THE post traumatic stress disorder FALLACY

A MENTAL HEALTH INDUSTRY BONANZA

OF PROFIT AND HUMAN DESTRUCTION

TRILOGY: PART 1

H. Nattanya Andersen

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A Mental Health Industry Bonanza of Profit and Human Destruction

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This book was written for educational purpose only to share with those experiencing Post Traumatic Stress Disorder what I did to successfully recuperate and heal myself and emerge relatively unscathed from the existential crises that PTSD constitutes. You should not rely on this information as a substitute for, nor does it replace, professional medical advice, diagnosis or treatment. I have no direct or indirect involvement with any of the treatment modalities of any and all genre mentioned in "*The Post Traumatic Stress Disorder Fallacy: A Mental Health Industry Bonanza Of Profit And Human Destruction*" other than I was subjected to several of them and used those I found worked for me.

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To my grandmother Hedwig Margarete Kröger, who made this life's journey with relative ease possible. To Psychiatrist William Courtney, Summerhill, Ireland, for making my survival in good health possible.

To Leslie Roy for his unwavering support throughout the journey through Hell.

To my dogs with gratitude for their unconditional love, loyalty and affection.

Contents

Acknowledgements

This is the story of my PTSD recovery after a Boeing 727 engine exploded five feet away from me at 6000 feet altitude. I was working as a flight attendant for one of the world's ten largest air-carriers. By a hair's breath, I escaped a mid-air explosion. My recovery was possible due to numerous factors in my pre-and post-PTSD life. The most important one among them was my twice daily meditations. This was followed by the work of authors of a multitude of genres, among them numerology and astrology, psychiatry and psychology, as well as Ayurvedic, Traditional Chinese and naturopathic medicine. Other treatments that helped me were acupuncture, dogs' healing abilities, the benefits of yoga, Tarot card readings, dream analysis, chakras, auras and fung-shui. All are mentioned in the text and sourced in the bibliography. To all, I am deeply grateful.

I extend special thanks to North American Airways, a pseudonym, as "my" airline is just as good or bad as any other large North American based air-carriers. In particular I thank my fellow flight attendants, NorAm's Flight Attendants' Union shop-stewards and bosses and the employer-owned and operated Workers' Compensation Board staff, in particular their psychiatrists, psychologists, whose co-ordinated attacks propelled me onto my path of discovery. Through it, I gained the knowledge that we humans indeed have the power to heal our Self, despite the expert manipulation and modus operandi by those we trust to prevent our healing.

My gratitude goes forth to the United States of America's Department of Veterans Affairs, its Veterans' Health Administration and in particular the National Centre *for* PTSD. The latter's publications of their psychologists and psychiatrists explorations on PTSD treatment modalities and statistics concerning PTSD-affected soldiers and veterans were most valuable to me. That no statistic seems to exist for those, due to their predicament finding themselves incarcerated, dwelling in insane asylums or living in abject poverty or on city-streets, is regrettable.

I extend my appreciation to the *Headstrong Project* and its affiliates for their PTSD perception and ideas of healing it, as well as to those believing pharmaceutical drugs, marijuana, ecstasy and like concoctions could be *the* cure to the existential crisis they term PTSD. I especially wish to thank the pharmaceutical conglomerates and distributors for their extensive and detailed publications on the effects their drugs have on humans' body and mind. It frees them form all responsibility, as they enable every human soul swallowing psychotropic poison to take responsibility for

the results.

My deep appreciation and gratitude also goes to SOTA instruments' owners and staff for their micro-currents, colloidal silver, pulsed magnetic fields, ozone, light and healthy frequencies easy-to-use products to improve human health and wellbeing. I also thank the composers and producers of 432-Hertz harp music. These actually worked for me. And of course I thank my brilliant editor David Leonhardt, who cruised with the project as if born to it.

Buddhist scriptures, the Holy Bible, the Koran and the Talmud, the Emerald Tablets and Zarathustra all helped me recover. The writings of Arthur Koestler, C.G. Jung, R.D. Laing, Miguel de Unamuno, Michael Newton, Scott M. Peck and numerous others of larger or lesser renown were also instrumental in my healing. I wish to particularly thank Joan Borysenko. Through her writings, she helped me to maintain my *Fire in the Soul*, the title of her exquisite book. Special gratitude goes to Deepak Chopra, M.D., in particular for his book *Unconditional Life: Discovering the Power to Fulfill Your Dreams.* He brought home to me the vital importance of meditation for body and mind healing. He also kindled in me the understanding of living in heaven or hell, depending on my thinking. This I perfected with the assistance of *The Diamond Cutter* (1st Edition) by Geshe Michael Roach, to whom I am deeply grateful, as well.

Mind you, all works mentioned in *The PTSD Fallacy* trilogy were instrumental in my recovery. Thus, it brings me great joy to have the opportunity to bring the exquisite knowledge and insights contained in those works to PTSD-affected soldiers, veterans, police officers, firefighters and aircrew members (the ones working in the four high-risk, PTSD-causing professions) and others diagnosed with the existential crises mistermed PTSD.

One will never be the same after a PTSD-causing event-moment. Why not? Because our soul, thinking death imminent and unavoidable, speeds off. It leaves our physical body behind to face its demise. But it leaves us with one precious gift: to create another life for ourselves in this life. Once we grasp the enormity of this opportunity, we are on the path to healing.

My recovery occurred by osmosis, without precise aim and knowledge. I found nothing extraordinary about it until attending a gathering of about 25 PTSD-affected passengers, most of them US military personnel, on a *Norwegian Star* 16-day voyage across the Atlantic, upon Canadian-Lebanese stage hypnotist Rebecca Hyman's gracious invitation. This 50-minute encounter generated *The PTSD Fallacy*.

I had little choice in the matter, if I wanted to die contently.

Guru Rinpoche, the 8th-century Indian Buddhist master, also known as Padmasambhava or Padme, the "Lotus-Born" who introduced Tibetans to the practice of Tantric Buddhism, noted:

If you want to know about your past lives, look at your present condition.
If you want to know about your future life, look at your present actions.

By applying discipline, determination, persistency and willpower I finally discovered through my writing how I freed myself from the PTSD predicament despite all odds and relatively unscathed. I did it. Therefore you can, too. Just go for it!

Introduction

I set foot on the *Norwegian Star* in April of 2016 to putter around on the sea's highways and byways between Tampa, Florida, and Copenhagen, Denmark. The last thing I imagined was walking off board plagued in my mind to investigate what I had done to recover from my Post Traumatic Stress Disorder (PTSD) experience. My PTSD was incurred when a Boeing 727 engine exploded five feet away from me mid-air. By a hair's breath, 144 passengers and six other crewmembers had escaped being blown out of the sky. But I had written about it already in my book *Broken Wings: A Flight Attendant's Journey into PTSD* some years earlier, so why would I bring it up again? It was all hypnotist Rebecca Hyman's doing. She was engaged by the cruise line to entertain passengers during some of the nightly on-board showroom performances. Due to her kindness and generosity of spirit, she invited those on board living with PTSD to a private gathering one afternoon mid-cruise.

I did not want to go. I had done "my thing". *Broken Wings* had been my catharsis, or at least, so I thought. Only due diligence propelled me to attend. Thus I went, and the moment I crossed the small room's threshold I began to cry, knowing precisely why. The sorrow, the despair, the trauma radiating from the 25 or so people gathered was overwhelming to me, palpable, all seemingly stuck in the PTSD-causing event moment, which most likely had been preceded by a number of equally hair-raising and life-threatening incidents.

Tears streaming down my face, I launched right into sharing with those present that the Australian Aborigines maintain that in extremely life-threatening situation without the possibility of survival, the soul leaves the body. When against all odds death does not occur, the body, finding Self on Earth without the soul, goes into shock manifested by the symptoms nowadays termed PTSD. Few others than Ms. Hyman spoke. Most, if not all, of those present were US military personnel. When Ms. Hyman wanted to put us under 50 minutes later, I got up, thanked her for her graciousness and generosity, said I did not believe in hypnosis, as in my opinion it merely masked the symptoms without healing anything. I tucked my *Broken Wings* card into her hand saying its writing had been my catharsis and left, thinking that was the end of that.

But the experience puzzled me, and my mind left me no peace, incessantly nagging: "What did you do to escape from ten years of pure hell relatively

unscathed?" It daunted and haunted me until the ball inadvertently began rolling three weeks later when I learnt that a Delta flight attendant had sued Atlanta Airport Authority for causing her PTSD. How, I thought? Because an uncapped sewer line in the crew-lounge had dowsed her and other crewmembers in feces and urine. Checking further into the matter I stumbled across an interview conducted with a University professor of psychology, purportedly expert in PTSD, spewing forth such nonsense about the ailment that it propelled me to such unexpected fury that I burst out laughing saying: "Well, woman, you better start writing if you want to leave this Earth at peace with yourself."

As said as done, I began that very same moment, ending up with a, for me, life-changing, meticulously researched trilogy. Again my life turned upside down, this time in most wonderful and unexpected ways. As the American psychiatrist, author, businessman and media personality Dr. David S. Viscott (1938–1996) states in his book *The Making Of A Psychiatrist*, we all spend our lives existing between two worlds that we can never really grasp, and so we live in an illusion of our own creation. Each of us perceives the world we must perceive, and even though the outside world is the same and feelings are universal, no two people share the same illusion of our own creation. And, he found, in the end, nothing hurts more than a wound that cuts through the illusion and therefore makes us see through ourselves. Such a wound is incurred in the PTSD-causing event moment. And such a wound can be healed only by looking at the Self with magnifying glasses to understand the Self, forgive the Self and learn compassion and empathy for the Self. We learn to create a new Self by building a knew illusion for it. Thus, in fact, the PTSD experience is an opportunity of a lifetime to create a Self exactly to one's own liking. And the path to that creation is what I try to share with my audience in *The PTSD Fallacy*.

The opposition will be fierce. The manure will fly in all directions. Hearing the truth has seldom charmed anyone. I merely do what I have to do to end this PTSD charade, this killing and destroying of genuine PTSD journeyers by way of drugging them into oblivion. That only enhances naturally occurring PTSD symptoms, even enticing them to suicide, when all they need for recuperation is peace, quiet, financial stability and time. Instead, we are methodically harassed, our confidence undermined, our belief in Self destroyed, the mental disorder misnomer in itself a wrong. Combine that with the aim of financial ruin. With the exception of a handful of psychiatrists and mental health practitioners, compassion, kindness, peace and quiet, and nurture in the form of financial stability is frowned upon by the powers that be, who view genuine PTSD experiencers as human debris,

expandable flesh. In particular, they know that only bright humans will acquire the condition, which proves that ignorance indeed is bliss. As bright humans throughout history were a threat to authority, their destruction has always been pursued.

My path to recovery did not occur by osmosis, as I hitherto thought. There was much more than that involved, as I discovered. It is also most likely that the way to heal the Self differs in accordance with our innate aptitudes and our sense of compassion and empathy for the Self. Our eagerness to either look at our PTSD situation as a journey of discovery, exploration and opportunity of personal growth or as one of perpetual trial and tribulation also makes a difference. It doubtlessly depends greatly on the time it takes for us to free the Self from the delusion that mental health practitioners of whatever rank and file can heal us from our existential crisis. It also most likely depends on our subconscious desire of dwelling in victimhood misery or fortitude to heal ourselves.

In my trilogy I merely chart out the course I took without intent or pre-knowledge. Mind you, in a way it began decades earlier when in preparation for a paper written for a physical anthropology college class I read in the *Tibetan Book of the Dead*, the *Bardo Thödol*:

> "Wherever I am born, at that very place,
> May I meet the yidam of this life face to face,
> Knowing how to walk and to talk as soon as I am born,
> May I attain the power of non-forgetfulness and remembrance of past lives."

The *Bardo Thödol* overall intends to guide us through the experiences our consciousness has after death during the bardo, the interval between death and the next rebirth. The yidam is a special deity one works with in meditation as a means towards recognizing one's own awakened nature. The text also includes chapters on the signs of death and rituals to undertake when death is closing in or has taken place. Thus, it is fully aligned with the experiences PTSD journeyers face after the PTSD-causing event moment. Be it as it may, in the beginning, most instrumental to my recovery was my phenomenal anger against those who enthusiastically and relentlessly pursued my destruction, and thus fanned the fire in my soul. It propelled me to write *Broken Wings*. But my true recovery occurred with understanding myself and what I had lived through by way of writing this trilogy.

It demanded much reading, investigation, research and learning. That helped me understand that only a deep look at the Self to finish off the pre-PTSD-causing

life and the consequent creation of a new being, a new Self by the Self through persistent self-observation and control of thought and behavior can lead to a PTSD recovery. And that I needed to have a good time when engaging in such self-exploratory endeavors.

Nothing better for amusement than watching what one thinks, outright outrageous at times, inspiring gratefulness that ESP has yet to become the norm. Nothing else will do, but no one says it better than Sun Tzu in a round-about way:

Know thy self, know thy enemy.
A thousand battles won, a thousand victories.

Healing Your Self Yourself

Four months it took me. Yes, four long and excruciatingly despairing months. I had to make up my mind whether to live or die after the engine exploded five feet away from me at 6000 feet altitude shortly after takeoff. The aircraft's 4000-foot drop in my mind portended certain death for me. It promised death for 144 passengers. And it promised death for the six other crewmembers aboard. It was written in the sky. No other possibility existed. Death's inevitability was so clearly obvious that I ended my life at that moment, awaiting impact as calmly as if I were strolling along a seashore on a sunny summer's day.

But impact never came. We made a full emergency landing on one engine after dumping fuel over northern Quebec's forests for about two hours. Fire trucks in tow,

we escaped a mid-air blow-up by a hair's breadth. Rushed onto the miraculously waiting, spare aircraft, we returned to home base.

Life continued and I with it. Post-Traumatic Stress Disorder (PTSD) showed up quickly. New behaviors emerged. I bought a Cadillac Eldorado 1973 — the largest, heaviest and in my imagination safest means of transportation I could get my hands on. It turned out to be a complete lemon, but what did I know? Besides, armored tanks were not available.

This was not the first near-miss I had survived. I escaped from an extraordinary number of them in my 25-year career as a North American Airways (NorAm) flight attendant, 10 of them since the PTSD-causing event. I felt the need for protective cover if I was ever to venture out again and feel at ease in this perilous world, danger and death lurking everywhere.

Over the four months following the explosion, everybody knew how badly I wanted to fly again:

- my immediate circle
- the flight attendant union shop stewards
- the powers that be, NorAm's management
- the Workers' Compensation Board (WCB)

As I had never been in such a situation before, I didn't notice just how little people cared. None of them tried to contact me. None of them offered to help me recover, in particular not NorAm. Until recently, it had been government-subsidized, but was then being publicly traded. For them, I may as well not have existed. Mind you, a sick employee means loss in shareholder profit. That's all that counts at any large, shareholder owned, corporation. Besides, a PTSD affected employee would share her PTSD experience and consequent treatment received from the airline, the WCB and the union with other flight attendants when back on the line. That could disrupt worker moral.

WCB demanded that NorAm let me work again nine months after the PTSD-causing event. The treating psychiatrist consented. And I smelled no rat. In my infinite ignorance, I believed the company was eager and delighted to help me mend my broken wings. In particular, I assumed the mental health professional assigned to help me was acting in my interests. I trusted that they knew best, even though I voiced my trepidation.

I returned to work, believing that my healthy survival had been guaranteed by

them for the rest of my career. I looked forward to at least another 20 years of working in the profession I adored. Nothing could have been further from the truth.

Only when recurrent PTSD crept up on me 30 months later did I smell that rat.

In the line of duty, I discovered that the psychiatrist treating me, and his equally well-papered wife, were both NorAm affiliated. They most likely enjoyed the inherent perks of free flights and vacations at exotic locations. I realized that he was working in the company's interest, not mine. So it would be with almost all "professionals" dealing with my case afterwards, 24 in all.

Only two acted with honor and integrity, ethics and morals. One of those was my Irish psychiatrist, a frequent NorAm first class flyer. He would save my life, my sanity, my sustenance and my livelihood by covering my back.

It was, however, my own probing, what I found and what I did with that information that made me whole again.

No other mental health practitioner played a role in my recovery. The others just aggravated it. You see, PTSD is not at all a mental disorder, even though the so-called "experts" with purported knowledge in the field say it is.

Instead, a PTSD-causing event creates an existential crisis. It makes a person question life's very foundations, its meaning, its purpose, its values. Thus the resolution to/of PTSD can be found solely by the one living through it. No other human being can help.

James T. Webb, Ph.D., is one of the 25 most influential American psychologists on gifted education. In his 2011 Supporting Emotional Needs of the Gifted (SENG) article "Existential depression in gifted individuals", he explains the risk to gifted and talented people. Those with higher intellectual ability are more likely to experience an existential depression than non-gifted people. The depression stems from a major loss or the threat of a loss, which highlights the transient nature of life. This existential depression lingers within, while the PTSD sufferer tries to come to terms with the very basic issues of existence.

Irvin David Yalom (1931–) is an American existential psychiatrist and professor emeritus at Stanford University, California. He describes four basic issues of existence or "ultimate concerns":

- death
- freedom
- isolation

- meaninglessness

Two things become excruciatingly clear during a PTSD-causing event. First, death is inevitable. Second, it is ever-present and can occur at any second. This is what always lingers foremost beneath the surface of a PTSD experiencer's mind. This constant awareness of death as an inevitable occurrence isn't the only force at work. It combines with the PTSD-associated loss of sense of invulnerability to form quite a combination with which to come to terms.

Freedom in an existential sense means not having an external structure. Humans do not enter a world that is inherently structured. Webb asserts that we give the world a structure, which we ourselves create.

Isolation means that no matter how close we get to another person, a gap always remains. We are still alone.

Meaninglessness stems from the first three: death, freedom, and isolation. If we must die, if we build our own world, and if each of us is ultimately alone, then what meaning does life have?

After the PTSD-causing event, PTSD sufferers are overcome by an overwhelming meaninglessness of life. If there is no meaning in anything, and death is the result of everything anyway, why go through the motion of living?

PTSD travelers have two decisions to make. They have to choose whether to live or die. We can will ourselves to die. But if we choose to live, we have to give our individual world a structure. This is something only we can create for ourselves. The PTSD-causing event wiped our slate clean, with all its structure and habits. All our wishes and desires, joys and fears, likes and dislikes–gone. All our loves and hates of friends and foes, marriage and partners, children and friends–gone. Our soul left with the event, while the body remained on Earth–lost.

No one tells us what it is we are suffering. We have no idea what happened to us. We are unaware that to create a completely new structure for our life is a necessity if want to live. There is nobody out there to enlighten us. The experts pretend to know about how it is to live with PTSD, but they are the blind leading the blind. They have no idea about the reason for a despair so overwhelming and colossal that it opens the way to hell. Consuming pharmaceutical and other drugs only makes it worse. It's not about healing; it's about reconstruction. PTSD is actually a gift. But we don't see it, and the professionals have no idea. Thus, the knowledge of imminent death at any given moment of life, the ensuing refrain becomes ever-present:

"Why go through the motion of doing anything?"

The desire for isolation may also be a barrier to reconstruction.

The initially incomprehensible feeling of desolation and emptiness within creates the need for isolation. The sense of an overwhelming bleakness of life and living suddenly felt within creates the need for isolation. The feeling of barrenness in everything one sees and everything one looks at creates the need for isolation. The sense of being in this world but no longer of it, creates the need, the desire for complete isolation. This isolation is needed to subconsciously figure out what happened to the Self. The isolation due to the complete feeling of desolation we feel is twofold, though. It precedes the decision whether to live or die.

As mentioned, isolation means that no matter how close we become to another human being, a gap remains. We are always alone. So why go through the tedious effort to maintain old relationships? What is the purpose, if death will part us anyway? Why bother?

The isolation we feel is twofold, though. Due to the PTSD-generated existential crisis brewing within, we need time for isolation, peace and quiet. We need this time to figure out what has happened, what is happening and what, if anything, to do about it once we decide to live.

The problem is that no one, not even the afflicted, knows what is happening. Those pretending to know bark up the wrong tree, from lover to husbands and partners. That includes:

- foes
- peers
- friends and family at large
- mental health practitioners

They all push and pull in various directions. They create more aggravation, more hostility despair and turmoil in the PTSD sufferer's psyche.

No human being alive can ever understand what the other is living. No one can ever understand . . . without having experienced it.

They don't understand how life turns upside down for the PTSD experiencer without having experienced it. Even those we formerly loved and cherished, with exception of the dog, hold little value and may never do so again. This throws all parties off and out of rotation and creates further friction in the PTSD sufferer's domain.

It is isolation that we desperately need to recuperate. It is isolation that PTSD afflicted desperately seek. Neither the powers that be nor family members will grant that isolation. That is what causes the PTSD experiencer's fall into the abyss, as the peace we need for healing is denied by all. Sex no longer has appeal. Nor does chatting or socializing. Nor does shopping or anything else that might previously have been of interest. Nothing holds any interest, nothing other than the overwhelming desire for peace, peace. Everyone just go to hell and leave me in peace.

All this adds to the sense of futility and meaninglessness. It amplifies the "What's the point?" mantra. It amplified my despairing cry within: "Leave me alone. Leave me well enough alone. I need peace." But no one listened, quite to the contrary. But more of that later.

Meaninglessness stems from the first three of the "ultimate concerns": death, freedom and isolation. If we must die, if we build our own world, and if each of us is ultimately alone, then what meaning does life have?

For PTSD sufferers who unexpectedly find Self on Earth after the event, the only place to be is alone. The only place to be is in isolation. We need complete solitude to try to solve this turmoil within.

The experts pretending to know what would improve the PTSD sufferer's state of mind don't have a clue. They may or may not know we need isolation. We only know that it is denied. They thus deny PTSD sufferers the only means to heal the Self. They deny us the isolation. They deny us the solitude. They knowingly or unknowingly shut us out of our own healing process.

Instead, the powers that be force PTSD sufferers to engage in their so-called healing modalities. They prescribe opiate pharmaceuticals of all types for healing. These only exacerbate PTSD symptoms and create suicidal tendencies. But we follow in good faith the garden path toward self-destruction, trusting "doctor knows best". Doing so, however, merely prolongs and even increases our suffering, often lasting to the end of the PTSD sufferer's natural life.

It seems to dawn on only a few that there is something wrong with these PTSD treatment modalities. As you will see, I am one those few.

"Why should such existential concerns occur disproportionately among gifted persons?" Webb asks. "Partially, it is because substantial thought and reflection must occur to even consider such notions, rather than simply focusing on superficial day-to-day aspects of life." Furthermore, he states, a gifted and talented person of higher intellectual ability is more likely to spontaneously have an existential

depression. A major loss or the threat of a loss, highlighting the transient nature of life, might trigger it.

But Webb also suggests that sometimes an existential depression leads to a "positive disintegration experience". In other words, Webb says that the PTSD-causing event could lead to two conditions. First, it could cause the spontaneous existential depression. Second, it could cause a positive disintegration experience afterwards.

Kazimierz Dąbrowski (1902–1980) a Polish psychologist, psychiatrist and physician, developed the theory of Positive Disintegration. It describes how a person grows as a result of accumulated experiences.

The Theory of Positive Disintegration is very different from other theories of personality development in one important way. Dąbrowski stressed the role of psychic discomfort in psychological development. He observed that psychological hardship triggered self-reflection. This introspection helped people mature psychologically (Dąbrowski 1972).

Dąbrowski's model is hierarchical. A person passes through each stage in a linear fashion. With each stage, the mind becomes more accomplished, more satisfied and more moral.

"Disintegration" refers to the maturing of thoughts, which move one's personality to a more developed level. Dąbrowski had a lifelong dedication to the field of psychology. He set up a rehabilitation center in Zagorze, near Warsaw, Poland, for patients suffering mental disorders after difficult life events. What he learned through his lifelong research at this facility helped shape his concepts. He, too, may be describing PTSD experiencers' event-aftermath.

However, he would be confusing the existential crisis with a mental disorder, the classic error of mental health professionals. But then, psychology is not a science. It is merely based on hypotheses dreamt up by academically trained and papered people.

Positive disintegration is said to propel humans to higher levels of development. It transforms them from self-serving beings into people conforming to self-awareness and direction. They transcend their primitive natures and strive to "walk the moral talk."

We need certain prerequisites, certain personal attributes and characteristics, for this journey from egocentrism to altruism:

- a facilitative social environment

- the Theory of Positive Disintegration (TPD)
- PTSD, if the afflicted ever sees the light to recognize the fabulous possibilities hidden within the predicament

Facilitative conditions are those conditions and counsellor-attitudes that enhance the therapeutic relationship between the mental health provider and the patient. They are deemed to be conducive or non-conducive to successful outcomes in counselling and psychotherapy. The three primary facilitative conditions were first suggested by the American psychologist Carl R. Rogers (1902–1987). He was one of the founders of the humanistic approach, a client-centered approach to psychology as described in his 1951 publication Client-Centered Therapy. These conditions are:

- unconditional positive regard
- genuineness
- empathy

According to Rogers, if counsellors express these core conditions, those being helped become less defensive and more open to themselves and their world. They tend to behave in more pro-social and constructive ways. Rogers believed these three conditions are both necessary and sufficient for positive counselling outcomes. Other theorists have argued that, although these conditions may be necessary, they are not sufficient. Current discussions identify the therapeutic relationship as also being essential to client progress. The facilitative conditions are key to establish a positive therapeutic relationship.

By the way, in 1946, Rogers co-authored "Counseling with Returned Servicemen" with John L. Wallen, (the creator of the behavioural model known as The Interpersonal Gap. They documented the use of the person-centered approach to counselling military personnel returning from the Second World War. He followed up his approach to education in *Client-Centered Therapy* by *Freedom to Learn,* devoted exclusively to the subject (1969). *Freedom to Learn* was revised twice. The new Learner-Centered Model is said to be similar in many ways to his classical person-centered approach to education. In PTSD, you have a choice. You can learn and live. Or you can vegetate and die, while allowing others to rule your mental and physical health in the interim.

The second prerequisite attribute is the Theory of Positive Disintegration.

Dąbrowski explains TPD in his *Theory of Positive Disintegration: Some implications for teachers of gifted students.* It is cited by Author Sal Mendaglio (AGATE. Fall 2002 15(2) 14–22).

In Bernard Guenther's view, the Theory of Positive Disintegration is a novel approach to personality development. Mainstream psychology tries to adjust a person to society and its norms through anti-depressants and other mood-altering pharmaceutical drugs. The Theory of Positive Disintegration says that being maladjusted to society is an opportunity for personal growth and the integration of higher, non-egocentric values.

The various levels of Disintegration and Integration as defined by Dąbrowski can be compared to the Staircase of esoteric evolution and moral bankruptcy. For example, man feels disillusioned when his old, conditioned Self conflicts with the emerging true individuality, the soul/essence.

Dąbrowski saw the "average" man just like Gurdjieff and other teachers of esoteric self-work did. He saw them on Level I as a mechanical robot-like being who simply exists based on lower impulses and programs. Those impulses are dictated/conditioned by society and "official culture". As such, most people live in a reactionary and mechanical state of external stimuli and influences under the illusion of free will. Guenther asserts says that neither true individuality nor true free can be formed on that level.

Certain people of all ages experience so-called overexcitability (OE), for example. These people have the potential to grow out of the lower levels and integrate their being into the higher ones. However, Dąbrowski points out that this process requires conscious work. It does not occur by osmosis or by itself. In other words, one must use the "shocks" of disillusionment to further one's soul evolution. Else, one can't gain Self-Awareness and invite the alchemical fire, the spark existing within all human beings for transmutation. Without using that disillusionment, one will stay at the lower level where most of humanity exists. One will remain mechanical and reactionary based on conditioning and programming. The mass-media and the educational system from Kindergarten through university will keep one in a sleepwalking state, dreaming to be awake. (*Bernhard Guenther,* Original Source: Positive Disintegration; the spiritualintellect.com, 2017).

The third, in my opinion, is PTSD. Some of the afflicted are blessed to recognize the fabulous possibilities hidden within the predicament. They recognize the opportunity to transition from the egocentric to the altruistic way of living. That assumes that this truth catapults into reality through the PTSD-causing event.

Without that possibility in our own psyche and innate personality from birth, it would most likely never take place in our life. Now the choice is to take that baton and run with it to the best of one's ability, to grasp the possibility of this positive disintegration. We stagger along in the beginning. We pick up speed as we move on. Or we can choose to ignore it. We then live a miserable, fear-filled and oft times drug-dominated existence until the time of the also self-induced death. In my academically un-papered-in-the-field-of-psychology opinion, no other outcome is possible.

We have a clear choice. On the one hand, we can get with it and pull ourselves up by the bootstraps. We can examine Self inside-out. We can search in earnest for ways to manipulate and coax ourselves into action. We can choose to return to living life and figure out a way to enjoy it.

On the other hand, we can will the Self to die. We can commit suicide. We can cave in to those purporting to know how to handle PTSD sufferers. Those who will prescribe:

- opiates
- ecstasy
- marihuana
- prescription drugs
- whatever else they want us to swallow

Is taking their substances an option for one's improvement and well-being? Do their cognitive behavioural treatment modalities feed the soul? Do their pharmaceutical remedies feel good to the spirit? Does listening to their doctrines make one feel more wholesome and well? Or do they, one's intuition yells, lead to the further destruction of mind, brain, consciousness and body?

Does one follow their orders to swallow 18 different pills to fight PTSD because it is the easy way out? Or does one's intuition yell to stop? Do sufferers know that they lead only to numbing down and eventually destroying the mind, brain, consciousness and body?

Does one follow their orders because of laziness or lack of willpower? Is it for a lack of discipline or determination? Is the idea of spending life on the couch watching television, drinking beer and watching baseball, as I did for a while, and doing nothing else in a drug-infused stupor, more appealing?

Or is the idea of being a victim of it all, including life itself, the catalyst to do

nothing about the PTSD predicament. Is victimhood preferable to taking charge of one's own life, one's own healing?

Does the "Doctor knows Best" fable cause one to ignore the innermost Self, where the solution lies? Does the fable blind one to the need for isolation necessary to the PTSD healing process that those who hold sway over one's life steadfastly refuse to grant? That isolation, that solitude so instrumental for a PTSD recuperation to take place. Only when surrounded by those who have had the PTSD experience is the solitude optional. Only they can understand. Only they can productively be sounding boards for each other. Whether in splendid solitude or not, however, we must travel the road to the inner Self and healing in splendid solitude.

Why, one may wonder, should PTSD or other existential concerns occur disproportionately among gifted human beings? Webb says that is partly because one must be capable of substantial thought and reflection. One needs these skills to consider notions like existential crises and depressions. Otherwise, one simply focuses on life's superficial day-to-day aspects. Guess what that means? Some people are more susceptible to PSTD than others:

- brighter people
- all round-globally-oriented people
- people well-educated academically
- people well-educated through life experience

These people are more likely to develop PTSD after an earth-shattering event. Due to their intellectual ability, they will tend to analyse the PTSD-causing event and its possible consequences. In particular, they will analyse for an indeterminable amount of time in its aftermath.

There is safety in stupidity, ignorance and lack of creativity and imagination. Caring only about soccer, football, tennis, golf, everything to do with balls, CNN, MMA, NBC et al. hockey, WWW and politics does have its advantages.

Webb furthermore asserts that creating one's own world structure and managing one's freedom of choice works better than cuddling for PSTD sufferers. He says that the intellectual issues and choices one makes are more effective in an emotional crisis than the reassurance of touch as a sensory solution. Cuddling up to someone to sooth sorrows and pain does not help with PTSD. Leave me well enough alone is far more likely. This explains the disinterest in sex among most PTSD voyagers. It is the

very last thing on their minds.

Webb gives hope to gifted children who feel overwhelmed by the myriad choices of an unstructured world. He says they can find comfort in studying and exploring alternate ways in which other people have structured their lives.

Therefore, it is logical that gifted adults such as PTSD experiencers can do the same. They, too, are overwhelmed by the myriad of choices of an unstructured world. They, too, are still unsure what if anything to do with it. They, too, are unsure whether they want to live or die. So they, too, can benefit from studying and exploring alternate ways of living. They can look at how other people live and think, or have lived and thought, at any time in history and anywhere in the world. There's nothing to lose by doing so. And if one ever wants to laugh again, there is everything to gain. It might help the PTSD sufferer recognize the one vital thing held from them:

> "I am not the same as I was before the PTSD-causing event. I will never be the same as I was before. Therefore my life and my relationships with everyone in it will never again be the same as it was before. Nor will my views, attitudes, values, anything I lived and liked pre-PTSD event ever be the same as before. Everything has been destroyed. Everything must be structured anew. Everything has to be created and evolved from scratch, whether I like it or not. If I don't, I may as well will myself to die. The choice is mine."

But how? Some of our restructuring could perhaps come through reading about the lives and thoughts of others. Could it also give us a glimpse of the Self, an increase of our understanding of it, a glimmer of hope for recovery?

The approach itself is called bibliotherapy, a therapeutic approach that uses literature to support good mental health. Through reading about people who have chosen specific paths to greatness and fulfillment, gifted youngsters get relief. Bibliotherapy helps them see that choices are merely forks in the road of life. Each choice can lead them to their own sense of fulfillment and accomplishment. Webb writes. Therefore, the PTSD afflicted, regardless of age, can use bibliotherapy, too.

To begin on this healing path of learning, however, the PTSD affected needs to apply a few simple tools:

- willpower
- discipline

- determination
- persistency

These tools are vital in searching for ways to help the Self to create a life that holds meaning. This is the hardest part for PTSD journeyers, even though some ways to heal the self might present themselves as if by osmosis, out of the blue.

"We all need to build our own personal philosophy of beliefs and values, which will form meaningful frameworks for our lives and will need frequent revisiting and reconsideration," says Webb. In other words we must clean out our mental household. But no one explained anything about this to me when I entered 10 years of hell. And no one was there to teach me that I, myself, was brilliantly equipped to heal my Self, nor how to go about it. No one was there to assure me that I had that power.

According to Webb, existential issues have lead many gifted people to bury Self in "causes". These causes might be academic, political, social or even a cult. He says this happens when existential issues prompt periods of depression mixed with desperate attempts to "belong." Aiding young gifted people in such situations to recognize basic existential issues may help, but only if done in a kind and accepting way. Webb furthermore states that these youngsters, and thus the PTSD afflicted, need to understand that existential issues are not one-time issues. They need to be frequently revisited and reconsidered. As a matter of fact, it does demand one-day-at-a-time living and constant observation and correction of ones thoughts, as we shall see later.

In essence, Webb conveys that many people with existential depressions can be helped. That includes those with PTSD. One way to help them onto the path to recovery is by helping them to realize that they are not so alone. Another way is to encourage them to adopt the message of hope written by African-American poet, social activist, novelist and columnist from Joplin, Missouri, James Mercer Langston Hughes (1902–1967):

Hold fast to your dreams,
For if dreams die,
Life is a broken-winged bird
That cannot fly.
Hold fast to dreams.
For if dreams go,

Life is a barren field
Covered with snow.

This poem reflects how I felt when I decided to give life another try. I was bereft of dreams. Everything previously fulfilling in life was shattered and meaningless. I saw no beauty, no desire for anything and no fulfillment in anything. Life was a barren, snow covered field. I was unable and unwilling to take flight, unable to see a future worth living. Everything was desolate, futile, one big bore. I was trying hard to come to terms with how life had been until the event. I was trying to make peace with my pre-PTSD experiences among so many new emotions and pains:

- nightmares
- a sea of tears
- emotional numbness
- bone-crushing unhappiness
- debilitating tension headaches

The futility and senselessness of it all was overwhelming.

Fear Setting In: Will This Go On Forever?

However, it was progress. Until I decided to live, only death was on my mind. It was a death that six crew-members, 144 passengers and I had cheated when escaping the explosion in mid-air by a hair's breadth.

Until that decision, I had no interest in anything. I vegetated with beer, mindlessly watching baseball, occasionally feeding Jessie Alabama, a wonderful Irish wolf hound black Labrador cross. We walked together when the spirit moved me, but mostly only once a day, as dogs go stir-crazy otherwise. In this abysmal misery, I was haunted by these questions:

- Who am I?

- What am I?
- Why am I here?
- What is the meaning of life?
- What is my reason for living?

These questions swirled endlessly in my head, searching for answers. No one around wanted to listen or guide me.

No one around understood, other than those who had lived that same colossal emptiness.

But we are rarely there to support each other. Those of us exposed to the possibility to get PTSD every time we go on duty are fire-fighters, police officers, soldiers, veterans and aircrew. Until a short while ago we were as good as the only ones qualifying for a PTSD diagnosis other than rape victims. We would benefit immensely from each other's support, yet we were and are kept well away from each other.

You see, some powers that be would not welcome us comparing notes on how they treat us. That includes:

- the unions
- employers
- mental health practitioners
- the Workers' Compensation Board (WCB)
- the United States Department of Veterans Affairs (VA)

These are the ones signing our compensation cheques for our injuries. They have the power to cut off our financial sustenance and medical assistance if we choose not to obey their commands the moment they are issued. I learned this well in the course of time.

I spent a while of moping and groaning. I cried, suffering terrific tension headaches that no pills would alleviate. There were nightmares. There was never ending beer consumption and television watching. After a while, fear set in: "What is it with me? Will this go on forever? Will I ever get better?"

Fear is binding. What we fear we attract.

My fear perverted my thinking. It stunted my ability to grow out of my acute functional depression. It blocked my ability to apply the logic and reason I needed to help myself. It paralyzed me even further, because I had almost no desire to move in

any direction, either physically or mentally. I was motivated only to do what I felt I had to. I took care of the house and garden, as I liked a neat environment, and I walked Jessie. I forced myself to cook for him, as he was used to home cooked food. So, I ate a bit myself.

At some point in the almost four months this inertia lasted, I must have recognized that it was fear that enslaved me. I must have realized that it was fear that fostered the anger I felt within. I must have realized that it was fear that strangled my innate guts, courage and bravery. It was my fear that kept me from returning to live life.

Perhaps U.S. President *Franklin Delano Roosevelt's 1933 inauguration speech phrase* crossed my path and touched something in my soul.

"The only thing we have to fear is fear itself"

I recognized that it was fear itself, more than anything else, that crippled my soul. It nourished my inactivity and perceived incapacity. I also must have subconsciously picked up that it was a fear not of death, but of life. I must have clued in that if I did not conquer this fear, I would destroy myself.

Before the PTSD-causing event, I was the fearless type. I would tread where angels feared to go often throughout my life, without thinking anything of it. I would always get out of the most peculiar situations unscathed.

I slowly, slowly perceived glimmers of light appear in this PTSD-generated haze of fear. By nature a curious soul, I recognized fear of living as the main culprit of this stuck-in-no-man's-land feeling. I considered what, if I were to go on living, I could do to overcome my cowardice, leading to the Cadillac Eldorado 1973 purchase. I asked myself how I could structure my new life. I was still in phenomenal innocence and naiveté. I believed that those said they wanted to help me recover would see me through the rest of the journey.

I coaxed myself into looking for ways to help myself while still following the commands of the powers that be. Things began to look up as I, unbeknownst to me until I began writing this book, had entered the path to heal myself.

Learn To Love The Self

That there is no time, all PTSD experiencers will confirm. Therefore, there is no timeframe for one's discoveries on this journey. The timeframe to return from the PTSD frame of mind depends, in my view, entirely on when the discoverer makes the choice to help the Self. It might even depend on the sequence in which the possibilities and revelations for Self-help are looked for or present themselves.

As we are dealing with a clean PTSD event-caused slate, however, let's read what Webb says about gifted children in his previously mentioned article. We are like those children when brave enough to return to life and create a new Self. Webb asks why such existential concerns or crises occur disproportionately to gifted persons. Partially, it is because it takes substantial thought and reflection to even consider

such notions. Otherwise, people just focus on superficial day-to-day aspects of life. However other more specific characteristics of gifted children — and PTSD experiencers — are important predisposers, as well.

Gifted children are able to consider possibilities. They can see how things might be. PTSD travelers are bright enough to know the trip to heaven barely passed them by. So, they tend to be idealists. However, they are simultaneously able to see that the world falls short of how it might be. Because they are intense, gifted children feel keenly the disappointment and frustration of ideals not reached.

Similarly, these youngsters — and PTSD journeyers — quickly or not so quickly spot the inconsistencies, arbitrariness and absurdities in society and in the behaviours of those around them. They question or challenge traditions. For example:

- Why do we put such tight sex-role or age-role restrictions on people?
- Why do people engage in hypocritical behaviors, saying one thing, but doing another?
- Why do people say things they do not mean at all?
- Why are so many people so unthinking and uncaring when dealing with others?
- How much difference in the world can one person's life make?

When gifted children–and PTSD experiencers–share their concerns with others, they usually get reactions ranging from puzzlement to hostility. They discover that others, particularly of their age and for PTSD folks much older, don't care. The others are too focused on more concrete issues and on fitting in with society's expectations. The others are not prepared to discuss such weighty concerns. Often by even first grade, these youngsters, particularly the more highly gifted ones, feel isolated from their peers and perhaps from their families.

Sometimes, their intensity is combined with multi-potentiality; they have many skills. That's when these youngsters become particularly frustrated with the existential limitations of space and time. There simply aren't enough hours in the day to develop all the talents many of these children have. Choosing from the possibilities is arbitrary; there is no "right choice".

Are you listening, PTSD Journeyer? You have all this power and all this creative talent. Do you really want it to go to waste? For gifted youngsters, even choosing a vocation can be difficult, says Webb. How can young people make a career decision

between equal passions, talents and potential in violin, neurology, theoretical mathematics and international relations? Well, at least we don't have to make that choice. We loved what we were doing. Otherwise we would not have chosen these highly dangerous professions.

The reaction of gifted youngsters to these frustrations is often one of anger. I, too, reacted with anger. In my case, the powers that be created that anger. Their expert sleight of hand incessantly rocked me off my boat and nothing else, once I got off the drug Ativan.

Gifted children discover, apparently much faster than I did, that their anger is futile. They see that it is really directed at "fate" or at other matters we are seemingly unable to control. Powerless anger evolves quickly into depression. Depression, enhanced with pharmaceutical opiate drugs, creates suicide-desires.

There are around 20 or so suicides daily in the USA among PTSD affected U.S. veterans. One of U.S. President Trump's reasons for signing the Enhancing Veteran Care Act on December 21, 2017, was to address this problem. The Act would allow regional Department of Veterans Affairs (VA) officials to engage non-profit organizations to identify and report deficiencies at VA hospitals. The goal would be more and faster investigations, to bring accountability to VA workers. This would help solve the problem of veterans not always receiving the standard of health care they deserved, reported Nikki Wentling of *Stars and Stripes*.

During his 2016 presidential campaign Trump, called the VA "the most corrupt" and "most incompetently run agency in the United States". He released a 10-point reform plan for the department. He had already signed the VA Accountability and Whistleblower Protection Act, one of the largest reforms in VA history, in June 2017. This sped up the process that the VA uses to discipline, suspend and terminate poor-performing workers. It created an accountability office in the agency's Washington headquarters.

"Veterans were put on secret wait lists, given the wrong medication, given the bad treatments and ignored in moments of crisis for them. Many veterans died waiting for a simple doctor's appointment. What happened was a national disgrace, and yet some of the employees involved in these scandals remained on the payrolls. Out-dated laws kept the government from holding those who failed our veterans accountable," the President said.

The average wait time for a VA mental health care appointment is 120 days. If a veteran needs a specialty physician, such as an ophthalmologist, it takes about five months (Dan Merica, CNN, June 2017). But more of that later.

No wonder depression and suicides abound under such circumstance. It is particularly hard when struggling with PTSD, with no clue about what it is.

Mind you, no one will tell the truth about PTSD anyway. Not because they don't want to, but because they don't know. They, the mental health practitioners, merely hypothesize in accordance with their own hallucinations and ideas to practice on their PTSD afflicted.

DSM-5 is the standard classification of mental health disorders. Jon Rappoport said a mouthful in his January 2018 article about the so-called experts in mental health who created the DSM: "None of the roughly 300 officially certified and labeled mental disorders has a defining diagnostic test. None."

And still they rule the world. Their hypothesized diagnosis of hyperactivity put children on methamphetamine such as Ritalin. This drug, believe it or not, causes increased activity and talkativeness, and decreased appetite. It creates a pleasurable sense of well-being or euphoria accompanied by long-lasting and harmful effects on the central nervous system (National Institute on Drug Abuse, 2013). Their drugs of choice to heal PTSD, opioids, are equally as vicious. They, too, destroy the central nervous system. They, too, dull the brain's joy centre into non-existence. Thus, they prevent a PTSD recovery.

Gifted children in a depression typically try to find some sense of meaning. They seek an anchor point they can grasp to pull themselves out of the mire of perceived "unfairness." PTSD experiencers seek the same sense of meaning. But the more they try to pull, the more they become acutely aware that life is finite and brief. The more they become aware that they are alone, and that they are only one very small organism in quite a large world. The more they become aware that there is a frightening freedom regarding how one chooses to live one's life.

It is at this point that they question life's meaning and ask:

> "Is this all there is to life? Is there no ultimate meaning? Does life have meaning only if I give it meaning? I am a small, insignificant organism who is alone in an absurd, arbitrary and capricious world where my life can have little impact, and then I die. Is this really all there is?"

Most soldiers develop PTSD only after returning home. Is this because they are suddenly alone? Is it because they have no one to talk to with even a vague idea of what it is like to be on a battle field or in the "Theater of War", as those instigating wars call it? Is it because there is no one able to adequately "cover their backs" on the home front, as retired Army Captain Dr. William Mount said on YouTube in

January 2018?

Such existential depressions deserve careful attention. Webb claims they can be precursors to suicide. The self-proclaimed experts in the field, the ones whose verdicts rule the world of psychology and psychiatry at the VA's National Centre for PTSD, don't breathe the word "existential crisis". It makes me wonder if they even know it. We will see.

How can one help these bright youngsters, and thus PTSD-affected adults, cope with existential questions? One cannot do much about the finiteness of existence. However, one can help youngsters learn to feel that they are understood and not so alone. One can teach them ways to manage their freedom and their sense of isolation, says Webb. One can reduce the isolation to a degree by simply communicating to the youngster that someone else understands the issues that he/she is grappling with. "Even though your experience is not exactly the same as mine, I feel far less alone if I know that you have had experiences that are reasonably similar. This is why relationships are so extremely important in the long-term adjustment of gifted children," Webb, Meckstroth and Tolan said in 1982. What works for those youngsters also works for the PTSD affected. In fact, this is Roger's Person-centered Therapy approach in action.

One way of breaking through the sense of isolation is through touch. In the same way that infants need to be held and touched, so do people experiencing existential aloneness. Touch seems to be a basic and instinctual aspect of existence, as shown by mother-infant bonding or "failure to thrive" syndrome. Webb says:

> "Often, I have 'prescribed' daily hugs for a youngster suffering existential depression and have advised parents of reluctant teenagers to say, 'I know that you may not want a hug, but I need a hug.' A hug, a touch on the arm, playful jostling, or even a 'high five' can be very important to such a youngster, because it establishes at least some physical connection."

That explains why I always felt tempted to hug those I thought would effectuate my healing, from WCB psychologists and psychiatrists to my Irish psychiatrist, to my saving grace the best papered of them all.

The reassuring aspect of touch is a sensory solution to an emotional crisis. Webb points out that the issues and choices of managing one's freedom are more intellectual. Gifted children often feel overwhelmed by the myriad choices of an unstructured world. They can find a great deal of comfort in studying and exploring alternate ways in which *other* people have structured their lives. They can read about

those who have chosen specific paths to greatness and fulfillment. Bibliotherapy is a method of understanding that choices are merely forks in the road of life. Each fork can lead to its own sense of fulfillment and accomplishment (Halsted, 1994).

This indeed, is fully applicable to PTSD journeyers. Each human needs to build an individual philosophy of beliefs and values, which forms a meaningful framework for our lives. Both our reality as a whole and our perception of our own Self changes during the PTSD journey into:

- ourselves
- the myopic world around us
- the unseen, the spiritual aspects of our lives

As a matter of fact, our whole being changes as we discover that nothing we ever held true really is. Nothing we believed to be the truth really is. Nothing really is at all until the moment we directed it to be and created it by our thoughts and behavior. Once we understand this, the reason for our PTSD experience is revealed when we start looking for it within ourselves. Then, it dawns upon us that we are infinite awareness, on Earth merely by choice to have a human experience. We are tailored to enhance our personal growth in this earthly dimension, this vibration, if you will.

I came to learn that I arrived on Earth to learn to love myself. I came here to give thanks and show gratitude for my many innate talents I took for granted. I am here to appreciate and love the life I have lived and would live until death. I came here to love everything I was still going to do. I was to make peace with those who I perceived hurt me in the pre-PTSD life. I was meant to learn empathy and compassion for myself. My role was to learn that I had the power to guide my life in any direction I wanted by learning to control my thinking, to make me the Producer and Director of my daily show.

The PTSD-causing event taught me that death is a non-threatening affair. I learned that we never die, but merely pass on to somewhere else in the Universe or wherever. Through my studies, I learned that my time of death was set. All I had due until the arrival of that blessed day was to carry myself with as much honor, integrity, graciousness and apply discipline, persistency, determination and willpower as I could muster while structuring my new, post PTSD-event life.

Throughout this 10-year-PTSD journey, my ex-husband supported me unquestioningly. He had lived through PTSD and knew what it felt like. He gave

me the all-important space I needed to recuperate. I was with him then, as he was and is with me now. He was the one who covered my back by never asking unanswerable questions like:

> "How are you feeling? What are you feeling? Can I do something for you? Do you want me to do something for you? What's the matter with you? Pull yourself together, stop crying, don't drink, don't smoke, you drink too much, you smoke too much, let's go shopping, I want to go to the movie, let's visit the in-laws. Why do you do this or that? Why don't you do this and that? Are you hungry? Why aren't you hungry? Do you want sex? Why don't you want sex?"

And so on and so forth ad nauseam and never ending.

He left me in peace, but was always there when I called. He always showed up with a large bottle of wine, though he himself seldom drank and never did drugs. Even though perhaps understanding it was with good intention, those questions would have driven my PTSD-inflicted condition to new heights of unfathomable despair. I was living in no-man's-land, without any answers for the seemingly weird feelings and behavior. I wanted only to vegetate in peace and isolation with Fido, undisturbed by mundane banalities, to figure it all out. Why the dog? Because it gives love in abundance, never carries a grudge and demands nothing in return.

Another thing I learned through perpetual self-observation was to recognize triggers that could make me erupt in anger. In me, it was signaled by a palpable rise in blood-pressure. I also learned that watching my own thinking is great fun. It also is pure joy to watch myself change my thinking and see the outcome. With the same level of awareness, I learned to slow myself down when under stress or in a rush. I learned to breathe deeply and slowly when demands by the powers that be or friends and family become too overwhelming, instead of flying of the handle. Before the PTSD recovery journey can begin, however, it seems unavoidable that a choice has to be made. Do I love myself enough to live or do I want to die? I made that choice subconsciously by buying the Cadillac. Mind you, suicide was no option. I already knew when the near-miss occurred that if I took my own life, I would have to live it all over again.

Another choice to make soon after the PTSD-causing event is who is trustworthy. Not doing so because of my infinite stupidity, ignorance and belief of good will in all mankind almost dug my grave for me. But by then, the 10 years of unadulterated hell had almost passed. To reach that point, I had completed four

Minnesota Multiphasic Personality Inventories (MMPI), the first step to the PTSD affected's destruction.

The MMPI & Its Consequences

During the month of the PTSD-causing event, I saw two North American Airways (NorAm) physicians. One suggested Robaxacet; the other diagnosed a functional depression. Both assured me that my at times excruciating headache would in due time go away all by itself. The latter also approved my astrologer as my counselor; I refused to see strangers.

Both were off the wall, as my immediate research proved. I heard nothing more from the airline.

The Union was equally quiet.

The WCB invited me to an interview three months after the incident. I went ballistic at the delay. They moved it up one month. Meanwhile, I began to sort

matters out with the help of a handwritten journal until a lengthy first interview with a WCB psychologist. I then completed in good faith the 567 multiple-choice question of the Minnesota Multiphasic Personality Inventory (MMPI). I trusted it was presented to assist me on my way to a speedy recovery of a yet to be diagnosed ailment.

The MMPI is the most widely researched and used standardized psychometric test of adult personality and psychopathology. A standardized test is administered and scored in a consistent, or "standard", manner. Everything is consistent:

- questions
- interpretations
- scoring procedures
- conditions for administering

They are all administered and scored in a predetermined, standard manner. Psychometrics is a field of study concerned with the theory and technique of objective measurement of skills and knowledge, abilities, attitudes, personality traits, and educational achievement. Mental health practitioners use various versions of the MMPI to, purportedly, develop treatment plans and help with a differential diagnostic procedure. It is a process of elimination in this sense:

1. A patient might have certain diseases or conditions.
2. Each is just a hypothesis at first.
3. The MMPI questions help them rule out some possible diseases or conditions.

The list of "probable" conditions shrinks to negligible levels by using evidence, such as:

- symptoms
- patient history
- medical knowledge

This adjusts epistemic confidences in the mind of diagnosticians or for computerized and computer-assisted diagnosis. Epistemology means logical discourse. It is a branch of philosophy that studies the nature of knowledge and the

justification and rationality of belief centering on four areas:

- the philosophical analysis of the nature of knowledge and how it relates to such concepts as truth, belief, and justification
- various problems of scepticism
- sources and scope of knowledge and justified belief
- the criteria for knowledge and justification

Epistemology addresses such questions as:

- "What makes justified beliefs justified?"
- "What does it mean to say that we know something?"
- "How do we know that we know?"

The MMPI is often used in legal cases, including criminal defense and custody disputes. It is also used as a screening instrument for certain professions and high-risk jobs, although in this manner it is controversial. University of Minnesota's psychologist Starke R. Hathaway and psychiatrist J.C. McKinley developed it in the late 1930's. While it might not be perfect, the revised MMPI-2 is regarded as a valuable tool for clinical psychologists to diagnose and treat mental illness.

Clinical psychology tries to integrate the so-called "science" of psychology with the treatment of complex human problems. It first assesses, then treats, mental illness, abnormal behaviour and psychiatric problems. The goal is to understand, prevent and relieve psychologically-based distress or dysfunction. Its purported aim? To promote subjective wellbeing and personal development.

Central to the practice of clinical psychology are psychological assessment and psychotherapy. Clinical psychologists may also engage in:

- research
- teaching
- consultation
- forensic testimony
- program development and administration

They may clinically manage patients with brain injury, an area known as clinical neuropsychology. This is the branch of practitioners/psychologists that usually

engages PTSD-affected people. It is these clinical psychologists whose mandate/commands of treatment ideas, doctrines and hypotheses we must adhere. Only by following their edicts can we maintain employer sponsored financial compensation through the WCB. This is true, whether the injury in the PTSD-causing event was sustained on military, police, fire-hall or aircrew duties.

The work performed by clinical psychologists requires a formal relationship with the client. It tends to be influenced by various therapeutic approaches and practices related to certain theoretical perspectives. The procedures they use are intended to:

- form a therapeutic alliance
- explore the nature of psychological problems
- encourage new ways of thinking, feeling and behaving

Clinical psychology has four major theoretical perspectives.

The first is Psychodynamic psychotherapy. This is a form of depth psychology. Its primary focus is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension.

The second theoretical perspective is cognitive behavioural theory (CBT). According to A. A. González-Prendes and S. M. Resko's *Cognitive-behavioral (sic) theory*, these are rooted in the fundamental mental principle that humans' cognitions play a primary role in developing and maintaining emotional and behavioural responses to life situations. Thus, in CBT models, the primary determinants of humans' feelings and actions in response to life events are cognitive processes in the form of:

- meanings
- judgments
- appraisals
- assumptions

These either help or hinder the process of adaptation. (SAGE Publications). This view dictates Cognitive Behavioural Therapies and treatment modalities developed and recommended by the National Centre for PTSD et al. and others.

The third theoretical perspective on which clinical psychology bases its existence and values is humanistic-existential psychology. This is based on the belief in a person's intrinsic potential for personal growth and development. Central to

humanistic psychology is accepted truth that all human beings are subjects to multiple negative factors:

- social
- genetic
- familial
- environmental

These can be changed by attaining a positive attitude. Humanistic psychology eschews the "medical sickness" model. Instead, it embraces one of mental growth and emancipation. Its humanistic psychotherapies differ from both Freudian psychoanalysis and the behaviorism championed by BF Skinner. Skinner's research included imprisoning his two-year old daughter in a cage for two years to gauge her reactions.

The last theoretical perspective used to justify clinical psychology is family therapy. This type of counselling views problems as patterns or systems that need adjusting, rather than problems within an individual. This is why family therapy is often referred to as a "strengths based treatment."

Family therapy is recommended to improve communication and reduce conflict between members of the same household who played a long-term supportive role. It is viewed as an ideal way to help members adjust when one of them struggles with addiction, or medical or mental health diagnosis.

All four hypotheses and ideas influence PTSD sufferers' evaluation and treatment. How each idea affects them depends on the person's tolerance levels and consequent actions. It also depends on who conducts their interviews and issues their omnipotent individual diagnosis. It is here that the traumatization of the traumatized begins, when the MMPI is completed.

Professor Stephen Palmer, Ph.D., is an award winning psychologist and founding Director of the Centre for Coaching and Centre for Stress Management, London, UK. He finds that there has been a growing movement to integrate various therapeutic approaches. He sees an increased understanding of issues of culture, gender, spirituality and sexual orientation. This comes from more robust psychotherapy research, showing that most major therapies are of roughly equal effectiveness. The key common element for success is a strong therapeutic alliance. Because of this, more training programs and psychologists are adopting an eclectic therapeutic orientation. They work with a variety of methods, principles and

philosophies to create a treatment program that caters to a patient's unique needs. Rather than adhere to a certain school of therapy, eclectic therapists treat patients with techniques from all schools.

In the book *Integrative and Eclectic Counselling and Psychotherapy,* authors Professor Palmer and Ray Woolfe further clarify the distinction between integrative and eclectic approaches to therapy:

> "Integration suggests that the elements are part of one combined approach to theory and practice, as opposed to eclecticism which draws ad hoc from several approaches in the approach to a particular case."

In other words, psychotherapy's eclectic practitioners' are not bound by the theories, dogma, conventions or methodology of any one particular school. Instead, they may use what they believe or feel or experience or think will work best in general. Or they can use what they deem to be suitable to the needs of individual clients. They work within their own preferences and capabilities.

Dr. Salters-Pedneault, Ph.D., is a clinical psychologist whose research and clinical work focus on psychological trauma and trauma-linked conditions, such as borderline personality disorder (BPD) and posttraumatic stress disorder (PTSD). She was a research associate of the National Center for PTSD Behavioral Science Division at the VA Boston Healthcare System. She was also an instructor of psychiatry at the Boston University School of Medicine. She works as Assistant Professor of Psychology at Eastern Connecticut State University and in private practice. She researches emotional processing and fear learning in traumatized populations. In her 2017 article "Therapeutic Alliance in BPD" (*Verywell.com*), she maintains that the foundation for any course of therapy is a strong therapeutic alliance. The relationship and level of trust between the therapist and the patient dictates therapy outcomes.

This connection may be hard to build, she says, providing us with the following guidelines:

First, a good therapist gives patients undivided attention. He/she:

- listens to what patients have to say,
- asks clarifying questions,
- does not seem preoccupied,
- does not sift through emails,
- not only gives thoughts or opinions, and

- needs to have an understanding of what patients are going through in order to help them.

Second, patients should be comfortable telling their therapist anything, even if it's embarrassing. The therapist should put patients at ease and make them aware their conversations are confidential.

Third, therapist and patients should work towards the same endpoint. Keep that in mind when you consider the PTSD treatment you receive or received.

Keep one thing firmly anchored in your mind: any field of psychology is not a science, but a hypothesis. Even American psychologist Lightner Witmer (1867–1956) makes this clear. He introduced the term "clinical psychology" in a 1907 paper, defining it as "the study of individuals, by observation or experimentation, with the intention of promoting change." Witmer contributed to many branches of psychology, including school psychology. He created several firsts:

- the world's first "psychological clinic" at the University of Pennsylvania in 1896
- the first journal of clinical psychology in 1907
- the first clinical hospital school in 1907

Clinical psychology is one of the most popular subfields within psychology that extensively uses the MMPI. The test is used to evaluate the effectiveness of treatment programs including those of substance abuse. I am certain it is also used to evaluate the effectiveness of PTSD treatment programs, as I was asked to complete it five times.

Kendra Cherry wrote "What Is the Minnesota Multiphasic Personality Inventory? A Look at the History and Use of the MMPI" (*Verywell.com*, 2017). She explains that for years after the MMPI test was first published, clinicians and researchers questioned its accuracy. Some critics pointed out that the original sample group was inadequate. Others argued that the results showed possible test bias. Still others felt the test itself contained sexist and racist questions.

In response to these accusations, the MMPI test was revised in the late 1980s. Many questions were removed or reworded, and new ones were added. New validity scales were also incorporated and the revised test edition in 1989 published as MMPI-2. This was further revised in 2001, 2003 and 2008. The last edition, known as the MMPI-2-RF, has fewer questions and is still in use today. Because the

University of Minnesota holds its copyright, clinicians must pay about US $110.00 to use the test, which is why it is seldom used in private practice.

What is in the MMPI-2 test? Jane Framingham, Ph.D. of Psychcentral.com explains that it is designed with 10 clinical scales. It assesses 10 major categories of what is considered abnormal human behaviour. It also has four validity scales to assess a person's general test-taking attitude and whether they answered questions truthfully and accurately.

With 567 questions, the test is designed for people age 18 and older and "should" take about 60 to 90 minutes. That, however, is a fable. The time fluctuates wildly, depending on the person's reading and reasoning skills.

Once the test is done, a professional should administer, score and interpret it. This should preferably be done by a clinical psychologist or a psychiatrist with extensive training in the MMPI's use, interpretation and analysis. An evaluation or diagnosis should never be based on the MMPI test result alone. The test should collaborate with other assessment tools. There are plenty of them. In fact, PTSD-affected people have so many thrown at them, until they stomp out in disgust and despair, throwing in the towel.

The MMPI-2 has 10 clinical scales to show a person's different psychological conditions. These diagnostic systems and rating scales are used in psychiatry and clinical psychology to patient-evaluation. These scales are:

- hypochondriasis (hs)
- depression (d)
- hysteria (hy)
- psychopathic deviate (pd)
- masculinity femininity (mf)
- paranoia (pa)
- psychasthenia (pt)
- schizophrenia (sc)
- hypomania (ma)
- social introversion (si)

Clearly, the test is primarily built to detect any of those personality traits or tendencies. The usual clinical scales sought in the average mental health practice to gauge/pinpoint patient-ailment are said to be:

- addiction
- ADHD
- autism spectrum
- anxiety
- dementia and cognitive impairment
- dissociation
- depression
- eating disorders
- mania and bipolar disorder
- personality and personality disorder
- schizophrenia
- psychosis

Without doubt, all of these are intertwined with MMPI-2 test results.

Despite the names given to each scale, they are not pure measures. Many conditions are said to have overlapping symptoms. Because of this, most psychologists refer to each scale by number. Let's analyse these scales piece by piece. Let's clearly see what information we, the ones being tested, are conveying when we do the MMPI. Let's see what enormous powers the result hands to our opponents.

Reading The 10 MMPI Scales

Reading the scales below can be very useful. Every one of them will most likely hang on the PTSD incurred-in-the-line-of-duty experiencers, unless they learn in advance what it is all about. Only by educating ourselves can the results be manipulated. Only by educating ourselves can their assertions be rendered dead in the water. Only by educating ourselves can we keep them from insisting that pre-morbid disorders and conditions caused the PTSD problem. Only then can we keep them further undermining our fragile condition.

SCALE 1: HYPOCHONDRIASIS: This is a morbid concern about one's health, especially when accompanied by delusions and fear of serious physical disease and

illness. It lasts for six months and is beyond and despite medical reassurance.

Hypochondriacs were once viewed as comical figures in the way Molière depicted them in his 1673 play "Le Malade Imaginaire" (The Imaginary Invalid). Hypochondriasis is now recognized as a psychiatric disorder.

It is when a person is preoccupied with bodily functions and interprets normal body sensations, like sweating and minor abnormalities such as aches, as major problems of medical importance. It is said to usually start in teen-age years and young adulthood. It sometimes starts when someone close becomes seriously ill or dies.

The 32 items on this scale concern somatic symptoms and physical wellbeing. It was developed to identify patients with symptoms of hypochondria. It is now designed to assess the subjects' neurotic concern over bodily functioning. The two primary factors this subscale measures are poor physical health and gastrointestinal difficulties.

SCALE 2: DEPRESSION: This scale was designed to identify depression, which was characterized by:

- poor morale
- lack of hope in the future
- a general dissatisfaction with one's own life situation

Very high scores of this scale might indicate depression, but moderate scores tend to reveal a general dissatisfaction with life. American Psychological Association members found that depression is not just sadness, but a lack of interest and pleasure in daily activities. Symptoms include:

- lack of energy
- inability to concentrate
- significant weight loss or gain
- insomnia or excessive sleeping
- recurrent thoughts of death or suicide
- feelings of worthlessness or excessive guilt

Depression is thought to be a most common, albeit treatable mental disorder, according to Cherry. A combination of therapy and antidepressant medication

"should" lead to recovery. We will shortly discover the contrary.

SCALE 3: HYSTERIA: This scale was designed to identify people who show hysteria in stressful situations. Well-educated and high social class people tend to score higher on this scale, and women tend to score higher than men.

The term "hysteria," used for over 2,000 years, has become broader and more diffuse over time. In modern psychology and psychiatry, the term features hysterical disorders in which a patient has physical symptoms of psychological rather than organic causes. The symptoms include histrionic personality disorder, featuring excessive emotions, dramatics and attention-seeking behaviour. Found more often in women than in men, the patients typically work on emotion rather than fact or logic, their conversations full of generalizations and dramatic appeal.

The histrionic patient's enthusiasm, flirtatious behaviour and trusting nature can make them appear charming. But their need for immediate gratification, mercurial displays of emotion and constant demand for attention often alienates them from others.

Framingham, however, begs to differ. She says the Hysteria scale primarily measures five components:

- shyness
- cynicism
- headaches
- neuroticism
- poor physical health

A tendency of hysteria, regardless of gender, is loaded with possibilities for enemies to twist and exploit. Someone with such a tendency would never fly undetected for long in military, aircrew, fire-fighters or police personnel.

Nevertheless, I assure you that all attempts will be made by those in power to apply the hysteria label to PTSD sufferers. This makes our life miserable, as such accusations undermine self-esteem, or what little is left of it after the PTSD-causing event. That label was stuffed down my throat by one or two of the 23 mental health-impaired professionals who had never seen me. Another of them who had never met me claimed I must have been raped, otherwise I could not feel the way I did. Such is the sorry treatment of PTSD sufferers.

SCALE 4: PSYCHOPATHIC DEVIATE: This scale was developed to identify

psychopathic patients. It measures social deviation, rejection of authority and amorality. This MMPI test portion is used to identify these traits:

- hostility
- narcissism
- exploitiveness
- social maladjustment
- absence of strongly pleasant experiences

According to Cherry, items on this scale tap into complaints about family and authority figures, self-alienation, social alienation and boredom. They are posed to find out how well a person is adjusted to society and culture. Typical questions address:

- boredom
- family relations
- feelings about authority
- self and social alienation

Designed for Americans, one could deduce that it can apply only to those born and raised in the American culture, thus inapplicable to aliens. Thought of as a measure of disobedience, low scorers are viewed as more authority accepting. High scorers are deemed to be more rebellious. They are usually diagnosed with a personality disorder rather than a psychotic disorder.

The difference? According to the MMPI to be analyzed later, a personality disorder is a chronic and pervasive mental disorder affecting thoughts, behaviours and interpersonal functioning. It is an enduring pattern of inner experience and behaviour that:

- deviates markedly from the expectation of the person's culture
- is pervasive and inflexible
- has an onset in adolescence or early adulthood
- is stable over time
- leads to distress or impairment

Because these disorders are chronic and pervasive, they can lead to serious

impairments in daily life and functioning.

Yes, and the powers that be who sit in judgment over the PTSD psyche will not hesitate for one moment to claim that those personality traits and deficiencies fit right into military and aircrew personnel. We've been employed for possibly decades without anyone detecting them. They have been harbouring in the PTSD-affected psyche, while we brilliantly perform our duties until the PTSD-causing event. That's what the powers that be will tell you.

SCALE 5: MASCULINITY/FEMININITY: This scale was designed by the original authors to identify homosexual tendencies. It was found to be largely ineffective, says Cherry. But it is now used to measure:

- activity-passivity
- personal sensitivity
- aesthetic preferences
- interests in vocations and hobbies

It measures how rigidly a person conforms to stereotypical masculine or feminine roles. High scores are assumed to relate to intelligence, socioeconomic status and education. Women generally score low, according to Framingham. Mind you, one analyst declared me to be a lesbian. Another insisted that my difficulties with men had caused my PTSD. I wonder if I should sue them for libel.

SCALE 6: PARANOIA: This scale was originally developed to identify patients with paranoid symptoms:

- rigid attitudes
- suspiciousness
- excessive sensitivity
- feelings of persecution
- grandiose self-concepts

Those scoring high would tend to have paranoid symptoms, thus qualifying for personality disorder. That's a chronic and pervasive condition, characterized by disruptive patterns of thought, behaviour, and functioning. Paranoid personality disorder is thought to affect between one and two percent of U.S. adults. Symptoms often resemble schizophrenia. There is some research showing a possible genetic

link between the two disorders. People with paranoid personality disorder are at greater risk for depression, substance abuse and agoraphobia.

This scale, however, is said to mostly measure:

- suspiciousness
- interpersonal sensitivity
- moral self-righteousness

Framingham claims that some of the items used to score this scale are psychotic themselves in that they acknowledge the existence of paranoid and delusional thoughts.

SCALE 7: PSYCHASTHENIA: This scale is meant to measure a person's inability to resist specific actions or thoughts, regardless of their maladaptive nature. Psychasthenia is an old term. It describes what we now call obsessive-compulsive disorder (OCD). It was originally used to measure:

- obsessions
- compulsions
- excessive doubts
- unreasonable fears

The diagnostic label is no longer in use. The symptoms on this scale are more reflective of obsessive-compulsive disorder, shown by obsessive-compulsive thoughts and behaviours. They also tap into abnormal fears, self-criticisms, guilty feelings and difficulties in concentration.

SCALE 8: SCHIZOPHRENIA: This scale was developed to identify schizophrenic patients. With 78 questions, it is the test's largest scale. It is said to measure a wide variety of areas:

- impulse control
- social alienation
- bizarre thoughts
- sexual difficulties
- peculiar perceptions
- lack of deep interests

- poor familial relationships
- difficulties in concentration
- disturbing questions of self-worth and self-identity

The Mayo Clinic considers schizophrenia to be a severe mental disorder in which people interpret reality abnormally. It can result in some combination of hallucinations, delusions, and extremely disordered thinking and behaviour. These traits impair and disable daily functioning. Considered a chronic condition, it purportedly requires lifelong treatment. This scale is said to be difficult to interpret, so we can assume with confidence that it is applied to PTSD sufferers whenever possible. The powers that be grasp for any label.

SCALE 9: HYPOMANIA: According to Framington, this scale was developed to identify characteristics of hypomania:

- irritability
- flight of ideas
- elevated mood
- brief periods of depression
- accelerated speech and motor activity

Meant to measure milder degrees of excitement, this scale features elated but unstable mood, psychomotor excitement (such as shaky hands) and flights of unstoppable strings of ideas. The scale taps into over-activity — both behaviourally and cognitively — grandiosity, irritability and egocentricity.

Hypomania literally means "under mania" or "less than mania". It is a mood state featuring persistent disinhibition and pervasive elevated euphoria, with or without irritable mood. It is viewed as less severe than full mania. Characteristic behaviours are displays of extreme energy, talkativeness and confidence, often with flights of creative ideas.

Disinhibition is a lack of restraint, by ignoring social conventions. It includes impulsivity and poor risk assessment, affecting several aspects:

- emotional
- instinctual
- perceptual

Signs and symptoms similar to the diagnostic criteria for mania are thrown in. These include:

- hyperphagia
- hypersexuality
- aggressive outbursts

Hyperphagia is a medical sign meaning excessive hunger and abnormally large intake of solids by mouth. Hypomanic behaviour is said to often generate productivity and excitement. But it can be troublesome if the subject engages in risky or unwise behaviours. Manic episodes are "staged" according to symptomatic severity. Hypomania and related features constitute stage I of the syndrome. The cardinal features are most evident:

- flight of ideas
- pressure of speech and activity
- euphoria or heightened irritability
- increased energy and decreased need for sleep

Thus, this scale at stage I gives ample room to hang it on PTSD sufferers. After all, where there is a will there is a way.

SCALE 10: SOCIAL INTROVERSION: This scale, Cherry notes, was developed later than the other nine. It was designed to assess a person's tendency to withdraw from social contacts and responsibilities. It is one of the major personality traits identified in many theories of personality. The scale is said to measure a person's social introversion and extroversion. It presumes a social introvert is uncomfortable in social interactions, typically withdrawing from them whenever possible. They may have limited social skills, or simply prefer to be alone or with a small group of friends. Framington suggests that they tend to focus more on internal thoughts, feelings and moods, rather than seek out external stimulation.

Note the word "theories" above, reflecting that all their assertions presented as scientific, empirical evidence are merely speculations and hypotheses. None of them are provable, because each human being is an individual. Each one functions to the beat of their own drummer, step by step with their own individual make-up.

The terms "introversion" and "extraversion" were popularized by Swiss

psychiatrist Carl Gustav Jung (1975–1961). In 1902, he completed his doctoral dissertation *On the Psychology and Pathology of So-Called Occult Phenomena* to graduate from the University of Basel with a medical degree. These terms became central parts of other prominent theories of personality.

