2004.



Dr. Hopewell was commissioned a U. S. Army Medical Service Corps Officer upon his graduation from the Texas A&M Corps of Cadets in 1971. He retired with a Regular Army Commission as Major in the United States Army, having seen active duty service both in the U.S. as well as abroad. He is a Vietnam Era, Cold War, and Operation Iraqi Freedom/ Surge Veteran. His father, the South Compound World War II prisoner of war (POW) stenographer for Nazi Stalag Luft III, (The Great Escape,) was his inspiration for his military service.

During his initial tours of duty, he fully developed the first neuropsychological clinic at Landstuhl Army Regional Medical Center in Germany during his Cold War Service. He was also instrumental in helping LARMC obtain its first ever Joint Commission certification, setting the foundation for the Traumatic Brain Injury (TBI) services there which have become so important after 9/11.

Volunteering to return to active duty after 9/11, Dr. / MAJ Hopewell was the first Medical Psychologist Army Officer with a state license as a Prescribing Psychologist and the first to manage psychiatric prescriptions in a combat theater. While in Iraq, he was also designated the neuropsychological traumatic brain injury consultant for the entire Theater and did explosives/concussion research in the field with an Explosive Ordnance Detachment (EOD). For this he was awarded a Bronze Star Medal for meritorious service in Operation Iraqi Freedom along with Surge Campaign Star. He was also formerly the Officer in Charge (OIC) of the largest outpatient psychiatry clinic in the world: the Resilience and Restoration Center at the Carl R. Darnall Army Medical Center, Fort Hood, Texas. Also, while at Fort Hood he founded and was the OIC of the Traumatic Brain Injury Clinic, Carl R. Darnall Army Medical Center.

Based upon his combat service and as a prescribing psychologist, he was awarded one of the highest honors of the American Psychological Association, being elected a Fellow of the APA. He is currently an Assistant Professor of Psychiatry and Behavioral Medicine at the University of North Texas Health Science Center.

ABOUT THE AUTHOR

Michael L. Adams, PhD, LTC (RET) was born into a military family. My paternal grandfather was a Soldier in the Army of the Czar of Russia. He and my grandmother escaped from the old country by hiding in a hay wagon. He bribed the guards to miss them when the guards stabbed the hay with bayonets. They emigrated to America around the turn of the last century. My father was born in the United States of America. When he was fifteen, he came home from school to learn his last name had been legally changed from Abramov to Adams. As a child, he remembered folding bandages for wounded Soldiers from WW I. When he was in college, he joined ROTC. He attended law school and undergraduate college simultaneously, graduating with a law degree before he graduated with his undergraduate degree. When WW II began, he commanded a coast artillery battery and later went to Europe as an intelligence officer. While in Europe, he was blown up in the air by a V-1 bomb. He flew on missions with B-17 bomber crews and had shrapnel pierce his helmet and travel around inside it, while missing his skull. He never talked much about his experiences, especially during the Korean War.



On my mother's side of the family, I know one uncle served in WW II. He fought in the Pacific and was affected by night hand to hand combat with Japanese soldiers. He told me how to fight with a knife as he had done.

I was the middle child of three. With a family background of military service, I was expected to join the military. In college I joined Air Force ROTC just as my brother had before me. I graduated with designation Distinguished Military Graduate in 1966. I entered active duty in January 1968 and was ordered to Intelligence Officer School, where I was invited to accompany the commander to Southeast Asia. I was stationed in Thailand where I was part of electronic interdiction of traffic on the Ho Chi Minh Trail, which extended from North Vietnam through Laos to South Vietnam. This was the main route of people and supplies for the communists. We were operating in real time ambushing enemy convoys and people as they travelled south. I also joined a flying unit, the Airborne Battlefield Command and Control Squadron and flew about 800 hours of combat. I provided support for our allies on the ground in Laos.

After my time in the war, I was assigned to Strategic Air Command (SAC). I became Officer in Command (OIC) of a cartographic section making air target charts. There were about 25 people in my section. I re-organized us so each of the senior sergeants was able to step up and run the section. There were no vital individuals whose absence would cause work to stop. There were just two ways to leave SAC - either leave the Air Force or die. I left and went to graduate school to study psychology. I was told the Army would pay me to go to school, so I applied and was one of fifteen people that year to become Army graduate students.

My first assignment was to the Academy of Health Sciences as an instructor. I created some instructional materials about human development before there were any textbooks that I could find. I also helped create a course to lower stress in nursing anesthetist officers. I taught assertiveness to Army nurses. I went to William Beaumont Army Medical Center for internship after two years at the Academy.

The internship is where we began to identify what became called post-traumatic stress disorder (PTSD) in Soldiers who had been in combat in Vietnam. We began to develop treatments to restore the Soldiers to full functioning. This was a lot harder back then because we did not grasp the complexity of the condition. Sometimes experts were brought to the Internship to educate us. I remember well that the chief of psychiatry from the Israeli Army spoke to us about the Six Day War and how quickly PTSD developed as well as what they did to reduce PTSD. We were astonished and asked how they developed the treatment. He looked puzzled and then told us the Israeli mental health people copied our procedures from the Korean War. None of us knew of the Korean War procedures. By the time of the Vietnam War, we had forgotten our own history.

My next assignment was to Combat Developments at Fort Benjamin Harrison. The most important contribution there was when I became curious about continuous operations. I reviewed twenty years of research in continuous operations and reduced it to two paragraphs for a General Officer talking paper. After it was presented at a conference, changes were made so that our Soldiers would have enough water to drink. Another doctrine change was about how often to drink water. These changes allowed our Soldiers to fight in the Gulf War in 1991 for longer than 45 minutes, which is how long the fight could go on under the previous doctrine of water conservation.

From Combat Development, I was assigned as the Division Psychologist for the 25th Infantry Division. There we noticed that whenever deploying Soldiers were boarding aircraft to go to South Korea for an exercise, some Soldiers would get to the bottom of the aircraft ramp, suddenly drop their packs and rifles, and RUN AWAY. Looking further, we found ALL of them were Vietnam Combat Veterans. We were able to get their commanders to send them to Mental Health for help instead of punishing these Soldiers. We stayed busy. I also wrote a proposal for computer communication between the medical center and our mental health at Schofield Barracks in Hawaii so we could ensure continuity of care. Prior to that, Soldiers would be discharged from psychiatry and returned to their units, with no follow up at all.

From Schofield Barracks I moved to Fort Hood's Carl R Darnall Army Community Hospital to the Department of Psychiatry. I left active duty and became a school psychologist for the Copperas Cove School District in Texas. There I developed an autism assessment team and also maintained functioning of three self-contained classrooms for children with severe behavioral problems. I stayed there for seven and a half years and until being called back to active duty for Operation Desert Storm. I stayed with the Army hospital for most of the next 19 years, treating many more Soldiers who had deployed to the wartime theater and their family members. At the age of 60, I retired from the Army, but returned as a volunteer for three more years in 2005, serving as chief of the Department of Psychology and chief of the combined departments of behavioral health. This included departments of psychiatry, psychology, social work, and substance abuse treatment. This was an exciting time for high-speed change. My life became more intense after former Major Hasan massacred 14 people at Fort Hood on 5 November 2009. I estimate I treated over 4,000 Soldiers for PTSD from 1978 until I finally retired in 2015.

The Fort Hood Massacre - Ten Years Later

By Kathy Platoni, Psy.D., DAIPM, FAIS

COL (RET), U.S. Army, COL, Ohio Military Reserve/State Defense Forces

The only thing necessary for the triumph of evil is for good men (and women) to do nothing. – Edmund Burke, 1729-1797

I am a survivor of the Fort Hood Massacre of 5 November 2009. It has been ten years, which feels more like ten seconds for those of us who somehow and miraculously made it out of the Fort Hood Massacre alive. The things we cannot unsee, unhear, or unfeel are never far from conscious awareness. For this kind of horror, there is no off switch. Our old selves are gone, no longer hanging in the closet to don in aftermath of this holocaust of hatred that cost 13 lives, leaving 33 wounded and unquantifiable injuries to the souls and the psyches to the survivors and the families of the fallen. Hopelessness and futility rule. Lives have been shattered. Eight have been snuffed out by suicide. There will be more. The deceit and betrayal perpetrated against the wounded, the families of the fallen, and the survivors continue to hemorrhage at the hands of the Department of Defense, the Department of the Army, the FBI, the Joint Terrorism Task Force, and the previous presidential administration. These remain travesties of justice of epic proportions, buried in a cover up under a rug the size of the lower 48 (states).¹

The Fort Hood Massacre is still labeled an act of workplace violence and the shooter is not considered an enemy of the state, ten years after the fact. Both the Department of the Army and President Obama himself made solemn promises that the wounded, including civilian police officers, SGT Kimberly Munley and SGT Mark Todd, who felled the shooter, sparing countless more lives, to be provided all the medical and psychological treatment that would have allowed them to be made whole again. They are still

waiting. In March of 2010, this same president urged Congress to delay any investigation of the terrible tragedy of Fort Hood and the “alleged” gunman.² We are still being forced to swallow this despicable false narrative in our relentless pursuit of justice, yet we continue to be strangled by the travesty of it. The Fort Hood Massacre is shrouded in all things unholy.

Per Mr. Berry, this is our “Domestic Benghazi,” a massive loss of innocent lives at the hands of a jihadist madman, whose primary mission in life was to burn, behead, assassinate by gunshot, and pour acid down the throats of as many American Soldiers as inhumanely possible to shut down the missions of troops deploying to the combat theaters of Iraq and Afghanistan. I know. I was there. The shooter was to be assigned to deploy with my Army unit, the 467th Medical Detachment [Combat Stress Control], and I was to have been his direct supervisor, marked for death at the top of his hit list. I am far from alone in the struggles of survivor guilt, questioning why someone else must have received the fatal rounds meant for me. I didn’t walk out of there alive when marked for death just to keep my mouth shut. This is my mission, my calling, my very reason for being and for continuing to walk the earth. I have been tossed into the steaming pile of this national tragedy, the largest mass shooting on any military installation in the history of the United States, to undertake what right looks like. I have been threatened twice into forced silence by members of Congress, one of them right in my private practice office to my face. It’s not working.

The proliferation and perpetuation of

lies continues to be force fed to the American populace.... that terrorism is not alive and well and that we reside in a safe place here in these United States. This is a fallacy. When a presidential administration personally blocks and puts an end to surveillance of a known terrorist, who regularly communicated and funded known terrorist Anwar al-Awlaki, and whose sole reason for living was to torture and kill as many American Soldiers to promote a jihadist agenda, we have derailed into something subhuman. The Fort Hood shooter live from death row at Fort Leavenworth, Kansas, continues to publicly support and to celebrate the Islamic state and is free to do so, unencumbered by the steel bars of his solitary confinement. And

yet, we survivors and whistleblowers are doomed to the darkness to be nullified and muted by intimidation. We wonder what the shooter thinks now that his Caliphate master blew himself up because he was scared of a dog.³ We wonder why the truths of the matter remain hidden and in obscurity from the President of the United States. Whatever happened to no one left behind"? Hell, we are the ones who have been left behind.

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ABOUT THE AUTHOR

Kathy Platoni, Psy.D. has been a practicing clinical psychologist for more than 37 years and maintains her private practice in Centerville, Ohio. In service of her country and as an Army Reserve clinical psychologist, she has deployed on four occasions in time of war. As a survivor of the tragic Ft. Hood Massacre in November of 2009, she is an ardent activist for reconsideration of this shooting incident as an act of terrorism to assure that the wounded and the families of the deceased are awarded long overdue benefits and was very instrumental in the awarding of the Purple Heart Medal to the Fort Hood wounded and to the families of those who lost their lives on that tragic day.

Dr. Platoni is a graduate of the School of Professional Psychology of Nova University (now Nova Southeastern University) in Davie, Florida. She held the position of Army Reserve Clinical Psychology Consultant to the Chief, Medical Service Corp for six years and is a graduate of the U.S. Army Command and General Staff College. Dr. Platoni retired from the U.S. Army with the rank of Colonel in October of 2013. In 2015, COL Platoni was sworn in as a member of the 4th Civil Support and Sustainment Brigade, Ohio Military Reserve; back in uniform for her 38th year, this time as Brigade Psychologist for State Defense Forces. She also serves as the Dayton SWAT psychologist and Mental Health Advisor to the Dayton Hostage Negotiation Team.

Two landmark books, written and edited by Dr. Raymond Scurfield and Dr. Platoni on the subject of war trauma, *Expanding the Circle of Healing - Trauma in Its Wake* and *Healing War Trauma - A Handbook of Creative Approaches* were published in 2012. She serves as Editor of the *Combat Stress* publication and publishes regularly in Google News, Apple News, and Lemonwire about subject matter pertaining to wartime service, the Fort Hood Massacre, and the moral injury of war.



Letter to The President of The United States, Donald J. Trump Regarding the Fort Hood Massacre

By COL (RET) Kathy Platoni, Psy.D., DAAPM, FAIS

This is not the first, second, or even third letter that we, the survivors of the Fort Hood Massacre, and the countless supporters from every conceivable walk of the Army and the civilian sector, have penned to the President regarding the fact that the Fort Hood Massacre **is still considered workplace violence and the shooter, not an enemy of the state after ten long and agonizing years of fighting this battle.** What we are asking is simple: **an executive order to be issued by the President to officially declare the Fort Hood Massacre an act of domestic terrorism and the shooter, an enemy of the state.** The last letter of request to the President yielded a bona fide phone call from the White House (September of 2018) to obtain more information regarding the timeline of events. I was informed that it was unlikely that this would go much further in terms of the granting of such a request for an audience with the President, as I/we have no star power like that of Kim Kardashian. (She had recently met with the President regarding her prisoner release initiatives.) Yes, that is actually what the White House liaison person stated. One must ask what level we have sunk to for such a vile statement to be made regarding a coverup of such massive proportions. The fury unleashed by this comment led to the submission of the letter to the President that follows, written primarily by international terrorism expert and my former boss 41 years ago, Dr. Gary Jackson. (Please note that former Ohio State Representative Jim Trakas wrote 2 of the previous versions sent to the White House.) The assistance of such heroes as Dr. Jackson and Mr. Trakas have been

a formidable force in moving forward on this issue and the battleground surrounding the Fort Hood Massacre, 10 years after the fact.

This latest letter was personally delivered by me, COL Platoni to 2 separate White House staffers during a ceremonial visit with the President and the First Lady in the aftermath of the Dayton Mass Shooting on 4 August 2019 in Dayton, Ohio. I was invited to stand with members of the Dayton Police Department during this event as their psychologist and first responder to this tragic event. The attached photos tell the story. It was an extraordinary experience to witness the tribute paid to the law enforcement heroes of this terrible tragedy on 7 August 2019. (They were later awarded Medals of Valor at the White House and deservedly so.) Two weeks later, these letters were sent back, as they could not be vetted. They had no Anthrax sprinkled in them and no pipe bombs in the envelopes. We are still trying to understand why these letters were never read or delivered to the Oval Office.