Everyone has some degree of both introversion and extraversion. However, Cherry claims that quiet, reserved and introspective introverts expend energy in social situations. They often need to recharge their batteries by spending time in solitude. On the other hand, extroverts gain energy from social interaction.

Beyond each scale's definitions, they share one common trait. These scales are deadly in the hands of mental health professionals, in particular those hired by large corporations, who evaluate injured workers. The MMPI is ideally designed to destroy healthy human beings, including PTSD experiencers. Generally reduced to mincemeat within months of test results, they are thrown on the garbage heap described by L. White in *Human Debris: The Injured Worker in America* (Seaview/Putnam: New York, in 1983, pp. 59–73). Equally as valuable is *Research on Canadian Workers' Compensation,* published in 1995 by the IRC Press, Industrial Relations Center: Queens University, Kingston, and edited by T. Thomason and R.P. Chaykowski. Both are worthwhile reading. Both will give you insight into what you are up against from impeccable sources. How does the MMPI's evaluation process work, you ask? Let's take a look.

Evaluating MMPI Scores

The MMPI and other psychological tests are considered objective, standardized measures of a sample of human behaviour. The term "sample of behaviour" refers to a human being's performing tasks that have usually been prescribed beforehand. The most common type of test uses paper and pencil. If properly made, performance on paper-and-pencil tests produces a test score believed to reflect a psychological construct.

Differences in test scores are thought to reflect individual differences in the construct the test is supposed to measure. The technical term for the science behind psychological testing is "psychometrics". This field of study concerns the theory and technique of objective, psychological measurement of a subject's:

- aptitude
- attitudes
- cognitive ability
- personality traits
- skills and knowledge
- emotional functioning
- educational achievement

Some psychometric researchers focus on creating and validating assessment instruments such as:

- tests
- questionnaires
- personality tests
- evaluators'/raters' judgments

Others research measurement theory. In short, psychometric research involves two major tasks: creating instruments and developing procedures to measure the results. Practitioners in these fields are mostly psychometricians. These are psychologists with advanced graduate training. They are the folks who decide how to measure the validity of test responses. They design the validity scales used to gauge how reliable the answers are. They try to detect defensiveness, malingering and careless or random responding.

The Minnesota Multiphasic Personality Inventory validity scales measure:

- questions not answered
- "appearing excessively good"
- over-reporting somatic symptoms
- answering questions all true/all false
- denial/evasiveness in the test's last half
- client "faking bad" in the test's last half
- client "faking bad" in the first half of the test
- frequency of showing up for an appointment
- client "faking good" in the first half of the test
- honesty of test responses/not faking good or bad
- answering similar/opposite question pairs inconsistently

Somatic symptom disorder is when a person focuses on physical symptoms, such as pain or fatigue, to the point that it causes major emotional distress and problems functioning.

Mind you, the usefulness of the current validity scales is sometimes questioned. Tests may not be designed to detect a deliberate attempt to skew the results. In other words, there seems to be ample room for an evaluator to manipulate MMPI test results. This depends on who does the interpretation, which for PTSD and other severely injured workers may be detrimental to their health. According to Cherry, the MMPI-2 validity scales read as follows:

THE L SCALE is also referred to as the "lie scale". It detects patients' attempts to present themselves in a favourable light. People scoring high on this scale deliberately try to make themselves look good. They reject shortcomings or unfavourable characteristics. Well-educated people from higher social classes tend to score lower.

THE F SCALE is used to detect attempts at "faking good" or "faking bad." People who score high on this test are trying to appear either better or worse than they really are. This scale asks questions to determine if test-takers contradict themselves in their responses. The "F" does not stand for anything, although it is mistakenly sometimes referred to as the Infrequency or Frequency scale. It is intended to detect unusual or atypical ways of answering the test items, like if a person were to randomly fill out the test. It taps a number of strange thoughts, peculiar experiences, feelings of isolation and alienation and a number of unlikely or contradictory beliefs, expectations and self-descriptions. If a person answers too many F and Fb scale items incorrectly, it will invalidate the entire test. Contrary to some descriptions, F scale items are scattered throughout the entire test up until around item 360.

BACK F (FB) – THE BACK F SCALE measures the same issues as the F scale, but only during the last half of the test.

THE K SCALE is sometimes referred to as the "defensiveness scale". It is a less obvious way to detect attempts to present oneself in the best possible light. It is designed to identify psychopathology in people who otherwise would have profiles within the normal range. It measures self-control and family and interpersonal relationships. People who score highly on this scale are often seen as being defensive. Research shows, however, that those of higher educational level and socioeconomic status tend to score higher on the K Scale.

THE ? SCALE is also known as the "cannot say" scale. It counts the number of items

left unanswered. The MMPI manual recommends that any test with *30 or more unanswered questions* be declared invalid.

THE TRIN SCALE, the True Response Inconsistency Scale, detects patients who respond inconsistently

THE VRIN SCALE, the Variable Response Inconsistency Scale, is another method to detect inconsistent responses.

THE FB SCALE includes 40 items that less than 10% of normal respondents support. A high score might mean that the respondent stopped paying attention and began answering questions randomly.

Dr. Framingham, Ph.D., of Psych Central calls the Minnesota Multiphasic Personality Inventory a protected psychological instrument. By that, she means it can be given and interpreted only by a psychologist trained to do so. You cannot find the test online, although you can read about it online.

The MMPI is commonly administered by computer. It requires no direct professional involvement to administer it. However, an interview with the psychologist doing the testing nearly always precedes the test. After the computer scores the test's results, *the psychologist writes a report interpreting the test results in the context of the person's history and current psychological concerns.* I highlighted the last sentence, because it shows so magnificently how subjective the whole enterprise is. It's a mixture of psychic viewing and pure conjecture. And it can so often be used to the detriment of the unsuspecting, injured worker.

To prove my point, Framingham interprets the MMPI validity scales:

> "The MMPI-2 is not a valid measure of a person's psychopathology or behaviour, if the person taking the test does so in a way that is not honest or frank. A person may decide, for whatever reasons, to exaggerate or deny the behaviour being assessed by the test. To navigate those muddy waters, the MMPI-2 contains four validity scales designed to measure a person's test-taking attitude and approach to the test."

When the MMPI-2 is done, scores are converted to normalized "T scores" on a scale of 30 to 120. The "normal" range of T scores is from 50 to 65. Anything above 65 and anything below 50 is considered clinically significant. That means it is open for interpretation by the psychologist.

Through the years and over numerous professional studies, a set of standard

clinical profiles on the MMPI-2 called "codetypes" have emerged. A codetype is when two scales show significantly high T scores, with one being higher than the other. For instance, a 2-3 codetype means that both Scale 2 and Scale 3 are significantly elevated. It suggests:

- helplessness
- significant depression
- lowered activity levels

It means a person might have become used to their chronic problems and often has physical complaints. Dozens of clinical codetypes are well-known and understood. So are T scores that "spike" on a single Scale such as a "Spike 4". That is a sign of a person who shows:

- rebelliousness
- impulsive behaviour
- poor relationships with authority figures

People with little or no psychopathology or personality concerns will not have any particular codetype. Framingham says that most people with personality issues or mental health problems usually have just one codetype. Or they have one codetype, with a spike on a third scale.

Once the scores have been evaluated, the psychologist creates an interpretive report. Like all psychological interpretation, scores are analyzed in context of the individual being tested — not in a vacuum. Ideally, the MMPI-2 is administered as a part of a battery of psychological tests. That way, each test can confirm or deny the *hypotheses suggested* by the MMPI-2.

A lot of people comment on how the MMPI questions do not seem to make a lot of sense. On their own, they do not. Framingham explains that the questions do not directly measure mental health problems or psychopathology. The items used were derived from an original set of over 1,000 items the researchers collected in the 1930s from:

- clinical experience
- personality inventories
- psychiatric textbooks of the time

To appear on a specific scale, an item had to be answered significantly differently by patients who were independently determined to have the problem of the scale's focus. For instance, for the hypochondriasis scale, the researchers looked at a group of 50 hypochondriacs. They then compared this group with a group of people without psychiatric problems, a normal population that served as a reference group. The original MMPI was normed on 724 people who were friends or relatives of patients in Minneapolis' University Hospitals who were not being treated by a doctor.

The MMPI-2 updated and reworded many of the items in the original MMPI. This effort:

- added new items
- reflected language changes
- removed items that were no longer good scale predictors

It was then standardized on a new sample of 2,600 people. They came from seven geographically diverse states, reflective of the U.S. Census. The MMPI-2 purportedly differs insignificantly from the MMPI in terms of how the test is administered. Its clinical and validity scales are similar, too.

In 2008, the MMPI-2 Restructured Form (RF) was published as an update to the MMPI-2. It is not, however, a replacement of the MMPI-2. It was designed to better address current (different) models of psychopathology and personality. The restructured clinical scales bear no connection to the MMPI-2's original clinical scales above. The new ones are:

- Cynicism
- Demoralization
- Ideas of Persecution
- Somatic Complaints
- Antisocial Behaviour
- Aberrant Experiences
- Hypomanic Activation
- Low Positive Emotions
- Dysfunctional Negative Emotions

Framingham states: "We trust that the restructuring occurred to better reflect

today's societies psychological tendencies and problems."

One could deduce that the MMPI test is a most sinister and formidable weapon for the powers that be if one completes its 567 questions according to the instructions. It reveals a person's innate personality traits to perfection. Thus, it becomes the perfect tool, through psychological manipulation and to, to destroy any given human, both mentally and physically. Mental upheaval inevitably leads to physical collapse.

In PTSD-experiencing workers, MMPI results will, without a shadow of a doubt, be misused by the VA, the WCB, the Union, their mental health practitioners and whoever else has a say in the matter. They will use the results to put the blame for our suffering squarely on our shoulders. Most of the time, they get away with it.

Those demanding the MMPI's completion know what they are doing. They are experts in creating further mayhem in PTSD sufferers' mind. They try to rob us of our self-confidence. They want to make us lose faith in ourselves. They make us lose faith in the system purportedly designed to help us recover, heal and protect us through the process. In fact, it is geared to wear us down to the bone, and preferably entice us to commit suicide. If that is not forthcoming, at least to land us on skid-row. If this mode of operation fails after 10 years, they will start settlement negotiations for the least amount of money possible. By then, due to the MMPI's test result, completed truthfully and diligently by the trusting and conscientious worker under the delusional idea of assistance, most injured are on the street defeated or dead. That saves stakeholders tons of money.

I had that delusional idea of assistance when I filled out the first MMPI. I didn't know I was taking my first step on the long journey through hell. I didn't know I would need years of recovery from the trauma inflicted upon me by people purporting to help me.

I take full responsibility for it. It was I who had infinite ignorance and belief in the goodwill of all men. It was my imbecilic and pathetic belief that all and sundry were eager, able and willing, nay, delighted, to return me to good health and flying. It was I who somehow missed for the longest time that the opposite was the case.

I started out blind as a bat on a clear sunny day to do the first MMPI in the end of July. I went in good faith, trusting that things would turn out alright now that I was between the WCB's good and benevolent hands.

That almost cost me my life.

To my saving grace, however, I learned to help myself. By the time I was asked to complete the fourth MMPI seven years later, I had researched its purpose. I knew

how to invalidate it by double-answering or not answering at least thirty of the 567 multiple-choice questions. To be on the save side I left fifty unanswered.

When asked shortly thereafter to complete it a fifth time, I graciously declined.

The journey ended then, as they no longer knew how to manipulate me. But that, thank heavens unbeknownst to me when I completed it the first time, was years and years into the future. Shortly after my first MMPI experience, I began to gingerly take interest in the activities going on around me. Precisely four months after the PTSD-causing event, I forced myself to attend a seminar at the newly opened Reflections bookstore in my neighborhood. The seminar was called *Everything you always wanted to know about metaphysics.* This would be the first step towards my PTSD recovery, the first step to return to living life

Psychometry & The Rise Of Psychology

Reflections had opened its doors a couple of weeks before my PTSD-causing event, but I had yet to visit it. I rarely ventured out, other than for my astrologer-consultant and psychiatrist's appointments and to walk the dog. I spend my time watching baseball, drinking beer, smoking cigarettes and grieving. I was desperately trying to get a hold on what had happened to me.

Who was I with this sorrow in my heart? Who was I with this grief I felt, this feeling of futility, this emptiness? Who was I, with this lack of enthusiasm permeating my whole being, other than for drinking beer, watching baseball, smoking cigarettes and occasionally for hours at a time digging up dandelions in the yard? Who was I trying to come to grips with me and what to do about it, all the

while suffering excruciating tension-related headaches and crying and crying?

When I saw Reflections' advertisement in the local paper about the three hours 'everything-you-always-wanted-to-know-about-metaphysics' seminar, however, I kicked myself to attend. In a nutshell, metaphysics is a way of understanding "things" and being able to change things because of this new understanding. It is a branch of philosophy exploring the fundamental questions of life, including being, existence, and reality. It has two branches — cosmology and ontology. Traditional metaphysics seeks to answer the questions: What *is there*? And what is it *like?* Topics of metaphysical investigation include:

- existence
- possibility
- space and time
- cause and effect
- basic categories of being
- objects and their properties

Metaphysics also considers how all these fields relate to one another. Some philosophers and most scientists reject the entire subject of metaphysics. They think it meaningless and unverifiable. Others think it legitimate. I suggest *Stanford Encyclopedia of Philosophy on Metaphysics* to begin further investigation.

Two psychics conducted the seminar and around 20 people participated. I was so tongue-tied that I was barely able to introduce myself. I kept quiet throughout, until asked if anything unusual had happened to me lately. I was told I had no aura, none whatsoever, something the presenters had never before seen. A light went on for me. That explained why I felt I was not here/there/anywhere. Why indeed should I have an aura?

I did not check out my lack of aura further at that time. I was too fragile and disinterested to preoccupy myself with such topics, when I myself did not know whether I was coming or going, who, what and why I was. But I began weekly yoga classes at the store. That was another step toward my recovery. I participated in many more seminars. Carol, Reflections' owner, made me aware of books that turned out to be very helpful in the struggle to find myself. In tandem with that struggle, my curiosity about metaphysics increased. Out of necessity, I found the courage to venture out. Thus, I enrolled into a night-school course in psychometry. This is the supposed ability to learn about events or persons by touching inanimate

objects associated with them. It is here I learnt to pay attention to the jewelry I wore, in particular at appointments with the powers that be.

MacKenzie Wright's article *Spiritual Properties of Metals: How your Jewelry Might Affect You* appears in Psychics Universe. She explains that psychometry readings can be done from any object, but are most often times done from pieces of jewelry. She points out that different metals have different influences on our wellbeing, as each natural substance has a unique vibration that creates an energy field. We can influence our daily life to our advantage when knowing the influence of the metal of jewelry we wear. It influences our own vibrational energy field when wearing it.

It is important to remember that most jewelry is made from a combination of metals, says Wright. Even precious metals in fine jewelry usually have a touch of other types of metals to make them more durable. Let's look at some common metals and their best-known properties.

Gold is the most popular choice for jewelry. Whether gold-plated or 24 carat, it is considered cream of the crop. It has been known since prehistoric times to strengthen confidence and symbolize wealth. Wright claims that you can actually use your gold to attract more wealth to you simply by wearing it while you envision yourself growing richer. Gold also enhances the crown chakra's opening. It is also known to help wearers' open up to wisdom transmitted from sources in the Universe. It has also long been hailed for its protective properties, the reason why it is commonly used for talismans, amulets and protective symbol charms.

Silver is closely associated with the moon. One of its key traits is the increase of sensitivity, particularly psychic sensitivity. Silver is a good choice to wear when trying to develop one's psychic abilities. In medicine, silver has been known to enhance hormone production and regulate gland-function.

Copper is particularly useful in strengthening bonds between people. It is also hailed for improving circulation. Wearing copper can also help to heighten and expand one's awareness and consciousness. Mind you, even though few people wear pure copper, it is mixed into a lot of jewellery.

Nickel is often found in inexpensive and faux silver jewellery. It is a great metal to use for psychological healing. Wearing it can also act as a negative energy detoxifier and help to drain away depression, fear and anger. Nickel can help purge our mind of compulsive thoughts or dreams. It furthermore encourages creativity and a lightness of spirit. In other words, all those suffering an existential crisis from a PTSD event might do well to wear nickel jewellery to help the Self.

Stainless steel is popular in jewellery making, because it is strong, durable and

affordable. Plus, people with skin allergies are less prone to be allergic to it. Stainless steel is associated with the planet Mars, the Roman God of War. Its energy is highly projective; wearing stainless steel can be like donning spiritual armour. Wear it to protect the Self from psychic attacks, extreme negativity or anything that would suck the energy right out of you. Stainless steel is the ideal jewellery for PTSD experiencers to wear when meeting with the powers that be.

People like Wright, practicing psychometry, are able to "read" the history of an object by touching it. That object is usually a piece of metal jewellery a person was or is wearing. The reader senses the object's impressions as images, sounds, smells, tastes and emotions, says Stephen Wagner in his 2017 *ThoughtCo* article "What Is Psychometry?"

Psychometry is a form of scrying. Wagner explains that this is also known as seeing, peeping or detecting significant messages or visions for personal guidance, prophecy, revelation or inspiration. Throughout the ages, however, scrying in various forms has also been a prominent means of divination and fortune-telling. Some people can scry using a crystal ball, black glass or even the surface of water.

With psychometry, extraordinary visions come from touch. For example, a psychometrist holding an antique glove can tell something about the life and experiences of the person who wore it. The psychometrist can sense what the person was like, what they did and even how they died. Perhaps most importantly, the psychic can sense how the person felt and the emotions of the person at a particular time. Emotions seem to be most strongly "recorded" in the object, whatever it may be, says Wagner.

The psychic may not be able to do this with all objects at all times, and as with all psychic abilities, accuracy can vary. Although some believe that psychometry is controlled by spiritual beings, most researchers suspect that it is a natural ability of the human mind. Wagner draws this conclusion by mentioning Michael Coleman Talbot (1953–1992), an American author of several books highlighting parallels between ancient mysticism and quantum mechanics. Talbot espouses a theoretical model of reality that suggests the physical universe is akin to a hologram. In this model, ESP, telepathy and other paranormal phenomena are merely a product of this holographic model of reality. He says that "the holographic idea suggests that the talent is latent in all of us."

Joseph Rodes Buchanan (1814–1899), was a physician and professor of physiology at the Eclectic Medical Institute in Covington, Kentucky. He coined the term "psychometry" from the Greek words "*psyche*" (soul) and "*metron*" (measure).

The term means that knowledge comes directly by the psychometer, the instrument of the soul.

Buchanan came to prominence in the 1840s, when mesmerism and spiritualism were popularized. He promoted his science from that time onward. In 1893, he released *Manual of Psychometry: the Dawn of a New Civilization* (Boston; Frank H. Hodges 1893 p. 3–4). In this comprehensive treatise, he predicted that Psychometry would eventually supersede and revolutionize every other field of science. And it has, as we shall see.

Though he was a physician, he denounced contemporary schools of medicine in his lectures as *educated ignorance,* whilst vigorously promoting psychometry.

Using his students as subjects, he would place various drugs in glass vials. He then asked the students to identify the drugs merely by holding the vials. Their success was higher than by mere chance. Buchanan published the results of his study in his book *Journal of Man.* He theorized that the phenomenon occurred because all objects have "souls" retaining memory.

The Japanese scientist Dr. Masaru Emoto (1943–2014) seems to have reached a similar conclusion. He claimed that human consciousness has an effect on the molecular structure of water. He said that water reacts to positive thoughts and words, and that polluted water could be cleansed through prayer and positive visualization.

That water has a soul is a controversial position. The scientific community vigorously, vehemently and viciously opposes even the possibility of a soul even for human beings, never mind inanimate objects. The scientific community has a trans-humanistic aspiration and atheistic belief structure that won't allow for such a possibility.

Buchanan inspired other bright and academically well-rounded Spiritualism-based men, such as Stephen Pearl Andrews (1812–1886). Andrews was an American individualist anarchist, linguist, political philosopher and outspoken abolitionist. He was also an author of several books on the labour movement and Individualist anarchism.

Some people, such as the Polish-born American psychologist Joseph Jastrow (1863–1944) criticized Andrews' work as based on delusion and wishful thinking. Jastrow was noted for inventions in experimental psychology, designs of experiments and psychophysics. He also worked on the phenomena of optical illusions, some of it popularized in his work. He believed that everyone had their own, albeit often incorrect, preconceptions about psychology. One of his goals was

to use scientific methods to separate truth from error, and educate laypersons on his views by way of speaking tours, popular print media and radio.

Jastrow is of particular interest, as he was one of the American Society for Psychical Research's (ASPR) founding members. ASPR is based in New York City, where it maintains offices and a library. It is dedicated to parapsychology for the study of the "mesmeric, psychical, and spiritual," and open to interested members of the public to join. It also publishes the quarterly *Journal of the American Society for Psychical Research*. Early members of Jastrow's society were sceptical of paranormal phenomena. But Jastrow took a psychological approach, believing that it was foolish to separate " . . . a class of problems from their natural habitat . . . ", the human being.

Nevertheless, by 1890, Jastrow had resigned from the society to become an outspoken critic of parapsychology. He complained that psychical researchers were rarely trained psychologists; therefore their research lacked credibility. Given psychical phenomena's lack of scientific, empirical evidence, he furthermore spewed forth that psychologists should not waste time disproving claimed psychical phenomenon. In his book *The Psychology of Conviction* (Houghton Mifflin Company, Boston 1918), however, he used an entire chapter to expose what he called "Eusapia Palladino tricks".

An Italian Spiritualist physical medium, Palladino (1854–1918) claimed extraordinary powers, through:

- levitating tables
- her spirit guide John King
- communicating with the dead
- transmitting other related supernatural phenomena

Many people were convinced of her powers. But she apparently was caught in deceptive trickery throughout her career. Magicians and sceptics evaluating her claims concluded that none of her phenomena were genuine and that she was a clever trickster. Be it as it may, she was the competition.

Deborah J. Coon, in her 1972 *American Psychologist* article "Testing the limits of sense and science: American experimental psychologists combat spiritualism, 1880–1920" puts a different spin on the situation. She points out the difficulties American psychologists faced at the turn of the 19th century. They tried to erect and maintain boundaries between their purported science and its "pseudoscientific" counterparts,

namely spiritualism and psychic research. A few psychologists wanted to seriously investigate spiritualistic and psychic phenomena, because the public sought their opinions on spiritualism. But many psychologists believed that such investigation would risk the scientific reputation of their infantile discipline.

They could not readily avoid the topic, if they wanted to make money. So, some psychologists studied spiritualistic and psychic phenomena to prove them fraudulent. Others studied them to explain them via naturalistic causes. Still others developed a new sub-discipline: the psychology of deception and belief applicable to them nowadays.

As Coon points out, psychologists used their battles with spiritualists to legitimize psychology as a science. They created a new role for themselves as guardians of the scientific world-view. To the detriment of many, they succeeded. The MMPI, created by that generation's immediate offspring, proves it.

The word "psychology", was most likely coined in the mid-16th century by the German Melanchthon. It comes from the Latinized form of the Greek "psyche" (breath, spirit, soul) and "logia", a word-forming element meaning speaking discourse, treatise, doctrine, theory or science.

In itself ambiguous, what does the job of "psychologist" officially mean? It means a professional who evaluates and studies behaviour and mental processes. It requires completing a university degree in psychology–in some countries a master's degree, in others a Ph.D.

The American Psychological Association (APA) lists 56 different divisions of psychology, in general described as either "research-orientated" or "applied". The common terms for those who conduct research are "scientists" or "scholars". The common terms for those who apply what they esteem to be their psychological knowledge are "practitioners" or "professionals". The latter are called clinical or counselling psychologists, providing mental health care, and social or organizational psychologists, who conduct research and provide consultation services. In contrast to the psychologist, only the much higher educated and medical degree equipped psychiatrist can prescribe pharmaceutical drugs.

That clarified, let us return to Buchanan's soul-measuring psychometry, nowadays ignored by most mental health practitioners. William F. Denton (1823–1883) was an American professor of geology, a naturalist and an explorer. He was so intrigued and inspired by psychometry as to experiment with his geological specimens to see if it would work on them. In 1854, the professor wrapped some geological specimens in cloth. He placed the wrapped packages to his sister's

forehead. She could not see them. She could only feel the cloth against her forehead. When asked what they were, sure enough, she accurately described them by way of the mental images she received.

The German ophthalmologist Pagenstecher (1844–1932) developed vibration theory. It is the one getting the most serious attention from researchers. Psychics often get information "through vibrations imbued into the objects by emotions and actions in the past," writes Rosemary Ellen Guiley in *Harper's Encyclopedia of Mystical & Paranormal Experience*. These vibrations are not just a New Age concept; they have a scientific basis.

In his book *The Holographic Universe*, (Harper Perennial 1992), Michael Talbot says that psychometric abilities "suggest that the past is not lost, but still exists in some form accessible to human perception." Talbot calls on his scientific knowledge that all matter exists essentially as vibrations on a subatomic level. He asserts that consciousness and reality exist in a kind of hologram that contains a record of the past, present and future. He suggests that psychometrics might be able to tap into that record. Thus, instead of fading into oblivion, all actions are recorded in the cosmic hologram. They can always be accessed.

Other psychical researchers think information about an object's past is recorded in its aura. That is the field of energy surrounding every object, as well as every living human. According to an article published in *The Mystica*, the connection between psychometry and auras is based on the theory that the human mind radiates an aura in all directions and around the entire body. This impresses everything within its orbit, as all objects, no matter how seemingly solid they appear, are porous. They have small or even minute holes. These minute crevices in an object's surface collect tiny fragments of the mental aura of the person possessing the object. Wagner explains:

> "If an object has been passed on down the family, it will contain information about its previous owners. The psychic can then be thought of as a tape player, playing back the information stored on the object."

Mario Varvoglis, Ph.D., at *PSI Explorer* believes that psychometry is a special form of clairvoyance. Wagner says:

> "The individual performing the psychometry may gain psychic impressions directly from the person to whom the object belongs through telepathy or may clairvoyantly learn about past or present events in the life of the person. The

> object may simply serve as a kind of focusing device which keeps the mind from wandering off in irrelevant directions."

In other words, the psychic's ability is available to all of us, as we are all born psychics. But we must hone our innate abilities by tuning into ourselves. PTSD-affected people might find it particularly valuable to test the vibration when visiting VA, WCB or the employer's locales or mental health practitioners' consultation rooms. We can *feel* the atmosphere and thus get a sense of our opponents' intention.

When the course was over, I never developed my psychometry reading talent further. My most valuable take-away was to learn about a small spiritualist church fairly close to where I live. I failed to notice the difference between spiritualist and spiritual. The former seeks communion with the dead. The latter seeks communion with the infinite creator, the divine spirit. That this had escaped my attention would lead to interesting repercussions later, but at that moment, it mattered not.

So, one sunny Sunday morning nine months after the PTSD-causing event, I went to check it out. I was late, because I had problems finding it. The psychic giving messages after the service focussed on me the moment I stepped through the door saying:

> "You have had many extraordinary experiences in your life, and look at them just as such – extraordinary experiences. The last one you had rattled you immensely, and should you decide to die you surely will, either by drinking and smoking yourself to death or by the illnesses arising from it. Should you decide to live and do something productive with this new life of yours, however, you will be better than you ever were before this happened. Your guides, teachers, guardians and helpers will protect, lead and guide you and watch over you in all of your endeavours. In case you decide to live, watch out for signs directing you, for books falling into your lap or attracting you, watch and record your dreams, and write down what comes through in your meditations."

That I had already practiced meditation twice daily for four years would become instrumental in my survival, healthy in body and mind. On that day, however, I floated out of the church jubilant hope filling my heart, my spirit soaring with joy.

The quaint church became my focal point. It was a place of last resource where the downtrodden, the destitute and the despairing congregated. It was where I would, for many years, find an outlet for my innate desire to serve the public and be

of help to my fellow human beings.

As a side-line, it is where I would educate myself on how earthlings behave when not on board an aircraft. It was a rather shocking and sometimes choking experience. I had associated mostly with aircrew for much of my life. And it cured me forever of participating in organized spiritualist or religious organizations ever again. Instead, I developed my own faith.

The message I received that Sunday morning gave me such a boost, however, that when the psychiatrist shortly thereafter suggested I return to in-flight duty, I consented. He assured me if it did not work out, he would take me off the line again. I had voiced my apprehension. I recalled the three wide-body aircraft crashing in rapid succession within days of each other only a few weeks before, with almost all souls aboard lost. He heard. He reassured me. So, I consented.

Driving to the airport for my first flight destination, London, England, I heard on the radio that an aircraft had crashed on the East coast. Only one flight attendant survived. In hindsight, that set the tone for my comeback.

Nevertheless, the psychic's message and advice at the church that day turned out to be another stepping stone towards my true recovery. It lit a fire in my soul. It gave me a glimpse of something worth exploring, an incentive to go on with life. During the 10 years of pure hell, it was my sanctuary. It gave me opportunities to learn about and develop my own psychic abilities from tarot cards to aura reading. I quickly recognized that there is no one in the world better equipped than me to be my own best psychic. Therefore, everyone else in the world is their best psychic, too.

Pre-Sensory Intuition & The Field Of Psychic Abilities

Psi is the 23rd letter of the Greek alphabet and the first letter of the word "psyche". Parapsychologists use the term for all kinds of psychic phenomena, experiences and events related to the psyche and mind unexplainable by established physical or scientific principles. In the United States, the Parapsychological Association (PA) examines questions about PSI abilities in the most scientific manner. Since 1969, it has been affiliated with the American Association for the Advancement of Science (AAAS). The PA was created in Durham, North Carolina, in 1957. Dr. J. B. Rhine proposed its creation at a workshop in Parapsychology held

at Duke University's Parapsychology Laboratory, of which he was director.

The time, states the PA on its website, could not have been more opportune nor the audience more receptive. Long before the PA began, many of those active in the field had felt a need for better communication with each other. The 1953 international Parapsychology Foundation convention was held at the University of Utrecht, Holland. Those present saw how meetings of professional workers could help to overcome their isolation and act as encouragement to research.

The PA's first president was Dr. R. A. McConnell of the University of Pittsburgh's Biophysics Department. Dr. Gertrude R. Schmeidler of City College of New York's Department of Psychology was the first vice-president. The association's goals were to:

- disseminate knowledge of the field
- advance parapsychology as a science
- attract well-trained and qualified scientists worldwide
- emphasize the association's professional and international character
- promote better communication between scientists working in the field
- integrate findings of parapsychology with those of other branches of science

By the end of 1964, the PA had 74 Members, 92 Associates and six Honorary Members. This group, no larger than a physics department at a medium-sized university, included most of the world's active parapsychologists. The PA hoped to increase the number of research workers by improving working conditions in the field and in the lines of communication with the scientific community at large. The promise that parapsychology held for reaching a wider understanding of man justified a much larger work force. Their goal has been achieved. In 2010, 187 full and associate members and a total of 316 members, affiliates and honorary members graced their ranks.

The PA held its first convention at New York's City College in 1958. Since then, it has held an annual convention to focus on PA activities. The first convention outside the USA took place at Oxford University, England, in 1964. PA conventions are now held alternately in North America and in Europe.

I found an article by Dr. Mario Varvoglis on PA's online encyclopaedia defining "psi" as every kind of unexplainable psychic phenomenon seemingly related to the

human mind. The article also quantified what it means to be "psychic." It is an experience involving interactions different from those considered "normal" methods of interacting with the world around us. The scientific definition of types of "psychic abilities" refers to abilities to perceive things about the world through a sixth sense. That is why all types of psychic abilities are referred to as extrasensory perception (ESP).

What are Psychic Abilities? Some psychics claim to have but one psychic ability. Others claim to have a slew. My experiences in the spiritualist church taught me that the vast majority of those professing to be psychics are less so than my dog. I also know that I am the best psychic for myself. I can also tune into the vibrations of others with ease, if I put my mind to it. We all can do it, once we develop this inherent trait. I often did this intuitively aboard the aircraft, never giving it a second thought.

Psychic abilities are easily faked. Most humans seeking advice ask the same question: love, money, relationships, health and job, not necessarily in that order. Any money-seeking psychic knows the formula to fake it:

1. As a starting point, assess the client's jewellery, clothing and overall bearing
2. Follow that with a fishing expedition, easy to do once experienced in the craft
3. Give the answers the client wants to hear.

Much better to tune into the Self to find answers to *all* our questions. Sit down quietly, pen and paper at the ready. Tune in and ask. It's fool-proof. Paulina Fink explains the benefits in her *Light of Mind* article "14 Easy Ways to Develop Psychic Abilities, Intuition and ESP". They are bountiful, including a greater understanding of the Self. Digging into our own mind always allows for a better understanding and relationship with the Self. It also improves our intuition, so vitally important for PTSD experiencers struggling with the powers that be. It also helps us connect deeper with the world at large by learning to feel the energy of people, places and things around us. This is a confidence-booster for people of all ages. Building these skills can also help us to make like-minded friends.

There are many psychic abilities on the *Psychic Junkie's* complete A to Z list of psychic abilities. They compile it for our information and reference, and it is an ongoing project. Let's look at Ryan Dube's shorter list of psychic abilities to develop.

ASTRAL PROJECTION is the ability to position your conscious awareness outside of your physical body. It is also referred to by the literature as an out-of-body experience (OBE). Some experiencers of this psychic phenomenon report seeing their body on an operating table and watching medical technicians work to revive them. Some experiencers wake up later and, to everyone's astonishment, are able to describe details to medical staff.

AURA READING is when a "sensitive" perceives a disturbance in the air around a person, animal or object. Some people refer to auras in spiritual terms, while others use purely scientific terms. Whether these auras are caused by spirit or by electromagnetic radiation doesn't matter. The ability to see or sense auras is a very common psychic ability.

AUTOMATIC WRITING is a technique that many clairvoyants use to pass information from the spirit world through their subconscious mind and onto paper. The theory is that the psychic's hand is controlled by outside intelligence.

CHANNELING is similar to automatic writing. Instead of the outside spiritual intelligence controlling the psychic's hand, it takes over the Psychic's vocal chords. People with this ability are called "mediums," because they serve as a medium, or vessel, for communication with the invisible entity.

CLAIRVOYANCE refers to the capacity of a psychic to see visions of events, people and places beyond *the normal* visual range of the psychic. This form of psychic ability is most commonly referred to as "remote viewing". It is widely used by the "military industrial complex", the informal alliance between a nation's military and the arms industry that supplies it, seen together as a vested interest influencing public policy.

CLAIRAUDIENCE is very similar to clairvoyance. It is the ability to hear sounds normally inaudible to regular hearing. This does not refer to hearing voices of invisible spirits. It is the ability to hear the voices of people very far from the psychic.

CLAIRSENTIENCE is the awareness of information hidden from the psychic. An example of clairsentience is when a psychic meets someone for the first time, and knows his or her name or birthday.

ANIMAL TELEPATHY is the less well-known ability to communicate telepathically with animals. Also called "pet psychics," these people claim to have a psychic connection with the thoughts and feelings of animals. Some people believe that people who excel at training animals tend to have this form of telepathy, often without knowing it.

DIVINATION includes the best-known activities of most commercial psychics, such as fortune telling and prophesying. Divination is the ability of a psychic to foretell the future. If you do it yourself, however, you can be much more precise than a psychic can ever be.

DOWSING is an age-old art of using rods or sticks to find water and objects. Many folks swear that it works, but no one can explain why.

INTUITIONS are an innate sense of events, thoughts, activities or feelings going to unfold or are in the process of unfolding. As said before, we all have psychic abilities. Our intuition is one of the strongest, if we were to begin to listen, to sense and to feel the vibrations around us and within us. The sinking feeling in the stomach always is an indication of something bad heading our way. Some consider intuitive people to be of borderline psychic perception, a sign that all humans are. I always listen to my intuition, finding it much more trustworthy as an advisor than my brain.

LEVITATION is a rare ability to levitate one's body above the ground. Levitation is reported in many cases of demonic possession, but it is also been reported in other spiritual cases. In the 16th century, for example, Santa Theresa of Avila is said to have levitated while she was meditating during mass.

PRECOGNITION is the ability to foretell the future. This form of future viewing involves obtaining specific information about an event, rather than a visual "viewing" of the future. By the way, if a psychic tunes into something unfortunate to happen to you in the future, she/he will not share it with you, as everything is fluid and the event might not occur.

PSYCHOMETRY, as we know, is the ability of a psychic to perceive energies, also called vibrations or impressions, from an object. This ability has been portrayed often in movies and TV shows, where a psychic touches an object and receives flashbacks about the person who last touched it.

PYROKINESIS is an alleged psychic ability to create and control fire with the mind. This is a highly specialized form of psychokinesis. Just because someone has pyrokinetic ability does not mean that he or she has all forms of psychokinesis.

TELEKINESIS or psychokinesis is one of the most commonly portrayed psychic abilities in the media. It refers to the ability of a psychic to affect or move objects.

TELEPATHY is the ability to communicate with others through mental thought alone.

Are psychic abilities real, you may ask?

If you try to tap into your own, you would know they are. Of course, it is hard to get scientific, empirical evidence, and thus they continue to elude scientists. On the other hand, psychics can be found in almost every community around the world. While many may be frauds or magicians, some do use their abilities to counsel and help others. Why do you think even some psychologists and psychiatrists use hypnosis in patient-consultations? They help clients tune into their thoughts and find an avenue of healing from their innermost self — their psyche, their soul.

Unfortunately, most mental health practitioners, including those affiliated with the VA et al. in PTSD research don't use their psychic abilities. They find it far more lucrative to disrupt the healing process by trying to decide whether PTSD is a mental weakness. Is it?

Is PTSD A Mental Weakness?

It was October 31st — Halloween, 18 months after my reintegration into the workforce. The airline intended to fire me that day, citing my deteriorating performance-record as the reason for my dismissal.

My physician had already diagnosed recurrent PTSD as the cause for my distress. The firing was aborted. Labour laws prohibit dismissing an employee injured in the line of duty. The airline's disgruntlement was palpable. It would be much more cost-effective for shareholders to get rid of the human debris that I was in their eyes than to start that hustle again. So seemed to be their thoughts.

But there would be other ways to dispose of me, I should discover.

I knew nothing about PTSD when I incurred it the first time. I still knew

nothing about it when I returned to flying 10 months later. The psychiatrist, company physician and WCB psychologist had made a unilateral decision to send me back to work. So, I believed my broken wings were mended.

Happy to be going back, the news of a commuter plane crashing back east on my way to the airport that same day did not unduly disturb me. Nor did the superstitious belief that two more crashes would follow in rapid succession. I was not even disturbed by the realization that I could be in one of them.

As it turned out, however, PTSD would raise its ugly head again. Expert cooperation between NorAm, WCB and Union personnel meant perpetual harassment on and off duty, including:

- drafting me for flights mid-air
- taking me off flights unwarranted
- arranging for bellowing smoke out of galley-ovens
- mid-air electrical failure, resulting in an emergency landing
- drafting me for an afternoon flight at 6am in the morning, when we had arrived at the hotel at 2 am
- stuffing me into a foyer broom closet wind howling through the absent door threshold, without a window and with a well-used ten-thousand-nights-old queen seize mattress at Montreal's Reine/Queen Elisabeth II hotel, pretending no other rooms were left (an impossibility, considering NorAm had contracted with them for crew accommodations practically since its existence)
- arranging for employees traveling incognito, as well as paying passengers, to harass and hustle me (including unwarranted touching and sexual overtures and expressing their disgust with my purportedly rotten performance in complaint letters)

In addition, there were some very, very close calls that brought forth my PTSD. One was a wind shear 30 feet above the runway. It threw the aircraft onto the ground after a 60-minute roller-coaster approach in a blistering winter storm on the East coast. That was the only event not engineered by NorAm.

No wonder my PTSD had again slowly raised its ugly head leading to the Halloween day 18 months later.

An appointment with the company physician a few days hence confirmed recurrent PTSD. Then began the dance through hell to prove or disprove the

diagnosis.

In 2010, the VA's National Center *for* PTSD updated its report *Consensus Conference Recommendations for Veteran Treatment of PTSD and Comorbid TBI.* It confirmed that: "No screening instruments available can reliably make the diagnosis [*of PTSD*]; the gold standard remains an interview by a skilled clinician." Thus, my PTSD was criminally exacerbated by the powers that be. I was at the mercy of their mental health physicians imposing on me their individual opinions, likes and dislikes of me.

There were and are no quantitative biological symptom measures that can help clinicians define PTSD pathology. There was no way to ensure a reliable diagnosis. There still are no efficient prognostic tools to provide better targets for treatment. This is also true for the other anxiety and mood disorder diagnoses. Many of them are frequently comorbid with PTSD, according to Peter J. Lang and Lisa M. McTeague in the 2011 *Journal of Clinical Psychology* article "Discrete and Recurrent Traumatization in PTSD: Fear vs. Anxious Misery".

The National Institute of Mental Health (NIMH) could not accept that no biological symptom measures can define PTSD pathology to assure a reliable diagnosis. So, its initiative Research Domain Criteria (RDoC) has been prompted to define, for research purposes only, any promising domains of study not constrained by traditional diagnostic categories. The aim, Lang and McTeague explain, is to create measures to serve as endophenotypes that better relate to emerging genetics and clinical neuroscience data.

An endophenotype is a genetic epidemiology term. It is used to separate behavioural symptoms into more stable phenotypes with a clear genetic connection. Phenotypes are behaviours that:

- arise from their environment
- come from an organism's genes
- are interactions between the genes and their environment

Consistent with this RDoC program, researchers are studying the psychophysiology of the full range of anxiety spectrum disorders. They are evaluating reflex outputs from the brain's fear/defense circuitry. They are assessing samples of treatment-seeking anxiety patients and community controls.

The next major use for this research would be in psychiatric genetics. It would bridge the gap between high-level symptoms of a "mental" illness and low-level

genetic variability. This gap would be relevant where some distinct genes could underlie certain endophenotypic traits in schizophrenia, bipolar disorder and suicide.

Psychiatric genetics is a subfield of behavioural neurogenetics and behavioural genetics. It studies the role of genetics in psychiatric conditions such as alcoholism, schizophrenia, bipolar disorder and autism. The basic principle behind psychiatric genetics is that genetic polymorphisms are part of the etiology of psychiatric disorders. For example, there might be a variation in a single nucleotide polymorphism that occurs at a specific position in the genome, where each variation is present to some appreciable degree within a population, > 1% (SNP).

In other words, psychiatric genetics appears to seek answers for the age-old question: Are behavioral and psychological conditions and deviations genetically inherited?

The goal is to better understand the etiology, the factors or causes responsible for or related to psychiatric disorders. Psychiatrists could purportedly use that knowledge to improve treatment methods. Further, based on genetic profiles, there are plans for pharmacogenomics to develop personalized treatments by studying the genome role in drug response. In other words, the goal is to transform parts of psychiatry into a neuroscience-based discipline. Human beings would be the guinea pigs. The pliable soldier and veteran PTSD affected would rank first and foremost among the guinea pigs, if they want to maintain their VA financial support. After all, they are the most physically fit and the brightest specimens on the market.

For Lang and McTeague, during their startle response assessment the eye blink was of particular interest. The brain's fear/defense circuit mediates the startle potentiation, according to several decades of infrahuman neuroscience research. In regards to human fear, recording the startle response to a brief acoustic probe (e.g. 95 decibels of white noise) has provided productive, cost-effective and *non-invasive* measures of defensive neural activation. Aversive hyper-arousal and exaggerated startle responses are DSM (Diagnostic and Statistical Manual of Mental Disorders)-IV designated PTSD symptoms. That means that the startle response is used by psychiatrists to diagnose patients. These are among 300 formerly normal human reactions and emotions that are now considered mental disorders. Case reports of returning veterans are replete with descriptions of profound and functionally disruptive startle responses to loud, albeit mundane, noises heard in daily life. There is plenty of laboratory evidence of exaggerated startle response and hyper-arousal, claim Lang and McTeague.

It seems that heightened reactivity in PTSD cannot always be found, due to the dearth of startle research on accumulated trauma or comorbid groups of symptoms. In other words, anybody who develops a mental illness must be genetically predisposed. Therefore anyone who develops PTSD must also be. PTSD-afflicted people's intelligence and education is never considered, nor are similar events he/she might have experienced and survived in the same setting. Those recurring trauma events might be in a battlefield or aboard an aircraft in flight. Or they could be in any other context where PTSD-causing incidents occur.

Both intelligence and education are said to influence human reaction to PTSD-causing events, Webb said earlier in *Existential depression in gifted individuals* (Supporting Emotional Needs of the Gifted (SENG) Davidson Institute). What Webb said is applicable to PTSD voyagers, as well, in my view. But no one engaged in PTSD research studies has thus far bothered to check that part when researching PTSD-affected people. Neither is there interest in scientific, empirical evidence from those who have rehabilitated themselves.

Only one thing is certain, its symptoms have been around since warfare began roughly 6000 years ago with Cain and Abel. And it will continue until the Earth is destroyed completely or humanity awakens from its deep sleep and purges all evil.

In my view, the increasing power and influence of psychology over humanity is detrimental to human health and wellbeing. It contributes to misconceptions and stigma of PTSD. Therefore, those voyaging through the experience are on their own and all alone. We are alone.

As an outsider, reconsidering one's points of view on PTSD might lead to compassion and empathy. That would be much better than endless scorn, ill will and belittling of suffering fellow service members in whatever category of military, police force, firefighter or aircrew profession. Unless of course you are jealous, as ignorance is bliss in this case, as in many others when living rather than vegetating life.

What is appropriate support, pray tell? Not constant harassment. Not threats of financial cut-off. Not actually cutting off finances. Not questioning, whining and complaining by dear ones. Not having to give perpetual explanations of why we feel the way we do, which only fosters us to go deeper into silence or become intolerably aggressive, angry, abusive and volatile. Under those circumstances, and tired of it all and hopeless, what can we do? To take a slurp or two or 20 of the bottle seems to be the only way to cope and to survive.

PTSD And Comorbidity

Comorbidity is when more than one disease or disorder co-occur with each other. It is also a preferred condition to hang on PTSD-afflicted people by those claiming to be experts in the field. Among their astounding number of hypotheses, they like to combine PTSD with other "psychiatric disorders". They claim that data from epidemiologic surveys show that the vast majority of people with PTSD meet criteria for at least one psychiatric disorder. They further claim that a substantial percentage of patients have three or more psychiatric disorders. This is according to K.T. Brady, M.D., et al.'s 2000 *Journal of Clinical Psychiatry* article "Comorbidity of psychiatric disorders and posttraumatic stress disorder". They assert that several hypothetical constructs had been used to explain this high comorbidity. And they

apply the self-medication hypothesis to understand the relationship between PTSD and substance use disorders. Thus, they find that many symptoms overlap between PTSD and major depressive disorder. This high degree of symptom overlap can contribute to diagnostic confusion. One result might be an under-diagnosis of PTSD, in particular when trauma histories are not specifically considered, as in my case.

The most common comorbid diagnoses mental health practitioners and others like to hang on PTSD experiencers are:

- anxiety disorders
- depressive-disorders
- substance use-disorders

After all, some studies suggest that these are disorders most likely to co-occur with PTSD, at least in Brady et al.'s opinion.

That PTSD is an existential crisis and not a psychiatric disorder, however, had hitherto escaped their attention. That it worsens with pharmaceutical drugs has yet to be acknowledged. That it also creates and intensifies depression, and eventually may lead to suicide, is also graciously swept under the rug. In other words, they create the very "causes" of PTSD, but that doesn't seem to cross their minds.

Brady et al.'s suppositions and hypotheses about comorbidity of PTSD and depression are highly suspect. Those most commonly affected by PTSD are active soldiers, veterans, fire-fighters, police-officers and aircrew. These are the very people who could not have been fulfilling their chosen duties to satisfaction if affected by depression.

Commercial airline and military pilots, however, will most likely never suffer PTSD. Why not? They are far too busy fixing problems when the manure hits the fan. It's either that or die. It's as simple as that. And when it is the latter, as is usually the case, it is one of *the* most glorious events in their lifetime. Meanwhile, those ducks in the back of the barrel might not know for hours, as in my case, whether or not departure from Earth is imminent. They have ample time to lose their sense of invulnerability, leading to the mislabeled PTS Disorder.

PTSD and depression is one thing. PTSD and substance abuse comorbidity is quite another.

The self-proclaimed experts, however, seem to find PTSD and substance abuse disorder comorbidity hard to evaluate. They say that it often develops into self-

medication in the painful PTSD aftermath. They say this makes tracking hard, while forced withdrawal exaggerates the symptoms.

Thus, appropriate PTSD treatment in substance abusers is furthermore controversial. Psychologists believe that addressing trauma-related issues in early recovery could also precipitate a relapse. This is why they apply Cognitive Behavioural Therapy with a vengeance, as it disallows healing. But more of that later.

Lang and McTeague simply opine that comorbidity in PTSD is the rule rather than the exception. They also purport to have observed that several disorders appear in PTSD journeyers:

- chronicity
- comorbidity
- mood disorder
- principal anxiety
- defensive impairment

They present an often complicated and highly comorbid view of returning service personnel. In this context, psychophysiological measures could be useful, irrespective of primary clinical complaints. In other words, they insinuate genetic predisposition to be the cause of PTSD, with neither human emotions nor intelligence playing a role. Instead, they call for basic brain research to address the function, structure and connectivity in humans' emotional circuits. They want to know how these circuits mediate the brain's pathology of anxiety and mood disorder, so as to find the cause of PTSD.

Their data also suggest that sustained stress of cumulative trauma has a profoundly debilitating effect on brain function and behaviour. They admit, however, to the effect of repeated warzone deployment and Traumatic Brain Injury (TBI). TBI is a non-degenerative, non-congenital insult to the brain from an external mechanical force. They admit that repeated warzone deployment and TBI might make people susceptible to further trauma. They admit to possible results from sustained stress of such cumulative trauma:

- high psychiatric comorbidity
- reduced or altered state of consciousness
- permanent or temporary impairment of cognitive, physical and

psychosocial functions

Lang and McTeague noted in their sample of civilian subjects that childhood abuse was frequent among recurrently traumatized patients. They suggest that a trauma history of pre-service events was equally important for the prognosis and treatment for military patients.

They laud Prolonged Exposure (PE) and other treatments aimed at extinguishing the patient's exaggerated fear response. They claim that these approaches were clearly effective in helping them recover from discrete trauma exposure. However, this is debatable, as no empirical scientific efficacy data appear to exist.

The Association for Psychological Science published the article "The Facts About Prolonged Exposure Therapy for PTSD" in January 2015. It describes what this treatment demands of PTSD-affected people. They are asked to approach places and people they have been avoiding in both imaginary and real-life settings. The repeated exposure to the perceived threat is said to disconfirm a person's expectations of harm. Over time, it would reduce their fears.

US Marine Corps Veteran David J. Morris wrote about this in his 2015 *New York Times* article "After PTSD, More Trauma". He obviously begs to differ when chronicling his PTSD treatment at San Diego's Veterans Affairs hospital. "More trauma" describes his adverse reactions to Prolonged Exposure (PE) therapy (and to his treatment, in general).

But who cares? Mental health practitioners insist PE is one of the only PTSD treatments with wide-reaching empirical support, although, no data of its empirical scientifically proven PTSD healing effectiveness seem to exist.

Harvard University's Department of Psychology *Professor and Director of Clinical Training* McNally Laboratory Richard J. McNally studies several disorders:

- PTSD
- depression
- complicated grief
- social anxiety disorder
- obsessive-compulsive disorder (OCD)

A major emphasis, we read on his website, is defining cognitive biases of the patients. Then tests can be created to reduce these biases, thereby reducing the symptoms. Hence, much of his work falls under the rubric of experimental

psychopathology. It aims to learn how emotional disorders function.

McNally was asked to share his thoughts about Morris' article and to clarify the evidence for PE's effectiveness. He explained that Morris had lived through multiple traumatic events as a civilian war correspondent with American combat units in Iraq. He said that Morris was an atypical case, as most patients do benefit from PE and many recover from PTSD.

Then McNally did what most, if not all, of his peers do — he mixed apples with oranges. He compared Morris with over 300 female assault survivors. They were in a study where the symptoms of 8.1% of patients on the wait list got worse, whereas none of the symptoms of patients receiving PE did. So, McNally implied that people with PTSD ran a greater risk of worsening symptoms if they do *not* receive PE than if they do. He implies this, even though a minority fails to improve from this treatment, according to *The Facts About Prolonged Exposure Therapy for PTSD: Observation: Your source for the latest psychological research,* published by the Association for Psychological Science, in 2015. Anyone vaguely capable of reasoning should know better than to compare female assault victims with a war correspondent embedded with combat units? But what, NorAm's physician compared me to thrill-seeking race-car drivers involved in accidents.

I could find only two studies reporting that PE is effective. It was in a 2007 article by Nitsa Nacash, Psychiatrist at the Sheba Medical Center, Tel HaShomer Hospital, Tel Aviv District, Israel: "Prolonged Exposure Therapy for Chronic Combat-Related PTSD: A Case Report of Five Veterans" (reserachgate.net). She wrote that Prolonged Exposure (PE) therapy reduced PTSD symptoms mostly among rape victims, but that it had not been explored in combat-related PTSD.

Five patients with severe chronic PTSD, unresponsive to previous treatment (medication and supportive therapy) enrolled in her study. After 10 to 15 PE therapy sessions, all patients showed marked improvement. Their PTSD Symptom Scale-Interview scores fell by 48%.Their Beck Depression Inventory score, a test most PTSD experiencers have to complete (like the MMPI, but much shorter) fell by 69%.

Moreover, four patients maintained treatment gains or kept improving 6–18 months after the treatment. The results thus suggest PE could also be effective in reducing combat-related chronic PTSD symptoms

The other study I found is "Prolonged Exposure Treatment of Chronic PTSD in Juvenile Sex Offenders: Promising Results from Two Case Studies". It found that with 16 to 19 sessions, it was feasible to treat PTSD in juvenile sex offenders. The

report also stresses the need for more rigorous evaluations (e.g. randomized designs) of the effect of PE in improving sex offender treatment outcomes of trauma exposed youth (J.A. Hunter: *Child & Youth Care Forum*, Oct. 2010 vol.39).

Nice! There must be more, but I could not find them.

Be that as it may, even Lang and Teague seem to suggest that PTSD treatment after cumulative trauma is a big challenge. Once the brain's fear memory circuit is compromised, they say, the reflex-physiology of fear is hard to wipe out.

Plus, there is little data reporting on the widespread comorbidities and effects of prolonged stress, even though many functional neuroimaging PTSD studies have been conducted. In Lang's and McTeague's opinion, the Department of Defense (DoD) should join with the National Institute of Mental Health (NIMH)'s 2009 Research Domain Criteria (RDoC) project. Together, they could search for neuroscience biomarkers of PTSD pathology, unconstrained by current diagnostic categories — for trans-humanistic purposes, I assume. NIMH's project aims to:

1. integrate multiple scientific disciplines around the world to identify "fundamental behavioural components" that might play a role in various mental health disorders, and that can be linked to neurobiological circuitry;
2. define dimensions of these fundamental behavioural components that range from normal to abnormal;
3. set up standardized, reliable and valid measures of these components, to aid continuity across research studies; and
4. start to assemble the underlying "genetic, neurobiological, behavioural, environmental, and experiential components" that make up these disorders (Cuthbert & Insel, 2013).

RDoC is based on four assumptions, namely:

1. that a diagnostic approach is based on biology as well as symptoms and be free of current DSM categories;
2. that Mental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion or behaviour;
3. that each level of analysis must be understood across a dimension of function; and
4. that mapping the cognitive, circuit and genetic aspects of mental

disorders will yield new and better targets for treatment.

The RDoC, maintained by the American Psychiatric Association, differs from the Diagnostic and Statistical Manual of Mental Disorders (DSM). The RDoC aims to be a biologically valid framework for understanding mental disorders, by bringing the power of modern [scientific] research approaches in genetics, neuroscience, and behavioural science to psychiatric problems. Conventional diagnostic systems typically rely on self-reporting and behavioural measures only. The RDoC has the "explicit goal" of giving researchers access to a wider range of data, including measures of behaviour and insights into:

- cells
- genes
- circuits
- molecules
- physiology
- large-scale paradigms

Spoken like true trans-humanists, or the reverse. According to Max More (1990):

> "Trans-humanism is a class of philosophies of life that seek the continuation and acceleration of the evolution of intelligent life beyond its currently human form and human limitations by means of science and technology, guided by life-promoting principles and values."

We can thus assume that PTSD experiencers will soon be subjected to:

- brain scans
- gene testing
- other biological testing

Without such tests, they might not get any help to overcome the predicament. Unless they are financially independent and can kiss the VA, military, airline, fire department or police force good bye, they will be forced to take the tests. The usual coercion tactics will be applied, with the threat of losing any modicum of financial stability.

Mind you, shortly before the 2013 DMS-5 publication, NIMH director Thomas

Insel stressed that the RDoC would not be a diagnostic tool to replace the DSM. He said it would be just a research framework for future development. His argument centers on the claim:

> "Symptom-based diagnosis, once common in other areas of medicine, has been largely replaced in the past half century as we have understood that symptoms alone rarely indicate the best choice of treatment."

As a result of his position, the NIMH is no longer using the DSM as the criteria for evaluating and funding future clinic trials. However, in looking at older neuroscience research, the diagnostic system is not informed by recent breakthroughs in:

- genetics
- cellular neuroscience
- systems neuroscience
- molecular neuroscience

Nevertheless, new research using high-resolution positron emission tomography (PET) brain imaging is said to have made the connection. It has linked specific symptoms of PTSD, including listlessness and emotional detachment, to specific abnormalities in brain function.

What Is a PET scan? It is an imaging test using a special dye with radioactive tracers injected into a vein in the arm. Organs and tissues absorb the tracer. When highlighted under a PET scanner, the tracer shows how well our organs and tissues are working by measuring blood flow, oxygen use, glucose metabolism and much more.

Not everyone seems impressed with the Research Domain Criteria (RDoC). Daniel R. Weinberger. M.D., Ira D. Glick, M.D., and Donald F. Klein, M.D., wrote in the December 2015 edition of *JAMA Psychiatry*: "Whither Research Domain Criteria (RDoC)? The Good, the Bad, and the Ugly." They have this to say about the RDoC:

> "Do we need to replace categorical with dimensional diagnoses to make progress in psychiatry research? No."

In their view, the RDoC 2013 release, debuting along with the DSM-5 publication, was touted as a better classification system for psychiatric disorders. Its supposed advantage was based on mechanisms rather than symptoms. Pushback

from clinicians and researchers, however, has led NIMH to partially refashion RDoC goals. The initial emphasis on improved diagnosis has been changed. The claims of a scientific nosology for clinical research have also been changed.

Any new scheme for categorizing patients has to prove better on multiple levels to the consensus clinical tactics of DSM-5. Weinberger at al doubt this will occur with RDoC, because it lacks the very scientific foundation that it proclaims. Two things most surprised them. One was the striking omission in the RDoC "matrix" to in any way appreciate the remarkable difference between well and sick. Nor did the RDoC recognize the critical importance of time in defining course or prognosis in clinical decision making. How one determines that somebody is "a case" with disability and distress also remains obscure. For example, there is no tactic to distinguish unhappiness or demoralization from clinical depression.

Well, that's the plan. Humans without emotions are the agenda's aim. They will find out how to stop emotions by hook or by crook. It's all so very simple.

The Brain & Behaviour Research Foundation published "Brain Imaging Helps Link Specific Symptoms of PTSD with Specific Brain Activity" in 2014. The article suggests an exciting possible target for future PTSD treatments. It would "personalize" medication management for this disabling illness, claimed Alexander Neumeister, M.D. He is Grantee and Co-Director of New York University's Langone Medical Center's Steven and Alexandra Cohen Veterans Center for the Study of Post-Traumatic Stress Disorder and Traumatic Brain Injury. In his words:

> "Understanding more about where and how symptoms of PTSD manifest in the brain is a critical part of research efforts to develop more effective medications and treatment modalities."

Here is what the study reported. They compared PET scans of purportedly healthy volunteers with those of patients clinically diagnosed with:

- PTSD
- major depression disorder
- generalized anxiety disorder

The subjects they chose had symptoms ranging from emotional detachment to isolation. Their primary finding was that exposure to trauma results in low levels of KOR in the brain's amygdala. That's where fear response comes from. These low KOR levels were linked to symptoms of listlessness and emotional detachment, but

not anxious arousal or hyper-vigilance.

What is KOR? It is the κ-opioid, a receptor and a protein in humans encoded by the OPRK1 gene. The OPRK1 gene is one of four related receptors binding opioid-like compounds in the brain. It is responsible for mediating the effects of these compounds. These effects include altering:

- mood
- nociception
- motor control
- consciousness

KOR is a type of opioid receptor that binds the opioid peptide dynorphin as the primary endogenous ligand (a substrate that grows naturally in the body). A variety of natural alkaloids, terpenes and other synthetic ligands also bind to the receptor. The KOR may also provide a natural addiction control mechanism. That is why drugs that act as agonists and increase the activity of this receptor might have therapeutic potential to treat addiction.

The secondary finding is that too little KOR might be linked to more severe symptoms. That is because lower KOR might be linked to lower cortisol levels. The researchers suggest that cortisol might serve as a biomarker for certain types of PTSD symptoms.

Cortisol is a hormone naturally released by the body when the corticotropin-releasing factor (CRF) system responds to stress, we hear. Neumeister explained in a CBS interview:

> "People with cancer have a variety of different treatment options available based on the type of cancer that they have . . . We aim to do the same thing in psychiatry. We're deconstructing PTSD symptoms, linking them to different brain dysfunction, and then developing treatments that target those symptoms. It's really a revolutionary step forward that has been supported by the National Institute of Mental Health (NIMH) over the past few years in their Research Domain Criteria Project."

By way of cortisol? So it seems. That might be the next treatment mental health practitioners and trans-humanistic scientists wish to stuff down the PTSD afflicted's throat. So, let us look at what cortisol is and what it does. And let's look at the side-

effects, should one be stupid enough to consent to have it injected.

Cortisol is often called the "stress hormone" because of its connection to the stress response. However, it is much more than just a hormone released during stress. Many authorities say that understanding cortisol and its effect on the body can help us balance our hormones and achieve good health.

Made in the adrenal glands, cortisol is one of the steroidal hormones. It is distinguishable from other hormones by its insolubility in human blood plasma. This makes it function differently than other hormone types, such as protein hormones, the predominant type of hormones in the human body. Hormone secretion is controlled by three glands:

- the adrenal gland
- the hypothalamus
- the pituitary gland

Because most cells have cortisol receptors, cortisol affects many body functions:

- control blood sugar
- regulate metabolism
- reduce inflammation
- control blood pressure
- control salt and water balance
- support the developing foetus during pregnancy
- help create memory (how we retain and store short and long term information)

All of these functions are said to make cortisol a crucial hormone for overall health and well-being.

What, then, are the problems with high cortisol levels, you wonder? In its normal function, cortisol helps meet life's challenges. It converts proteins into energy, releases glycogen and reduces inflammation.

At sustained high levels, cortisol acts quite differently. It gradually tears the body down as it destroys healthy muscle and bone. It slows down healing and normal cell regeneration. It co-opts bio-chemicals needed to make other vital hormones. It impairs digestion, metabolism and mental function. It interferes with healthy endocrine function. And it weakens the immune system.

At times, tumours on the pituitary or adrenal glands contribute to a condition known as Cushing's syndrome. This condition comes with high cortisol levels in the blood and rapid weight gain in the face, abdomen and chest area. Cushing's syndrome also causes a flushed face, high blood pressure and changes in the skin. Osteoporosis and mood swings are also a factor with Cushing's disease.

High cortisol levels can contribute to changes in a woman's libido and menstrual cycle, even without the presence of Cushing's disease.

Anxiety and depression might also be linked to high cortisol levels. Depression also appears to be the case for the vast majority of pharmaceutical drugs prescribed for PTSD. Cortisol would be just another addition to the insanity or crime committed against the incapacitated, medically uneducated, and trusting PTSD-afflicted humans. It would be just one more tool mental health physicians would have to take advantage of personal ignorance and incapacitation. As you sow, you shall reap.

What about low cortisol effects, you wonder? They can cause the autoimmune disease called Addison's. This disorder occurs when the body produces too little of certain hormones produced by the adrenal glands. In Addison's, the adrenal glands produce too little cortisol and often too little aldosterone, as well. These glands are just above the kidneys. They are part of the endocrine system, producing hormones that give instructions to almost every organ and tissue in the body.

The Mayo Clinic staff explain that Addison's occurs in all age groups, affects both sexes and can be life-threatening. Symptoms include:

- nausea
- vomiting
- irritability
- depression
- mouth-sores
- low heart rate
- fainting spells
- cravings for salt
- muscle-weakness
- decreased appetite
- low blood pressure
- fatigue and tiredness
- darkening in skin color

- low blood-sugar levels

If untreated, Addison's can turn into an Addisonian crisis. This is a life-threatening medical emergency that begins with confusion, fear, restlessness, loss of consciousness, high fever and sudden pain in the lower back, belly and/or legs. If an Addisonian crisis is untreated, it can lead to shock and death.

Overall adrenal fatigue may be a factor in many related conditions, such as:

- arthritis
- fibromyalgia
- hypothyroidism
- premature menopause
- chronic fatigue syndrome

It might also produce a host of other symptoms from acne to hair loss, says Marcelle Pick, OB-GYN NP, in her 2016 article "The Destructive Effect Of High Cortisol Levels".

Still want to be the guinea pig for cortisol, or any other PTSD cure, for that matter? Again, depending on your pre-PTSD situation you may have little choice. Obedience is demanded if you need continued financial aid, putting you between a rock and a hard place. Your mental and physical destruction means nothing to those suggesting their inane treatment. They even seem to thrive on ruthless experimentation of human beings' for the sake of scientific discovery, enjoying the suffering in the process.

Mind you, all you have to do, if you have the guts and gumption, is to graciously convey to the powers that be that: "I will be delighted and enthused, nay, overjoyed to do whatever you say and follow every command you issue, if you will guarantee in writing that the treatment you force upon me under threats and coercion will cure my PTSD and neither inflict physical nor mental ill health upon me." Present it to them in writing! Graciously demand their response in writing! Then see what happens.

All these hypothesis, all these imaginations, all these hallucinations. They are coughed up by those engaged in the field of psychology, originating from metaphysics mixed with parapsychology. Combined with mind-altering prescription drugs, such treatment can easily spin PTSD-afflicted people completely off their axis. Thus, a slide into abysmal depression happens and an equally abysmal

lethargy. The powers that be will term this “pre-morbid etiology”, as they do with all comorbidity issues, when they themselves are causing them. Human debris, all right, but whom? Them or us?

Danger: Lethargy & Depression Due To False PTSD Information

I knew nothing about their modus operandi when I got PTSD the first and second time. In ignorant glory, I still trusted those around me. I still trusted those assigned by the WCB et. al. I still trusted the Union, who said they knew how to heal me. Mind you, I was busy getting my degree.

Only after graduation did I feel it timely to conduct my own research. By then, it was over five years after the PTSD-causing event. I focused on aircrew only. *Broken Wings* was the result. It was also the mechanism preventing my slide into lethargy and depression, although I came close a few times.

Psychologist number 15 or so deserves credit for waking me up. Without ever having set eyes upon me, he declared I must have been raped; otherwise I could not feel the way I did. Undesired penis within? No, engine explosion without! Those were my thoughts. But it so infuriated me that I researched for weeks on end at the university library, gathering the material that would be *Broken Wings'* foundation.

Stopping the Ativan cold turkey was the other savior of my sanity. Someone prescribed Prozac once. Fortunately, it made me so violently ill from just half a tablet, that I never took a second dose. That reaction saved me from sliding deeper into an abyss of despair.

Being drug-free I think fanned the spark of light still burning in my soul. Drug-free vigorously increased that light with writing *Broken Wings*. Actually, it truly lit the fire in my soul. "Not with me," I thought. "Not with me!" I learned about the brutal treatment severely injured workers receive from employers, WCB and Unions. It's a treatment tailored so expertly to throw them into depression and lethargy. Even Lang, McTeague and a slew of other mental health practitioners mention this PTSD side effect. They, however, refrain from mentioning its related powers.

What else do they keep top secret? That it is furthermore enhanced by practitioners' treatment hypotheses and modalities? That their innate character flaws and mental deficiencies make it worse? That accusations and assertions foisted upon PTSD journeyers also cause depression and lethargy? That all of it is engineered to heighten PTSD experiencing workers' desire to kiss it all bye-bye by sliding into a depression and lethargy, into peace and quiet, most likely while nursing a bottle? That the result is to live the futility lingering just beneath the mind's surface? That the futility thrives due to the trauma imposed by those in authority, radiating the illusion of knowing what they are doing? That all they know is how to destroy? That this is inconsequential to them, as it is splendid for the employers' bottom line? So much being kept top secret to secure and enhance the financial bottom line of the powers that be.

To crawl into this shell of inner protection from the outside world may be a wonderful thing to do — for a while. To stay there forever, however, may be unwise. It would mean throwing away the opportunity of a life-time — to create the Self in the way one wants it from a *tabula rasa*, a clean slate, created by the PTSD-causing event.

But no one tells us, so how would we know that PTSD is to be embraced rather than cursed? Encourage the "Let me know what I can do with this", rather than the

"I'm dead. I may as well fade out and vegetate until I die for real."

Or it would mean willing the Self to die right on the spot. What a waste it would be. Once we are aware of this, however, we can gather the willpower after the initial PTSD grieving process. That phase typically lasts three to four months. Then we can begin to help ourselves by learning:

- to meditate to facilitate the process
- who we are and what we are, infinite spirits having an earthly experience
- to control our thinking and thus haul ourselves out of the depression–little by little

First, we must overcome personal laziness and lethargy for a few hours daily. Do it by sheer willpower, if need be. Lethargy impedes growth in any direction. It creates ill-will and feelings of guilt against the Self, which must be avoided at all costs. Plus, kicking one's Self into action builds enormous self-esteem, which enhances self-confidence. An explorative, curious, open mind is a good idea. So is any effort to turn into an indomitable spirit. It is far more difficult for the powers that be to destroy a strong, powerful and knowledgeable person than an ignorant and weak one.

We human beings have enormous power, but no one ever tells us. You now have the God-graced possibility to educate yourself about your power under your own steam. The questions to ask are: "Do I really want these blood-sucking vultures to destroy me? Or do I want to explore and see what I can do to help myself?"

The choice is yours. You have the power.

Mandate number one, however, is to stop taking pharmaceutical drugs and opioids of any kind. No cannabis. No ecstasy, causing the perpetual traumatization of the traumatized until their natural death or suicide. This can only be imposed by the mental health industry and their purportedly PTSD savvy mental health practitioners' henchmen. They can only impose these drugs on PTSD-affected soldiers, veterans, fire-fighters, aircrew and police officers because we entrust them with our power.

And how did the profession originate, pray?

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All these things impair our functioning as human beings. Wonder why the mental health profession is still in business and thriving? To keep the population in a drug infected daze, that's why. Easier to govern them that way. That's why the PTSD journeyers are such a big target. Getting themselves together, they may awaken a few of their fellow PTSD inmates. Watch *The Matrix* number one.

One thing is certain. Psychiatry is fake. It's fraud. It's pseudoscience from top to bottom, complete fiction dressed up as fact. But, Rappoport asks, if this extensive "branch of knowledge" is nothing more than an organized delusion, what other branch of science might likewise be parading as truth when merely paper blowing in the wind? Who knows? But somehow they are working at a scheme to delude the public further. The Group for the Advancement of Psychiatry (GAP) has set out to fill a void in psychiatric education. They have published a series of videos exploring

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Thus, are those pretending to be in control of the herd really to blame? In this case, are scientists of neuro-anatomy enhanced by the non-existent science of psychiatry experts used as manipulators of their victims really to blame? Are their linear and limited thinking, inhuman attitudes and lack of thought and emotional flexibility their fault? Or are their probably never-analysed brains influencing their non-humane interests and behaviours?

12

The Rise Of Psychiatry

Kenneth J. Weiss, M.D., and the Group for the Advancement of Psychiatry wrote about psychiatry's origins in the article "A Trip Through the History of Psychiatry" (*Psychiatric Times,* Nov. 2017). They researched psychiatry from ancient times through the present. They learned about health and illness over time and across cultures and continents. They found that cultures around the world struggled with the same issues psychiatrists do today:

1. understanding mental suffering
2. understanding behavioural differences
3. seeing these through the filter of shared beliefs and practices

4. applying remedies in accordance with those beliefs

They saw how the roots of psychiatry in ancient cultures are still practiced today:

- the Ayurvedic medicine of India
- the Chinese focus on the flow of energy (*qi*)
- the Greek theory of the humors of the body (imbalanced blood elements are still called *dyscrasias*, or bad mixtures).

Organized psychiatry in America began in Philadelphia in 1844. Thirteen asylum superintendents formed a guild now known as the American Psychiatric Association. They published their proceedings in the *American Journal of Insanity*. Weiss notes that the issues they discussed then are virtually the same as those being discussed by psychiatrists today:

- asylum care
- somatic therapies
- prevention of harm
- the classification of mental disorders
- international approaches to mental illness

Apparently, psychiatry constantly reinvents itself, though it may not be always apparent. "In our everyday world of scheduling evaluations, wrangling with insurers, documenting progress, and, of course, being compassionate healers, it's easy to lose sight of the longer arc of psychiatry over the years," says Weiss. His expression "compassionate healer" is one I have rarely observed in his profession.

The idea of mental disturbances being associated with inflammation flourished in America during the late 18th century. This led to reducing the heat by bleeding the patient — many times with fatal consequences. Weiss notes that current psychiatric research has circled back to inflammation being associated with mental illnesses. Perhaps this time psychiatry might get it right.

In *The Link Between Brain Inflammation and Mental Health* on *Integrative Psychiatry,* we read that brain inflammation is linked to virtually all types of mental illness and mood disorders, such as:

- anxiety

- autism
- dementia
- depression
- schizophrenia

Inflammation is also a contributing factor in cardiovascular disease, asthma and allergies. Autoimmune diseases like arthritis and hypothyroidism may also be influenced by inflammation.

What does inflammation mean and why does it affect humans negatively in many ways, you wonder? Inflammation is an immune system response to environmental irritants, toxins and infection. When one of these intruders activates the immune system, pro-inflammatory hormones signal the white blood cells to rush in and clean up the infected or damaged tissue. Once the invaders are subdued, anti-inflammatory agents move in to begin the healing.

In a normal immune system, a natural balance exists between inflammation and the anti-inflammatory agents. But sometimes, the immune system gets stuck in high gear and symptoms of inflammation remain. This is known as chronic inflammation.

Inappropriate inflammation over a long period of time can lead to damage or destruction of tissue. This damage can lead to cardiovascular disease and cancer. It can lead to neurodegenerative diseases, such as Alzheimer's and Parkinson's and other forms of dementia. It can lead to ADHD, autism, anxiety and depression. All this because of nutrition and digestion.

Indeed, a great deal of evidence suggests inflammation has its roots in the gastrointestinal (GI) tract. The digestive system is designed to remove toxins, bacteria and viruses from our food before it reaches the rest of the body. The GI tract is the first line of defense against infection and disease. Poor nutrition, medications, stress and environmental toxins can damage the gut and cause inflammation. The inflammation can then spread freely and unchecked throughout the rest of the body. What are the greatest culprits for inflammation?

- caffeine
- animal fats
- refined sugars
- foods high in acids
- alcohol, unless brewing your own

- dairy products, unless natural and right from the farm, I am sure
- processed and refined flours (white bread, cookies, pasta, crackers, etc.)

Hidden food allergies cause body and brain inflammation. The ancients in the East knew all this, as we will discover later.

The Group for the Advancement of Psychiatry advocates a nonjudgmental approach to the seemingly quaint, retarded, un-evolved, non-monotheistic, spiritual beliefs and healing practices of ancient peoples. They discovered recently that active ingredients of mental health diagnosis and treatment appear to apply in all cultures. They include:

- identifying behaviours or mood states out of balance with Self, family, culture, general health, shared values or spiritual domains;
- the presence of a leader, shaman, priest or identified medicine-person; and
- a set of rituals known within the culture to restore balance, such as somatic interventions, trance states, sleep, special words by the healer or temple services.

Weiss says that we should still take specific practices with a grain of salt. Hippocrates' humoral theory focussed on black bile, yellow bile and phlegm. Phrenology steered scientific thinking toward a system of diagnosis and treatment in the 1800s. Psychiatry's current focus and pursuit is of neurotransmitters and the Holy Grail of correlative neuro-anatomy.

Jon Rappoport would seem to agree with Weiss. He wrote *"A whole branch of science turns out to be fake?"* on November 29, 2017. He analysed the purported science of psychiatry somewhat askance, saying:

> "Devotees of science often assume that what is called science is real and true. It must be. Otherwise, their faith is broken. Their superficial understanding is shattered. Their 'superior view' of the world is torpedoed."

Take psychiatry, for example, says he. It is slowly becoming an open secret that there are no definitive laboratory tests for any so-called mental disorder. PTSD experiencers' should keep that firmly anchored in their minds. They need your MMPI answers in particular to have an iota of an idea how to attack and disprove

your claim of PTSD.

Furthermore, all so-called mental disorders are concocted, named, labeled, described, and categorized by a committee of psychiatrists from human behaviors' menus. Their purported findings are published in periodically updated editions of The Diagnostic and Statistical Manual of Mental Disorders (DSM), printed by the American Psychiatric Association.

This fraudulent science of psychiatry is nothing new to many of them. Even psychiatrists have been blowing the whistle on this hazy, crazy process of research, says Rappoport. But pharmaceutical companies love these disorders. They make highly toxic drugs to treat every one of these "disorders". This leads to the invention of more and more mental-health categories, so that they can sell more drugs and make more money by the minute. As drug suppliers, psychiatrists get a chunk of the action.

Are you still surprised that some PTSD journeyers are prescribed 15 and more drugs to take daily? Are you still surprised that we take them because we have lost all sense and sensibility to think?

But a mind-boggling twist occurred in December 2010. Dr. Allen Frances was one of psychiatry's greatest stars, who had been out in front in inventing mental disorders. He did something totally unexpected. He went public, blowing the whistle on himself and his colleagues.

Frances is the man who headed up the project to write the latest edition of the DSM-IV in 1994. That is the psychiatric bible, which defines, labels and describes every official mental disorder. It now lists 297 of them. On April 19, 1994, Daniel Coleman in "Scientist At Work", the *New York Times*, called Frances: "Perhaps the most powerful psychiatrist in America at the moment . . . " And surely he was, considering he sculpted the entire canon of diagnosable mental disorders. His colleagues, insurers and the government followed his lead. Pharma had to sell drugs matched up to the 297 DSM-IV diagnoses he approved.

It was long after the DSM-IV publication when Frances let the cat out of the bag. Gary Greenberg interviewed him for his *Wired* article: "Inside the Battle to Define Mental Illness". His exact words were: "There is no definition of a mental disorder. It's bullshit. I mean, you just can't define it." Moments later, he added: "These concepts [of distinct mental disorders] are virtually impossible to define precisely with bright lines at the borders." Needless to say, major media ignored the interview to protect its clients, the pharmaceutical Deep State corporations.

Rappoport feels that Frances should have mentioned another fact. His baby, the

DSM-IV, had unscientifically rearranged earlier definitions of ADHD and Bipolar to permit many MORE diagnoses. This led to a vast acceleration of drug-dosing with highly powerful and toxic compounds. It also added another smoking-gun statement made by another prominent mental-health expert in the PBS Frontline series. The episode was: "Does ADHD Exist?"

PBS FRONTLINE interviewer: "Skeptics say that there's no biological marker-that it [ADHD] is the one condition out there where there is no blood test, and that no one knows what causes it."

Dr. Russell Barkley, professor of psychiatry and neurology at the University of Massachusetts Medical Center:

> "That's tremendously naïve, and it shows a great deal of illiteracy about science and about the mental health professions. A disorder doesn't have to have a blood test to be valid. If that were the case, all mental disorders would be invalid . . . There is no lab test for any mental disorder right now in our science. That doesn't make them invalid."

Unintentionally, Barkley blew an ear-shattering whistle on his own profession. He is essentially saying, "There is no lab test for any mental disorder. If a test were the standard of proof, we wouldn't have science at all, and that would mean our whole profession rests on nothing — and that is unthinkable, so therefore a test doesn't matter."

That logic is no logic at all. That science is no science at all. Barkley is proving the case against himself. He just doesn't want to admit it, and how could he. It'll destroy him and his cabal. After all, medical science and disease-research rests on the notion that a diagnosis can be backed up by lab tests. If they cannot be produced we enter the realm of fantasies. They might be hopeful "educated guesses" launched from traditional centers of learning and backed up by billions of dollars of grant money, but they are still fantasies.

Thus, Rappoport reflects my sentiments precisely:

"Psychiatry is all fraud all the time. Without much of a stretch, you could say psychiatry has been the most widespread profiling operation in the history of the human race. Its goal has been to bring humans everywhere into its system. It hardly matters which label a person is painted with, as long as it adds up to a diagnosis and a prescription of drugs."

Almost 300 so-called mental disorders caused by . . . what? No lab evidence. No defining diagnostic tests. No blood tests, saliva tests, brain scans, genetic assays

backed up by what? Nothing.

Still, psychiatrists insist they are the masters of causation. They know what's behind "mental disorders". They're in charge. Why? Because the dumbed-down public is too ill-educated to know the difference. We allow it, and reap what we sow.

Take the generalized "chemical imbalance" hypothesis. It states that all mental disorders stem from imbalances in the brain. You swallow that crap whole as well, right? Too busy on the cellphone asking your mother's permission to fart, are you?

At least Dr. Ronald Pies, editor-in-chief emeritus of the *Psychiatric Times*, laid that hypothesis to rest. In the *Times* July 11, 2011, issue, he made this staggering admission: "In truth, the 'chemical imbalance' notion was always a kind of urban legend — never a theory seriously propounded by well-informed psychiatrists." Read it again, perhaps? The point is that for decades, the whole basis of psychiatric drug research, prescription and sales has been: "We're correcting a chemical imbalance in the brain."

The funny thing is, researchers had never established a normal baseline for chemical balance. So all along they were shooting in the dark. They had no idea if something was broken. And they had no way to tell if it was fixed. They were faking a theory and pretending they knew something when they knew nothing.

In his 2011 *Psychiatric Times* piece, Pies tries to protect his colleagues in the psychiatric profession with this fatuous remark:

> "In the past 30 years, I don't believe I have ever heard a knowledgeable, well-trained psychiatrist make such a preposterous claim [about chemical imbalance in the brain], except perhaps to mock it . . . the 'chemical imbalance' image has been vigorously promoted by some pharmaceutical companies, often to the detriment of our patients' understanding."

And often to the detriment of our health, I would add.

Rappoport says that is absurd. He says that many psychiatrists do explain to their patients that drugs are prescribed to correct a chemical imbalance. If all psychiatrists have known all along that the chemical imbalance theory is a fraud, why on earth have they been prescribing tons of drugs to their patients? If they know full well that those drugs are developed on the false premise that they correct an imbalance and do nothing other than impair and unbalance the human body-system, why exactly are they prescribing them?

Psychiatry's game has been exposed. The chemical imbalance theory is a fake.

There are no defining physical tests for any of the 300 so-called mental disorders. All diagnoses are based on arbitrary clusters or menus of human behavior.

That drugs are harmful, dangerous and toxic is still under the carpet. That some of them incite violence, suicide and homicide is still under the carpet. That others cause brain damage is still under the carpet. I am sure they'll find a way to keep it there, unless humanity starts to awaken to this enormous fraud perpetrated upon it, with us PTSD journeyers leading the charge.

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13

The Left Brain Vs. The Right & The Ambidextrous One

The brain was not always held in high regard. The Greek philosopher Aristotle (384–322 BC) thought the heart, not the brain, was the location of intelligence and thought.

The ancient Egyptians did not think much of the brain, either. They scooped it out through the nostrils when preparing a mummy and threw it away. Meanwhile, they carefully removed and preserved the heart and other internal organs either within the body or in a jar placed beside it.

Nevertheless, ancient Egyptians were responsible for the world's oldest known

written record using the word *Brain*. They made the first account of its anatomy, the meninges — the brain coverings — and the cerebrospinal fluid. It was written around 1700 BC, based on texts going back to 3000 BC.

Despite the understanding of the human brain being in its infancy today, it appears that brain surgery is one of the oldest of the practiced medical arts. Evidence of "trepanation" can be found in archaeological remains dating back to the Neolithic period, around 10,000 BC. Trepanation, also known as trepanning, trephination, trephining or burr hole, is surgery in which a hole is drilled into the skull to expose the brain. Cave paintings from the late Stone Age suggest that people believed the practice would cure epileptic seizures, migraines and mental disorders. Perhaps they thought that the operation would allow evil spirits to escape. There is also some evidence that such surgery was undertaken to prevent blood clots forming and to remove bone fragments following a head injury.

Hippocrates, born on the Aegean Island of Cos in 470 BC and considered the father of modern medical ethics, wrote many texts on brain surgery. Quite familiar with clinical signs of head injuries, he was the first human known to speculate that the brain's two halves were capable of independent processing. He called it "mental duality".

When French philosopher and founding father of modern medicine René Descartes, had to deal with the Pope to get bodies for dissection, brain research suffered a setback. The Pope finally agreed, however, as long as Descartes would not have anything to do with the soul, mind or emotions, as those were the church's realms. This agreement set the tone for Western science for the next two centuries. It divided the human experience into two distinct and separate spheres never to overlap. Even today, people are skeptical of illnesses caused by mental processes.

A North American railway worker suffered damage to his brain's frontal lobe in 1848. It was pierced by a metal rod that shot through his skull during an explosion. He turned from a quiet, industrious worker before the accident, into a surly, aggressive man who could not hold down a job. This case was an important milestone in the study of brain-anatomy, because it suggested that important parts of the personality reside in the frontal lobe. It also led to the development of the lobotomy procedure, based on the theory that removing parts of the frontal lobe could cure mental derangement and depression.

Be it as it may, there is no argument that the brain is split into two roughly similar hemispheres. They are separated by a deep, longitudinal fissure and "cross-wired". The left hemisphere controls movement on the right side of the body and

the right hemisphere controls the left. Most, but not all, of its different structures, lobes and organs have a left and right hemisphere element. The hemispheres communicate with each other through a thick bundle of nerve tissues, the corpus callosum. This makes a full brain out of two half-brains, explains Luke Mastin in his 2012 article "Handedness and the Brain". By rough estimate, this bundle of nerve tissue has over 200 million axons. An axon is a, nerve fiber that carries electrical impulses from neurons' cell bodies. Axons handle communication between the brain's two sides.

Unlike other body cells, most neurons in the human brain are able to divide to make new cells only during foetal development and for a few months after birth. They might grow in size until the age of about 18 years, but they are designed to last a lifetime.

The only brain area where neurogenesis (cell renewal) has been shown to continue throughout life is the hippocampus. The hippocampus is in the medial temporal lobe of the brain, underneath the cortical surface. Divided into halves, lying in each side of the brain, it is mainly linked to memory and spatial navigation.

Like the hippocampus, the brain's two sides are not exactly alike. Each brain hemisphere tends to have some functional specialization. In other words, the neural mechanisms of a certain brain function are mostly in one half of the brain. An example of this is the two areas of the brain where speech production and language comprehension are processed. These are known respectively as Broca's and Wernicke's areas. Both are usually in the brain's left hemisphere.

Mathematical, analytical and logical processings are usually also done in the left hemisphere. The right side usually handles most:

- face recognition
- artistic functions
- sense perception
- spatial recognition
- emotion processing

This lateralization and specialization of each area of the brain is much more marked in humans than in animals. Indeed, Mastin says that it becomes increasingly marked as we move from early childhood to adulthood.

Functional Magnetic Resonance Imaging (fMRI) in the 1990s, however, showed brain lateralization to be far more intricate than it was thought to be. Dutch

research in 2009 showed that face recognition, normally a right hemisphere function, usually occurs in the left hemisphere of left-handers. The research showed that the ability to order a list of manual activities is an exclusive specialty of the left hemisphere, regardless of whether a person is left or right-handed. Other findings seem to have little or no logic to them at all, explains Mastin. Some evidence suggests, for example, that women tend to process language more evenly between the two hemispheres. This flies in the face of findings that more men than women are left-handed.

It is also becoming clear that some redundancy is built into the brain's systems. For instance, one eye is able to perceive both sides of a view if necessary. Most, but not all, of one side of the body can be paralyzed after a one-sided brain injury. In fact, a whole brain hemisphere can be removed at a young age. This redundancy and the brain's innate plasticity can develop higher mental functions almost completely unimpaired.

In general, however, our brain's left and right hemispheres process information in different ways. This concept came from research in the 1960's by the American psycho-biologist Roger W. Sperry. While we might have a natural tendency towards one way of thinking, our brain's two sides work together in everyday life. The right side focuses on the visual and processing information in an intuitive and simultaneous way, looking first at the whole picture then the details. The left hemisphere processes information in an analytical and sequential way looking first at the pieces then putting them together to get the whole.

The best illustration of this is to listen to people giving directions, according to the article "Left Brain Vs Right Brain" by the Universal Concept of Mental Arithmetic System (UCMAS). The left-brain person will say something like "From here, go west three blocks and turn north on Vine Street. Go three or four miles and then turn east onto Broad Street." The right-brain person will sound something like "Turn right (pointing right), by the church over there (pointing again). Then you'll pass a McDonalds and a Walmart. At the next light, turn right toward the Esso station."

Though right-brain or non-verbal thinking is often regarded as more creative, UCMAS points out that there is no right or wrong here. These are merely two different ways of thinking. One is not better than the other, just as being right-handed is not superior to being left-handed. What is important is to be aware that there *are* different ways of thinking. By knowing what one's natural preference is, one can train oneself to improve the less dominant side, and thus broaden one's

hemispheric horizon. For example, by learning abacus through the UCMAS's systematic training approach, children can fully realize their potential by activating both sides of their brain. By consciously using the right side of the brain, we can become more creative. This comes in handy, particularly as left-brain strategies are the ones used in the classroom. Right brain activities have been out of style for decades at all levels of the educational system, from Kindergarten to the Ph.D. curricula and beyond.

Why should we nurture right-brain thinking? By activating the power of both hemispheres, people of any age will be able to retain knowledge better and become proficient in any subject, especially math, throughout life. In other words, it would create a much brighter population. People would be able to apply reason and logic, rather than be dependent on the powers that be when trouble of any sort arises, including PTSD, if both brain hemispheres were powered up.

The left brain is called the digital brain. It controls reading, writing, calculation and logical thinking. The right brain is called the analog brain. It controls three-dimensional sense, creativity and artistic senses. UCMAS explains that when working together, these two allow us to function as human beings, which brings us to ambidextrous people.

Michael C. Corballis, Ph.D., is Professor Emeritus of cognitive neuroscience and psychology at the University of Auckland, New Zealand. He says that about 90 percent of people are right-handed. The remaining 10 percent are either left-handed or ambidextrous to some degree. People with "true" ambidexterity, with no dominant hand at all, make up only about one percent of the population.

If logic was to prevail, one would think that ambidextrous people would fare much better in the world than one-sided brainers. They have equal access to both sides of their symmetrical brain. The scarce research done on the topic is not very conclusive. Some studies show ambidexterity to create rather nutty individuals. But the research also shows that the people with the best cognitive performance are the folks not heavily wedded to a single hand. The more ambidextrous they are, the better they perform on cognitive skill tests, says American science journalist Maggie Koerth-Baker in her 2013 article "Being ambidextrous could give you a cognitive advantage" (boingboing.net 2013).

Corballis, however, begs to differ. He says that recent evidence shows being ambidextrous from birth is associated with developmental problems, including reading disability and stuttering. A study of 11-year-olds in England compared those who were ambidextrous with left- and right-handers. It showed that those who are

naturally ambidextrous are slightly more prone to academic difficulties than either left- or right-handers.

Research in Sweden found ambidextrous children to be at a greater risk for developmental conditions, such as attention-deficit hyperactivity disorder (ADHD). ADHD is usually a sign of either being bored stiff or high sugar intake.

Another study revealed that ambidextrous children and adults both performed worse than left- or right-handers on a range of skills. Rachel Fallon says they performed worse in math, memory retrieval and logical reasoning, in "Can training to become ambidextrous improve brain function?" (*Scientific American,* 2016)

Some scientists hypothesize that all ambidextrous people have symmetrical brains. They theorize that this is useful from an efficiency point of view. Having both sides of the brain knowing how to do math could be redundant and inefficient. These scientists figure that if only one hemisphere needs to know how to do math, it frees up the corresponding brainpower on the other side to do other things, like judging emotions, for example.

Other researchers assume that this symmetric brain activity comes with a cost. Ambidextrous people are said to score slightly lower on IQ tests than those with a dominant brain side. They also have a lower ability in reasoning, mathematics and memory.

But it is *true* that ambidextrous people tend to do better in sports, arts and music.

So what may really be going on, inquiring minds want to know? One theory, advanced by Corballis, could explain both sides' of the debate. He thinks the ambidextrous brain has more trouble communicating with itself across the hemispherical divide. It is this slight loss of information that he says might explain both the slightly lower IQ and the increased creativity. The missing information might lead to more creative thinking. Go figure?! Neuroscience, the research of the brain, has one huge advantage: it is speculative, thus ideal for the "science of psychology," where anything goes.

It might appear that some general rules about hemispheric function specialization are in place. However, I hear that for scientists, the actual situation is said to be much more complex than they ever thought. It's not easy playing God. Rather than firm rules, the findings should be seen more as indicators. In fact, Mastin says that the plasticity and complexity of the brain appears to allow for significant variation from these indicators.

This leads to the most likely scientifically-unanswerable question. Is the brain's thought functioning, its development and use related to such things as:

- color
- religion
- parentage
- nationality
- place of birth
- belief structure
- academic background
- intellectual tendencies

Are these characteristics in the child and the child's caretakers influential in creating the scientist, the artist or the inventor. Do they influence interest or success in the run-of the mill sports or politics? The MMPI and other tests I have been forced to take don't address this basic question, even though we know that it has an enormous impact in human lives. For example, it was influential in the Muslim invasion of Europe.

What about an individual's life path and human experiences? What about the inherent soul manifested by the spark of light we human beings carry within? This is the only thing we truly have in common, the only thing in which we truly are equal? Was the path of life laid out before ever touching down on Earth? This concept is so alien to scientists and left hemisphere oriented people in general, that the question itself throws them into spasms of protest and revulsions. Except, of course, the Nassim Haramein's of the world, of which there is one in a billion.

May our unconsciously chosen life path have anything to do with our hemispheric development and usage? Are we in our brain development and exploration following our own individual soul-path in accordance with pre-set rules and regulations of an unknown jurisdiction? When living on a free-will planet like Earth, can we decide when to act upon ideas and aspirations, to choose right over wrong, good over evil, trans-humanism over morals and ethics? Can we perhaps even choose between right or left hemisphere dominance or even choose ambidexterity?

It is just a blessing the powers that be did not know about my ambidexterity. Otherwise they would have blamed my PTSD on it, as no stone will be unturned to blame PTSD experiencers for our impairment. My ambidexterity might have helped them force me into traditional non-evidence-based PTSD treatments and pharmaceutical drugs. My ambidexterity could have helped them make my life more miserable and make me disappear off the radar.

Reflections' Carol brought to my attention Michael Newton's 1994 book *Journey of Souls.* This was soon after I was taken off the line with recurrent PTSD and the manure hit my fan full force. This book would shed light on many of the questions I posed above. It would shed light on my situation and make it much easier for me to live through it.

Journey Of Souls: Why Are You Here? Where Will You Go After Death?

When Aristotle wrote his treatise *Peri Psuchēs* — On the Soul — he created a description of psychology within a biological framework. It was not a work about man's spirituality or his soul, with all its possible implications. His discussion centres on the different kinds of souls that inhabit different kinds of living things. He distinguishes them by their different operations. He presents the soul as the *form* or *essence* of any living thing, an indistinct substance from its body. Having a soul of a specific kind makes an organism an organism. To him, the notion of a body without a soul or of a soul in the wrong kind of body is simply unintelligible.

He also argues that some parts of the soul — the intellect — can exist without the body, but most cannot. Thus, Aristotle's idea of the soul differs somewhat from our popular view of the soul as the spiritual substance animating humans, animals and plants. We see it as more akin to a spiritual life force that is always in motion, affected by our thoughts, experiences and environment.

The existence of energy fields around living organisms has been scientifically proven using many different techniques. People have photographed these energy fields, which Aristotle may in essence have sensed. There is little doubt that he thought of the psyche as a basic principle of living beings and an important part of the natural world, as the title of his treatise indicates. Psyche in itself means *life* in the sense of *breath.* It comes from the verb *psycho, to blow*, the breath of life. This is what animates our spirit, soul, ghost — the Self, resulting in our conscious personality.

In Homeric poems, the word 'soul' is used in two ways. It can be something human beings risk in battle and lose in death. Or it can be what leaves the person's limbs at the time of death and travels to the underworld. There, it would have a more or less pitiful afterlife as a shade or image of the deceased person.

Whichever way, once the soul leaves the body, the person is dead. No doubt about it. Some of us have seen it happen; the PTSD journeyers have lived and are living it. Many PTSD survivors are walking corpses, as only the presence of the soul distinguishes an animated human body from a corpse. This is not to say, however, that the soul was thought of, now or in Homeric times, as accountable and/or responsible for human activity. It was not seen as the cause of responses, endeavours, actions and reactions, or anything else we perform during our lives. Mind you, a broad range of ways of acting and being acted on is attributed to the soul. Pleasure from food, drink and sex is attributed to the soul. Even the souls of gods and men are claimed to be subject to sexual desire. Its intense emotion or crisis, love and hate, joy and grief, anger and shame are associated with the soul. "Nothing bites the soul of a man more than dishonour," says Ajax just before he commits suicide, in a fragment from a tragedy of unknown authorship.

Moreover, the soul has also been connected with boldness and courage. Courageous people are thought of as having enduring or strong souls. In the Hippocratic text *Airs, Waters, Places,* the soul is portrayed as the place of courage or, as the case may be, its opposite. Thus the connection between the soul came to be thought of as the source and bearer of our personal characteristics and moral qualities like:

- mercy and justice
- endurance and courage
- temperance and goodness

If such qualities and tendencies flow from a soul's moral character, one can deduce that the soul engages in activities like thinking and planning. If the soul is responsible for courageous acts, for instance, it would grasp what courage calls for and how the courageous act must be performed. Thus the soul is held responsible for practical thought. This would be a connection between familiar uses of *soul* in emotional contexts and attributions to the soul of cognitive and intellectual activities and achievements.

Homer apparently never said that people did anything in virtue of or with their soul. Nor did he attribute any activity to a living person's soul (*Ancient Theories of Soul*; Stanford Encyclopaedia of Philosophy, 2003). Thus, though the presence or absence of soul marks a person's life, death or in between, he did not otherwise associate it with how that life is lived. Furthermore, to even mention the soul was to suggest death. The soul supposedly came to mind only when life was thought to be at risk. By the way, only human beings were thought to have and to lose souls. Homer never envisioned shades or images of non-human creatures in the underworld. This suggests the soul is conceived as being specifically associated with human life.

Over time, it became natural to speak of soul as what distinguishes the animate from the inanimate. Its existence was extended to animals and plants. Some philosophers even claimed that human souls were able to animate plants. Empedocles (c. 490–c. 430 BC) said he had in previous incarnations been among other things a bush, a bird and a fish.

A person's continued existence after death was a given. From Homer to Dante, the underworld after death was exquisitely discussed and described throughout the ages. It was Socrates who concluded that, since life belonged to the soul, the soul must be deathless — that is, immortal. Mind you, he also attributes a large variety of mental and emotional states such as beliefs and pleasures, desires and fears not to the soul, but to the — animate — body. Mind you, he also claimed that the soul, too, may have a number of other attributes:

- learning and appreciating truth
- intellectual desires of the corporeal

- passionate desires of the corporeal

He also claims that the soul regulates the body and its affections, its beliefs and pleasures, its desires and fears. It would do this by way of suitable judgments arrived at or supported and controlled by reasoning.

His pupil Plato points out that the soul is characterized by cognitive and intellectual features. Plato says it is something that reasons more or less well, depending on the extent to which it is disturbed or distracted by the body and its senses. It is something that regulates and controls the body, its desires and affections. Presumably, it does so in a way that involves and renders effective judgments about what it is best to do and how it is best to behave, especially if it is a wise soul.

Plato, applying his theory to the souls of all living things, including animals and plants, also opines that a creature's soul lives on after death. He assumes that it persists through a period of separation from body and then returns to animate another body in a change. He argues that the soul is immortal because it has life the way fire has heat.

He also maintains that each human soul has its own particular evil. This will cause it to deteriorate and eventually to be destroyed. Just as the body is prone to disease, he says the soul, too, is open to injustice and ignorance. In other words, he claims that a soul can only be destroyed by its own specific evil, its own inner weaknesses, thus applying the cause and effect theory. There is no proof that the soul is made morally worse by life. Nor is there proof that a soul's specific affliction to amorality can harm or destroy it, however. Therefore, Plato concludes that the soul had to be indestructible and thus had to be immortal. PTSD travelers know it is.

Aristotle was Plato's student, and in *De Anima*, Latin for "On the Soul", he portrays the vital functions of all animate organisms in relationship to the soul as non-corporeal. Moreover, he seems to think that all soul-related abilities of plants, beasts and humans require bodily parts and organs.

Human thought involves activity of the perceptual apparatus. Thus, he says it requires the proper arrangement of suitable body parts and organs. He also says *phantasmata* — sensory impressions — are involved in every act of human thought. He argues that only the immaterial mind, the agent intellect, is able to exist without the body, and thus is immortal.

Perhaps the most important argument in the whole book is Aristotle's demonstration of how the thinking part of the human soul is immortal (Ch. V). He

takes a premise from his *Physics*, that as a thing acts, so it is. He argues that, since the mind acts with no bodily organ, it exists without the body. And if it exists apart from matter, it therefore cannot be corrupted. Therefore the human mind is immortal. See *Stanford Encyclopaedia of Philosophy: Aristotle's Psychology* for a complete account.

Two dominant Hellenistic schools, Epicurus' Garden and the Stoa, came to share a common set of beliefs:

- the soul is corporeal reasoning
- only bodies affect one another
- soul and body do affect one another in cases of bodily damage and emotion

Both doctrines hold that the soul is a particularly fine kind of body, diffused all the way through the perceptible organism's animate flesh-and-blood body. They believe that the soul is dispersed at death, along with its constituent atoms. Thus, it loses the powers that it has while contained by the body of the organism it ensouls.

For Epicurus (341–270 BC), an atomist, the soul is made of atoms, like everything else except for the void. He admitted that atoms do not always follow straight lines, but occasionally swerve. This allowed him to avoid the determinism implicit in the earlier atomism and to affirm free will.

Compare this with the modern theory of quantum physics. It postulates a non-deterministic, random motion of fundamental particles. (Physicist Nassim Haramein explains this brilliantly in his YouTube lectures).

Epicurus is unclear as to the kinds of materials he takes to be involved in the composition of soul. He explains perceptual beliefs in terms of sense-impressions and the application of concepts. In turn, he explains concept-formation in terms of sense-impression. He views memory as preconception, cognition, correct belief, conception or universal 'stored notion' of what is often externally evident.

Epicurus also asserts that death ought not to be feared. He says that when a man dies, he does not feel the pain of death because he no longer is, and he therefore feels nothing. Therefore, he said: "Death is nothing to us." When we exist, death is not. When death exists, we are not. As we shall see, Epicurus is not the only who knows this. All sensation and consciousness ends with death. Therefore in death, there is neither pleasure nor pain. The fear of death arises from the false belief that in death there is awareness and ignorance, and thus fear, of the afterlife.

Stoicism was a school of Hellenistic Philosophy founded in Athens by Zeno of

Citium in the early 3rd century BC. It flourished throughout the Roman and Greek world until the 3rd century AD. Predominantly a philosophy of personal ethics, stoicism is informed by its system of logic and its views on the natural world.

The Stoics taught that emotions resulted in errors of judgment. These errors were destructive due to the active relationship between cosmic determinism and human freedom and the belief that it is virtuous to maintain a will that is in accordance with nature. Because of this, the Stoics presented their philosophy as a religion (*lex divina*). They thought that a person's philosophy was revealed not by words, but by behaviour. To live a good life, one had to understand the rules of the natural order, since they taught that everything was rooted in nature.

According to stoicism, the path to happiness for humans is found in accepting each moment as it presents itself. Happiness is not allowing ourselves to be controlled by our desire for pleasure or fear of pain. It is by using our minds to understand the world around us. Happiness comes when we do our part in nature's plan and when we work together and treat others in a fair and just manner.

The stoic philosopher Chrysippus (279–206 BC) agrees that the human soul is immortal, surviving the person's death by separating from the perceptible body. He apparently thought that souls of wise people persisted as fine, imperceptible corporeal structures all the way to the next conflagration in the cosmic cycle. He also believed that souls of other people lasted for some time, before being dispersed. Thus, Chrysippus accepts for the souls of the wise what Socrates' claimed — that the soul is altogether indissoluble "*or nearly so*" (*Phaedo* 80b).

Stoic physics allows for three kinds of *pneuma,* meaning "breath". They differ in two ways. First, in degree of tension from the expanding and contracting effects of two constituents. Second, in their consequent functionality.

The lowest kind of *pneuma* accounts for the cohesion and character of inanimate bodies (e.g. rocks). The intermediate kind called natural *pneuma* accounts for the vital functions characteristic of plant life. And the third kind is soul, which accounts for the reception and use of impressions or representations — *phantasiai* — and impulse, which generates cognition and desire.

Evidence suggests that Stoic theory found all three kinds of *pneuma* in the body of an animal. In fact, it advocates the tri-partition of the soul. The lowest kind would be responsible for the cohesion and character of parts like teeth and bones. Natural *pneuma* would be in charge of metabolism, growth and the like. And soul would account for distinctively mental and psychological functions. In humans, this would be the cognition by sense, intellect and desire.

If this is indeed the Stoic belief, the soul is not responsible for all vital functions and aspects of life, but only for specifically mental or psychological functions. In limiting the functions of soul, the Stoics may well have played part in the Cartesian concept of mind. This concept asserts that the mind is not something that animates living bodies. As evidence on Stoic theory seems to be scarce and difficult to interpret, however, much remains guesswork. Nevertheless, the Stoic psychological framework seems to suggest that minds of adult humans include motivationally relevant forces that do not depend on assent or reason. In other words, they are not fully subject to rational control.

Ancient philosophy and theorization, speculations and pontifications by philosophers on the soul, did of course continue through the ages. Christian writers, such as Clement of Alexandria and Gregory of Nyssa, continued this entertainment of the unknown. They used especially Platonic philosophical theories of soul as their basis to introduce their own hypotheses, phantasmata and phantasiai. They used these for their own financial and psychological advantages when spreading their hypotheses.

Does a person's soul exist? Does it play a significant part in a human's life? Does it survive a person's death? Empirical, scientifically documented evidence is hard to obtain, though. So much better for psychology practitioners of all ranks and colours. Thus, they deny its existence and ignore it altogether, which they do brilliantly. As a matter of fact, it seems to be their only expertise, at least in the PTSD field of knowledge.

But that does not matter at all, right? Their lack of knowledge about the soul and death, and dying in general, inflicts great psychological pain on other humans and, by extension, on themselves. I propose that they, too, occasionally wonder: "What will happen to me when I leave the Earth? Where will I go after death?" I understand from Elisabeth Kuebler Ross' book *On death and Dying*: *What the Dying Have to Teach Doctors, Nurses, Clergy & Their Own Families* (A. Scribner, Simon & Schuster Inc., NY, U.S.A. 2014), these are questions most humans ask on their deathbed. For the PTSD-afflicted, it has already been answered. There is no death. There is merely a passing on to another level of vibration, another sphere of reality.

Once the decision to live has been made, consciously or subconsciously, "Why am I here?" should be the next question to ask the Self. That is if we allow Self time for contemplation, rather than running away from it by mind-numbing pharmaceutical medications and opiate remedies, such as marijuana, ecstasy and the like. When in the PTSD condition with a clean slate to fill, "Why am I here?" is

possibly the most difficult question to answer. But it can be done. Where there is a will there surely is a way, and Michael Newton is a most wonderful educator on finding one's soul purpose en route the PTSD journey of recovery.

Questions have to be answered, decisions must be made.

- Why am I here? What am I doing here?
- Do I want to be here?
- Do I have a way out now? What is it?
- Which way do I have to go?
- What happens if I take my own life? What are the consequences if any?
- Is it worth it to stick around?
- Is there a purpose?
- How can I help myself?

Questions upon questions upon questions about life and living piled up a mile high, one upon the other, it seems. These questions are all unanswerable with any degree of certainty. There is definitively none of the empirical evidence so cherished by academia. There is only the supposition that, in a well-ordered universe, a reason there must be.

Thus there are a multitude of opinions and suggestions to discover. There are a multitude of avenues to explore and contemplate the all-important issue of life and living. There are a multitude of ways to find the answers necessary to heal the PTSD-affected soul. These answers can be found only within the Self, if brave enough to look within. Answers of immense value from outside sometimes suddenly pop up out of nowhere. They come from places of knowledge:

- public libraries
- seminars and lectures
- metaphysical bookstores
- night schools and universities
- even conversations with complete strangers

These answers serve the Self. They give clarity when applied within the Self, if brave enough to look within and clean out the pile of emotional manure.

This personal assessment of one's own Self is the innermost self-examination

and evaluation. It is jump-started by the PTSD-causing event. It is my understanding that, if ignored, it will prohibit all enjoyment during this lifetime. It would slowly but surely strangle the Self to death by misery all by itself. So perhaps, for all we know, the path in this lifetime is to understand that life and living is all about enlightening and helping ourselves, as everything flows from the Self?

Books are wonderful sources of information about the soul and its purpose. They tell us about the inner peace felt when recognizing and accepting that imminent departure from Earth was unavoidable. It has always lived in one's mind, making "sticking around" so much more difficult. Books are great places to gain knowledge about the reason and meaning of life, which seems to be most urgent.

For me, Michael Newton's *Journey of Souls* was *the* book. It made crystal clear to me that an untimely and wilfully forced departure from this Earth was out of the question. I did not want to have my own death on my conscience. A certified Master Hypnotherapist and member of the American Counselling Association, Newton (1931–2016) held a Doctorate in Counselling, was faculty at higher educational institutions as a teacher and was active in private practice in Los Angeles, California, USA. He developed his own age regression techniques to effectively take his hypnosis subjects beyond their past life memories. They went to the more meaningful soul experience between lives. Thus, they uncovered the mysteries of our life in the "spirit world."

In *Journey of Souls,* Newton narrates and comments upon the progressive "travel log" of 29 clients. These travel logs describe what happened to them in between their earthly reincarnations. They reveal graphic details about:

- how it feels to die
- what the spirit world is really like
- where we go and what we do as souls
- who meets us immediately after death
- why and how we choose to come back in certain bodies

In this book, Newton summarizes 10 years of research working with people he placed in a state of deep hypnosis, during which they recalled their experiences between lives as eternal spirits. It all came about when Newton was regressing his clients back in time to access their memories of former lives. He discovered that it was possible to see into the spirit world through the mind's eye of his subjects in their hypnotized or super-conscious state. He found that clients in this altered state

were able to tell him what their soul was doing between lives on Earth. Newton's insights help us understand the purpose behind our life choices and how and why our soul — and the souls of those we love — lives eternally. So says Kevin Williams in his *Journey of Souls* in-depth compilation and analysis "Dr. Michael Newton's Journey of Souls Research", published on near-death.com.

First, Newton points out, some souls are spiritually damaged before dying. Sometimes, they are so severely damaged that they are detached from the mainstream of souls going back to spiritual home base after death. Fortunately, the damaged souls are few, compared to all returning entities.

Second, there are two other types of displaced souls. There are those who fight returning to the spirit world. These souls do not accept the fact that their physical body is dead, due to reasons of personal anguish. These spirits are said to often have unpleasant influences on those wanting to finish their human lives in peace and quiet. We call them ghosts, but sometimes we call them demonic spirits, because they are accused of invading people's minds with harmful intent, as seen in exorcism rituals.

There are also those who have been subverted by, or had complicity with, criminal abnormalities when in their human body.

After physical death, souls end their journeys back home by debarking into the space reserved for their own colony, as long as they are not very young or isolated for other reasons.

Those subverted from the mainstream due to criminal acts committed while on earth in the spirit world undergo separation at the time of orientation, with guides greeting them upon arrival. They travel different routes than other souls. They go into seclusion upon re-entering the spirit world. And they are seemingly kept apart from other entities for quite a while.

Because wrongdoing on Earth takes so many forms, spiritual instruction and the type of isolation is different for each soul. The nature of each variation is apparently evaluated during spirit-world-orientation at the end of each life. The relative time of seclusion and re-indoctrination is not consistent, either. "For instance," says Newton, "I have had reports about maladjusted spirits who have returned back to Earth directly after a period of seclusion in order to expunge themselves as soon as possible by a good incarnated performance."

All souls, regardless of experience, will eventually arrive at a central port in the spirit world. Newton calls this the staging area. Once past the orientation station, there seems to be no further detours for anyone entering this space. Apparently,

large numbers of returning souls are conveyed in a spiritual form of mass transit. Spirits are brought in, collected, and then projected out to their final destinations. It's a lot like a central terminal of a metropolitan airport, able to fly people out in any direction. This way, they can join their soul-groups, people with whom they have shared oft times numerous lives. The most outstanding characteristic of this world is a continuous feeling of a powerful mental force directing everything in uncanny harmony. It's a place of pure thought.

Group placement is determined by soul level. First, souls are joyously welcomed into their soul groups. Then they are summoned to appear before the Council of Elders. Although not prosecutorial, the council examines souls' activities before returning them to their groups.

The souls in these cluster groups are intimate old friends who have the same awareness level. Members of the same cluster group are closely united for all eternity. These tightly knit clusters are often made of like-minded souls with common objectives, which they continually work out with each other. Usually they choose lives together as relatives and close friends during their earthly incarnations.

The levels of soul groupings at this stage seem to be arranged into Beginner and Intermediate Souls. There appear to be two types of Beginners:

- truly young souls, in terms of exposure to an existence out of the spirit world
- souls who have been reincarnating on Earth for a long period of relative time, but remain immature

Newton believes that almost three-quarters of souls in human bodies on Earth are still in the early stages of development. At full maturity, by the way, souls are said to end their incarnation on Earth. However, some might choose to return to help those dwelling upon her.

Beginner Souls may live a number of lives in a state of confusion and ineffectiveness. They might be influenced by an Earth curriculum different from the coherence and supportive harmony in the spirit world. The lesser developed the soul, the more inclined it is to surrender its will to the controlling forces of human society and its socio-economic structure. This causes many souls to become subordinate to others.

Souls can be stifled by a lack of independent thinking. This is mostly honed by governmental educational systems, television, mass media and complete

dependency on others. Dependence comes through I-phones and the like, in combination with an indoctrinated absence of individual discipline, willpower, determination and persistency. Thus, inexperienced souls not only tend to lean towards self-centeredness, but are also unable to see and accept others for who they are.

Mind you, everyone on Earth was once a Beginner. Once our soul advances into the intermediate ranges of development, there seems to be much less group cluster activity. This does not mean we return to the kind of isolation of novice souls. It means that souls evolving into the middle development level have less association with primary groups, because they have the maturity and experience to operate more independently.

These souls also reduce the number of their incarnations, as they are at last ready for more serious responsibilities. The relationship we have with our Guides at this point changes from teacher-student to one of colleagues working together. Our old Guides get new student groups, and it is now our turn to develop teaching skills. This eventually qualifies us for the responsibilities of being a Guide to someone else. Needless to say, this is a significant stage for our soul development. We are now handed an ever-increasing responsibility to guide younger souls.

Thank heavens the responsibility and status of a guide is bestowed upon us gradually. As with many other aspects of soul life, we are carefully tested on that path of learning. The intermediate levels are trial periods for potential teachers. Our mentors assign us one soul to look after. They then evaluate our leadership performance, both in and out of physical incarnations. Only if this preliminary training is successful, are we allowed to function at the level of Junior Guide.

Of course, not everyone is suited for teaching. This does not keep us from becoming advanced souls. Guides, like everyone else, have different abilities and talents, as well as shortcomings. By the time we reach the advanced level our soul aptitudes are well known in the spirit world. We are given occupational duties suited to our abilities, as different approaches to learning eventually bring all of us to the same end — spiritual wholeness.

I can feel through my whole being that this process is ongoing while we dwell on earth. When I grieved and reviewed my previous life during those four months following the PTSD-causing event, I saw how many *Angels,* my Guides, had been and were part of it. Later, with the help of *Journey of Souls* and Michael Roach's book *The Diamond Cutter,* I became increasingly aware of life's infinity. I also awakened to the daily opportunity to be an Angel to *The Other* — my fellow soul-travelers

presently dwelling on Earth — or not. The choice is mine, and therefore, yours as well.

15

Touched By An Angel

The American television series *Highway to Heaven* and *Touched by an Angel* portrayed and explored the Guardian Angel theme to perfection.

In *Highway to Heaven*, running from 1984 to 1989, actor Michael Landon depicts Jonathan Smith. Smith is an angel sent down to earth "on probation" with the mission to do enough good to regain his wings and, presumably, ascend to heaven. He pairs up with his human partner and friend, Mark Gordon, played by actor Victor French. The two follow assignments dictated by "The Boss," God. To complete the assignments and help troubled souls overcome their problems, they must use their humanity:

- empathy
- kindness
- gentleness
- compassion
- encouragement
- generosity in all aspects of the word

They helped families dealing with sick loved ones and people experiencing loss of a family member, such as war widows. They gave encouragement to people considered all-around losers, to help them find self-worth. They helped people struggling to lead their flocks. They encouraged greedy businessmen to use their wealth and charlatans to use their civil rights to help others, rather than to squander it away on personal gains. They discouraged prejudice towards people of different ethnicities, socioeconomic backgrounds, disabilities and other social issues.

Dealing sensitively with those situations, the show also used humor, in particular between Jonathan and Mark. Their personalities often clashed. Angel Jonathan was much more sensible and compassionate, but naïve. Mark was more cynical and pragmatic. Despite it all, they always supported each other.

Touched by an Angel (1994 to 2003) was billed as a supernatural drama television series. It starred Roma Downey as young Angel Monica, and Della Reese as her supervisor Tess. Throughout the series, Monica is tasked with bringing guidance and messages from God to people at crossroads in their lives. The angel of death Andrew, played by John Dye, frequently joins them in their endeavours to help human beings.

The episodes generally revolved around Monica's cases. She had first participated in the heavenly choir and annunciation, and had been recently promoted from the "search and rescue" division. When people face large problems or tough decisions, Monica and Tess give them messages of hope from God and give them guidance towards making right decisions. As time goes by, Monica gains experience as a caseworker and learns some lessons of her own.

During one of Monica's assignments, God sent her a trainee Angel and instructed Tess to act as supervisor. She does well and is up for promotion to supervisor, pending the outcome of a difficult case. She must defend an innocent drifter accused of causing a boiler explosion at a small town school, killing most of the children and leaving the citizens devastated. Even though there is no evidence, only the hear-say words of an out of town developer, the drifter is convicted.

Monica did all she could to help him, but the prosecutor, Satan in disguise, outfoxed her. After the trial, she helps citizens see their mistake of a wrong conviction, but cannot free the prisoner. Visiting him in jail, however, she reveals her Angel status. She promises to be his guardian angel forthwith to protect him from harm in prison by foregoing her coveted promotion.

When she returns the next morning, his cell is empty. The citizens decide not to search for him. That is when she learns the drifter was God, and that her defense of him was a test, which she passed with flying colours, due to her willingness to dedicate her life to him. Her promotion to supervisor thus granted, Tess leaves her job to rest at God's feet.

With that in mind, let us see what the *Journey of Souls* has to say about our possibilities of advancements. Is it dictated by our own behaviour towards Self and others, and do we have a say in it?

16

The Advanced Soul

As noted, Newton believes that old and highly advanced souls are scarce on Earth. With their high maturity, they would rarely, if ever, seek out a life-regression therapist to resolve life-plan conflicts. In most cases, they would be Earth dwellers acting as incarnated Guides.

Having mastered the fundamental issues most humans wrestle with every day, advanced souls are much more interested in making small refinements toward their own specific tasks. They go about their good works in a quiet and unassuming manner, without displaying self-indulgence. Their fulfillment comes from improving other people's lives, as they focus more on enhancing individual human values than on institutional matters.

The mark of an advanced spirit is having patience with society and showing extraordinary coping skills. Most prominent is their exceptional insight. This is not to say life has no karmic pitfalls for them; otherwise, they probably would not be here at all. Found in all walks of life, the advanced soul is frequently in the helping professions or combatting social injustice, in some fashion radiating composure, kindness and understanding toward others. Not being motivated by self-interest, they may disregard their own physical needs and live in reduced circumstances. In between lives, these souls return to the heavenly realm, but will return to Earth sooner or later to continue their evolution.

When the time comes for souls to once again leave the sanctuary of the spirit world for another trip to Earth, here is what happens. Souls must first prepare to leave a world of all-encompassing wisdom, where they exist in a blissful state of freedom. In exchange, they will shoulder the physical and mental demands of a physical body. Needless to say, once back in the spirit world, souls have misgivings about even temporarily leaving. It's not easy to trade self-understanding, comradeship and compassion for a planetary environment of uncertainty and fear brought about by aggressive and competing humans. Despite having family and friends on Earth, many incarnated souls feel lonely and anonymous among large, impersonal populations.

The rejuvenation of energy and the personal assessment of one's own Self on planet Earth after so-called death takes longer for some souls than others. Newton claims, however, that eventually the soul is motivated to again start the process of incarnation. How? While our spiritual environment is hard to leave, we also remember the physical pleasures of life on Earth with fondness and even nostalgia. Thus when the wounds of a past life are healed and we again are totally at one with ourselves, we seem to feel the pull, the desire, of having another physical expression for our identity — a yearning to return to Earth.

Training sessions with our counselors and peer groups provide a collaborative spiritual effort to prepare us for the next life. Our karma of past deeds towards humanity, as well as our mistakes and achievements, have all been evaluated with an eye toward the best course of future endeavors. We, as souls, must now assimilate this information and take purposeful action based upon three primary decisions:

1. Am I ready for a new physical life?
2. What specific lessons do I want to undertake to advance my learning and development?

3. Where should I go and whom shall I be in my next life for the best opportunity to work on my goals?

Thus, the soul makes the decision to incarnate again. The next stage in the return process is the visit to the place of life selection where Souls consider when and where they want to go on Earth before deciding who to be in their new life. Spiritual locales for life selection are difficult for subjects to describe. However, they are said to resemble movie theaters in which souls are allowed to see themselves in the future playing different roles in various settings. They preview the life span of more than one human being within the same time cycle.

When leaving this area, most of us are said to be inclined toward one leading candidate for our soul's occupation. However, our spiritual advisors give us ample opportunity to reflect on what we have seen as our possible future before we choose a path or life. In other words, we take responsibility for the life we are going to live, for better or for worse, before we ever touch down.

The souls decide when to incarnate after they complete their consultations with Guides and peers about the many physical and psychological ramifications of a new life- and body-choice. It would seem logical that they would then go immediately to Earth. However, this does not happen before much preparation.

Souls first visit what in the spirit world is commonly called the "place of recognition", or recognition class. Newton's subjects say the activity there is like cramming for a final exam.

After that, and one of the last requirements before embarking for many souls, is to appear the second time before the Council, who wants to reinforce the significance of a soul's goals for the next life.

Some return to their spirit group after this meeting to say goodbye. Others leave immediately for reincarnation. Those souls getting ready to go to Earth are like battle-hardened veterans, girding themselves for combat. This is the last chance for souls to enjoy the omniscience of knowing just who they are before they must adapt to a new body. This is their last chance to know that their return to the spirit world, an environment personified by order, is guaranteed.

We are furthermore given to understand that finding our place in the spirit world starts a deep process of healing. It shows us the purpose behind significant life choices and how and why our soul — and the souls of those we love — lives eternally.

By reading Newton's book, I gained a better understanding of my soul's immortality. In particular, by way of my meditation, I learned or glanced that I had

lived a similar experience to the PTSD-causing event in another life. In that one, I did not fare well at all. I also believe, as the author suggests, that I could meet the challenges of this one with a greater sense of purpose, as I began to understand the reasons behind events in my own life.

I seemed to breathe easier. There was a meaning in this madness of living a life. There was a reason for the PTSD experience. There was a reason to complete this exercise, a feeling nothing was for naught, and what goes around comes around. I saw that everything I did would resonate with someone for better or for worse, depending on my own behaviour, my own actions. It may even have given me some sense of power at the time, without realizing it.

17

The Destiny Of Souls

Newton's second book *Destiny of Souls* is, in my opinion, equally valuable for the PTSD experiencer. He expanded my understanding of the incredible sense of order and planning in the Spirit World for the benefit of human beings. You can peruse the book on Unicus Magazine's website, with Dr. Newton's introduction.

Newton says that at the moment of death, our soul rises out of its host body. Later, the world-renowned Scottish psychiatrist R.D. Laing confirmed it, as we shall see later. I knew this not only from the latest PTSD experience. I had also lived it in another life when the ship I captained — my ship — ran into a typhoon and sank. It took 32 bodies and me with it into the deep blue sea, our souls having long before departed.

If the soul is older and has experience from many former lives, Newton says, it knows immediately it has been set free and is going home. No one needs to greet those advanced souls. They've returned many times before; they know the drill.

Most souls Newton worked with, however, were met by Guides just outside Earth's astral plane. A young soul or a child who arrives may be a little disoriented until someone comes closer to ground level for them.

Some souls choose to remain at the scene of their death for a while, but most want to leave at once, experiencing the Let-me-get out-of-here syndrome. Discarnates who choose to comfort someone who is grieving or have other reasons to stay near the place of their death for a while, experience no sense of time loss. Time has no meaning in the spirit world. It becomes now-time for the soul, as opposed to linear time, as vividly portrayed in Richard Matheson's 1978 novel *What Dreams May Come*. PTSD experiencers already know this truth, as they have lived it. There is no time and still there always seems to be the right time for everything once we tune into the Self.

After shedding their bodies, souls are said to have an increasingly brilliant light around them as they move farther away from Earth. Some will briefly see a grayish darkness and will sense passing through a tunnel or portal. The difference between these two phenomena depends on the soul's exit speed. That, in turn, relates to its experience.

The pulling sensation from our Guides might also be gentle or forceful, depending on our soul's maturity and capacity for rapid change. In the early stages of their exit, all souls encounter a "wispy cloudiness" around them. As it soon becomes clear, they can look off into a vast distance. This is the moment when the average soul sees a ghostly form of energy coming toward them. This figure could be a loving soul mate or two, but more often than not it is our Guide. When we are met by a spouse or friend who has passed on before us, our Guide is also close by to take over the transition process.

Throughout his years of research, Newton never had a single subject who was met by a major religious figure like Jesus or the Buddha. By the time souls become reoriented again to the place they call home, the spirit world, their earthliness has changed. They are no longer quite human in the way we think of a human. They no longer have a particular emotional, temperamental and physical makeup. They do not grieve about their recent physical death in the way their loved ones left behind do. It is our souls that make us human on Earth, but without our bodies we cease to be humans.

The soul's majesty is beyond description. Newton urges us to think of souls as intelligent light forms of energy. Right after death, no longer encumbered by a temporary host body with a brain and central nervous system, souls suddenly feel quite different. Some take longer to adjust than others. The soul's energy, by the way, is also said to be able to divide into identical parts similar to a hologram. It can live parallel lives in other bodies, although Newton says this is much less common than may be read about. Because of this capability, however, part of our light energy always remains behind in the spirit world. Thus, it is possible to see one's mother upon returning from a life, even though she may have died thirty Earth years before and has reincarnated again.

Orientation periods with our Guides take place before joining our cluster group. These periods, vary between souls and between different lives for the same soul. This is a quiet time for counselling and the opportunity to vent any frustrations we have about the life just ended. This is also an initial debriefing session, with gentle probing by perceptive, caring teacher-guides. It may be long or short, depending on the circumstances of what we did or did not do to accomplish our life contract. Special karmic issues are also reviewed, although they will be discussed later in minute detail within our soul cluster group.

Souls contaminated by their physical bodies and who became involved with evil acts are not sent back into their soul groups right away. Apparently, there is a difference between wrongdoing with no premeditated desire to hurt someone and intentional evil. The degrees of harm to others from mischief to malevolence are also carefully evaluated. Souls who have been associated with evil go to special centers. Some of Newton's clients call them *intensive care units,* where their soul energy is remodelled to make it whole again.

Depending on the nature of their transgressions, these souls could be returned to Earth rather quickly. That gives them the chance to serve as victims of the evil acts of others in the next life. If their actions were prolonged and especially cruel over a number of lives, however, this would denote a pattern of wrongful behaviour. Such souls could spend a long while in a solitary spiritual existence, possibly over a thousand Earth years or more. A guiding principle in the spirit world is that intentional or unintentional wrongdoing on the part of all souls must be redressed in some form in a future life. This is not considered punishment or even penance, as much as an opportunity for karmic growth. There is no hell for souls, except perhaps on Earth itself, states Newton.

Some lives are so difficult that the soul arrives home very tired. Despite the

energy rejuvenation and replenishing process initiated by our guides, who combine their energy with ours at the gateway, we might still have a depleted energy flow. In these cases, more rest and solitude may be called for, rather than celebrations. Many souls who need rest receive it before rejoining their groups.

Our soul groups may be boisterous or subdued, but they are respectful of what we have gone through during an incarnation. They welcome back their friends with deep love and camaraderie. Most of Newton's subjects told him they were welcomed back with hugs, laughter and much humour. He found this to be a hallmark of life in the spirit world. The really effusive groups, who have planned elaborate celebrations for the returning soul, may even suspend all other activities. One subject of his said about his homecoming:

> "After my last life, my group organized one hell of a party with music, wine, dancing and singing. They arranged everything to look like a classical Roman festival with marble halls, togas and all the exotic furnishings prevalent in our many lives together in the ancient world. Melissa, a primary soul-mate, was waiting for me right up front re-creating the age that I remember her best and looking as radiant as ever."

Soul groups range between three and 25 members, the average having about 15. How a subject views the group cluster setting is based on the soul's state of advancement, although memories of a schoolroom atmosphere are always very clear. In the spirit world, educational placement depends on the level of soul development. Simply having been incarnated on Earth since the Stone Age is no guarantee whatsoever of high attainment. Newton relates one experience:

> "In my lectures I often remark about a client who took 4,000 years of past lives finally to conquer jealousy. I can report he is not a jealous person today. Yet he has made little progress with fighting his own intolerance."

Just as in any earthly classroom, some students take longer than others to learn. On the other hand, all highly advanced souls are old souls in terms of knowledge and experience. Newton explains:

> "In *Journey of Souls* I broadly classified souls as Beginner, Intermediate and Advanced and gave case examples of each, while explaining there are fine nuances of development among these categories. In general, the composition of a group of souls is made up of beings at about the same level of

> advancement, although they have their individual strengths and shortcomings. These attributes give the group balance."

Souls help each other with the cognitive aspects of absorbing information from life experiences. They review the way they handle the feelings and emotions of their host bodies directly related to those experiences. To bring greater awareness, every aspect of a life is dissected, even to the extent of reverse role-playing in the soul group, to bring greater awareness. By the time souls reach the intermediate levels, they begin to specialize in major areas of interest where they have shown skill.

Another very meaningful aspect of Newton's research was his discovery of energy colors displayed by souls in the spirit world. These colors relate to a soul's state of advancement.

> "This information, gathered slowly over many years, has been one indicator of progress during client assessments and also serves to identify other souls my subjects see around them while in a trance state. I found that typically, pure white denotes a younger soul, and with advancement the soul energy becomes denser, moving into orange, yellow, green and finally the blue ranges. In addition to these center core auras there are subtle mixtures of halo colors within every group that relate to each soul's character aspects. For want of a better system I have classified soul development as moving from a level I beginner through various learning stages to that of a master at level VI."

Level VI souls are greatly advanced, with a deep indigo color.

> "I have no doubt even higher levels exist, but my knowledge of them is restricted, because I only receive reports from people who are still incarnating. Frankly, I am not fond of the term 'level' to identify soul placement, because this label clouds the diversity of development attained by souls at any particular stage. Despite these misgivings, it is my subjects who use 'level' to describe where they are on the ladder of learning. They are also quite modest about accomplishments. Regardless of my assessment, no client is inclined to state they are an advanced soul. Once out of hypnosis, with a fully conscious self-gratifying mind in control, they are less reticent."

While in a super-conscious state during deep hypnosis, Newton's subjects tell him that in the spirit world, no soul is looked down upon as having less value than any other soul. All are seen to be in a process of transformation to something greater than our current state of enlightenment. Each of us is considered uniquely qualified to make some contribution toward the whole, no matter how hard we struggle with our lessons. If this were untrue, we would not have been created in the first place.

Thus, we could again deduce that PTSD-affected people chose this opportunity of a life-time to create the Self. The soul has chosen this situation before ever touching down on Earth. Now, it has the choice to fulfill or not fulfill the contract, depending on the willingness to examine and dissect the Self. We must slowly and surely take responsibility for everything that occurred and was done in pre-PTSD-causing event. We must forgive the Self for all perceived wrongdoings and misbehaviours committed. We must develop gratefulness for everything, including this almost mindboggling experience. We must create the new Self by the insights made thus far during this present earthly journey. Else, we end up listening to those proclaiming to be PTSD experts, and allow their destructive remedies to destroy us, as they surely will. Again, you kick into gear, or you die a slow and gruesome, miserable death while making them richer and ourselves immensely poorer both while on the Earth and in the spirit world. It is our choice to take or leave it. Let's not forget, if we take up the challenge we already get an A for effort.

We might assume colors of advancement, levels of development, classrooms, teachers and students make the spirit world one of hierarchy. Such a conclusion is quite wrong. According to Newton's clients, the spirit world is hierarchical only in mental awareness.

> "We tend to think of organizational authority on Earth as represented by power struggles, turf wars, and the controlling use of a rigid set of rules within structure. There certainly is structure in the spirit world, but it exists within a sublime matrix of compassion, harmony, ethics, and morality far beyond what we practice on Earth. In my experience the spirit world also has a far-reaching centralized personnel department for soul assignments. Yet there is a value system here of overwhelming kindness, tolerance, patience and absolute love, and when reporting to me about such things, my subjects are humbled by the process."

That's a soothing thought! Here's another one, still by Newton.

> "An old college friend of mine, an iconoclast [a person who attacks cherished beliefs or institutions] who resisted authority all his life suspects that the souls of my clients have been 'brain-washed' into believing they have control over their destiny. He believes authority of any kind, even spiritual authority, cannot exist without corruption and the abuse of privilege and power."

For him, there is too much order in the heavenly realm for his liking. Regardless, all of Newton's subjects believe they have had plenty of choices in their past lives and that this will continue into the future. They claim that advancement through personal responsibility does not involve dominance or status ranking, but rather recognition of potential interests where certain skills have been shown. Furthermore, they claim to see integrity and personal freedom everywhere in their life between lives. For me, it shows that honour, integrity and graciousness, combined with discipline, determination, willpower and persistency, create and rule our lives.

We are also assured, we Earthlings living with or without the PTSD experience right now, that when returning to the spirit world, we are not forced to reincarnate or participate in group-projects. We know we are free to do our own thing. Souls can have the solitude they want. And if we wish to put our advance in assignments on hold, that, too, is honoured. One subject, for example, had skated through many easy lives and liked it that way, because he had not wanted to work hard. Sooner or later, however his Guides would prompt him to change, as learning has to take place. Souls also feel humble at having been given the opportunity to incarnate in physical form. We feel humble for the many choices already pointed out, both in and out of the spirit world. Those choices come from the intense desire of most souls to prove themselves worthy of the trust placed in them. "We are expected to make mistakes in this process," Newton shares. The prime motivator for our efforts is to move toward a greater goodness in conjunction with the Source that created us.

"I have been asked many times if my subjects see the Source of Creation during their sessions. In my introduction I said I could go only so far upriver toward the Source because of the limitations of working with people who are still incarnating." Advanced subjects do, however, talk about the time of conjunction when they will join the "Most Sacred Ones". "In this sphere of dense purple light, there is an all-knowing Presence. What all this means I cannot say, but I do know a Presence is felt when we go before our Council of Elders," the author shares.

In between lives, we are said to visit this group of higher beings a step or two above our teacher-guides once or twice, though. In *Journey of Souls*, Newton gave a couple of case examples of these meetings. In *Destiny of Souls,* he elaborates in greater detail on our visitations with these masters, who are as close as he could get to the Creator. It is here that the soul experiences an even higher source of divine knowledge from an energy force his clients called "the Presence." This council is not a tribunal of judges in a courtroom, where souls appear to be tried and sentenced for wrongdoing. But once in a while, someone would tell Newton that they felt that going in front of the Council was like being sent to the principal's office in school. Council members want to talk to us about our mistakes. They want to give us advice and suggest what we can do in the next life to correct negative behaviour.

It also seems that this is the time and place where considerations for the right body in our next life begin. That is when, as the time for rebirth approaches, we venture to a space where a number of bodies that might meet our goals for the future life are reviewed. It is here that we have the chance to look into the future and actually test out different bodies before making a choice.

Some souls voluntarily select less than perfect bodies and difficult lives to address karmic debts or to work on different aspects of a lesson they had trouble with in the past. Most souls accept one of the bodies offered to them in this selection room. According to the author, a soul can reject what is offered and even delay reincarnation at his point. A soul may even ask to go to a physical plane other than Earth for a while, we hear.

If we accept the new assignment as is, however, we are often sent to a preparation class to remind us of signposts and clues in the upcoming life, especially of those moments when primary soul mates come into it. Finally, when the time comes for our return, we say a temporary goodbye to our friends. We are escorted to the space of embarkation for the trip to Earth. We join our assigned hosts in the womb sometime after the third month of pregnancy, so the embryo has a sufficiently evolved brain to work with before birth.

During part of the foetus state, we are still able to think as immortal souls while we get used to brain circuitry and our host's alter ego. After birth, an amnesiac memory block sets in and souls meld their immortal character with the temporary human mind. This produces a combination of traits for a new personality. Newton describes his research:

> "Before I take the client down into their mother's womb, I use a systematic approach to reach the soul mind by

> employing a series of exercises for people in the early stages of hypnotic regression to take the subject into the deeper ranges of hypnosis for more questions, and then into the most immediate past life for a short review. By the time the client has passed through the death scene of that life and reached the gateway to the spirit world my bridge is complete. Continual hypnosis, deepening over the first hour enhances the subject's disengagement from their earthly environment. They have also been conditioned to respond in detail to an intensive question and answer interview of their spiritual life. This will take us another two hours. Subjects who come out of trance after mentally returning home have a look of awe on their faces that is far more profound than if they had just experienced a straight past life regression."

Surviving the loss of a loved one seems to be one of life's hardest trials. It is well known that the process of grief survival involves going through the initial shock. We then cope with denial, anger and depression, finally arriving at some sort of acceptance. Each one of these stages of emotional turmoil varies in length of time and intensity from months up to years. Losing someone with whom we had a deep bond can bring such despair that it feels as though we are in a bottomless pit, where escape is impossible because death seems so final. In my experience, this is how PTSD voyagers feel after the PTSD-causing event. If "treated" by the self-proclaimed mental health practitioners and PTSD geniuses who use the National Centre *for* PTSD treatment modalities, a PTSD recovery is impossible.

Newton saw that the belief in the finality of death in Western society is also an obstacle to healing. We live in a culture where the possibility of loss of personhood is unthinkable. The dynamics of death in a loving family is akin to a successful stage play thrown into disarray due to the loss of one of its stars. The supporting cast flounders around over the need for script changes. Just look at the disarray in families with a PTSD-affected actor to see how it works.

Dealing with this huge hole in the story line left by the dearly departed affects the future roles of the remaining players. That`s because in North American culture, no one properly prepares for death during life. Nay, people outright fear even the thought. With a PTSD affected person in their midst, it is even more difficult, because the dearly departed is still visible in the flesh.

"When discussing life after death on my lecture tours I was surprised to find that

many people who held very traditional religious views seemed to be the most fearful of death," Newton observed. In his view, the fear for most of us stems from the fear of the unknown. Unless we have had a near-death experience or undergone a past life regression where we remembered what death felt like in a former life, death is a mystery. Therefore, when we must face death either as a participant or as an observer, it can be painful, sad and frightening. The healthy do not want to talk about it and frequently neither do the seriously ill.

PTSD-affected people, however, have little choice but to look at physical death and the above-mentioned issues before leaving the Earth. If they want to live a contented life until the clock runs out, the computer dies, the consequent natural and blessed departure from this Earth adventure occurs, they have to face death. It is that simple.

Mind you, things have changed recently. Most people in the US during the early 20th century traditionally held that they had only one life to live. But over the past half century, an estimated 40 percent of the population believe in reincarnation. This change in attitude should make acceptance of death a little easier for people who have become more spiritual and no longer believe in oblivion after life. Newton explains:

> "One of the most meaningful aspects of my work in the spirit world is learning from the perspective of the departed soul what it feels like to die, and how souls try to reach back and comfort those left behind and that soul mates are never truly apart from each other, and that there are certain methods used by souls to communicate with those they love."

These methods of communications can begin right after physical death and can be very intense. Nevertheless, the departing soul *is* anxious to get moving on its way home, as Earth density drains its energy. This is depicted in *What Dreams May Come*. Souls are able to contact us on a regular basis from the spirit world. Quiet contemplation and meditation should provide our consciousness with a heightened sense of awareness and make us more receptive to the physically departed, advises Newton. No verbal messages from the other side are necessary. Just removing the blocks of self-doubt and opening our mind to even the possible presence of someone we love will help us recover from grief, the author shares.

Dr. Newton, in *Destiny of Souls,* uses 67 case studies and numerous quotes. He shares his findings as a reporter and a messenger, stating:

> "Before I begin every lecture to the public, I explain to my

> audiences that what I have to say are my truths about our spiritual life. There are many doorways to the truth. My truths come from an accumulation of great wisdom from a multitude of people who have graced my life as clients over many years. If I make statements that go against your preconceptions, faith, or personal philosophy, please take what fits well for you and discard the rest."

As I have often said, "He who has ears to hear will hear; he who has eyes to see will see."

PTSD experiencers have one advantage already, namely that death is not. Death simply does not exist. That eliminates the fear aspect. The huge problem is the distinct absence of desire to hang out on Earth any longer. It might be *the* greatest problem, enhanced by the initial shock of still being alive when the soul has left, then coping with the express disinterest in continuing this life. This disinterest is mirrored by apparent apathy in everything around, including ones formerly beloved and whatever else that was enjoyable before the PTSD-causing event. Only my dogs hauled me through that part of it.

Then comes the anger at having little choice but to either learn to cope with still being on Earth, or to accept this almost overwhelming desire to depart. The latter, of course, leads to the tedious decision of whether or not to physically die. That, in turn, might mean having to decide by what means, suicide included, with all the implications that involves.

As if that isn't enough to consume a person, we have to deal with the employer's lack of debriefing, compassion and empathy. The inane demands made by the V.A, stand as an example. No wonder, when one reads the *Daily Caller's* National Security/Politics Reporter Jonah Bennett's Dec. 3, 2017, article "VA Hired Doctors With Malpractice Claims, Felony Convictions Against Them."

A *USA Today* investigation found that the VA's hiring process for physicians may not be as thorough as it seemed. The process entails license verification and reference-checking. But it appears that VA officials have discretion when they discover medical licensing problems, malpractice or felony convictions. In other words, VA officials can simply disregard sordid pasts and approve hiring of questionable doctors. For example, in one case *USA Today* uncovered, a VA hospital in Muskogee, Oklahoma, brought on a psychiatrist in 2013, despite his history of actions against his medical license for sexual misconduct, among other things.

Physicians might even get kickbacks for shafting veterans and soldiers, as

recently reported in the news. This might very well take place at the WCB and other places with power over PTSD journeyers' emotional and financial stability. Thus, the powers that be perpetuate the existential crisis of PTSD.

This search to re-establish one's emotional equilibrium is further disturbed by interviews with so many mental health personnel clueless about what is needed to re-establish PTSD sufferers' equilibrium and peace. Or perhaps they do know and purposely and knowingly push their treatment modalities and pharmaceutical remedies. If so, they purposefully intensify the longing for the peace of mind we had for a few seconds when leaving the Earth was a certainty and having finished within seconds the life we had lived.

This constant turmoil leads to depression over the attitude and behaviour of one's fellow earthlings regardless of the roles they play. It leads to disdain and depression over the stench of attitude and evil permeating from those supposed to help. It leads to more turmoil when we can't understand why this is being done to us, because PTSD-affected people are wilfully kept apart to avoid comparing notes about the "treatment" we receive.

What if one does not cave in to their demands of drugging and cognitive-behavioural treatment modalities? The good news is that one has a good chance to arrive at some sort of acceptance of still being alive. One slowly learns to understand that grieving leads to nothing very productive for life's enjoyment. One will likely decide not to kill oneself. And with the help of books like Michael Newton's, one can learn to believe that there is indeed a meaning for this madness, and that it is one's duty to find the meaning.

Reading *Journey of Souls* and *Destiny of Souls* may be a good way to start out on the path of the dilemma and onto the road of PTSD recovery. Dr. Newton's final words of *Destiny of Souls* are:

> "Spiritual perception must be an individual quest or it has no meaning. We are greatly influenced by our own immediate reality, and we can act on that reality one step at a time without having to see too far into the distance. Even steps in the wrong direction give us insight into the many paths designed to teach us. To bring the soul Self into harmony with our physical environment, we are given freedom of choice to exercise free will in the search for the reasons why we are here. On the road of life, we must take responsibility for all our decisions without blaming other people for life's setbacks

that bring unhappiness."

As I mentioned, to be effective in our individual missions, we are expected to help others on their paths whenever possible. By helping others, we help ourselves. Reaching out to others is inhibited, when we nurture our own uniqueness to such an extent that we become totally self-absorbed. However, being an absentee landlord in your own house makes you ineffective as a person as well. You were not given your body by a chance of nature. It was selected for you by spiritual advisors and, after previewing their offerings of other host bodies, you agreed to accept the body you now have. Thus, you are not a victim of circumstance. You are entrusted with your body to be an active participant in life, not a bystander."

For PTSD voyagers, goal number one must therefore be to become ruler of one's own house! To uplift our mind from feelings of disenchantment, we must expand our consciousness. We must forgive ourselves for our mistakes. Newton says this is vital for our mental health. We must learn to laugh at ourselves and the ridiculous, foolish and funny predicaments we get into along life's road. Life is full of conflicts and struggle, pain and happiness experienced in individual measures in quantities precisely weighed in accordance with what each of us can handle. A hangnail is an equal crisis for one, as a PTSD crisis is for another. All are reasons for learning on Earth, and each day there can be a new beginning.

Furthermore we are not alone, says Newton. He is convinced that everyone on this planet has a personal spiritual Guide or Guides who speak to our inner mind if we are receptive and if we ask for help. While some Guides are more easily reached than others, each of us can call upon them and will be heard.