Thanks now to the efforts of Veterans, COL D.J. Reyes and Luis Quinonez (the likely next Secretary of Veteran Affairs and national heroes and patriots in their own right), said letter has now gone forward through a variety of other channels in hopes that it will eventually reach President Trump: through Secretary of Defense, Dr. Mark Esper, and the White House Pentagon Liaison.

Still, we wait. The tears never stop. The anguish does not diminish. If it takes another 20 years, we have it in us to plow forward and to right this ship, for the fools sailing it know not the damage they have done.

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2 August 2019

The Honorable Donald J. Trump
President of the United States
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear President Trump,

At 1:34 PM on Thursday, 5 November 2009, Army psychiatrist, Major Nidal Hassan, entered the Soldier Readiness Processing Center at Fort Hood, Texas. This was a gun free zone. Military personnel, other than Military Police, are not authorized to carry firearms on base in the continental United States. Hassan took a seat at an empty table, bowed his head for a few seconds, then abruptly stood up, shouting, "Allahu Akbar," while surfacing his concealed semi-automatic FN Five-seven pistol. He then immediately began to slaughter Soldiers, both readying for and returning from deployments in Iraq and Afghanistan. He sprayed the room with a hail of lethal fire in rapid succession, followed by targeted shootings to assure that those he had felled with gunshots and intended to kill were, in fact, assassinated. Witnesses say that he avoided civilians who were hiding, though one civilian lost his life regardless. Amidst the mass chaos, confusion, and a room murky with smoke from the gunfire of 214 rounds, the floor was so slippery from the massive amounts of blood spilled, that many victims could not be reached as they lay dying. Valiant attempts to block the shooter with chairs and tables thrown in his path resulted in heroic but certain death.

This ruthless and sadistic massacre ended when Hassan was finally apprehended by the heroic actions of civilian police officers, SGT Kimberly Munley and SGT Mark Todd - SGT Munley becoming disabled after her weapon jammed. The shooter then fired upon her three times. She sustained 3 gunshot wounds. The blood bath ended with 13 of Hassan's fellow Soldiers and one civilian killed in action and 33 Soldiers wounded in action. Most were shot multiple times, one begging for the life of her unborn child as she was slain. This was the worst mass attack on any military installation within the United States in US history.

Without apparent logic, President Obama labeled the Fort Hood Massacre as workplace violence and not an unmistakable act of domestic terrorism. Such a failure in accurate classification has resulted in withholding benefits for victims and families, including desperately needed medical care, and the awarding of Combat Action Badges and Combat Medical Badges to the many heroes who rushed to save the wounded and the dying under fire (Purple Hearts classification). Hassan's systematic assassinations and pre-meditated acts of capital murder were admittedly inspired by radical Islamic motives. In Hassan's own words during his grand rounds

employee and his wife. President Obama did not label this as workplace violence. Fourteen people were killed and 20 were injured. In the national address, President Obama stated the following:

"Our military and counterterrorism professionals have relentlessly pursued terrorist networks overseas -- disrupting safe havens in several different countries, killing Osama bin Laden, and decimating al Qaeda's leadership. Over the last few years, however, the terrorist threat has evolved into a new phase. As we've become better at preventing terrorist threat has evolved into a new phase. As we've become better at preventing complex, multifaceted attacks like 9/11, terrorists turned to less complicated acts of violence like the mass shootings that are all too common in our society. It is this type of attack that we saw at Fort Hood in 2009; in Chattanooga earlier this year; and now in San Bernardino". (Transcript released by the White House as reported by Reason, December 6, 2015).

It is important to note President Obama's labeling of the Fort Hood and San Bernardino attacks as terrorism and not workplace violence, although both occurred in a workplace. Still, the Fort Hood Massacre, to date, has never been formally classified as domestic terrorism. This has enormous ramifications for the wounded, the survivors, and the families of the fallen. The similarities between the Fort Hood mass attack and the San Bernardino attack, labeled by President Obama himself as terrorism, are striking. Both occurred in a workplace and both massacres were committed by radical Islamic anti-American attackers using semi-automatic weapons. Although there are different definitions of terrorism, all include the need to leave a political message by the act itself, including selection of targets (U.S. government, military, etc.) (Gary M. Jackson, *Surviving Mass Victim Attacks*. Rowman & Littlefield, 2018). This is exactly what Hassan did.

This is particularly relevant because at the time of the 2009 Fort Hood Massacre and even at the time of the quoted national address in which he included the Fort Hood Massacre as terrorism and not workplace violence, President Obama and his administration officially persisted in labeling the Fort Hood attack as workplace violence in the years following. The labeling of the Fort Hood attack as workplace violence has, to this day, resulted in the denial of benefits to the victims and families of that horrific attack. One has to ask why benefits are still withheld, especially within the context of the following key facts:

- "Though the 5 November 2009 shooting was not on the scale of a 9/11-style attack, it served the same purpose: to terrify "the Crusader West" and shake America off kilter, according to an al Qaeda spokesman" (Patrik Jonsson, *Christian Science Monitor*, October 19, 2010). Quoting Jarret Brachman, an expert on international terrorist groups and author of *Global Jihadism: Theory and Practice*, Jonsson continues, "Hassan has become almost everything they've [Al-Qaeda] been hoping ... he's legendary now within their movement"
- On 14 December 2011, the 112th Congress, 1st Session Issue: Vol. 157, No. 192 — **Daily Edition of the Congressional Record captured the transcript labeled, "FORT HOOD SHOOTINGS: WORKPLACE VIOLENCE OR TERRORISM?"** Since the 2009 Fort Hood Massacre, there has been an outcry over the insistence of the Obama administration to label the attack workplace violence as opposed to the unequivocally more accurate label of terrorism. Representatives John Carter (R-TX) and Louie Gohmert (R-TX) presented an impassioned plea

presentations for the duration of his psychiatric residency training and during his subsequent fellowship, he openly advocated for the burnings and beheadings of American Soldiers. His plan was to shut down the missions of troops deploying to Iraq and Afghanistan by killing as many American Soldiers as humanly possible. During the shooting, Hassan carried 177 additional rounds in both 20 and 30 round magazines in the cargo pockets of his uniform, with 3000 more rounds in the trunk of his vehicle; this to ensure the job would be perfectly executed. Unmistakably, the shooter turned the Soldier Readiness Processing Center into a blood-drenched battlefield.

Hasan had exhibited strong and obvious warning signs prior to this merciless attack. He had frequently and publicly expressed increasingly stronger radical Islamic and anti-American viewpoints, particularly focused on U.S. military actions against Muslims in Afghanistan. At the time of the massacre, he was scheduled for deployment to Afghanistan within 30 days. One of the authors of this letter, COL Kathy Platoni, was to have been assigned as his direct supervisor.

Throughout his well-documented pre-attack radicalization, Hassan aligned himself with Muslim cleric, Anwar Awlaki, who was vehemently anti-American and a key part of the infamous al-Qaeda terrorist organization. Hassan had been in frequent communication with Awlaki, who applauded the Hasan's Fort Hood attack after the fact and assisted in the planning of other terrorist attacks against the United States. This association alone, even with Hassan's frequent anti-U.S. military sentiments and statements notwithstanding, is more than sufficient reason to classify the massacre as an act of terrorism.

President Obama labeled and maintained his view of Hassan's mentor, Awlaki, as a terrorist. Five months after the Fort Hood Massacre, President Obama ordered the killing of Awlaki for his terrorist ties. This order was controversial because Awlaki was a U.S. citizen. Awlaki was, in fact, killed by a U.S. drone on September 30, 2011. The following are President Obama's remarks as reported by *Front Lines* on September 30, 2011: "Earlier this morning, Anwar Awlaki, the leader of al Qaeda in the Arabian Peninsula, was killed in Yemen. The death of Awlaki is a major blow to al Qaeda's most active operational affiliate. Awlaki was the leader of external operations for al Qaeda in the Arabian Peninsula."

The communication between Hassan and Awlaki and their common and publicly espoused radical Islamic anti-American views helped to solidify the more accurate label of Hassan's vicious 2009 attack as domestic terrorism. In his attack, beginning with the typical radical Islamic terrorist attack cry, "Allahu Akbar" and focusing on killing U.S. soldiers just prior to their deployment to Afghanistan, would make any expert very hard pressed to label the massacre as workplace violence. *Allahu Akbar* is a signature call that has accompanied many radical Islam-inspired terrorist attacks and never has been associated with attacks defined as workplace violence.

In comparison to the Fort Hood attack, there have been similar domestic terrorist mass attacks labeled correctly by President Obama — even those occurring within a workplace. As an example, on 6 December 2015, President Obama addressed the nation, focusing on the then recent San Bernardino Inland Regional Center mass attack. The deadly assault was committed by a radicalized U.S. citizen

to the House of Representatives to properly label the Nidal Hassan Fort Hood attack in 2009 as terrorism and not as workplace violence. As they explained, the Obama administration's insistence on the workplace violence designation had resulted in lack of rightful benefits to victims and families. Mr. Carter described a resolution he presented to the House the day before. Because of its relevance and importance, it is presented here verbatim, as captured in the Congressional Record referenced:

"Whereas the United States Army Major Nidal Hasan is reported to have communicated on multiple occasions with radical Islamic terrorist, Anwar al-Awlaki, on the topic of justifying jihad on the United States and its Armed Forces; Whereas Major Hasan delivered addresses to the Department of Defense personnel concerning the justification of jihad against the United States Armed Forces; Whereas Major Hasan is reported to have planned and trained for an attack on unarmed members of the United States Armed Forces at Fort Hood, Texas, with the specific intent to kill and injure those troops before the deployment to overseas theaters of war; Whereas Major Hasan is reported to have declared his attack to be an act of jihad in defense of Islam, and civilians; Whereas Major Hasan is currently charged with murder of 13 and attempted murder of 32 (the correct number is 33) United States citizens during that attack; And whereas the Department of Defense submitted correspondence to the United States Senate Committee on Homeland Security which referred to the violent workplace violence: Now, therefore, be it resolved, that the House of Representatives recognizes the attack on Fort Hood, Texas, as an act of radical Islamic terrorism and jihad against the United States Armed Forces.

- Senator John Cornyn (R-TX) and Representative John Carter (R-TX), began pushing against the workplace violence label that resulted in denial of benefits for Fort Hood Victims very quickly after the shooting. Senator Ted Cruz (R-TX) joined their effort in 2013. To correct the injustice, Senator Cruz added an amendment to the National Defense Authorization Act that specifically required a review to (... assess whether the members of the Armed Forces killed or wounded at Fort Hood and Little Rock qualify for award of the Purple Heart under the criteria as members of the Armed Forces who were killed or wounded as a result of an act of an enemy of the United States. (National Defense Act for Year 2014).
- In an interview, Senator Ted Cruz said, "The Obama Pentagon fought tooth and nail against that." He went on to say, "They insisted the attack was workplace violence. And they refused for nearly five years to award those Purple Hearts."
- It is important to note that attacks committed by terrorists resulting in wounds have qualified for the Purple Heart since 1984. On February 14, 1984, Ronald Reagan signed an executive order allowing the Purple Heart to be issued for injuries suffered as a result of terrorism." (T. Christian Miller, *A History of the Purple Heart*, NPR, September 8, 2010).

- In 2014, Senator Ted Cruz released a video urging President Obama to sign the legislation that would recognize the 2009 Fort Hood shooting as an act of terrorism - not workplace violence. Senator Cruz stated: "It wasn't workplace violence," It was an act of terror against American heroes, and we need to speak the truth." "It is abundantly clear that this was an act of radical Islamic terrorism," Senator Cruz stated. "The only explanation for the administration's persistent denial of that is politics." Labeled correctly as a terrorist attack, the Fort Hood massacre victims and families would receive such benefits as life insurance, combat pay, tax breaks, and the Purple Heart. (Washington Free Beacon Staff, December 14, 2014).
- On April 10, 2015, to correct the injustice of improper labeling and after the National Defense Act amendment addressing the issue, 44 medals were finally awarded to the victims of the 2009 Fort Hood attack (Purple Hearts for Soldiers and Defense of Freedom Medals for civilians). This took 5.5 years from the date of the shooting. However, deserved benefits continued to be withheld.

Six days after the meritorious awards on 16 April 2015, John McHugh, then Secretary of the Army, reported that he directed the Army to "provide all possible benefits to victims of a 2009 attack at Fort Hood who were recently awarded the Purple Heart medal." He went on to say, "After making the determination that the victims of the Fort Hood attack are now eligible for the Purple Heart, it seems only right and fair that these soldiers also receive the benefits it traditionally entails." Secretary Hugh continued, "That's why I directed an expedited process to make certain that happens." (Molly Hennessy-Fiske, The Washington Post, October 19, 2015). This order did not result in benefits being awarded. In fact, to this day, the wounded live in fear of even revealing what benefits they have yet received, if any.

On 5 November 2012, a wrongful death suit was filed by Fort Hood Massacre victims against the senior U.S. government officials and civilian employees, exactly 3 years after the Ft. Hood Massacre (Manning, et al. v Esper, Secretary of the Army). The court delayed the case until Hassan's court martial hearings were completed. Taking almost another year, Hasan was convicted on 3 August 2013. However, the court granted the defendant's request to continue to stay the case for many additional years (until March of 2017), held up by post-conviction court martial proceedings. Based on technicalities, the case was dismissed in January of 2019, nearly ten years after the Fort Hood Massacre, allowing full benefits to be denied the victims of the massacre and their families to this day. Technicalities aside, not focusing on the appropriateness of the lawsuit, it is tragic that survivors were driven by almost a decade of unjust denials of benefits to even be placed in the position of filing such a suit.

- It is very significant to note that COL Platoni has contacted the following elected officials over the course of the last nine years, not a single one providing any assistance whatsoever and in most cases, refusing to respond. In two cases, military and Veteran liaison staff went to extraordinary lengths to provide assistance, but were limited by the inaction of the congressmen

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- for whom they worked. In two cases, COL Platoni received threats to cease and desist, one in person at her place of business. These elected officials, several contacted by their civilian constituents and supporters of the Fort Hood victims, are as follows:

Congressman Mike Turner
 Congressman David Joyce
 Congressman Warren Davidson
 Congresswoman Kay Granger
 Senator Kristin Gillibrand
 Senator Charles Schumer
 Senator Johnny Isakson
 Senator Jerry Moran
 Senator John Boozman
 Senator Dean Heller
 Senator Bill Cassidy
 Senator Mike Rounds
 Senator Bernie Sanders
 Senator Sherrod Brown
 Senator Jon Tester
 Senator Mazie Hirono
 Senator Joe Manchin
 Senator Thom Tillis
 Senator Dan Sullivan
 Senator Richard Blumenthal
 Senator Patty Murray
 Senator John Cornyn
 Senator Kelly Ayotte
 Senator Ron Wyden

Other survivors have worked relentlessly to right this wrong. Colonel (Dr.) Kathy Platoni is one such survivor, who later found she was to be Hasan's supervisor, placed at the top of Hasan's hit list. A dear friend died at her knees, having sustained mortal wounds while trying to "rush" the shooter with a chair. As a clinical psychologist who specializes in treating PTSD, she knows both the horror of such an attack, as well as the longstanding and lifelong psychological aftereffects. She has written and spoken often about the tragedy, including numerous articles in such publications as *TIME* (April 19, 2016) and the *Wall Street Journal* (March 19, 2015). Shawn Manning of the referenced Manning, et al. v Esper lawsuit is another example. SSG Manning was shot six times, including in one lung and in his liver by Hasan and lives with two rounds left in his body. SSG Alonzo Lunsford was shot 7 times, losing his vision in one eye.