There are no accidents in life, nor is there randomness. It is the philosophy of ignorance that works against thoughts of spiritual order. It seems to be easier to feel we have no control in our lives, to resent taking responsibility for anything. It seems to be easier to view the enterprise of "finding ourselves" pointless, as if nothing we do matters anyway. Believing in this randomness of events negatively influences our reaction to situations. It allows us to avoid thinking about explanations for them. As a matter of fact, we take thus our own power away from ourselves with a fatalistic outlook on life by saying "It's God's will" or even "It's my karma." This contributes to inaction and lack of purpose, as I will go into in a later chapter.

That which is meaningful in life comes in small pieces or in large chunks all at one time, Newton conveys. Self-awareness, however, can take us beyond what we thought was our original destination. I know this, as I have lived it. That is the gift bestowed on us, the PTSD journeyers, by the PTSD experience. But we can claim

this gift only if we are able to fire the flickering soul-flame into enough enthusiasm to begin to investigate. And only if we are brave and gutsy enough to take on the powers that be and defeat them, rather than lie down flat and die — if not in body, then in heart and soul.

It is Newton's view that Karma sets in motion those conditions on our path fostering our learning. The concept of a Creator-Source orchestrating all of this need not be pretentious. Spiritual insight comes to us in quiet, introspective and subtle moments, manifested by the power of a single thought. Whether we listen or not, life is a constant change toward fulfillment, as our place in the world today may be different tomorrow. One must learn to adapt to these different perspectives in life, because that, too, is part of our chosen development plan. In so doing, there is a transcendence of Self from the masking of a temporary outer shell to that which lies deep within our permanent soul-mind, Newton explains:

> "Coming to Earth is about traveling away from our home to a foreign land. Some things seem familiar, but most are strange, until we get used to them, especially conditions, which are unforgiving. Our real home is a place of absolute peace, total acceptance and complete love. As souls separated from our home, we can no longer assume these beautiful features will be present around us. On Earth, we must learn to cope with intolerance, anger, and sadness, while searching for joy and love. We must not lose our integrity along the way, sacrificing goodness for survival and acquiring attitudes, either superior or inferior, to those around us. We know that living in an imperfect world will help us to appreciate the true meaning of perfection. We ask for courage and humility before our journey into another life. As we grow in awareness so will the quality of our existence. This is how we are tested. Passing this test is our destiny."

In my perception gathered from my own experience, this is why Webb claims that humans capable of questioning and applying analysis, reason and logic to their lives and its events are more likely to have an existential crisis, such as PTSD, than those just cruising through life. In other words, the PTSD experience, like all human soul experiences, was tailor-made and chosen by us, with our full knowledge, for the advancement of our souls before we ever touched down on Earth. It was created as an opportunity to grow into something bigger and better,

perhaps even a Guardian Angel, or falter.

How to handle the situation is our choice. That it is a do or die situation is just too bad. But it should sooth PTSD-effected spirits, if this knowledge floats to the surface of their minds. This can occur only when the system is free of mind-altering pharmaceutical drugs and marijuana, ecstasy and other shite of that genre. And it can happen only in combination with introspection, meditation, persistency, willpower, determination, discipline and research, whilst looking for understanding and love of the Self for the Self.

On Reincarnation

Reading especially *Journey* and *Destiny of Souls* should inspire a curiosity about the concept of Karma. This inevitably leads to an interest in Dharma. This leads to reincarnation, as the three concepts go hand in glove, one almost idiotic without the other.

Most people born and raised in the U.S. are said to either reject the idea of reincarnation outright or do not know much about it. In fact, most do not wish to know enough about it to even contemplate the issue, never mind make an informed decision about its possible validity.

Paranormal investigator Jeff Danelek of Denver, Colorado claims reincarnation has a good deal of hard evidence to support it. He also claims this evidence is

frequently more impressive than many people are aware. His book *The Case for Reincarnation* (Llewellyn Worldwide, 2010) presents a fascinating, thought-provoking examination of reincarnation and the elements involved. He addresses some key questions:

- What happens after we die?
- What is the Divine, the eternal soul?
- What happens to souls drawn to evil?
- What is the purpose of reincarnation?
- What are linear time, past-life memories and ghosts?
- What are spiritual lessons and the link between the spiritual and physical worlds?
- What is the role in this process of the soul, free will, karma, soul mates and God?

In this compelling exploration of reincarnation, Danelek sheds light on it all:

- the necessity of evil
- the mechanics of rebirth
- the influence of past lives
- the spiritual purpose of rebirth
- how the next physical life is chosen
- the difference between the soul and personality
- what happens between lives to illuminate the path to soul perfection.

In Danelek's opinion, the strongest and best-documented evidence of reincarnation, seems to have been documented by Dr. Ian Pretyman Stevenson (1918–2007). He was a Canadian-born U.S. psychiatrist. He studied psychoanalysis at the New Orleans Psychoanalytic Institute and the Washington Psychoanalytic Institute, graduating from the latter in 1958. He became head of the department of psychiatry at the University of Virginia a year later. He worked there for fifty years, first as Chair of the department of psychiatry, then as Carlson Professor of Psychiatry and Research Professor of Psychiatry until his death.

Stevenson described as the leitmotiv of his career his interest in why one person would develop one disease and another something different. He came to believe

that neither environment nor heredity factors could account for certain fears, illnesses and special abilities. He thought that some form of personality or memory transfer might provide a third type of explanation. His arguments against the orthodoxy within psychiatry and psychoanalysis were ill received by his colleagues. They did not warm up to his paper on the subject "Is the human personality more plastic in infancy and childhood?" (*American Journal of Psychiatry*, 1957) Their response prepared him for the rejection he later experienced over his work on the paranormal.

Never able to propose how personality traits might survive death, much less be carried from one body to another, he did not commit himself fully to reincarnation. He only argued that his case studies were unexplainable by environment or heredity. Thus, reincarnation was the best, albeit not the only, explanation for the stronger cases he investigated.

Stevenson's position was not a religious one. It represented what Robert F. Almeder (1939–), professor emeritus of philosophy at Georgia State University, calls the minimalistic reincarnation hypothesis:

> "There is something essential to some human personalities . . . which we cannot plausibly construe solely in terms of either brain states, or properties of brain states . . . and, further, after biological death this non-reducible essential trait sometimes persists for some time, in some way, in some place, and for some reason or other, existing independently of the person's former brain and body. Moreover, after some time, some of these irreducible essential traits of human personality, for some reason or other, and by some mechanism or other, come to reside in other human bodies either some time during the gestation period, at birth, or shortly after birth."

Almeder, known in particular for his work on the philosophy of science, has also written on the philosophy of mind, epistemology and ethics. He is the author of 24 books, including:

- *The Philosophy of Charles S. Peirce* (1980)
- *Death and Personal Survival* (1992)
- *Harmless Naturalism: The Limits of Science and the Nature of Philosophy* (1998)

- *Human Happiness and Morality* (2000)
- *Truth and Skepticism* (2010)

Almeder broadly rejects scientism and materialism. He was strongly influenced by Stevenson's reincarnation research work on children who claimed to remember past lives. This convinced him that minds are irreducible to brain states. He has argued in several papers and in his *Beyond Death: The Evidence for Life After Death* (1992) that Stevenson's critics have misunderstood the nature of his work. He singles out the philosopher Paul Edwards.

Stevenson found that sitting on the fence disabled him from reaching a conclusion. He reached his ideas by traveling extensively, collecting around 3,000 case studies based on interviews with children from Africa to Alaska. He found that 61 per cent of the children claimed to recall lives that had ended violently. The rest had died under age 12, either suddenly after a brief illness or with a sense of unfinished business. He was impressed with their ability to remember:

- the date they died
- their previous life names
- details about the villages in which they had previously lived

Many were even able to accurately identify members of their "former" families. They could often recount "pet names" and intricate details of their previous lives with uncanny accuracy. Many of the children Stevenson studied could also remember how they died in their previous life. They gave details of their demise with a degree of certainty and knowledge inexplicable for a child. These impressions were strong. In a few cases, the children identified so completely with their past life that they insisted on being called by their former name. They even felt alienated from their present family. They preferred and in some instances becoming clearly upset when not permitted, to spend more time with their "previous" family.

During the course of his travels, Stevenson sometimes noticed birth marks on the bodies of some of the children he studied. Those marks precisely matched the fatal wounds they claim their previous personality had suffered at the time of death.

For instance, an 11-year-old Turkish boy recounted having been accidentally shot in the head with a shotgun by a neighbor in a previous incarnation. Remarkably, the boy was born with a badly deformed right ear that closely mimicked the wounds the deceased man had received. Stevenson later confirmed

the wound by medical records and photographs he got from local authorities during his investigation.

This was by no means an unusual case. Stevenson recounts scores of similar examples. In some, toes and fingers lost in a previous life were missing in the current one. In a few cases, even entire limbs lost in a previous incarnation were missing. He relates more startling instances in which there were multiple birthmarks that closely resembled the precise wounds received by the past life subject. In one case, a previous personality had died from a gunshot wound to the head. He found matching entrance and exit wounds in a subject that closely corresponded to those wounds.

Of course, the chances of such perfectly matching marks occurring naturally even once are astronomical. But Stevenson had a number of such cases on record, shares Danelek. The most impressive thing about these memories was that these children had not been hypnotized or otherwise 'regressed' into remembering previous lives. They had conscious memories of past lives spontaneously from a very early age. In fact, Stevenson made it a point to ignore past life memories acquired through hypnosis. He considered them unreliable and fantasy prone.

These memories and inclinations tended to fade after a few years and disappear almost completely by adolescence. In Danelek's view, they remain among the best available evidence for reincarnation to date.

Psychologist and psychotherapist Dr. Helen Wambach, Ph.D., (1932–1985) was another of the earliest scientific researchers into past lives and reincarnation. She was author of three books:

- *Life Before Life* (Bantam 1978)
- *Reliving Past Lives* (Bantam 1978)
- *Reliving Past Lives: The Evidence Under Hypnosis* (1984)

Wambach worked with internationally acclaimed author, lecturer and regression therapist Dr. Chet Snow, Ph.D. After her death, he published *Mass Dreams of the Future* (1993), reflecting the results of 2,500 people in depth future life progressions that Wambach had hypnotized.

Wambach initially hoped to debunk reincarnation. So in the mid-1960s, she began a 10-year survey of past-life recalls in 1,088 subjects under hypnosis. She asked very specific questions about the time periods in which they had lived. She asked about their clothing, footwear, utensils, money and housing. Wambach found

peoples' recollections to be amazingly accurate, writing that fantasy and genetic memory could not account for the patterns that emerged in the results. She noted that, with the exception of 11 subjects, all descriptions of clothing, footwear and utensils were consistent with historical records.

Victor Zammit (victorzammit.com) in "A Lawyer Presents the Case for the Afterlife" reports on Wambach's research. He says her scientific analysis on the past lives of her 10,000 plus volunteers came up with some startling evidence of reincarnation.

- Exactly mirroring the population, 50.6 % of the past lives reported were male and 49.4 % were female.
- The proportion of people reporting upper class or comfortable lives was exactly the same as historians' estimates of class distribution when they purportedly had lived
- Recall by subjects of clothing, footwear, type of food and utensils was more accurate than in popular history books.

One of her most controversial findings was that people have some choice in their current lives. She claimed that the disembodied consciousness, the soul, does not enter the body until near birth. Said Wambach:

> "The soul usually enters the body near birth, and has a choice of which foetus to enter. If one foetus is aborted, it is possible to choose another. In some cases, the soul who will occupy the foetus is in contact with the soul of the mother and can influence her decision regarding abortion."

Of the people she hypnotized, 89% said they did not become part of the foetus until after six months of gestation. A large group said they did not join the foetus until just before or during the birth process. They existed fully conscious as an entity apart from the foetus. Even after six months gestation, many reported being "in" and "out" of the foetal body.

Many subjects also said the onrush of physical sensations on emerging from the birth canal was disturbing and very unpleasant. The soul apparently exists in a quite different environment in the between-life state, Wambach reports. The sudden physical senses when emerging from the birth canal bring so much vivid input that the soul feels almost "drowned" in light, cold air and sounds.

The frequent report that the newborn feels cut off, diminished and alone

compared to the between-life state much surprised her as well. She understood from her subjects that to be alive in a body is to be alone and unconnected. She speculated: "Perhaps we are alive to learn to break through the screen of the senses, to experience while in a body the transcendent self we truly are."

Her overall conclusion? "I don't believe in reincarnation — I know it!" (Wambach 1978).

Perhaps one of the more fascinating, though rare, evidences for reincarnation is "xenoglossia". There are a handful of well-documented cases of hypnotized people reliving a past-life suddenly speaking in a language they do not know That is xenoglossia. Sometimes they say a few foreign words or phrases. Other times, it's an entire fluent conversation in a language the subject is not even aware exists.

In some cases, the subject might even use an archaic dialect. When the language has not been in regular usage for centuries, it is extremely unlikely to be a fantasy, a hoax or a case of "cryptomnesia" (forgotten memories). These are some of the most credible and compelling xenoglossia cases on record.

The late actor Glenn Ford, for example, while under hypnosis during the 1960s recalled a past life as a French cavalryman under King Louis XIV (1638–1715). Ford had said he knew only a few basic phrases in French before being hypnotized. Under hypnosis, he spoke French with ease while describing this life. When recordings of his regression were sent to UCLA for analysis, they found that Ford was speaking a 17th century Parisian dialect. It had not been heard in over three centuries. Thus, xenoglossia remains one of the more compelling evidences for reincarnation. As they are rare, however, too little data is available for researchers to come to any conclusions, says Danelek.

Then there are the prodigies. These children possess a special talent, usually for science or the arts at which they excel. They become remarkably proficient years ahead of their contemporaries.

Blaise Pascal (1623–1662), a French mathematician, physicist, inventor, writer and Catholic theologian and Christian Philosopher, was a prodigy. He outlined a new geometric system by age 11. Educated by his father, a tax collector in Rouen, France, Pascal's earliest work was in the natural and applied sciences. He made important contributions to the study of fluids. He clarified the concepts of pressure and vacuum by generalising the work of Evangelista Torricelli (1608–1647) an Italian physicist and mathematician. Torricelli is best known for his invention of the barometer, but is also known for his advances in optics and on the method of indivisibles.

In 1642, while still a teenager, Pascal started some pioneering work on calculating machines. After three years of effort and 50 prototypes, he built 20 finished machines over the following ten years. His machines were called Pascal's calculators and later Pascalines. They established him as one of the first two inventors of the mechanical calculator. Pascal also wrote in defense of the scientific method, a body of techniques for:

- studying phenomena
- gaining new knowledge
- correcting and integrating previous knowledge

The German musician and composer Wolfgang Amadeus Mozart (1756–1791) was another prodigy. Able to compose simple arrangements of music at the age of four, by adolescence he composed entire symphonies. But "What Makes A Child Prodigy" asked Kate Gammon in her October 2014 *Popular Science* article? Generally, "talented" and "gifted" are labels casually tossed to bright children.

But a prodigy like Mozart is a rarity, and it is children like him that Assistant Professor, Psychology, at Ohio State University Joanne Ruthsatz studies. She followed more than 30 child prodigies over her academic career. She claims that a Mozart only comes around one in 5 to 10 million, developing professional abilities before the age of ten most often in the rule-based fields of:

- art
- chess
- music
- mathematics

Different theories about their talents' origins abound. Some suggest they are products of intense study. Some suggest they are gifted due to genetics/biologically. Ruthsatz claims to have found a link between autism and child prodigies' behavior.

In 2014, she was preparing to collect DNA from her cohort and their biological autism-suffering relatives. She wanted to intensify her research to find the first strong candidate gene for autism. Thus, I assume, she hoped to find the reason and avenue for prodigy-birth.

That strong empirical evidence suggests autism to be caused by health-ruining vaccinations is beside the point.

That Mozart and other prodigies were never vaccinated seems also to be inconsequential.

That no one throughout the world's known history had autism-affected relatives is also ignored.

Ruthsatz et al. did, however, find that prodigies have certain traits in common. An exceptional memory is a must. Their study of eight prodigies published in the journal *Intelligence* (2014:44(1): 11–14) documented that each of them had working memory ability in the 99th percentile. Attention to detail, which aligns with people on the autism spectrum, is apparently another factor. So is an elevated general intelligence, ranging between an QS of 100 to 147, with a mean of about 128.

The most curious thing setting prodigies apart from the rest of us, says Ruthsatz, is their altruism far above and beyond the general population: "They're just benevolent souls." That it could be due to a soul-substance and desire that these children are born prodigies is of course unfathomable to the empirical scientifically-inclined practitioner in the field of psychology. That most of them die young also went unmentioned.

Modern science attributes these rare gifts to simple brain chemistry or genetic make-up. Thus, it fails to ask the question of why their brains are wired differently than other peoples' or, precisely, in what way they are differently wired. Is it some genetic mutation or a one-in-a-million mix of DNA? If so, why does it not seem to similarly affect their normal siblings, asks Danelek? Or could it be that these special people possess their remarkable ability because they have done it all before in another life?

Déjà vu is another puzzling aspect of life and living. It is the sense that one is experiencing something strangely familiar. It is when meeting someone one is sure to have known, but never in this life. It is when one inexplicably knows the layout of a building or city that one has never visited before.

Some people consider such experiences evidence of a past life. They think it is an echo or ill-defined memory that has somehow survived the rebirthing process, to be inadvertently triggered by some event in the present.

Others, in particular scientists and atheists, think such experiences are simply a coincidental similarity between a present and a similar, but forgotten, experience in this life.

However, even a similarity of places or events cannot explain, for instance, how a person can correctly name and describe the maze of streets that lie just ahead in a small village they never before visited. Nor does it seem to logically account for how

someone is able to recall with unerring accuracy the precise layout of a home they see for the first time? After all, a similarity with places or things experienced in the past can only go so far in Danelek's opinion. The odds against correctly guessing the precise layout of a city or the location of various rooms within a sprawling mansion are astronomical. That makes reincarnation in such cases at least a possibility.

On my first visit to Rome and surroundings, staying close the Campus Martius in a most charming old hotel, the Tre Apis, I knew everything and fared around like a born and bred Roman, so familiar the city was to me.

Idiomatic phobias are another topic of curiosity, as many people have phobias without knowing why. Phobias are overwhelming fears of things not usually a genuine danger. They are portrayed as a well-understood process resulting from some trauma or event, usually in childhood, showing itself in later life as an irrational fear. But are they really?

What if they originated in past lives? What of those phobias that develop without an accompanying trauma? That's what Danelek asks. For example, a therapist might find that a man who has been afraid of water and drowning for as long as he can remember has never experienced a near drowning. He might find another who is terrified of horses, though he has never been near one in his entire life.

During a past life regression, many subjects recall being traumatized in past lives, and carry the resulting fear into the present incarnation. Interestingly, once the past life trauma is identified, the sufferer often makes a surprisingly quick and complete recovery. This often happens far more quickly than is commonly seen with more conventional therapies.

Danelek asserts that even the medical community agrees that such therapies are an effective means of dealing with severe, unexplained phobias. Still, they generally dismiss reincarnation as a viable explanation for it. Instead, medical practitioners claim that past life "memories" are just subconsciously manufactured fantasies created to mask the real trauma behind the phobia. Here, too, nothing has changed. The PTSD affliction, by hook or by crook, has to be the fault of the experiencer. Thus, those claiming to be experts in the PTSD field search for pre-morbid PTSD conditions. Even PTSD healing through past-life regression, proven to be an extremely effective means of curing a phobia, is frowned upon.

Why? Is it because the mental health community would rather commit suicide than belief in reincarnation, never mind the existence of the soul? The exception is Ruthsatz, to my pure amazement, as the concept goes entirely against the

empirically-ruled and scientifically-documented system.

David Icke, in his book *Phantom Self (And how to find the real one)* (David Icke Books LTD, 2016), shares his views on Clinton Richard Dawkins. Dawkins is an English ethologist, evolutionary biologist, author and emeritus fellow of New College, Oxford, and the University of Oxford's Professor for Public Understanding of Science from 1995 to 2008. The esteemed professor, best known for his popularization of the gene as the principal unit of selection in evolution, exclaims:

> "*You cannot both be sane and well educated and disbelieve in evolution. The evidence is so strong that any sane, educated person has got to believe in evolution.*"

He adds:

> "This world is all there is, and this one life is all there is, and that's your lot."

He means the lot of those inside the Matrix, the humans of this apparent reality. Icke calls it "The System", a translation from Latin, meaning "the sewer." Dawkins, of course, is one of them, a programmed phantom-self doing the boss's bidding. Does he know it? Who cares? He'll find out soon enough after departing this earth, whether or not he steadfastly goes on with aplomb to pronounce:

> "*Don't kid yourself that you're going to live again after you're dead. You're not*!"

Meanwhile, quantum physics is perpetually throwing huge wrenches into his and other scientists' assertion. Evidence keeps mounting that our so-called reality is anything but physical, predictable or isolated from and operating independently of consciousness. A group of scientists recently even announced that, "the world only exists when we look at it", reports David Icke in *Phantom Self.* The eminent, self-taught and entirely ignored by academia physicist and biophysicist Nassim Haramein's gives wonderful evidence of it in his you tube lectures.

Tell the 'Lords' of Karma That You Are Sovereign by Cameron Day at AscensionHelp.com and GeniusBrainPower.com is also noteworthy. He calls Dawkins et al. the "Turds of Karma (ToK)". For him, they are the primary gatekeepers that allow or deny beings access into and out of the demiurgic system. As such, they must be exposed, because their perversion of the natural law of reincarnation and Karma is so staggering in scope. He claims it is they who are responsible for forcing human beings to reincarnate over and over again in clear violation of Universal Law. In the "Free Universe" outside the corrupt demiurgic enslavement system in which we live, beings are free to incarnate onto any planet

they choose, Day claims. When physical life comes to an end, beings are said to return to Infinite Source. There, they rest and decide what they want to do next in order to continue to learn and grow. Nowhere in this process is a hierarchical group of controlling, manipulative beings like the "lords" of Karma present, says Day.

When a person's body dies, they move out into the astral realms and begin to shed most of their previously-held identity. If this process were allowed to occur without interruption, Day claims, the True Light of that being would emerge from within. It would release layer upon layer of limiting beliefs generated in that incarnation.

What happens within the realms of the demiurgic control system, however, is quite different. The ToK intercept those beings just as their light starts to emerge from within. They surround them in a dazzling display of colorful external light. This is what most people with near-death experiences report as going through a tunnel of light. The dazzling outer display distracts from the light emerging from within their Self. It hypnotizes them through frequency entrainment, while activating any and all religious programming that being had while on Earth, Day suggests.

In his opinion, these are the ToK's primary tools to manipulate beings into accepting nearly endless reincarnation. The false-light beings then convince the human being that Universal Law does not exist. They convince that one has no inherent right to self-defense, that one must submit to ToK's "authority". They convince one that people must worship the psychopathic demiurge and his "angelic" beings, the so-called Ascended Masters et al. They claim one must do this for access to "God's kingdom" one day when one merits it, according to their laws.

The truth is that we have never been separate from Infinite Source, as it is a metaphysical impossibility. We can choose to ignore the connection, or believe it is not there. We can even believe the connection has been severed. But belief in a lie does not make it true. As Ghandi said: "Even if you are a minority of one, the truth is the truth."

Richard Mathesons confirms Day's view on the topic in his book *What Dreams May Come*.

Information and views on reincarnation is available in abundance on the internet and in libraries. Years ago, I started off with The Tibetan Book of the Dead, the *bar do thos grol* a title popularized by Walter Evans-Wentz's edition, first published in 1927 by Oxford University Press. Dr. Evans-Wentz chose this title because of the parallels he found with the Egyptian Book of the Dead. I used it

decades ago in an academic paper in physical anthropology to get a grip on the origin of language. The Tibetan text describes and is intended to guide one through the experiences that consciousness has after death. This interval between death and the next rebirth is called the "bardo". The text also includes chapters on the signs of death and rituals to undertake when death is closing in or has taken place.

The *Bardo Thodol* differentiates the intermediate state between lives into three bardos:

1. The *chikhai bardo* or "bardo of the moment of death". This features the experience of the "clear light of reality", or at least the nearest approximation of which one is spiritually capable. In our case, it is the PTSD causing event moment, I believe.
2. The *chonyid bardo* or "bardo of the experiencing of reality". This features the experience of visions of various Buddha forms, or the nearest approximations of which one is capable. This happens in meditation.
3. The *sidpa bardo* or "bardo of rebirth". This features karmically impelled hallucinations, which eventually result in rebirth, typically yab-yum imagery of men and women passionately entwined. I don't know about this part, as my body obviously remained on earth.

The *Liberation Through Hearing During the Intermediate State* also mentions three other bardos:

1. "Life", or ordinary waking consciousness
2. "Dhyana" (meditation)
3. "Dream", the dream state during normal sleep

Together, these "six bardos" form a classification of states of consciousness into six broad types. Any state of consciousness can form a type of "intermediate state" between other states of consciousness. Indeed, one can consider any momentary state of consciousness a bardo, since it lies between our past and future existences. It invites us to experience reality, which is always present but obscured by the projections and confusions that are due to our previous unskillful actions.

I discontinued my discoveries into that field of education soon thereafter, but did discover Edgar Cayce (1877–1945). He was an American clairvoyant who answered

questions while in a trance, on subjects as varied as:

- wars
- healing
- Atlantis
- reincarnation
- future events

Also named "The Sleeping Prophet", other abilities were attributed to him. These include astral projection, prophesying, mediumship, viewing the Akashic records or "Book of Life" and seeing auras. Criticism of him abounds to this day. Skeptics, including the medical health professions of all genres, challenge Cayce's alleged psychic abilities, unorthodox treatments, and support for various forms of alternative medicine. They regard these as quackery. Thus, nothing has in essence changed. Be it as it is, I found his material fascinating and eye-opening and you might too.

The discovery of my own lives in past incarnations might have been encouraged by such readings. But I never pursued it through "experts" in past life regression charging money.

When we discussed past lives among flight attendants — as a rule, aircrew are fascinated by these issues — This is the view I expressed: "Why do I want to know about my past lives, when it might disturb me in living this one to the fullest?"

It was through meditation that my own enlightenment on past lives occurred. It came suddenly and out of the blue. The revelation lead me to believe that learning about past lives, when it is beneficial, is almost a necessity for going on with life.

I was shown a few times that I've been around this place before. It began with a PTSD-causing event caused by an engine explosion right beside me when aircraft were round and had portholes like on old ships. The same people playing major roles in that life of mine were also with me in this one, their expressions of care similar as well. In that life, I was shown during my meditation, I died like a street dog in an insane asylum while endlessly washing endless white-tiled floors, hands red and raw from detergents and my body and soul eaten up by despair and exhaustion.

Only three of those with me in both lives managed to redeem themselves in this one. The knowledge of that life, together with a couple of dreams, made me aware of the enormous danger I faced. I was shown the destruction I was again facing by

the same powers that be. In turn, it propelled me into high alert and take actions to protect myself against a repeat performance of the same fate. I escaped it by a hair's breath, thanks to meditation, life without pharmaceuticals and other mind altering drugs. And thanks just as much to my guardian angels, guides, guardians, helpers, teachers and friends in the for-humans-unseen benevolent realms.

For me, therefore, there is absolutely no doubt that reincarnation exists. It is a logical conclusion, but do your own research. That, I am sure, will lead to your inquiries into Karma and the seldom-acknowledged Dharma flowing with it. In the present PTSD condition, it might safe your sanity, as it opens up another avenue to heal the Self. Instead of falling into the trap of "blindness is bliss" category designed for imbeciles, think of Einstein's proverb *"Condemnation without investigation is the height of ignorance"*. For your peace of mind and personal satisfaction, to educate yourself on these topics may thus be of great value to you.

19

Karma Vs. Dharma; Ignorance Vs. Knowledge

"As the blazing fire reduces wood to ashes,
similarly, the fire of Self-knowledge reduces all Karma to ashes."
–The Bhagavad Gita

What is Karma? Karma is a word in Pali, an ancient Middle Indo-Aryan language of the Indian subcontinent. Pali is best known as the language of many of the earliest extant Buddhist scriptures. The term "Karma" literally means "action" or "doing". Any kind of intentional action, whether mental, verbal or physical, is regarded as Karma. It covers all that is included in the phrase "thought, word, and

deed". Generally speaking, all good and bad actions are Karma.

In its ultimate sense, Karma means all moral and immoral volition. Involuntary, unintentional or unconscious actions, though technically deeds, do not count as Karma. Volition, the most important factor in determining Karma, is absent.

Karma does not necessarily mean past actions. It embraces both past and present deeds. Hence in one sense, we are the result of what we were; we will be the result of what we are. In another sense, we are not totally the result of what we were and we will not absolutely be the result of what we are. The present is without a doubt the offspring of the past and thus is the future the offspring of the present. But the present is not always a true reflection of either the past or the future. In short, Karma is the law of cause and effect in the ethical realm.

Karma is action, and Vipaka, the fruit or result thereof, is its reaction. Each volitional activity is inevitably accompanied by its due effect. Karma is like a potential seed and Vipaka the tree and fruit arising from it. Vipaka is the effect or result. The leaves, flowers and so forth correspond to health, sickness and poverty, inevitable consequences manifest, the results of cause an effect.

Strictly speaking, however, both Karma and Vipaka pertain to the mind. As Karma may be good or bad, so may Vipaka, the fruit, be good or bad. As Karma is mental so Vipaka is mental. One experiences it as happiness and bliss, or unhappiness and misery, according to the karmic seed. *The* concomitant advantages can be material things such as prosperity, health and longevity. Disadvantageous can be wretchedness, and appear as poverty, ugliness, disease, short life-span and so forth. As we sow, we reap somewhere sometime in this life or in a future birth. What we reap today, we have sown either in the present or in the past. What we sow today we will reap in the present or future, as exquisitely expressed in the ancient Buddhist scripture Samyutta Nikaya, loosely translated as "Connected Discourses" or "Kindred Sayings":

> *"According to the seed that's sown,*
> *So is the fruit you reap there from,*
> *Doer of good will gather good,*
> *Doer of evil, evil reaps,*
> *Down is the seed and thou shalt taste*
> *The fruit thereof."*

Whichever way it is, in my view the greatest beauty of Karma is that it is a law onto itself. It operates in its own field, without the intervention of any external,

independent ruling agency. Because of it, I become the ruler of my present and my destiny. The creator of every moment of my daily life, I am the creator of my future.

Needless to say, many theories of how, when and why Karma and rebirth originated have been floated throughout man's revealed history. But scientifically substantiated evidence is hard to come by, as with many other aspects of human existence on this Earth. The concepts of reincarnation and the cycle of rebirths, however, are fundamental to Hinduism, Buddhism, Jainism and Sikhism. They are intensely debated in India's ancient literature. Various schools of religions consider the relevance of rebirth as either essential, secondary, or unnecessary fiction.

The diversity of views on the definition of Karma among the schools of Hinduism alone are dazzling. Some consider Karma and rebirth linked and simultaneously essential, some considering Karma but not rebirth essential. A few discuss and conclude that Karma and rebirth are a flawed fiction. Others apparently having ongoing debates as to whether Karma is a theory, a model, a paradigm, a metaphor or a metaphysical stance.

Some researchers suggest that Karma is a basic concept, whereas rebirth is a derivative one. Others assert that Karma is a fact, while reincarnation is a hypothesis. Others opine that rebirth is a necessary corollary of Karma. Mind you, as a concept, the Karma-theory across the reincarnation-believing Indian religious traditions is said to have certain common themes:

- rebirth
- causality
- ethicization

Ehicization affirms that the secular morality of ethics that govern everyday life should extend to govern our lives after death. Thus, lying or fornication or stealing is an ethically wrong action in most human societies. It is simultaneously deemed a religiously wrong action in Buddhism, Christianity and Islam. This means that entry into the afterlife is conditional on ethical conducts during one's earthly existence. (Amerindian Rebirth: *Reincarnation Belief Among North American Indians and Inuit*, edited by A. Mills and R. Slobodin; University of Toronto Press, 1994). The question to ask is if it is otherwise, do we end in Dante's hell as reflected in the *Divine Comedy?*

Furthermore, for some people the concept of Karma has multiple meanings. In the *Encyclopedia of Science of Religion* (2003), Harold Coward asserts that its meaning,

importance and scope varies. It is not the same in Hinduism, Buddhism, Jainism and other traditions and various schools of thought in each of those traditions. Whatever one wishes to believe, in the language of science, Karma is called the law of cause and effect. It is the law of moral causation, a belief prevalent in India even before the advent of Gautama Buddha (6th BCE). Nevertheless, it was the Buddha who supposedly explained and formulated this doctrine in the complete form in which we find it today.

The Dhammapada is a collection of sayings of the Buddha in verse form. It is one of the most widely read and best-known Buddhist scriptures. Each saying records a different occasion in response to a unique situation that had arisen in the life of the Buddha and his monastic community, the Buddhist scholar Buddhaghosa explains. Each saying in the collection presents the details of these events and is a rich source of legend for the life and times of the Buddha, who lectured:

> "The [human] mind is the chief, the forerunner of all good and bad states. If you speak or act with a bad mind unhappiness will follow you just as the wheel that follows the hoof of the ox. Similarly if you speak or act with a good mind, happiness too will follow you like the shadow that never leaves you. "Karma is volition," says the Buddha, meaning both good and bad mental action. It is not an entity, but a process of action, energy and force. It is our own doings reacting on ourselves. In its ultimate sense, Karma means all moral and immoral volition. Involuntary, unintentional or unconscious actions, though technically deeds, are said to not constitute Karma, because volition, the most important factor in determining Karma, is absent."

Karma is simply action, a process, which in Buddhism is called Karma, writes the SriLankan journalist Manjari Peireis in his article "Karma — the law of cause and effect", published on the Mihitalava Lake House website. A person experiences pain and happiness as a result of his or her own deeds, words and thoughts reacting on themselves. Our own deeds, words and thoughts thus produce our prosperity and failure, happiness and misery.

A person moves mentally or physically. His or her motion is action. The repetition of actions is habit, and thus habit becomes one's character. In other words, it is up to me whether I want to remain in the PTSD-caused state of mind. It is up to me whether I wish to help myself by using my mind to pull myself out of it.

Nobody can help me make the decision. It is entirely up to me, as it is clear as a bell to me that we are the result of what we were. And we will be the result of what we are from one moment to the next, depending on our mind. It depends on our way of thinking.

Similarly, we are not absolutely what we were and will not continue to remain what we are. That is, PTSD-affected people are blatant examples of this, because if everything were fixed and determined, there would not be free will and no moral or spiritual life. Thus, we would merely be slaves of our past.

Similarly, if everything were undetermined, there could be no cultivation of moral and spiritual growth. The art then is to look at the PTSD condition as personal growth. It is not an overwhelming and insurmountable tragedy and travesty to be suffered until leaving the Earth, at least in my view.

There are no hidden mediators directing or administering rewards and punishments. Peireis suggests that Buddhists should not rely on prayers to some supernatural forces to influence karmic results. The Buddha tells us that Karma is neither predestination nor determinism imposed on us by some mysterious unknown powers or forces to whom we must pray or offer ourselves. Therefore, everyone else who thinks there might be some truth to Karma should also not rely on prayers to influence karmic results.

Peireis says praying would be in vein. Karma solely results from our own, our personal, our individual past and present thoughts and actions. No one else is involved. No one can yet read what motivates us to actions. This is the result of our mind.

Thus, a person's destiny in the next life does not in the least depend on what particular religion is chosen. One's fate depends entirely on one's deeds, thoughts and speech. If one does good deeds, one is bound to be in a happy world in the next life. If one thinks evil thoughts and does evil deeds, one is bound to be born to lead a wretched life.

Karmic thoughts alone are said to determine a person's destiny, both in this life and in the next. Thus, one cannot blame others or fate for a miserable state of affairs, but only the Self. Could it be a good idea, therefore, to change ways? Remember what Padme said:

> *"If you want to know about your past lives, look at your present condition. If you want to know about your future life, look at your present actions."*

Karma also explains the inequalities existing among mankind. Why else should

one person be brought up in the lap of material luxury and be endowed with fine mental, moral and physical qualities while another lives in abject poverty and misery? Why should one person be a mental prodigy and another an idiot or severely handicapped? Why should some be congenitally blind, deaf, or deformed while others are born Olympic athletes? | Why should one person be born with saintly characteristics and another with criminal tendencies, carrying out amoral behavior with glee? Why should some be linguistic, musical or mathematically inclined from the very cradle, while others have purely science-oriented minds? Why should some be blessed and others cursed from their births? This is what The Venerable Mahasi Sayadaw U. Sobhana (1904–1982) asked in The Theory of Karma. He was a Burmese Theravada Buddhist monk and meditation master. Why indeed?

One could surmise that only insensible and inhumane beings would view this inequality and diversity among humanity as purely accidental, attributing it to blind chance. Even the blindest of the blind must be able to see if putting their noses to it, that people are not equal. The fantasies of "Liberté, Égalité, Fraternité" popularizing the 1789 French Revolution are unsustainable. They are a fable due to the law of cause and effect.

"Liberté, Égalité, Fraternité" remains the national motto of France's and the Republic of Haiti. But it has been a farce since its inception. It's a hallucination, as none of it is possible under Karmic conditions and cosmic law as far as I can see with my utterly limited vision.

Thus, I agree with Mahasi Sayadaw, who asserts that nothing happens to a person in this world that s/he does not for some reason or other deserve. He concedes that men of ordinary intellect usually cannot comprehend the actual reason or reasons why it is so. He also claims that definite invisible causes of visible effects are not necessarily confined to the present life. They could be traced to a proximate or remote past birth.

Inequality is not due only to heredity, environment and "nature and nurture" either. It is also due to Karma, the result of our own past actions and our own present doings. We are responsible for our own happiness and misery; we created and create our own earthly Heaven or Hell. We are the architects of our own fate by the way we think and act. Our fate is not heredity. Our fate is not genetic. Our fate does not originate with our religion or nationality. Our fate is the result of our actions. It is Karma alone, so we must take responsibility for our successes and failures including the PTSD journey into hell.

We may be unable to see Karma in action, as it is an invisible force. But Peireis

assures us the results of it are stored in the subconscious mind in a manner that leaves flowers and fruits, thorns and thistles, stored in their seed. They can be used as actions demand, and nothing shall go to waste.

Mahasi Sayadaw points out that some people experience certain karmic effects only in this lifetime. Other karmic effects take place in the next or later births. Certain unspecified karmic effects are said to even follow doers as long as they remain in the wheel of existence, until attaining Nirvana. The difference is apparently owing to a person's mental impulse, the time when a thought arises in the mind to do either good or bad.

Those violating karmic law have to face the consequences, irrespective of their religious beliefs. Karma is unbiased towards each and every soul, regardless of whether or not they believe in it. Karma pays no attention to which religion they embrace or if they are proclaimed atheists. Karma is not the exclusive property of any faith, nor is it stored up somewhere in the universe for future use. It is that simple, even though the misconception that karma operates only for certain people according to their faiths seems to be alive and well, states Peireis.

"There is no place to hide to escape from karmic results," the Buddha admonished. But he said we have the power at any moment and every opportunity to influence our own karma and the direction of our lives.

Thus, we are not complete prisoners of our actions, nor are we slaves to our Karma or mere products of nature. Our minds are mightier than Karma. We have the strength and the ability to change it. But we must be wise enough to conquer our own karmic forces, rather than surrender to them, by honing our hopes and efforts to influence Karma for our benefit by doing meritorious deeds. We must purify our minds, rather than relying on worshipping, performing rites or torturing our physical bodies to overcome our karmic inheritance. Leading a noble life and acting wisely can overcome the effect of one's evil deeds. Ignorance of the nature of cause and effect and of good and bad deeds intentionally committed is no excuse to justify or avoid the karmic results.

This cycle continues indefinitely, except for those consciously breaking it by reaching moksha. "Moksha" is a term in Hindu philosophy referring to various forms of emancipation, liberation and release. One achieves it by crashing through the barriers presented by what Cameron Day calls the "Turds of Karma".

Whichever way it is, I believe the Law of Cause and Effect influences all we think and do. It helps our speedy worldly and spiritual progress, if we make the effort, and for PTSD experiencers' it is another avenue to healing.

Statuses of birth, beauty and ugliness, time and personal effort and intelligence might have aided or obstructed the Karma before the PTSD-causing event. But these have been swept away. We have the blessing of a Tubula Rasa, a clean slate. A new life is being created and immediate karmic events and effects can be overcome to a certain extent. The trick is to adopt several methods suggested in the Anguttara Nikaya discourses by the Buddha stating:

> " . . . persons are as a rule not reduced to mere collections of aggregates, elements and sense-bases, but are treated as real centers of living experience engaged in a heartfelt quest for happiness and freedom from suffering."

Peireis refers to one of those discourses when pointing to three misinterpretations in relation to Karma:

- the belief that everything arises without reason or cause
- the belief that everything is a result of acts in previous lives
- the belief that everything is the result of what is willed by a Supreme Creator

He suggests that the wise should investigate these misconceptions and abandon them.

By leading a noble life and acting wisely alone, a person can overcome the effect of evil deeds or thoughts. Therefore, effort and intelligence are the most important of many factors affecting Karma. Ignorance of Karma's good and the bad effects is no excuse to justify or avoid the karmic results committed intentionally, states Peireis. We have the power, though few seem to desire to act upon it. Too much work; much easier to do beer and baseball.

Professor Karl Harrington Potter suggests that Karmic principles can be understood as principles of psychology and habit. That is because Karma seeds habits, and habits create the nature of man. Potter is a US born writer, academic and Indologist known for his writings on Indian Philosophy. He made these comments in his 1964 article "The Naturalistic Principle of Karma ".

Karma also seeds self-perception, and perception influences how one experiences life-events. Both habits and self-perception affect the course of one's life. Breaking bad habits is not easy. It requires conscious karmic effort. Thus, according to Potter and others, habit and perception link karma to causality as portrayed in ancient Indian literature. The idea of karma may therefore be

compared to the notion of a person's "character". Both are assessments of a person, and both are determined by one's habitual thinking and acting.

In 1988, Professor emeritus of philosophy at Augsburg College in Minneapolis, Minnesota, Bruce R. Reichenbach wrote "The Law of Karma and the Principle of Causation," In the article, he says that the theories of karma are ethical theories, because India's ancient scholars linked intent and action to merit, reward, demerit and punishment.

A theory without ethical premise would be a pure causal relation, he reasons. Merit or reward or demerit or punishment would be the same, regardless of the actor's intent. In ethics, he continues, one's intentions, attitudes and desires matter in evaluating one's action. Where the outcome is unintended, the moral responsibility for it is less on the actor even, though causal responsibility may be the same. Thus, a Karma theory considers both the action and the actor's intent, attitude and desire before and during the action. It also encourages each person to seek and live a moral life.

The Concise Oxford Dictionary of Current English defines Karma as the:

> "sum of person's actions in one of his successive states of existence, viewed as deciding his fate for the next."

In Sanskrit, Karma means "volitional action that is undertaken deliberately or knowingly". This dovetails self-determination and a strong will power to abstain from inactivity, says Hindu expert Subhamoy Das in his article "What Is Karma? The Law of Cause & Effect" (hinduism.about.com). In his view, all human beings are responsible for their acts and thoughts. So, all humans' Karma is entirely in their own hands to shape into their own future by schooling the present Self. The following rings true:

> *Now as a man is like this or like that,*
> *according as he acts and according as he behaves, so will he be;*
> *a man of good acts will become good, a man of bad acts, bad;*
> *he becomes pure by pure deeds, bad by bad deeds;*
>
> *And here they say that a person consists of desires,*
> *and as is his desire, so is his will;*
> *and as is his will, so is his deed;*
> *and whatever deed he does, that he will reap.*
>
> – *Brihadaranyaka Upanishad*, 7th BCE

In 1964, Walpola Rahula (1907–1997), a Sri Lankan Buddhist monk, scholar and

writer became Professor of History and Religions at Northwestern University. He was the first Buddhist monk to hold a professorial chair in the Western world. Here is how he explained Karma:

> "The theory of karma should not be confused with so-called 'moral justice' or 'reward and punishment'. The idea of moral justice or reward and punishment arises out of the conception of a supreme being, a God, who sits in judgment, who is a law-giver and who decides what is right and wrong. The term 'justice' is ambiguous and dangerous, and in its name more harm than good is done to humanity. The theory of karma is the theory of cause and effect, of action and reaction; it is a natural law, which has nothing to do with the idea of justice or reward and punishment."

What to do, then, to kick-start this operation of awareness and influence of Karma, and create only good Karma for the Self by the Self? Get knowledge, because we handle karmic-generated hurdles based on our knowledge. The more knowledge, the more power to overcome the hurdles. Logical?

What are the pre-requisites?

- understanding and control of one's own thinking
- desire to observe the Self like a hawk and to enjoy doing so
- to carry Self with honor, integrity and gracious at all times
- to get:
    - knowledge
    - discipline
    - willpower
    - determination
    - persistency
    - love for Self
    - patience

Most of all, to live nobly with the awareness of Dharma — knowledge — the huge facilitator in karma creation, including an understanding of who we are. The associated gift?:

> *"The self-controlled person, moving among objects, with his senses free from attachment and malevolence and brought under his own*

control, attains tranquility." — *Bhagavad Gita* II.64.

With tranquility come reason and logic; with it, anger is easier mastered, and the powers that are threatening PTSD journeyers at every step of the way are defeated. Life again begins to flow with purpose. Practice makes perfect. It is in our own hands. It is that simple.

On Dharma

The *Treasure of the Dhamma* by Dr.K. Sri Dhammananda fell from the second hand bookstore's shelf into my hands one day when browsing. The week before, I had stopped my Ativan consumption cold turkey. Familiar with Karma Dharma, or Dhamma in the Pali language, was entirely unknown to me, thus meriting investigation. Dhamma means *Nature* or *the way things really are*. Its study consists of:

- the renunciation of suffering
- attaining Enlightenment by way of gaining knowledge
- rebirth into illusory existences and realms to escape the suffering

inherent in all incarnate life-forms

One transforms the Self through contemplation, renunciation and devotional practise of various types of mindfulness and meditation. A major aspect of it is to conduct one's life in accordance with the Eightfold Path (dharmathai.com), another ideal process for PTSD-affected people to jumpstart the PTSD healing process.

Dharma and related concepts are found in the oldest Vedic literature of Hinduism. They also play a central role in Buddhism and Jainism. Ideas overlapping Dharma are also found in Chinese Tao, Egyptian Maat and Sumerian Me, its meaning and conceptual scope having evolved over thousands of millennia.

In the earliest texts and ancient Hindu myths, it meant cosmic law, the rules that created the universe from chaos and rituals. The realized soul and saint, the poet, Tulsidas (1532–1623), Brahmin by birth and said to have been the incarnation of the Hindu Sage Valmiki, is the author of the Sanskrit epic *Ramayana*. He lived around the first millennium BC, and defined the root of dharma as compassion, but to find a precise single-word-translation for it in western languages is as good as impossible. Dharma's root is "dhri", meaning "to support, hold or bear", the thing that regulates the course of change by not participating in change, but being the principle, which always remains constant.

In earliest texts and ancient Hindu myths, dharma meant cosmic law, the rules that created the universe from chaos, and rituals. In later Vedas, Upanishads, Puranas and the Epics, the meaning became refined, richer and more complex. The word "dharma" was applied to diverse contexts to define human behaviours considered necessary and in accord with Rta, that which is properly and excellently joined; order, rule: "truth". It is the principle of natural order, which regulates and coordinates the operation of the universe and everything in it. These are:

1. principles that prevent chaos
2. the order of things making life and the universe possible
3. behaviours and action necessary to all life in nature, society, family
4. at the individual level, ideas such as duty, rights, character, vocation, religion, customs and all behaviour considered appropriate, correct or morally upright.

Sir Monier Monier-Williams (né Monier Williams), KCIE (1819–1899) was born in Bombay as the son of Colonel Monier Williams, surveyor-general in the Bombay

presidency. He was the second Boden Professor of Sanskrit at Oxford University, England, a position established in 1832 with money bequeathed to the university by Lieutenant Colonel Joseph Boden. He studied documenting and teaching Asian languages, especially Sanskrit, Persian and Hindustan. Not surprisingly, he became a widely cited resource for definitions and explanation of Sanskrit words and Hinduism concepts. He offers as definitions for the word "dharma" that which is established or firm, a steadfast decree, statute, law, practice, justice, virtue, morality, ethics, religious merit, good works, nature, quality and property. Yet, he says, each of these definitions is incomplete, as the combinations of these translations fail to convey the full sense of the word.

In common parlance, dharma means the 'right way of living, a path of righteousness. The former journalist and communications professional Subhamoy Das, Hindu by birth, has researched and written extensively on Hindu philosophy and Indology. He is the guiding principal of ThoughtCo.com. He describes Dharma as meaning "that which holds," encompasses, the people of this world and the whole creation. It is the Moral Law of the World, its natural universal laws, whose observance enables humans to be content and happy. These laws give people the possibility to save themselves from degradation and suffering and, combined with spiritual discipline, guide their life.

In traditional Hindu society, dharma also denotes Vedic ritual, ethical conduct, caste rules and civil and criminal law. Its most common meaning pertaining to two principal ideals?

- that social life should be structured through well-defined and well-regulated classes
- that an individual's life within a class should be organized into defined stages

Thus the individual's age, caste, class, occupation, and gender affect Hindu's dharma. In the ancient Hindu scripture *Atharva Veda*, the fourth Veda describes dharma as:

> "This world is upheld by dharma. It is that which upholds, supports, and/or maintains the regulatory order of the universe."

Sometimes called the "Veda of Magical Formulas," a name disapproved of by scholars, the Atharva Veda is a collection of 20 books of hymns, chants, spells and

prayers. It also addresses issues like healing of illnesses, prolonging life, black magic and rituals for removing maladies and anxieties. Its hymns are dedicated to prolonging life, seeking cures from herbs, gaining a lover or partner or world peace, as well as the nature of good and evil. Some sources state that this Veda is the origin of medicine, tantra and yoga, as it contains one of the earliest references to breathing techniques and yoga practice. Unlike the other three Vedas, the Atharva Veda is less concerned with sacred rituals, addressing instead the daily problems of the common people.

As Hindus staunchly believe in reincarnation, they also content that what determines the state of existence while alive is Karma. This, in turn, is composed by the actions undertaken by body and mind. Thus, in order to achieve good Karma, it is important to live life in accordance to Dharma, that which is right. This means doing what is right for the Self, the family, the class or caste and the universe itself. Dharma is like a cosmic norm, says Subhamoy Das. If one goes against the norm, it can result in bad Karma, as dharma does affect the future according to the accumulated Karma. Therefore, one's dharmic path is necessary to bring good Karma into fruition.

The *Bhagavata-purana*, Sanskrit for "Ancient Stories of God [Vishnu]," is the most-celebrated text of a variety of Hindu sacred literature known as the Purana. It discusses topics like cosmology, genealogy, geography, mythology and legend to music, dance, yoga and culture. It also covers righteous living, meaning living life on the dharmic path and honoring its four aspects:

- purity
- austerity
- truthfulness
- compassion

The essence of dharma lies in the unique combination of spiritual brilliance and physical prowess. Therefore, Dharma's purpose is not only to attain a union of the soul with the supreme reality. Subhamoy Das proposes that it also suggests a code of conduct to secure both worldly joys and supreme happiness. He points out that the practice of dharma makes life disciplined and puts peace, joy, strength and tranquility within the Self.

The ten essential rules of Dharma were written by the ancient sage Manu, the title or name of Earth's mystical sage-ruler. They call for the following observance:

- reason
- honesty
- sanctity
- patience
- forgiveness
- truthfulness
- absence of anger
- piety and self control
- control of the senses
- knowledge and learning

When combined with non-violence, truth, non-coveting, purity of body and mind and control of the senses, these reflect the essence of dharma. In other words, dharmic laws govern both the individual and society at large.

In Hindu philosophy, justice, social harmony and happiness require that people live per dharma. The notion of *Dharma* as duty or propriety is found throughout India's ancient legal and religious texts.

Available evidence also suggests that India once upon a time had a large collection of dharma related literature, but only four, referred to as Dharma-sutras, remain. Along with the laws of Manu, they reveal parallel, different and conflicting compendium books of law by ancient scholars, which are neither exclusive nor supersede other sources of Dharma in Hinduism. These Dharma-sutras include instructions on education of the young, their rites of passage, customs, religious rites and rituals, marital rights and obligations, death and ancestral rites, laws and administration of justice, crimes, punishments, rules and types of evidence, duties of a king, as well as morality.

The Hinduism concepts of *Rta* and *Māyā* are also linked to Dharma. As mentioned earlier, *Rta* in the Vedas is explained as truth and cosmic principle regulating and coordinating how the universe and everything in it works. Maya, in later literature means illusion, fraud, deception and magic. Maya misleads and creates disorder contrary to reality and the laws and rules establishing order, predictability and harmony. The former strengthens law, order and moral life, whereas the latter corrupts it to its chore. These concepts referring to order and customs make life and the universe possible. They include behaviours, rituals, rules that govern society and ethics. They also include religious duties, moral rights, other duties and behaviours enabling social order, and right and virtuous conduct. They

apply to every human being in their interaction with other human beings, with nature and with all of the cosmos and its parts (Oxford Dictionary of World Religions). The Rta and Maya functions are reflected brilliantly in David Icke's 2016 book *Phantom Self*.

Dutch Indologist Johannes Adrianus Bernardus van Buitenen (1928–1979) was Professor of Sanskrit and Indic studies in the Department of South Asian Languages and Civilizations at the University of Chicago, Illinois. In his 1957 article "Dharma and Moksa", he claimed that Dharma, through its natural laws, prevented chaos.

Therefore, it was the principle concept all people had to accept and respect in order to sustain harmony and order in society and within the Self. It allowed pursuit and execution of one's own nature and true calling. It helped one playing one's own role in the cosmic concert in the same way as dharma of the bee helped it to make honey. In the same way as dhama of the cow helped it to give milk. In the same way as dhama of the sun helped it to radiate sunshine. In the same way as dhama of the river helped it to flow. So, too, it helped humanity to be of service and interconnected with all of life, as reflected in the *Mahabharata*, the Epic of Hinduism.

A symbolic treatise about life, virtues, customs, morals, ethics, law, the *Mahabharata* discusses Dharma extensively at the individual level. It covers topics like free will versus destiny, when and why human beings believe in either, and so forth. It concludes that the strong and the prosperous naturally uphold free will, while those facing grief and frustration naturally lean towards destiny. Buitenen says in *Dharma and Moksa*:

> "In the Epic, free will has the upper hand. Only when a man's effort is frustrated or when he is overcome with grief does he become a predestinarian, [a believer in destiny]. This association of success with the doctrine of free will or human effort (purusakara) was felt so clearly that among the ways of bringing about a king's downfall is given the following simple advice: 'Belittle free will to him, and emphasise destiny.' (Mahabharata 12.106.20)"

Here, in my opinion, we see why some overcome the PTSD predicament and others are incapable of doing so: strong, free-willed people versus labile, destiny-karma refusing-to-take-responsibility-for-Self prone folk.

In Buddhism, dharma also means "cosmic law and order." Rahula wrote:

> "There is no term in Buddhist terminology wider than

> dhamma. It includes not only the conditioned things and states, but also the non-conditioned, the Absolute Nirvana. There is nothing in the universe or outside, good or bad, conditioned or non-conditioned, relative or absolute, which is not included in this term (*What the Buddha Taught* (Grove Press, 1974) p. 58)."

In Jainism, Dharma refers to the teachings of the Tirthankaras variously called "Teaching Gods", "Ford-Makers", "Crossing Makers" and "Makers of the River-Crossing". These are saviours and spiritual teachers of the dharma, whose body of doctrine pertains to the purification and moral transformation of human beings by following the right path. For Sikhs, the word dharma means the "path of righteousness."

In the *Guidelines to Jainism,* we are told that to understand the meaning of the Jain dharma, it is absolutely necessary to have a thorough knowledge of the word "dharma" or "religion". This is because, for thousands of years innumerable wrong notions about dharma had been held and nourished by people.

Dharma or religion is neither a cult nor a creed, nor a reserved system of any community. Nor is it entirely related either to an individual or to a society, nor is it confined to any area. It is the essential nature of a person or an object.

Shramana Bhagawan Mahavir, Jainism's founder, explained the meaning of dharma thus: "Vatthu Sahavo Dhammo. Dharma is nothing but the real nature of an object. Just as the nature of fire is to burn and the nature of water is to produce a cooling effect, the essential nature of the soul is to seek self-realization and spiritual elevation."

Who was Shramana Bhagwan Mahavir, Lord Mahavira? He is considered the last Tirthankar in the phase of decline, the descending half of the worldly time cycle, now in full swing not only per Jain philosophy. He is considered a saviour who succeeded in crossing over life's stream of death and rebirths and made a path for others to follow. Mahavira was the last Tirthankara to appear, his predecessor Parshvanatha living about 250 years earlier, according to tradition.

Other Tirthankaras mentioned in the Jain scriptures cannot be considered historical figures. Each cosmic age is said to produce its own group of 24 Tirthankaras, the first of whom — if it is an age of descending purity — being giants. But they decrease in stature after shorter intervals of time, as the declining age proceeds.

Mahavira, more or less a contemporary of Gautama Buddha, Lao-Tse, Confucius

and Socrates, was born to the King and Queen of Bihar, India, in 599 BC. He left home at age 30, abandoning all worldly possessions in pursuit of spiritual awakening. Thus, he assumed the life of Sädhanä, literally meaning "accomplishing something". This is a generic term referring to any spiritual exercise aimed at taking the sādhaka towards the ultimate expression of life in this reality.

After practicing intense meditation and living in severe austerities, Mahavira gained Kevala Jnana. This can be roughly translated as absolute knowledge, supreme knowledge, total omniscience or actually knowing everything that can be known.

At this point, he began to teach that the observance of the vows of non-violence, truth, non-stealing, chastity and non-attachment was necessary for spiritual liberation. He gave the principle of Anekantavada or many sided reality. This is the notion that ultimate truth and reality is complex, with multiple aspects. It can also be interpreted to mean a rejection of fanaticism that leads to terror attacks and mass violence.

Syadvada is the doctrine that all judgments are conditional, holding good only in certain conditions, circumstances, or senses. It is expressed by the Sanskrit word "*syāt*" ("may be"), as the ways of looking at a thing – called "*naya*" – are infinite in number. How we view the world depends entirely on our perception, which arises from our life-experiences from the cradle to present day.

Give that some thought if you are placing your children in other people's care for their upbringing, while you hunt down the all-elusive mighty dollar, eh? David Icke's book *Perception Deception* speaks also to this in brilliant ways. He talks about the theory of Nayavada, the theory of partial truth, an integral part of the conception of Anekantavada, essential to conceive the sole nature of reality. It provides for the acceptance of different viewpoints on the basis that each reveals a partial truth about an object. Naya investigates analytically a particular standpoint of the problem.

Mahavira's teachings, called Agamas, were since the 1st century transmitted by Jain monks through oral tradition, as the original texts are either lost or in the Vatican's archives. The day of his Nirvana, his liberation and salvation, is celebrated as Diwali. On this event's 2,500th anniversary, Jainism's monks of various sects assembled to resolve their differences and arrive at some common points of agreement about its history and philosophy. These were arising from Mahavir's 30 years of lectures, while he himself had passed on and his remains cremated in 6th century BC at the age of 72.

It becomes clear that, if we examine the matter thus, we find that dharma has different definitions in different contexts. But it has a simple and clear meaning. Dharma can be applied to the elaborate codes of conduct and ideologies that enable people to understand and realize the true meaning of life. Dharma means the only path open to attain nobility and spiritual exaltation in life. To me, it seems that Dharma in essence is what leads the soul on the path of being active and progressive, and through it to felicity, peace and spiritual bliss.

The antonym of "*dharma*" is "*adharma*", meaning that which is "not dharma." Karma versus Dharma Karma in itself is not reward and punishment, but the law that produces the consequences, opine both Francis X. Clooney in his 1989 article "Evil, Divine Omnipotence, and Human Freedom: Vedānta's Theology of Karma," and Wilhelm Halbfass (1940–2000), a University of Pennsylvania professor of Indian Philosophy in Asian and Middle Eastern and South Asia Regional Studies, in his 1998 article on "Karma and Rebirth — Indian Conceptions"

Both say that good karma is considered as *dharma* leading to merit, whereas bad karma is considered *adharma* leading to demerit, to sin. The adharmic, unrighteous connotations of life include unnaturalness, wrongness, evil, immorality, wickedness, pride and vice. As with *dharma*, the word *adharma* includes and implies many ideas. In common parlance, it means that which is against nature, immoral, unethical, wrong or unlawful. It means all those sentiments and ideas making the stomach of healthy human beings sink.

Paul Hacker (1913–1979) wrote in his 1965 article *Dharma in Hinduism* that Dharma ought to be an empirical and experiential inquiry for every man and woman. A couple of lines from the *Apastamba Dharmasutra* illustrates the point. *Apastamba Dharmasutra* is one of the oldest Dharma-related Sanskrit texts of Hinduism written in the first millennium BC. It is used in Patrick Olivelle's book *Dharmasūtras: The Law Codes of Ancient India*. Here what it says:

> "*Dharma* and *Adharma* do not go around saying 'That is us.'
> Neither do gods, nor gandharvas [distinct heavenly beings],
> nor ancestors declare what is *Dharma* and what is *Adharma*."–
> *Apastamba Dharmasutra*

German-Canadian Klaus Klostermaier (1933–) says that the 4th century Hindu scholar Vātsyāyana explained dharma by contrasting it with adharma, suggesting that Dharma is not merely in one's actions but also in the way one thinks, speaks and writes. Vātsyāyana's comparisons state firstly that adharma of body is mirrored by violence, theft and sexual indulgence with someone other than one's partner. On

the other hand, Dharma of body is about charity, succor of the distressed and rendering service to others.

Secondly, Klostermaier reports that Vātsyāyana explains the Adharma from words one speaks or writes is made of falsehood, caustic talk, calumny and absurd talk. On the other hand, Dharma from words one speaks or writes mirrors truth and facts, talking with good intention, gentle, kind talk and self study.

Thirdly, he tells how Vātsyāyana explains Adharma of mind being about ill will to anyone, covetousness and the denial of the existence of morals and religiosity. On the other hand, Dharma of mind expresses compassion, respecting boundaries and faith in others.

Klostermaier should know. He is advisor to the Vatican's Papal office on non-Christian religions, and a prominent scholar on Hinduism, Indian culture and history. He has a Ph.D. in philosophy from the Gregorian University in Rome (1961). He has another in "Ancient Indian History and Culture" from the University of Bombay (1969), which he earned while living with practicing Vaishnava Hindus.

In the mid 20th century Indian Emperor Asoka's (268–232 BC) rock inscription from the year 258 BC was discovered in Afghanistan. It was written in Sanskrit, Aramaic and Greek, the latter rendering *eusebeia* for the Sanskrit word for Dharma as meaning:

- to venerate the gods
- to hone spiritual maturity
- to adopt a reverential attitude toward life
- to maintain the right conduct toward one's parents, siblings and children, the right conduct between husband and wife and the right conduct between biologically unrelated people

In other words, it suggests that during Asoka's reign the central concept of Dharma was not only about religious ideas. It was also about ideas of right, of good and of every individual's duty toward the human and animal community.

Whereas Karma knowledge to various degrees abounds, much remains unknown in the Western world about the ancient concept of Dharma. According to various Hinduism scholars, Dharma encourages and enables a person to:

- do the right thing

- be helpful to others
- be good, be virtuous
- learn to live well spiritually
- strive for stability and order
- live a lawful and harmonious life
- interact successfully with society

These traits are rarely, if ever, mentioned in the Western world.

In my opinion, everything flows from Dharma. It influences and encourages good Karma in the future. It enables us to resolve past Karma by acting in accordance with it. But I had never heard of it until *Treasure of the Dhamma* fell from that shelf in the second hand bookstore less than a week after I had stopped taking Ativan. Dhammananda, its author, wrote that the Buddha himself expressed that one must apply attention to Dhamma by way of devotion and intelligence in order to comprehend the abstract nature of his teachings. He said that only those who did would easily understand the Dhamma's teachings.

For me, these teachings were and are a blessing. In my view, therefore, they may be ideal for other PTSD-afflicted people as they were for me. They opened my heart and mind to a brand new avenue of thought on the deeper meanings of life, regardless of my pre-PTSD religion. It clarified my PTSD situation and helped me to shed the feeling of futility and lethargy. They let me begin a path towards fulfillment and achievement by slowly and consciously changing myself by myself.

When following the path of the Dhamma, it also seems to gift a sense of power. And this ever-increasing power over the Self radiates into all daily actions by controlling the thinking. Life becomes much easier and a lot more fun, rather than the drudgery so familiar to PTSD voyagers. Karmic hurdles like the PTSD-causing event become easier to jump, and thus healing begins.

We are the thoroughly abused and perpetually psychologically molested PTSD experiencers. We are weakened by the PTSD condition and bright enough to understand the concept of Dhamma. By following the Dhamma, we can overcome the powerful, who do only one thing well, namely contribute expertly to further our destruction.

Of course it takes guts to relentlessly engage in Self-inquiry and observation. It takes discipline, willpower, determination, persistency, honor, integrity and graciousness. It takes lots of prayers to whomever to conquer and vanquish those who view PTSD as a human debris mental disorder affliction.

But I am proof that, with a dharmic attitude, it can be done with relative ease. When the first successes of conquering the Self show themselves, when one first proves to the Self that one *can* actually control it, it gives an indescribable sense of joy, of achievement, of power. When anger is controlled once, one knows one can always control it, remembering that practice makes perfect. Thus, PTSD healing started for me.

Soon, it became a delightful challenge to be aware of my thoughts and change them, to control my fast-witted one-liners of the George Carlin variety. With increase in control, harmonious thinking also increases. Awareness heightens. Life begins to run ever smoothly and harmoniously. The soothing of the spirit and the calmness of mind generate the joy with the Self because of the Self. With it, miracles begin to happen at an ever-increasing rate, as thoughts are things. I know. I am living it, as through Dharma I influence Karma, which in itself is a miracle to me.

Mu Sigma Trainee Decision Scientist and ardent fan of mythology Hemanth Venkatesh so brilliantly states in his article "What is the main difference between Dharma and Karma?":

> "Karma is reaction, dharma is action. Karma is unconscious, dharma is conscious. Karma is like a feather being blown around by the wind, dharma is like an arrow fired straight at its target."
>
> "They're opposites essentially. Generally you're either following the path of Karma like most people, or you've broken free and you're following the path of dharma instead. Karma means passively reacting to external situations; Dharma means deliberately doing what you need to do to progress spiritually. You need to get through the karmic phase, before dharma becomes clear to you."

Thus, the purpose of dharma is twofold. It is to attain a union of the soul with the supreme reality. But it also suggests a code of conduct intended to secure both worldly joys and supreme happiness. The practice of dharma gives an experience of peace, joy, strength and tranquility within one's Self and makes life disciplined. Walpola Rahula explained in *What the Buddha Taught* (1959, 1974) why this is significant:

> " . . . instead of promoting resigned powerlessness, the early Buddhist notion of karma focused on the liberating potential of what the mind is doing with every moment. Who you are

> — what you come from — is not anywhere near as important as the mind's motives for what it is doing right now. Even though the past may account for many of the inequalities we see in life, our measure as human beings is not the hand we've been dealt, for that hand can change at any moment. We take our own measure by how well we play the hand we've got."

As Zen teacher John Daido Loori states so succinctly, "Cause and effect is one thing. And what is that one thing? You. That's why what you do and what happens to you are the same thing." So it is up to you and me to play our hand, and nobody else can do it for us.

With the consideration of Dharma concepts at the forefront of our minds our thinking capability increases. Logic and reason re-awaken. Life slowly becomes an enjoyable undertaking just by observing and controlling ourselves and the wonderful consequences of our self-observation creates. Slowly, slowly the perpetual observation of one's thoughts and the reaction to them and the command of self-control becomes habitual. They become second nature, as practice makes perfect. What in the beginning seemed difficult now is done with ease.

Rome was not built in a day. Neither is the re-building our Self, though the PTSD-causing event makes it so much easier. The event even creates the tabula rasa, the clean slate on which to build. The following advice written in the *Treasure of the Dhamma* may encourage your undertaking: "*A single day's life of useful intense effort is better than a hundred years of idleness and inactivity*."

When in the PTSD predicament, the latter seems to be the gravest and most enticing temptation. Something else, however, may also play a role in our reaction to the world and everything in it, namely the state of our Atlas. I discovered this one sunny spring day shortly after the 10 years of hell had finally come to a halt.

21

The Atlas Adjustment

The top most vertebra in the spinal column is the Atlas (C1), taking its name after the Titan god Atlas of Greek mythology. After losing the war against the Olympians, Atlas was condemned by the Olympian god Zeus to eternally stand on the western side of Gaea, the earth, holding Uranus, the sky, on his shoulders.

The Atlas and the axis (C2) together form the joint connecting the skull and spine. Thus, it is responsible for the suspension, equilibrium and management of the spine and skeleton. The Atlas and axis are specialized to allow a greater range of motion than normal vertebrae and are responsible for the nodding and rotation movements of the head.

The Atlas's chief peculiarity is that it has no body. It is shaped like a ring and

consists of two arches (anterior in front and posterior in back) and two lateral sections connecting the arches. Acting as a pivot, the axis allows the Atlas and attached head to rotate on the axis from side to side.

The Atlas and axis are important neurologically, because the brain stem extends down to the axis. The brain stem is the posterior part of the brain that joins the spinal cord and is structurally continuous with it. The Atlas design allows for a tremendous range of motion in the neck, nowhere else possible in the spine. But it is also the spine's weakest link. Unlike the rest of the vertebrae, it has no interlocking projections, but is held in place by ligaments only.

The doughnut-shape with two arches allows the second axis to create the pivot upon which it nods and rotates, turns and flexes in all directions.

The Atlas has a hole or middle opening, where the brainstem extends. This allows trillions of nerve fibers to travel from the brain into the spinal column, according to Brain World Magazine's November 2011 article "*Nod Your Head Up and Down * Make Yourself Happy*". Together with cerebral nerves, the arteries, veins, spinal cord and spinal fluid all pass through the Atlas opening at the base of the skull.

Together, the brain and spinal cord form the central nervous system, which is part of everything we do. It controls how we walk and talk and the things our body does automatically, like breathing and digesting food. It is involved with our senses — seeing, hearing, touching, tasting and smelling — as well as our emotions, thoughts and memory.

The brain, a soft, spongy mass of nerve cells and supportive tissue, which controls most of the activities of the body, has three major parts:

- the cerebrum
- the brain stem
- the cerebellum

The parts work together, but each has special functions. The cerebrum, the largest part of the brain, fills most of the upper skull. It has two halves called the left and right cerebral hemispheres. The cerebrum uses information from our senses to tell us what's going on around us and how our body should respond. The right hemisphere controls the muscles on the left side of the body, and the left hemisphere controls the muscles on the right side of the body. This part of the brain also controls speech and emotions, as well as reading, thinking and learning.

The cerebellum, under the cerebrum at the back of the brain, controls balance and complex actions like walking and talking. The brain stem connects the brain with the spinal cord. It controls hunger and thirst and some of the most basic body functions, such as body temperature, blood pressure, and breathing.

The brain is protected by the bones of the skull and by a covering of three thin membranes called meninges. The brain is also cushioned and protected by cerebrospinal fluid. This watery fluid is produced by special cells in four hollow spaces in the brain called ventricles. It flows through the ventricles and in spaces between the meninges. Cerebrospinal fluid also brings nutrients from the blood to the brain and removes waste products from the brain.

The spinal cord, made up of bundles of nerve fibers, runs down from the brain through a canal in the center of the bones of the spine. These bones protect the spinal cord. Like the brain, the spinal cord is covered by the meninges and cushioned by cerebrospinal fluid. Spinal nerves connect the brain with the nerves in most parts of the body. Other nerves go directly from the brain to the eyes, ears and other parts of the head. This network of nerves running through the Atlas in the brainstem carries messages back and forth between the brain and the rest of the body.

The brainstem lies beneath the cerebrum and consists of the:

- pons
- medulla
- midbrain

It lies in the back part of the skull, resting on the part of the base known as the clivus. It ends at the foramen magnum, a large opening in the occipital bone. The brainstem continues below this through the Atlas as the spinal cord, protected by the vertebral column.

The cerebral cortex with about 15–33 billion neurons each connected by synapses to thousands of other neurons, communicate with one another by means of long protoplasmic fibres called axons. These carry trains of signal pulses to distant parts of the brain and by way of the brainstem, through the Atlas to different parts of the body.

The brainstem is thus a critically important part of our brain functioning. From a Darwinian evolutionary perspective it is said to be the oldest and smallest region in the human brain. It purportedly evolved some odd million years ago and is

seemingly comparable to the entire brain of present-day reptiles. For this reason, it is often called the "*reptilian brain*".

Probably the best-known model for understanding the structure of the brain and its evolutionary history is the famous triune brain theory. It was developed by American physician and neuroscientist Paul D. MacLean (1913–2007). He contributed to the fields of physiology, psychiatry, and brain research through his work at Yale Medical School and the National Institute of Mental Health. In his evolutionary triune brain theory, MacLean proposed that the human brain in reality had three brains in one:

- the neocortex
- the limbic system
- the reptilian complex

Over the years, however, with grants for trans-humanistic ideology's neuroanatomical studies hugely favoured over other fields of research, elements of his model have been revised. Let's give it a closer look to better understand the enormous importance of a properly aligned Atlas, shall we?