Survivors, as well as a myriad of supporters, find it inconceivable that Soldiers preparing for impending deployment or returning from Iraq and Afghanistan, those charged to fight for their country, and who were killed or wounded, continue to be denied benefits, even after receiving Purple Heart Medals. The incomprehensibility of this fact, along with the pain stemming from colossal deceit and betrayal by their own government, remains a series of egregious acts against all those victimized by the Obama administration. These assaults last a lifetime for the victims and their families. Most have given up and

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lead shattered lives. PTSD is rampant among the wounded and the survivors. Six have taken their own lives, in addition to one incomplete suicide. There will be more. This is one of the greatest injustices ever perpetrated by the United States Government against its own Soldiers and their families in the history of this country.

It is abundantly clear that the strong and persistent calls from a myriad of experts, the survivors, the Secretary of the Army, and congressional representatives to properly label the Fort Hood Massacre for what it is: an act of domestic terrorism committed by an enemy of the state, remains ignored. This includes an amendment to the National Defense Authorization Act to specifically label the attack as terrorism, which resulted in the awarding of the Purple Heart and Defense of Freedom Medals for victims. Yet, benefits have not been forthcoming. **This year will mark 10 years since the 2009 Fort Hood Massacre. Hasan, the self-admitted assassin and radical Islamist, was court martialed in 2013 and is on death row. The 12 soldiers, one civilian, and the unborn child massacred, as well as those injured at the hands of a radical Islamic terrorist shouting the signature "Allahu Akbar" in his merciless and savage attack on a military base, deserve victim relief.**

While the Purple Heart and Defense of Freedom Medals are appreciated, the refusal to provide associated benefits to these victims as ordered by the Secretary of the Army, undermines the very medals that were very reluctantly awarded, made even more offensive by the denial of Combat Action Badges and Combat Medical Badges to those who placed their lives on the line under fire to save their wounded and dying comrades. There are several survivors and wounded who are alive today because of the heroic deeds of these unintended first responders. **The Army is supposed to take care of its own. They have failed to do so. That the Fort Hood Massacre is not classified as an act of domestic terrorism and Hasan, not classified as an enemy of the state, resulting in the denial of full benefits for almost ten years, is unconscionable. The time is long past due to stop penalizing the families of the fallen, the wounded and the survivors, as well as to repay those who would have gladly died to spare the lives of their dying brothers and sisters in uniform at the hands of a madman. We are asking that you issue an executive order so that this may transpire. You are our last hope, Mr. President.**

This egregious travesty of justice begs your direct attention, Mr. President. We ask for an audience with you personally to assure that the facts are presented, and the hidden truths brought to light after ten long years, directly from those who witnessed the slaughter that is the Fort Hood Massacre.

Thank you, Mr. President, for your consideration.

Yours most sincerely,
Kathy Platoni
 Kathy Platoni, Psy.D., DAIPM, FAIS
 COL(RET), US Army
 COL, Ohio Military Reserve/State Defense Forces
 Dayton SWAT
 Editor, *Combat Stress*

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Also cited on the Letter to the President:

Gary M. Jackson, Ph.D.
(Former Secret Service Psychologist and CIA Intelligence Officer)
President & CEO
ANBECO, LLC

Representative James P. Trakas
Ohio House of Representatives 1999-2005

Michele Vannote, nee Gaffaney
Sister of Captain John Gaffaney, Mortally Wounded by Rushing the Shooter

Maria B. DiMenna
Holmes Beach, FL
MAGA

Deborah L. Hawkins
Program Director/Coordinator Southwest Ohio Critical Incident Stress Management Team (SWOCISM)
Colleague
Resident of the State of Ohio
Citizen of The United States of America

Lee Jean Heller, Ret EMS,
Volunteer, Southwest Ohio Critical Incident Team, Ohio
Volunteer for NYPD After 9/11
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MAJ (RET) US Army
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American Board of Clinical Neuropsychology
Fellow, American Psychological Association
Operation Iraqi Freedom; Surge Campaign Star; BSM
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Elaine Giacomo
Nelson, NH

Ted R. Schwalm
US Army Veteran SP5
June 1966 - June 1969
War in Vietnam May 1967 - May 1968
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Kathleen J. Burch, Psy.D., R.N.
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Walter P. Knake, Jr. Ph.D.
CPT, US Army 1963-1972
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COL Audley J. Woodward
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Former SGT, 467th MED DET (CSC), US Army
Survivor, Fort Hood Massacre
Denver, CO

Frank Valencia III, ACSW
Chaplain (MAJ), U.S. Army Reserve
Survivor, Fort Hood Massacre
Plymouth, MN

LtCol (RET) John D. Hutchinson, USAF
Spouse of Fort Hood Survivor, COL Kathy Platoni
Beavercreek, OH

Beverly Kay Peyton
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Daniel J. Kirsch, Ph.D.
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Navy Contractor, Editor-in-Chief, Combat Stress
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Michael L. Adams, PhD, LTC (RET), US Army
Former OIC, Triage and Behavioral Health CRDAMC
Veteran, the War in Vietnam, Operation Desert Storm, Activated for Operation Iraqi Freedom at Fort Hood, TX
Survivor, Fort Hood Massacre
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A Ceremonial Visit by the President and First Lady on 7 August 2019, as a Tribute to the First Responders in the aftermath of the Dayton Mass Shooting on 4 August 2019 in Dayton, Ohio.

Tribute visit with the Dayton Police Department, the Dayton Fire Department, and the staff of Miami Valley Hospital by President Trump and the First Lady.



Command staff of Dayton Police Department, the heroes of the Dayton Mass Shooting, and Col. Kathy Platoni (Invited guest, Psychologist for Dayton PD and member of Dayton SWAT), 7 August 2019.



President Trump and the First Lady visit injured victims of the Dayton Mass Shooting, Miami Valley Hospital, Dayton, OH.

President Trump and the heroes of the Dayton Police Department.



Award presented to the President of the United States by LTC Matt Carper, Assistant Chief, Dayton Police Department and Officer Brian Rolfes, 7 August 2019.

• IN THE NEWS •



Saluting Our Men and Women in Blue: IACP Conference 2019, President Trump, and COL (RET) Kathy Platoni

The 2019 International Association of Chiefs of Police (IACP) annual conference convened on the weekend of October 26-29 in Chicago, Illinois, with an impressive roster of attendees and speakers. President Donald Trump delivered a rousing keynote address, and the American Institute of Stress' own COL (RET) Kathy Platoni presented the results of a new study on the effects of Alpha-Stim among police officers.

The IACP has been "shaping the law enforcement profession" since 1893. The annual conference "has been the foundation, providing leaders with new strategies, techniques, and resources they need to successfully navigate the evolving policing environment." The importance of this conference is greater now than ever before; serving as a police officer is a noble and often dangerous pursuit, and one that requires men and women to selflessly prioritize and pursue the safety of their communities.

President Donald Trump delivered the keynote speech, expressing his admiration of and support for our men and women in blue. "You don't hear it enough," President Trump said to the assembly of police officers, "You do an incredible job. The people of this country know it, and the people of this country love you." President Trump also announced that he would be signing an Executive Order to establish a new Commission on Law Enforcement and the Administration of Justice. The Commission will address challenges faced by law enforcement and will study best practices for providing for the safety and wellbeing of police officers.

One such practice was highlighted in Dr. Platoni's presentation, "Managing Mental Health and Pain with Alpha-Stim: Putting First Responders First", which was on a recent study in which police,

sheriff officers, and firefighters in Texas and Ohio used Alpha-Stim over the course of 6 weeks to treat their anxiety, insomnia, depression, and pain. Across all four indications, a clinically significant decrease in symptoms was reported by the participants, with no adverse effects.

Dr. Platoni is especially qualified to speak of the benefits of Alpha-Stim, and to understand the mental trauma that police officers and other first responders may grapple with. Not only is she a psychologist, trained to treat men and women with combat stress, but she is the survivor of the mass shooting at Fort Hood in 2009. Dr. Platoni regularly works with the police officers of Dayton, OH, counseling them through officer-involved shootings and other incidents that can cause lasting trauma. So, when Dr. Platoni is impressed by the results of a study, people pay attention – and for good reason.

But what is Alpha-Stim, and why was it a topic of discussion at such an important conference? Alpha-Stim is an FDA cleared medical device proven by over 100 clinical research studies to safely and effectively treat anxiety, insomnia, depression, and pain. It is not a drug, so there is no risk of addiction or lasting side effects, and no risk of it hindering a police officer's ability to do his or her job.

Alpha-Stim uses a modality called cranial electrotherapy stimulation (CES). It sends a tiny and painless current of electricity to the brain through two small electrodes that clip onto the earlobes. Treatments take just 20 minutes, but the relief is long lasting and the results with Alpha-Stim are cumulative over time. Its convenience and efficacy make it a powerful tool for police officers who need to feel better fast, so they can perform at their best.

The American Institute of Stress salutes our men and women in blue and is honored to have the support of Dr. Platoni.

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TO GET
STARTED**



A Response to Veteran Suicides

By Reverend John Thurman



When I hear of another Veteran taking his or her life, regardless of age, it is a sad, sobering moment. One of the most disturbing trends has been the number of Veterans taking their lives while in VA facilities.

Recently I watched an episode of Seal Team Six, which brought this dilemma directly into the living rooms of all who follow the show. The storyline focused on

team members who are seeking help from the VA for a Traumatic Brain Injury (TBI). However, because there is no record of his TBI, the VA cannot help. As a result of his frustration, he takes his life in the VA parking lot.

Sadly, these events seem only to be escalating, and we have seen Veteran suicides ranging from the lowest ranks to general officers. There are many excellent articles on the topic of Veteran suicides and scores of articles

that point blame at the VA. The focus of this article is a brief strategic view and a transition from a tactical to a practical approach on how communities and individuals can help lower the suicide rates.

I have spoken with several Iraq and Afghanistan Veterans, many of whom are now in their 30's, who have known people who committed suicide. They agree that some of the reasons for this tragic loss of life include long and multiple deployments, difficulties with reintegration back into "normal" life and relationship issues. Also, many feel that the VA system should be easier to access. Too many are never even informed about the VA benefits to which they are entitled.

The VA National Suicide Data Report for years 2005 to 2016, which was released in September of 2018, highlights an alarming rise in suicides among Veterans ages 18 to 34, at a rate of 45 per 100,000 Veterans. Younger Veterans have the highest rate of suicide, however those ages 55 and older still represent the most significant number of suicides.¹

The suicide rate for older Veterans is higher than that for non-Veterans as this applies to Veterans age 55 to 74 years of age; the rate of suicide is 26 per 100,000. Nationally, the suicide rate in the same age group is 17.4 per 100,000 for non-Veterans. The rate ticks up even higher for Veterans over the age of 85.²

The Veterans Health Administration has focused on finding risk factors that could lead someone to kill themselves, such as isolation, previous suicidal thoughts, family history of mental health issues, and access to firearms. Another significant risk factor is that older men are also more likely to reject treatment for

mental health issues.

"Among the people who have those risk factors, we still do not know who will attempt suicide," said Colin Depp, a psychologist at the San Diego VA, who has researched suicide among older Veterans.³ We are not very far ahead in understanding who is out there, who is likely to take their lives in the next hours, days, months," he said. The VA emphasizes getting potentially suicidal Veterans in the door, where healthcare workers deploy a range of treatments, according to Depp.

This is what has helped 76-year-old Robert Nielson. He was 73 years old before he sought help. As part of his treatment, Neilson is now writing letters of encouragement to fellow Veterans who are just beginning therapy as part of a VA program in San Diego.

Recently there have been a couple of news stories that may provide a ray of hope regarding the ways that Veterans can access health care. The VA has implemented new health care guidelines, anchored in the 2018 Mission Act which was signed into law June 6, 2018.

Here is an excerpt from the VA's Blog about the Mission Act. A key aspect of the MISSION Act is the consolidation of VA's community care programs, which will make community care work better for Veterans and their families, providers and VA employees. When this transition is complete, the following will occur:

- Veterans will have more options for community care.
- Eligibility criteria for community care will be expanded, including new access standards.
- Scheduling appointments will be easier, and care coordination between VA and community providers will be better.

Going forward,
community care will be
easier to use, and
Veterans will remain at
the center of their VA
health care decisions.

- Eligible Veterans will have access to a network of walk-in and urgent care facilities for minor injuries and illnesses.

“Transitioning to the new eligibility criteria for community care should be seamless for Veterans,” Wilkie said. “Veterans will continue to talk to their care team or scheduler as they have been doing to get the care they need.”

VA also has been working closely with community providers to ensure Veterans have a positive experience when receiving community care. For example, VA has developed education and training materials to help community providers understand some of the unique challenges Veterans can face.

Going forward, community care will be easier to use, and Veterans will remain at the center of their VA health care decisions.⁴ Hopefully, these new paths will allow vets excellent access to both physical and mental health.

Another exciting announcement is the promising hope of a new treatment for Post-Traumatic Stress Disorder (PTSD). The new procedure called stellate ganglion block, or SGB is so fast-acting that many believe it could be a game-changer. As an effective way to treat chronic pain, it has only recently been tried for treatment of PTSD. Now the U.S. Army is spending \$2 million to find out more. Nobody is calling it a cure, but the promise of a new therapy cannot come soon enough for many Veterans who are frustrated and despairing that nothing they have tried has worked.⁵ The treatment is relatively new; its potential is very encouraging.

While these new treatments are cause for

optimism for Veterans, I want to shift from the big picture to the strategic to the tactical and into the practical, fire team, flight level.

Also, on a personal note, I am encouraged to see some of the long-needed changes occurring at the VA. Recently I was talking with a psychologist who is also a Veteran with more than fifteen years of experience of working at the VA. I asked him about his views about the VA’s treatment, and he stated that one of the major issues were the metrics that the VA used to treat Veterans. Sometimes a Veteran has to work through a complicated, slow, and confusing maze to get help.

He and I have worked with a veteran whose PTSD was becoming more intense as was his frustrations at all he had to navigate with the VA treatment protocols. Fortunately, my friend, who is also an officer in the Reserve Components, took the individual over to the VA and introduced him to the various key players who helped the young veteran navigate the system. Partially due to the psychologist help and the young veteran’s tenacity, grit, and resilience, he was able to push through and get the help that he needed. As a testimony to this young man, he now helps other Veterans process through our local VA’s treatment options. This is just one example of how we can move from strategic thinking to tactical and practical thinking regarding Veteran suicides.

I am encouraged that the VA is taking leadership in spearheading efforts to broaden their reach in helping Veterans. The VA is expanding its efforts to reach out to the men

and women who took an oath to protect this nation and to let them know that we will not abandon them in their hour of need.

The goal of VA's suicide prevention efforts is not to get every eligible woman and man enrolled in VA care, but rather to equip communities to help Veterans get the right care, whenever and wherever they need it. This change in perspective means using prevention approaches that cut across all sectors in which Veterans may interact and collaborating with Veterans service organizations, state and local leaders, medical professionals, criminal justice officials, private employers, and many other stakeholders. However, the VA must ensure suicide prevention is a part of every aspect of a Veterans' life, not merely during their interactions with VA.⁶

While these steps are moving us into a more comfortable place, I want to focus on what you and I can do on a local level. I will be sharing from three perspectives, first as a fellow veteran, as a Licensed Clinical Mental Health Counselor, as a Retired Army Chaplain, and as a concerned citizen.

As one who has served my local community for more than thirty years, I have seen the gamut of how local mental health providers regard Veterans. A majority demonstrate tremendous respect and provide appropriate care of Veterans, on the other extreme a minimal number of mental health providers show disrespect and disdain for our Veterans. Another challenge for many providers is the ability to find common ground with some of their Veteran clients.

After years of working with Veterans, firefighters, EMS, and police officers, I have

learned that on the one hand, they can discern if someone is fake. On the other hand, they can use the line, "no one understands me unless they have been through what I have been through" as a wall.

There are only two ways to move through this barrier to treatment. First, the provider must learn and understand the frame of reference for the client. Second, the client must cooperate with the counselor to help them understand the issues. This collaboration can be a win-win for all concerned. First, if the provider is teachable, you as a client can let them join you as you share your story. A good clinician will have a good set of tools to help out as you share your story with them.

Many Veterans may opt-out of using the VA resources for any number of reasons. Some decline due to access to care issues while others may decline because of something as simple as using their work insurance, private insurance, or the self-pay route.

I believe that looking to the VA as the sole-service provider can be an unrealistic expectation.

In most states, there are multiple levels of networking and connecting with other Veterans, health care providers and helping agencies.

Additional networking and connection points could be through your church, synagogue, or temple.

The third is through local mental health professional. Here are some tips if you choose to use your resources or insurance on a local Licensed Mental Health Professional.

Some traits of an excellent clinician

1. Non-judgmental - You need a clinician who

Research tells us that healthy spirituality can be a tremendous accelerator in recovery.

validates you as a person regardless of the issues you bring to the table.

2. Engaging - You need to feel like the clinician is tracking with you. You are both talking and collaborating about where you are, what might be helpful, and what may be holding you back. The key is that both of you are working to help you find the answers that will work best for you.

3. Relational - At its core, therapy is all about building a relationship. Part of that means that you can relate to your therapist. It means that the interactions can be fluid, sometimes intense and other times humorous. It is essential to find a therapist whom you find it easy to share your story. This is why it is crucial for you to "interview" your therapist to see if there is a connection.

4. Focused - A good therapist will provide focus and structure to the sessions. Focus helps you clarify where you are and enables you to design a plan on where you want to be. One of the critical traits of a good therapist is their ability to help you develop a workable mission plan.

5. Future-oriented - While some of the things you may be dealing with may have profound and deep roots in the past, a good therapist will work to help you identify some of those issues, not to build a shrine to them, but to see them for what they are and to help you push through them with the idea of moving forward. For example, a rearview mirror is designed to know where you are coming from, but if you try and drive a car and you are always looking back in the rearview mirror, you might have a wreck and hurt yourself and others.

6. Practical - While life is very complicated,

sometimes the best explanations in the world are the most

obvious and straightforward. Simple, however, does not mean easy. If it were "easy," people would not need therapists. Practical therapists won't get lost in the maze of the past, but rather allow an earlier point in time to inform how change can be created in the here and now. Additionally, a good therapist will offer concrete feedback to help you get where you want to be.

7. Hopeful - Hope is a terrific motivator. Feeling that something is going to work is often a large part of the equation in successful treatment. However, a good therapist isn't unrealistically hopeful. Competent therapists know how to strike a balance between realism and hope.

If you are using the private sector instead of the VA for treatment, remember, you are the consumer, and the clinician is the provider, be sure you do what you can to learn about the provider and make sure you find one that you feel comfortable with.

Now, I will put on my chaplain/minister hat.

Research tells us that healthy spirituality can be a tremendous accelerator in recovery.

Whether it is a traditional Native American practice, Eastern practices, or more conventional Catholic, Orthodox, Jewish, or Protestant types of spiritual disciplines, there is substantial research indicating positive overall outcomes, but mainly for the moral injury component of trauma.

For an excellent and concise review of the concept of moral injury, check the link in the endnotes.⁷

In recent years, this author has seen a

positive move by many churches to be more inclusive of Veterans in their ministries. By this, I mean more than just standing for your branch of service during the Sunday services (Veteran's Day weekend) when many churches honor all the service branches.

Apart from the fact that many Veterans are becoming either ordained ministers or are becoming involved in various lay ministries, more and more churches are developing and hosting support groups for Veterans.

I know, my church and many other churches in the U.S., provide and promote various support groups for Veterans to gather, to share their stories, and in many cases study

the scriptures, as well as to have fellowship and accountability.

Other community programs that can be an invaluable help are the older traditional veteran service agencies like the AFW and more recent groups appealing to younger vets like IAVA.

What can you and I do as private citizens to come alongside our vets?

When I discover that a person served, I always will say thank you for your service and then ask them about their experience, some of their stories, and ask how things are going. I have yet to find a vet who doesn't open up a little bit when I ask.

To go a little deeper, what do you do if you

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are talking with someone, anyone who is hinting that they might be feeling suicidal?

In the late 80's I was fortunate enough to be assigned to the 351st MASH unit, an Army Reserve unit located in Albuquerque, NM. One of the mandatory training programs in our unit was a relatively new Army-wide program called the Combat Lifesaver Course. The version that I took in the late '80s has evolved as the needs of the battlefield have changed.

The U.S. Army Combat Lifesaver Course is an official medical training course conducted by the U.S. Army, intended to provide an intermediate step between the buddy aid-style essential life support taught to every soldier and the advanced life support skills taught only to U.S. Army Combat Medics.⁸

With that positive imprint, I began to realize the importance of developing some model ordinary civilians could use in the area of Psychological First Aid, particularly Suicide Prevention and Intervention. Let's face it; in most cases, the first responder in a possible intervention is not going to be a medic or mental health professional.

So, moving from the Strategic and Tactical to the Practical Realm, let's look at the real world, real-time actions you and I can do to help lower the impact of suicide.

What do you do when you fear a friend or family member may be suicidal? How do you assess the seriousness of your suspicion or their 'suicidal comments'?

Listen to Your Suicidal Friend!

Be willing to talk about suicide. Several years ago, I began to ask the question directly. Many suicidal people want to

voice their thoughts, but their family and friends won't let them. You don't have to have all the answers; you need to be willing to listen. Take your friend seriously.

When in Doubt, Ask!

If the person is talking around the subject, I will ask, "When was the last time you felt like taking your life? Often, they will say something like, "a few days ago." At that point, I will usually say something like, "Well, it has been a week since you had those thoughts. What helped you pull through that rough patch?" Usually, they will say something like my spouse, my family, my buddies. At this point, I don't care what it is; I identify it as an incredible strength to get help through a rough time.

If your friend's intentions are not clear, ask them point-blank: "Are you thinking about suicide?" It seems counter-intuitive, the opposite of what you think you should do, but asking will not push him to act. Talking about their thoughts and feelings may serve as a release-valve, thus buying more time. Learn as much as you can about their suicide plan. The acronym SLAP is a suicide threat assessment tool that I find helpful.

The SLAP method was developed by Dr. Kenneth Morris and has been used to train laypeople as a simple helping tool. NOTE: This is not clinically validated protocol, it is a simple tool that any layperson, neighbor, or friend can use to be that initial caring person that can be a link to saving a life.

Here is the breakdown of the SLAP Method:

S - Specific: How specific is the plan? The more

specific a person is about their plan of suicide, the more concerned you should be. While any discussion about ending life should always be taken with seriousness if an individual states a specific plan and talks about a specific day, this calls for immediate action. That action is two-fold, continue the conversation, and continue to ask questions to ascertain lethality.

L - Lethality: How lethal is the method considered? If the plan is deadly, they are at a 50% risk. What you're trying to discern here is if there's any window to step in for intervention. For example, a weapon is more lethal than a bottle of pills. Without a doubt, both are lethal, but a bullet is almost immediate, while pills

allow time to intervene and possibly save their life. Minutes matter when you're dealing with a person who is contemplating suicide.

A - Available: How available is the method? Do they have access to the means or the methods to kill themselves? If they have access to the method they are considering, this is cause for high alarm. If a person says, "The rope is tied around the rafter" or "The gun is in my hand" that availability immediately raises the urgency.

P - People/Proximity: Is there someone, anyone that can help immediately? Are there any people around to prevent this? Is anyone in proximity to stop this? Is this student up in their bedroom and the parents are downstairs



watching television or is this student secluded in the woods? In this scenario, you are trying to see if there's a way to stop the attempt.⁹

On a personal level, I hope that you will never have to use this tool, but if you are confronted with a friend or coworker who is suicidal, this tool could help you get the help you need to help them.

I believe that you and I have a moral responsibility to help each other out. With this simple yet useful tool, you may be able to be a part of saving your buddy's life.

Here are some practical tips you can use if your friend or coworker is distressed.

- 1.** Do not pretend like things are ok. If you sense something is going on, ask. Better to attempt to ask someone how they are doing, then ignoring them.
- 2.** Use discretion, and you can have very private, caring conversations in a public place if you use your head. If they feel somewhat shielded from others, they will tend to be more open.
- 3.** Be present, focused, and listen. Do not try to plan your next sentence; instead listen with your head, your heart (intuition), your eyes, and your brain. With this focused, caring attention, you will almost intuitively know what to say next.
- 4.** Let them speak their piece, say what they need to say. Please do not cut them off.
- 5.** Don't try to fix or rescue the person. You can use some of the principles of SLAP to help with the conversation.
- 6.** Ask how you can help the person. Ask what would make them feel better.
- 7.** Develop a help plan. What do they need at this critical moment? A listening ear? A family

member? Professional help? Please do what you can legitimately do to get them through the immediate crisis.

- 8.** Think forward. If they have settled down, ask them if you could check up on them in the next couple of days.¹⁰

Where do we go from here?

First, make yourselves aware of the resources. Second, realize that you do not have to be a mental health professional to help another in a crisis. While you are not trained to deal with someone who is dysfunctional, you can do a few things to help someone in distress.

So, with that in mind, what are some resources that are available for Veterans?

Here are some other suicide prevention resources:

- National Suicide Prevention Lifeline
1-800-273-8255
- Military Crisis Line Call
1-800-273-8255 and Press 1
- National Crisis Text Link
Text the word CONNECT to 741741
- Here is a link to a listing of various State Suicide and Crisis Lines www.sprc.org/states

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ABOUT THE AUTHOR

John Thurman is a Licensed Clinical Mental Health Counselor, author, speaker, Retired U.S. Army Chaplain, and International Crisis Response Specialist. He holds a Masters of Divinity and a Masters of Art in Counseling.

John retired after twenty-two years of serving in the U.S. Army Reserves, National Guard, and on active duty Army status. During Desert Storm, he was mobilized and assigned to the world-renowned U.S. Army Burn Unit at Fort Sam Houston, Texas. In this position, John worked as both a chaplain and a mental health provider. As an additional duty, John worked with the Fort Sam Houston, Medical Debriefing Team, which focused on medical personnel who were returning from deployment.

During his time in the Army, he was also part of a small group of select chaplains who were chosen to attend a week-long Awareness and Prevention Program at the Menninger Clinic. Some of the lessons learned from this event became part of the Army's Suicide Awareness and Prevention Training in the early '90s.

Currently, John works as an Employee Assistance Consultant providing Stress Management Training, WorkLife Balance Presentations, and management consultation to multiple federal agencies, to include the U.S Air Force.

John is also on the National and International Response Team for Federal Occupational Health. In this capacity, he has deployed to the Democratic Republic of Congo, working with the State Department. Also, he has deployed on five national disasters as a FOH Stress Counselor, working with FEMA.

John is listed as a Certified Corporate Crisis Response Specialist by the American Academy of Experts in Traumatic Stress. In this capacity, he has deployed on 152 disruptive workplace events, ranging from corporate downsizing to his most recent deployment to El Paso, supporting the Wal-Mart Mass Shooting incident.

John is also an instructor with SheildCoreGlobal, providing specific training on stress management in extreme environments.

John and his wife of 47 years live in Albuquerque, NM.



Veteran Mentors for Hillsborough County Veterans (MHCV 501c3)

By DJ Reyes, Colonel U.S. Army (Ret), Senior Mentor Program Coordinator
13th Judicial Circuit (FL) Veterans Treatment Court

"To never leave a Service Member behind on the battlefield or here in Tampa Bay."

www.HillsboroughCountyMentors.org

A National Dilemma: Since September 11, 2001, and during the longest continuous U.S. conflict in history (Global War on Terror), more than 2.6 million men and women have voluntarily served in uniform. This is less than 1 percent of the current U.S. population; yet, more than 20 Veterans a day commit suicide. More than 700,000 Veterans are in some phase of the U.S. criminal court process. One out of six Veterans have a substance abuse problem. One out of five Veterans have been diagnosed with some type of mental illness or cognitive impairment. This includes Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI), stemming from roadside bombs and suicide bombers (IEDs). In many cases, upon returning stateside, these Veterans subsequently commit a criminal offense, which can be directly attributed to military service or combat related injuries. Sadly, and in many cases, these Veterans are not properly identified, and they become lost in the criminal justice system without the necessary help, medical treatment or therapies. This encourages a vicious cycle of hopelessness, non-recovery, and ultimately, serious injury or death.

The Response: The Veterans Treatment Court, or VTC, is a hybrid court, blending aspects of the traditional drug, criminal, mental health, and diversionary court processes. Its primary focus is on the effective identification, treatment, and successful reintegration of every enrolled Veteran back into his or her local community.

There are currently over 450 VTCs in more than 40 U.S. states. Here in Tampa and the 13th Judicial Circuit's VTC, the program has received accolades and recognition from the local, state and national levels since its inception in late 2013. Currently the largest in the nation in terms of docket size (currently 175 - 225 Veteran defendants), the key ingredient that directly accounts for Tampa VTC's success in terms of non-returning graduates (over 80 percent) and local county tax cost savings (currently over \$4 million per annum) lies within the ranks of its Volunteer Veteran Mentor Program (currently 65 actively serving mentors from a total program of 138).