The *neo-cortex,* is also called the neopallium and the isocortex. It handles higher-order brain functions such as sensory perception, cognition, generation of motor commands, spatial reasoning and language. It is the largest part of the cerebral cortex and is responsible for language development, abstract thought, imagination, and consciousness. It has almost infinite learning abilities and is responsible for human cultural evolution and collapse.

The *limbic brain* records memories of behaviours that produced agreeable and disagreeable experiences. As such, it is the seat of human emotions and value judgments often made subconsciously. This is documented in taped reverse speech recordings first advocated by the Australian David John Oates. Subconscious value judgments occur in one's own speech when played backwards as can be heard quite clearly in grammatically correct sentences mixed in with the gibberish. This details what is happening in the speaker's subconscious mind. If a person is lying in forward speech, their reverse speech reveals the truth even to the Self.

At deeper levels, reverse speech can reveal psychological causes for current issues, whether they be mental, emotional or physical. During spoken language production, speakers seem to subconsciously give insights into their innermost thoughts and values, intentions and judgments of themselves and others. But these

surface only when their speech is played in reverse. The speaker's consciousness talks to and judges the speaker — a stunning revelation.

Needless to say, as it has applications in psychotherapy, criminology, and business negotiation, it is shunned as pseudoscientific by the judicial system, academia and mainstream science. It could be a very good tool for PTSD journeyers when being interviewed by the powers that be, though. But never mind.

The third part of our brain, the reptilian complex, controls the brain's vital functions such as heart rate, breathing, body temperature and balance. It also controls all original neurology needed to survive, including the origin of nerves controlling:

- taste
- sight
- sleep
- speech
- hearing
- balance
- salivation
- mastication
- swallowing
- muscle tone
- blood pressure
- facial expression
- our olfactory sense
- sensation to our face
- postural relationship to gravity.
- head, neck and shoulder movement
- thoracic and abdominal organ function
- proprioception (knowing where one is in space)

The brainstem and the cerebellum are also in the reptilian brain. In humans, it tends to be somewhat rigid and compulsive. The reptilian brain is also the seat of *fight or flight* impulses not felt by PTSD experiencers, because neither flight nor fight is a possibility as sitting ducks in a sealed barrel.

The three parts of the brain constantly cooperate and influence each other through their many interconnections. The neural pathways from the limbic system

to the cortex, however, seem especially well developed.

All messages and instructions for the biological body to survive pass through the Atlas by way of the brain stem. That's where the brain ends and the spinal cord begins. Every organ and tissue of the body gets its instructions and signals from the brain through the nerve connections of the spinal cord. Spinal nerves branch off from the brain and spinal cord to transmit the signals of life throughout the body. I learnt much about this from *How an Iowa Scientist Discovered One of the Hidden Keys to Relieving Pain . . . Find Out Why Former Chronic Pain Sufferers call it the "Neck Secret" . . . That's Finally Being Published in Medical Journals and Reported By Mainstream Media . . . 80 Years After its Discovery!* It was written by Dr. Donald Liebell, of *The Liebell Clinic: Chronic Pain & Wellness Solutions* in Virginia Beach, Virginia, Edgar Cayce territory. PTSD journeyers' may also wish to explore his abilities and advice.

Thus, a correctly aligned Atlas allows the brain stem's unobstructed passage to the brain, the body's power generator and master computer. The brain sends electrical and chemical messages back and forth to the entire body at the speed of light. The messages go through the Atlas by way of the spinal cord and brainstem. Therefore the Atlas and its anatomically correct aligned position could actually be considered the body's most important part. Only when the Atlas is correctly positioned can body and mind function supremely.

Because the Atlas' opening is so small, however, displacement can throw the Atlas out of position. Even the smallest displacement can restrict nerve-impulses and distort messages traveling from the brain to the different parts of the body. This creates imbalance, improper nerve function, disease and pain. At the same time, it restricts blood-flow to the brain, thus making the brain's and body's superb functioning impossible. The technical term for misaligned vertebrae, including the Atlas, by the way, is "vertebral subluxation".

As pointed out earlier, at every moment of life, the spinal cord carries vital communication between the brain and every organ and gland of the body. Thus, any obstruction along this central conduit interferes with signals traveling from the brain says Dr. Phillip Greenwood, who performs chiropractic and bodywork at his clinic in Temecula, California.

The Atlas is the most mobile vertebra in the spine. Therefore, it is the most common to subluxate, or misalign. Such an event puts pressure on about one billion nerves traveling through the spinal cord, he explains. The question to ask then is: "How many possible ways can subluxation in the upper neck affect those nerves? How many possible health problems can result from it?" "Too numerous to count,"

says Greenwood, adding that a malfunction in that area can have a "domino" effect on the body's entire musculoskeletal, circulatory and respiratory Conditions. Three of the four most common medical conditions reported in 2012 were musculoskeletal conditions:

- arthritis
- low back pain
- chronic joint pain

The other most commonly reported medical condition is chronic hypertension. Logically, Atlas obstruction can also affect the nervous systems by creating imbalances and dysfunctions in various other parts of the body over time. These can turn into serious health problems, rendering the body unable to function as it should without being able to identify or diagnose a clear-cut organic cause.

Dr. Paiso is a chiropractor in Livermore, California, USA, specializing in Atlas correction. He says that despite all the wonderful things our bodies can do, it is completely helpless to restore proper neck alignment by itself. In his opinion, Atlas misalignment has something to do one of two situations. It could relate to physical trauma, when alignment can be lost due to mal-rotation. Or it could come from birth, when the baby's ligaments get stretched and torn a little and heal with the Atlas out of place.

The Atlas can be adjusted and put back in place, though, he purports. There is a certain amount of slack that takes time to heal so that the bone stays put longer. However, in his opinion, no adjustment lasts forever. Children as young as two weeks old have been adjusted in his practice without trauma or accident:

> "We also see a lot of children and find they respond well from tonsillitis, ear infections, sinus infections, even behavioral problems and bed wetting,' adding that 'from what we have observed, every person over the age of eight or nine shows signs of a misalignment, with or without symptoms."

Many years of clinical research have apparently shown, however, that the Atlas in almost all humans is mal-rotated to some degree from birth. As a matter of fact, a number of chiropractors do believe that subluxation often occurs with the forceful manner in which fetus' are handled during the delivery.

German medical researcher Dr. G. Gutmann, for example, found that over 80% of infants examined shortly after birth suffered from injury to the cervical spine and

neck causing a variety of health problems. Gutmann reports that blocked nerve impulses develop a clinical picture that ranges from central motor and development impairment to lowered infection resistance especially to ear, nose, and throat. Gutmann has examined and adjusted more than 1,000 infants with Atlas blockage. The results are amazing and generally swift. From his and other German medical studies, Gutmann concludes that approximately 80% of all children are not in autonomic balance and that many have Atlas blockage. It seems that Dr. Gutmann perceives component #2 of the Vertebral Subluxation Complex, neuropath physiology/neuropathology, as the preeminent factor in spinal related neuropathology. (*Blocked Atlantal Nerve Syndrome in Babies and Infants*. G. Gutmann, Manuelle Medizin, 25:5–10,1987)

Dr. Abraham Towbin, Harvard Medical School Department of Neuropathology, presented research at the Eighteenth Annual Meeting of the American Academy For Cerebral Palsy. He found "the birth process, even under optimal conditions, is potentially a traumatic, crippling event for the fetus. Spinal cord and brain stem injuries occur often during the process of birth but frequently escape diagnosis." (*Spinal Injury Related to the Syndrome of Sudden Death (Crib Death) in Infants*; Abraham Towbin, M.D., Department of Pathology, Boston University School Medicine, Mallory Institute of Pathology, Boston, Massachusetts, The American Journal of Clinical Pathology, Vol. 49, No. 4,1968, Williams & Wilkins Company.)

He also stated that:

> "Death may occur during delivery or, with respiratory function depressed, a short period after birth. Infants who survive the initial affects may be left with severe nervous system defects . . . During the final extraction of the fetus, mechanical stress imposed by obstetrical manipulation — even the application of standard orthodox procedures — may prove intolerable to the fetus."

He added:

> "I find that of those that get through the birth process without obvious injury, most have upper cervical alignment issues. If these are not corrected the babies' nervous system, immune system and organ functions will be continually impaired creating health problems that can confound both parents and pediatricians."

Atlas Subluxation Complex Syndrome produces effects that reach far beyond the

upper neck. It can affect the central nervous system and the peripheral nervous system. This, in turn, can produce adverse and unhealthy changes in any body organ, gland or tissue. Dr. Towbin says that many common childhood problems like colic and earaches often improve very quickly when underlying spinal nerve problems are corrected. The Atlas's mal-rotation and/or misalignment can lead to continuous pressure on the spinal cord, nerves, blood vessels, and lymphatic channels. This can also cause serious physical and mental problems. It can harm muscles, joints, eyes, ears, jaw, nerves, circulatory system — both the organs themselves and their equilibrium.

Therefore it seems of utmost importance that infants' Atlas alignments be examined as soon as possible after birth. To my knowledge, however, that is rarely if ever the case.

Employees of the Swiss company ATLANTOtec also claim that:

- the Atlas plays a primary role in the spine
- that it is the hidden cause of many ailments
- that a malfunction located in that area has a "domino" effect on the entire human musculoskeletal, circulatory and nervous systems by creating imbalances and dysfunctions in various parts of the body
- that malfunctions turn into serious health problems over time as the body is no longer able to function the way it could and should without clear-cut organic causes, thus confirming what has been said already

As such misalignment has been found to cause disorders and conditions at both the physical and the mental level. Because conventional medicine does not consider Atlas misalignment a possible cause of patient disorders, it may be of value to research, as this problem generally goes undiagnosed. ATLANTOtec staff advise of some facts to know about Atlas vertebra misalignment.

First of all, childbirth trauma creates in many infants a permanent misalignment of the Atlas and sometimes also of the axis. Later on in life, physical traumas like whiplashes, falls and intubation during surgery under total anesthesia can also cause or worsen Atlas and axis misalignment.

Furthermore, regular X-rays and magnetic-resonance imaging (MRI) do not show Atlas misalignment, thus leading to failure to diagnose it. A multi-slice helical CT scan can detect and measure Atlas misalignment, but only if the radiologist sets

up the device specifically for it. Leaving aside extremely severe Atlas dislocation requiring surgery, conventional medicine offers no treatment to correct its misalignment.

This leads me to wonder how many patients have been told by their physicians that their problems were undetectable and so must be of psychosomatic origin — only exist in their head. Of course, this advantages the physician, as it allows multiple pharmaceutical drug prescriptions. This in turn adds to their income by way of big bonuses paid by Big Pharma. Look at all the Atlas misalignment symptoms that *ATLANTO*tec patient records show, each a bonanza for Big Pharma to "treat":

- hip pain
- epilepsy
- lumbago
- cervical pain
- chronic sinusitis
- pelvic asymmetry
- Ménière's disease
- recurrent tendinitis
- sacroiliac joint pain
- trigeminal neuralgia
- stiff neck — torticollis)
- jaw pain — jaw cracking
- insomnia — falling asleep
- compressed spinal nerves
- muscle tension — muscle pain
- pain in the legs, knees or feet
- back pain, functional scoliosis
- functional leg length difference
- chronically cold hands and feet
- chronic pain following whiplash
- chronic fatigue syndrome (CFS)
- asthma (may have other causes)
- recurrent middle ear inflammation
- vertigo — dizziness-unsteadiness
- formication/numbness of the arms

- shoulder pain — one shoulder higher
- tennis elbow/carpal tunnel syndrome
- buzzing or ringing in the ears — tinnitus
- headache — tension headache — migraine
- depression (if resulting from chronic pain)
- limited or painful head rotation or bending
- sciatica — inflammation of the ischiadic nerve
- vision disorders — recurrent eye inflammation
- chronic diarrhea — constipation — irritable bowel
- tachycardia — hypertension — low blood pressure
- herniated disc — disc disease — protrusion of discs
- arthritis — osteoarthritis (if arising from poor posture)
- gastritis/gastric ulcer, gastric hyperacidity, gastric reflux
- allergies/hay fever (improvements for unknown reason)
- learning difficulties — dyslexia (difficulty reading or writing)

Studies by Tatsuo Akimura *et al.* using magnetic resonance (MR) imaging showed changes in the Atlas' natural anatomical position. That caused changes in blood circulation through the vertebral artery, resulting in worsening of hypertension. Two other studies using MR imaging techniques also found a significant association between vertebral artery compression and changes in the posterior fossa of hypertensive, but not normotensive, people. Thus, alterations in Atlas anatomy can change the vertebral circulation that may be associated with high blood pressure.

It is well known that it takes two or more antihypertensive agents, e.g. pharmaceutical drugs, to reach blood pressure (BP) goals in more than 70% of hypertensive people. So, many people are searching for alternative ways to lower arterial blood pressure. The article "Atlas vertebra realignment and achievement of arterial pressure goal in hypertensive patients: a pilot study" conducted by G. Bakris et al. and published in *Journal of Human Hypertension* (2007 21, 347–352.) gives us one idea. It documents how changes in the Atlas' anatomical position can change the circulation of the vertebral artery, and how that can worsen hypertension. BP continued to decrease eight weeks after Atlas correction. It was unrelated to pain or pain relief or any other symptom that could be associated with a rise in BP. Bakris et al. claimed that their findings were the first demonstration of a sustained BP lowering effect from correcting Atlas vertebra alignment. The improvement was

similar to taking two different antihypertensive agents simultaneously. They did not know the mechanism as to why this improvement occurred, nor could the study reveal it.

The researchers noted that other studies also suggested that changes in cerebral circulation is related to the position of the Atlas and the associated vertebra (C2), the axis, affecting BP. In fact, Bakris et al. reviewed data linking changes in Atlas anatomy and posterior fossa circulatory changes associated with hypertension dating back more than 40 years.

That the Atlas is uniquely vulnerable to displacement is obvious when we look at its design and placement. Unlike vertebrae that interlock one to the next, the Atlas relies solely on muscles and ligaments to maintain alignment And because its displacement is pain-free, it usually goes undetected, undiagnosed and untreated. That is why resulting health-related problems are attributed to other causes.

It was clear to the researchers, however, that a significant change in "sympathetic tone" was probably not a major contributing mechanism, as heart rate was not significantly changed. This encouraged them to raise some questions including:

- How does Atlas misalignment affect hypertension?
- Is there a cause and effect relationship between Atlas misalignment and hypertension?
- Is the mal-position an additional risk factor for the development of hypertension?

Hypertension is on the rise in the population at large, and control it seems to be getting more difficult due to a variety of factors. Bakris et al. think that linking Atlas misalignment correction to the subsequent lowering of blood pressure may be an important advancement in the screening of such patients. How to go about it? Atlas vertebra misalignment can be determined by as simple a means as assessing a patient's pelvic crests. Not only should this be considered in people with a history of hypertension who require multiple medications for treatment, the researchers say. It should also be considered in those with refractory hypertension and a history of neck injuries regardless of the presence or absence of pain, as none of the patients randomized in their study had pain.

As for knowledge and techniques now available to screen for Atlas misalignment, team Bakris recommended that Atlas screening should be the responsibility of the primary care physician and should be performed on patients

with histories of head and neck trauma, even if deemed insignificant. Patients with pain related to head and neck trauma, however, should not be screened. Mind you, all of it is nothing new. The relationship between hypertension and circulatory abnormalities around the Atlas vertebra area and brain's posterior fossa has been known for more than 40 years. It has hitherto been thoroughly kept under wraps, as it is better for physicians' bottom line.

Let's take a look at "Symptoms and Signs of Atlas" posted in June 2011 by Atlassubluxation.wordpress.com. It tells us that the joint between the skull and the neck designed for nodding movements has an expected maximum rotation of about 3–4 degrees on turning well to the left or right. The worst case the writer had seen was a rotatory subluxation of about 25 degrees, shown on a CT upper cervical spine. Mechanical misalignment symptoms can include:

- headaches
- low back pain
- chest wall pain
- one leg shorter than the other
- migraines with marked agitation
- pain between the shoulder blades
- disc injuries due to abnormal posture
- pains or injuries in one hip, knee and ankle
- jaw joint pains or dysfunction and a clicking jaw
- nausea and crackling or grating noises at the skull's base when turning the head

Symptoms of restricted nerve and blood vessel blood flow due to Atlas subluxation and vertebra misalignment can include:

- nausea
- tiredness
- dizziness
- heartburn
- constipation
- irritable bowel syndrome
- chronic fatigue syndrome
- fibromyalgia and depression

- fainting or near fainting episodes
- mental fogginess such as in ADHD
- mild incoordination and clumsiness

These symptoms are likely caused by brainstem injury when the misalignment occurred. There are also multiple reasons to believe that Atlas subluxations may cause sympathetic over-activation. The traction on the brain stem caused by the typical head forward position of most people with brainstem injuries activates a stress response. There might even be further impacts on sympathetic ganglia (nerve cell clusters) lying close to the spine along the spine's whole length. Symptoms would include chronic anxiety and impulsiveness as well as fine tremors and raised heart rate. Chronic sympathetic activation can be contributory to immune suppression, hypertension, diabetes, osteoporosis, disturbed sleep and depression.

Other possible effects of a misaligned Atlas might include:

- allergies
- insomnia
- skin problems
- learning disorders
- high blood pressure
- knee and foot problems
- brain disorders like anxiety
- headaches, including migraines
- sensory problems affecting vision and hearing
- reproductive disorders and menstrual problems
- immune problems like ear infections and chronic fatigue
- neurological problems, including seizures, vertigo and fibromyalgia
- spinal problems like back pain, sciatica, scoliosis and sports injuries
- stomach and digestive problems like ulcers, acid reflux and irritable bowel syndrome
- other body problems such as carpal tunnel syndrome

These findings were reported in the article "A neuroscientific account of how vestibular disorders impair bodily self-consciousness" by Christophe Lopez. They were based on research for the Laboratoire de Neurosciences Intégratives et Adaptatives of Aix-Marseille Université, Marseille, France. The results were first

published in *Frontiers Integrative Neuroscience* on December, 6, 2013.

Mind you, not all disorders may disappear in everyone undergoing Atlas misalignment correction, we read on ATANTOtec's website. They have found that some clients have other causes or contributing factors to be corrected. It would therefore be wrong to interpret an Atlas correction as a miracle cure solving all problems. On the contrary, it is essential to understand that *ATLANTO*tec purpose is not to diagnose or "cure" a variety of disorders. Its goal is only to check if it is necessary to treat the Atlas. The miraculous part is the body's self-regulation ability, once the Atlas is put in its correct position.

It was about 40 years ago, that a small cadre of American chiropractic specialists went to forego the typical 'full-spine manipulations' chiropractic method to limit their practice to a precise, delicate manual alignment of only the Atlas. Nowadays, these practitioners make up the National Upper-Cervical Chiropractic Association (NUCCA). They devoted themselves to the life-changing impact countless patients, doctors and students experience from impeccable upper cervical care and the profound healing effects of the NUCCA procedure.

This gentle, non-invasive technique was developed by Dr. Ralph Gregory, a gifted healer and visionary. His lifetime work focused on the relationship between the upper cervical spine (neck) and its profound influence on how the central nervous system and brain stem function. This relationship affects every aspect of human function, from the feeling sensations in our fingers to the regulation of hormones. It controls our movements and gives us the ability to hear, see, think and breathe as the Creator intended.

According to the NUCCA, Dr. Gregory created a radically new way of healing that can help restore body balance and perfect health. Chronic complaints after whiplash trauma, recurring migraine attacks and headaches from Atlas misalignment can be corrected. The correction eliminates the need for pharmaceutical drugs, which eliminates the risk of detrimental-to-the-health side-effects.

Furthermore, Atlas correction is an ideal way to improve posture as it corrects postural defects such as:

- pelvic obliquity
- functional scoliosis
- functional short leg
- hyperlordosis/hollow back

- a structurally normal spine that appears to have a lateral curve

It can also correct loss of the cervical lordosis, a condition occurring due to excess curvature of the cervical spine, which can lead to pain and discomfort.

How would an allopathic physician treat cervical lordosis? Treatment is mainly based on the cause, along with symptomatic treatment. Pain medications, muscles relaxants, nerve tonics and nutritional supplements like vitamin D may be given. Depending on the severity of the neck pain and difficulty in neck movements, a brace or neck collar might be advised. Physical therapy and exercises are often helpful in muscle strengthening, as well as improving range of motion and flexibility. Healthy lifestyle and maintaining ideal body weight is advised to relieve excessive strain on the spine.

Our body posture should be supported by passive, not strained, structures of joints and ligaments says Dr. Greenwood. When there is structural imbalance, however, the body is forced to maintain its balance with its muscles. But muscles are normally used to move around, not to work full time to structurally support the body. By supporting the body, the muscles use massive amounts of energy in a way for which it was not intended. All this is due to structural imbalance caused by Atlas misalignment, as demonstrated in lordosis.

Furthermore, for the body's organs and cells to work well, they need uninterrupted brain signals. The nervous system pathway from the brain down the spine through the Atlas is critical to our wellbeing. If out of whack, it is like driving a misaligned car. One can replace the tires, but the tires' wear and tear continues unless one adjusts the alignment. The same holds true for the human body. One can take medication to ease pain, but unless Atlas alignment is corrected, it will continue to damage other body parts. Often, that increases discomfort in excruciating ways. Rather than making it better, the pharmaceutical drugs lead to a slow, joyless and lingering path towards the grave.

It is logical to conclude that when the Atlas has been out of alignment since birth, all muscles and ligaments are aligned with this misaligned Atlas position. Therefore, once it is corrected it takes time for the body to adjust to prime positions as designed by the Creator. It depends on the length of time of misalignment (a person's age), how long it takes to reach that state. As Dr. Paiso points out:

> "When this vertebra [the Atlas] is not in its proper position just below the skull, it can cause about any symptom. The concept of Atlas Specific Correction, which is performed at his

> clinic, is a very simple one. The body then heals itself by means of commands from the brain, our on-board computer. If the computer functions as it should, one has very few health problems, and little need for drugs, pain killers, physical therapy, or even surgery. A life with very few health problems is possible, perhaps with as little as the adjustment of the Atlas."

How can we ascertain whether or not our Atlas is misaligned based on the symptoms or ailment we have? A personal visit is always needed for an assessment, we understand. Furthermore, ATLANTOtec staff states:

> "Experience tells us that an assessment of the position of the Atlas carried out by a physiotherapist or by a doctor who is not specialized in the Atlas correction technique, often proves to be totally erroneous. The techniques taught in the relevant training courses are in fact created and learnt by persons who have never carried out a suitable radiological investigation on the Atlas so as to ascertain the reliability of their tests. You don't believe so? Let your Atlas be tested by 5 chiropractors, osteopaths or assorted doctors. You will be surprised by the result!"

"If I get it done, how many sessions are necessary," you perhaps wonder? Just one session and subsequent check-up, rare exceptions excluded/ATLANTOtec explains:

> "We must consider that, in the presence of a constantly profound stress or anxiety or a skull-mandibular dysfunction, even though it is unlikely that the Atlas will become misaligned again, the treatment does not grant immunity from muscular tension. When needed, a repeat session to lighten the muscular tension might prove useful."

Is Atlas correction dangerous? Many people deem it dangerous to intervene in the spine. I am one of them. The *ATLANTO*tec and other similar methods, however, exploit a totally new principle. This approach is absolutely danger-free, as it has nothing in common with chiropractic treatment or osteopathy. (Osteopathy is a branch of medical practice emphasizing treatment of medical disorders through manipulation and massage of bones, joints, and muscles.) There are no sudden head movements. There is no stretching or straining of the neck.

In my travels on the World Wide Web researching this topic I stumbled across a regular chiropractor's description of the activity he used to make an Atlas and cervical adjustment to a 70-year old man interested in the AtlasProfilax treatment:

> "First I described to him the difficult means I use for producing and delivering the upper cervical corrective force by positioning my body in proper orientation to the patient's upper cervical spine determined according to X-ray analysis calculations. I described the skill required in using my base of support from the ground up, in the positioning my hands on the patient's neck along an X-ray analysis determined corrective pathway, and the production of the corrective vector by the locking together of my hands, arms and shoulders as an instrument, and using my triceps to pull my arms back within my shoulder sockets, resulting sideways compression of my chest, the overcoming of upper cervical resistance and the production of the corrective vector. I described how the initial postural distortion measurements are immediately returned to normal and he [the patient] was interested to hear how the patient's pelvis would be level, the center of their pelvis and upper back would align with their center of gravity, the difference between the right and left standing body weight would balance, and their leg lengths would be even. I also explained how I took two upper cervical X-rays following the patient's first upper cervical spinal correction. I told him I used my analysis of these follow-up X-rays to verify the upper cervical correction or to provide the information required for improving the correction of the patient's abnormal upper cervical spinal mechanics.
>
> "The man was interested to hear about the holding power of my upper cervical correction, and that I require at least 4 follow-up visits per year to insure my patients' continue to enjoy the benefits they receive from their corrective care. I told him my average patient holds their upper cervical spinal alignment for months and years, but not usually for life. The man considered everything I told him about the time involved in performance of my detailed diagnostic and

> corrective procedures. He was interested in the details of these procedures and the expertise involved in my upper cervical corrective procedures."

The thought of such treatment makes me shudder. The outcome of the above case is unknown. The State of Oregon, USA, authorities declared any other methods of treating Atlas misalignments quackery.

*ATLANTO*tec purports to have nothing in common with any chiropractic manipulations, either in terms of methods of execution or in terms of results. Whereas cervical manipulations must be regularly repeated in chiropractic adjustments, we are told that the *ATLANTO*tec method needs just one conclusive treatment. The chiropractic cervical manipulations entail some degree of risk, whereas *ATLANTO*tec is risk-free since it does not involve cervical manipulation. According to their website, there is no intent to denigrate other therapies. Rather, they introduce a more effective and riskless technique of interest to both patients and therapists compared to previous treatment modalities. On the basis of ATLANTOtec's experience, an incorrect Atlas position cannot be corrected using chiropractic or osteopathic manipulation or manual medicine. As today's research documents and theory asserts: "Blocked articulation always results from a vertebra's incorrect position. Once corrected, the blocked articulation is also removed."

As we have seen, however, this cannot be applied to the Atlas as it behaves mechanically more like a part of the cranium than a vertebra. A chiropractor therefore can adjust an Atlas misalignment, but the misalignment apparently returns after a short time due to the Atlas' mobility.

If spiral CT images were used before and after chiropractic treatment one could see how Atlas misalignment continues even after manipulation. That's why disturbances return shortly after a period of relief. Atlas Profilax and *ATLANTO*tec Atlas correction techniques usually require only one treatment to return the Atlas solidly to its anatomically correct position. Of course, prevention is the best cure, since it is an "investment" in the Self to attain, maintain and assure good health. In my opinion, realignment should take place as soon a child is born. That enables the body to function and develop to its full potential right from the get-go — unless it has been vaccinated and doomed to steady decline from the first day of birth.

Dr. Donald Liebell of *Chronic Pin & Wellness Solutions* also confirms that if the Atlas becomes tilted or rotated away from its level position, our head also shifts away from its vertical position. This causes the rest of our neck and even our lower spine to go out of balance. In turn, if the Atlas shifts out of the normal the position,

it can cause total body imbalance. It can also cause abnormal nerve function, because our body can be balanced and straight only when our spinal column is balanced and straight. And the most important factor for the spinal column to stay straight is having the weight of the head centered over the neck, beginning with the Atlas. You see, the Atlas not only carries the skull, but is also responsible for its suspension and equilibrium. It manages the spine and human skeleton.

In Liebell's opinion, hundreds of millions of people are most likely walking around literally without their heads on straight. And they have the pain to prove it, because the body below goes out of balance to compensate for the change. In an effort to keep the head centered over the neck, the rest of the neck, the lower spine and the pelvis will twist. Many joints of the spine can get locked up like rusty hinges, causing pain and tenderness, swelling, muscle tightness and disturbed blood flow as we grow older.

Body imbalance also causes asymmetrical strain and tension on muscles, joints and nerves from head to toe. It can make one leg pull up "short", in turn causing pain and dysfunction in multiple areas of the body. For example, Dr. Liebell claims, many people diagnosed with Fibromyalgia or suffering chronic headaches and even migraines have a structural neck imbalance as the underlying cause. He says this understanding of a body's imbalance is important for preventative healthcare, as well as for crisis care, in children and adults. In other words, when our spine breaks down, so do we! When our head is not centered, sitting level over our Atlas vertebra, our whole body twists off center.

Needless to say, all these possible physical problems might come from faulty nervous system interference. This interference would be caused by the Atlas misalignment radiating throughout the entire body. As we already heard, the nervous system is crucial in providing function to every tissue, organ and system throughout the body. We already heard how Atlas misalignment causes the entire spine and body below it to twist and shift; we heard that it in turn causes imbalances not just to muscles and blood supply, but throws nerve messages vital to body functions off balance, too. That includes messages to regenerate cells, tissues and organs.

So, long-term Atlas misalignment consequently result in:

- muscle imbalance
- organ dysfunction
- reduced nerve and blood supply flow

- general degeneration of different areas of the body

This causes:

- disease
- organ dysfunction
- loss of mobility in limbs
- lowered resistance to illness
- mild to severe pain in various areas

Research done through the University of Colorado at Boulder proved that pressure on a spinal nerve equal to the weight of a feather falling in ones hand can reduce nerve function up to 50 percent. It only takes the slightest shift of a bone to irritate a nerve.

"Is there a way to find out about the condition of the Atlas just by looking at the neck," you may ask? There is, and I have done it with ease in others once I knew where to look. With Atlas subluxation the Atlas area always bulges visibly outward.

Atlanto-occipital subluxation is the orthopedic decapitation or internal decapitation describing ligamentous separation of the spinal column from the skull base. The physical signs of this separation are straight forward, and the diagnosis usually confirmed without investigation.

Atlas misalignment is almost always present when a person's posture is askew. The head gets carried forward of the shoulders to differing degrees. In an anatomically correct posture, the shoulder-joints center is aligned vertically and directly below the ear canals. When a person has great difficulty straightening up to hold the head in a correct position, a front-on-view often clearly reveals the problem. The head might be tilted to one side. The neck might be rotated a few degrees off straight ahead. The trunk's midline might not be vertical or having a degree of hunch or a sway back. Furthermore, if Atlas misalignment is present, one shoulder will be higher than the other. The pelvis will often be visibly off level as well, usually high on the side of the low shoulder.

From the back, the difference in shoulder level is more apparent. One shoulder is pushed out to the back.

The head, shoulders and hips viewed from above might be out of alignment as well. The neck is almost always tender just below the ears and behind the jaw. The neck bone might also feel closer to the jaw on one side than on the other. Postural

issues, muscle spasm or a "bull neck," however, can make this sign difficult to identify.

These signs are easily visible in a mirror, but when did it happen? We already heard Dr. Liebell's opinion. Others in his field think it may have been genetically engineered into us some time ago, because the off-alignment rotation seems to always go in the same direction. This would be most unlikely if happening accidentally at or after birth. That, at least, is Swiss born René-Claudius Schümperli's conclusion.

Schümperli is the founder of Atlas Profilax, who developed a device making Atlas adjustment easy and pain-free. For him, upright walking and good health were for the longest time only a dream, as he was handicapped the moment he took his first breath. The reasons for his suffering were unknown. Western medicine, osteopathy and any other known therapies were unable to improve his condition. His suffering led to relentless and persistent searches for ways to help himself. This, in turn, led him to suspect that a mal-rotated first cervical vertebra, the Atlas, could be the reason for his malaise/trauma.

It was then that Schümperli developed his revolutionary method, which aligns the Atlas into a stable position without cracking, rough handling or traction in one short session. It worked for him and others in similar predicaments, thus confirming the truth of his idea. His invention is a neuromuscular vibrational massage technique focusing on:

- the Atlas
- the axis vertebra
- the base of the skull
- the short muscles of the neck
- the sub-occipital muscles surrounding and stabilizing the head joints

This massage releases the neck's muscular tension, so the Atlas can be moved back into its natural, anatomical precise Creator-of-All created position. The release of muscular tension in the neck alone corrects ligamentous and muscular compression on the Atlas vertebra. That, in turn produces a positive effect on the body, while immediately stimulating its healing capacity and ability. In my case, it came with a highly noticeable rush of blood to the brain.

I had a subsequent follow-up. It was confirmed that the Atlas remained in its realigned natural position. Due to anatomical and mechanical reasons, it is never

again able to rotate out of its correct position. It gave me complete physical, spiritual and mental capabilities for the rest of my life

Can there be other reactions after the AtlasPROfilax treatment? Yes, in some cases showing up right away, in other cases weeks later. Ranging from fatigue to muscle tension in the neck and back to general exhaustion, some aches and pains experienced pre-Atlas realignment might also flare up. In fact, these are signs of progress in the self-healing process, Schümperli claims. He says to pay attention to the body, note changes in ones condition and support this self-healing process with regular massages.

Schümperli's method differs completely from other approaches and methods, as their applications are based on the assumption of a minimal mal-rotation. I, however, have had only one AtlasPROfilax safe and non-invasive treatment, which gave me lasting results. Please be advised, though, that I had no difficulties health-wise in any regards before the Atlas alignment. I merely wanted it done, because the concept made sense intrigued me. Now I consider it a very important step in my PTSD recovery.

Be it as it may, Schümperli, too, noticed Atlas mal-rotation in most of his cases.

Jean-Claude Koven is a Rancho Mirage, California, based writer and speaker. He is the author of *Going Deeper: How to Make Sense of Your Life When Your Life Makes No Sense*. In the book, he shares his experience with ATLASPROFILAX. Shortly before delivering a talk at the Body, Mind, Spirit Expo in San Diego in 2006, he was introduced to Ranan Shahar. Shahar is Master in Chinese Medicine and founder of the L. A. New Dawn Clinic. He had just attended an Atlas Profilax seminar in Switzerland to learn the process. A renowned healer, Shahar, had treated more than 10,000 people worldwide with his life-changing treatment *Atlas Evolution* by 2018. By that time, he had *also* noticed that virtually every single human's Atlas is dislocated (luxated in chiropractic terms). The dislocation not only causes energy blockages in the spinal column, but also a host of physical and mental disturbances.

Koven accepted Shahar's invitation to experience the ATLASPROFILAX process for himself. Koven, too, was one of the 99.9 percent of humanity with a significantly luxated Atlas despite all his previous metaphysical practices, countless Rolfing sessions, deep tissue work and chiropractic adjustments. The treatment and massage of the tissue surrounding the Atlas including use of the pulsating probe only took 15 minutes. If performed properly, it should last a lifetime. It is Koven's article "Reversing the Curse: The Block in the Homo Sapien" that relates how the luxation is always in the same direction. He notes that this is a statistically impossibility, if

the displacement is simply the result of physical trauma occurring during the birth and delivery process.

Koven, completely underestimating the treatment effect at the time of his Atlas correction, writes of his experience immediately afterwards: "Imagine standing in a dry riverbed, just below a dam as it is being demolished." His old self was ripped away in a torrent of freely flowing energy. He could all but see himself emerging from his personal chrysalis. Within minutes, the flood modulated into a steady flow while, receiving the distinct message "*telling me that I had broken through a blockage deliberately engineered into the human genome*."

"While I enjoy a good story every now and again, this one begged for independent corroboration," Koven continues. A few days later, he called his friend Wynn Free, author of *The Reincarnation of Edgar Cayce.* Free teamed with Terry Brown in channelling an evolved extraterrestrial intelligence named the Elohim, who confirmed the information. The luxated Atlas was deliberately engineered into the human coding by the Anunnaki to render their native pool of mining slaves more docile, programmable and controllable. It has remained in humans' genetic makeup since. Koven adds: "I suspect it is well known to those who understand how best to exploit such things."

Although realigning one's Atlas seems to be a good and necessary process, in Koven's opinion it comes with a price. After all, who knows what darkness is amassed behind our personal dammed walls? Once the energy bursts free, both the physical and emotional bodies of each Atlas realignment patient might have plenty of catching up to do.

Koven's spiritual body soared and his emotional body quickly adjusted to the new game at hand. But it took a while for his physical body to find its footing and to adjust within this higher vibratory state. Ten days after the treatment, he experienced a severe spasm under his left shoulder that lasted for 72 hours. Within weeks, he needed the work of a healer to help clear considerable blockages in his digestive tracts. Even as he wrote these words about his ATLASPROFILAX experience, he was recovering from an onset of sinus and chest infections that were cleansing years of accumulated debris. As for myself, having no known physical ailment whatsoever, I had no reactions other than a marked decrease in desire for alcohol, my Achilles heel, and the quasi elimination of open heights to the point that I ventured on a glass bottom helicopter trip while at Uluru, Australia.

Shahar aspires to train as many practitioners as he possibly can in the ATLASPROFILAX method. Feeling that we live in a time of awakening, he wants to

spread the knowledge about it to free the human race. At present, I feel, each of us is being challenged to emerge from the false comfort of our individual hiding places in the still, dark waters behind our own individual dam. This is precisely, I think, why I was thrown into the hellish PTSD experience.

Einstein said: "No problem can ever be solved from the same level of consciousness that created it." Others feel that ignorance is bliss. The PTSD sufferer is already on a different level of consciousness, of vibration, due to the PTSD-causing event. Atlas's misalignment correction can only help in this fascinating and horizon-opening journey of recovery in an effortless way. As Koven says, applicable to humanity overall:

> "If we are to put an end to the insanity that has a death grip on our collective sensibilities, then we all need to move to a higher level of consciousness before it is too late."

The PTSD recoverer has little choice. It is either that or to die spiritually and, sooner or later, physically, if adhering to allopathic PTSD treatment modalities. What is there to loose? US$250.00 or thereabouts.

Due to Atlas alignment, impaired abilities in imagination and conscience would most likely be restored. So would disabled and improper brain functions that inhibit us from exploring the brain's full capabilities.

Our attitude towards each other, oftentimes based on colour, nationality, religion, affluence, hygiene, eating habits and overall upbringing, may mellow and disappear with full blood-flow to the brain. After all, these are all beyond our control as none, or at least very, very few of us Earth-dwellers consciously chose any of it. A change in attitude towards each other might lead to a multitude of sensitive, kind and great thinking souls such as the world's Nassim Haramein, Michael Tsarion, Jordon Maxwell, G. Edward Griffith, Eustache Mullins, David Icke and others. Atlas alignment might even turn trans-humanist scientists like Lang, McTeague and Neumeister with their atheistic beliefs and inhumane views and attitudes into people with some humane emotions. After all, miracles do happen, and the result of Atlas alignment, in my view, is one of them.

Mental health profession's clinical psychologists and psychiatrists are similar in behaviour. In my experience, they carry the same inhumane attitudes. Nothing seems to suit them better than to *practice* on injured and ill human beings without regards of the consequences. They practice on them with their inane treatment modalities and massive amounts of pharmaceutical drugs with ecstasy and marijuana for PTSD affected on their agenda.

The enjoyment from destroying immensely capable men and women like true PTSD journeyers', the fire-fighters, police officers, veterans, active soldiers and aircrew is clear. It becomes ever increasingly visible when looking at the fluctuations in PTSD treatment modalities and the demands made on those PTSD afflicted subjects at their commands. It makes me wonder what condition their Atlas is in, really! Helter-Skelter? It makes me wonder how many PTSD journeyers they may have landed in insane asylums because of their Atlas misalignment and lack of blood-flow to their brain, never mind which side of it?

No statistics exist on institutionalization of PTSD-affected people. Nor are there statistics on the success of such PTSD treatments. All that is known is that in the United States of America alone, vast numbers of PTSD experiencers were successful, active soldiers and veterans who now live in abject poverty on American streets. They have been shat and pissed upon by their government for decades. Most everyone else in the PTSD position is treated the same, unless a member of a secret society.

This is called living in a civilized society? But what the heck. We are considered human debris. Ethics, empathy and compassion are not in style with those in power — the present rulers of this world, the trans-humanist and the so-called elite. Are they possibly the offspring of those accused of genetically manipulating the Atlas subluxation into our genome, as they could not care less about the PTSD sufferer they throw on the streets?

Again, however, in essence we are the ones left with taking responsibility for ourselves, the ones responsible for helping our Self if we want to survive the PTSD ordeal in style. This in turn directly leads us to investigate the physician and patient relationship.

22

The Physician & The Patient

"Most Doctors Outside VA Lack Training To Handle Vets' Health Issues." So screeched the November 1, 2016, headline in the Scranton, Pennsylvania, *The Times-Tribune.* Reporter Jon O'Connell's announced to the world that mental-health-practitioners both inside and outside the United States Veterans' Administration compounds lacked the knowledge to adequately treat PTSD patients. So do many other VA personnel. U.S. President Donald J. Trump confirmed this in his January 2018 State of the Nation address. That was why he had fired 1,500 of them in his first year in Office.

Scranton should know. It is the largest city in Northeast Pennsylvania. It is home to the National Guard's 1st Battalion, 55th Heavy Brigade. It is close to the

Tobyhanna Army Depot, the 55th Heavy Brigade Combat Team (HBCT) "STRIKE BRIGADE," maintained by the Pennsylvania Army National Guard. A subordinate formation of the U.S. Army National Guard's 28th Infantry Division was headquartered in the Watres Armory from 1900–2012, before relocation to the Armed Forces Reserve Center near the borough of Throop, PA.

Scranton's military history with the 55th HBCT began in July 1898 with the organization of Company K, 11th Pennsylvania Infantry Regiment. The company was re-designated Company K, 13th Pennsylvania Infantry in August 1899. In September 1916, Company K was activated for service on the Mexico-United States border during the Pancho Villa Expedition. It was again activated for federal service in August 1917.

In October, Company K, 13th Pennsylvania was combined with Company K, 1st Pennsylvania Infantry. The new unit was re-designated Company K, 109th Infantry. This regiment fought in France during World War I as part of the 28th Infantry Division. Demobilized in May 1919, in July 1920 the unit was reorganized as Company K, 13th Pennsylvania Infantry Regiment.

A 1921 reorganization renamed the unit Company B, 109th Infantry Regiment. In February 1941, it was activated for service in World War II, fighting in Europe as part of the 28th Infantry Division. It was demobilized in October 1945.

The 109th Infantry was again activated with the 28th Infantry Division during the Korean War and served in West Germany from 1950 to 1954. In June 1959, Company B was reorganized and designated Company B, 1st Battle Group, 109th Infantry. Company B was re-designated Headquarters, 3rd Brigade, 28th Infantry Division in April 1963. In February 1968, 3rd Brigade was renamed 55th Brigade. Its soldiers and units took part in Bosnia-Herzegovina's 2002 and 2003 Operation Joint Forge.

Since September 11, 2001, 55th Brigade participated in operations both as individuals and as members of units in Operations:

- New Dawn
- Noble Eagle
- Iraqi Freedom
- Enduring Freedom

In 2003–04 the 55th Brigade led "Taskforce Keystone," a major deployment of about 2,000 soldiers of the 28th Infantry Division, to Europe to provide force

protection and enhanced security in the wake of September 11. Another 1,100 28th Division soldiers served as the core American peacekeeping presence in Bosnia. Its 3rd Battalion, 103rd Armor, was awarded the Meritorious Unit Commendation for its 2008 service in Afghanistan. And about two Battalions of the 55th Armored Brigade Combat Team deployed to Kuwait in 2012 and 2013. Their role was to conduct security operations at several logistical bases in support of Operation Enduring Freedom. As of 2013, the task organization consisted of:

- Special Troops Battalion (Scranton)
- 228th Brigade Support Battalion (Sellersville)
- 3rd Battalion, 103rd Armor Regiment (Lewisburg)
- 1st Battalion, 109th Infantry Regiment (Scranton)
- 1st Squadron, 104th Cavalry Regiment (Philadelphia)
- 1st Battalion, 109th Field Artillery Regiment (Wilkes-Barre)

The 55th Brigade Support Battalion is the former 103rd Engineer Battalion. In other words, Scranton has been filled with very active and battle-hardened military personnel and their families for over a century. We can thus surmise that many of those returning home from combat carry visible and invisible scars of battle. That is the issue addressed by Scranton's *Times-Tribune*'s Staff writer O'Connell.

His interest in the topic might have been sparked by Garry J. Augustine's April 14, 2016, Task & Purpose publication *Give Veterans Greater Access To Quality Care, Not Healthcare Credit Cards*. A combat-wounded Vietnam veteran, Augustine is executive director of the nearly 1.3 million-member Washington, DC-based Disabled American Veterans (DAV) organization. His responsibilities include DAV's National Service and Legislative Programs oversight. As such, he is the organization's principal spokesperson before Congress, the White House and the U.S. Department of Veterans Affairs, the VA.

Augustine's main concerns at present seem to be both in the veteran healthcare system and private-sector healthcare providers. Neither seem prepared or willing to accept large numbers of new military patients because of the lengthy appointment wait times it would create for patients already in their care if they did. Therefore, he says, even though giving veterans vouchers or plastic cards they can use to pay for healthcare wherever they choose may at first glance seem like an attractive idea in reality it is not. Why? It assumes that veterans are able to readily access private sector quality care whenever and wherever they want when it is not readily or at all

available.

The first 'Choice Cards' were first mailed in early November 2014 to 320,000 Vets living more than 40 miles from a VA medical facility. It all found its origin with the VACAA, the Veterans Access, Choice, and Accountability Act of 2014, a law enacted by Congress and signed by President Obama in August 2014 to improve health care for Veterans. The cards came with letters explaining how to use them. By late November 2014, another 370,000 vets facing waits longer than 30 days for VA appointments were the second group to get the cards. This was reported by the VA's acting principal deputy under secretary for health Dr. James Tuchschmidt. By the end of January 15, 2015, another 8 milllion enrolled veterans had received Choice Cards. These vets, however, were only eligible to use them to access non-VA care if:

- they live over 40 miles from VA-owned medical facilities
- the VA is unable to provide care within 30 days, based on a veteran's preferred date or the date deemed medically necessary by their physician

But there have been widespread problems of scheduling-mistakes, billing veterans instead of providers, and the latter not getting paid. This seems to tell a very different story.

Scripps News Washington Bureau's journalists Mark Greenblatt and Aaron Kessler teamed up with WCPO's Daniel Monk to write a *Special investigation*: *Dereliction of Duty* report on conditions and factors in the Cincinnati VA, published February 16, 2016. They used the testimony of nearly three dozen whistleblowers, who came forward stating its medical center was in complete disarray. They also claimed that veterans were deprived of the care they needed right there in the Secretary of Veterans Affairs' own backyard. President Obama had appointed West Point graduate and former Cincinnati, Ohio-based Procter & Gamble's chief executive Bob McDonald. About 866,000 veterans lived in Ohio in September 30, 2014, a number most likely little changed after President Donald J. Trump replaced him with David L. Shulkin in 2017, followed in July 2018 by lawyer and US Naval Reserve intelligence officer Robert Leon Wilkie Jr. (1962–), who since 2006 had served as Under Secretary of Defense for Personnel and Readiness.

Greenblatt et al. had talked to 34 current and former Cincinnati VAMC staff members since October 2015. That included 18 doctors from several departments, who sent an unsigned letter to McDonald in September 2015. The letter described

"urgent concerns about quality of care" at this hospital serving more than 40,000 area veterans. They alleged a pattern of cost cutting that:

- reduced access to care
- put patients in harm's way
- forced out experienced surgeons

At the controversy's center were Dr. Barbara Temeck and Jack Hetrick. Temeck assumed the role of acting chief of staff at the Cincinnati VAMC in July 2013. Temeck received her medical degree from Georgetown University and went on to become a thoracic surgeon. Hetrick was the Department of Veterans Affairs' regional director of the Veterans Integrated Service Network (VISN) 10, which oversees VA centers across Ohio. He was the highest-ranking VA official in Ohio, Michigan and Indiana, He was Temeck's boss.

The VA launched one investigation and requested the Office of Inspector to open an additional independent one. The VA also temporarily removed the Cincinnati hospital oversight authority from Hetrick to prevent conflict of interest. While the investigations proceeded, Cincinnati VA was to report to a Pittsburgh-based regional director.

Benjamin Krause, JD weighed in on February 2016. Krause is a lawyer, investigative reporter, award-winning veterans advocate, author of *Voc Rehab Survival Guide for Veterans* and chief editor of DisabledVeterans.org. He wrote "*Why Do Skeletons Follow Cincinnati VA's Dr. Barbara Temeck?*' In the article, he shared that at the amazing and record-breaking speed of 12 days, the VA substantiated misconduct allegations against Temeck and Hetrick. Further investigation revealed that Temeck had a trail of skeletons behind her at the Hines VA, the St. Louis VA, the Dorn VA and now the Cincinnati VA.

Temeck was removed from her duties and reassigned, pending possible criminal charges. She was purportedly paid for two positions instead of one. She pocketed almost $400,000 annually as both surgeon and chief of staff even though not truly functioning as a surgeon. She also illegally prescribed controlled substances to Hetrick's wife. Further, some accuse her of illegally diverting funds in her discretionary budget away from direct veteran care programs inside the VA.

The Dorn VAMC, South Carolina, opened at its current location in 1932. It has 204 skilled nursing beds, which include acute medical, surgical, psychiatric and long-term care. It provides primary, secondary and some tertiary care. In the 2013 fiscal

year it received a total of 75,813 unique patients. This included 6,381 female and 15,829 male veterans from the Operations Iraqi Freedom, Enduring Freedom and New Dawn (OIF/OEF/OND) period of service. It also treated 936,424 outpatients and 5,005 inpatients through seven Community-Based Outpatient Clinics (CBOC) located throughout South Carolina.

All clinics except one (Rock Hill) are staffed with VA employees, and all clinics have mental health components available. One of the main accusations against Temeck during her tenure in charge of Dorn is to have improperly delayed colonoscopies. Despite receiving mountains of money to pay for the procedures in previous years, 700 were still outstanding. In 2011, the backlogged VA Government Issue (GI) clinic also received massive funds to pay for non-VA care GI procedures to alleviate the backlog. Of the $1.02 million received, however, Temeck's team spent only $275,000 on such care. The rest of the money was siphoned off without explanation or accounting.

On September 6, 2013, Joey Holleman revealed further problems in *Military News*. He said that Dorn VAMC mismanaged its gastroenterology program so badly that at one point in 2011 almost 4,000 patients were waiting to be examined. This came in a report by the VA's inspector general. Temeck was blamed for Dorn's poor management of its gastroenterology consultation program. She was also blamed for long delays in hiring staff, lack of tracking systems and spending only about $200,000 of the $1 million meant to reduce examination backlogs.

Delays in diagnosis and treatment were "associated" to cancers among 52 of those patients. At least nine patients or their families had filed lawsuits about the delays. A VA Office of the Inspector General Report (OIG) stated:

> "We substantiated that VISN 7 gave the facility $1.02M in early September 2011 to use to address the GI backlog but that only approximately $275,000 was actually used for this purpose through August 2012. The Business Office was not aware that the additional monies were 'earmarked' to address the GI backlog and obligated the funds as usual. The VISN 7 CFO told us that although the facility was given $1.02M expressly to address the GI backlog, they did not have to report back to the VISN on how the funds were used. The CFO reported that facilities may use their discretion to determine how to best meet the needs of their patients; however, fee care was specifically identified as a mechanism to

reduce the backlog."

Before Dorn, Temeck was deputy chief of staff at St. Louis VAMC. That is a full-service healthcare facility with inpatient and ambulatory care in medicine, surgery, psychiatry, neurology, rehabilitation and over 65 subspecialty areas. It is a two-division facility with 355 beds, and serves veterans and their families in east central Missouri and southwestern Illinois. The building is in the Jefferson Barracks Division, a multi-building complex overlooking the Mississippi River in south St. Louis County. It also provides:

- geriatric healthcare
- psychiatric treatment
- healthcarerehabilitation services
- a nursing home care unit
- regional spinal cord injury treatment
- a rehabilitation domiciliary program for homeless veterans

Under Temeck's 2010 tenure, more than 1,800 soldiers, veterans and their families might have been exposed to HIV and hepatitis when receiving dental work. Workers failed to properly sterilize their dental equipment using detergent. The warning signs were everywhere.

After Temeck's move, other scandals surfaced, such as withholding psychiatric care from veterans. One psychiatrist trying to increase the number of patients he saw in a day from six to 12 was threatened by supervision to not rock the boat. This scandal started in 2012, after Temeck took over, and carries her signature budgetary move to withhold care from veterans. Krause states:

> "I am unable to find a source that directly ties in Dr. Temeck with the specific misconduct, but her history of mismanagement seems to result in this type of problem given the more recent events at Dorn VA and Cincinnati VA."

Before St. Louis, Temeck was chief of staff at Hines' VA from about 2001 to 2011. During her stay:

- the thoracic surgery program was underfunded
- Veterans not needing open-heart surgeries were operated on
- EKGs of veterans needing urgent attention remained unread for months

The facility was dramatically understaffed. Those working there were fearful to whistle blow under Temeck's rule. It took a couple years and investigations by the Office of Special Counsel (OSC) of the U.S. Justice Department's Civil Rights Division before the scandals starting under Temeck surfaced in the public domain.

In May 2014, Frank Holland of WGN-TV, Chicago, reported that federal investigators were now looking into the Chicago area Hines VA Hospital in Maywood, Illinois. There were claims that officials kept secret waiting lists so executives could collect bonuses for speedy treatment. According to the report, Hines thus joined a handful of other VA hospitals across the country embroiled in scandals stretching from Spokane, Washington, to Texas. Pending allegations claimed that vets were waiting for physical or mental treatment for days, weeks, months. The allegations said they were silently on waiting lists only hospital executives knew about in order to make the executives look good and get them bonuses.

Germaine Carno was president of the union representing Hines VAMC's doctors, psychiatrists and physical therapists. She explained that the administrators made it seem like the hospitals are meeting their goals, which is tied to big bonuses. But veterans would wait three or four months for treatment.

In 2011, all VA hospitals were issued a mandate that veterans had to receive treatment within two weeks of their request. Carno said:

"We have so many veterans and not enough staff to think a veteran can call and get an appointment in two weeks is absurd. However, the official reports were written so it appeared the vets received treatment within the two week period."

According to its website the 471-bed Hines facility served more than 50,000 vets in 2015. Temeck was apparently involved in research focusing on "patient traffic control" and "time-sensitive performance problems."

According to Krause, however, most of the above-mentioned problems surfaced after Temeck went on to St. Louis' VA hospital. For at least 15 years, Temeck has been shuffled around the VA, following the scandals that surfaced at Hines VA Hospital. So why did her budgetary decisions leave a trail of lost money and dead veterans? Why was she allowed to carry out her unethical and likely unlawful actions under both a Republican and a Democratic president, Krause asked? Why indeed, and revelations unfolding in the wake of the FISA memo might answer that question. As for her boss in Cincinnati, VA's regional VISN Director Jack Hetrick, he announced a sudden urge for peaceful retirement. This came in February 2016, immediately after Sloan Gibson, Deputy Secretary, U.S. Department of Veterans

Affairs, proposed his removal. At the same time, Gibson suspended Barbara Temeck from all duties. The allegations that led to the VA's Office of Medical Inspector and Office of Acountability investigations had caught up with her.

U.S. Rep. Mike Turner, R-Dayton commented in the *Dayton Daily News* on Feb. 25, 2016:

"Once again an official that has allegedly violated basic medical standards has retired without facing the consequences for accountability at the VA. "There is clearly a lack of accountability that continues to block quality of care to our veterans."

Greenberg reported on January 10, 2018, that Temeck was convicted of illegally prescribing a generic form of Valium for her friend, the wife of her former boss Jack Hetrick in November 2013. The conviction followed nearly two years of turmoil for the 67-year-old cardio-thoracic surgeon who spent more than 30 years in the U.S. Department of Veterans Affairs serving as an administrator in Chicago, St. Louis, Columbia, South Carolina, and Cincinnati. But Judge Michael Barrett has yet to rule on a defense motion to dismiss all charges against the Cincinnati VA's former chief of staff. There has not been sufficient expert testimony that Temeck's prescriptions were beyond the scope of legitimate medical care.

Mind you, in a way Temeck dug her own grave when she tried to outsmart the system by putting a spin on the evolution of things. Krause reports in May 2016, under the headline:

> "Former Cincinnati VA chief Dr. Barbara Temeck came forward as a whistleblower following allegations that she herself had engaged in wrongdoing at the facility"

Temeck alleged that she was demoted from her position as acting chief of staff in retaliation for pushing back against wrongdoing. She claimed the demotion derby occurred because she pushed back against management encroachment from the University of Cincinnati's leadership. Temeck also blasted the unanimous letter filed last fall by 34 doctors, nurses and caregivers complaining about her. She called it "an orchestrated rouse used to help wrongdoers benefit from the lack of accountability at the Cincinnati VA." She asserted that the unanimous complaints were an end run against her reforms. Those reforms, she asserted, would have kept the non-VA healthcare spending in line with that of other facilities.

In her statement to the Office of Special Counsel per *The Enquirer,* Temeck alleged that the Cincinnati VA would pay more than $1 million in unnecessary overtime in 2016. This would pay nurses and other health-care providers to cover

for absent surgeons, who would also claim their salaries.

The VA had a contract with the University of Cincinnati (UC) Health. That is where the region's top clinicians and researchers are said to provide world-class care for Cincinnati and beyond. The contract was for more than $1.5 million to provide radiology services. Temeck replaced the contract by hiring staff radiologists, which she alleged greatly upset the UC leadership.

She also alleged that the [UC] medical school billed the VA for $887,000 in extra educational costs for medical residents at the Cincinnati facility But, she said, she analyzed the bill and found the actual amount due was closer to $67,000. She said a disappointed medical school official told her, "We'll do better next year."

She furthermore alleged that most Cincinnati VA surgeons worked only four days a week. They were supposed to be working for the VA five days a week. But she said that many of them also worked for UC Health at UC Medical Center.

She claimed that VA surgeons were often unavailable for VA clinics because they were working at UC Medical Center. "Physician staffing is controlled and manipulated" by UC Health, Temeck's statement said. As a result, she said, Veterans were sent to UC Medical Center for procedures that the Cincinnati VA could do. That would assume that it was properly staffed with surgeons. She said the Cincinnati VA keeps an operating room ready and staffed with nurses 24 hours a day.

She also accused the UC Health of blocking her from reaching out to TriHealth or Mercy Health for help in hiring for open jobs that UC Health or the College of Medicine promised to fill but did not. In poker, it would be called bluffing. "So who should we believe in this 'he said, she said' mess in Cincinnati," Krause asks. "Is it curious, that the Office of Special Counsel complaint from Temeck came only after she was removed as chief of staff for wrongdoing?"

Dr. Richard Freiberg, former Cincinatti VA's chief of orthopaedics, told team Greenblatt:

> "This was a model hospital. We were serving veterans with almost every imaginable problem and doing state-of-the-art care. Now, we're unable to care for almost all of them. I've worked very closely with them to make sure we get them back on track.

He said that shortly after Temeck came to Cincinnati, she called a sudden meeting of the hospital's full-time total joint surgeons: "We were told that we were going to be reduced to one full time between the three of us." Dr. Freiberg ended his

VA employment in October 2016. He was frustrated by cuts that rendered the hospital unable to do complex joint replacements for hips, knees and shoulders. He continues to volunteer for the facility: "I wanted to make sure that this organization was set solid for the future. I think we're there."

Since then the hospital has consistently received four or five stars, which are the VA's highest ratings.

Let's keep in mind the mountains of drugs prescribed by VA mental health physicians for PTSD travelers' daily consumption alone. It goes up to up to 18 medications daily, I hear. To drag Dr. Temeck as a scapegoat into court to prosecute her under so flimsy a charge is laughable. It is ridiculous, nay sinister. It is a mere deviation away from the VA swamp. The money spent on lawyer and court costs alone would be better used to help PTSD-experiencing soldiers and veterans. It would be better spent helping those who almost lost their lives, if not their limbs, in battles. Their sacrifices just make the rich richer, while human beings get poorer by the minute in knowledge and material sustenance. Unable to see what is being done against them, they refuse to take responsibility for the SELF. But the whole affair also reflects the physician–patient relationship, in particular when considering that patients are physicians' prime source of income.

In August 2014, Travis J. Tritten of *STARS AND STRIPES* reported that Congress overwhelmingly passed a $16.3 billion plan to overhaul the VA, Then-American Legion National Commander Daniel M. Dellinger applauded the move. He had earned his place in the Legion through his service in the U.S. Army during the Vietnam War as an infantry Officer. He praised lawmakers for putting aside political differences to pass a bipartisan compromise bill.

But Dellinger also emphasized that measures to decrease wait times by expanding veteran access to private care must be only temporary. He said a permanent solution to the department's crisis in patient-access must be found.

Lawmakers, in turn, repeatedly warned that it would likely take years to turn the deeply dysfunctional VA around. After all, it is the second-largest federal agency and runs the nation's largest integrated healthcare system. Each day, 200,000 veterans seek care in about 1,700 facilities.

The department reported in August 2016, that about 636,000 veterans had been waiting more than a month to get care at VA hospitals and clinics. VA inspector general audits and congressional testimony during the past few months had revealed staff attempts to cover up the long wait times. They had been awarded bonuses based on false treatment statistics. The goal of the reform was to make it easier for veterans

to get speedy access to care. But doctors and nurses in the Cincinnati VA say the hospital's leaders had used it as a budget-balancing tool. They claimed that, instead of fast access, veterans received the exact opposite.

Take Vietnam veteran Bill Hatfield, for example. He bought a lifetime of spine trouble lugging heavy artillery shells through monsoon-muddy fields in Vietnam. More than 40 years after ruining his back, he found it hard to find anyone at the Cincinnati Veterans Affairs Medical Center who had his back. Yes, there was a $10 billion reform program adopted in the wake of the VA's national wait-time scandal. But that reform also created an incentive for the hospital to reduce or eliminate expensive medical services inside the VA. That sent veterans like Hatfield into a bureaucratic abyss. Over 19 months, he was bounced around in phone calls and visits between the VA, private providers and healthcare administrators #0 times. "This is crazy,"" he said. "There are people in far worse shape than I am. How are they getting their treatment?"

At Hines VAMC, the situation also looked grim. Tori Richards of Fox News, as well as numerous other news agencies, reported on this in September 2016. The headlines yelled::

> ""New low': Dead vets left to 'decompose' in VA morgue for weeks without burial."

The Illinois Veterans Affairs hospital located in Chicago's Western suburbs was already under fire for excessive wait times. Its problems, as reported by whistleblowers, included:

- festering black mold
- kitchen cockroaches running wild
- bodies of dead patients left unclaimed, frozen in the morgue for up to two months without proper burial

Senator Mark Kirk, R-Ill, whose office also received the complaint, slammed the hospital over its recent history of controversies. The whistleblower, who had spoken with Kirk's office, also described a "horrible issue" at the hospital in a letter to the Inspector General: "Some veterans' remains have been left in our hospital morgue for 45 days or more until they are stacked to capacity at times." On at least one occasion, a body had liquefied. Alissa McCurley, Kirk's deputy chief of staff said the bag burst when staff tried to move it. *It might serve as a reflection how American heroes are treated throughout the land. Absolutely dreadfully! In particular, given* the

Department of Veterans Affairs charge to fulfill President Lincoln's promise *"to care for him who shall have borne the battle, and for his widow and his orphan."* What happened to the remains after two months' morgue-residency is not mentioned, which makes me wonder if they end up in hamburgers, pray, as has recently been reported (http://www.healthfreedoms.org)

Under these circumstances, one could but wait with baited breath to see how the Department of Veterans Affairs would use its 2017 budget of $182.3 billion, a lovely five percent increase above the one of 2016. But before that blessed time arrived, Jon O'Connell of Scranton's *The Times-Tribune* published a splendid article: "Most Doctors Outside VA Lack Training To Handle Vets' Health Issues." That report was issued on November 1, 2016.More than two years earlier, in August 2014, Congress had overwhelmingly passed the $16.3 billion plan for a VA overhaul.

On November 18, 2015, the Congressional Research Service had published the Department of Veterans Affairs FY2016 Appropriations. The brief was compiled by Sidath Viranga Panangala, Specialist in Veterans Policy. It was entitled *The President's Budget Request for FY2016 and Congressional Action.* President Obama had submitted his fiscal year 2016 budget request to Congress on February 2, 2015. He wanted $164.6 billion for the VA. This amount included $70.1 billion for VA discretionary programs and $94.5 billion for mandatory benefits and services. His request for the VHA was about $60.6 billion, without collections. He asked for $1.3 billion for the three medical care accounts in addition to the enacted 2016 advance appropriations of $58.7 billion for the VHA. Including his $622 million request for the medical and prosthetic research account. The total requested for the VHA was a whopping $1.9 billion increase over the 2015 Fiscal Year amount.

Despite this phenomenal increase, it appears that VAMC's facilities' waiting times over the past two years have decreased little; most veterans get some of their healthcare from private doctors. This is even though most of them lack training to identify service-related illnesses. About 40 percent of veterans get some healthcare from the VA. Only around 20 percent rely entirely on the VA, according to a 2015 government survey. For example, according to the U.S. Census Bureau only 29 percent of about 800,000 veterans living in Pennsylvania sought VA care in 2015. The rest sought help from outside healthcare providers. This fact seems to have hitherto escaped US the government.

Jeffrey L. Brown, M.D. is a retired community physician who teaches as Clinical Professor of Paediatrics at New York Medical and Weill Cornell Medical College. He is a frequent speaker on veterans' cultural awareness and healthcare topics. He said:

> "While everybody seems to be mostly focused on the health care that veterans are getting at the VA, it sort of went unnoticed that 80 percent of veterans get most of their health care from civilian providers."

Today's private-sector physicians are unprepared to accept large numbers of new patients. They have lengthy appointment wait times. They are equally unprepared to take care of millions of veterans. In particular, those who are severely injured and ill pose a problem, says Brown. Nor do most of them have the expertise or experience VA's full-time healthcare practitioners have in treating veterans.

Veterans enrolled in VA's healthcare system have more chronic health conditions than the general population. They need access to primary care physicians with knowledge of the unique issues facing veterans. Men and women who have been exposed to Agent Orange in Vietnam or burn pits in Iraq, for example, need special care. They need more than is available in the private sector, where 15-minutes appointments are the norm. This despite the fact that both physicians and patients alike complain about the rushed caretaking.

The VA, on the other hand, maintains it manages patient loads magnificently well allowing clinicians oodles of time to listen to and care for veterans. Thus, the real problem appeared to be that most doctors in private practice were untrained to identify soldiers' and veterans' service-related illness. Dr. Brown, meanwhile, was working hard to educate civilian clinicians on military medicine.

A retired U.S. Army medic, Brown served in Vietnam during 1966 and 1967. He was the battalion surgeon for the 2nd Battalion/14th Infantry (1st Bde, 25th Inf Div). He was assigned later on as a Brigade Surgeon and Commanding Officer of a Clearing Company. He was the recipient of both the Bronze Star (Valor) and the Combat Medical Badge. Ad it was in a *New York Times* article in his post-military community practice that he read how anyone who served in Vietnam should consider himself or herself exposed to Agent Orange.

Agent Orange is a carcinogenic defoliant used to kill thick plant growth. It exposed hidden Vietnamese fighters, but put soldiers and civilians at great risk of cancer, diabetes and heart disease. This fact was kept secret. Brown learned of this risk from a newspaper. It was a problem for him. But it was this revelation that inspired his quest to educate other physicians about military service-specific health ailments.

In Brown's view, the biggest deficiency in anyone's medical practice is not asking new patients whether they had served in the military. Physicians are often hesitant

to ask patients about it, because they don't know what to ask. They don't even know why to ask them. And they don't know if a soldier or veteran-patient might be offended by being questioned on the issue. Psychiatrist and senior medical director for the Community Care Behavioural Health Organization(BCHO) Richard R. Silbert suggests:

> "Unless you speak up and say you are a veteran or your spouse is a veteran, the issue might not even come to light. There's just so many other things that they're asking in a doctor's office. Do you drink? Do you smoke? How's your diet? Everything's kind of competing."

Community Care Behavioral Health Organization (Community Care), a non-profit and federally tax-exempt behavioral health managed care organization headquartered in Pittsburgh, Pennsylvania, was incorporated in 1996. Its mission is to improve the [mental] health and well-being of the community through the delivery of effective, cost-efficient, and accessible behavioural health services. As such, it ties roght in with Dr. Brown's talks addressing Veterans' culture. He says the most common medical and psychological symptoms associated with military service are:

- toxic exposures
- infectious diseases
- traumatic brain injury
- early and late-onset PTSD

Brown also presents short sections on "moral injury" and psychological trauma suffered by military medical personnel. He clarifies why every patient including pregnant ones as well as the parents of paediatric patients should be asked: "Have you or someone close to you served in the military?" He describes the few essential elements necessary for adequate history and follow-up. He says PTSD and moral injury have become the signature psychological conditions of recent wars. While PTSD is commonly associated with physically traumatic events, moral injury occurs from a breach in deeply held beliefs of right and wrong. This is sometimes described as "injury to a person's soul". At the most simple level, teaching soldiers to kill requires a redefining of traditional morality. That redefinition no longer seems relevant when a soldier looks retrospectively at his or her actions. The moral and ethical guilt and shame for some become overwhelming. When no longer able to

live with the Self, it increases the risk of self-harm. The result? Commit suicide, drug self to the hilt on a perpetual basis, or analyze the self to make peace within. No one can help with it; it is a solitary exercise.

Dr. Brown discusses the difference between moral injury and "everyday" guilt in his lectures. He explains the role moral injury can play in PTSD. He talks about which people he believes are most vulnerable. He explains how modern warfare has changed to create moral injury. And he identifies the types of treatment modalities that are purportedly available. Psychological strategies seem to run parallel to faith-based strategies. But he opines that they may both be useful for specific patients.

To date, 10 percent of U.S. adults have served in the military, but private doctors rarely seem to identify which of their patients are veterans. That can lead to frequent misdiagnosis of conditions like chronic multisystem illness and agent orange symptoms. It can lead to lack of screening for risks associated with deployment. It can leave at-risk spouses and children unidentified. And it can lead to EHR data not be mined for correlations between deployment and medical conditions, such as birth defects and pregnancy problems.

I find some things puzzling. Dr. Brown was teaching future physicians at the university level. Still, he was unable to put two and two together on the *Agent Orange* situation. Dr. Silbert lives in a State with 800,000 veterans in a country at war 222 times since its 1776 Declaration of Independence. Yet the possibility of a patient's military career never seems to have crossed his mind.

But then, stranger things have happened. After all, Brown and Silbert are *practicing* medicine. That means they practice repeatedly so as to become proficient in their chose craft by treating medicine or psychiatry on their patients, their guinea pigs. It is that simple, so don't complain. It is all our own doing when trusting them.

One thing is for certain. A 2016 comparison of the VA community healthcare summary of research compiled by the association of VA psychologist leaders shows why VA healthcare is so important. VA facility patients are much more likely to be screened for many serious chronic conditions and illnesses. This includes diabetes and high blood pressure. On the other hand, they are also more likely to receive so-called preventative medicine, such as deadly flu shots, than in the private sector. Anybody and his dog knows from the documentary VAXXED that flu shots are detrimental to health. Flu shots cause Alzheimer after three shots, but so what. Soldiers have been used as governmental and research subjects for generations. Why change now?

What, then, does the word *patient* mean, precisely? Julia Neuberger posed this

question in her article "Let's do away with 'patients'" (British Medical Journal, June 1999). In conjunction with illness, the word conjures up a vision of quiet suffering. We see someone lying patiently in bed, waiting for the doctor to come by to *visit* and practice his or her skill. It's a seemingly unequal relationship between the user of the healthcare services and the practicing provider of the same, perhaps? The user is described simply as patiently suffering with no input on his/her treatment. Meanwhile, the healthcare providers have titles. They are nurses or doctors, physiotherapists or phlebotomists, the technicians drawing blood by venipuncture or for transfusion, apheresis, diagnostic testing, or experimental procedures, psychologists or psychiatrists. They are all at liberty to practice without impunity, even at great risk for the patient. And what art form are they practicing on the PTSD affected, in particular, pray? What do they do when there is nothing to be probed and prodded? The word "patient" originates from the Latin "patiens", from "patior", meaning to suffer or to bear. The patient in this style of language is truly passive, bearing whatever suffering is necessary, patiently tolerating the outside interventions of outside experts, if choosing to play that role. In PTSD-affected patients, that can be deadly.

What if a patient turns active, though, doing "his own thing"? If PTSD patients do their own research, in particular when researching whatever the "experts" demand be done to effectuate a possible means to end their suffering, they become hostile claimants. Why? It is a threat to the experts' assumed authority, viewed by them as most dangerous to their superiority, their ego. The assumption is that users of their services will remain passive in sickness, hopefully forever util death. Otherwise, the river of income will dry up. It assumes and takes for granted that healthcare practitioners — rarely anything professional about them — can take the active, the superior, part. It is they who tell the user what to do, not the other way around. Active patients are hostile patients, as they upset the hierarchical applecart and spoil the spoils going down the specialty rank as so to speak, as patient-deterioration follows the prescribed path of treatment until death.

Passive patients, on the other hand, are good lambs doing and accepting what they are told while being led to the slaughter. They patiently await a recovery that may never occur. The healthcare provider of whatever genre merely practices his craft, with interest or not awaiting the outcome, the rules set, his role of healer cast. Recipients, on the other hand are by and large prohibited from taking part in their own healing, never mind thinking of alternative treatments outside of the realm of allopathic medicine for his or her own health improvement.

If following the "Dr. knows best" recipe, PTSD voyagers run the risk of being impaired in mind and body for the rest of their lives due to pharmaceutical drug-therapy prescribed. And if they refuse to follow mental health practitioners' orders, PTSD-affected people injured on the jobsite are cut off all financial support. That is the crux of the matter. Thus, in itself, the power of the individual to help Self is taken away by the description "patient", with its multitude of connotations. After all, the meaning of words reflect the present and project into the future.