The Tampa VTC Volunteer Veteran Mentor Program and the 501c3: Established and led by its Program Coordinator, Colonel DJ Reyes (U.S. Army retired) since its inception in October 2013, the current VTC Volunteer Mentor Program is comprised of a nine man Senior Mentor Council that directs the "Mentor - Veteran" assignments and ensures that the Veterans "stay on track" and complies with the VTC Judge's court mandates.

Experience wise, the Senior Mentor Council enjoys over 270 years of combat, operational, and command leadership experiences ranging from the Vietnam War to the current Global War on Terror in the Middle East and North Africa. In direct support to the VTC Judge, they oversee, train and direct fellow volunteer Veteran Mentors that are assigned to 8 Task Force Teams - each Mentor receives one or more



Veteran defendants to individually mentor, encourage, and assist in navigating through the VTC requirements in a program that can range from nine months to over two years in duration.



Vietnam Veterans of America (VVA), Veterans of Foreign War (VFW), The American Legion, Team Red White and Blue (RWB), Mission

Although the Mentors appear with their Veteran defendants before the VTC Judge during the scheduled monthly VTC sessions, the true work is performed “in between Sundays”, where the most Mentor interactions and support are rendered. There are multiple accounts of mentors directly and positively impacting their Veterans and improving quality of life for them and their families.

Specifically, Mentors provide critical guidance and resources to assist the VTC Veterans in the areas of alternative transportation, employment, community service, educational assistance, food, housing and clothing support. To support this effort, the Senior Mentor Council created **an extensive community resource network at the local through federal levels.** This includes local strategic partnerships with the following: educational institutions (Keiser University, National Louis University, Stetson and Western Michigan (Cooley) Law Schools); legal support organizations (Hillsborough County Bar Association’s Military and Veterans Affairs Committee, Bay Area Legal Services); religious institutions (Idlewild Baptist Church, Christ the King Men’s Ministry and The Society of St Joseph, Knights of Columbus); various law firms and businesses; and numerous Veteran Service Organizations (VSOs) that include the

United/The United Way, and the Camaraderie Foundation. The Program also recently partnered its efforts with Diversity Action Coalition (DAC) - a local 501c3 that fundraises for direct support to local needy military and special needs families, and the WalMart South Tampa branch stores, to support the “Bikes for Vets” Gift Program. Finally, the Mentors closely interact with the James Haley Veterans Administration to ensure medical support requirements are provided in accordance with the VTC Judge-directed orders.

In 2016 and in support of the ongoing awareness and education efforts, former VTC Judge, the Honorable Gregory P. Holder and Colonel Reyes travelled to Washington DC to brief both Chief Judge Robert Davis (U.S. Court of Appeals for Veterans Claims) and U.S. Secretary of Veterans Affairs, the Honorable Robert McDonald. Colonel Reyes also briefed the program’s successes to Florida Governor Rick Scott, Tampa Mayor Bob Buckhorn, and at the 2017 FL Bar Association and Conference in Boca Raton. Tampa Bay’s City Council, led by Councilman Luis Viera, also honored the VTC Mentor Program with a commendation for achieving a milestone 100th Volunteer Mentor in support of the program. In June 2019 Reyes (as a member of the National Veterans Court Alliance) briefed White House Administration officials and Congressman Charlie Crist in

Capitol Hill, in support of his bill, HR886, the Veterans Treatment Court Coordination Act of 2019. This bill will, if passed, provide the needed federal resources required to assist all 50 states in establishing and maintaining their respective VTC programs.



Colonel Reyes has voluntarily assisted several Florida and non-Florida VTC Mentor Coordinators in establishing or refining their respective mentor programs. In October 2019, by invitation of Chief Justice Lawton Nuss (Kansas State Supreme Court), Reyes and VTC Judge Michael Scionti will provide the Tampa VTC and Mentor Program briefing at the Annual Kansas Judicial Conference in Wichita. Tampa's VTC/Mentor Program is also scheduled to host the first Regional Florida VTC and Mentor Training Workshop and Conference in November 2019. The purpose is to collaborate and share best practices with the local area Florida Circuit Court VTC teams.

To fully leverage the power of community support and financial backing, the Senior Mentor Council established "Mentors for Hillsborough County Veterans", a 501c3 whose mission is to help "identify, assess, treat, successfully rehabilitate, and reintegrate veterans back into the local communities as positively contributing citizens." Through this 501c3 the Senior Mentors have been able to raise the necessary funding required to support the Veterans' essential needs in the VTC.

The Tampa VTC Volunteer Mentor Program epitomizes the true "all in" community spirit and "can do" attitude that successfully solves

problems plaguing our local bay area communities. Demographically, the Mentors are a cross-representation of not only the US

military, but also of our great Nation. Ethnically, they represent Caucasians, African-Americans, Hispanics, Asians, and Pacific-Islanders. They are both males and females. They represent enlisted, Non-Commissioned Officers, Warrant Officers, and Commissioned Officers. More than half of the current active serving Mentors have had combat deployments, from Vietnam to Afghanistan. Several have VA-rated (service and combat) disabilities, and two Mentors are wheelchair disabled. In fact, one of the wheelchair bound Veteran Mentors, Mike Nicholson, is a current multi-gold medalist in the 2016 and 2019 Wounded Warrior Games. More than half of the current active serving Mentors are active duty military/retired, active reservists, or Department of Defense civilians and contractors. The remaining are current lawyers, law students, or businessmen and businesswomen.

In summary: Driven by the U.S. military values of loyalty, duty, respect, selfless service, honor, integrity and moral courage, the Volunteer Mentors are Tampa Bay's unsung heroes. Their "reward" is in the grateful acknowledgement from those Veterans and their families. The volunteer Veteran Mentors are the "quiet warriors" who will not rest until every Veteran in trouble with the law is provided the needed resources to get well again and successfully reintegrate into our community.

ABOUT THE AUTHOR



DJ Reyes is a retired U.S. Army Colonel with over 33 years of faithful service to our great Nation. Earning his bachelors, masters, and juris doctor degrees from the University of Notre Dame, the U.S. Naval War College, and Temple University School of Law, DJ also commanded or served in primary staff positions in special forces / operations, military intelligence, infantry, airborne, air assault, Joint/ Interagency, and Multi-National organizations. His combat and contingency deployments included tours in Iraq, Afghanistan, North Africa, Bosnia, Kosovo and Haiti. In addition to providing independent consulting for organizations supporting Veterans, military families with special needs, and victims of human trafficking, DJ previously served as a Department of Defense contractor assisting local FL Veterans and their spouses with employment opportunities. DJ currently sits on the following advisory boards: National Veterans Court Alliance, Washington DC; U.S. Congresswoman Kathy Castor (D-FL 12th) U.S. Service Academy Nomination Committee; U.S. Congressman Gus Bilirakis (R-FL 14th) Veterans Advisory Committee; FL Department of the VA Executive Director Danny Burgess' "Forward March" Veteran Program Legal Sub-Committee; Legislative Chair, FL Veterans Council, Orlando. Finally, DJ devotes significant time and energy in his community service role as senior military advisor and mentor to the 13th Judicial Circuit's Veterans Treatment Court, or VTC. The VTC identifies those Veterans in trouble with the law resulting from some disorder or disability incurred during military service, gets them the necessary medical treatment and therapies, helps in the rehabilitation process, and assists in successful reintegration back into the veterans' local communities.

Within Tampa Bay, DJ was recognized in 2014 with the Tampa Bay Business Journal's "Heroes at Work" Award for his continuing public service as a Veteran owned business consultant supporting both military and special needs communities. In 2016, DJ was awarded with the Hillsborough County Bar Association's highest award - the Liberty Bell Award - for his exemplary efforts in promoting, and advocating for, the legal judicial system and process as it supports the local Veterans and special needs communities. Additionally, the Hillsborough County's Sheriff's Hispanic Advisory Council announced DJ as the 2016 recipient of the Raymond E. Fernandez Award. This award is presented each year to an individual who has made outstanding contributions to the criminal justice system. Finally, the Notre Dame Club of Greater Tampa Bay recently announced DJ's nomination for the 2020 Father Corby Award for Distinguished Military Service.

North Country Public Radio interview

Roland Van Deusen

On September 5 of 2019, I was contacted by North Country Public Radio (WSLU at 89.3 FM) of Canton, NY, Serving Northern New York State, some parts of Vermont and Canada, and St. Lawrence University. Assistant News Director David Sommerstein responded to my article about reducing Veteran suicides. This was published in the Summer issue of Combat Stress. The link below contains our five-minute interview.

Although the clientele throughout my career included many Veterans, I was not exclusively or primarily a Veterans' counselor.

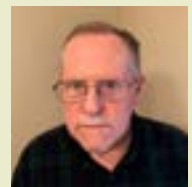
It is significant to note that we will begin our nineteenth year of continuous warfare in November of 2019.

www.northcountrypublicradio.org/news/story/39486/20190905/counselor-urges-veterans-to-save-the-quot-warrior-in-the-mirror-quot-to-prevent-suicides



ABOUT THE AUTHOR

Roland Van Deusen is a Vietnam era Navy Veteran. He earned a master's degree from Syracuse University, now named the number one private college for Veterans by "Military Times." During his career as counselor and psychiatric social worker, he treated incarcerated Veterans, Army Soldiers and substance abusers. Twenty years of his career was behind bars, where he counseled sex offenders, domestic violence offenders, psychiatric patients and adolescent drug users.



Challenging the CBT Dogma to Treat PTSD

By Louise Gaston, PhD, FAIS

In an article entitled “In pursuit of truth: A critical examination of meta-analyses of cognitive-behavioral therapy,” Wampold and colleagues denounced the enthusiastic, yet ubiquitous, conclusion that cognitive-behavioral therapies (CBT) are superior in efficacy for treating psychological disorders.¹ Such an inflated conclusion is also pervasive in the field of post-traumatic stress disorder (PTSD). This is an unfortunate pro-CBT bias in research on PTSD leading to

misguided clinical guidelines. This pro-CBT bias needs to be corrected.

Having seen the deep contradictions between research conclusions and clinical realities, I wish to draw attention to the need for healthy skepticism toward research findings and clinical guidelines. Despite claims of high efficacy, the actual observed efficacy of CBT is quite limited – in the ideal conditions of randomized clinical trials (RCT) with civilians, only partial PTSD remission was observed in about 50% of volunteers only, and those are highly selected and usually present with no comorbidity.^{2,3} The situation is worse with Veterans, with a loss of PTSD diagnosis in only 28% to 40% in the ideal conditions of conducting RCTs.⁴

Nevertheless, clinical guidelines for treating PTSD recommend using CBT almost exclusively, dismissing healthy scepticism toward research findings.^{5,6} Such biased recommendations are not surprising given that almost all RCTs have been conducted by CBT researchers examining the efficacy of CBT for treating PTSD.

In the Reality of the Efficacy of Psychotherapy for PTSD

Debriefing Is Ineffective and Harmful

Since the 1990s, debriefing has become extremely popular. Debriefing is a trauma-focused CBT intervention,

conducted in a group setting in the aftermath of a traumatic event. Debriefing was heavily marketed as preventing PTSD.⁷ Debriefing involves having participants describe in detail the sequence of the traumatic event recently experienced while reporting on their behavioral, cognitive and emotional experience during the event. Debriefing also involves non-trauma-focused components such as normalizing post-traumatic reactions and identifying effective coping strategies.

In research, not only was debriefing shown to be inefficacious, but also damaging.^{8,9} A study even found that debriefing was associated with PTSD exacerbation three years later, functional deterioration, and financial hardship.¹⁰ Even normalization was unfavorable, increasing the incidence of delayed PTSD.¹¹

Consequently, debriefing should never be offered because its practice can be considered unethical.⁸ Unfortunately, trauma-focused CBT remains a popular practice sponsored by health care organizations, agencies and governments.

CBT Is Not So Efficacious

Contemporary guidelines strongly recommend CBT for treating PTSD, concluding that CBT is superior in efficacy to other psychotherapies.^{5,6} However, such a conclusion is faulty.^{3,12} Almost all RCTs were conducted by CBT researchers



examining the efficacy of CBT, involving the bias of research affiliation. Contrary to claims, efficacy of CBT is quite limited – only partial PTSD remission was found in about 50% of participants in ideal settings.² The efficacy is even weaker with combat-related PTSD, with only about 33% exhibiting partial remission.⁴

A meta-analysis examined the efficacy of various CBT therapies for PTSD. Being strong proponents of prolonged exposure (PE), these authors concluded that PE is “highly effective” and a “front-line” treatment for PTSD.¹³ However, all other CBT therapies were determined to be equally efficacious to PE. Surprisingly, the control condition was also seriously biased by putting together conditions which should never be regarded as similar (dynamic therapies, supportive therapies, placebo, and waiting list). In addition, this meta-analysis included RCT involving dubious, non bona fide, provisions of non-CBT.¹⁴ Their conclusions should thus be dismissed.

To illustrate, let’s look at a couple of RCTs. In early 1990, a ‘seminal’ study attempted to demonstrate the superior efficacy of PE over stress inoculation and supportive therapy but the supportive therapists were instructed to avoid discussing the traumatic event, which is non-representative of clinical reality (only the stress inoculation was found superior to the waitlist).¹⁵ In another study, only PE was reported to be efficacious for reducing PTSD, but the dynamic therapy was provided by master’s degree interns trained for only 2 days, which is dubious to a point of ridicule.¹⁶ Such confirmatory bias simply cancels any valid conclusion possibly emanating from these studies.

In PTSD research, there is thus a pervasive pro-CBT bias and an anti-non-CBT bias. Such biases can only lead to non-valid conclusions, with or without randomization. Unfortunately, by embracing such biases, researchers offer faulty conclusions and interfere with the identification of potentially effective therapeutic regimens for treating PTSD.

Other Psychotherapies Are Efficacious

There are psychotherapies other than CBT that were shown to be efficacious in real-world conditions for treating PTSD. Such therapies are dynamic therapy, present-centered therapy, emotion-focused therapy, and interpersonal therapy.

In a seminal RCT,¹⁷ a bona fide brief dynamic therapy PTSD¹⁸ was found to be equally efficacious to two CBT trials, with large effect sizes hovering around 1.0. The effectiveness of dynamic therapy was evaluated using pre-post designs in a clinical setting revealing that dynamic therapy improved PTSD, relations, functioning, depression, hostility, and substance abuse.¹⁹

Present-centered therapy was found to be as efficacious as CBT for treating PTSD in a few studies, with large to very large effect sizes ranging from 0.88 to 1.27.²³ Interpersonal therapy was also found to be superior to waitlist and to be equally efficacious as PE or relaxation.^{24,25} Emotion-focused therapy also reduced PTSD severity.²⁶

An integrative dynamic psychotherapy for PTSD was found to be effective at the clinic specialized in PTSD which I founded and direct, thus a real-life setting, for a pilot

study conducted for a neuroimaging study.²⁰ Retrospectively, an independent team examined 100 randomly selected files (we did not see Veterans in those years). Patients presented with severe PTSD, and most had multiple comorbid disorders. Therapy was approved and paid by compensation agencies. PTSD diagnoses had been made using a structured interview. At termination (after 9 months in average), an impressive 96% rate of PTSD remission was found: 48% of full remission and 48% of partial remission.²¹ In the ensuing neuroimaging study, a 65% rate of PTSD remission was obtained after 6 to 9 months of psychotherapy still in progress.²² Integrative therapy can, therefore, be an effective option.

Given the above findings, various non-CBT therapies should be recognized as reducing PTSD severity. Importantly, research funds should be allocated to further investigate the efficacy of all bona fide therapies for PTSD and their effectiveness in real-world conditions.

CBT Effects Are Not Necessarily Maintained Over Time

For 30 years, numerous RCTs examining the efficacy of CBT for PTSD have been conducted. This timespan should have allowed CBT researchers to conduct long-term follow-up studies. However, the maintenance of CBT gains has mostly been examined after just a few months or one year. Such brief follow-ups

seriously limit any conclusions regarding the maintenance of CBT effects. Nonetheless, a few long-term follow-ups have been conducted.

After performing their meta-analysis, Powers and colleagues wrote in the abstract “prolonged exposure is a highly effective treatment, resulting in substantial therapeutic gains that persist over time.”¹³ However, their own results clearly indicated that the effect size associated with PE in comparison to controls

was 1.08 at post-test dropping to 0.68 at follow-up. A 40% loss of efficacy suggests that PE effects decay over time, contrary to the authors’ claim.

One study examined the maintenance of PE effects over

a prolonged period.²⁷ Cognitive therapy and PE were found to be more efficacious at post-test than medication, placebo and waitlist in reducing PTSD. However, after both a few months and three years, rates of PTSD remission were found to be equivalent across all groups.²⁸ Taken together, these findings suggest the possibility that any superior efficacy at post-test was due to confounding variables such as experimenter bias, subject reactivity, spontaneous remission, etc.

Another study followed participants of cognitive therapy and PE at a 5-year follow-up.²⁹ At posttest and one-year follow-up, both therapies were associated with equal PTSD reductions. After 5 years, no participant in cognitive therapy presented with PTSD, with no

Cognitive therapy and PE were found to be more efficacious at post-test than medication, placebo and waitlist in reducing PTSD.

changes in PE reductions. However, dropouts were excluded and 40% of completers that presented with the most severe PTSD at posttest did not participate in the 5-year follow-up. Consequently, no conclusion can be derived from this study. Indeed, 40-50% of PTSD spontaneously remit over 4 years, especially if PTSD is of a lesser severity.^{30,31}

With respect to EMDR, moderate PTSD improvements were observed at post-test in one study,³⁰ but a long-term follow-up was later performed and revealed clinical deteriorations over time.³³ At a five year follow-up, PTSD had severely worsened in all participants, with very large effect sizes in EMDR ($d = -0.82$) compared to large effect sizes in waitlist ($d = -0.83$). Although the sample of this study was small, such deteriorations should have sounded the alarm throughout the field of PTSD research, but they were simply dismissed to maintain the status quo.

As for dynamic therapy, five meta-analyzes have shown that its effects persist and even increase over the years after its termination, across diverse psychological disorders.³⁴ These meta-analytic findings are valuable because they analyzed findings obtained from patients presenting with severe psychiatric disorders complicated by comorbidity and treated under real-life conditions. However, no long-term data is available regarding PTSD.

Trauma-Focused CBT Is Not Superior in Efficacy

There are two basic forms of CBT for treating PTSD: trauma-focused and non-trauma-focused. In their meta-analysis, Powers and colleagues reported

that non-trauma-focused CBT, such as stress inoculation training and cognitive therapy, are as efficacious as trauma-focused CBT, such as prolonged exposure (PE), Eye Movement Desensitization and Reprocessing (EMDR) and Cognitive Processing Therapy (CPT).¹³ In another meta-analysis, CPT was also found to be equally efficacious with or without its trauma-focused component.³⁵

With Service Members and Veterans, one study reported that, while trauma-focused PE and CPT are mostly studied by researchers, only 33% to 40% of participants lose their PTSD diagnosis.¹³ Such limited efficacy is particularly worrisome because PE and/or CPT are therapies of choice at clinics for Veterans in the United States and Canada, and these therapies are often enforced within such contexts.

Trauma-Focused CBT Is Not Readily Applicable

The applicability of a therapy can be verified by its dropout and practice rates. Any lack of compliance renders an intervention found to be efficacious in RCT to be ineffective in real-world conditions.³⁶ Therefore, dropout and practice trends need to be considered.

Trauma-focused CBT have been associated with higher dropout rates than any other therapies, even though the participants in RCT were highly pre-selected and some declined participating after being informed of all therapies offered.³⁷ A meta-analysis reported that 36% of participants abandoned PE and EMDR, while the dropout rate of non-trauma-focused therapies was just 22%.³⁸ Another meta-analysis on CPT found that the

dropout rate was 26% in CPT in contrast to 19% in traditional cognitive therapy.³⁵ Finally, present-centered therapy was found to induce less dropout than 'strongly recommended therapies,' with dropout rates of 14% versus 31% respectively.²³

At-home practice of PE was examined across studies and daily listening of the audio recording of PE sessions was performed by only 7% to 57% of participants, with an average of 43%.³⁸ The practice of PE is thus not obvious.

Consistent with these findings, two surveys revealed that most trauma experts and practitioners do not employ PE due to the likelihood of dropout and adverse effects. In one survey only 17% of psychologists used PE to treat PTSD, even though half were familiar with the technique.⁴⁰ In another survey only a small minority of trauma experts reported using PE, but the percentage was not specified.³⁹ These findings are particularly significant because the surveys were conducted by PE proponents. Therefore, as most trauma experts agree, it is important to consider the possibility of attrition and adverse effects with trauma-focused CBT.

Trauma-Focused CBT Can Be Harmful

Proponents of trauma-focused CBT have repeatedly emphasized the absence of iatrogenic effects associated with their therapy of choice. Overenthusiasm is operative again.

Foa and colleagues concluded that PE did not induce iatrogenic effects.⁴² Challenging this conclusion, Wampold and colleagues recalculated their data and found adverse

effects associated with PE, with effect sizes ranging from -0.37 to -0.51 (negative sign added to emphasize the direction of the effect).¹

To better understand such adverse effects, let's look at a few studies conducted in the 1990s by non-enthusiastic PE researchers. One study reported that 30% of PE participants developed severe psychiatric complications: major depressive disorder, suicidal ideation, relapses of drug, alcohol abuses, and/or panic attacks.⁴³ In parallel, another study reported that 31% of PE participants experienced a worsening of PTSD symptoms.⁴⁴ Many other studies have reported similar severe side effects.⁴⁵ To illustrate this point, an ex-Marine wrote in his auto-biography that PE is "an overhyped therapy built on the premise that the best way to escape the aftereffects of hell was to go through hell again," and thankfully his severe iatrogenic bodily symptoms receded in a few weeks after ceasing PE.⁴⁶

On the website of the EMDR Institute, it is written "As with any form of psychotherapy, there may be a temporary increase in distress." (www.emdr.com/frequent-questions) and some people rave about EMDR on the internet. However, marked side effects have been documented by clinicians, including an intense homicidal drive toward the therapist in a clinic for Veterans.^{47,48} They have also been reported by patients on the internet.⁴⁵ From 1997 to 2007, I toured the United States offering courses of continuing education on PTSD and clinicians testified about alarming adverse side effects associated with EMDR - ranging from self-mutilation to severe dissociative episodes, psychotic episodes, suicide attempts, etc.

As for CPT, its adverse effects are usually

not reported by researchers or clinicians (https://www.ptsd.va.gov/professional/treat/txessentials/cpt_for_ptsd_pro.asp), but they are reported by patients. Indeed, a website managed by patients report the following effects: repressed memory, avoidance of people, cognitive confusion, excessive anger, flashbacks, and guilt with depression (<https://www.patientslikeme.com/treatment/cognitive-processing-therapy-cpt>). Personally, I know of a colleague who used the exposure component of CPT with a woman victim of rape. After writing about the rape at home by herself, she got into such a rage that she threw most of her furniture out of the window. I also know parents who are suing in court all professionals involved into enforcing CPT onto their son, a Veteran (even though he was suicidal for two years after his initial participation and stated his unwillingness to engage in CPT again) who ended up killing himself.

Clearly, research and clinical realities do not match when it comes to trauma-focused CBT. Proponents seem to be blind to the severe adverse effects induced by their therapy. When I have discussed these effects with some of them, the usual response has been, "There are side effects to any therapy!" Such blinders are regrettable because PTSD sufferers pay the price.

Indeed, trauma-focused therapy CBT can induce adverse side effects. It is thus legitimate to question the sine qua non use of trauma-focused therapy as it is recommended.^{5,6} This is particularly salient given that trauma-focused CBT were repeatedly shown to not be superior in efficacy. Given the risk of adverse effects, clinicians should be very cautious toward any

trauma-focused CBT, following the Hippocratic Oath 'First do no harm.'

Trauma-Focused CBT May Reduce PTSD Via Emotional Inhibition

Possible change mechanisms involved in trauma-focused CBT are portrayed as being identified, although there is little support for the theories offered by proponents.

PE is theorized as inducing habituation and a cognitive change,⁴⁶ but its precise mechanism for inducing PTSD reduction is not yet established.⁴⁸ As for EMDR, enthusiasts claim that the eye-movement component fosters PTSD resolution by enhancing co-hemispheric communication and an integration of parts of traumatic memories (see <http://www.trauma101.com/what-is-trauma/index.html>), but the eye-movement component has been shown to be no better than other tasks of dual-attention such as fixing a point on a wall.^{32,51,52} However, the eye-movement component was shown to reduce heart rate in the participants reporting benefits.⁵³

To understand the possible change mechanisms involved in trauma-focused CBT, I turned to field of neuroimager. Two excellent reviews in neuroscience have proposed solid theoretical models based upon a wealth of neuroimaging data.^{54,55} These authors both identified the amygdala and the anterior cingulate cortex (ACC) as playing key roles in generating and regulating emotions and anxiety, two major aspects of PTSD. In neuroscientific terms, the ACC is involved in the top-down control (inhibition) of the bottom-up reactivity of the amygdala (emotionality and anxiety).

In a review of studies focusing on the neural correlates of PTSD reduction in psychotherapy, PTSD reduction was associated with reduced amygdala reactivity and increased ACC activity, upon the presentation of a trauma-related stimulus.⁵⁵ All the therapies associated with this neuronal pattern (decreased amygdala and increased ACC activity) included a CBT trauma-focused component. Therefore, the PTSD reduction obtained in trauma-focused CBT could be explained by a spontaneous increase in the ACC activity (emotional inhibition) to reduce the amygdala reactivity (emotionality and anxiety). This top-down control corresponds to emotional inhibition, not habituation or PTSD resolution, but without the activation of the ACC, the amygdala would fire up. Let's also note that the activation of the ACC is known to reduce heart rate.⁵⁷ This neuronal pattern of top-down control by the ACC over the amygdala is also observed in dissociative PTSD, suggesting that trauma-focused CBT may induce dissociation when it succeeds in reducing PTSD.⁵⁸

In non-trauma-focused therapies for PTSD, a differential pattern of neural responses was observed in two studies where PTSD reduction was highly associated with a concomitant deactivation of the amygdala and ACC.^{57,59}

The therapies inducing such a pattern were treatment-as-usual or treatment-as-usual plus group cognitive therapy,⁵⁸ and integrative dynamic psychotherapy.⁵⁷ This concomitant deactivation of both amygdala and ACC suggests that non-trauma-focused therapies do not have to induce emotional inhibition in order to reduce emotional reactivity, which is consistent with conflict resolution as change mechanism.

Finally, the therapeutic alliance was also found to be a key ingredient in the efficacy of psychotherapy for PTSD, with correlations varying from .35 to .50.³ In a study focusing on Veterans, 12% of CPT efficacy could be explained by the variable of the therapist

alone - some therapists are more skilled relationally than others, while it is known that only 2% of outcome variability is due to treatment methods per se.³

In summary, the change mechanism of trauma-focused CBT is likely to correspond to emotional inhibition, not habituation or resolution, according

to neuroimaging findings. In contrast, one of the change mechanisms of non-trauma-focused therapies may well be conflict resolution, providing a more permanent decrease in bottom-up reactivity in the amygdala. An additional change mechanism of psychotherapy for PTSD is the alliance, as always.

The therapeutic alliance was also found to be a key ingredient in the efficacy of psychotherapy for PTSD, with correlations varying from .35 to .50.³

A Few Final Words

To bring some scientific and clinical realism into the clinical practice of PTSD, I have outlined many erroneous beliefs and challenged them. Over part of the last century, the mental health profession was under the spell of the psychoanalytical dogma, but the field has now succumbed to the CBT dogma, particularly in the field of PTSD.

Let's remember that it is unethical to make faulty research conclusions (for example, the

authors of a meta-analysis⁶⁰ concluded that trauma-focused CBT was superior for treating adult survivors of childhood abuse, but they excluded a major RCT finding no differences⁶¹ and they themselves reported no significant difference in controlled effect sizes between trauma-focused and non-trauma-focused therapies in comparison to waitlist/no-contact controls.

It is also unethical to inflate the efficacy of any therapy. For example, a Veteran reported to a colleague of mine that a PE therapist tried to



recruit him by saying “Come to be treated at our clinic for Veterans. You will be a new man after ten sessions!” It is also unethical to be on the defensive about one’s therapy when a patient reports experiencing negative side effects, and it is utterly unethical to threaten a patient denouncing iatrogenic effects. For example, an ex-Marine reported, “Following a heated discussion, in which I declared the therapy ‘insane and dangerous’ and my therapist ardently defended it, we decided to call it quits. Before I left, he admonished me: ‘P.E. has worked for many, many people, so I would be careful about saying that it doesn’t work just because it didn’t work for you.’”⁴⁶

Based on the literature one can only truthfully conclude that clinicians need to employ an integrative approach for treating PTSD. Any trauma-focused technique should be used only if it seems to be pertinent, only if a solid alliance is established and only if prerequisites about the patient’s capacities are obviously present. PTSD is mostly a structural disorder so PTSD should not be considered and treated as a phobia.¹⁹ I concur with other clinical researchers specialized in PTSD,^{3,12} that published guidelines for treating PTSD should be ignored.^{5,6}

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ABOUT THE AUTHOR

Dr. Louise Gaston, psychologist, has founded in 1990 a clinic specialized in PTSD, TRAUMATYS, in Canada, where she developed an integrative model for treating PTSD, which is flexible and open-ended. In addition, she elaborated a comprehensive 2-year training program in PTSD and trained more than 200 experienced clinicians in evaluating and treating PTSD. Thousands of individuals presenting with PTSD and comorbidity have been treated with this integrative model for PTSD. According to an independent and retrospective study, the associated PTSD remission rate is 96%: 48% complete and 48% partial. Dr. Gaston is the author of several book chapters and more than 40 scientific/clinical articles.