What the powers that be want us to be are patient patients patiently following orders of those practicing on us, in our case slavishly adhering the NC for PTSD generated treatment modalities and patiently await our betterment due to such treatment, while sinking deeper into the PTSD oblivion of despair. I think the idea of being strong enough or capable enough to help oneself seldom dawns on those professing to save and assist. PTSD patients meanwhile struggle to figure out who they are, where they are and how to get out of the swamp in which they have been embedded. And so, the jaw clenches, the teeth ache and the headache pounds. The nightmares abound, the night sweat pours and one begs the powers that be for peace, just a little while of peace so one can find the Self. But the peace is denied. Why? So that those practicing something of which they have no knowledge and which they cannot fix have someone on which to practice. And so they destroy all hope of recover, as peace and inner contemplation is the only method to PTSD healing. But "We reap as we sow," and "Help yourself so helps you God" are age-old adages well remembered when in the situation.

One step to the PTSD recovery seems to be well associated with the mean of Self-medication, usually by way of alcohol. It helps to create some peace in the turmoil filled soul and it is the least harmful to body and mind, as I concluded during the research for this book. The home-brewed variety, the turbo yeast stuff, suffices, as money is scares, and it is easy to brew. The art is of course to be in control of the consumption, and not the other way around. When living in abject poverty and despair it may be very hard to do, when the added threat of homelessness is never far away going hand in hand with PTSD.

As to The Veterans Choice Program (VCP), a notice was posted on the VHA Office of Community Care on May 11, 2018 stating:

> "Exhaustion of Choice Funds Notice — The Veterans Choice Program (VCP)will have exhausted all of its funding as early as May 31, 2018, and possibly as late as June 15, 2018, due to the unique nature of health care and the variability in health

care costs. Once the funds are exhausted, VA will no longer be able to provide services under VCP. VA is publishing this notice of the exhaustion of funds as required by the Veterans Access, Choice, and Accountability Act of 2014, P.L. 113-146. VA has also published a notice in the Federal Register regarding the exhaustion of the VCP's funds. Please refer to Federal Register Notice Doc. 2018-10058."

23

Who & What Runs The PTSD Treatment Show

In 2014, researchers proclaimed the identification of a specific opioid receptor linked to emotions purportedly associated with a specific group of PTSD symptoms. Two of these are said to be listlessness and emotional detachment ("Research Shows Possible Neurological Patterns for PTSD Symptoms Imaging shows brain receptor linked to emotion also has ties to some trauma symptoms"; JAMA Psychiatry Sept. 2014). The researchers worked with scientists at:

- the Yale School of Medicine

- the School of Medicine at the University of California, San Diego
- the U.S. Department of Veterans Affairs National Center for Post-Traumatic Stress Disorder

The study's lead-author, Alexander Neumeister, M.D., said:

> "Our study points toward a more personalized treatment approach for people with a specific symptom profile that's been linked to a particular neurobiological abnormality. Understanding more about where and how symptoms of PTSD manifest in the brain is a critical part of research efforts to develop more effective medications and treatment modalities.

Neumeister was a 2007 NARSAD independent investigator grantee. He was also a co-director of New York University's Langone Medical Center's Steven and Alexandra Cohen Veterans Center for the Study of Post-Traumatic Stress Disorder and Traumatic Brain Injury.

NARSAD is an acronym for National Alliance for Research on Schizophrenia and Depression. It awards grants to researchers chosen by the Scientific Council of the Brain & Behaviour Research Foundation, a group of 138 mental health practitioners considered leaders in their fields. NARSAD's goal is to alleviate suffering caused by mental illness by awarding grants that will lead to advances and breakthroughs in scientific research. That many mental illnesses arise from pharmaceutical drugs and vaccinations is rarely, if ever, mentioned.

The researchers used new positron emission tomography (PET) scan tracers to examine different brain regions presumed to be PTSD symptoms-related by injecting a special dye with radioactive tracers into a vein in the arm. The dye is absorbed by organs and tissues. When highlighted under a PET scanner, the dye shows physicians how well organs and tissues are working. They can check for diseases, as well as measure blood flow, oxygen intake and glucose, organ and tissue metabolism. Most commonly used to detect cancer, the scanner can also detect:

- seizures
- heart problems
- memory disorders
- coronary artery disease
- brain disorders and tumours

- problems with the central nervous system

Tracer-radiation levels are considered by Mayo Clinic staff low, and the risk to normal body processes minimal. They consider the benefits resulting from the ability to diagnose causes of serious medical conditions to be much greater than the risk. Radiation is not considered safe for foetuses or when breast-feeding, however, and in rare instances does cause major allergic reactions.

A new type of tracer binds to a class of kappa opioid receptors (KOR). Prior research in animals had established a link between KORs and dynorphin. Dynorphin is a naturally occurring opioid released by the body during times of stress. Neumeister et al., wanted to see if there was a similar link in human subjects. They compared PET scans of purportedly healthy volunteers with those of people clinically diagnosed with PTSD, major depression and generalized anxiety disorder. Their symptoms ranged from emotional detachment to isolation.

In the clinically diagnosed subjects, the teams' primary finding showed a low KOR availability in the brain's amygdala region. That's where fear response may originate, associated with heightened symptoms of listlessness and emotional detachment, but not with anxiety arousal or hyper-vigilance.

Its secondary finding was that this reduced KOR availability may be linked to more severe fear symptoms because of lower cortisol levels. This possibly suggests a new role for cortisol as a biomarker for certain PTSD symptoms. Cortisol is a hormone naturally released on the corticotropin-releasing factor system's (CRF) signal, in response to stress.

In the short term, the Corticotropin-releasing hormone (CRH) can suppress appetite, increase subjective feelings of anxiety, and perform other functions like boosting attention. Although the distal action of CRH is immunosuppression via the action of cortisol, CRH itself can actually heighten inflammation. This process is being investigated in multiple sclerosis research.

Mind you, the American neuroscientist Dr. Joseph E. LeDoux Ph.D. (1949–) refutes this. His research primarily focuses on the biological underpinnings of emotion and memory, especially in brain mechanisms related to fear and anxiety. He vehemently refutes the idea that the amygdala is a "fear centre" out of which effuses the feeling of being afraid. He asserts that "fear" is a cognitively assembled conscious experience based on threat detection, arousal, attention, perception, memory and other neural processes ("The Amygdala Is NOT the Brain's Fear Center. Separating findings from conclusions", *Psychology Today,* posted Aug 10,

2015). He wrote:

> "I've been studying the amygdala for more than 30 years. When I started this work, research on this brain region was a lonely field of inquiry. The hippocampus was all the rage, and I sometimes felt jealous of the attention lavished on this brain region because of its contribution to memory. These days, though, it is the amygdala that is in the spotlight. This little neural nugget has gone from an obscure area of the brain to practically a household word, one that has come to be synonymous with 'fear'. And for many people, my name, too, is practically synonymous with 'fear' I am often said to have identified the amygdala as the brain's 'fear' center. But the fact is, I have not done this, nor has anyone else. The idea that the amygdala is the home of fear in the brain is just that — an idea. It is not a scientific finding but instead a conclusion based on an interpretation of a finding. So what is the finding, what is the interpretation, and how did the interpretation come about?"

Pay attention. This makes perfect sense in PTSD journeyers. But it is wholeheartedly ignored by those interested in trans-humanistic endeavours to create the docile human animalistic, feeling- and emotion-devoid slave and super-soldier killing machine. *When the amygdala is damaged, previously threatening stimuli come to be treated as benign.*

Says LeDoux:

> "When the amygdala is damaged, previously threatening stimuli come to be treated as benign. The classic discovery was that monkeys with amygdala damage were "tamed;" snakes, for example, no longer elicited so-called fight-flight responses after amygdala damage. Later studies in rats by me, and others, mapped out the amygdala's role in a neural system that detects and responds to threats, and similar circuits were found to be operative when the human brain processes threats."

A Rattus under stress may lose some of its visual acuity, and its hearing increases to painful levels. That is one side-effect of acute stress when in the PTSD condition, which will doubtlessly be revealed once it has learned to talk. It will then be able to

share its experiences with its researchers, such as Kathryn C. Gilchrist. She wrote "Genetic Predisposition of Anxiety-Like Behaviours in Rattus norvegicus as a Result of Selective Breeding" (*The Pulse*: Volume 6, Issue 1. Fall 2008). In the article, she talks about anxiety disorders such as generalized anxiety disorder, obsessive-compulsive disorder and posttraumatic stress disorder. She says they may well benefit from animal studies that employ selective breeding to determine the degree of heritability of specific anxiety traits. Such research may also reasonably lead to better understanding of and even identifying specific genes, transmitters and pathways involved with the processes of anxiety. This understanding, asserts Ms. Gilchrist, would contribute to providing relief for the great number of people who suffer from anxiety disorders. How relief is to be provided is unmentioned. Gene-therapy, perhaps?

Never mind, and be it as it may, lesions of the basolateral amygdala have been shown to inhibit fear conditioning (LeDoux, 1996). This, even as unconditioned anxiety remains intact (Davis, Walker, and Yee, 1997), leading to LeDoux's 2015 interpretation that:

> "Since damage to the amygdala eliminates behavioural responses to threats, feelings of 'fear' are products of the amygdala People are indeed less responsive to threats when the amygdala is damaged (in humans amygdala damage can occur as a result of epilepsy or other medical conditions or their surgical treatment). Yet, these people can still experience (feel) 'fear'. In other words, the amygdala is an important part of the circuit that allows the brain to detect and respond to threats but is not necessary to feel 'fear'.

Dr. LeDoux continues:

> Imaging studies of healthy human brains without damage suggest something similar. When they are exposed to threats, neural activity in the amygdala increases and body responses like sweating or increased heart rate result. This is true even if the threatening stimuli are presented subliminally, when the person is not consciously aware that the threat is present and does not consciously experience (feel) 'fear'. Thus, amygdala activity does not mean that fear is experienced. The conclusion that the amygdala is the brain's fear center wrongly assumes that the feelings of 'fear' and the responses

> elicited by threats are products of the same brain system. While amygdala circuits are directly responsible for behavioural/physiological responses elicited by threats, they are not directly responsible for feelings of 'fear'.

He also points out:

> "One of the first things a scientist learns is that a correlation does not necessarily reveal causation. The interpretation that the amygdala is the brain's fear center confuses correlation and causation. Actually, there are two confusions involved: (1) because we often feel afraid when we are responding to danger, fear is the reason we respond the way we do; and (2) because the amygdala is responsible for the response to danger, it must also be responsible for the feeling of fear.
>
> "From the beginning, my research suggested that the amygdala contributes to non-conscious aspects of fear, by which I meant the detection of threats and the control of body responses that help cope with the threat. Conscious fear, I argued in my books *The Emotional Brain* (Simon and Schuster, 1996) and *Synaptic Self* (Viking, 2002), and most recently in *Anxious* (Viking, 2015), is a product of cognitive systems in the neocortex that operate in parallel with the amygdala circuit. But that subtlety (the distinction between conscious and non-conscious aspects of fear) was lost on most people . . . When one hears the word fear', the pull of the vernacular meaning is so strong that the mind is compelled to think of the feeling of being afraid. For this reason, I eventually concluded that it is not helpful to talk about conscious and non-conscious aspects of fear. A feeling like fear' is a conscious experience. To use the word 'fear' in any other way only leads to confusion."

I read him loud and clear. Consciously recognizing and acknowledging fear allows the conquering of fear. Being afraid leads to paralysis. There is a loss of the innate sense of invulnerability associated with the PTSD-causing event moment. This loss makes living life somewhat more tedious, as it requires conquering fear at much greater intervals. That's because of the knowledge possible instant death always hovering in one's mind. Conscious fear-recognition and its conquering eventually leads to a PTSD recovery. However, allowing Self to slide and remain in

fear because of unconsciousness and ignorance leads to self-strangulation.

Do you understand the concept, my fellow PTSD travelers? If not, try hard, as it is of vast importance to the journey of recovery. We can only conquer and change what we recognize within ourselves. What we experience when feeling fear has nothing to do with being cowards. On the contrary. It is a normal, God-given sense of protection to prevent us from injuring ourselves when moving about on Earth in everyday activities. It covers from how to slice the bagel, how to set our feet, how to walk on pebbles and rocks, how to cut with scissors, how to drive the car with care and so on and so forth. It is all encompassing, once we begin to contemplate the issue. It cautions us when in action, when moving about. Allowing ourselves to be afraid for no reason whatsoever, on the other hand, hinders and limits us to a level that takes all joy out of our life, almost to the point of being catatonic. This is what creates the shut-in syndrome in PTSD affected individuals, I am sure, the one I unknowingly circumnavigated because of my dogs.

But it can be changed once we understand one simple truth. When consciously recognizing fear within us, we can conquer ourselves, have something very interesting to work with, the Self, and be jubilant when we do. I try it often when forcing myself to go on the highway rather than puttering along city-streets. After all, I do drive a Thunderbird 1966 with a 428 hp engine, which likes to be driven fast at least once in a while. The problem is that I am acutely aware of the idiots drag racing around me. I sense the enormous rigs with B-trains swerving behind them, the wheels which can fall of them as I experienced once when it almost hit me on the I 5, that hubcaps can turn and cut off nipples, easily leading to catastrophe, which I narrowly escaped. I know that engines can blow at any moment. All that subconsciously cruises through my head while I am on the highway becoming slower and slower. Until I read Dr. LeDoux's words on the amygdala, I had no idea why. Now I know, I can make the conscious decision to either torture myself into conquering this fear of mine or to go on to less torturing endeavours. After all, what is more valuable? Saving a few minutes of traveling here and there, or my peace of mind, being at ease and enjoying driving this beautiful car of mine? The choice if and what I want to conquer within myself, if anything, is mine. The choice of driving at 60 mph clenched in fear versus at 40 and having a good time is mine. The choice to conduct my life in fear or without is mine. I have the power of choice. It is, after all, mind over matter, to conquer or not to conquer the Self, PTSD or not.

Again, however, fear-conquering exercises within the Self can of course only be undertaken when free of pharmaceutical drugs and in a sober state of mind. If not,

it can spell nothing but trouble, as both substances cause huge states of inability to drive or operate machinery, as we already saw in my race-car-attitude driving to the Union's office once upon the time whilst under the influence of Ativan.

And what do you think? Do those claiming to be experts in the PTSD field have a clue about these concepts, from the amygdala influence to the pharmaceutical drug poisoning of the mind? Do they? Is that why they stick with their tune of pre-deposition to PTSD development from the cradle to the grave, as healing of human beings is alien to their agenda? Otherwise, one would think they would change their tune and climb out from underneath the trans-humanistic rock, under which they concoct their PTSD treatment modalities and hypotheses, descending into Dante's Divine Comedy, the world of Neumeisters'.

To refresh our memory, it is Alexander Neumeister who in 2014 published "Brain Imaging Helps Link Specific Symptoms of PTSD with Specific Brain Activity" (*Brain & Behaviour Research Foundation,* p.29). He suggested that brain imaging would be an exciting possible target for future PTSD and traumatic brain injury treatments. He claimed that it would "personalize" medication management for these disabling illnesses.

Neumeister also stated at that time that understanding more about where and how symptoms of PTSD manifest in the brain was critical to develop more effective medications and treatment modalities. He, too, as Dr. LeDoux did, compared PET scans of purportedly healthy volunteers with those of people clinically diagnosed with PTSD, major depression and generalized anxiety disorder with symptoms ranging from emotional detachment to isolation. I am certain he, too, tried it out on monkeys and on Rattus before venturing on to humans.

He, however, left out the feeling of fear. He purported that primary findings showed that exposure to trauma resulted in a low availability of KOR in the brain's amygdala. Those findings resulted in or were associated with heightened symptoms of listlessness and emotional detachment, but not anxious arousal or hyper-vigilance. In other words, it is the lack of KOR in the brain's amygdala causing the emotions, he claims. It is not the human emotion, the innate God-given substance innate in all human beings.

Neumeister continued, saying during his CBS interview:

> "People with cancer have a variety of different treatment options available based on the type of cancer that they have. We aim to do the same thing in psychiatry. We're deconstructing PTSD symptoms linking them to different

> brain dysfunction, and then developing treatments that target those symptoms. It's really a revolutionary step forward that has been supported by the National Institute of Mental Health (NIMH) over the past few years in their Research Domain Criteria Project. We know from previous clinical trials that antidepressants, for example, do not work well for dysphoria and the numbing symptoms often found in PTSD."

Dysphoria, a state of unease or generalized dissatisfaction with life, is not at all caused by or related to PTSD. To repeat myself, the latter is a colossal existential crisis, not a disappointment with life and living, and not a mental illness. Scientists and mental health practitioners, however, seem unable to fathom the difference. It is a waste of breath, time and energy to even try, as David Icke's lectures at Oxford University, United Kingdom, proved (David Icke Speaks at the Oxford Union — Mind Control & The New World Order).

Be it as it may, Neumeister furthermore stated:

> "Currently available antidepressants are just not linked specifically enough to the neurobiological basis of these symptoms in PTSD. Going forward, our study will help pave the way toward development of better options. Returning veterans are a particularly vulnerable population, so we are hopeful this research will lead to better treatments for them, since they represent an escalating demographic of victims of PTSD."

And you, the PTSD-afflicted veteran, active soldier or civilian, the police officers, firefighters and aircrew members . . . it is on you that they wish to practice. There is one impediment however: "You, their intended and needed guinea pigs, have to allow it!" If you do, may the Creator of all there is in all of Creation help you, as they will destroy, if not kill, you, without a shadow of doubt. That pharmaceutical drug consumption alone is an invitation to suicide ought to be well known by now. Mind you, even the Food and Drug Administration's (FDA) Department of Health and Human Services found Team Neumeister's study lacking in precision and thoroughness. It found multiple instances of misconduct in his studies. The FDA said that the study failed to "maintain adequate and accurate case histories that recorded all observations and other data pertinent to the investigation on each individual administered the investigational drug or employed as a control in the investigation [21 CFR 312.62(b)]". The Health Department advised Neumeister in a

February 19, 2016, warning letter:

> "As a clinical investigator, you are required to prepare and maintain adequate and accurate case histories that record all observations and other data pertinent to the investigation on each individual administered the investigational drug or employed as a control in the investigation. Case histories include the case report forms and supporting data including, for example, signed and dated consent forms and medical records, including, for example, progress notes of the physician, the individual's hospital chart(s), and the nurse's notes. For Protocol (b)(4), case histories include study records of required procedures such as medical history, psychiatric evaluations, physical and neurological examinations, and suicide risk assessments. You failed to maintain adequate and accurate case histories when your sub investigator's [sic] name was recorded as having conducted certain required study procedures that, in fact, you or another study employee conducted,"

But it is wise to refrain from the illusion that this warning is of consequence. The common aim remains to get all human beings on mind-altering drugs. They want to, by hook or by crook, force all of us into the Matrix, Agenda 21, Common Core society, where SOMA will be administered daily to keep us in a perpetual zombie state. Many are already there, but few know it.

After Neumeister's dismissal, *Retraction Watch* asked: "*A prominent psychiatry researcher is dismissed. What's happening to his papers?*" They wanted to know if psychiatric and scientific journals that had published Neumeister's papers had taken a second look at his work after the dismissal. Several noted they planned to investigate or to do so if asked by a specific institution; many believed there was little cause for concern.

In other words, the quest to manipulate human beings into drug-consuming and dependent creatures continues in full swing. They keep pretending that gene-manipulation and pharmaceutical drug concoction will heal the human mind and body, although both will merely in tandem destroy both. *Retraction Watch*, by the way, is a blog reporting on retractions of scientific papers. It was launched in August 2010 and is produced by science writers Ivan Oransky, vice president and global editorial director of *MedPage Today*, and Adam Marcus, editor of *Gastroenterology &*

Endoscopy News.

Ironically, or hilariously, CBS was right in step with the trans-humanist agenda. It told those still enjoying their regularly programmed programming that Neumeister's study represented a shift within the field of psychiatry. He was taking us away from a "one-size-fits-all" approach to more individualized treatments for mental health issues by targeting specific areas of the brain. Thus we have confirmation that scientists view human bodies solely as animalistic, mechanical, scientifically fixable devises. We are repairable on command, as soon as a problem in one of its parts has been identified.

Atlas mal-rotation is never mentioned either, despite the MRI and PET scans part of spinal cord and brain research. It appears as if none of these self-proclaimed spinal and brain research geniuses discovered that in most, if not all, of their human subjects it is mal-rotated. That a correction might be a good start to healing for many of them, including PTSD-sufferers, has yet to dawn on them as well. When it is that simple, and when there are thousands upon thousands of PTSD-sufferers crying out for help, how can it still escape their attention? Or is it wilfully overlooked? Or is it because the left-brain has problems perceiving the possibility, limited in imagination as it is? Or is the right side of their brains shut down in most of these geniuses?

Neumeister appears to be one of the blind-sided ones. Far from new in this field of research, his 2007 NARSAD-funded research was the largest PET study on PTSD at the time. It is said to have identified how early trauma changes the brain and can cause PTSD. At that time, he was working at the Icahn School of Medicine's Department of Psychiatry, Mount Sinai, New York, NY. He tracked the response of stress on the brain's serotonin system. Apparently, he discovered that people who experienced trauma early in life had fewer serotonin 1B receptors than healthy control subjects. Neumeister's ultimate goal? According to the Brain & Behaviour Research Foundation, which sponsors some of his research, it is to identify pathological processes and find targets for treatments. It seems that the efficacy of the only class of drugs, selective serotonin reuptake inhibitors (SSRIs), approved for treating PTSD is limited. And the answer is . . . more pharmaceuticals!

And who are NARSAD and the Brain & Behaviour Research Foundation, and what orientation do they follow? According to its own description, NARSAD is the world's leading donor-supported organization dedicated to finding the causes of and improve treatments and cures for psychiatric illnesses. It raises and distributes funds for scientific research on depression, bipolar disorder and schizophrenia. It also supports research on anxiety disorders like post-traumatic stress disorder, obsessive-

compulsive disorder and childhood disorders such as autism and attention deficit hyperactivity disorder. It aims to bring the joy of living to those affected by mental illness and their loved ones.

NARSAD's grant-funds are raised and distributed by the Brain & Behaviour Research Foundation. The Foundation is an anonymous family movement, which began in 1981 and since became the world's leading private mental health research funder. It funds the most innovative ideas in neuroscience and psychiatry to better understand the causes and develop new ways to treat brain and behaviour disorders. These illnesses include

- addiction
- attention-deficit hyperactivity disorder (ADHD)
- anxiety
- autism
- bipolar disorder
- borderline personality disorder (BPD)
- depression
- eating disorders
- obsessive-compulsive disorder (OCD)
- post-traumatic stress disorder (PTSD)
- schizophrenia

In 1985, the three leading national mental health organizations at that time decided to unite. These were the National Alliance for the Mentally Ill, the National Mental Health Association and the National Depressive and Manic Depressive Association. They formed the National Alliance for Research on Schizophrenia and Depression (NARSAD). The Brain & Behaviour Research Foundation was set up to award NARSAD grants, the only donor-supported organization in the US to fund breakthrough research across all psychiatric disorders. Since awarding the first NARSAD grant in 1987, the Foundation awarded $380 million to fund more than 5500 grants to more than 4500 scientists worldwide, Neumeister among them. It also has resulted in over $3.8 billion in additional research funding for these scientists.

Of them, the organization claims to have funded the best and the brightest. They are chosen by the Brain & Behaviour Research Foundation's prestigious Scientific Council of 165 volunteers. These volunteers are leaders in the mental health field,

including:

- two Nobel Prize winners
- chairs of psychiatric departments
- three National Medal of Science winners
- four former National Institute of Mental Health (NIMH) directors
- world-renowned researchers in psychiatry, genetics, neurology and neuroscience

One of them is physician and psychiatrist Dr. Herbert Pardes, MD (1932–). He was NIMH director from 1978–1984, and executive vice chairman of the New York-Presbyterian Hospital between 2000–2011. He led the Foundation for many years. During his unprecedented career in healthcare, Dr. Pardes has been an outspoken proponent for many causes. These include academic medicine, medical research, children's health education, mental health, access to care, humanism and empathy in care delivery, information technology and medicine.

He has chaired three different departments of psychiatry at Downstate Medical Center, the University of Colorado and Columbia University. He served from 1989 to 2000 as the dean of the Faculty of Medicine at Columbia University College of Physicians and Surgeons and as vice president for Health Sciences. A noted psychiatrist, he served as director of the National Institute of Mental Health and the United States assistant surgeon general during the Carter and Reagan administrations. He was also president of the American Psychiatric Association.

He has served on commissions related to health policy appointed by Presidents George Bush and Bill Clinton. These include the Presidential Advisory Commission on Consumer Protection and Quality in the Healthcare Industry and the Commission on Systemic Interoperability. He serves on the NYC Board Executive Committee for Information Technology, and is vice chairman of the New York Genome Center. He is former chairman of:

- the Greater New York Hospital Association
- the Association of American Medical Colleges
- the New York Association of Medical Schools
- the Hospital Association of New York (which on whose board he continues to sit)

Pardes also is the former president of the American Psychiatric Association (1989). He has been president of NARSAD's Scientific Council since its formation in 1986, the same year that the NIMH established its Schizophrenia Branch of research. In fact, the incestuous relationship between NARSAD and the NIMH continues to this day. So said the Citizens Commission on Human Rights (CCHR) International, a mental health watchdog, after investigating NARSAD. CCHR is a non-profit organization founded by psychiatrist Thomas Szasz in 1969 and funded by the Church of Scientology.

The Foundation's council reviews over one thousand grant applications annually across all major areas of brain and behaviour research. It recommends grant awardees through a rigorous and competitive process for research to advance and make breakthroughs in brain and behaviour research. The Foundation also sponsors the Schizophrenia Research Forum website, an online community of scientists collaborating in their search for better understanding of schizophrenia.

Again, all this appears to be made possible by the generous support of two family foundations covering all operating expenses, including, we deduce, Council members' volunteer compensation fees.

"Why should you support NARSAD," they ask on their website? Because one in four Americans experiences a mental health disorder, which year in and year out alters the lives of millions of people and their families, often resulting in a lifetime of struggle for balance. Mental disorders are the leading cause of disability in the United States and Canada, we are told. The direct and indirect economic burden of serious mental disorders is said to exceed $300 billion annually. Of course they do, as each year passes, more human beings worldwide become dependent on physician-prescribed, mind-altering, opioid-containing pharmaceutical drug concoctions, both legal and illegal, and all causing or enhancing mental illness.

But consider this for a moment. Psychiatrist Dr. Herbert Pardes, MD, was interviewed by the mental health watchdog *The Citizens Commission on Human Rights International* (CCHR). He admitted that schizophrenia could not even be defined. "I do not know what this disease is yet; I do not know how many diseases it may entail," he announced to those who listened. He told the truth, as we shall see later.

By the way, Dr. Pardes has been well compensated. As we heard, he ran the New York-Presbyterian Hospital and health-care system, the city's largest private hospital network, between 2000 and 2011. Already in 2008, he got a $1 million bonus on top of his $1.67 million salary, due to the hospital's "pay for performance" policy. His bonus was smaller than in 2007, however, even though he met his 2008 goals to

'reflect the current external environment' manifested by the engineered economic crises, I gather. But Pardes' 2008 overall compensation in fact totalled $9.8 million because he invested in a retirement plan that paid $6.8 million when he left in 2011.

He also received a $93,500 housing allowance and the use of a car and driver, we learn from *Healthcare Renewal.* In that publication, we read that all this compensation madness is not about markets or talents or incentives. Rather, it is about insiders hijacking established institutions for their personal benefit. The question than naturally arises: "Does the Behaviour & Brain Research Foundation do their thing for the benefit of humanity or for their own benefit?" As testimony to the possibly biased recommendations for NARSAD grants the Council might advocate, consider that when Pardes was head of the NIMH (1978 to 1984) his chief of the Center for Studies of Schizophrenia was Dr. Loren Mosher (1933–2004), founder and first editor-in-chief of the *Schizophrenia Bulletin.* Mosher was a giant in the humane treatment of those diagnosed with serious mental illness. Pardes was apparently instrumental in terminating Mosher's employment with the NIMH. Dr. Gary G. Kohls, MD, special guest to *Natural Blaze*, a community for alternative health news and natural wellness tips, on January 19, 2017, reported Dr. Mosher as saying:

> *"Psychiatry has been almost completely bought out by the drug companies . . . We're so busy with drugs that you can't find a nickel being spent on [non-drug] research."*

In other words, Mosher was advocating against the agenda of his peers.

His *Schizophrenia Bulletin* lives on, however. It nowadays purportedly seeks to review the latest news and data-based hypotheses on the etiology and treatment of schizophrenia. Its editors explain:

> "We view the field as broad and deep, and will publish new knowledge ranging from the molecular basis to social and cultural factors. We will give new emphasis to translational reports which simultaneously highlight basic neurobiological mechanisms and clinical manifestations,"

They consider the *Bulletin* to be an ideal platform for special reports, such as treatment guidelines, or to present translational science. It publishes the proceedings and abstracts of the International Congress on Schizophrenia Research, as well as:

- first person accounts,

- succinct discourses on clinical and basic neuroscience concepts
- *At Issue* articles expressing opposing views on controversial scientific issues
- brief essays on the role of specific environmental and genetic factors in schizophrenia

But now the clincher. Much of the *Bulletin* content will be invited reviews and manuscripts organized as a theme by special guest editors. Also, the *Bulletin* will carry two types of unsolicited manuscripts of high quality. The first type reports original data related to theme issues. The second type is where the *Bulletin* can provide a special venue for a major study.

Publication by peer selection geared to trans-humanistic aims and elite desires. Mosher, who departed the Earth in 2004, is turning in his grave. Throughout his career, he advocated non-drug, non-hospital, home-like, residential treatment facilities for newly identified, acutely psychotic persons. The PTSD affected may fall into that category, as we shall document in a little while.

What about Mosher's statement: *"Psychiatry has been almost completely bought out by the drug companies?"* Psychiatrist Dr. Robert Hirschfeld, a NARSAD advisory board member, moderated NARSAD's symposium on October 30, 2009. He told attendees: "We take no pharmaceutical money, we take no money from the government to fund our researchers."

You don't?

As an advisory board member, Hirschfeld would know that NARSAD's 2007 Annual Report shows potentially $185,000 in Pharma donations:

- Bristol-Myers Squibb Company
- Forest Pharmaceutical ($50,000+)
- Eli Lilly and Company
- Janssen ($30,000+)
- AstraZeneca Pharmaceuticals
- Wyeth-Ayerst ($10,000+)
- Otsuka America Pharmaceutical, NAMI — Eastside Wayne County and Virginia Chapters ($5,000+)

Its 2008 annual report shows almost double that — potentially $236,000.

Hirschfeld alone apparently brought with him access to many pharmaceutical

companies. From 1992 to 2003, he received more than $5.7 million in pharmaceutical company grant money for research, the CCHR alleges. That's an average of over half a million dollars annually, in addition to $25 million the NIMH gave him for clinical studies from 1974 to 1990.

He has also served as an advisor or consultant to:

- GSK
- Abbott
- Forest
- Eli Lilly
- Sandoz
- Novartis
- Janssen
- AstraZeneca
- Organon, Inc.
- Zonagen, Inc.
- UCB Pharma
- Wyeth-Ayerst
- Pfizer-Roerig Shire
- Bristol-Myers Squibb
- Pharmacia and Upjohn

And he was the chair of the Work Group to Develop Guidelines for Bipolar Disorders. That was part of the controversial Task Force on the DSM-IV (Diagnostic & Statistical Manual of Mental Disorders). The task force came under major scrutiny because of so many members' undisclosed financial ties to drug companies.

Could one therefore deduce that these financial ties resulted in following the trans-humanist agenda in the DSM creation, rather than pursuing the holistic principals of mental disorder healing, as advocated by Loren Mosher?

Pursuing holistic principles is what a working group led by Dr. Konstantinos N. Fountoulakis, MD, did. It did so when developing the first International College of Neuropsychopharmacology (CINP). It did so when establishing clinical guidelines for the treatment of bipolar disorders in adult patients.

He and his team conducted a historical review of bipolar disorder going back 5000 years. The review included its natural course of illness, phenomenology and development of treatments. Only then did he create *Treatment Guidelines in Bipolar*

Disorders and the Importance of Proper Clinical Trial Design, including nonpharmacological treatments.

Fountoulakis is associate professor of psychiatry at Aristotle University of Thessaloniki, Greece. He received a three-year fellowship in psychosomatic medicine and a one-year postdoctoral fellowship for research from the State Scholarships Foundation of Greece. Until 2003, he served as a medical officer in the Greek Armed Forces and retired with the rank of Major. In 2005, Dr. Fountoulakis was a research fellow in the Department of Psychiatry, Division of Neuropsychiatry, at the University of Geneva in Switzerland. Fountoulakis' areas of clinical and research interest are reflected in the topics that he teaches:

- schizophrenia
- mood disorders
- general psychiatry
- biological psychiatry
- personality disorders
- psychopharmacology

He is an active member of a number of national and international professional organizations. He is peer referee for the Cochrane Collaboration. He serves on the International College of Neuropsychopharmacology (CINP) Advisory Board to the Task Force on the Usefulness of Antidepressants. He also serves on the Mental Health Economics Task Force of the International Psychogeriatric Association (IPA).

It seems that Fountoulakis is well-known in his field, and non-related or funded by NARSAD. This might have something to do with his historical mental disorder research.

Mind you, Brain & Behaviour Research Foundation participants are proud of the multitude of partnerships they developed to accelerate better understanding, treatment and cures for mental illness. But Asclepius seems to be far from their mind. The BBRF Annual Report proudly publishes all contributions over $1000. Its IRS Form 990 is accessible on its website, claiming that at least 95% of annual funds are from individuals and family foundations. It proclaims that pharmaceutical company contributions are accepted for educational programs and fund raising events only. It also states corporate contributions do not carry an endorsement of products or services.

But if that is the case, why would Dr. Mosher lie? He was a psychiatrist, clinical professor of psychiatry and expert on schizophrenia. He was chief of the Center for Studies of Schizophrenia in the National Institute of Mental Health (1968–1980). He earned medical degrees from both Harvard and Stanford. Mosher spent his professional career advocating for humane and effective treatment for people diagnosed as having schizophrenia. He was instrumental in developing an innovative, residential, home-like, non-hospital, non-drug treatment model for newly identified acutely psychotic persons. Why would he lie?

There was no reason for him to do so. He was the highly esteemed founder of the experimental *Soteria Project*, subtitled "Community Alternatives for the Treatment of Schizophrenia," from 1971 to 1983. The project proved that patients with first-onset psychotic breaks could be successfully treated and even cured:

- outside of insane asylums
- by non-professional caregivers
- in unlocked neighborhood facilities
- without the coercive use of neurotoxic, dependency- and *dementia-inducing* drugs

Five years before his untimely death in 2004, long after he was chased and hounded out of the NIMH and mainstream psychiatry for doing the right thing, Dr. Mosher wrote:

> "Despite what the pharmaceutical companies would have us believe, we don't need 'a better life through chemistry'. Books like The Drug May Be Your Problem will help debunk this myth and provide practical advice on how to avoid psychiatric drugs and get off them."

In tribute to Dr. Mosher following his death, the *Washington Post* reported that Dr. Mosher decried:

- excess drugging of the mentally ill
- the sway pharmaceutical companies had over professional groups
- large treatment facilities like St. Elizabeth's Hospital [in Washington DC] that he would have preferred to raze

St. Elizabeth's Hospital opened in 1855 as the United States' first federally

operated psychiatric hospital. It housed over 8,000 patients at its peak in the 1950s. At one point it had a fully functioning medical-surgical unit, a school of nursing and accredited internships and psychiatric residencies. Its campus was designated a National Historic Landmark in 1990.

Since 2010, its hospital functions have been limited to a portion of the east campus, operated by the District of Columbia Department of Mental Health. The mentally ill were thrown onto city streets. The west campus has been redeveloped for use as the U.S. Department of Homeland Security's child agencies headquarters.

Mosher's highly workable "largely drug-free treatment regimen for schizophrenics" was used at his Soteria House. It was based on a view that schizophrenics are tormented souls who needed emotionally nourishing environments in which to recover. He said, drugs were almost always unnecessary, except in the event of a violent or suicidal episode. His approach was long ignored by those able to implement it.

After showing patient recovery studies to NIMH staff, Mosher's project lost its funding amid a strong peer backlash. He wrote:

> "By 1980 I was removed from my post altogether. All of this occurred because of my strong stand against the overuse of medication and disregard for drug-free, psychological interventions to treat psychological disorders."

In 1998, Dr. Mosher resigned from the American Psychiatric Association (APA) calling it a "drug company patsy." No truer words about the mental health cabal were ever said. Every PTSD-affected soldier and veteran, aircrew member, fire fighter and police officer can attest to it. Every honourable and successful person (until struck down in the line of duty due to no fault of their own), can attest to the cabal's ludicrous hallucinary and health-destroying PTSD treatment modalities adding and abetting their cause — keep them sick and make them sicker is their modus operandi.

Breathtaking, actually. Since Freud et al, with very few exceptions, the mental health cabal has done little else but to help big Pharma develop drugs, that rob human beings of their mental and physical health and turn them into drugged zombies. Some venture to opine that they return humanity back to the days of Noah.

As to PTSD, it is but one colossal existential crisis. The mental disorder is nothing but a fable. It alone lays dead all research in the field, never mind all medication. The latter merely exacerbates PTSD-related symptoms, including

suicide. The medication so fervently advocated by the NC *for* PTSD and applied throughout the Western world, constitutes human rights violations, as they advocate purposeful endangerment of human life.

As late as in 2002, 85 to 90 percent of Dr. Mosher's patients returned to the human community without conventional hospital treatment. The same results would be achieved by PTSD affected veterans et al., if treated in accordance with *Soteria House* principles.

That Dr. Mosher echoes the eminent world-renowned Scottish psychiatrist R.D. Laing's philosophy and experience with those viewed as schizophrenic patients is also swept under the rug by NIMH personnel, NARSAD and Brain & Behaviour Research Foundation participant and employees. No money to be made from it; no slow death or trans-humanistic possibilities. Do you, the PTSD journeyer, still want to be their patient? Do you still want to serve science as a PTSD guinea pig, whether while on active duty or when destitute and living on the streets?

Homelessness & PTSD

There are hundreds of thousands of PTSD afflicted soldiers and veterans crying out for help where none is to be found. Many might be tempted out of ignorance and desperation to enroll in Brain & Behaviour Research Foundation-sponsored NARSAD research conducted by the world's Neumeisters. For them, there is no better place than the United States Army to recruit their human subjects. It is a never-ending supply, as it endlessly conducts warfare throughout the world by hook or by crook, in accordance with war-is-a-racket principles. This was pointed out by Major General US Marine Corps antiwar activist Smedley Darlington Butler (1881–1940) in the 1930s. Not only are these imminently suitable guinea pigs readily available in both genders, but they also come in all colors, creeds, social backgrounds

and educational standing. In the US army, at least, they come even in differing nationalities, in a broad and colorful spectrum so appropriate to PTSD.

PTSD is non-gender, non-racial, non-religious, non-nationality, non-color, non-social-class and non-education related. And just as few of us humans have consciously chosen our place of birth, color, race and nationality, few of us have consciously chosen to experience PTSD. That, at least, is something trans-humanist mental health practitioners and scientists will find difficult to contradict. They find it just as difficult to prove that the original pre-PTSD causing event brain's composition, substance and formation differs from that of the post-one. They can't prove that which is irretrievably lost, if it indeed changed. But that seems, by and large, inconsequential to them. Practicing their craft of improving God's Creation seems to be their only goal. And they want to practice on you, the PTSD affected, as their agnostic philosophy and view of humanity in mind, see you as damaged goods worth a farthing, if anything at all, mere chattel even when healthy. Face it, and you will begin to prosper.

Ericka Blount Danois is a University of Maryland Philip Merrill School of Journalism professor, award-winning journalist, writer and editor. In her May 2015 article "He Cries Alone: Black Men and PTSD", she points out that many African-American men struggling with mental illness and post-traumatic stress disorder are veterans. She also points out that many more are active soldiers and civilians struggling in secret. They are too ashamed to even come forward to seek help because of the stigma attached to PTSD.

Among them are men like 26-year-old, active-duty, Fort Bliss soldier Sergeant James Brown, who served two tours in Iraq. Diagnosed with PTSD upon returning home in 2012, he ended up going to jail in El Paso, Texas. The sentence was imposed for driving under the influence of alcohol. No sooner did he arrive at the jail, than several guards in riot gear detained him and forced him to the ground.

It was then that he began to bleed through ears, nose and mouth.

It was then that his blood pressure dropped to a dangerous level.

It was then that his liver and kidneys shut down.

Thus, after going into jail on a Friday afternoon, he was carried out dead two days later after he had voluntarily checked himself in. He had Haloperidol and Ativan in his system, two legal medications. He came to serve a two-day sentence, and died while in jail-house staff care. At the time of the incident authorities claimed that he had a pre-existing medical condition. A shocking video from inside the prison released in May 2015 and revealing his dying moments proved otherwise.

His mother received a call from him just before jail guards began to abuse him. She said it might have started when Brown was told he was to serve a seven- instead of a two-day sentence. When Brown told them he was active military and had to report to duty on Monday, the event began to escalate. The video omits the guards' response, only showing them swarming on top of Brown while he struggles to get free. He says at least 14 times that he could not breath while being restrained and that he was choking on his blood. He does nothing to resist. By video-end, he is shown naked, unblinking, non-responding and barely breathing. When brought to a hospital much later, he was pronounced dead on arrival. He had no criminal record.

The toxicology report showed Brown had no *illegal* drugs in his body. The autopsy report stated that he died of natural causes involving a pre-existing medical condition. The El Paso, Texas, Sheriff's office report found Sgt. James Brown's death to be related to natural causes including PTSD. No further investigations were conducted until Brown's family, who suspected foul play, managed to get the event's video revealing the cause of his death.

At first, it was ruled natural, due to a crisis of an undiagnosed sickle cell blood disorder. Then, in 2015, a forensic pathologist hired by El Paso County as part of its defense in a wrongful death lawsuit filed by Brown's family concluded it was a homicide. He cited the restraint methods that jailers had used as the reason for his death. The sheriff's department investigation determined that no disciplinary action against the officers involved or changes in policy were needed. A grand jury also declined to charge anyone. The county ultimately settled the lawsuit.

But Brown's mother Dinetta Scott is committed to preventing similar jail deaths. "Nobody deserves to go to jail and die," she said, believing her son's post-traumatic stress disorder caused him to become hostile toward jailers. But it was not PTSD that caused him to turn hostile. It was the Ativan and Haloperidol that did it.

Jail records show that Brown reported in writing to the jail that he was diagnosed with post-traumatic stress. But there is no record of whether or not he reported on his pharmaceutical drug consumption. If he did, were the police brutal due to ignorance of and lack of education on the side effects of pharmaceutical drugs in combination with PTSD? Could it then be termed involuntary manslaughter? If he did not enlighten them on his pharmaceutical drug consumption, however, did they neglect to ask the right questions when the flag of PTSD was carried forth — namely, was he on any drugs? Is it because of their negligence or his omission, that the guards attacked him in the most brutal manner causing his death? Is it

because of their ignorance that they failed to order medical attention for him when he begged for his life? What, then, are the side effects of Haloperidol and Ativan?

On the U.S. government's "Medline Plus: Trusted Health Information for You website" (medlineplus.gov), we read that older adults are often susceptible to dementia. This is a brain disorder that affects the ability to remember, think clearly, communicate and perform daily activities. It may also cause changes in mood and personality similar to those in distress. These clients, when taking antipsychotics medications such as Haloperidol for mental illness, have an increased chance of death during treatment. There is little doubt that Sgt. Brown was under great distress before entering prison, never mind whilst in it. We can also assume that he did not research what he willingly swallowed, most likely on a regular basis, and was under the illusion it would lessen his anxiety.

Haloperidol is in a group of medications called "conventional antipsychotics", said to work by decreasing abnormal excitement in the brain. It is used to treat psychotic disorders and conditions that make it hard to tell the difference between things or ideas that are real and things or ideas that are not real. That includes schizophrenia. Could such differences in reality and ideas be caused or created by differences of world-view from one human to the next? That is left out of the mental health profession's equation.

Haloperidol is also used to treat confusion and difficulty thinking and understanding caused by severe physical or mental illness. It is also used to control motor tics, the uncontrollable need to repeat certain body movements. It also treats verbal tics, the uncontrollable need to repeat sounds or words in adults and children. Tourette's disorder is a condition characterized by motor or verbal tics, for which Haloperidol is often prescribed. These tics can also occur naturally when in the PTSD condition and put under enormous stress by the powers that be. I know. I have lived it.

Haloperidol is also used to treat severe behavioural problems, such as explosive, aggressive behaviour or hyperactivity in children who cannot be treated with other medications or psychotherapy. It comes as a tablet or concentrated liquid to take orally, usually two or three times per day.

Special precautions should be followed before taking Haloperidol, however.

First tell your doctor and pharmacist if you are allergic to Haloperidol or any other medications. Who knows how one should know if one is allergic, when one has most likely never even heard of it, is the question? When one can't breathe?

Tell your doctor and pharmacist what prescription and nonprescription

medications, vitamins and nutritional supplements you are taking. Be sure to mention any of the following:

- quinidine
- sedatives
- thioridazine
- methyldopa
- tranquilizers
- sleeping pills
- procainamide
- antihistamines
- pimozide (Orap)
- dofetilide (Tikosyn)
- epinephrine (Epipen)
- ipratropium (Atrovent)
- moxifloxacin (Avelox)
- disopyramide (Norpace)
- amiodarone (Cordarone)
- rifampin (Rifater, Rifadin)
- lithium (Eskalith, Lithobid)
- narcotic medications for pain
- anticoagulants (blood thinners)
- sotalol (Betapace, Betapace AF)
- erythromycin (E.E.S., E-Mycin, Erythrocin)
- sparfloxacin (Zagam) (not available in the US)

Also mention medications for anxiety, depression, irritable bowel disease, mental illness, motion sickness, Parkinson's disease, seizures, ulcers or urinary problems.

Also tell your doctor if you have or have ever had Parkinson's disease (PD), a disorder of the nervous system that causes difficulties with movement, muscle control and balance. Your doctor will probably tell you not to take Haloperidol, we read. And also tell him or her if you or anyone in your family has or has ever had prolonged QT syndrome, a condition that increases the risk of developing an irregular heartbeat. That might cause loss of consciousness or sudden death.

Long QT syndrome is a heart rhythm disorder that can cause serious irregular heart rhythms (arrhythmias). Normally, our heart circulates blood throughout our

body during each heartbeat. The heart's chambers contract and relax to pump blood. These actions are controlled by electrical impulses that travel through the heart and cause it to beat. After each heartbeat, the heart's electrical system recharges itself in preparation for the next heartbeat.

In long QT syndrome, the heart muscle takes longer than normal to recharge between beats. This electrical disturbance, which often can be seen on an electrocardiogram (ECG), is called a prolonged QT interval.

An ECG measures electrical impulses as they travel through the heart. Patches with wires attached to the skin measure these impulses, which are displayed on a monitor or printed on paper as waves of electrical activity. An ECG measures electrical impulses as five distinct waves, labeled as P, Q, R, S and T. Q through T show electrical activity in the heart's lower chambers (ventricles).

The space between the start of the Q wave and the end of the T wave (QT interval) shows the time it takes for the heart to contract and then refill with blood before the next contraction. Doctors can measure whether the QT interval occurs in a normal amount of time. If it takes longer than normal, it's called a prolonged QT interval. Long QT syndrome results from abnormalities in the heart's electrical recharging system. However, the heart's structure is normal. The upper limit of a normal QT interval takes into account the subject's age, sex and the regularity and speed of the heart rate. Abnormalities in the heart's electrical system may be inherited or come from an underlying medical condition or a medication, Mayo Clinic staff states.

Before taking Haloperidol we should also tell the practitioner:

- if we have chest pain
- if we have ever had seizures
- if we have ever had an irregular heartbeat
- if we have or have ever had breast cancer
- if we have ever had heart or thyroid disease
- if we have ever had trouble keeping our balance
- if we have low calcium or magnesium blood levels
- if we have citrullinemia, a condition causing build-up of ammonia in the blood
- if we have bipolar disorder, a condition causing episodes of depression, mania and other abnormal moods
- if we have ever had an abnormal electroencephalogram (EEG), the

test described above recording electrical activity in the brain transmitted to the heart)

Hidden away in the middle of this, we are also advised to tell the practitioner if we ever had to stop taking a medication due to mental illness caused by the drug's severe side effects. Sgt. Brown might have manifested it, thus causing his own death.

We must also tell the practitioner if we plan to become pregnant, or are in the last few months of pregnancy — if he or she is blind — or are breast-feeding. We are warned that the drug may cause problems in newborns following delivery if it is taken during the last months of pregnancy. Never mind the damage it could cause while still in the womb, as we are to advise the physician when we become pregnant while taking Haloperidol.

If having surgery, including dental surgery, we are to advise the doctors of Haloperidol ingestion.

We are also told that the drug may make us drowsy and affect our thinking and our movements. It might cause dizziness, lightheadedness and fainting when getting up too quickly from a lying position. To avoid this problem, one should get out of bed slowly, resting the feet on the floor for a few minutes before standing up.

Driving a car or operating machinery, at least until we know how this medication affects us, is also to be avoided. I read this with shock, bursting forth: "Excuse me?" Had my physician at the time of my race-car episode not told me how I had most likely driven, and I could see he was right on once he made me aware of my possible driving, I would never have known that it was Ativan causing my sudden car-racing skills, propelling me to the airport in much less time than it normally took me.

It is also advised to enlighten our doctor about our alcohol consumption whilst on Haloperidol, as alcohol can make the side effects worse. Did Sgt. Brown know that, I wonder, considering he was in jail for driving under the influence?

What other side effects of Haloperidol should you tell the doctor about if persistent?

- Nausea
- Vomiting
- Agitation
- Diarrhea
- Heartburn

- Headache
- Dry mouth
- Constipation
- Nervousness
- Restlessness
- Blurred vision
- Mood changes
- Loss of appetite
- Increased saliva
- Difficulty urinating
- Breast milk production
- Blank facial expression
- Increased sexual desire
- Missed menstrual periods
- Breast enlargement or pain
- Uncontrollable eye movements
- Decreased sexual ability in men
- Difficulty falling asleep or staying asleep
- Dizziness, feeling unsteady or having trouble keeping your balance
- Unusual, slowed or uncontrollable movements of any part of the body

That's just for the very normal side effects to suffer through without much attention. If, however, the following symptoms occur, the physician is to be called immediately:

- Fever
- Falling
- Seizures
- Skin rash
- Sweating
- Confusion
- Neck cramps
- Muscle stiffness
- Decreased thirst
- Tightness in the throat

- Eye pain or discoloration
- Fast or irregular heartbeat
- Erection that lasts for hours
- Yellowing of the skin or eyes
- Difficulty breathing or swallowing
- Seeing everything with a brown tint
- Tongue that sticks out of the mouth
- Fine, worm-like tongue movements
- Decreased vision especially at night
- Uncontrollable rhythmic face, mouth or jaw movements

So, what do you say now? Still hallucinating that this might improve your PTSD condition in any way. Or are you dreaming about hastening towards your untimely and gruesome death? Even the government website, seemingly interested in creating the NWO zombie matrix society, cautions that even though swallowing Haloperidol may help control your situation, it will not cure it. Sgt. Brown's death vividly demonstrates the statement. At the same time, the state yells:

> "And, for heaven's sake, continue taking it even when feeling splendid! Only stop after a consultation with your doctor, who will most likely decrease the dose gradually."

Why this apprehension about stopping cold turkey, other than the loss of income it would bestow on the physician?

Because Haloperidol discontinuation can make you feel like a prisoner in your own mind and body, that's why. How so? Also known as Haldol, Haloperidol's withdrawal symptoms are deemed to be some of the worst of any drug.

Withdrawal effects can be so severe that it usually takes intense Haloperidol withdrawal treatment to ensure that a taker safely tapers off the medication. Whatever the motivation, you have a right to free yourself from using psychiatric meds. But the Alternative to Meds website advocates that if one wants to safely withdraw from Haldol, it is crucial to have the support of a medical professional. Better still, they recommend a prescription medication withdrawal specialist who can provide successful Haloperidol withdrawal help.

Should you wish to do it yourself anyway, cold turkey Haloperidol withdrawal symptoms apparently include:

- nausea

- anxiety
- insomnia
- restlessness
- muscular reactions
- non-described strange reaction to antipsychotic withdrawal (a life-threatening symptom)

Haloperidol withdrawal side effects may also include breathing problems, tightening of the muscles, dry mouth, loss of tongue control, blurry vision and pacing back and forth. In fact, withdrawal causes the same reaction as taking it, it seems.

What are Haloperidol alternatives? We learn that the best way to prevent Haloperidol withdrawal side effects is to reduce the dosage gradually. The more slowly the withdrawal the less severe the effects. You can do your own research, as you are invited to call and find out the types of help available at www.alternativetomeds.com. I self-medicated myself away from Ativan treatment with the help of an ample quantity of port-wine, a voluminous book of interest, the still-in-use cigarettes and bed-rest. It did the trick wonderfully well, and for very little money. Within three days I was free, and cured from mind-altering pharmaceutical drugs forever, yes EVER.

Sergeant Brown took Haloperidol together with Ativan. Both. Together. That was a recipe for one colossal disaster. In fact, the physician who prescribed this concoction for him ought to have been held culpable and accountable for causing his wrongful death, rather than anyone else. That neither Sgt. Brown nor prison guards were educated on the possible causes for Brown's action made the situation worse. There seem to be no plans to change prison protocol to included screening new inmates for pharmaceutical drug use. Nor are there plans to educate police and jail guards on the consequences of using such drugs. But how many potential Sgt. Brown's are in the lucrative privatized jail system for acting stupid in public due to the combination of PTSD and psychosomatic drugs, one may wonder?

As Ericka Blount Danois documents and points out, his case relates to many issues combined:

- PTSD
- the disparities in treatment between nationalities and races
- the criminalization of mental health as it relates to black

communities
- how it severely affects peoples' chances of gaining and maintaining steady employment

Destitute, nearly 50,000 veterans are homeless in American streets on any given night. Roughly 40 percent of those homeless veterans are African American or Hispanic, according to the National Coalition of Homeless Veterans.

The African American Post Traumatic Stress Disorder Association, headquartered in Lakewood, Washington, does everything in its power to inform veterans and their families about resources and compensation available to them. That way they can receive the benefits guaranteed to them because of their military service. They help them with understanding the VA's rating schedule, file VA claims and receive adequate medical attention. They also run safe houses, emergency overnight shelters and other facilities for homeless veterans. In addition, they educate veterans and their dependents about benefits earned from the services they provided to the people of their nation.

As a mission of hope, they strive to connect Vietnam and present-day war veterans in all 50 States. They improve the lives of United States veterans and their dependents by letting them know that help is available to them.

There are other US veterans' centres like it around the US. Some of them also offer group therapy and individual, marriage and family counseling. VA hospitals have their own inpatient PTSD programs. They offer residential and day hospital treatment programs, programs for substance abuse, facilities for homeless veterans and clinics for women veterans. In addition, information on many private clinicians and non-profit agencies is given on the African American Post Traumatic Stress Disorder Association's website. We also learn that waiting lists for those services often are weeks and months long.

Precisely how many US veterans suffer PTSD is unknown. To my knowledge, it is also unknown how many are incarcerated or in mental institutions. The number of PTSD-suffering veterans living on the streets is also pretty much unknown. In January 2014, 49,933 sheltered homeless individual veterans (SHIV) were identified during point-in-time counts representing 8.6 percent of the total homeless U.S. population. That was a 67.4 percent decrease of homeless veterans from what was counted in 2009. At that time, there were an estimated 132,160. Of those, 94.5% were men, 51.4% were Hispanic; 44.5% were between the age of 31 and 50, and 53.3% were considered disabled, according to the VA's *Profile of Sheltered Homeless*

Veterans for Fiscal Years 2009 and 2010, prepared by the National Center for Veterans Analysis and Statistics, September 2012.

In the United States, the homeless are counted in every community. The reason? Estimates of local homeless populations are required to apply for the US Department of Housing and Urban Development, Continuum of Care (CoC) funding programs responding to homelessness. This complies with The McKinney-Vento Homeless Assistance Act amended by S. 896, the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009.

The Act's SEC. 103. [42 USC 11302]. GENERAL DEFINITION OF HOMELESS INDIVIDUAL states:

(a) IN GENERAL. — For purposes of this Act, the term "homeless", "homeless individual", and "homeless person" means —

(1) an individual or family who lacks a fixed, regular, and adequate nighttime residence;

(2) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(3) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);

(4) an individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;

(5) an individual or family who —

(A) will imminently lose their housing, including housing they own, rent, or live in without paying rent, are sharing with others, and rooms in hotels or motels not paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, as evidenced by —

(i) a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;

(ii) the individual or family having a primary night-time residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days; or

(iii) credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause;

(B) has no subsequent residence identified; and

(C) lacks the resources or support networks needed to obtain other permanent housing;

The Act creates a single grant program called the Continuum of Care (CoC) from three former homeless assistance programs administered by HUD:

- the Shelter Plus Care Program
- the Supportive Housing Program
- the Moderate Rehabilitation/Single Room Occupancy (SRO) Program

The Act also codifies into law the CoC planning process. This part of HUD's application process helps homeless people, by coordinating the responses to their needs. The HEARTH Act directs HUD to promulgate regulations for these new programs and processes. The regulatory implementation of the CoC Program is achieved through the CoC program interim rule, which focuses on regulatory implementation of the CoC program including its planning process.

Overall, CoC is designed to help unaccompanied homeless youth and families. They help them move into transitional and permanent housing, with the goal of long-term stability. More broadly, it is also designed to promote community-wide planning and strategic use of resources to address homelessness. It improves coordination and integration with mainstream resources and other programs targeted to homeless people. It improves data collection and performance measurement. And it allows each community to tailor its programs to its own particular strengths and challenges in helping homeless individuals and families.

Thus, the Continuum of Care refers to a community-based group of representatives from a cross-section of providers. These include those for homeless veterans, community entities, representatives of mainstream resources and people from one or more localities who have joined together for these purposes. The CoC organization is responsible for developing local community-based solutions to homelessness and applying for HUD funding through a collaborative grant

application.

Therefore, eligible applicants to CoC program grants are those proposing the following:

- promote a community-based solution to end homelessness
- provide funding to non-profits, states and local governments to prevent homelessness and quickly re-house newly homeless individual and families
- Minimize the trauma and dislocation of homelessness on individuals, families and communities
- Promote the effective use of mainstream resources.

The HUD seeks these grant applications through the CoC and facilitates grants designed to address these together with other federal agencies. The Trump budget request for the 2019 Homeless Assistance Grants (HAG) program is $2.4 billion, equals the 2017 enacted level.

HUD announces the beginning of the annual grant competition by publishing a notice of funding availability (NOFA). The NOFA provides details about the application process, including deadlines, eligibility, activities and costs. Anyone interested in applying for HUD funding should become familiar with the federal legislation governing CoC funding, Program Interim Rule Part 578 Continuum of Care Program and the NOFA. Applicants are also admonished to check HUD's website often, as the grant information is updated on a regular basis.

There are few problems counting people in homeless shelters each night. Estimating numbers of homeless living on the street, in parks or in "unconventional" housing, however, is another matter. According to Kim Hopper et al., authors of "Estimating Numbers of Unsheltered Homeless People Through Plant-Capture and Postcount Survey Methods" (*AM J Public Health* August 2008), HUD endorses two methods to obtain point-in-time unsheltered homeless people count, It is done either by directly counting them in public places or by screening those using selected services.

The Point-in-Time (PIT) Count Methodology Guide therefore provides the CoC with standards and guidance for acceptable ways to conduct Point-in-Time (PIT) counts of homeless people. The audience for this guide are CoC stakeholders involved in planning and executing the PIT count. This includes:

- the CoC collaborative applicant
- the Homeless Management Information System (HIMS)
- the Consolidated Plan (Con Plan) jurisdictions
- other CoC members and local stakeholders involved in planning and executing the PIT count

The guide helps determine a process for collecting high-quality data on the number and characteristics of sheltered and unsheltered homeless people in the community. The Housing and Urban Development (HUD) agency recommend CoCs regularly review and refer to this guide. It answers questions about PIT count preparation, implementation and analysis.

New York City's authorities are constantly trying to better estimate the size of its unsheltered homeless population. It notes that, regardless of the methodologies in place, even extensive street counts are fated to miss a large portion of unsheltered homeless people, for a couple of reasons.

First, operational irregularities, contingencies such as weather and logistical limitations coverage will always fall short of being complete. These results can be further compromised because of reduced numbers of plants, the definition given to actors playing homeless peoples. Uneven training of counters and the seemingly widespread practice of discounting also leads to uncertainty. The count depends on enumerators' subjective personal determination whom to count and not to count as homeless. Such judgments, whether made through observations or interviews, are subject to a host of inaccuracies, Hopper et al. state.

Secondly, the less easily remedied source of error resides at the heart of street survival strategies themselves. The counts of visibly homeless individuals, for example, miss all those unsheltered people who remain out of sight during counts. Because invisibility serves the homeless' purpose of security and uninterrupted sleep, many homeless people tend to favour it. Easily accessed but visibility-blocking structures such as shanty settlements may also be excluded from counts in the interest of volunteer safety. For the same reason, poorly lit parks will only be sketchily explored. For examples, plants at 17 sites (29%) reported being missed in the count, because counters either did not visit those sites or did not interview the plants. Of 293 homeless service users who were not in shelters, 31% to 41% were in locations deemed not visible to counters.

Conversely, many people using services for the homeless and destitute such as soup kitchens are not at all homeless. As a result, counters of those users must

determine whether the arrangements of these individuals on nights in question do or do not meet the official definition of homelessness.

Other strategies to count the homeless, such as relying on outreach and social workers for estimates of their numbers are unlikely to be effective. Only a minority of homeless-service-users report contact with such workers. It is also important to recognize that one-night street counts represent only a small proportion of those affected by homelessness. Therefore, Hopper et al. recommend period prevalence estimates of unsheltered homeless people, such as yearly estimates. These would be less subject to vagaries of weather and provide a more reliable base for judging the success of efforts to reduce street homelessness. They may also be more valid than improving point prevalence estimates on a given night.

As to homeless veterans living on city streets, the authors contend that their exact number is a guessing game more than anything else. Be it as it may, each state must establish homeless numbers to comply with Federal regulations requiring them to submit a homeless needs' assessment as part of its Consolidated Plan. The Con Plan is designed to help States and local jurisdictions assess their affordable housing and community development needs and market conditions. That way, they can make data-driven, place-based investment decisions (consolidated planning).

What is a Consolidated Plan (HUD.GOV, US 2016)? The plan must describe the nature and extent of homelessness. That includes rural homelessness and individuals of each category of homeless persons including:

- families with children
- unaccompanied youth
- veterans and their families
- chronically homeless individuals and families
- how many people exit homelessness each year
- how many days people experience homelessness
- how many people experience homelessness each year
- how many people experience homelessness on a given night
- how many people lose their housing and become homeless each year
- any other measure specified in the prescribed HUD form

The plan must also contain a brief narrative description of the nature and extent of homelessness by racial and ethnic groups to the extent that information is available. We note that people are not asked why they feel they became or are

homeless. This brings us back to the base of our investigation: how many veterans suffer homelessness due to PTSD?

Homeless veterans' general demographics, however, seem to be well-known:

- 91 percent are men
- 98 percent are single
- 76 percent live in a city
- 54 percent are deemed to have mental and/or physical disabilities

Black veterans are substantially overrepresented, 39 percent of homeless veterans, but only 11 percent of all veterans

Homeless veterans are most likely to be males between the ages of 51 and 61, of whom 43 percent served in the Vietnam War. It is anticipated, however, that as troops return from operations in Iraq and Afghanistan, homeless veterans will be increasingly younger and include more women and heads of households. It is also anticipated that the number of homeless veterans over the age of 55 will drastically increase in the next 10 to 15 years.

Why are veterans more likely than civilians to become homeless? The general US civilian population is at a significantly increased risk of homelessness when having:

- a mental health disorder
- a low socioeconomic status
- a history of substance abuse

The veteran populations' most substantial risk factors for homelessness are having experienced traumatic brain injuries and PTSD during military service. Some of the recent Iraq and Afghanistan veterans, men as well as women, also experienced sexual trauma while in the military. This greatly increases their risk of homelessness. I talked with two of them in the course of my travels. They assured me that the VA merely drugs them to the hilt, but otherwise and without hesitation financially compensates them for their trouble. Furthermore, the VA seems to be fully aware that veterans have difficulty adjusting to civilian life without devastating PTSD-causing experiences. So they also know that PTSD-affected veterans will have a very hard time returning to civilian life and making a living.

Without a strong social support network and without skills easily transferable to

civilian employment, landing on the street after a military career is an easily accomplished task. After all, veterans face the same shortage of affordable housing and living wage jobs as all Americans, Trump or not. These facts, combined with PTSD and/or traumatic brain injury, as well as mental illness from substance and pharmaceutical drug use, can easily land veterans on the street. Or they can persuade those on the verge of homelessness to enroll into Neumeisterian brain-research trials. After all, it almost landed me there.

Add to that the scathing remarks made about the PTSD affected by fellow workers, be they active soldiers, veterans, fire fighters, police officers or aircrew. These were so well reflected by recently retired UFC Middleweight and professional MMA fighter Tim Kennedy's August 2016 Facebook tirade. He was also a Green Beret, Special Forces sniper and Army Ranger. Such remarks can push PTSD journeyers' further towards the edge. He portrays brilliantly with what incomprehension, ignorance, scorn and arrogance military personnel view their PTSD experiencing comrades. That is, until they themselves are hit by it should they be bright enough. Would they, the world's Kennedy's, be intelligent and strong enough to handle it?

The same attitude permeates and consequently affects police officers, firefighters, active soldiers and aircrew members. As one RCMP officer said when I explained the pre-condition of intelligence for the PTSD acquisition to him: "Thank-heavens, I am safe then," he sputtered forth, laughing himself half silly by doing so, his fast-witted remark making him a prime candidate for a PTSD journey should it be in his life-path. He'd never succumb to either homelessness or psychiatric drug and brain manipulation experimentation should it hit his fan, though. He would have the inner resilience and strength to get him out of it.

Compatriots' View Of The PTSD Affected

The Las Vegas, Nevada, based Ultimate Fighting Championship (UFC), is the largest mixed martial arts (MMA) promotion company in the world. Kennedy used to be featured as one of the top-ranked fighters in this so-called sport. Due to the kindness of his heart, in September 2016 he spoke at a UFC event. In his *A message of encouragement,* he said:

> "I'm asked daily about how and why I don't have PTSD. I'm probably the last person on Earth you should ask about this stuff. I have killed kids and women during war. I have seen my friends and fellow soldiers burn alive. My adult life is filled with the things horror movies are made of. I could have

nightmares every night or be a medicated PTSD victim if I didn't choose every day to make a difference for myself and more importantly for the men that died to my left and right. I don't give a fuck about how they say we are supposed to heal. I'll tell you how to get better.

"You stop being a pussy. You get up early and train. You train so hard your hands bleed, and you sweat acid. You train so hard you collapse seeing stars. You go get cleaned up. Have a healthy meal. Look your best, dress nice. Then know that the real work is about to start. Find something bigger than yourself and pour every ounce of who you are into it. If that's your family, be the best father on Earth. If you are a cop, firefighter, or a trash man, be the BEST. Know every law, regulation, or route like the back of your hand. Be the best shot on the force. Be in better shape than every officer in the country, and serve the community like it's your reason for living.

"When you finally get home, be a generous lover then collapse into bed. You should be falling asleep before your head hits the pillow because you worked so hard every moment of the day. Get up the next day . . . and start all over again. At some point, and I'm not sure when, you won't need to do these things any more . . . but you will, because you know you are making a difference. It won't be about you getting better or healthier. It will be about you contributing and giving. It will be about being the best version of yourself, and that version is a badass that is hard to kill, that doesn't give a fuck about what other people think. You do the right thing because you believe in it. When you finally get to heaven and get to see your brothers, they will high five you as you walk by because you made their death worth something and made your life meaningful. Hell you might even get a little wink and a pat on the ass from God as you walk by." #greenberet #ranger #sniper #oef #oif #infantry #Isis #pstd.

That's wonderful. What else will he cherish? Killing more innocent men, women and children? Slaughtering more infants? Creating and filling his life with mayhem

registering in his soul wherever he goes? What kind of god is it he is talking about patting him on the ass? Lucifer or Satan? Kali, or Shiva perhaps?

His biography may give some insight. Born September 1, 1979, Timothy Fred "Tim" Kennedy was until January 2017 an American professional mixed martial artist competing in the UFC's Middleweight division. That came after competing for Strikeforce, an American mixed martial arts and kickboxing organization. It also came after the World Extreme Cage-fighting. And it came after the *ShoMMA: Strikeforce Challengers* series produced by Strikeforce and the US based television *Showtime* cable network, an outlet for various MMA and combat sports promotions highlighting up and coming MMA fighters. In July 2016, he was 11th in official UFC middleweight rankings.

Kennedy grew up in Atascadero, California, a small town with around 30,000 people, founded in 1913. He is the second son of an Irish-decent Catholic Christian family with three children. As a youth, his mother placed him in cooking and piano lessons. His father enrolled him and his brother in shooting schools, boxing lessons, wrestling teams and Japanese ju-jitsu classes.

Kennedy graduated from the Eagle Academy, a private high school. He then attended the Columbia College of Missouri, a private, non-profit, independent liberal arts and sciences college in Columbia, Missouri. Founded in 1851 as a non-sectarian college, it has retained a covenant with the Christian Church Disciples of Christ, a mainline Protestant Christian denomination, since its inception.

While earning a B.A. in criminal justice in 2002, he began competing in sanctioned mixed martial arts fights. In January 2004, he enlisted in the United States Army. By 2007, he had completed basic combat training, advanced individual training, airborne school, special forces qualification course and ranger school. He then was assigned to the 7th Special Forces Operational Detachment Alpha (ODA), also known as an SFOD-A or an 'A-Team', the Green Berets primary fighting force.

ODAs are made up of 12 men, each with a separate Military Occupational Specialty (MOS). Each ODA member is cross-trained in other specialties. During this time, Kennedy was also a sniper, sniper instructor and principal combative fighting instructor for C Company, 3rd Battalion, 7th Special Forces Group. He deployed multiple times in support of Operation Iraqi Freedom and Operation Enduring Freedom. He was awarded the Army's Bronze Star Medal with V device for valor under fire. He transitioned to the Texas Army National Guard in 2009, serving as Special Forces Weapons Sergeant.

He continued to compete in the MMA during his Green Beret career.

The Green Berets, so named because of their distinctive green service headgear, are a special operations force tasked with five primary missions. The original and most important mission is unconventional warfare, followed by foreign internal defense, special reconnaissance, direct action and counter-terrorism.

The first two, unconventional warfare and foreign internal defense, emphasize language, culture and training skills in working with foreign troops. As of June 2018, there are 76 of them, according to Breitbart. The other duties consist of

- manhunts
- peacekeeping
- hostage rescue
- counter-narcotics
- security assistance
- counter-proliferation
- information operations
- humanitarian demining
- humanitarian assistance
- psychological operations
- combat search and rescue (CSAR)

Other United States Special Operations Command (USSOCOM) may also specialize in these secondary areas. Many of their operational techniques are classified, even though some doctrinal manuals are available. Tough guys, without a doubt. And when the Army instituted a service-wide combatives tournament in 2005, Kennedy won the Light Heavyweight division three years in a row. By June 2016, adored by the American public, he saw fit to tell someone on twitter objecting to his florid language: "I'm sorry your parents raised you to be a pussy that bitches about everything, but that shouldn't affect my freedom of speech."

*Where The Hell Does The Word 'P***y' Come From, Anyway?* This is what HuffPost United States deputy enterprise editor Katherine Brooks investigated after now President D.J. Trump blurted forth the statement "Grab them by the pussy" during a hot mike moment heard around the world. Few people misunderstood those words leaked just weeks before the 2016 presidential election. Brooks cross referenced the definition of pussy with Merriam-Webster online and found the number one entry is "cat," followed further down by "vulva," "sexual intercourse," or "the female partner in sexual intercourse."

But who actually uses "pussy" in conversation about a cat? No one! Pussy is primarily used to talk about sex — whether it's the sexual organ or the woman attached to it, or some conflated and generalized combination of the two, or it is used as a slur against men without guts and brawns? Thus the upheaval.

Seemingly somewhat obsessed with *pussy,* Kennedy is also the father of two daughters.

On September 10, 2016, scathing judge of PTSD experiencers and seemingly proud of killing women and children at leisure, he took his vitriol to Facebook. When a few people voiced their objection to his style of vocalization, thoughts and utterings, he yelled back at them:

> "Tomorrow is #September11 I want to be perfectly clear on one specific point. If you fuck with us, myself or men like me will hunt you down and destroy everything you love."

Oh? You want free speech but threaten others with destruction when they exercise theirs? Is that Kennedy's projection of a harmonious and peace-loving spirit, or is it an Archon-possessed, Neumeisterian-generated, demon-possessed entity? Archons are types of collective unconscious energy forces with the intention of keeping humanity asleep in the darkness of fear, ignorance and hatred.

Particularly offending to those chewing through Kennedy's PTSD opinion was his "*Pussies*" description for PTSD affected soldiers. So claims journalist, social media producer and UFC video-contributor Michael Hutchinson. In a September 2016 Sports Blog (SB) Nation editorial, he wrote "Opinion: Tim Kennedy's problematic perspective on PTSD; Breaking down the problems with Kennedy's controversial comments".