Since 1980, Dr. Gaston has been practicing psychotherapy. She has been trained and supervised over 15 years. She knows all major models of psychotherapy (dynamic, humanistic, cognitive, and behavioral) and has been trained over 5 years in treating personality disorders.

As a clinical researcher, Dr. Gaston collaborated with many colleagues in diverse settings. She has carried out two clinical trials. Her main research topic was the alliance in psychotherapy and its interaction with techniques as they contribute to better outcomes. In collaboration with Dr. Marmar, M.D., she has developed the *California Psychotherapy Alliance Scale*, CALPAS, a measure of the alliance in psychotherapy which is worldly used.

In 1988, Dr. Gaston completed a 2-year postdoctoral fellowship in PTSD and psychotherapy research, at the Langlely Porter Psychiatric Institute, University of California, San Francisco, under the supervision of Dr. Horowitz, M.D., author of *Stress Response Syndrome*, and Dr. Marmar, M.D., both ex-presidents of the *International Society for Psychotherapy Research* and the *International Society for Traumatic Stress Studies*. Afterwards, she was assistant professor in the Department of psychiatry at McGill University in Canada from 1988 to 1994. Dr. Gaston elaborated scales on the MMPI-2 to assess PTSD in civilians.

For many years, Dr. Gaston has provided courses of continuing education across the USA: *Integrating Treatments for PTSD, Trauma and Personality Disorders*, *Memories of Abuse and the Abuse of Memory*, and *Ethics Working for You*. Nowadays she writes, trains, and supervises on PTSD.

Reducing Therapeutic Obstacles: One Psychologist's Experience Utilizing CES in Clinical Practice

By Josh Briley, PhD, FAIS, Clinical Psychologist

Working in direct patient care since 1997, I have had the pleasure of witnessing, first-hand, the joys of utilizing therapy to facilitate positive change in a client's life. Through individual and group therapy, I have had successes in helping my clients reduce their emotional distress, improve their relationships, return to the workforce even when other professionals told them their symptoms were too severe, and become content in their lives.

I have had the privilege of a ring-side seat into unexpected and positive effects in a client's family, friends, coworkers, and acquaintances as a result of that individual's work in therapy. I have worked in correctional settings, academic settings, medical clinics, and most recently, providing counseling services online to clients around the world.

My professional training and experiences have instilled a strong belief that therapy is a very effective tool for helping people overcome the struggles in their lives. However, there are factors that very frequently undermine the efficacy of therapy. Such factors include the support of a client's family and social network, the readiness of the client to engage in the often-difficult work of confronting one's demons and overcoming them, rapport between therapist and client, and a client's pessimism regarding the efficacy of therapy for him or her.

Psychotropic medication, which is prescribed with the intent of helping the client, is fairly often a hindrance to therapeutic efficacy itself. Clients can become discouraged with the difficulty in finding the "right" medication for them. Additionally, the side-effects of medications can adversely affect a client's quality of life, especially due to the very commonly experienced sexual side-effects. Suicidal ideation is another side effect of several antidepressant medications that can

develop quite suddenly and severely. Perhaps the most frequent and significant hindrance to therapeutic effectiveness I encounter in my current practice is chronic pain. Whether by injury or by illness (such as fibromyalgia, arthritis, or lupus), patients with chronic pain have difficulty engaging in therapy, despite sincere determination and a desire to change.

Pain medications are being carefully scrutinized within the current medical culture, which results in patients not receiving their medications timely, or dosages being lowered to the point they are no longer effective. The result for patients is quite often an immediate and severe decrease in quality of life, an increase in depression and stress, and a feeling of hopelessness regarding their ability to live a normal life.

I have had many clients overcome some, or even all, of the hindrances described above and reclaim their lives. However, I have also had clients for whom therapy, with or without medications, was insufficient to overcome their symptoms. These clients either gave up on therapy or resigned themselves to a lower quality of life. Therefore, as most therapists can attest, for every success story throughout my career, there are also therapy failures. Until recently, however, it was my firm belief that therapy was the single most effective tool for helping clients achieve emotional peace, satisfying relationships,



and an improved quality of life. That was until approximately a year ago when I was formally introduced to the Alpha-Stim AID, a cranial electrotherapy stimulator (CES) device that treats anxiety, insomnia, depression, and physical pain.

This article is not a scientific exploration of how this device works or a review of the literature espousing its efficacy. There are literally over

one hundred studies on using Alpha-Stim technology to treat a variety of diagnoses. You can find many of these studies, as well as an explanation of the mechanisms of CES specific to the patented Alpha-Stim AID, on Alpha-Stim's website (www.alpha-stim.com). My intent

here is to provide an explanation of my experiences using this device in treatment with hundreds of clients within the past 12 months and explore how this device helps reduce some of the therapeutic obstacles mentioned above.

The protocols for using an Alpha-Stim AID are not complicated. The user sticks the electrode pads on the ear clips, applies a few drops of Alpha-Stim Conducting Solution to each pad, and then attaches the ear clips to his or her ear lobes like a clothespin. Once the AID is turned on, the user simply sets the desired time (20, 40, or 60 minutes), and turns the current up until he or she feels lightheaded or dizzy. Some describe it to feel as if they are rocking on a boat. The sensation is not subtle, it is definitely

noticeable. Once the user notices these feelings of dizziness, he or she turns the current down until the feeling subsides. A higher current allows for a shorter treatment time, but it need never be raised to an uncomfortable level. Typically, if a person can tolerate 250 microamperes or more out of a maximum, of 600, treatments can be completed in 20 minutes. Those who are

sensitive to the current and use it between 100 and 200 microamperes might need 40- or 60-minute treatments. If the feelings of dizziness returns, the user turns the current down further. Without getting into technical details on how the AID works, the device alters the user's brainwaves to achieve more alpha waves,

which is the frequency range of brainwaves we have when we are relaxed, but still awake.

When I initially recommend using an AID to help a client treat their insomnia, anxiety, or depression, they are understandably skeptical. I receive some common questions, such as "Is this going to shock me?" perhaps being the most frequently asked. Some clients ask about side effects, and I explain that vast majority of clients experience no side effects from the device. Some clients are eager to try the AID, and others are reluctant, but agree with the understanding they can stop it if they feel they need to. In thousands of trials I prescribed over the past 12 months, no one has stopped a trial prematurely.

I ask the client for an estimate of his or

With very rare exceptions, my clients report that they feel better at the end of the trial. Sometimes they express astonishment at the change in their mood and energy level.

her emotional distress level and pain level on a scale of 0 to 10 and record the subjective ratings. During the initial trial, which is at least 20 minutes, the client and I talk; sometimes about the device, but more often about the difficulties that bring him or her to therapy. The client is not sitting in a dark room, eyes closed, listening to relaxing music during the trial. The session proceeds as it would without the device.

With very rare exceptions, my clients report that they feel better at the end of the trial. Sometimes they express astonishment at the change in their mood and energy level. They usually report a decrease in emotional distress and physical pain. Sometimes the difference is minor, but at other times the reduction is significant or pronounced. I have witnessed men who report their knees are “bone on bone” and require a cane for mobility, get up and leave my office, leaving their cane behind. Of course, I chase them down and give them their canes, but the fact they can stand and walk with no pain and with more physical stability amazes them. I had one patient, a retired police officer, who has also been a firefighter and Marine, walk to his car, turn around and walk back to my office to tell me he was amazed and grateful he could walk without pain or fatigue. During one of my early trials, my client began raising his arm over his head and lowering it, repeatedly. After several seconds, I asked about the repetitive motion. He stated he had been unable to raise his arm above the level of his shoulder for years, and doctors had told him he would need surgery to regain even a fraction of the use of that arm.

Relief from physical pain, however, is only one of the benefits of using an Alpha-Stim AID with clients. Most of my clients suffer

from depression, anxiety, posttraumatic stress disorder (PTSD), and anger problems. Many have been prescribed psychotropic medications for years. Some have been in individual or group therapy, either with me or with other therapists, sometimes for years or decades. These are men and women who, unfortunately, believe there is no hope for relief from their emotional struggles. They have made their symptoms part of their identity. For years, success in therapy with this population was sporadic. The depth of the client’s emotional distress makes significant progress difficult, as discussing the thoughts, emotions, and events that contribute to their problems can become too overwhelming if done too quickly. Additionally, as humans we tend to avoid things that hurt, and psychological therapy confronting chronic and severe symptoms can be painful. As the psychologist, it is part of my responsibility to encourage my clients to go to the dark places they usually try to avoid, but it is also my duty to guide them out of those areas safely. It can be emotionally challenging and difficult work, for both therapist and client.

The Alpha-Stim AID, as mentioned above, reduces that emotional distress, not over a period of weeks, as medications do, but in just a few minutes. Clients will bring their devices to therapy with them and engage in nothing more substantive than small talk until they have the device on for a few minutes. As the client begins to talk about their difficulties, the device is alleviating the depression, stress, anxiety, or anger as it rises. The clients feel these emotions, they are not suppressed or removed, but the intensity of the emotions is no longer overwhelming. As a result, they are able to stay engaged in discussion of topics for a much

longer period of time, explore painful past experiences, or finally talk about emotionally-laden topics without becoming overwhelmed and freezing emotionally. As a result, therapeutic progress is made much more quickly, both within each session and over the course of several sessions. As clients continue to use their devices at home between sessions, the benefits continue to build on themselves, and clients report significantly improved quality of life, better sleep, and feeling happier. Some clients have been successful in decreasing or stopping their psychotropic and/or pain medications with regular use of Alpha-Stim. One client with PTSD stated that before he began using the AID in

therapy, he had difficulty recalling the details of his traumatic event, and his anxiety and anger would spike to the point he would have to stop talking about it. However, after using the AID, he experienced a clarity which allows him to better recall the details of his trauma and actually process those thoughts. So, he is less distressed by them. He also noticed a corresponding decrease in his symptoms as a result.

In using the AID in conjunction with Cognitive Behavioral Therapy (CBT) approaches, I have witnessed some unexpected benefits for clients. Clients with Parkinson's notice their tremors stop while using the device and are not as severe when they return some time later.

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One client diagnosed with depression with psychotic features reported the voices are silent for several hours after he uses the AID. One client with chronic, severe depression and Asperger's Syndrome has reported a surge of suppressed memories from childhood of being abused and neglected, memories he has been able to process and resolve, thus decreasing his depressive symptoms. I have noticed in this client that as he continues to use the AID daily, he is less rigid in his thinking and social interactions, he has begun to develop friendships, and shows an interest in those around him (rigid cognitions, difficulties in social interactions, and disinterest in others are core symptoms of Asperger's Syndrome).

An important and helpful benefit, for me as a psychologist, is in using the AID with a client who comes to my office in a crisis, such as feeling suicidal or having a panic attack. Within minutes, they visibly relax, report feeling emotional relief, and are able to more calmly discuss the factors that contributed to their crisis. One such client recently referred to the device as a "miracle worker," in that it reduced his anxiety from near-panic levels to almost non-existent within 20 minutes. While I would not recommend utilizing the AID in lieu of admitting a suicidal individual for inpatient treatment in every case, I have been able to, with the help of this device, help clients who report experiencing acute suicidal ideation to resolve the emotional crisis and no longer require hospitalization.

As with any type of treatment, there have been clients for whom the AID was not as successful. One client with depression and PTSD was eager to use the device, however, he has had three significant strokes in the past few years. He stated continued use of the device made him

forget what day it was and become disoriented. He experienced the relief of his emotional distress but did not like the disorientation he experienced. A woman with bipolar disorder reported almost immediately "I don't like it, it feels funny," in her initial trial. She completed the 20-minute trial, but continued to report "I feel funny, I don't like it." She denied feeling light-headed, dizzy, or nauseated, just reporting "feeling funny" and unable to explain it. A few weeks later, she and I realized the device helped her feel relaxed. As her "default" is hypomanic, she was unaccustomed to feeling relaxed and reacted with anxiety over the strange, new feeling. One client with severe PTSD tried diligently to receive benefit from the AID, even using the device for an hour in his second trial but felt no emotional or physical relief from the device. Finally, a recent client in withdrawal from Suboxone treatment for pain and opioid addiction reported feeling "a combination of being on an acid trip and having the flu" while using an Alpha-Stim during her withdrawal, but does experience relief from her pain, anxiety, and depression once she removes the ear clips.

The vast majority of my clients have experienced significant benefit by incorporating use of the Alpha-Stim AID in their treatment. This device helps overcome many of the common obstacles seen in traditional therapy. By reducing their physical pain and other symptoms of medical disorders (such as the tremors inherent in Parkinson's), the client's quality of life improves instantly. Improved quality and quantity of sleep (rather than a reliance on sleep medications), reduction in severity and chronicity of emotional distress in general, and specifically during therapy, helps my clients process the memories of unpleasant experiences and overcome the

emotional pain associated with these memories. Family members become eager partners in treatment as they can see more rapid and efficient reduction in emotional and physical distress and improvement in daily functioning. In my two decades as a practicing therapist, I have not witnessed any treatment approach or device

that has been so instrumental in improving the quality of my clients' lives. I have become an advocate for the use of this device, helping other providers learn how to order them for their clients, explaining to colleagues how and why it works, and encouraging my clients to use their devices regularly. I would not want to practice without it.

ABOUT THE AUTHOR

Dr. Josh Briley, PhD, FAIS is a licensed clinical psychologist. His multi-faceted career has given him experience with a wide variety of populations and psychological difficulties. He began his career working for the Federal Bureau of Prisons first as a staff psychologist at the Federal Correctional Complex in Beaumont, TX, then as a Residential Drug Abuse Program Coordinator at the Federal Correctional Institution in El Reno, OK. While employed with BOP, he also served on, and was later assigned to lead, two institutional Crisis Support Teams. He was also selected to be an Assistant Team Leader for the Regional Crisis Support Team in the South-Central Region of the Bureau of Prisons and served as both a Regional and National trainer for Crisis Support Team exercises and classes. His duties with Crisis Support Teams made him proficient in Psychological First Aid, disaster response, critical incident management, and shelter management. After leaving the Bureau of Prisons, Dr. Briley served as the clinical psychologist for a community outpatient clinic in Central Texas for the Veterans Health Administration. He became proficient in treating Veterans with posttraumatic stress disorder, as well as with depression, anxiety, substance abuse, suicidal ideation, and family difficulties. In addition, Dr. Briley has served as an Adjunct Professor for the University of Phoenix online, teaching several courses in Statistics, Research Methodology, and Abnormal Psychology for the Master of Psychology program. Dr. Briley concurrently served as a part-time professor for Capella University online teaching an introductory to the psychology program to undergraduates. Dr. Briley ran a private practice for five years, providing a wide range of psychological assessments and therapy to members of a rural, Central Texas community. For the past two and a half years, Dr. Briley has worked with BetterHelp.com and its affiliates, providing therapy online to clients in Texas and throughout the world.