Few seem to think that to be called a pussy by this man, a slang-word for women's genitalia, should be viewed as flattering. About Kennedy's seemingly naïve opinion on PTSD, Hutchinson says:

> "Although his statement is problematic for many reasons, there is more than just that one line [the pussy-line] that needs to be examined and criticized. Kennedy framed the message as one of inspiration for his fellow veterans. Kennedy believes that soldiers who suffer from PTSD can find relief from their symptoms by keeping their mind busy through work, physical activity and, 'serving the community like it's your reason to live.'"

When it comes to PTSD, having a healthy, exercise-filled, active lifestyle is not

enough. What Kennedy proposes to overcome PTSD equals running away from the Self. But it should be used as a healthful adjunct, purports Carol Woodbury. She is a certified exercise specialist, personal trainer and lifestyle and weight management consultant, as well as a T'ai Chi, Chi Kung and Cycle Reebok instructor. She spent years working with clients who went through various traumatic events, such as auto accidents, sexual abuse, kidnapping, and sudden loss of a loved one. She notes that any of those events can cause anxiety, depression, phobia and self-blame. She also knows that the effects of exercise on those with PTSD symptoms have been subject of many studies, particularly in the United Kingdom, were primary care prescribes exercise for depression.

There are three psychological theories on how exercise might exert antidepressant effects. First, it might serve as a distraction from stressful input. Second, exercise is a form of mastery or control, which allows a person to regain control over her/his body and life; it has been suggested that depression is a result of a perception of a loss of control over one's life. The third theory suggests the antidepressant effects are due to the psychological benefits derived from social interaction that accompanies group activity.

The Headstrong Project's head clinician Gerard Ilaria, holding a B.A. in Psychology and a Master of Social Work from Columbia University, claims in his response to Kennedy's PTSD face book tirade that:

> "PTSD results from an overactive sympathetic nervous system. It's the same part of the brain that kept our ancestors alive when lions jumped out of the bushes. It's 'fight or flight.' If a soldier's mind stays in that mode for too long, it doesn't always come back. PTSD creates the feeling that something terrible is always around the corner. It can cause anxiety, confusion, and isolation from loved ones. But worst of all, it can make it seem like things will never get better. The maddening thing about PTSD is that it's completely fucking fixable. PTSD is an anxiety disorder and we can treat it. But you've got to get help. In the military, you hear things like 'shake it off' or 'rub dirt on it.' If your nervous system is broken, it needs to be fixed. Just like a broken leg needs to be fixed. It's not weakness. It's science. And it can be solved,"

he told *Humans of New York*, a magazine featuring interviews with peoples around the world and on New York City streets.

Obviously Ilaria never experienced PTSD, just as Kennedy is a couch potato judge of an experience he cannot comprehend until he experiences it. Pray that they never will. If they do, it would be far too late for them, as both Kennedy's and Ilaria's ideas of "healing the hidden wounds of war," would destroy them. Kennedy advocates running away from it as fast as one can, so one never needs to face the Self and the deeds it hitherto performed. Ilaria advocates the trans-humanist agenda of gene-manipulation and other pharmaceutical remedies combined with it. Both of their ideas of PTSD healing over time lead to the destruction of mind, soul and body in one way or another, without the possibility of making peace with the Self. Therefore, no healing can take place.

To recognize PTSD not as the symptom of an *overactive sympathetic nervous system,* as Ilaria so charmingly describes it, but as an existential crisis mirrors the mindset. Mind you, he says he has provided one-on-one treatment for most veterans featured in *Humans of New York*. Many credit him with saving their life. Amazingly, the Headstrong project for their mission to heal PTSD-afflicted veterans had a $750,000 budget in 2015. More on it later.

Ilaria does state, however, that the military's view of its PTSD afflicted could negatively impact PTSD patients:

> "It's easy to understand that soldiers are used to tough love and that Kennedy's words are founded by that mindset. The problem is that it is the wrong approach. The correct approach is in-depth psychological analysis, followed by a stern regimen of mental therapy. This is the process that is unanimously agreed upon by the scientific community."

And that precisely is the crux of the matter. The *unanimously*-agreed-upon-by-the-scientific-community PTSD treating process, a process destroying the humane human and creating the trans-human fighting machine.

How can anyone but the PTSD experiencer heal the Self? How can anyone who doesn't have a clue what the other, any other, never mind the one walking through PTSD, feels or thinks? Is it all hallucinations and imaginations by those who most likely have chosen to deal with the mentally ill because they themselves are mentally ill? How else can it otherwise be, that they cannot possibly, even if their life depended on it, differentiate between PTSD as a mental disorder and a colossal existential crisis? Because they have mentally ill tunnel-vision thought patterns? This leads us to perhaps the most problematic statement in Tim Kennedy's PTSD observation, namely: *"I don't give a fuck about how they say we are supposed to heal."*

Why? Because he is doing his own thing, which is wonderful to hear, indeed. Perhaps reading Loren Mosher, R.D. Laing and C. G. Jung may be a fine addition to his self-healing?

That Kennedy gave a giant middle finger to those using scientific methods to adjust PTSD-suffering soldiers, urging them to enjoy their predicament by killing more, is pure joy to see. Despite the purportedly existing empirical scientific and statistical and irrefutable evidence persistently bragged about by the profession as proof of their successful PTSD treatment modalities, methods and remedies, best evidence for any of them has yet to surface. It is unfortunate that Kennedy's words can have negative consequences for his PTSD-affected military peers. PTSD-suffering active soldiers will not cure their night terrors, sweats and anxieties by putting in a hard day's work of physical exercise. It won't help those veterans to avoid triggering memories of the PTSD-causing event moment, either, as Michael Hutchinson exclaims. It is the Kennedy-type opinion, however, that might drive PTSD-affected soldiers to suicide.

Military culture has often derided soldiers suffering from PTSD or depression as cowards or worse. So reported Yochi Dreazen of the Washington Post in November 7, 2014. One unit at Colorado's Fort Carson left mock forms titled "Hurt Feelings Report " near a sheet where troops sign out to see doctors. The document began, "Reasons for filing this report" and offered choices including "I am thin skinned," "I am a cry baby" and "I want my mommy."

The anonymous author(s) might be surprised to know that Navy SEALs, Army Rangers and other elite troops from the military's secretive Special Operations community are also killing themselves at record rates. Admiral William McRaven, who oversees those forces, said in April that he was worried about the well-being of his men — troops specially selected for their mental and physical toughness. "My soldiers have been fighting now for 12, 13 years in hard combat. Hard combat. And anybody that has spent any time in this war has been changed by it. It's that simple," McRaven told a conference in Tampa.

That must include high-ranking officers. Top commanders routinely talk about the importance of reducing the stigma that keeps soldiers from seeking help. But few have been willing to share stories of their own struggles with combat stress, PTSD or depression. Only one, retired Army Major General David Blackledge was willing to speak to Dreazen on the record and acknowledge that he sometimes thought of taking his own life.

Blackledge spent over 33 years as a military officer and reservist. He was

deployed to the Persian Gulf War (1991–92), Haiti (1994), Bosnia-Hercegovina (1997–98), US Embassy in Kuwait (2000–01) and two tours in support of Operation Iraqi Freedom (2003–04 and 2005–06). He also has 15 years of experience as Manager with Procter & Gamble Company, seven years in the paper industry and eight years in the healthcare sector. Mr. Blackledge has been awarded five Bronze Star Medals and two Purple Hearts.

Mr. Blackledge served as special assistant to the chief, army reserve in the US Army Reserve Command (2011–12). He was commanding General, U.S. Army Civil Affairs & Psychological Operations based at Fort Bragg, North Carolina. There, he was responsible for recruiting, training, equipping and deploying 13,000 personnel with expertise in civil affairs and psychological operations in support of U.S. national objectives (2009–2011).He also served as assistant deputy chief of staff (G-3/5/7) for mobilization and reserve affairs at headquarters, Department of the U.S. Army. Prior to that, Mr. Blackledge was commander of the 352nd Civil Affairs Command and commander of the 354th Civil Affairs Brigade (2003–07). Currently, he serves as director of the Estuarine Education and Leadership Development Center at Mississippi Gulf Coast Community College.

Mr. Blackledge has been a leader in publicly addressing the impact of Post-Traumatic Stress Disorder (PTSD) on soldiers returning from combat. He has been a supporter of various wounded warrior projects. He received his Masters of Business Administration degree from the University of Wisconsin-Oshkosh and a Business of Science degree in Mechanical Engineering from the United States Military Academy at West Point, an impressive record. We are not told whether or not Blackledge ever suffered PTSD himself.

We do know, however, that those in the high-risk PTSD professions all had successful careers long before PTSD hit them. One of them is Canadian Lieutenant-General Roméo Antonius Dallaire, OC CMM GOQ MSC CD (1946–). He is a humanitarian, bestselling author, public speaker, retired senator and general. Dallaire served as Force Commander of UNAMIR, the ill-fated United Nations peacekeeping force for Rwanda, between 1993 and 1994. He attempted to stop the genocide that was being waged by Hutu extremists against Tutsis and Hutu moderates.

After a 100-day reign of terror, some 800,000 Rwandan civilians were dead, most killed by their machete-wielding neighbours. Dallaire had sounded the alarm. He'd begged. He'd bellowed. He'd even disobeyed orders. "l was ordered to withdraw . . . by [then-U.N. Sec. Gen.] Boutros Ghali about seven, eight days into it. . . . and I

said to him, 'I can't, I've got thousands — by then we had over 20,000 people — in areas under our control,'" Dallaire said in a recent interview with *Amnesty Now*. The General's hands, always moving, rose beside his face as if to block the memories. "The situation was going to shit . . . And, I said, 'No, I can't leave.'"

In an assessment that military experts now accept as realistic, Dallaire argued that with 5,000 well-equipped soldiers and a free hand to fight Hutu power, he could bring the genocide to a rapid halt. The U.N. turned him down. Then US president Clinton ignored General Dallaire's plea for more troops. He even ignored the plea of U.S. Senators Jeffers and Simons. The sacrifice of human beings continued. You can read of the gruesome Rwanda engineering by the UN and the USA government in Terry Allen's article "The General and the Genocide", published in Amnesty International *NOW* magazine in the Winter 2002 edition. How the General found his way to PTSD recovery we explore in the second part of this trilogy. Street life and being called a pussy, however, were not in his cards.

Perhaps if more of those in the upper echelons would acknowledge that they, too, were vulnerable to the atrocity of war, the PTSD stigma would begin to lift. Perhaps then troubled troops would be more willing to ask for help rather than suffer in silence, worried that if they did, their careers would be ruined. In one way or the other, therefore, Kennedy may just have helped them onwards on the path towards self-help when bestowing the "Pussy" connotation on them. If it made them mad, if they still cared somewhat, Kennedy may unintentionally or intentionally through their anger have egged them onto the path to recovery by his ill-chosen words. Who knows? Even perception of the written and spoken word and its meaning differs from one human being to the next.

In Hutchinson's opinion:

> "Soldiers can certainly do without inspirational Facebook posts and *a nice kick in the ass* to cure their PTSD. What they need is real, one-on-one professional help, not advice from a hard-core Special Ops operating individual. Football and hockey players are not experts on concussions just because they have experienced hard hits on fields and rinks. In the same way, just because Kennedy was a high-ranking, accomplished soldier does not mean he is an expert on PTSD handing out advice."

Kennedy began his Facebook post with the line: "I'm probably the last person on Earth you should ask about this stuff." Good for him. He tries to point whoever

reads his stuff on PTSD in the right direction — or not. I guess he knows that his advice had some merit, whereas that of mental health practitioners has little or none at all. On the contrary, the majority of them destroy the PTSD affected rather than add anything to their healing.

But then, when one listens around, people in general seem to be unwilling to help themselves. It's so much easier to trust the doctor, whose pocket book they fill as long as the Medical Service Plan (MSP), available in Canada, pays for it. The MSP is carried by the population at large. So, seldom is a thought given to those who take care of their own health without the need of accredited general physicians (GP). They nevertheless pay for those thriving on a daily diet of McDonald's and fetus laden Coke's and Pepsi's, while GP's prescribe antibiotics for concussions and head-colds alike. It's called general healthcare, when it rather resembles from cradle to grave death care.

The United Nation's international covenants dictate that the state, any state, must provide all necessities of life to the people in the land. This flies right over their heads, as well. Combine that with overall sloth and torpor. Add a lack of discipline, determination, persistency and willpower, together with the general absence of honor, integrity and graciousness. So, you see where the inability to help and heal the Self originates. Hutchinson confirms it when stating: "You would seek a doctor's advice on any other medical issue, and PTSD should be treated the same." That PTSD has nothing to do with a medical issue has yet to dawn upon him, too, as brainwashed into the belief as he is by the media.

I am sure, therefore, that Hutchinson's encouragement: "If you or a loved one suffers from Post Traumatic Stress Disorder, it is strongly advised that you seek mental therapy from a licensed professional," is out of ignorance. I am also positive that the 37 percent of PTSD afflicted soldiers seeking help from those self-same "licensed", meaning government-sanctioned, "professionals" are doing so out of ignorance, as well. Thus, if following Hutchinson's advice, they will sign their own death sentence when consenting to this sure-fire avenue to destroy both mind and body.

More than 63 percent of returning veterans say they would *not* seek help from mental health professionals. This did not inspire or encourage him to investigate why they would not do so, either. Could it be, though, that they, the brightest of the crop, know what they "would be in for" if they did seek his highly praised, professional help? Statistics on which ones of the PTSD afflicted fare better, those who do or those who don't, are to my knowledge non-existing.

Kennedy, on the other hand, knows what he is talking about, at least to a certain degree. In fact, he holds a graduate degree in, yes, you guessed it, psychology, His wisdom came to light on the September 2016 broadcast of "Luke & Tim Kennedy discuss his controversial Facebook post about PTSD and military service personnel returning from combat zones". His advice in regards to exercise is sound. Walk every day to your heart's content or at least for one hour. Walk in all weather, rain or shine, preferably in Mother Nature, preferably with your beloved dog. It clears the mind and refreshes the soul on the path to the PTSD recovery.

As one PTSD sufferer expressed about Kennedy's PTSD rant on reddit.com, (a social media, social news aggregation, web-content-rating and discussion website), under "*Wayoftheland*":

> "I'm an ex operator and I was diagnosed with PTSD. What Tim said wasn't completely wrong in a sense, it's just the way he said it and he could have left a lot of it out. I can't blast someone for truly speaking their mind. I know in my case it works to constantly keep my mind busy doing other things but you cannot have any downtime to relax. Eventually it will catch up to everybody that has ever seen some shit. I get about 2 and a half hours of sleep every night, I take care of my kids, and am constantly moving from task to task. If I slow down, it gets to me. All I'm doing is running and buying time. How long do you think I'll live? What's going to happen when I'm old? My body will literally fail on me before I die from PTSD."

What indeed? And that is the point. One can run, but one cannot hide from either the Self or the PTSD dwelling within. It fills the soul, the mind, the entire being. It festers, waiting and wanting to be addressed, to be resolved through self-analysis, self-forgiveness, self-absolution and the resultant closure, a point thoroughly missed by Kennedy et.al.

And no, no one can help with facing the situation within the Self, no one. Only the Self facing the Self can bestow absolution of perceived sins committed in the path of life needing to be absolved before recovery and healing of the Self can occur. No one other than the Self can determine and differentiate between perceived sin or non-sin. What is sin for one may not be sin for the other. What inspires guilt in one may not do so in another. Under those circumstances, can another help in the absolution? Not a chance, in my view. And is suicide the way out to escape the Self?

The desire to commit suicide hits inactive as well as active duty soldiers. The

Pentagon reported 265 active-duty service members killed themselves in 2015. This trend of unusually high suicide rates has plagued the U.S. military for at least seven years. The number of suicides among troops began a steady increase from 145 in 2001 to 321 in 2012. That was the worst year in recent history for service members killing themselves. The suicide rate for the Army that year was nearly 30 suicides per 100,000 soldiers, well above the national population rate of 12.5 per 100,000 for 2012. Military suicides dropped 20% the year after that, 2013. It then held roughly steady at numbers significantly higher than during the early 2000s. The 2015 suicide rate of 265 compared with 273 in 2014 and 254 in 2013. By contrast, from 2001 through 2007 suicides never exceeded 197 (*USA Today*, April 1, 2016). Even though it was published on April Fool's day, I trust it was not meant as an April Fool's joke, though I momentarily wondered. Some folks have an odd sense of humor, the Deep State included.

Veteran suicide rate in 2013 was one every 65 minutes. In September 2017, the VA released veteran suicide statistics from its analysis of Veteran suicide data for 50 states, Puerto Rico and the District of Columbia. This was part of its comprehensive review of more than 55 million records from 1979 to 2014. The data will be used to develop and evaluate suicide prevention programs across every state, and continue expanding the veterans support network. The overall findings showed that veteran suicide rates mirrored those of the general population in the geographic region in which they lived. The highest rates were in western states, and most veteran suicides were in the heaviest populated areas. Furthermore:

- In 2014, about 65 percent of veterans who died by suicide were age 50 or older.
- Risk for suicide was 22 percent higher among veterans when compared to U.S. non-veteran adults.
- Risk for suicide was 19 percent higher among male veterans, compared to U.S. non-veteran adult men.
- Risk for suicide was 2.5 times higher among female veterans, compared to U.S. non-veteran adult women.

Distressed then-VA Secretary Shulkin uttered:

> "These findings are deeply concerning, which is why I made suicide prevention my top clinical priority. I am committed to reducing Veteran suicides through support and education. We

> know that of the 20 suicides a day that we reported last year, 14 are not under VA care. This is a national public health issue that requires a concerted, national approach."

Earlier, we heard about his valiant efforts and methods to carry out as he preached.

Be it as it may, however, Veterans in crisis or in a suicidal mood, and those knowing a veteran in crisis, have an emergency option. They can reach the Veterans Crisis Line for confidential support 24/7, year round:

- text to 83825
- call 800-273-8255 and press 1
- chat online at VeteransCrisisLine.net/Chat

For more information on the VA suicide prevention campaign, visit *Be there* or *ReportingOnSuicide.org*. We, however, will return to reactions and observations about the Pussy diatribe by God and sundry, as the saying goes.

26

Pussy Reactions

Prize-fighter and war veteran Tim Kennedy's "pussy" description for his PTSD-affected comrades and active soldiers alike resulted in a furor. It attracted numerous differing responses, spanning from outrage to compassion.

One of them came from combat-decorated Marine veteran Zachary J. Iscol. He had served in the United States Marine Corps between 2002 and 2007, with two tours in Iraq. I could find nothing on where and when he was trained. For his bravery in combat during the Second Battle of Fallujah, where he led a combined unit of 30 American and 250 Iraqi National Guard troops, he was awarded the Bronze Star Medal. He also served as first officer in charge of recruiting, screening, assessment and selection for U.S. Marine Corps Forces, Special Operations

Command. And he held other infantry assignments throughout Africa, the Middle East and Central Asia.

After quitting his military service in 2009, he returned to Fallujah to document the 2004 war in Al Anbar province. He went to confront the decisions he made and the demons he incurred while protecting his Marines and innocent Iraqi civilians during combat. His film was released in 2010.

Iscol, a digital media entrepreneur, is the founder and CEO of Lafayette Media Group. The company builds brands that support and empower the military community. Thus, he became the founder and CEO of Hirepurpose, a technology start-up that provides veterans, military service members and their spouses with:

- job matching
- job market analysis
- industry networking
- personalized career guidance

The Hirepurpose mission statement reads:

> "We believe in the American military community, and we're committed to helping transitioning service members, veterans, and their military spouses find careers they love. Hirepurpose is a Grid North company, a technology company empowering the next great generation of American veterans. Incorporating three brands — Hirepurpose, Task & Purpose, and Military One Click — Grid North offers unique solutions to challenges faced by service members, spouses, and military family members."

And what is a "Grid North" company? The term most likely came from the True North concept. According to The Art of Lean, Inc., this was one of the common buzzwords of the past decade used to describe parts of the Toyota production system or "The Toyota Way". The term itself is not really part of the original Toyota production system. The role of True North inside Toyota is similar to its basic meaning in English. True north, the geodetic north, refers to the direction along the Earth's surface towards the North Pole. In reality, the geodetic north differs from the magnetic north, the direction a compass points toward the Magnetic North Pole. It also differs from grid north, the direction northwards along the grid lines of a map projection. Geodetic true north also differs very slightly from *astronomical*

true north, typically by a few arcseconds, because the local gravity may not point at the exact rotational axis of Earth.

In navigation or in lean implementation, you need a way to get from point A to point B without getting lost. It is easy to move between two points if you are familiar with the terrain and the distance is fairly short. In real life and in lean implementation, however, this is not always the case. It is easy to get lost, sidetracked, disoriented, tired and confused. A fixed, unchanging point of reference helps with navigation. Hence, the true north, or the Grid North of Hirepurpose.

The term "True North" with respect to the Toyota production system has a history. Inside of Toyota, there has long existed the Japanese phrase "aru beki sugata". This roughly translates as "ideally the way things should be". It was a natural part of the corporate language of how Toyota wanted things to be in production, human resources, development, purchasing, engineering and so on. The Toyota Supplier Support Center (TSSC) began using the phrase "true north" in English fairly often in presentations in North America in the past decade. The term became a buzzword on this continent. Iscol et al.'s Hirepurpose modified the term to "Grid North", to help military personnel and their families find careers with top American companies in a grid north, straight-forward fashion.

Then in 2012, the rate of suicide among members of the 3rd Battalion was growing. In response, Iscol partnered with the Weill Cornell Medical Center to launch Headstrong. This non-profit's mission was founded to remove barriers to mental health treatment for post-9/11 military veterans suffering from:

- PTSD
- traumatic brain injury
- military sexual trauma
- other forms of mental illness

Iscol served as executive director since its inception. Since its existence, Headstrong has treated some 450 veterans and offers services in eight American cities.

In 2013, Iscol was a USA triathlon team member. He participated in the 2013 International Triathlon Union (ITU) London, UK, event. This is one of the multi-sport disciplines of triathlon, duathlon, aquathlon and other nonstandard variations. They typically number less than 10 events per annum, so this event is used to crown an annual world champion. Iscol also holds a fellowship with the

Truman National Security Project (TNSP). The Project is a nationwide membership organization of roughly 1700 frontline civilians, post September 11, 2001, veterans, political professionals and policy experts. They hail from 16 Chapters in 47 different states, doing education and advocacy work on national security and foreign policy issues in the United States.

Named after President Harry S. Truman (1884–1972), its members share a common vision of U.S. leadership abroad. They believe in a strong, smart and principled foreign policy. They see the US leading a growing community of nations towards shared security and prosperity by using diplomacy, defense, development and democracy promotion.

Together with its sister organization, the Truman Center, the TNSP identifies, trains and positions members across America. These people share this worldview and are committed to shaping and advocating for tough, smart national security solutions. Members are also united in their belief that America is strongest when standing with its allies to lead, support and defend a growing global community of free people and just societies. Their website explains:

> "We bring our members together with our partners and advisors to deliver concrete solutions to pressing global challenges for leaders at the local, state, and national levels, and we coordinate their action nationwide to shape the debate, fight for policy change, and support rising leaders who share our values."

Orwell's 1984 springs to my mind combined with NOW aspirations.

Iscol also serves on:

- the board of directors of Arts in the Armed Forces
- the board of advisors of the Center for a New American Security
- the board of directors of the International Refugee Assistance Project

He is also the founder and CEO of *Task & Purpose,* founded in 2014 and proclaiming to be the Web's fastest-growing military news and lifestyle website with roughly 3 million visitors monthly.

Shortly after Kennedy's PTSD Facebook publication set off vigorous debates across the system, Iscol responded. Whether or not there was merit to Kennedy's tough-love PTSD treatment proposals, or if he was simply an insensitive bloke sounding off to the countless PTSD-journeying soldiers and veterans populating the

US was beside the point. Iscol's response on Facebook was entitled "A Response To Tim Kennedy's 'Stop Being A Pussy' Message For Veterans With PTSD". He had this to say:

> "If you have the courage to get help, and you get the right help, you can get better. In addition to Task & Purpose I also run the Headstrong Project, a non-profit [society] dedicated to providing Iraq and Afghanistan veterans the world-class mental healthcare they need to recover from hidden wounds, free of charge and without any bureaucracy. So, this should surprise you. I actually agree with Kennedy. We have a saying at Headstrong: If you have the courage to get help, and you get the right help, you can get your life back on track and live the best version of yourself. Our job is to make sure that you get the right help. As veterans ourselves, we know how tough it can be to overcome the hidden wounds of war. We've lost friends, made the same choices, and walked the same ground. That's why we built the Headstrong Project, because we know that if you have the courage to get help, and you get the right help, you can overcome the hidden wounds of war. For every soldier we have lost in combat, 25–30 take their own lives."

Iscol ends with exclaiming that folk like Kennedy were lucky because they came home and were able to turn off the flight or fight response, finally uttering: "Not everyone has the same nervous system."

The same nervous system, pray? What does PTSD have to do with the nervous system? Nothing, as, to make it sink in, PTSD is not a mental illness or disorder, but an existential crisis. It has to do with human beings':

- souls
- emotions
- intelligence
- logic-ability
- reasoning-ability
- overall brightness of mind
- overall sensitivities to all things alive
- number of previous near catastrophic incidents and events
- innate and taught sense of ethics and morals applied in and out of

warfare

It has absolutely nothing to do with the God-given nervous system. This has been documented for thousands of years by Ayurvedic and traditional Chinese and Sumerian medicine and philosophical discourses.

If PTSD experiencers' nervous systems were defective, they would not have been where they were at the time the PTSD-causing event occurred. When working in the military, as aircrew in commercial aviation, as fire-fighters or as police officers in the line of duty, one has a strong nervous system. A fragile and defective nervous system would have prevented, nay disallowed, them a successful long-term career in those professions from the outset.

Furthermore, to compare the average PTSD-afflicted veteran with a MMA/UFC fighter is hilariously, ludicrously, ridiculously pathetic, bordering on the funny in a tragic-comedy, even in the Divine Comedy. To compare normal PTSD sufferers with professional killers like Kennedy and Iscol, with their apparent THEY LIVE sociopathic and psychopathic he-man attitudes toward humanity, is like comparing barracudas to sardines. It's like comparing the born killer with the newborn baby. Or, putting it more simply, it's like comparing apples with oranges. Be it as it may, however, what easy help *is* available at the Headstrong Project, I wonder?

Iscol elucidates:

> "Our head clinician Gerard Ilaria brilliantly articulated this in an interview with *Humans of New York*, a blog and bestselling book featuring street portraits and interviews collected on the streets of New York City, which recently profiled a number of veterans who've struggled with mental health issues."

Quoting Ilaria he continues:

> "PTSD results from an overactive sympathetic nervous system. It's the same part of the brain that kept our ancestors alive when lions jumped out of the bushes. It's 'fight or flight.' If a soldier's mind stays in that mode for too long, it doesn't always come back. Everyone expects veterans to return to normal when they come back home. The kids are so excited that Daddy's back. Their spouse wants them to get a good job, and join the rotary, and save for a bigger house. But it's only the veteran's body that has returned to safety. Their nervous system is still living in a dangerous place."

He seems to be unaware that, for reasons unknown, the "flight or fight" response differs in each human being. So, too, does the reaction to extremely life-threatening situations resulting in PTSD. Perhaps this is due to or influenced by the amount of television watched, what is watched, when it is watched, what movies are seen or what literature is read. It might also depend on the individual's color, race, religion, overall life's learning and academic education. Pre-PTSD event life-threatening experiences also spring to mind as possible variables. Earlier, we saw Dr. Joseph E. LeDoux Ph.D.'s (1949–) comments on the amygdala. We learned from them that the "flight or fight" response has nothing to do with PTSD arising from a flawed nervous system, as so vigorously shuffled down by the likes of Ilaria and sundry.

But then, who is Gerard Ilaria? He has a B.A.in Psychology and an M.A. of Social Work from Columbia University. But he was never in military combat, never mind in the military. Instead, he dedicates his life to academic pursuits, the provision as a clinician of mental health and healthcare in general, and to the stigmatized and underserved populations in particular. But his role thus far has only been in an administrative-leadership capacity, such as financial and strategic planning, staff development, grant writing and community outreach. Anything to do with money, much, much money. He currently manages the budget and operations at Cornell University's Department of Public Health at Weill Cornell Medical College as the department administrator, we read on the Headstrong Project's website. He also is Headstrong's co-founder and clinical director.

Breathtakingly, considering his apparently sheltered background, he seems to know everything there is to know about PTSD and the role and involvement of the nervous system in PTSD development. Could it be that Ilaria confuses the nervous system with the human soul? But then, let's face it, he, as many, if not the vast majority in the world of academia and in higher education, may refuse to recognize or address the topic of the soul, never mind its presence in the human body. The spark of God, the infinite spirit, the creator of all there is in all of creation residing within all human beings months before our birth, as documented in *Journey of Souls,* is seldom to one's liking when the trans-humanistic agenda is what one aspires to most.

It is, however, the only essence of our being in which all humans are equal, the only essence we have in common. This soul, with its spark of light within, has two choices. It can shine brightly or be let to wither. Which it chooses depends on a life lived with honor, integrity and graciousness, or by honing and practicing mayhem

and slaughter in words and deeds, theft, manipulation and deception. As the two are non-compatible, it has to be either one or the other. And for PTSD-suffering soldiers and veterans, and for those working in the other PTSD-susceptible professions, this realization dawns with the PTSD experience. It turns into an open wound that, if not cleaned, will fester for the rest of life. It remains bandaged with pharmaceutical drugs or other opioids until death parts us from the earth. The spark within slowly dims until extinguished by pharmaceutical drugs, marijuana, ecstasy and whatever other concoctions prescribed by mental health practitioners under the guise of assistance. In fact, it spells destruction, a spell pushed onto PTSD voyagers, because they are too distraught and too desperate to even sense the snag of the monumental deception. All this is an effort to create the drug-befuddled, destitute zombie society portrayed in the "The Matrix."

But it is the soul's light that gives us our creative and intellectual power. It gives us our free will and our heart and soul emotions. It gives us our innate sense of justice, ethics and morals, our sense of compassion and empathy, our heart essence. In short, it gives us all that is viewed as trivial by the world of Wall Street, where money and materialistic gadgets are the alpha and omega of life itself, the foundation of "War is a Racket."

It is the soul that gives us the power to return to life from the PTSD event-causing moment. It gives us the power to clean out our own personal pigsty. It gives us the power to create the human being we want to be, the one filled with honour, integrity and graciousness. It does this by encouraging us to apply discipline, persistency, willpower, and determination to get us out of it. And it does this regardless of the view and hallucinations of opinions bestowed upon us by those professing to know all about PTSD when having no clue about it. The more I educate myself on it, the more I know that we are used to enrich others financially. The more I know about it, the more I become aware that they are destroying our physical and mental health and/or using us as guinea pigs for trans-humanistic purposes in one way or the other.

Thus, "catching" PTSD, as phrased by Iscol and Ilaria, has nothing to do with the brain's structure and make-up. It has to do with an individual's perception of the reason and purpose of life and living suddenly propelled into awareness by way of the PTSD-causing event.

Headstrong Project's Iscol has a point, however, when piping in his reaction to Kennedy's pussy comment: "If you want to be the best shot on the police force, you find someone who can teach you to shave off hundredths of a second from your

draw." He merely forgot to recognize that it still is the pupil who has to do the practice. It is still the pupil who has to spend the time to better the Self in an effort to improve. And it is still only the pupil who can make the improvement, the same as with making peace with the Self.

But in Iscol's opinion, you have to be active to heal PTSD: "If you want to get stronger at the gym, you find someone who can help you build a better nutrition plan and a workout regimen that will help you achieve your goals."

Yes. But again, it is still the person who has to do the practice, the shopping, the cooking and the eating of those healthy meals.

And why this obsession with imposing a regimen on PTSD journeyers? Why a routine, why enforce all that which is detrimental to PTSD-affected humans, their life rotated out of proportion as it is? Why put that pressure on someone who lost the sense of the Self? Why impose these regimented pressures? Why impose schedules and demands, when the inner Self screams: "Leave me in peace, just leave me well enough in peace. At least for a little while, until I've figured out what is happening and am ready to re-join life?"

"If you want to be a better husband and father you look for a better husband and father to be your mentor and role model," Iscol pipes. And who is going to be the judge of who is the better father, the mentor or PTSD afflicted, pray?

"And if you want to overcome military-related health issues, you seek help," Iscol continues . He says:

> "I agree with Kennedy: you do need to put in the work. The veterans we treat will tell you that getting treatment has been one of the toughest things they've done. They leave sessions emotionally exhausted. But they come out stronger, more resilient, and better able to give more of themselves to their families, loved ones, and communities."

Empirical, scientifically documented evidence of his assertions, however, are unavailable. That Headstrong's patients may feel better because of the company of other veterans sharing their experience, however, may well be. Case in point? Watch CBS's *60 Minutes:* "Advanced PTSD Therapy", December 2013 broadcast.

But tell that to the world's Iscols and Kennedys. As Iscol says:

> "So if you can't sleep, or you're depressed, or you have anxiety and headaches, and even panic attacks, that isn't the symptom of being a pussy. Not reaching out and getting the help you need is."

In other words, it is the “pussy” moniker attached to the PTSD affliction, that elicits the deepest resentment of Kennedy’s diatribe. And rightfully so, as the description does reflect connotations of cowardice. That is considered a grave psychological flaw of character in most societies anywhere in the world, never mind when in the military or serving as fire fighters, police officers or aircrew, all professions incompatible with cowardice.

But then, and to each its own, Headstrong leaders seem to believe that quietness and calmness is deadly to PTSD-afflicted people. They profess that only physical exercise, combined with professional counseling, neuropsychological manipulations, gene therapy, and pharmaceutical drugs combined with willpower will heal PTSD. So why not take it under the microscope and see what we come up with, shall we?

27

Headstrong Or Not Headstrong?

After quitting service in the United States Marine Corps around 2008, Zach Iscol noticed his fellow veterans struggling with caring for their mental health. There was a lack of access to care and an inability to deal with psychological stress. He found that past generations of veterans returning from combat abroad had never received the correct form of mental healthcare, either. He was certain he would succeed where others before him over thousands and thousands of years had failed, other than by self-help, as we shall see later.

In 2012, he founded the non-profit Headstrong Project organization for that purpose. The idea was firmly anchored in his mind. Veterans just needed the courage to get help. With their courage and his project, they would receive the right

help to return to impactful and meaningful lives. Iscol took on the roles of chairman, executive director and co-founder of the non-profit Headstrong. He partnered with Weill Cornell Medical Center, NY, to fund and develop comprehensive mental healthcare programs to treat Iraq and Afghanistan veterans free of cost, stigma and bureaucracy. After all, he had graduated from Cornell University in 2001 with a Bachelor of Arts in government.

To Weill Cornell Medical Center's clinicians specifically trained in trauma and PTSD, he added to the team:

- psychologists
- addiction psychiatrists
- licensed clinical social workers

In 2015, Headstrong furthermore partnered with the Menninger Clinic in Houston, Texas. It was one of the USA's 10 leading inpatient psychiatric hospitals. It was said to be dedicated to treating people with complex mental illness, including severe mood, personality, anxiety and addictive disorders. To Headstrong, it was obviously an ideal spot to heal those having the courage to get Headstrong help.

Not only that. Menninger staff is equally dedicated to teaching future mental health practitioners how to deal with the, in their opinion, mentally ill. The purpose would be to advance mental healthcare through research. That should heighten institutionalized PTSD-affected inmates' experience in their facility to an hitherto unimaginable level. *One flew over the Cuckoo Nest* springs to mind again.

Headstrong also partnered with unspecified veteran services organizations to purportedly deepen its presence, reputation and rapport within the veteran community. *The Three Wise Men Veterans Foundation* is one of them, though. It was founded in 2014 by Marine Corps combat veteran Nathan Fletcher in honour of his three cousins, Jeremy, Ben, and Beau Wise, who served in the US Marine Corps Infantry. Together, they served over 1,600 days deployed in Iraq and Afghanistan. Two of them died in the line of duty.

Fletcher earned a B.Sc. in political science from California Baptist University. He then worked for the International Republican Institute, a nongovernmental organization seeking to build and improve democracies around the world. For him, this included time abroad working with non-governmental organizations in Myanmar, East Timor, Cambodia and Serbia.

He joined the United States Marine Corps as a reservist in 1997 and became an

active duty Marine in 2002. He served as a counterintelligence/human intelligence specialist. He graduated from the U.S. Army Airborne Course and Marine Corps Mountain Warfare Training Center. And he served eight months in the Sunni Triangle region of Iraq in 2004. During his time in Iraq, Fletcher worked to build community relationships with the native population. Leading supervisors described him as "compassionate and focused." He was responsible for authorizing 150 intelligence reports, which amounted to 31 percent of the reports generated by the team of six Counter Intelligence Marines.

Among his awards are the Navy-Marine Corps Achievement Medal with Combat "V" for valor, the Combat Action Ribbon and the Iraqi Campaign Medal. On his final deployment, he worked in the Horn of Africa, earning the Joint Service Commendation Medal and Global War on Terrorism Expeditionary Medal. He was honorably discharged as a staff sergeant in 2007.

From the armed forces, Fletcher transitioned to California State Assembly-member and served as Chair of the Assembly Committee on Jobs in the New Economy. He authored the landmark public safety legislation "Chelsea's Law". In his time in office, he passed and signed into law more than 30 bills addressing issues like tax reform, healthcare, homelessness, veterans, job creation, public safety and, most likely, safe cities.

Fletcher is now a professor of practice in political science at the University of California.

He remains active with many veteran organizations and, since 2017, is serving on Headstrong's board of directors. He also previously served as the senior director of global strategic initiatives for Qualcomm Incorporated. He is a frequent commentator, advocate and public speaker on television. He has appeared on *The Today Show*, *Larry King Live*, MSNBC's *Hardball*, CNN and Fox News, as well as in print publications, including the *New York Times* and *Los Angeles Times*.

He is a member of the World Economic Forum Global Agenda Council on Human Rights, the Leadership Council of the Public Policy Institute of California and the national advisory boards for both Organizing for Action and the Truman National Security Project. In other words, he is a well-connected fellow.

As an Ironman Triathlete and avid outdoorsman who enjoys alpine mountaineering/glacier climbing, Fletcher is dynamic company for Iscol and Kennedy.

The initial efforts in his non-profit-generating career with The Three Wise Men focused on raising awareness of challenges faced by returning soldiers and veterans.

He helped organize over 10,000 Veteran Day events in 50 US states and a dozen countries around the world. He worked closely with other veteran non-profit organizations and provided direct grants to support their efforts.

Over time, they began to address the stigma apparently preventing many veterans from seeking the help they purportedly can get by advocating for legislation to tackle the stigma of mental health injuries. Their campaign was successful, in that the legislation was signed.

They also launched a national campaign said to have reached millions of people. Their message was of hope and strength to veterans confronting their mental health injuries, and they asked for donations for their cause. Merged now with Headstrong's treatment plan, they offer cost-free, stigma-free and bureaucracy-free mental healthcare.

What is treated? PTSD, anxiety and depression, anger management, trauma, grief and loss, addiction and military sexual trauma.

How do they treat them? In accordance with NCforPTSD principles, it seems. They begin with a confidential psychiatric assessment, followed by individual psychotherapy. That means EMDR, CBT, mind-body techniques, motivational interviewing and a support group for loved ones. All this in a bureaucracy and stigma-free environment without cap on the number of sessions given. Clients are now also connected with a veteran within 48 hours of initial contact.

By merging with Headstrong, Fletcher not only expanded his operation's resources and momentum for veterans' mental healthcare across the country. The merger will also lead to a deeper impact in the San Diego area, the centre of the largest US marine base. In my understanding, it will enhance the organization's ability to find subjects willing to enroll in their programs.

Properly planned fundraising, based on the post September 11 veteran population, will be enhanced. So will the ability to discover how clinicians can effectively treat and track veteran clients. "After all, tracking, monitoring and managing key performance indicators and expenditures leads us to better understand our patients, clinicians, and partners," according to Headstrong's public relation folks. That PTSD is not a mental disorder has, willfully or otherwise, yet to dawn on them as well.

Headstrong Project's cost for a six months veteran treatment are at an exorbitant $5,000 or $803.33 monthly, which, I understand, does not include room and board. How veterans under Headstrong's PTSD treatment are to sustain themselves is kept a secret, however, albeit it is the most pressing issue. Why? Due to a backlog of

veterans compensation claims, a tranquil lifestyle is unlikely for the wounded warrior in all PTSD-vulnerable categories.

The problem is so prevalent that in May 2013, the United States' Office of Public and Intergovernmental Affairs announced a partnership to deal with the problem. The VA, the Disabled American Veterans (DAV) and The American Legion teamed up to help reduce Veterans' compensation claims backlog, and to end it in 2015. The effort — the Fully Developed Claims (FDC) Community of Practice — was to be the key part of the VA's overall transformation plan to process claims within 125 days at a rate of 98% accuracy. FDCs could be processed in half the time it took for a traditionally filed claim, the VA bragged.

The results? Dismal, to put it mildly.

That is much of the reason why PTSD-experiencing veterans are unable to resolve their PTSD event-causing existential crises. Due to financial uncertainty, they are unable to enter the path to recovery. That everything told about PTSD is upside down does not help either. But what else is new? As American journalist, Presbyterian minister and Princeton University professor Chris Hedges (1956–) says:

> "We now live in a nation [U.S.A.] where doctors destroy health, lawyers destroy justice, universities destroy knowledge, governments destroy freedom, the press destroys information, religion destroys morals, and our banks destroy the economy."

He should know.

The son of a Presbyterian minister, he graduated from Colgate University with a B.A. in English Literature. He went on to receive a Master of Divinity from Harvard. He has an honorary doctorate from Starr King School for the Ministry in Berkeley, California.

Hedges spent nearly two decades as a foreign correspondent in Central America, the Middle East, Africa and the Balkans. He was an early and outspoken critic of the US plan to invade and occupy Iraq and called the press coverage at the time "shameful cheerleading." In 2002, he was part of a team of reporters for *The New York Times* who won a Pulitzer Prize for the paper's coverage of global terrorism. That same year, he won an Amnesty International Global Award for Human Rights Journalism.

In his 2003 commencement address at Rockford College in Rockford, Illinois, shortly after the war in Iraq began, Hedges told the graduating class:

> " . . . we are embarking on an occupation that, if history is any guide, will be as damaging to our souls as it will be to our prestige, power and security . . . This is a war of liberation in Iraq, but it is a war of liberation by Iraqis from American occupation."

The Wall Street Journal ran an editorial, which denounced his anti-war stance. *The New York Times* issued a formal reprimand and forbade Hedges to speak about the war. Hedges resigned and became a senior fellow at the Nation Institute, a non-profit media centre dedicated to strengthening the independent press and advancing social justice and civil rights

He wrote the 2002 best seller, *War is A Force That Gives Us Meaning*, an examination of what war does to individuals and societies. In it, he states that war is the pornography of violence, a powerful narcotic that:

> " . . . has a dark beauty, filled with the monstrous and the grotesque. War gives us a distorted sense of self. It gives us meaning. It creates a feeling of comradeship that obliterates our alienation and makes us feel, for perhaps the first time in our lives, that we belong."

Of his own experience of war, living and working as a journalist in the war zones of Central America, the Balkans and the Middle East, he writes:

> "I have seen too much of violent death. I have tasted too much of my own fear. I have painful memories that lie buried and untouched most of the time. It is never easy when they surface."

In his 2008 book, *Collateral Damage*, he interviewed combat veterans of the Iraq war who had testified on the record about atrocities carried out by American soldiers and marines during the country's military occupation. His book is said to reveal in heartbreaking detail the devastating moral and physical consequences of the occupation. Could it be that these consequences are in some the reasons for their PTSD?

A prolific writer, Hedges also published the following books:

- *What Every Person Should Know About War* (2003)
- *Losing Moses on the Freeway: The Ten Commandments in America* (2005)
- *American Fascists: The Christian Right and the War on America* (2008)
- *I Don't Believe in Atheists* (2008)

- *Empire of Illusion: The End of Literacy and the Triumph of Spectacle* (2009)
- *Days of Destruction, Days of Revolt* (2012)

All and any of them may be fruitful reading for those who participated, PTSD journeyer or not, because, as he says:

> "Once we sign on for war's crusade, once we see ourselves on the side of the angels, once we embrace a theological or ideological belief system that defines itself as the embodiment of goodness and light, it is only a matter of how we will carry out murder."

Think about it. How does your soul, your conscience view killing others?

Headstrong's purported goal is to engage veterans and provide treatment to help them reduce the crippling symptoms associated with combat-incurred PTSD. Those symptoms include suicidal ideation. It advertises that it will change PTSD-afflicted lives by administering tailored and consistent mental health treatment combined with scientifically measurable remedies. They claim this will lead to:

- longer and better sleep
- improved emotional well-being
- better home and work relationships
- reduced harmful behaviours, including excessive substance use

PTSD clients are then able to go to school, get jobs and maintain sobriety from alcohol and drugs when indicated, we read on its website. Furthermore, in its view, the key to it all is the continuing growth of its brand. Success is reaching other markets with partners that understand the magnitude of having the youngest generation of veterans become mentally healthy. Why not keep it from becoming mentally unhealthy by calling troops home, one wonders, and stop engaging the whole globe in American warfare?

Headstrong's precise ways and means of treatment have yet to be revealed. So have its scientifically substantiated and documented statistics about its PTSD healing and recovery successes. On its website, On their website under *Program long term success, Program success monitored by,* and *Program success examples* the answer is: *Not available.* But under *How will they* [Who? Practitioners or veterans] *know if they are making progress*, we find under *Measurable Results*: "reducing substance abuse/self-medication, and weaning the veteran of prescription medications. After treatment,

our program has delivered highly positive clinical outcomes. 86% reported better sleep, 89% had fewer flashbacks and nightmares, 86% were less hyper vigilant, 92% had reduced suicidal ideation, 91% had improved mood, 95% had improvements in job and/or education, 89% used less drugs or alcohol, and 76% reported improved relationships, 78% required less or no medication for their symptoms."

There are three metrics:

- Program long term success
- Program success examples
- Program success monitored by . . . .

The answer under each is: "Not available." But under "How will they know if they are making progress", we find under "Measurable Results":

> "Reducing substance abuse/self-medication, and weaning the veteran of prescription medications. After treatment, our program has delivered highly positive clinical outcomes. 86% reported better sleep, 89% had fewer flashbacks and nightmares, 86% were less hyper vigilant, 92% had reduced suicidal ideation, 91% had improved mood, 95% had improvements in job and/or education, 89% used less drugs or alcohol, and 76% reported improved relationships, 78% required less or no medication for their symptoms."

It does not mention if these numbers occurred in 1 or 450 PTSD-affected clients. Nor does it mention who will know if they are making progress, practitioners or veterans?

But why disbelieve them? Does it matter that its directors have yet to review and sign Headstrong's Ethics & Transparency form, the conflict-of-interest policy or the disclosure statements? Does it matter that they have yet to conduct and publish a formal written self-assessment of the project's performance within the past three years? After all, do they not say in their website's opening statement:

> "We're Veterans Serving Veterans. We know what it's like to lose a friend, to face the tough and impossible choices of war, to shoulder the pain and guilt of making it back home. At Headstrong Project we are veterans serving veterans, and we understand first hand the hidden wounds of war."

Really? You do? How many of your directors or CEO and Executive officers, now

engaged and partnered with Headstrong, have served in theatres of war for any length of time, pray? How many of you have killed human beings in the line of duty? How many of you have killed civilians and active soldiers of the other side. How many of you have killed your own side in friendly fire?

Human beings engaged in warfare as soldiers with the duty to kill other humans are injured in one way or the other. This has been proven throughout history by way of epics and other accounts for thousands of years. Thus, it is a given that few individuals escape psychological injuries when participating or caught in a war, civilian or otherwise. The only exceptions are if they have psychopathic tendencies or are trans-humanized beings.

Does any of it translate into understanding what another soldier is living within mind and soul? Can one live one's brother's life? Can one really understand the Other's hidden wounds of war or emotions unless one has experienced something very similar? Can one really understand Others unless walking in their shoes?

Or is the presumption to understand the Other in any relationship just a presumption? Soldiers and veterans, husbands and wives, mothers and fathers, children and parents, friends and foes — are these presumptions just an empty saying without substance? Are these presumptions a floccule thrown out perpetually in all situations? Is the "I understand" nothing more than a waste of breath, a misconception or even a downright perversion of the truth?

How can a commissioned or non-commissioned officer understand the soldiers mandated to follow his or her orders, regardless of their idiocy? Those orders cost many a life, as documented in Vietnam, in Iwo Jima, in Monte Cassino and in Gallipolli. It reminds one of satanic rituals more than anything else. How does a human military drone pilot feel when he or she moves the joystick in an unintended direction and hits the wrong target, accidently killing innocent women and children? Do you know?

Does she or he feel different from the pilots actually dropping the bombs? What did those pilots incinerating at least 350,000 wounded soldiers, children and the elderly feel after bombing Dresden? What did they feel years or decades later, full well knowing whom they had bombed? Jubilance?

How can mental health practitioners — the psycho-the-rapists — understand any of it? How can they, when they have never lived even a fraction of the life-style, never mind the life, of those arriving at their offices? How can they, when they have never even contemplated such events and situations? How can they, when these subjects are for them just academic study and hearsay? How indeed?

Why not just call a spade a spade and say:

> "We do not understand what you are living through with PTSD, as we are not you. We never where in the army, Navy, Air Force or even in a theatre of war. We have never been a fire fighter, a police officer or a commercial aircrew member. Nor have we been a rape victim, but we would love to help. What can we do for you? Please tell us, and we will do our utmost to help?"

Why not support PTSD sufferers by distributing the funds "donated" for that purpose among PTSD journeyers? A lot of funds end up with organizations such as Headstrong and partners. PTSD journeyers seeking their help cost Headstrong at least $803.33 monthly. It would go a long way towards their calm and peaceful recuperation on their own. Why not give them the money and see what happens really? Perhaps because PTSD is a racket for the wealthy to exploit and thrive on the misery of those experiencing it? Or because seeing humans suffer is their entertainment and sustenance, the traumatization of the traumatized their energetic nourishment?

Who knows? The possibility exists. Human emotions and previously-held ethics and moral dogmas seem to be disappearing at an ever-increasing rate with the trans-humanistic, trans-gender agenda. So what to do? Trust complete strangers who use us as guinea pigs for their possible fame and fortune, or do our own thing, or will ourselves to die? Do we not will ourselves to death consciously or subconsciously if participating in the schemes of "professional practitioners"? What am I? Who am I? Stupid enough to trust them?

Far fetched? Not necessarily. Let us review those few Headstrong Project's head honchos of whom we have personal information to check how they are able to help. They can also serve as a template for those who most likely run not only the other PTSD not-for-profit agencies. They reflect the very few not-for-profit agencies I looked into and even became involved with through ignorance. That includes the spiritualist church I, in my infinite blindness, attended for many years, money making operations all, but not for the needy and suffering.

We know from its website's *Meet the Team* section, and from other websites, about Zachary J. Iscol, Headstrong's co-founder and executive director. We learned that in the second battle of Fallujah, he saw 33 comrades killed and more than 500 wounded. We do not know, however, if he himself actually participated in the killing spree. We also read that he helped build many of the components within the

US Marine Corps Forces Special Operations Command. And we know that he served as the first officer in charge of recruiting, screening, assessment and selection (RSAS).

We know that he is a fitness fanatic. We also know that he has enough time on his hands to train. So much so, that he qualified as team member of the 2013 Team USA for USA Triathlon and to compete in ITU World Championships. We also recall that he is CEO and founder of Task & Purpose and Hirepurpose. The latter is under the umbrella of a company known as Recruit Citizen, LLC.

Recruit Citizens, LLC, doing business as Hirepurpose, operates as an online career and staffing company in the United States. It is a technology start-up, providing veterans, military service members and their spouses with:

- job matching
- job market analysis
- industry networking
- personalized career guidance

It does this by connecting military veterans and transitioning service members with jobs at over 100 Fortune 1000 companies. In addition, it helps them to make smarter choices about where to live, what to study and what careers to pursue. Its career site enables job seekers to create a profile and take the assessment. The site also provides personalized career guidance and job matching services.

The company was founded in 2011 and is based in New York, New York. As of July 31, 2015, Recruit Citizens, LLC operates as a subsidiary of MarketSource Inc.

MarketSource Inc., provides outsourced sales solutions for organizations. It offers retailer solutions, such as direct sales, experiential demo days, consumer engagement, and merchandising audit and enhancement. It also offers manufacturer and services solutions, including training and brand advocacy, direct and assisted sales, experiential events, and merchandising audit and enhancement. The company also provides business-to-business sales through direct sales, indirect sales and sales support. Its solutions enable customers to gain new customers, launch new programs, grow market share, increase ROI and maximize mature products. The company was founded in 1975 and is based in Alpharetta, Georgia.

The digital news, culture and lifestyle site Task & Purpose is advertised as the fastest growing online destination for military audiences with 3 million people tuning in monthly. Mind you, in his September 27, 2017 broadcast, Alex Jones' of

Infowars fame called Task & Purpose a hugely left wing, hugely communist organization. He said it was run by former military personnel unable to cut working in the military and now working at the normalization of violence in the American population. Here is why.

We know that Iscol holds a Truman National Security Project fellowship. We know he serves on the International Refugee Assistance Project and Arts in the Armed Forces boards of directors. He also sits on the board of advisors for the Center for a New American Security (CNAS), a Washington, DC, based think tank established in 2007 by co-founders Michèle Angelique Flournoy (1960–) and Dr. Kurt M. Campbell (1957–). Flourney served as under secretary of defense for policy under Obama. Camp, a diplomat and businessman, also served as assistant secretary of state for east Asian and Pacific affairs under Obama.

Campbell is now chairman and CEO of The Asia Group, LLC. This strategy and capital advisory group is based in Washington, DC, with an affiliated office in Hong Kong. The firm was founded in 2013 by Campbell and Nirav Patel. Patel was deputy assistant secretary of state for strategy and multilateral affairs under Obama. The Asia Group works with clients to identify, integrate and advance new business opportunities. It also works with existing businesses to navigate the complexities of both established and emerging markets in Asia. The Asia Group, however, is not a lobbying organization.

Before that, Campbell was the chief executive officer and co-founder of the Center for a New American Security (CNAS). He was also a director of the Aspen Strategy Group (ASG), a policy program of the Aspen Institute based in Washington, DC. The ASG is a membership-based forum composed of current and former policymakers, academics, journalists and business leaders. Its aim is to explore the preeminent foreign policy and national security challenges facing the United States.

The Aspen Institute is established in Berlin, Rome, Madrid, Paris, Lyon, Tokyo, New Delhi, Prague, Bucharest, Mexico City and Kiev. It also has leadership initiatives in the United States, Africa, India and Central America. It is largely funded in three ways. Foundations, such as the Carnegie Corporation, the Rockefeller Brothers Fund, the Gates Foundation, the Lumina Foundation and the Ford Foundation contribute. It charges seminar fees. And it accepts individual donations. Its board of trustees includes leaders from politics, government, business and academia who also contribute to its support. The main activities include:

- its annual Summer Workshop meeting in Aspen
- several Track II dialogues such as the U.S.-India Strategic Dialogue and the U.S.-China Strategic Dialogue
- the Aspen Ministers Forum, led by Madeleine K. Albright and convening former foreign ministers from around the world to focus on international security

Campbell also was chairman of the editorial board of the *Washington Quarterly*. He was founder and principal of StratAsia, a strategic advisory company focused on Asia. Prior to co-founding CNAS, he served as director of the International Security Program. And he was the Henry A. Kissinger Chair in National Security Policy at the Center for Strategic and International Studies. Thus, Campbell is a very busy man indeed.

But what does Iscol have to do with all these seemingly New World Order organizations? The Center for a New American Security (CNAS), of which he is director, specializes in United States national security issues. Its stated mission? To "develop strong, pragmatic and principled national security and defense policies that promote and protect American interests and values." It focuses on:

- the future of the U.S. military
- terrorism and irregular warfare
- the emergence of Asia as a global power centre
- the national security implications of natural resource consumption

Former Deputy Secretary of State James Steinberg under Obama called CNAS "an indispensable feature on the Washington landscape." Steinberg is currently a professor of social science, international affairs, and law at the Maxwell School of Citizenship and Public Affairs at Syracuse University.

Bilderberger-affiliated U.S. Central Command Commander General David Petraeus spoke at the CNAS annual conference in June 2009. There, he observed that CNAS had in a few years established itself as a true force in think tank and policy-making circles. President Barack Obama's administration hired several CNAS employees for key jobs, and *The Washington Post* in June 2009 suggested, "In the era of Obama . . . the Center for a New American Security may emerge as Washington's go-to think tank on military affairs."

CNAS, however, only has around 30 employees and a budget under $6 million,

and still Iscol is on its board of directors. What does that have to do with soldiers and veterans PTSD, I wonder? Mind you, Iscol is a graduate of the private Phillips Exeter Academy, whose annual tuition fees for the 2015–2016 school year ran to $46,905 for boarding students and $36,430 for day students. In addition, each student will spend an estimated $850 for books. Mandatory fees are $885 for boarding students and $370 for day students. There are also optional fees of $1,310 for discretionary services.

After Exeter, Iscol did his B.A. at the private Ithaca, New York, based Cornell University's Department of Government. It is devoted to the study of how political power is shaped by institutions. It looks at how that power is channelled and challenged by civic engagement in local, national and international contexts. The department offers students a variety of opportunities to engage with politics and political science. It begins in the classroom, with hands-on learning of different analytical approaches, such as:

- survey research
- political psychology
- the close reading of texts
- working one-on-one with faculty in the honours program or as research assistants
- participating in internships in Washington, DC through the Cornell in Washington Program

Students can also draw on the department's ties with programs across the College of Arts and Sciences. Among the focuses are:

- peace studies
- regions of the world
- ethics and public life

All this for a mere $26,000.00 tuition fee per semester or $52,000.00 annually, books and such not included.

No sweat for Iscol, mind you. He was born with the proverbial silver spoon in his mouth. The world was his oyster from the moment of birth, including holidaying with Bill and Hilary Clinton. His father, Ken Iscol, was a 1960 Cornell University School of Industrial and Labor Relations (ILR) graduate who received an

M.B.A. in finance from New York University. He owned and operated mobile and personal communications businesses for more than 40 years. He served on the advisory council for the Personal Enterprise and Small Business Management Program in Cornell's College of Agriculture and Life Sciences. He also was a founding advisory member of Cornell's Center for the Environment. He was founder of the Jill and Ken Iscol Distinguished Environmental Lecture Program. He was also a life member of the Cornell University Council.

On Cornell's web page about Ken Iscol and his wife Jill, we read about the *Cornell University: College of Human Ecology Bronfenbrenner Center for Translational Research; The Iscol Family Program for Leadership Development in Public Service*. Zachary Iscol's mother, an educator and activist, holds a Bachelor of Arts magna cum laude from the University of Pittsburgh (1967). She has a Master of Philosophy in sociology from Yale (1990). And she earned a doctorate from the Teachers College, Columbia University (1976). She is president of the Iscol Family (IF) Hummingbird Foundation. Established in 1989, it supports domestic and international efforts to strengthen democracy and reduce social, economic and educational inequalities. As Democratic Party activist, Mrs. Iscol was also co-chair for the Hillary Rodham Clinton for Senate New York finance committee. And she was national vice-chair of Hillary Rodham Clinton for President 2008 finance committee and, according to the Huffington Post, was a member of the *Hillary for President* 2016 finance committee.

For the past two decades Mrs. Iscol is said to have developed an expertise in identifying visionary leaders and programs at the early stages of their development. She fosters their advancement by providing seed capital and guidance. Thus, she enables them to become stable, sustainable and successful organizations impacting lives around the globe.

Such organizations include Acumen Fund, a registered 501(c)(3) charity, purportedly raising charitable donations to invest in companies, leaders and ideas that are changing the way the world tackles poverty. The Rockefeller Foundation, Cisco Systems Foundation, and three individual philanthropists whose names are undisclosed provide the seed capital. Acumen was incorporated on April 1, 2001, an April 1st joke, perhaps, when considering the actions of those involved in the Clinton Foundation.

Acumen's mission statement reads:

- "Our desire was to transform the world of philanthropy by looking at all human beings not as distant strangers, but as members of a

> single, global community where everyone had the opportunity to build a life of dignity."

Its leitmotiv? "The Humility to see the World as it is, the Audacity to imagine the World as it could be." The question of course is *audacity* in whose imagination, estimation, views and desires? Theirs, the members of the global elite, deliriously aspiring to the New World Order. They, who rule the 500 million humans remaining on Earth as their mind-manipulated slaves when they have accomplished their goal reflected in the Georgia Guide Stones? Or our, humanity's, audacity to create the world as it could be, eliminating private bankers and the Federal Reserve (who is neither federal nor has reserves, by the way)? That alone would be a huge step to return us to the usurped Heaven on Earth.

Iscol's mother also fosters the Iscol Family Program for Leadership Development in Public Service at Cornell's College of Human Ecology. It is supported by the Iscol Foundation's Hummingbird Foundation endowment. According to the College's Dean Alan Mathios, Ph.D., the program aims to give undergraduate students inspiration and direction in translating their knowledge, idealism, and optimism into concrete action to build better communities for families and children. It tries to bring to campus people who embody the intelligence, energy, sacrifice and commitment it takes to successfully impact society. It also aims to support Cornell students in meaningful summer internships in public service.

Mathios sees this program as central to the College's mission of developing leaders who address significant societal issues. Human Ecology explores the relationship between people and the world around them from a variety of perspectives. It then strives to shape that world for the better through teaching, research and outreach by developing leaders, solving problems and strengthening communities. In accordance with the global elite's NWO and Agenda 21 desires. It's rat-living for the masses, 6 people on 400 square foot flats in high-rises, to preserve the earth for the rich and powerful to do as they please elsewhere, perhaps?

Why else would it be called Center for Translational Research? Whose translations translated how and by whom? And what, pray, is translational research to begin with? We'll return to that in a little while. Iscol Sr.'s support and participation on campus, together with vacationing and socializing with the Clinton's and their social circle, had its benefits. Cornell University's board of trustees recognized the couple as "Foremost Benefactors", a designation given to alumni and supporters who most generously support the university financially.

Both their children are Cornell graduates. Iscol Jr.'s sister received her B.A. in 2003 from the College of Agriculture and Life Sciences. Thus, the close relationship between the Headstrong Project and Cornell University's Weill Cornell Medical College is explained – somewhat.

Headstrong's medical director is Ann Bordwine Beeder, MD She works as associate professor of clinical public health and clinical psychiatry at Cornell's Weill Medical College and serves as chief of the Division of Community and Public Health Programs. She is also the medical director of The Midtown Center for Treatment and Research and the Vincent P. Dole Treatment and Research Institute. A very busy woman, indeed.

Beeder's research interests include translational medicine in viral hepatitis, alcohol and substance abuse, as well as psychiatric illness. We are told that she has treated patients suffering from trauma for more than 20 years and, through her partnership with Iscol, began treating trauma of military combat veterans. It is Beeder and her colleagues who developed the patient-centred and -tailored treatment approach that matches patients with modalities and treatments purported to work best on individual PTSD-traveling veterans.

Evelyn Polcari, Headstrong's director of development, joined the project in early 2012, when the Internal Revenue Service (IRS) granted the corporation's non-profit status. She spearheads fundraising, event planning, corporate sponsorship and administrative management. Beginning her career on Wall Street in the early 1980's, she was one of the first women members of the New York Stock Exchange. Her career spanned Goldman Sachs, Donaldson Luwin, Oppenheimer and Co., and Blumenthal Securities. Upon leaving Wall Street, she turned to philanthropic and service work in years hence. She established a focus on issues involving children, young adults and mental illness. At present, she is director at Kayne Anderson Real Estate in Boca Raton, Florida. She is also a court-appointed special advocate and translator for Hispanic children in the foster care system.

Gerard Ilaria, Headstrong's director of operations whom we mentioned earlier, holds a B.A. in Psychology and a Master of Social Work from Columbia University. His interests include sociology, growth and development, mental health theory and practice, human behaviour/social environment, psychology and research methods.

A licensed clinical social worker (LCSW), Ilaria is also trained in psychotherapy to help people deal with a variety of mental health and daily living problems and in improvement of overall functioning. Dedicated to providing healthcare to stigmatized and underserved populations, he practiced as a clinician and in

administrative-leadership capacities. He is now the administrator of the Department of Public Health at Weill Cornell Medical College. He manages the budget and operations of this complex research-, service- and clinical-oriented department.

Ilaria previously was director at the New York-Presbyterian Hospital/Weill Cornell Medical Center, running the Center for Special Studies adult AIDS program. He was responsible for the operations and financial management of a care program serving 2,400 people with HIV/AIDS. He also provided clinical supervision to 20 Masters level social workers. His professional experience also includes six years of rural health and mental healthcare as director of infectious disease at the Specialty Care Center of Catskill Regional Medical Center. He is experienced in clinical practice, financial and strategic planning, staff development, grant writing and community outreach, according to Headstrong.

Dustin Shryock joined The Headstrong Project as director of community engagement and partnerships. He previously worked in the public, private, tech and non-profit sectors. He recently earned his Master of Public Administration with a focus on non-profit management from The Robert F. Wagner Graduate School of Public Service at New York University. He also recently completed work at Cornell University, studying strategy tactics and leadership development. He is a graduate of Pace University, where he was awarded the New York State Conspicuous Service Cross.

A veteran himself, Shryock's service in the United States Army included two deployments in support of Operation Iraqi Freedom. He was awarded the Bronze Star Medal while spending nearly three years conducting operations in and around Baghdad, Iraq. He was also a White House intern, working on the Joining Forces team.

The Conspicuous Service Cross may be awarded to any current New York State citizen or person who was a New York State citizen while serving on federal active duty. One's entire service must remain honorable subsequent to the time of receipt of the citation. The eligible services are:

- Army
- Navy
- Air Force
- Marine Corps
- Coast Guard

- Army female nurse corps

One must have received a personal decoration issued by a brigade or equivalent higher headquarters of one of these organizations. It may also be awarded to any New York State citizen who, while serving with allied forces, received a personal decoration issued by a brigade or equivalent higher headquarters.

Shryock is an avid golfer, creator of original artwork and devoted alpine skier

Shyrock's war story was featured in the November 6, 2016 issue of the *New York Daily News* after an interview with its reporter Larry Mcshane. In "Anxiety attacks that would pop up for no reason," Shyrock recalls the problems that surfaced out of the blue in 2010, two years after serving two tours in Iraq. He started feeling somewhat wrong and did not know how to make it right.

> "I'd be sitting on the couch, doing nothing. You can just imagine a normal anxiety attack like a public speaking engagement. And a tiny little thing like that, over time, over and over, became debilitating. A lot of veterans don't even realize why they're suffering."

A fellow veteran pulled him aside with a solution: the Headstrong Project.

The idea for the project itself sprang forth when Iscol Jr. and his battalion commander were talking over a beer. They had noticed how many Fallujah fighters had committed suicide after returning to the U.S. A few days later, Iscol got in touch with Kayne Anderson Capital Advisors' real estate private equity business CEO Al Rabil and with Beeder. Headstrong was launched and treated its first patients at Manhattan's Weill Cornell Medical Center in the fall of 2012. Al Rabil III joined Headstrong's board of directors.

Al Rabil's career began in real estate financing at the Bankers Trust Company in the late 1980s. In the early 1990s, he joined the Real Estate Banking Group of the Union Bank of Switzerland (UBS). He became managing director and head of the Real Estate Banking Group for the Americas and Europe until early 2000. During his tenure, Rabil played a key role in making UBS a market leader in both syndicated debt and large loans, apparently. He handled more than $25 billion in transactions.

Between 2002 and 2007, he founded and was a Principal of the real estate investment firms RAMZ, LLC, and Rabil Properties, LLC. They developed more than $250 million of off-campus student housing. RAMZ, LLC, is a privately held single-location business, based in Pittsburgh, PA, categorized as commercial real estate agents and incorporated in Pennsylvania in 2004. Estimates of RAMZ's annual

revenue are $150,000, with a staff of just two.

Rabil holds a Bachelor of Arts cum laude from Yale University (1985) and an MBA in finance from Columbia University (1988). We hear from Headstrong that he is another of its founding members involved in numerous other non-profit ventures.

Clayton R. Hagerman, a director of client development for Kayne Anderson Capital Advisors, is another veteran. He served for three years as a Navy officer assigned to the U.S. Special Operations Command. His duty stations were in Tampa, Florida and the mountains of eastern Afghanistan. Before that, he managed a small distressed real estate venture. He spearheaded the mergers & acquisitions program for an IT/telecommunications consolidation. And he directed deal origination for his family's investment office.

A sixth generation Texan, Hagerman graduated from the New Mexico Military Institute (NMMI). NMMI prides itself on offering a rich history and tradition of educating tomorrow's leaders through a program of strong, challenging academics, leadership preparation, and character development. Known as "The West Point of the West," it remains the only state-supported co-educational college preparatory high school and junior college in the United States. Serving the educational needs of an international student population, the Institute has strict admissions standards. Each year, about 1,000 students enroll from 43 states, the District of Columbia and 13 foreign nations. Hagerman proceeded to obtain a Bachelor of Business Administration from Southern Methodist University and a MBA from Rice University. He also holds a direct commission in the U.S. Navy Reserves.

And lo and behold, Hagerman also sits on the Quick Reaction Foundation board of directors. Its purpose? A military unit that responds rapidly to emergency situations. Its ideal? "A veteran-focused non-profit providing immediate solutions for the health, welfare, and maintenance of elite special operations warriors and their families." QRF seeks to remedy areas of need that are overlooked and underserved that materially increase quality of life. Its leitmotiv?

> "A domestic emergency response organization that provides immediate solutions for the health, welfare and maintenance of elite special operation warriors and their families. QRF seeks to remedy areas of need that are overlooked and underserved that materially increase quality of life (qrfoundation.org)."

Who founded QRF and is it's CEO? Actor and former Navy SEAL Garrett

Golden of Golden Dynamics created QRF after his military career. His goal was to provide private sector solutions to unsupported and under supported areas of need within the teams. In addition to the QRF, Golden is actively involved in multiple entrepreneurial ventures of "unspecified nature", we read on QRF's website.

Another QRF co-founder is Bob Sinnott, CEO of Kayne Anderson Capital Advisors. He has over 40 years of investment experience, and oversees all of the firm's investment teams as well as serving on each strategy's investment committee. Since joining Kayne-Anderson in 1992, Sinnott founded and built Kayne's energy platform into one of the largest energy investment firms in the country. It has more than $24 billion in energy investments. He also is the firm's portfolio manager for two of Kayne's hedge funds. In addition, Sinnott is a director of Plains All American Pipeline, L.P. (NYSE: PAA), a large publicly traded MLP and its parent company, (NYSE: PAGP). He is a director of California Resources Corporation (NYSE: CRC), California's largest independent oil and natural gas producer. Another very busy man, indeed. He earned a B.A. from the University of Virginia and an MBA from Harvard Business School. His attachment to the military lasted three years aboard the U.S.S. Forrestal as a lieutenant junior grade.

But back to Headstrong, to continue following this particular enterprise, focused on serving the armed forces, but intertwined with other purportedly PTSD-related goals.

According to Bloomberg, board member Darlan Monterisi has been senior vice president of corporate communications at Computer Associates International, Inc, or CA, Inc., since May 2016. Ms. Monterisi is responsible for overseeing CA's global corporate communications function. She has been stewarding a highly integrated approach to delivering the corporate and product messages to key audiences. She served as the managing director and partner of the New York Office at Porter Novelli, Inc., since January 14, 2013.

A global public relations leader, Porter Novelli was founded in 1972 and is a part of Omnicom Group, Inc., (NYSE: OMC). In 90 offices in nearly 60 countries, Porter Novelli combines the power of immersion with the rigor of research to create deep human insights. These enable the agency to transform the opinions, beliefs and behaviours of those who matter most to its clients. Ms. Monterisi served as Porter Novelli's executive vice president and client relationship leader until January 14, 2013.

She has more than 13 years of experience overseeing U.S. and global communications and public affairs programs. Prior to Porter Novelli, she served as

the global PR director for Rockstar Games. Her role was to conceive, develop and execute integrated communications programs for such brands as Grand Theft Auto IV and Midnight Club: Los Angeles. Before that she served as an account director with Mullen, working on clients like the Department of Defense, BBN Technologies, H&R Block, Embarq and Wachovia.

Prior to that, Monterisi served for an undetermined amount of time as a Captain in the U.S. Marine Corps, working as a public affairs officer. She gave strategic public affairs guidance to top Marine commanders. She was also a spokesperson for the 2004 First Marine Expeditionary Force in Fallujah, Iraq during Operation Vigilant Resolve. She was named to PRWeek's "40 Under 40" in 2008. A well-connected powerhouse. In 2001, Monterisi earned a Bachelor of Arts in political science and Italian language and literature from the University of Chicago.

Headstrong's board director David Petrucco is a co-founder of Backcast Partners, a financial advisory, consulting and investment business located in Millburn NJ. Backcast Partners helps middle market companies identify their future goals. Then it helps put in place the financial and human capital and other required resources to achieve those goals. Formerly a Partner at Kayne Anderson and a managing director at Blackstone, Petrucco also worked at Royal Bank of Scotland (RBS) and UBS Securities.

Petrucco, also one of Headstrong's co-founders, is said to be highly involved in other military-associated charities, including the Special Operations Fund in Washington DC. A B.A. graduate in Economics from Boston College (1989), he is also noted as a screaming eagle, a somewhat nebulous connotation. According to urbandictionary.com it means one of two things. It could mean to have been part of the 101st Airborne. This is a group of specially trained paratroopers who were dropped behind enemy lines to start the D-Day invasion. But he is too young for that. The other possible meaning is to have participated in gang-rape, which is most unlikely.