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The Hero's Journey

By Dr. Charles Grantham, CW2, USA (RET)

Combat Stress is a magazine devoted to stories about combat and the stress that it inflicts upon those of us involved in it. This is my personal story. This article is installment 1. I am writing it in hopes that others may recognize they are on a similar journey. If I could find my way out of the befuddled maze, so can they.

My personal journey, as told here, is one of transformation. You could say that there were instances that were my 'call to adventure' or initiation to the process of transformation. I assure you that I did not see them as a coming adventure at the time. Only in retrospect can I now see those times when my equilibrium of numbness was punctuated.

This storm of change had been brewing for some time. Upon reflection, I can trace stirrings of restlessness, free floating anxiety and a downward spiral into a depressive state back to 2009. I hear something calling but cannot figure out where or from what direction.... purposeless twisting in the winds of change. I did not know what I did not know at the time.

Here's what the journey looks like:




The key point in these journeys, whether in the Odyssey, George Clooney in the Coen brothers' epic 'O Brother Where Art Thou?' or my own travel, is where one moves from the known into the unknown. So how does all that relate to wellness and such? For me that shift occurred twice - from not being to being, and from not well to well. Both of those events were literally lifesaving.

So, why me? A little context may help. I am a Vietnam Veteran with, let us say, a few disabilities. I served as a Counterintelligence Special Agent, assigned to MACV-SOG and that is about all I can say. Follow the link. When I returned, I went through a number of Special Operations

assignments and never put the uniform back on again. I never realized that trauma has a cumulative impact; 8 years living a double, secret life. Enough said.

The first wakeup call was when I was diagnosed with acute Post-Traumatic Stress Disorder (PTSD). I had no sense of 'being' and was sliding downhill through depression into places one does not wish to go. The second was the discovery of a noteworthy malfunction of my heart - which may or may not be related to my long-standing

A person is walking away from the viewer down a path in a misty, blue-toned forest. The trees are tall and thin, with bare branches, creating a sense of depth and mystery. The person is a dark silhouette against the lighter, hazy background.

**“The cave you fear
to enter holds the
treasure you seek.”**

- Joseph Campbell

PTSD condition. I will leave that story for another time, but I believe one to be a physical symptom of a mental cause.

One may ask why this took 30 years to manifest, but not much in my life is quite what it seems on the surface. Without drifting off into another tale of adventure, I did not officially exist in the Veterans Administration (VA) system until the mid-2000's, even though I was discharged from government service in 1975. "I'm sorry we have no records of him. And if we did, they would be classified."

With the intervention of two Congresspersons, an attorney, and several old Army buddies, my military records were finally declassified, unit awards (until then classified) were made public and the criteria for PTSD were accepted as genuine psychological conditions by the American Psychiatric Association. I became a real person and what the typical civilian healthcare system had never diagnosed correctly suddenly became paramount. Then my journey began.

This may be too much information for some, but it is very important. It illustrates that the impetus for transformations can lie dormant for long periods of time. In my case, it was a society in denial of the pain and suffering inflicted upon its warriors and administrative systems not working with a life-affirming purpose.

Initiation

It's a complicated story but suffice to say that a very insightful clinician picked up on the signals and suggested we talk about what was going on in my life that was causing all the stress that was beginning to affect my health.

What I didn't know at the time was that

she was leading me through a checklist of symptoms of Post-Traumatic Stress Disorder (PTSD). Combat experience, check. Multiple years in covert operations, check. Hyper-vigilance, check. Depression, check. Suicidal thoughts, check. Bingo!

Next was a series of evaluations; psychologists, psychiatrists, social workers, you name it. They said things like, "My friend, you have to make some major changes, or you will die either by accident or your own hand."

Involvement

Often when the call is given, the future hero first refuses to heed it. This may be from a sense of duty or obligation, fear, insecurity, a sense of inadequacy, or any of a range of reasons that work to hold the person in his or her current circumstances." When the pain to remain where you are is greater than the pain to change, then you can change. Stated another way, everybody wants to go to heaven, but no one wants to die.

Therapy, counselling, peer group work (which incidentally was probably the most helpful) lead to a plan. One must work on their spiritual selves. There will be many false starts. And I realized as I said up front, that there are those who are realizing that traditional support structures such as schools, health care and other public programs are of little benefit.

Tai Chi, Yoga, Qigong.... all nice, but not just there and then. I'm on a mission guided along by others who have been down this pathway. It's a small group of those who have seen the tiger smile, "Drive on. It don't mean nothin'." Those who have seen that usually don't talk about it - its' those who haven't seen it that seem to do the talkin'.

Inquiry

I am totally lost and don't have a clue about why I'm on this planet in this body at this time. Truth pops up and it's uncomfortable and you stuff it in a box inside your mind. It stays for a while and until someone kicks the box over and it spills out again. As it turned out, the VA just kicked that box over again.

My partner in life suggested that we go to a Reiki class. I'm in search mode, so let's do it. Damn, there she is, my mentor. She immediately senses my inner conflict, which I came to know later as a tremendous imbalance in energies. Again, do I ever wish I had had some way of knowing this before. Reiki is about energy healing and I'm there to work on my energy, but it becomes crystal clear there is a higher purpose to this. In my own transformation and healing process, I learned how to help others as well.

Harmonization

The threshold unknown to the known has been crossed. For some reason, I find that I am fairly gifted at the practice of this ancient Japanese art. The best way I can describe it is that Reiki became my ticket into the Super Max of spirituality and not knowing which movie to watch first.

I studied Reiki I, II, III, Advanced Level, and Master/Teacher; but there is more playing in the Super Max: Karuna-Ki Reiki; Akash (spiritual

intentionality); Chakra Healing; Crystal Healing and finally the capstone of Master of Healing Arts. This amounts to four years of crossing the threshold.

And no, I haven't stopped. I can't. You can't. Recovery is a lifelong journey. It is about nonlocal consciousness, "U-Theory of Change," and most recently, an intensive focus on Mindfulness. I'm not sure what the next

step is but it will present itself when it needs to.

Inspiration

My key revelation in all this is that we are the captains of your own ships. I am not responsible for the actions of others or life events, but I am responsible for my reaction to those things.

It's hard to separate this stage of the journey from what some people call harmonization. They are pretty much blended together for me. Being open to learning from others and trusting the universe to bring me what I need to continue my own development is a large part of it. It seems to be working.

Since 2014 when I sort of graduated from the more formal part of my training, I have been amazed how many people I find that resonate with energy healing. When I started sharing that I was a certified Reiki Master/Teacher, so many conversations opened up in the strangest places. People wanted to know more about it and so, here I am telling my story once more.

There are those who are realizing that traditional support structures such as schools, health care and other public programs are of little benefit.

Innovation

This is about seizing the prize. There is no “me.” I am merely a channel through which energy flows. So how do I live that out? Simply put, I see my practice as a way to blend Eastern/Western experiences of life based on universals of energy flows. It is wasted energy arguing the relative validity of these approaches. Instead I struggle to integrate the Eastern and Western perspectives on healing. For me, Reiki has become the door to these other approaches. Let me say that for every analytical process, there is a corresponding synthetic process. And for every verbal process there is a symbolic process. Reiki is my symbolic process.

Iteration

see this as Charlie’s journey from a human *doing* to a human *being* that was ignited by a personal traumatic series of events in my past.

I’ve returned with the treasure, I’ve woken up. Waking up means consciousness comes to us. Realization of your part in the universe, a spiritual awakening. I found peer group work to be the most effective path for me to deal with PTSD. There will be more on that in a subsequent article.

My next article will take a deep dive into that. I’ll call it “social network” interventions.

I’ll delve into how to define that group, create a picture of it and even measure it. All that will lead to some very practical advice about how to create and maintain your social network, provided in the interest of helping you deal with our own personal combat stress.

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ABOUT THE AUTHOR

Dr. Charlie Grantham is the Founder of the Awakeningtowholeness.net where he pursues his priorities of teaching, writing, speaking and mentoring, now focusing upon wellness, wellbeing and wholeness.

He received his PhD in Sociology from the University of Maryland in 1980. He has published eleven books and several dozen technical papers. He is a frequent speaker at international events and a “go to” resource for the media on a wide range of workplace issues – ranging from psychology to public policy. He also is a certified Master of Healing Arts is a credentialed Reiki Master/Teacher.

Dr. Grantham is a Vietnam combat Veteran, having served 8 years in the U.S. Army as a Chief Warrant Officer in the Intelligence Corps. His military service was followed by successful careers in academia as a professor and in multi-national technology companies as an Executive Director of Research and Development. He has now retired and moved to Baja - oh, I mean Tucson, AZ.



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Is There an App for That? How Your Phone Can Help You Manage Stress - *The Expanding Field of Digital Mental Health*

By Martha Neary, MSc, PsyberGuide Project Manager



As the availability of technologies like smartphones increases, tremendous opportunities exist to address mental health through apps, which have the potential to support Veterans and Service Members in many ways. There are a range of “therapy”- style apps, which allow users to talk through their feelings with licensed therapists, peers, virtual people, or chatbots (a computer program which mimics real-life conversations with a human). Some apps draw on well-established evidence-based practices, such as Cognitive Behavioral Therapy (CBT), walking the user through some key skills in those practices. Other apps allow for a mobile means to track and monitor stress or triggers. These are just some examples, but novel apps are being developed everyday. In fact, recent estimates have suggested that between ten and twenty thousand mental health apps exist.^{1,2}

Many of these apps, however, are not evidence-based and given the vast number of mental health apps available, it can be challenging to find one that is high quality. PsyberGuide.org, a Project of One Mind, is one resource that can help. At PsyberGuide, we regularly scan the mental health app marketplace and identify new and useful products. We

review apps on three metrics: credibility (the research, clinical, and technological support for an app), transparency (the clarity of an app’s privacy policy), and user experience (how fun, engaging, easy to use is the app). We also have an external expert from a relevant field review and make some recommendations for the use of different apps. Our App Guide allows people to filter apps, based on a combination of target conditions and/or treatment types (e.g. mindfulness, stress and anxiety, etc.) to find apps most relevant to their interests. People can also filter based upon audience (e.g. military personnel), platform (Android or iPhone), and cost. PsyberGuide is an official partner of the American Institute of Stress and provides information and reviews of apps designed for

stress management on the [stress.org](https://www.stress.org) Mental Health Apps page.

Mental Health Apps for Service Members and Veterans

Service Members and Veterans can face various challenges when accessing support for mental health and stress management, including confidentiality concerns and the stigma associated with seeking professional help.³ Apps can help overcome some of these challenges and offer a range of benefits, such as the following: They are easily accessible, with lots of free options to choose from, and can be used discreetly and “on-the-go”. They can increase adherence to and engagement with care, thus enhancing the effectiveness and efficiency of mental health treatment.⁴ They can also improve the quality of care by facilitating real-time symptom tracking.⁵ While apps are no replacement for receiving treatment from a licensed professional, they can supplement existing care. They can also offer a starting point for help-seeking when no other services exist, and can help provide additional support to help people transition from face to face mental health interventions/psychotherapy.

There are an increasing number of mental health apps specifically designed for Service Members and Veterans. Given the unique stressors faced by this population, it is important that these apps are culturally appropriate. For example, apps should have appropriate, inclusive language, and users should be able to “see” themselves in the examples and graphics in the apps. Apps should also come from a credible and respected source. Fortunately, a number of stress management apps have been developed

by the Department of Defense and Veterans Administration and were independently reviewed by us at PsyberGuide. These apps come from a reliable source and are backed by the opinions of authorities or expert committee reports from within the U.S. Department of Defense (with some apps having rigorous research data and empirical evaluation to support their use).⁶ Below, we highlight three of these apps and how they might be useful to our readers and their loved ones. Although developed specifically to assist Service Members and Veterans in coping with stress, these apps may also be useful to anyone interested in learning stress management skills. All of these apps are free and available on both iOS and Android platforms.

PTSD Coach

This app is developed for Service Members who may be experiencing symptoms of Post-Traumatic Stress Disorder (PTSD), containing educational information about PTSD, a checklist to help determine the accuracy of a PTSD diagnosis, skills for managing symptoms, and resources for obtaining support. The app contains a measure that is commonly used to assess PTSD (PTSD Checklist, also referred to as the PCL-5), which can be completed on a weekly basis to track and monitor symptoms and progress. There are a number of self-help tools available in this app, including guided imagery, audio-guided muscle relaxation and deep breathing exercises, coping skills for dealing with triggers, and tools to reduce isolation and manage stress. Users can customize symptom management features including the use of music, pictures, and personal contact lists. This app offers a way for users to keep track of how their



emotions/how they are feeling over time, which may help them to identify triggers and patterns,⁷ as well as to determine effective coping strategies and self-management practices.⁸ A number of studies have shown that users have favorable attitudes towards the app and/or see an improvement in their PTSD symptoms.^{9,10}

Virtual Hope Box

This multi-media app provides relaxation techniques, coping skills, and activities to reduce stress. The app can be very personalized and users can store a variety of rich multimedia content that they find personally supportive in times of need. For example, they may upload photos or videos of loved ones, inspirational quotes, music they find soothing, and memories and aspirations. There are also distraction techniques, which include games like Sudoku and word puzzles, a variety of guided

meditation exercises, and suggestions for activities to help relieve stress. Research suggests that Virtual Hope Box is a useful adjunct to mental health treatment among Service Members and Veterans. In one study, participants (U.S. Service Veterans in active mental health treatment who had recently expressed suicidal ideation) who used the app for 12 weeks reported a greater ability to cope with unpleasant emotions and thoughts as compared to controls.¹¹

Tactical Breather

Tactical Breather emphasizes mindfulness and breathing exercises for stress management. The app aims to help users gain control over the physiological and psychological responses to stress. Through training and repetitive practice, diaphragmatic breathing (also called belly breathing) can help users to manage heart rate, emotions and concentration.¹² The user is able to customize the graphics and voice gender, based upon their own preferences. In addition to guided breathing exercises, the app includes other game-like interactive exercises and educational information regarding the psychological and physiological effects of conflict.

These are just three apps which are available to support the mental health of Service Members and Veterans. Reviews of these apps, and many more, are available on the App Guide at PsyberGuide.org. You can use the App Guide to explore other options too. No one app will work for everyone, so it's important to find an app that's a good fit for you. Whether you are in need of support for your own mental health, or want to support a loved one, why not use these apps as a starting point for a

conversation around mental health?

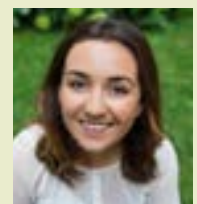
If you have questions about these apps or want to learn more about digital mental health, you can also follow PsyberGuide on Twitter and Facebook (@PsyberGuide) - we would love to hear from you.

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