Kenny Polcari is another Headstrong director. He is a New York Stock Exchange member and O'Neil Securities, Inc., director, representing the broker/dealer division of William O'Neil & Company. For the past 30 years, he has represented the interests of global institutional asset managers that need to access the world's equity markets. In addition to serving on Headstrong's board, Polcari is a board advisor and markets expert for The Integral Board Group. This is a high impact, fully engaged board service provider. For 15 years prior to that, he was a managing director at ICAP Corporates, LLC, which provides securities brokerage services

focusing on investment and non-investment grade corporate debt. The firm is based in Jersey City, New Jersey. ICAP Corporates, LLC, is a subsidiary of TP ICAP, a global firm of professional intermediaries that operates in the world's financial, energy and commodities markets.

Polcari also worked as inter-dealer broker and division manager with Salomon Brothers, directing their NYSE Division during the 1990s bull market. He presently functions as a CNBC contributing editor/market analyst, who can be seen giving market commentary from the floor of the NYSE across a range of their US programming. This includes "The Half-Time Report", "Power Lunch" and "Closing Bell", as well as programming in Asia and Europe. Polcari, furthermore, is a board member of The National Organization of Investment Professionals (NOIP), and a member of both the National Security Traders Association (STA) and The Security Traders Association of NY (STANY). He has leveraged his superior communication and presentation skills as the host of the "Fund-a-Need" portion of the annual Headstrong Project's "Words of War" fundraising benefit. He holds a Bachelor of Science in business administration and in finance from Boston University.

Headstrong director Paul Casey is a managing director and the chief operating officer of Morgan Stanley Private Wealth Management, a division of Morgan Stanley Wealth Management. It is comprised of 400 private wealth advisors, who collectively manage over $250 billion in ultra high net worth private client assets, where he is responsible for business strategy, business management and client development efforts.

Casey began his career at Morgan Stanley in 2002 as an analyst in investment management. In 2004, he joined the Global Wealth Management Product Development Group. He led strategic projects, competitive analysis, and due diligence efforts on both internal and external financial products and services. In 2007, he joined the Global Private Wealth Management Strategy and Business Management team as a vice president to lead efforts within the U.S.

His introduction to the Headstrong Project was as senior advisor to a select team of Morgan Stanley employees participating in the 2015 Morgan Stanley Strategy Challenge for charitable organizations. The Strategy Challenge team helped Headstrong formulate an expansion plan to cities in great need of help for veterans dealing with PTSD. Casey is also a board member of the National Football Foundation's NYC Chapter. Plus he is actively involved with Rebuilding Together. This non-profit organization works to preserve affordable homeownership and revitalize neighbourhoods, doing free home repairs and modifications for

neighbours in need.

A native of Buffalo, NY, Casey attended Fordham University and graduated with a Bachelor of Science in business management.

Peter Westmeyer, another Headstrong director, founded and is president and managing principal of Chicago, Illinois, based MBRE Healthcare. An institutional platform with an. entrepreneur perspective to *healthcare*, *MBRE Healthcare* is a full-*service* real estate company. IT acquires, develops, leases *and* manages *healthcare* real estate across the United States.

Westmeyer is responsible for MBRE's investments and asset management, including sourcing, analyzing and financing healthcare real estate investments. He also serves as the fund manager for the GP healthcare funds the firm manages. MBRE Healthcare acquires healthcare facilities across the United States from a variety of sources. Those include health systems and physician groups, institutional owners and local developers. MBRE Healthcare also leverages in-house development and project management teams to tackle ground-up development projects across the country in a cost effective manner.

MBRE manages more than 10 million square feet of healthcare facilities, and is said to have the resources and infrastructure to manage property effectively and efficiently. Prior to founding MBRE, Westmeyer worked as an associate for the Corporate Investment Group within the Investment Banking Division of Bank of America. He also worked in real estate investment sales, specializing in multifamily and land properties in Colorado. MBRE Healthcare's latest acquisition is the Excel Centre, an 83,213-square-foot medical office building in San Diego, California, for $37.1 million. Westmeyer got a Bachelor of Science from the University of Vermont and holds Masters of Science in finance and in real estate from the University of Denver.

Headstrong director Pete Petronzio spent 28 years in the United States Marine Corps. He retired at the rank of Colonel after a career in both conventional and special operations units. A combat veteran of Iraq, Afghanistan and other locations, Petronzio commanded diverse global organizations with thousands of Marines. He was known for his ability to build relationships and trust in new and complex organizations and environments. His final position in the military was as the 24th Marine Expeditionary Unit (MEU) Commander.

Petronzio, USMC, retired, also serves as a director of TrackingPoint, Inc., founded in 2011 and based in Pflugerville, Texas. It develops and produces precision-guided firearm systems and accurate shooting systems for long range

shooters. The company also offers products for night-time missions serving the military, SWAT teams, law enforcement and civilians. It also trades in precision guided firearms accessories and guided hunting rifles. It also sells accessories online.

The company serves hunting and target shooting industries and has a strategic partnership with Recon Instruments, Inc. Recon designs and develops smart eyewear for sports and high-intensity environments. It offers GPS heads-up displays for alpine sports, prescription inserts and ski and snowboard goggles called Recon Engage. Users can track activity and location in real time, see their stats, manage dashboards and get text and call notifications on their Recon device. The company also provides tools and documentation for designing, developing and distributing apps for Recon devices. The company offers its products through distributors and online. It was founded in 2008 and is based in Vancouver, Canada. As of June 16, 2015, Recon Instruments, Inc., operates as a subsidiary of Intel Corporation.

Petronzio retired from active military service as a joint specialty officer in 2011. His last assignment was as the commander of the 24th Marine Expeditionary Unit (MEU) in Camp Lejeune, North Carolina. He was one of the original members of the Marine Corps Special Operations Command, serving in and commanding operational units from platoon- to MEU-size. His overseas assignments included Kosovo, Bosnia, Iraq, Afghanistan, Haiti and other contingencies around the world. He has attended numerous military schools, including:

- U.S. Army Airborne
- U.S. Navy Dive School
- Armed Forces Staff College
- Draeger Closed Circuit SCUBA Transition
- Special Forces Military Free-Fall Parachute School
- Marine Corps Command and Staff College (non-resident seminar)

He holds a Bachelor of Science degree in education from Norwich University and an MA in educational leadership and administration from Troy State University.

In other words, Headstrong project directors and those actively involved with it are well-healed people. They work or were working on Wall Street and with international financial and conglomerates. They are each paid a minimum of $63,000.00, the national average volunteer salary of non-profit directors, according to Pay Scale USA. This is on top of their non-disclosed annual earnings.

Be it as it may, Headstrong's CEO and board members believe there are effective, evidence-based mental health treatments and protocols that can immediately help returning combat veterans suffering from PTSD and traumatic brain injury. The first challenge is to reach those veterans, engage them and retain them in care. Headstrong wrote on guidestar.org:

> "Our first goal is to enhance the mental health of wounded service members, and to help them foster healthy readjustment to civilian life."

What then are these revolutionary PTSD treatment modalities Headstrong's directors advocate? The ones that can enable those PTSD-suffering combat veterans' to spring into immediate action upon returning to the comfort of their home and country, pray, where all other treatment modalities have hitherto failed? They are the EEG Neuro-feedback and Cognitive Behaviour Therapies.

28

EEG, Neuro-Feedback, Neurotherapy, Neurobiofeedback & Cognitive Behaviour Therapies In PTSD Stabilization

WHAT IS EEG? An electrophysiological monitoring method to record electrical activity of the brain.

WHAT IS NEUROFEEDBACK (NFB), AKA. NEUROTHERAPY OR NEUROBIOFEEDBACK? A type of biofeedback that uses real-time displays of brain activity and function most commonly measured and charted by an EEG.

WHAT IS BIOFEEDBACK? Electronic monitoring of normally automatic bodily functions. It is used to train someone to take voluntary control of those functions

normally outside of conscious control.

HOW IS IT DONE? By using electrical sensors connected to the body, measuring and displaying physical or mental processes. This gives information — feedback — about the body — bio — for the purpose of heightening awareness of functions more difficult to feel or detect on our own.

HOW CAN BIOFEEDBACK BE USED? To learn to control the body's functions, such as heart rate.

TYPES OF BIOFEEDBACK?

The three most common methods of biofeedback include:

- electroencephalography (EEG) or neurofeedback: measures brain wave activity over time
- thermal or temperature biofeedback: measures body temperature changes over time
- electromyography (EMG) biofeedback: measures muscle tension as it changes over time

Other types of biofeedback include:

- galvanic skin response training: measures the amount of sweat on your body over time
- heart variability biofeedback: measures your pulse and heart rate

BIOFEEDBACK VS. NEUROFEEDBACK

- Neurofeedback is one specific type of biofeedback therapy. In fact, in the U.S, it's currently the most widely available and popular form of biofeedback training.
- Electroencephalography (EEG) feedback is another way to refer to "neurofeedback." Neurofeedback is basically a type of biofeedback that measures brain waves (electrical brain activity) using an electroencephalogram, or EEG.
- EEGs help measure how activity in different regions of the brain increases or decreases depending on someone's actions. This helps with training in self-regulation — and self-regulation allows for better control over one's stress response stemming from activity of

the central nervous system (specifically the autonomic nervous system).
- A key principle of neurofeedback is that electrical "oscillations" (such as theta waves or beta waves) influence awareness, arousal and ability to function — and that dysfunctional activities in certain key regions of the brain correlate with mental disorders.
- Like other forms of biofeedback, neurofeedback addresses problems that are made worse from stress and brain deregulation. These include: anxiety-depression spectrum disorders, attention deficits and behavioural disorders, sleep disorders, headaches and migraines, PMS and emotional disturbances.

This feedback, we read, helps focus on making subtle changes in the body, such as relaxing certain muscles. It helps achieve the results one wants, such as pain reduction. In essence, biofeedback gives us the power to use our thoughts to control our body and often to improve a health condition or physical performance. So, of course, do many other exercises without outside intervention, such as meditation and yoga.

Typically, sensors are placed on the scalp to measure activity. The measurements are displayed using video displays or sound. Positive feedback identifies desired brain activity and negative feedback identifies undesirable brain activity. Related technologies include hemoencephalography biofeedback (HEG) and functional magnetic resonance imaging (fMRI) biofeedback.

Your therapist might use several different biofeedback methods. Determining the method that's right for you depends on your health problems and goals. Biofeedback methods include:

- **BRAINWAVE.** This type of method uses scalp sensors to monitor your brain waves using an electroencephalograph (EEG).
- **BREATHING.** During respiratory biofeedback, bands are placed around your abdomen and chest to monitor your breathing pattern and respiration rate.
- **HEART RATE.** This type of biofeedback uses finger or earlobe sensors with a device called a photoplethysmograph or sensors placed on your chest, lower torso or wrists using an electrocardiograph (ECG) to measure your heart rate and heart rate variability.

- **MUSCLE.** This method of biofeedback involves placing sensors over your skeletal muscles with an electromyography (EMG) to monitor the electrical activity that causes muscle contraction.
- **SWEAT GLANDS.** Sensors attached around your fingers or on your palm or wrist with an electrodermograph (EDG) measure the activity of your sweat glands and the amount of perspiration on your skin, alerting you to anxiety.
- **TEMPERATURE.** Sensors attached to your fingers or feet measure your blood flow to your skin. Because your temperature often drops when you're under stress, a low reading can prompt you to begin relaxation techniques (Mayo Clinic).

Hemoencephalography (HEG) is a relatively new neurofeedback technique within the field of neurotherapy. Neurofeedback, a specific form of biofeedback, is based on the idea that human beings can consciously alter their brain function. Training sessions help them change the signal generated by their brain and measured via some neurological feedback mechanism. To do so, participants increase cerebral blood flow to a specified region of the brain. The result is increased brain activity and performance on tasks involving that region of the brain. Neurofeedback is a form of biofeedback based on a direct measure of brain activity (rather than something downstream of the brain). Neurofeedback aims to improve mental and emotional functioning by directly training the brain's physiological functioning.

WHAT IS HEG NEUROFEEDBACK?

Most neurofeedback is based on measuring EEG or brainwaves. In hemoencaphalography (HEG) neurofeedback, we're not looking at the brain's electrical activity — rather HEG detects changes in the brain's energy consumption. The result is a much simpler feedback signal — it goes up when the brain activates (increases its energy consumption). And it goes down when the brain deactivates (relaxes its energy consumption). None of the complex hard-to-interpret rhythms of EEG, and no difficult decision as to exactly what to train.

There is nothing new about the idea of using electricity in discovering brain-function and stimulation.

It was used, and some say it is still used, in insane asylums and MKUltra to this day. After all, the body is merely electrical vibration. It was in 1924 that the German

psychiatrist Hans Berger (1873–1941) connected a couple of electrodes, small round discs of metal, to a patient's scalp. He detected a small current by using a ballistic galvanometer, an electromechanical instrument that detects electric current. He is best known as the inventor of EEG. He found a way to record "brain waves". Coining the name, he was also the discoverer of the brain's alpha wave rhythm known as the "Berger wave." Among his many research interests in neurology, Berger studied brain circulation, psychophysiology and brain temperature. However his main contributions to medicine and neurology were twofold. First, the systematic study of the electrical activity of human brain. And second, the development of electroencephalography (EEG) by following the pioneering work of Richard Caton (1842–1926) This British physician, physiologist and Lord Mayor of Liverpool, England, worked with animals, and his studies were crucial in discovering the electrical nature of the brain.

In her fascinating article "Down a Rabbit Hole? A History of EEG Analysis" (sapienlabs.co, May 2018) Tara Thiagarajan writes about how crazy it sounded at the time. When Hans Berger first reported that he could measure electrical activity from the brain using surface electrodes and a Siemens galvanometer in 1929, no one believed him. It was finally acknowledged in the 1930s that these were indeed electrical potentials of the brain. But the big challenge was to make any sense of them.

Berger called these periods Alpha waves. Everything else that was typically non-periodic and tended to have complex fluctuations of higher frequencies that could not be characterized was called beta waves.

Slower frequencies were reported by Hoagland, Rubin and Cameron in 1936 to which they gave the name delta waves. That same year Jasper and Andrews claimed to have seen frequencies higher than 30 Hz. They called them gamma waves, but given technical limitations, this was met with scepticism initially. Overall, however, it was Berger who analyzed EEGs qualitatively and published 14 reports about his studies during the years 1929–1938. Modern knowledge of the subject, especially in the middle frequencies, is accredited to him.

In the 1930s, harmonic analysis of signals was also becoming important in the context of various signal transmission problems pertaining to radio transmission and astronomy. Fourier series was therefore the most prevalent mathematical approach to consider in analyzing EEG data. It was named after Jean-Baptiste Joseph Fourier (1768–1830), a French mathematician and physicist. He is best known for initiating the investigation of Fourier series as a way to represent a function as the

sum of simple sine waves, and their applications to problems of heat transfer and vibrations. A sine wave or sinusoid is a mathematical curve that describes a smooth periodic oscillation. A sine wave is a continuous wave. It is named after the function sine, of which it is the graph. It occurs often in pure and applied mathematics, as well as physics, engineering, signal processing and many other fields. The Fourier transform and Fourier's law are also named in his honour. Fourier is also credited with the discovery of the greenhouse effect.

Never mind. The Fourier analysis was known to EEG researchers of the time, but such analysis had to be done by hand and was laborious and impractical. It also limited the frequencies that they were able to address. Some folks nonetheless took this on, and in 1932, the German researcher G. Dietsch published a first Fourier analysis of the EEG signal. It consisted of a methodology and a table for a handful of frequencies, thus becoming the first researcher of what is called QEEG (quantitative EEG). Dietsch discovered that:

> "Es wird an Hand einiger harmonischer Analysen von E.E.G. gezeigt, daß in diesen Aktionsspannungen noch wesentlich andere Frequenzen enthalten sind, als man bisher annahm. Die hierbei auftretenden Fehlerquellen werden diskutiert. Während sich beim normalen E.E.G. Frequenzen bis zur 7. Harmonischen nachweisen lassen, sind bei den pathologischen Kurven solche bis zur 11. vorhanden. Das Verhältnis der Amplituden zur Grundwelle ist bei verschiedenen Krankheiten verschieden. Außerdem traten starke Schwankungen der Frequenz auf, die beim normalen E.E.G. nur gering sind. Zwischen den Phasenwinkeln bestanden keine einfachen Beziehungen. Ferner zeigte sich auch hier die starke Überlegenheit der Röhrenverstärker gegenüber den Spulengalvanometern (*Pflüger's Archiv für die gesamte Physiologie des Menschen und der Tiere*, Dezember 1932, Volume 230, Issue 1, pp 106–112; cite as Cite as Fourier-Analyse von Elektrencephalogrammen des Menschen)."

The English Translation by Marta Arena of translated.com:

> "On the basis of a number of harmonic EEG analyses, it is shown that substantially different frequencies are contained in these action voltages than has previously been assumed. The sources of error which occur here are discussed. While

> normal EEG frequencies up to the 7th harmony have been verified, in the case of the pathological curves, they are present up to the 11th. The ratio of the amplitudes to the fundamental wave differs in different diseases. In addition, there were strong fluctuations in the frequency, which are low in the normal EEG. There were no simple relationships between the phase angles. Furthermore, the tube amplifiers displayed a high level of superiority over the coil galvanometers (*Pflüger's Archiv für die gesamte Physiologie des Menschen und der Tiere*, December 1932, Volume 230, Issue 1, pp 106–112; cite as Fourier Analysis of electroencephalograms on people)."

The American-born British neurophysiologist, cybernetician and robotician William Grey Walter (1910–1977) was greatly influenced by the work of Ivan Pavlov of Pavlov's dogs' fame. He visited Berger's lab and subsequently set about developing better methodologies for characterizing EEG potentials. He built a device to photo-mechanically parse signals by frequency. Called the Walter Analyzer, this involved hooking up the recording apparatus with oscillators of different frequencies. These created as output sine waves of the select frequency. The waves had an amplitude somewhat representative of the 'power' of that frequency in the EEG — essentially mechanical band pass filters. Obviously it is not practical to have such analyzers for each frequency. For that reason the first Walter Analyzer had four frequencies, and later versions had 10.

Right from the beginning, however, Walter noticed the challenges of harmonic analysis when defining his analyzer. He discussed at length its considerable limitations. He expended considerable effort to explain how different phase relationships of the component frequencies can produce fundamentally different waveforms. He fretted over the challenge of maintaining his oscillators in phase with one another. Indeed, he questioned the very premise of such frequency-based separation of a signal that appeared so obviously non periodic.

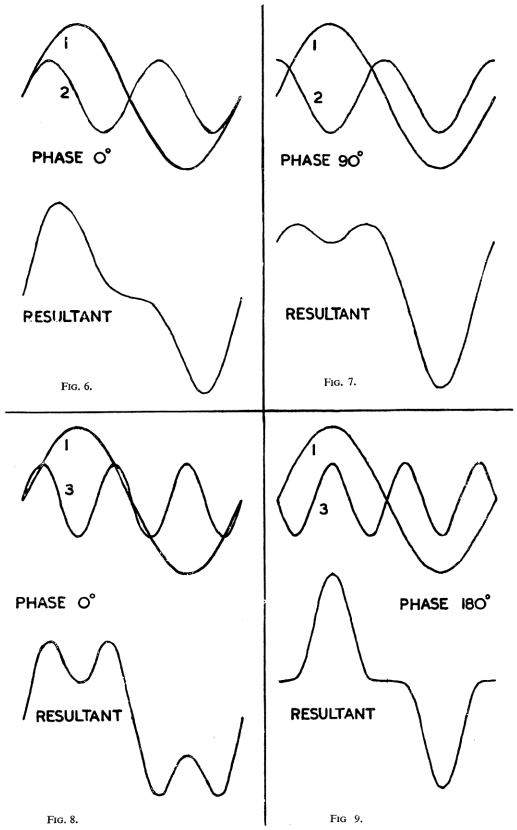

FIG. 6. FIG. 7. FIG. 8. FIG 9.

FIGS. to 6 9.—Graphs showing combination of fundamental with its second and third harmonic. Explanation in text.

(Dawson and Walter, "The Scope and Limitations of Visual and Automatic Analysis of the Electroencephalogram". *J. Neurology, Neurosurgery & Psychiatry.* 1944 Jul; 7(3–4): 119–133)

He says:

> "The chief limitation of automatic e.e.g. analysis with instruments at present available lies in the fact that whilst they will separate and measure mixed and modulated rhythms in the e.e.g. they give no information about the relative phases of the waves making up these rhythms. When harmonically related higher frequencies are added to a fundamental frequency, the shape of the resulting waves depends entirely on the phase relations of the harmonics to the fundamental. Therefore, two compound waveforms which have components identical in frequency and size, and so will show the same analysis, may yet have entirely different shapes. In the visual examination of an e.e.g. record it is

> important to know some of the forms a given set of rhythms may produce by phase . . . . A series of harmonically related components may produce an infinite variety of waveforms."

Walter was not the only one who took this on. In 1963, Edmund Kaiser and colleagues built the Kaiser filter (image below from Kaiser et al., 1964). It was made of six high Q resonators representing one delta filter, one theta filter, two alpha filters and two beta filters. It gained some popularity in the community. This, in fact, reduced the number of filters relative to others in use. However, there was also the practical issue of which analyzer would be manufactured and marketed, rather than remain a single-lab novelty This factor would influence the direction of the literature.

It is also important to note that it was not until the 1960s that mainframe computers came into accessible academic use. And it was 1965 by the time Cooley and Tukey came up with their FFT algorithm that is used today. Nonetheless, even in the sixties it was still no simple task to calculate the power spectrum of the EEG. The oscillograph output had to be carefully digitized and shipped off along with code to a mainframe computer, often far away. From a practical standpoint of computational time and efficiency, if you wanted any result at all, it still made more sense to be focused on specific frequency bands.

However, Tara Thiagarajan points out in her April 2017 article "The Blue Frog in the EEG" that, the EEG is also a time series and with the hint of oscillating components. So, researchers jumped on the bandwagon to make use of the latest signal processing technique. So much so, that much of EEG analysis today rests on decomposition of the EEG signal into its spectral components. Those components are the frequencies of which it is composed, using the Fourier transform.

This would be sufficient as an approach if it were that the brain simply produced a mix of oscillations that had to be parsed (read "What does the EEG signal measure?"). However, oscillations are not the only aspect of the signal and certainly not the dominant aspect.

Much of the signal is a complex temporal pattern. It often rides on top of oscillations and one can forget that *spectral decomposition of the EEG signal may lose critical information.*

A spectral decomposition of the signal, says Tara, can be thought of as similar to analyzing a work of art by transforming it into its color spectrum and describing it in terms of how much red, blue and green is in it. You lose the important information of how they mix and which color is next to which. If you looked at a lot of pictures

this way you might come up with some inference. You might conclude that 'pictures with lots of blue means it is a picture of the sky'. It might indeed be statistically significant that when you compare pictures dominated by blue to pictures dominated by red that the blue ones more likely represent sky. However, while color composition is certainly an aspect of a painting, you would miss the larger point of a Monet or Renoir or the blue frog she depicts in this article.

However, this is the same way that we make inferences about the EEG with studies that show things like 'more 'beta' means you are more alert'. The thoughts we produce are far more than simply the few permutations allowed by changing levels of five arbitrary frequency ranges. Simply looking at relative levels of broad bands of frequencies perhaps misses the point of the immense art of the human brain. Can we go beyond this to methods that are more discriminating of the contours of the picture, she asks? Can we indeed, in a scientific trans-humanistic oriented society? Where there is little interest in considering how heart and soul, the food we eat and the air we breathe influence our brain waves and behaviour?

Is neurofeedback, therefore, only the mechanized exterior way of applying control over our behaviour, with the assistance of the one controlling the input? Is it the way to go if wanting to be controlled by others? Ample information of measuring brain functions is available on the Internet. One recent publication on the topic are *Atlas of Brain Mapping: Topographic Mapping of EEG and Evoked Potentials* by Konrad Maurer and Thomas Diercks (Springer Science & Business Media, Dec. 6, 2012). Another is *Frequency-pattern functional tomography of magnetoencephalography data allows new approach to the study of human brain organization* (Front Neural Circuits. 2014; 8: 43). This one is by Rodolfo Llineas, MD, Ph.D., and Mikhail Ustinin. Llineas is affiliated with the Department of Neuroscience & Physiology at the University of New York, NY, USA. Ustinin is deputy director of the Institute of Mathematical Problems of Biology, Pushchino, Moskovskaya, Russia. The latter work states in its conclusion:

> "Finally, our results indicate that precise spectra are sui generis every subject, in particular concerning spontaneous activity. We propose this new analysis paradigm for brain research, based on the calculation of precise spectra and on their storage for future reference concerning the development of pathological conditions, among other uses. The general number of functional entities in the particular experiment can be estimated as 5–10 thousand. This number in the order

> of magnitude is close to the number of categories, introduced to describe cognitive processes in Huth et al. (2012). Functional entities, revealed by the method proposed (Llinás and Ustinin, 2012), correspond to emergent functions of neural circuits (Alivisatos et al., 2012) and the study of these entities can be the important component of the starting Brain Activity Map project."

Sui generis — unique, of its own kind — is the word! As Maurer and Diercks espouse in their observations and research:

> "From its discovery in 1929 by Hans Berger until the late 1960s, when sensory visual and auditory evoked potentials were dis covered and became popular, the EEG was the most important method of neurophysiological examination. With the advent of computer technology in the 1980s, it became possible to plot the *potential* fields of the EEG onto models of the scalp. This plotting of information as neuroimages followed the structural and functional techniques of Cf, MRI, PET and SPECf. The success of this method, which began in the early 1980s, has led to the brain mapping of EEGs and EPs being increasingly used for diagnostic purposes in neurology, psychiatry and psychopharmacology. The pioneers of this method believed in it and were committed to its success. However, many traditionalists felt that it gave no new information and so regarded the method with scepticism. Some found both the coloured maps and the mapping technique misleading, which led to unnecessary conflict between mappers and their chromophobic oponents. Emotions have run so high that some professional bodies have justifiably adopted guidelines and warned of the misuse of the method (italics mine)."

Sui generis, a person or thing that is unique, in a class by itself, an original artist of his or her life. It is an interpreter and analyzer of his or her own life experiences, his or her heart and soul feelings, emotional reactions, tastes, desires and dislikes. These cannot be considered by painted charts and maps. Nor can they be condensed into a one-form-fits-all format, but in one's own sui generis fashion.

Nevertheless and in all fairness, let's see how biofeedback can be used according

to *Brainworks: train your mind, Brain training excellence since 2007* (brainworksneurotherapy.com).

While most people are assumed to have normal brain function, we read on their website, they still have brain imbalances or chronic emotions that affect their day-to-day life. This is where neurofeedback can help. Needless to say, and as pointed out above, who is the one dictating what is and what is not normal or abnormal sui generis, is the question to ask.

Neurofeedback is a way to train — speak rearrange — brain activity directed by the biofeedback received from the brain. But first, we are told, to understand neurofeedback, we need to understand a little about brainwaves. Brainwaves are electrical impulses produced as brain cells communicate with one another. Using sensors on the scalp, practitioners, clinicians and scientists can measure and monitor this activity. With brain analysis software, a QEEG brain map, specific activity giving rise to specific symptoms can be identified. They can also tell those trained in reading those charts a great deal about how humans feel and function, their thought habits, stress levels, underlying mood and overall brain function.

Once the areas of concern are pinpointed, those reading the charts can create a plan to help draw the brain into a seemingly comfortable and efficient state. Sounds nice, but a comfortable and efficient state according to whom? Sui generis or catholic, generic, or violent or docile, or emotional or brutal, unemotional, and devoid of all humane feelings, the killer or the lamb?

During a neurofeedback session, we hear, our brain is actually evaluated to see if it is doing what one would like it to do, but according to whom? When the brain is nearing a more comfortable state, one is rewarded with a positive response on a computer screen. This positive 'neuro-feedback' response usually is in the form of a video game, music or movie. The sounds and images immediately tell when the brain approaches a more efficient place and when not. When the movie plays, it is because the brain is approaching the desired state. When the movie stops, it is because the brain is heading the other way. In accordance with whose desires, though, the sui generis or the one dictating the music or video performance?

This is much like physical exercises developing specific muscles. The more the brain is exercised into reaching a more comfortable, more efficient position, the better it gets at it, we read, but better at what? Watching movies while disconnecting the sui generis?

As with learning any new skill, it simply requires time and repetition, we learn. They got that right. Neuroplasticity, the brain's amazing capacity to change and

adapt, has been a known fact throughout human history. So has neurogenesis — the actual generation of new brain cells. Why else would the age-old adages "Practice makes Perfect ", "help yourself to help you God," and so on and so forth exist?

Brain research termed neuroplasticity merely proves the fact. It refers to the physiological changes in the brain that happen as the result of our interactions with our environment, they say. I beg to differ. In my opinion, it originates with our interactions and inter-relationship with ourselves, and the control we develop over our Self, the sui generis. This happens without electrode applications, neurofeedback map reading and applications applied by strangers. This happens without risking the loss of our sui generis way of thinking, aptitudes and the consequent actions we might carry out in the future.

How else would those PTSD journeyers receiving the appropriate care of peace and quiet without financial strain and homelessness have recuperated — as long as they kept off pharmaceutical and opioid drugs? By applying their sui generis, which allowed neurogenesis and encouraged neurofeedback. They did this through meditation, pranayama breathing, yoga and numerous other fields of knowledge mentioned in this book, all instrumental to a PTSD recovery. But of course, no research exists in these fields, as it is detrimental to the financial aspects of the Neumeisters et al. and those making a living in neurofeedback. It is also detrimental to those in the field of Trans-humanism, the basis for neuropsychiatry and the like.

From the time the brain begins to develop in utero until the day we die, the connections among the cells in our brains reorganize in response to our changing, needs we read on Brainworks neurotherapy. Our needs? Why not in accordance with our purportedly unchosen circumstances, though Michael Newton of Journey of Souls and others would beg to differ?

Why is it, then, that our brains are said to be immune to the feelings, the emotions of our mothers? Our exposure to love and caring? Our upbringing by strangers, often of doubtful standards and backgrounds, in a kindergarten versus being raised at home by our mother or our grandparents? Our regular exposure to television from the moment of birth versus walks in the park, so to speak. Keep in mind that it has been known for light years that a child's character is formed within the first two years of life, and by the age of six is finished?

What about our life experiences, our desires, our sui generis tendencies? Are they all of no consequence? Is it only our needs that dictate our neuroplasticity? Is it only the newest fad — childhood brain dysregulation caused by *neurological changes* — that happen in response to trauma early in life, such as the terrible two's, that dictate

our fate?

At the same time, these changes can dysregulate the whole nervous system, maintains *The Crappy Childhood Fairy,* who advocates neurotherapy to its prospective clients. The nervous system, we read, is what organizes everything our bodies do:

- our immune systems
- our hormonal systems
- our capacity to handle stress
- our mental capacity to pay attention and learn
- our natural tendency to connect and bond with other people

Thus, forget all about sui generis, those running the operation seem to yell. You are nothing but a machine, regulated with ease once you get your fornicating brain under control. You are stupid, and to heck with destiny, soul, emotions, feelings, character, sui generis, individual power, and so on and so forth.

But what about the mal-rotated Atlas impeding the nervous system's proper function, and the physical body from being in balance. What about how it keeps the life energy from flowing freely, the spiritual channels open to see more, feel more, experience more, help the Self more due to the restriction of blood flow from the spinal cord to the brain and vice versa? Why keep this knowledge hidden, when a one-time application that is a safe, effective and does not pose any health risk successfully aligns the Atlas vertebra. What about a method without cracking, rough handling, or traction? What about one short session to stimulate the body's healing capabilities and enable humans to solve their problems? Is that not better than an outside source such as the far-from-proven-benign EEG means and methods?

Be it as it may, neurofeedback is a specific application of biofeedback for visualizing and training the electrical activity of the brain, the electroencephalography (EEG).

Purportedly, through visualization/viewing of the EEG, the subject can learn to better self-regulate brain activity according to the principles of operant conditioning. And this can be done with the help of non-pharmacological and non-invasive equipment.

Operant conditioning? And what might that be, I wondered?

Operant conditioning is a method of learning through rewards and punishments for behaviour. It is through operant conditioning that a person makes an association between a particular behaviour and a consequence (Skinner, 1938). Behaviourism

thus is the systematic approach to understanding the behaviour of humans and *other animals*. It assumes all behaviours are either one of two things. They can be reflexes produced by a response to certain stimuli in the environment. Or they can be a consequence of a person's history, including especially reinforcement and punishment, together with the person's current motivational state and controlling stimuli. In other words, those advocating cognitive behavioural treatment modalities for PTSD journeyers view them as animals. Yes, that's the foundation for the treatment, although some behaviourists might accept inheritance in determining behaviour.

That explains the approaches to PTSD healing by and large applied by the powers that be. Only cognitive behavioural methods are accepted as valuable in PTSD treatment, even in Headstrongs' ideas and theories about PTSD recovery. This despite the evidence that they are as useless as tits on a bull for nurturing a newborn, in our case the PTSD journeyer, into a new life.

That everything neuroscientist and their ilk do and say is mere *theory*, *hallucination, illusion* and *hypothesis* is kept well under wraps. That their practicing those *theories*, *hallucinations, illusions and hypotheses* endanger the lives of PTSD experiencers' big time is also kept well under wraps.

Behaviourism, as such, emerged in the late 19th century as a reaction to depth psychology and other traditional forms of psychology. They often had difficulty making *predictions* that could be tested experimentally.

The term depth psychology — from the German term *Tiefenpsychologie* — was coined by the Swiss psychiatrist and eugenicist Eugen Bleuler (1857–1939). It referred to psychoanalytic approaches to therapy and research that take the unconscious into account. The term has since come to refer to the ongoing development of theories and therapies pioneered by Pierre Janet, William James and Carl Jung, as well as Freud. They explored the relationship between the conscious and the unconscious. Depth psychology states that psyche is a process that is partly conscious, partly unconscious and partly semi-conscious. In practice, depth psychology seeks to explore underlying motives as an approach to various mental disorders, with the belief that the uncovering of these motives is intrinsically healing. It seeks the deep layers underlying behavioural and cognitive processes (en.wikipedia.org).

All that sanity went down the drain with the evolution of Behaviourism. Behaviour is deemed to be the range of actions and mannerisms made by individuals — meaning humans and aliens — organisms, systems or artificial entities

in conjunction with themselves or their environment. That includes the other systems or organisms around, as well as the inanimate physical environment. It is the response of the system or organism to various stimuli or inputs, whether internal or external, conscious or subconscious, overt or covert, and voluntary or involuntary.

Originally combining elements of philosophy, methodology and psychological theory, the earliest derivatives of Behaviourism can be traced back to the late 19th century. That's when the American psychologist Edward Lee Thorndike (1874–1949) became interested in the animal 'man', i.e. the human being, to which he devoted his life. It is he who pioneered the *Law of Effect* in 1898. This is a psychological principle stating:

> " . . . responses that produce a satisfying effect in a particular situation become more likely to occur again in that situation, and responses that produce a discomforting effect become less likely to occur again in that situation."

Nowadays we call this "behavioural conditioning", with all its derivatives.

The terms "satisfying" and dissatisfying" appearing in the definition of the *Law of Effect* were eventually replaced by the terms "reinforcing" and "punishing" when operant conditioning came into vogue. "Satisfying" and "dissatisfying" conditions are determined behaviourally, as they cannot be accurately predicted. As we heard earlier, each animal — human being, alien — has a different idea of these two terms than another animal — his or her sui generis. What one human "animal" might find satisfying the other might not.

The new terms, "reinforcing" and "punishing," are used differently in psychology than colloquially. In the latter, it is *presumed* that something that reinforces a behaviour makes it more likely to again occur, Something that punishes behaviour is *presumed* to make it less likely to reoccur. This makes me wonder why those purporting to have the cure for PTSD persistently push PTSD experiencers into incessantly regurgitating their PTSD causing event moment? For reinforcement or punishment of what, pray? But never mind; perhaps the reason will reveal itself as we move along.

Thorndike's *Law of Effect* refuted the ideas of George John Romanes (1848–1894). Romanes was a Canadian-English evolutionary biologist and physiologist. He laid the foundation of what he called "comparative psychology", postulating a similarity of cognitive processes and mechanisms between humans and other animals. In his book *Animal Intelligence* (1882), he compared the mental abilities of animals ranging

from snails to humans. He used what he called "ejective inference", meaning the assumption of similarity between animal minds and human minds as his basis. What was Romanes's "ejective inference"?

> "Starting from what I know subjectively of the operations of my own individual mind, and the activities, which in my own organism they prompt, I proceed by analogy to infer from the observable activities displayed by other organisms what are the mental operations that underlie them." (Romanes, 1883/1977, in Roitblat, 1987)

His method of gathering data for his book was to collect *anecdotes*, stories such as would appear in a brief newspaper article or a letter from a friend. He knew that anecdotes were not a very scientific form of evidence. But he apparently felt that if he sifted through the anecdotes for the best and most revealing, it would be helpful in generating hypotheses for later scientific study. Romanes' thorough belief that animals had similar mental processes as humans justified his "ejective inferences."

Romanes did not hesitate to *anthropomorphize,* to attribute or ascribe human form or behaviour, to project human qualities upon animals, either. For example, Romanes would refer to a rat that had just been freed from a cage as happy and carefree. The mental life of a rat was assumed to be like that of a human in the same situation, minus the capacity of language. Anyone with dogs knows this, of course. With cats, perhaps, too, but the closest I ever came to a cat is my present dog Princess, cat lovers tell me. I hear though, that they are more restricted in expressing their feelings and emotions. Romanes's attitude and view is still thought to be common by some who think that humans find it natural to project their own experiences into animal minds. Consider the following excerpt from a report in the Science section of the *New York Times* (Angier, July 24, 2007):

> "The similarities between us and Rattus extend far beyond gross anatomy. They're surprisingly self-aware. They laugh when tickled, especially when they're young, and they have ticklish spots; tickle the nape of a rat pup's neck and it will squeal ultrasonically in a soundgram pattern like that of a human giggle. Rats dream as we dream, in epic narratives of navigation and thwarted efforts at escape . . . .
>
> Rats can learn to crave the same drugs that we do — alcohol, cocaine, nicotine, amphetamine — and they, like us, will sometimes indulge themselves to death. They're

> sociable, curious and love to be touched — nicely, that is. If a rat has been trained to associate a certain sound with a mild shock to its tail, and the bell tolls but the shock doesn't come, the rat will inhale deeply with what can only be called a sigh of relief."

Each of the *New York Times'* reporter's anthropomorphic claims is based on a research finding. Researchers are usually reluctant to go the last mile and infer such human-like experiences. To most humans, however, ejective inference comes naturally, we are told. To the mental health ilk is does not. Neither to Henry Kissinger and his trans-humanistic neuroscientistic inclined ilk, viewing humans, and in particular soldiers, as "dumb animals." Love, grief, anger and sorrow in their lives and souls appear to be eliminated, extinguished, non-existent. Viewing as they do humans as automaton, the question arises: what do they wish to accomplish with their QEEG neurofeedback treatment modalities?

Do they aim to teach clients to become their own psycho-the-rapist by raping the Self of all emotions? Do they want to turn it into the trans-humanist dream, the human zombie robot, as it results in the killing of the sui generis, the killing of spirit and soul, an empty vessel to inhabit by a demon?

Mind you, Romanes's reliance on anecdotes and his tendency to project human qualities upon animals was at the time popular with the public. Anyone who ever had animals knows that his observations are accurate. American psychologists of the 1890s and beyond, however, refused to endorse Romanes's observations. They were too focused on trying so very hard to gain a foothold in society by making psychology more scientific for the sake of their credibility, Instead, they portrayed his findings as a step backward toward folk science and speculation.

Thorndike, the man-equals-animal enthusiast, hypothesized that animals, the human beings, must physically interact with their physical environment to understand it. They must use trial and error, reward and punishment. And they must keep on until a successful result is obtained in accordance with the discipline or reward applicant's or his own liking. Nothing has changed. Everything is still based on the theory that human and animal behaviour can be explained in terms of conditioning. There is no need to appeal to or take into consideration thoughts or feelings. Psychological disorders are best treated by altering behaviour patterns enforced or mediated. And all their methodologies are enhanced by dousing clients ad nauseam in pharmaceutical drugs and other opioids, as advocated by the NCforPTSD and rampant in US society at large.

Behaviorism is in essence a psychological approach purportedly emphasizing scientific and objective methods of investigation. The basic idea was carried out by Russian physiologist Ivan Pavlov (1849–1936). He published the results of a series of experiments on conditioning after originally studying digestion in dogs. This is now commonly referred to as "Pavlov's Dogs". His research became renowned for demonstrating how to cultivate a particular association between one event and the anticipation of another. This is called "classical conditioning" or "Pavlovian conditioning", This approach or methodology is only concerned with observable stimulus-response behaviours. It espouses the idea that all behaviours are learned through interaction with the environment and little else (Saul McLeod: *Skinner–Operant Conditioning;* simplypsychology.org 2018).

The behaviourist movement began in earnest, however, in 1913. John Watson wrote an article entitled "Psychology as the behaviourist views it." It set out a number of underlying assumptions on methodology and behavioural analysis, the opening paragraph stating:

> "Psychology as the behaviourist views it is a purely objective experimental branch of natural science. Its theoretical goal is the prediction and control of behaviour. Introspection forms no essential part of its methods, nor is the scientific value of its data dependent upon the readiness with which they lend themselves to interpretation in terms of consciousness. The behaviourist, in his efforts to get a unitary scheme of animal response, recognizes no dividing line between man and brute. The behaviour of man, with all of its refinement and complexity, forms only a part of the behaviourist's total scheme of investigation." (Psychology as the Behaviourist Views it. John B. Watson (1913). First published in *Psychological Review*, 20, 158–177)

That explains. But let us look a bit deeper into the behaviourist approach of purportedly healing psychological human difficulties. Saul McLeod of simplypsychology.org, 2017, explains:

> **"ALL BEHAVIOUR IS LEARNED FROM THE ENVIRONMENT:** Behaviourism emphasizes the role of environmental factors in influencing behaviour, to the near exclusion of innate or inherited factors. This amounts essentially to a focus on learning.
>
> We learn new behaviour through classical or operant

conditioning (collectively known as 'learning theory'). Therefore, when born our mind is 'tabula rasa' (a blank slate).

"PSYCHOLOGY SHOULD BE SEEN AS A SCIENCE: Theories need to be supported by empirical data obtained through careful and controlled observation and measurement of behaviour. 'Psychology as a behaviourist views it' is a purely objective experimental branch of natural science. Its theoretical goal is . . . prediction and control.' (p. 158). The components of a theory should be as simple as possible. Behaviourists propose the use of operational definitions (defining variables in terms of observable, measurable events).

"BEHAVIOURISM IS PRIMARILY CONCERNED WITH OBSERVABLE BEHAVIOUR, AS OPPOSED TO INTERNAL EVENTS LIKE THINKING AND EMOTION: While behaviourists often accept the existence of cognitions and emotions, they prefer not to study them as only observable (i.e. external) behaviour can be objectively and scientifically measured.

Therefore, internal events, such as thinking should be explained through behavioural terms (or eliminated altogether).

"THERE IS LITTLE DIFFERENCE BETWEEN THE LEARNING THAT TAKES PLACE IN HUMANS AND THAT IN OTHER ANIMALS: There's no fundamental (qualitative) distinction between human and animal behaviour. Therefore, research can be carried out on animals as well as humans (i.e. comparative psychology).

Consequently, rats and pigeons became the primary source of data for behaviourists, as their environments could be easily controlled.

"BEHAVIOUR IS THE RESULT OF STIMULUS-RESPONSE: All behaviour, no matter how complex, can be reduced to a simple stimulus-response association. Watson described the purpose of psychology as: 'To predict, given the stimulus, what reaction will take place; or, given the reaction, state what the situation or stimulus is that has caused the reaction.'" (1930, p. 11).

Are there different types of Behaviourism? Historically, the most significant distinction within behaviourism has been that between Watson's original "methodological behaviourism", and forms of behaviourism later inspired by his work, known collectively as "neobehaviourism".

And then came Burrhus Frederic Skinner (1904–1990), who founded Radical behaviourism. He agreed with the methodological behaviourism's assumption that the goal of psychology should be to predict and control behaviour. Like Watson, Skinner also recognized the role of internal mental events. While he agreed such private events could not be used to explain behaviour, he proposed they should be explained in the analysis of behaviour.

Another distinction between methodological and radical behaviourism concerns the extent to which environmental factors influence behaviour. Watson's (1913) methodological behaviourism asserts the mind is tabula rasa (a blank slate) at birth. In contrast, radical behaviourists accept the view that organisms are born with innate behaviours. Thus they recognize the role of genes and biological components in behaviour. To top it off, Skinner published his book, *Beyond Freedom and Dignity* in 1971. In it, he argues that free will is an illusion, and that entrenched belief in free will and the moral autonomy of the individual, which Skinner referred to as "dignity," is counterproductive. He says it hinders the use of scientific methods to modify behaviour for the purpose of building a happier and better-organized society. *Some* summarized his ejaculations as an attempt to promote his philosophy of science. That would be the technology of human behaviour, his conception of determinism and what Skinner calls "cultural engineering".

Whichever way, though, an obvious advantage of behaviourism is its ability to define behaviour clearly and to measure changes in behaviour. We already saw it in the MMPI and numerous other tests measuring human behaviour and tendencies, aptitude and attitudes. We have seen earlier in this book how these have been applied to PTSD journeyers to their detriment.

According to the law of parsimony, the fewer assumptions a theory makes, the better and the more credible it is. Behaviourism, therefore, looks for simple explanations of human behaviour from a very scientific standpoint, we are told. However, is not all of it based on assumptions and speculation? Does the foundation not lack empirical, scientific evidence, as human emotions are hard to measure to the degree of best evidence?

Can Behaviourism provide more than a partial account of human behaviour, that which can be objectively viewed? We already know that important factors like emotions, expectations, higher-level motivation are neither considered nor explained. Therefore, says McLeod, accepting a behaviourist explanation — or diagnoses — could prevent further research from other perspectives. Could those perspectives uncover important factors in, for example, how PTSD sufferers can

recover, perhaps?

In addition, humanism rejects the scientific method of using experiments to measure and control variables. It creates an artificial environment with low ecological validity. As the American humanistic psychologist Carl Rogers (1902–1987) asserted, for people to "grow", they need a certain environment. It needs to provide them with genuineness, openness and self-disclosure. It needs to provide acceptance, meaning to be seen with unconditional positive regard. It needs to furnish empathy, being listened to and being understood. Without these, relationships and healthy personalities will not develop as they should, much like a tree will not grow without sunlight and water.

Rogers also believed that every person could achieve their goals, wishes and desires in life, stating:

> "The organism has one basic tendency and striving — to actualize, maintain, and enhance the experiencing organism" (Rogers, 1951, p. 487).

When, or rather if, they did actualize, maintain and enhance themselves, self-actualization would take place to fulfill one›s potential and achieve the highest level of ‹human-beingness› one could. Like a flower that will grow to its full potential if the conditions are right, so people will flourish and reach their potential if their environment is good enough. However, unlike a flower, the potential of the individual human is unique, and we are meant to develop in different ways according to our personality, says Sam McLeod.

Rogers also believed that people are inherently good and creative. They become destructive only when a poor self-concept or external constraints override the valuing process.

Carl Rogers believed that for a person to achieve self-actualization, they must be in a state of congruence. This means that self-actualization occurs when a person's "ideal self," the way they would really like to be, is congruent and in harmony with the way they behave. Their self-image has to match how they actually are from the inside out, from their soul, heart and mind.

And here we have the crux of the PTSD matter. Back on earth with a tabula rasa, PTSD journeyers have the chance of a lifetime. They are handed the phenomenal opportunity to create the congruent, the ideal self for themselves and by themselves. But they are prevented with all might by the powers that be to do so. We are blocked in all ways possible from reaching this state of self-actualization. We are not permitted this state of congruence necessary to go on with our lives, to

achieve harmony and peace within the Self.

But why is everything done to destroy the view of ourselves and our sui generis? Why are we forced into the deteriorating spiral of poor self-concept, perceptions and beliefs about the Self, our inner personality, our soul influenced by the experiences we had in our lives? Why belittle and demean our interpretations of those experiences? Why the external constraints that furthermore slowly erode our confidence in ourselves and everyone and everything around us? Perhaps to destroy the brightest and the fittest in society, as they always present a danger to their power?

The powers that be throughout the NCforPTSD to the VA joyously ignore Rogers' rejection of the deterministic nature of both psychoanalysis and behaviourism. This is obvious. His view that we human beings behave as we do because of the way we perceive our situation is also frowned upon. Those considering themselves expert in PTSD recovery theories and treatment modalities shun Rogers' approach that " . . . no one else can know how we perceive, we are the best experts on ourselves," But we are the very best experts, if not the only ones, to fix ourselves. We have the power, but that, too, is kept hidden from us. Tell that to those swaying their power over us, and your financial aid will be cut off so fast you won't know what hit you.

According to Rogers (1959), we want to feel, experience and behave in ways that are consistent with our self-image. We want to act in a way that reflects what we would like to be like, our ideal-self. The closer our self-image and real self are to each other, the more consistent or congruent we are and the higher our sense of self-worth. A person is said to be in a state of incongruence if some of their experience is unacceptable to them and is denied or distorted in the self-image. This is why rule number one for PTSD experiencers is to make peace with whatever they loved pre PTSD-causing event. This process is consistently prevented by the medical establishment of whatever genre. They start by dousing us with pharmaceutical drugs from the onset. Then they impose ridiculous behavioural psychotherapies. The former distorts how we perceive ourselves and the predicament in which we find ourselves. The latter imposes the view of the practitioners upon us and screws up our mind further, knowing neither whether we are coming or going.

Be it as it may, contrary to neuroscientists, neuropsychiatrists, neuropsychologists and neurotherapists, humanistic psychology assumes that humans have free will. They can make their own decisions in life and choose not to follow the deterministic laws of science. Humanists also reject the nomothetic

approach of Behaviourism, as they view humans as being unique and believe humans cannot be compared with animals. Humanistic psychology also assumes that humans have free will, whereas Behaviourism mainly concerns itself with studying what we have in common with other animals. That is to say, establishing laws or generalizations in total ignorance of the sui generis.

The psychodynamic approach includes all the theories in psychology that see human functioning based upon the interaction of drives and forces within the person. It particularly includes unconscious interactions. Those interactions are also between the different structures of the personality. This approach also criticizes behaviourism, as it does not take into account the unconscious mind's influence on behaviour and instead focuses on externally observable behaviour. Freud, whose psychoanalysis was the original psychodynamic theory, also rejected the idea that people are born a blank slate (tabula rasa).

Nevertheless, behaviour therapy and the associated behaviour modification combined with neurotherapy is the newest major approach to treatment of PTSD. It comes with its operant conditioning with reward and punishment, movies, videos and music if the PTSD experiencers do well. It comes with punishment if they don't.

Shortly, we assume, it will be enhanced by genetic injections a la "Genetically modifying Humans Across the World". As Professor Robin Lovell-Badge, Group Leader at London's Francis Crick Institute, told the Sunday Telegraph:"We will look back and think that this is the real beginning of gene therapy." (DailyMail.com April 2018). What better subjects on which to practice than the PTSD journeyers? But then, how many human beings would really know or care? After all, the "My people shall perish due to their lack of knowledge" was coined for a reason.

29

Modifying Operant Behaviour: Reinforcement & Shaping

Reinforcement and punishment are the core tools through which operant behaviour is modified. These terms are defined by their effect on behaviour. Either may be positive or negative, as described below.

- Positive reinforcement and negative reinforcement increase the probability of a behaviour that they follow. Positive punishment and negative punishment reduce the probability of behaviour that they follow.

There is an additional procedure called “extinction”

- Extinction occurs when a previously reinforced behaviour is no longer reinforced with either positive or negative reinforcement. During extinction, the behaviour becomes less probable.

Again, as pointed out earlier, reward and punishment are administered in accordance with the administrator’s wishes. The whole neurofeedback process is said to primarily focus on optimizing the brain rather than suppressing the symptoms, as done with medication. So, what is meant by optimizing brain function?

Daniel Gregory Amen is a clinical neuroscientist, psychiatrist and brain-imaging expert (1954–). He is an American celebrity doctor who practices as a psychiatrist and brain disorder specialist as director of the Amen Clinics. He views it as such:

> “The brain is a three-pound supercomputer. It is the command and control center running your life. It is involved in absolutely everything you do. Your brain determines how you think, how you feel, how you act, and how well you get along with other people. Your brain even determines the kind of person you are. It determines how thoughtful you are; how polite or how rude you are. It determines how well you think on your feet, and it is involved with how well you do at work and with your family. Your brain also influences your emotional well being and how well you do with the opposite sex (cerebromente.org).”

In other words, no sui generis, no free will and no independence of thought. No thought of blood-flow to the brain or of Atlas mal-rotation. There is merely the body computer, the brain, running the human being in its entirety. Still, neurofeedback is to optimize the brain computer’s function.

The Amen Clinics are a group of mental and physical health clinics that work on the treatment of mood and behaviour disorders. They were established by Amen in 1989. Clinical evaluations and brain single photon emission computed tomography SPECT imaging for diagnostic purposes are performed. SPECT is a nuclear medicine tomographic imaging technique, using gamma rays to measure neural activity through blood flow. It has a database of more than 100,000 functional brain scans from patients in 111 countries. Amazingly, none apparently detect that blood-flow

from the spinal cord through the Atlas and brain stem is restricted anywhere, even though 96 percent of humans are said to have the restriction.

Amens's marketing of SPECT scans and much of what he says about the brain and health in his books, media appearances and marketing of his clinics is suspect. It has been criticized by scientists and doctors as lacking scientific validity. It has been criticized as unethical, especially since the way his clinics use SPECT exposes people to radiation with no clear benefit.

John Seibyl of the Society of Nuclear Medicine and Molecular Imaging is a critic. He stated that there is no debate that SPECT is not valuable for diagnosing psychological disorders.

A 2012 review by the American Psychiatric Association found that neuroimaging studies "have yet to impact significantly the diagnosis or treatment of individual patients." The review also states that neuroimaging studies "do not provide sufficient specificity and sensitivity to accurately classify individual cases with respect to the presence of a psychiatric illness."

The American Psychiatric Association has concluded that, "the available evidence does not support the use of brain imaging for clinical diagnosis or treatment of psychiatric disorders in children and adolescents."

According to cognitive neuroscience researcher Martha Farah and psychologist S. J. Gillihan, "The lack of empirical validation has led to widespread condemnation of diagnostic SPECT as premature and unproven."

Neither has neurofeedback or any other neuroscientists', psychiatrists', psychologists' or therapists' contraption been empirically validated, mind you. So what gives, one wonders? At least Amen gives advice on mental health, without outside interference from people who may only have nefarious intentions and profit in mind. These suggestions are:

1. PROTECT YOUR BRAIN

Protecting the brain from injury, pollution, sleep deprivation and stress is the first step to optimizing its function, Amen says. Several brain areas are especially vulnerable to trauma, especially the parts involved with memory, learning and mood stability. One head injury can ruin a life.

Current brain imaging research also shows that chemicals are toxic to brain function. Alcohol, drugs of abuse, nicotine, much caffeine and many medications decrease blood flow to the brain. So, of course, does the mal-rotated Atlas, which is not mentioned here either.

Sleep deprivation also decreases brain activity and limits access to learning, memory and concentration. A recent brain imaging study showed that people who consistently slept less than seven hours had overall less brain activity.

Scientists have only recently discovered what the majority of those living with PTSD have known for the longest time: it negatively affects brain function. Stress hormones have been shown in animals to be directly toxic to memory centres; that it also negatively affects eye sight and hearing has yet to be detected or at least admitted by the geniuses of nothingness.

Brain cells can die with prolonged stress. Managing stress effectively is essential to good brain function, announces Amen. Though it does not advise how to manage it, at least in this write-up.

2. FEED YOUR BRAIN

The fuel you feed your brain has a profound effect on how it functions. Lean protein, complex carbohydrates, and foods rich in omega 3 fatty acids (large cold water fish, such as tuna and salmon, walnuts, Brazil nuts, olive oil, and canola oil) are essential to brain function.

Unfortunately, the VA and the NCfor PTSD neglect to advise their PTSD clientele about such details, and mostly prohibits adherence to it if they did, due to financial restriction. That the great American diet of mainly GMO polluted food is detrimental to human health does somewhat impede matters further. It generates emotional, sluggish, spacey and distracted behaviours, Amen asserts.

3. KILL THE AUTOMATIC NEGATIVE THOUGHTS (ANTS) THAT INVADE YOUR BRAIN

The thoughts that go through our mind, moment by moment, have a significant impact on how our brain works. Research by Mark George, MD and colleagues at the National Institutes of Health demonstrated that happy, hopeful thoughts had an overall calming effect on the brain. The research also showed that negative thoughts inflamed brain areas often involved with depression and anxiety.

Amen teaches his patients how to metaphorically kill the ANTs, that invade their mind by changing their thoughts and thus optimizing their brains. One way to learn how to change your thoughts is to notice them when they are negative and talk back to them. If you can correct negative thoughts, you take away their power over you. When you think a negative thought without challenging it, your mind believes it and your brain reacts to it. The “observe your thinking like a hawk and change it to your liking” application can generate miracles, if practiced with discipline, willpower, determination and persistency.

4. WORK YOUR BRAIN

Our brain is like a muscle, says Amen. The more we use it, the more pliant, flexible, vibrant and extended it becomes. Anatomist Marian Diamond, Ph.D., University of California at Berkely, who studied aging in rats discovered something interesting. Those rats who were allowed an easy life without any new challenges or learning had less brain weight than rats who were challenged and forced to learn new information in order to be fed. Thus, learning actually causes increased brain density and weight. Einstein said that if a person studies a subject for 15 minutes a day, in 1 year he will be an expert, and in five years he may be a national expert.

Thank goodness for continuing my university attendance a couple of semesters after the PTSD-causing event to finish my B.A., followed by the research and consequent writing of *Broken Wings*. I believe that's what prevented my untimely death during the 10 years of pure hell following it.

5. MAKE LOVE FOR YOUR BRAIN

In a series of studies by Winnifred B. Cutler, Ph.D., and colleagues at the University of Pennsylvania and later at Stanford University, it was found that regular sexual contact had an important impact on physical and emotional well being of women.

A problem with PTSD journeyers' overall seems to be, however, that they have somehow ended up on a different vibrational level. Sex seems to be the last thing on their minds while trying to figure out who they are, why they are, where they are and how they are. Sex doesn't figure into their query of what the hell is going on in this insane asylum called Earth, where they consider everyone to be insane and vice versa.

6. DEVELOP A "CONCERT STATE" FOR YOUR BRAIN

Amen espouses the idea that optimal performance is best achieved when a "concert state" exists in the brain. By "concert state", he means "a relaxed body with a sharp, clear mind," much as one would experience at an exhilarating symphony, as if the vast majority of Americans listened to symphonies. Rap is more the style, and we know what that does to the brainwaves and the thinking. Or do we?

Never mind. Achieving this state requires two simultaneous skills, we hear: deep relaxation and focus. Deep relaxation, we are told, is easily achieved by most people through diaphragmatic belly breathing exercises, the most natural, efficient way to breathe. It's the pranayama breathing and twice-daily at least 20 minutes each of meditation that will also do the trick.

Music also helps develop concentration skills. A University of California at

Irvine study revealed that students who listened to Mozart's Sonata for 2 Pianos (k448) increased visual-spatial intelligence by about 10 percent. Another unnamed study demonstrated that students who play a musical instrument scored higher on average on the SAT than children who did not. Others again swear to harp-music.

Music can either help or hurt concentration. In a recent study from Amen's own clinic 12 teenagers played the game Memory while listening to different types of music: rock, rap, classical and no music. Rap was associated with the worst performance. The rock group also scored poorly. The group did slightly better with classical music, however, than no music at all.

Another technique for developing clear focus is the "One Page Miracle." On one piece of paper write down the following headings:

- money
- work/school
- relationships
- spiritual health
- physical health
- emotional health

Next to each heading, write down what you want in each area. When you finish writing all of your goals make multiple copies of it and prominently display it where you can see it several times each day. Frequently ask yourself, "Is my behaviour getting me what I want?" This exercise helps to keep you focused on the things that are most important in your life. Work to develop a "concert state" by relaxing your body and developing mental clarity.

Last but not least, treat brain problems early, suggests Amen. Oh, yeah? Why not teach them to get their Atlas adjusted, to eat healthy, to limit or eliminate television watching? Or to learn how to read, write and count? How to think logically and to reason, to play musical instruments and so on and so forth, replacing them with the common ground educational indoctrination camps termed governmental schooling?

Most psychiatrists feel that there is a significant brain component to depression, anxiety problems, attention deficit disorder, obsessive-compulsive disorder, substance abuse problems and even violence, says Amen. But most psychiatrists also know how to enhance their pocket book by prescription drugs enhancing rather than impeding whatever symptoms the patient may have. The rarity was my Irish

psychiatrist. When seeing what Ativan almost did to me, he stopped prescribing drugs to this patients and lectured them on nutrition instead. The results were baffling. Why are no studies conducted on it is beyond my comprehension, or are there?

Unfortunately, the stigma associated with seeing a psychiatrist still prevents people from seeking help for obvious problems, Amen states. Is it that, or is it because the populace at large, and PTSD experiencers in particular, are awakening to the enormous scam the mental health practice is, by and large?

But back to how neurofeedback training enables a few more people claiming to be expert in the field of enriching themselves by way of PTSD research at taxpayers' expense.

We hear that with neurofeedback training, the medication that targets brain function can possibly be reduced or may no longer be required. To get a full physiological view and insight into mind-body interaction, however, it is suggested to combine neurofeedback with other physiological signals. For instance, with heart rate variability (HRV) and skin conductance (SC/GSR). Combined with other behavioural therapies, we hear, neurofeedback is effective for treating several attention span related problems and sleep disorders. The International Society for Neurofeedback & Research (ISNR) provides further information.

Training itself typically involves sensors placed on the scalp picking up electrical brain activity and displaying it on a screen. The client sits in front of a screen trying to change the waveforms displayed with their thinking. The theory goes that one can learn to create specific brain states such as concentration or relaxation to eventually better control one's own brain.

The results? Canadian researchers wanted to see if neurofeedback would affect mind-wandering. After a 30-minute session of alpha-wave training, participants displayed better cognitive discipline compared to a control condition that was given false feedback (Ros et al, 2012). Lead author, Dr. Tomas Ros, explained:

> "We were excited to find that increased metabolic coupling within a key cognitive network was reflected in the individual level of brainwave change provoked by neurofeedback. The same measures were found to be tightly correlated with reductions in mind-wandering during an attention task."

In regards to human perception of the world and everything in it, participants in a University College London study were told to concentrate on the visual cortex while being shown their own brain's activity as measured by an fMRI machine

(Sharnowski et al., 2012). They imagined various images and watched the activity of their brains change as they did so. Their visual perception was then tested. It was found was that those who had been trained could distinguish more subtle shades of grey. In other words: after focusing on the brain activity in the visual areas of the brain, their vision improved. Scharnowski, Prof. Dr. Assistant Professor and Group Leader of *Department of Psychiatry, Psychotherapy and Psychosomatics Psychiatric Hospital, University of Zurich, Zurich, Switzerland* said: "We've shown that we can train people to manipulate their own brain activity and improve their visual sensitivity, without surgery and without drugs."

Yes, and without placing the Atlas in its proper position and assuring proper blood-flow to the brain. And without teaching people that they can accomplish the task without outside intervention by daily meditation and learning to control their own thinking, right? And you take pride in your achievement? QEEG for you, perhaps?

Apparently, neurofeedback also created better micro-surgeons with their pinpoint precision.

Ros et al. (2009), who gave some trainee ophthalmic micro-surgeons eight 20-minute neurofeedback sessions, then tested them against those not given the training found that after the training, surgeons were more accurate on a test and, on average, 26 percent quicker.

Neurofeedback may have advantages in treating those suffering from post-traumatic stress disorder (PTSD), as well, we are told. A recent study by Kleutsch et al. (2013) recruited people who had suffered childhood abuse and gave them a 30-minute neurofeedback session. Afterwards, brain scans revealed key positive changes in neural networks. In addition, participants felt calmer. The authors claimed this showed that neurofeedback was able to directly modulate the brain bases of emotional processing in PTSD. Neurofeedback has been tested by NASA for training pilots. It has been used as a method for treating epilepsy, bed-wetting, depression and ADHD. Dancing can be enhanced (Raymond et al. 2005) with this proposed miracle cure to all human ailments, merely by attaching electrodes to the scalp and concentrating. How delightful.

As the "Affordable EEG and QEEG Assessment and Neurofeedback Software*Accuracy, Simplicity, Flexibility We Strive to Improve the Quality of Education, Research and Clinical Applications of EEG," NeuroGuide tells us, their users are psychiatrists, neurologists, psychologists, neuro-psychologists, mental health providers, researchers and students. They generally share a strong interest in

the human mind and the human brain. NeuroGuide is a "tool set" that a clinician or researcher can apply to help link symptoms and behaviour to functional networks in the brain. One of the tools is EEG Neuro Imaging. It helps evaluate Brodmann Areas and nodes and connections of functional networks in the brain likely linked to symptoms, statically or in real-time. NeuroGuide, like a microscope/telescope enhances the clinical application of conventional and quantitative electroencephalography QEEG and is easy to use technology fully in step with the 21st Century.

Another company has this to say:

> "We use cutting-edge technologies including NeurOptimal® Neurofeedback, Heart-Rate Variability, and other evidence-based supports to help you to heal, optimize, reduce stress, think more clearly, get the edge in your performance, and overcome past challenges. We help with all sorts of concerns and our happy clients attest to the changes they've experienced.
>
> "Our Clinicians are trained and certified professionals who will guide and inform you and can support your journey. We work with people of all ages and stages. Email us for questions about how we can help you."

30

Cure-All Neurofeedback?

Do your own research. Read blogs on it, as I did, to inform yourself. I love SOTA's gadgets. But those I can apply myself without outsider intervention. I love the Royal Rife machine, which I use every day without outside intervention. But then, I love everything I can do without outsiders' intervention. That just is the way I am, my sui generis.

Big claims are made for the miraculous changes obtainable with the help of outsiders through neurofeedback training. But results are viewed as somewhat variable, with many a researcher critical about how studies have been designed and carried out. Jim Robbins' article is considered a classic on the neurofeedback topic. He interviewed all the original leaders and took a historical look at the how the field

has evolved in his 1996 article "Wired for Miracles" (*Psychology Today*, March/April 1996). While it is unlikely to be a magical cure-all that some claim it is, the latest batch of more tightly controlled studies is said to be promising, whatever that may mean.

Robert Thibault and Amir Raz of McGill University state, however, that "placebo factors permeate EEG-nf [EEG-based neurofeedback] and likely account for the majority of relevant experimental findings and clinical outcomes". In the abstract of their paper "The psychology of neurofeedback:Clinical intervention even if applied placebo" (*American Psychologist*, Vol 72(7), Oct 2017, 679–688 and "Neurofeedback or Neuroplacebo?" Robert T. Thibault, Michael Lifshitz, & Amir Raz) they assert:

> "Advocates of neurofeedback make bold claims concerning brain regulation, treatment of disorders, and mental health. Decades of research and thousands of peer-reviewed publications support neurofeedback using electroencephalography (EEG-nf); yet, few experiments isolate the act of receiving feedback from a specific brain signal as a necessary precursor to obtain the purported benefits. Moreover, while psychosocial parameters including participant motivation and expectation, rather than neurobiological substrates, seem to fuel clinical improvement across a wide range of disorders, for-profit clinics continue to sprout across North America and Europe. Here, we highlight the tenuous evidence supporting EEG-nf and sketch out the weaknesses of this approach. We challenge classic arguments often articulated by proponents of EEG-nf and underscore how psychologists and mental health professionals stand to benefit from studying the ubiquitous placebo influences that likely drive these treatment outcomes (psycnet.apa.org)."

Mind you, their paper was received with less than joy by those making their money in the field. In his article On "The Psychology of Neurofeedback, by Thibault and Raz" Siegfried Othmer, Ph.D., BCIAC, on November 9, 2017, yells on EEG Info, his own website. As the chief scientist at the EEG Institute in Woodland Hills, CA, former president of the Neurofeedback Division of the Association for Applied Psychophysiology and Biofeedback, and a member of the board of the Western Association of Biofeedback and Neuroscience (formerly the Biofeedback

Society of California), he should know. He exclaims:

> "The subtitle of Thibault and Raz's latest diatribe against EEG neurofeedback sounds vaguely promising: "Clinical Intervention even if Placebo." But the ambivalence implicit in the title runs through the entire article. The tone of the paper is argumentative throughout, shoring up an essential posture of skepticism with respect to EEG-NF while also allowing for the possibility that we may have been right all along: there is something to neurofeedback after all. We appear to be witnessing the last stages of resistance by these neurofeedback deniers. A subtle repositioning is going on.
>
> Whereas it is irritating to neurofeedback practitioners to have to come to terms with yet another assault on our understanding, our competence, and even our integrity after all these years, the paper documents the abiding reality that academia has not contributed to the development of EEG-nf for over thirty years. Rather, academics have by and large conducted a sniping and hazing operation against neurofeedback from their fortified redoubt. They have resisted–or haughtily dismissed–promising developments at every turn. Progress in neurofeedback has therefore defaulted almost entirely to the clinical realm. Even the few academic studies that have come to our attention recently are pathetically naïve in their design and ham-fisted in their execution. Some of them smell of a death wish for neurofeedback (news.eeginfo.com).

With aplomb he finishes:

> "He who studies medicine without books sails an uncharted sea, but he who studies medicine without patients does not go to sea at all." — William Osler

Yes, that may well be. But rats constitute the patients, and patients are used as rats. That is the alpha and omega not pointed out to patients, is it not? If that part were above board, it would be somewhat ethical, perhaps, somewhat more in line with what Thibeault and Raz try to accomplish, would it?

In their glossary, they explain:

> "***Neurofeedback:*** a procedure wherein individuals learn to

modulate real-time signals from their own brain activity; often leveraged to self-regulate neural processes for therapeutic ends. Schabus et al. investigated electroencephalography neurofeedback. This technique records electrical brain activity from sensors placed on the scalp and remains the most popular form of neurofeedback.

"Sham neurofeedback: feedback from an unrelated brain signal or from the brain of another participant; employed as a control condition to isolate the specific influence of genuine feedback.

"Superplacebo: A treatment that is actually a placebo although neither the prescribing practitioner nor the receiving patient is aware of the absence of evidence to recommend it therapeutically."

Let us refresh our knowledge about sham procedures and the ethics of clinical trials:

"Placebo-controlled trials of pharmacological treatments are typically conducted double-blind — that is, neither the patients nor the investigators know whether the substance administered is the agent under investigation or placebo. The process of masking treatment assignment is generally considered ethically acceptable provided that the 'shared ignorance' has been made clear in the consent process. However, in circumstances where a surgical or medical procedure itself constitutes the treatment, a randomized placebo-controlled trial raises different issues. Here only the patient-subject is kept in ignorance, and the clinician, who can distinguish active from inactive treatment, may be required to engage in active deception. Examples are surgical operations, acupuncture and specific methods of psychotherapy. Recent papers on the ethics of such trials have focused on the risk–benefit assessment of invasive sham interventions. Little attention has been given to the psychological and ethical concerns generated by the need for deliberate deception." (Franklin G. Miller, Ph.D., Ted J. Kaptchuk, OMD: "Sham procedures and the ethics of clinical

trials" *J R Soc Med*. 2004 Dec; 97(12): 576–578).

Ethical considerations? Do no harm? Sham procedures posing risks to patients without the potential for therapeutic benefit? Minimizing risks? Sham-controlled trials posing greater net risks to subjects in control groups than active groups? Controlled trials comparing invasive procedure with medical or behavioural intervention? That, at least, is what Franklin G. Miller, Ph.D., of the Department of Bioethics National Institutes of Health touches upon in his publication *Sham-controlled Trials: Ethical and Policy Considerations*. But what are the risks? Killing of the sui generis?

Jacek Rogala et al. of the Laboratory of Visual System, Nencki Institute of Experimental Biology, Polish Academy of Sciences in Warsaw, Poland, published an article in *Frontiers in Human Neuroscience* in June 2016 . The article was entitled "The Do's and Don'ts of Neurofeedback Training: A Review of the Controlled Studies Using Healthy Adults". They state that, unfortunately, a sham-control for the positive effects is ethically challenging. The use of placebo, which includes also sham groups instead of clinical treatments, may lead to a deterioration of symptoms. This is against the 1964 World Medical Association's Declaration of Helsinki — Ethical Principles for Medical Research Involving Human Subjects stating in paragraphs 9 and 10:

> "9. It is the duty of physicians who are involved in medical research to protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subjects. The responsibility for the protection of research subjects must always rest with the physician or other healthcare professionals and never with the research subjects, even though they have given consent.
>
> "10. Physicians must consider the ethical, legal and regulatory norms and standards for research involving human subjects in their own countries as well as applicable international norms and standards. No national or international ethical, legal or regulatory requirement should reduce or eliminate any of the protections for research subjects set forth in this Declaration."

Therefore, well-controlled EEG-NFB studies can be carried out only on treatment-resistant or healthy subjects, team Rogala purports. The recent review series by Gruzelier (2013a,b, 2014) stemmed from the increasingly abundant

number of studies devoted to EEG-NFB experiments performed on such healthy participants, we are told. The author presented overwhelmingly positive interpretation concerning the state-of-the-art of EEG-NFB research, we hear. However these reviews included multiple studies, which did not include proper controls for nonspecific training effects.

Consequently, Rogala et al. posit and conclude that neurofeedback methodology used in the majority of the reviewed experiments failed. It did not enable proper targeting of the brain regions responsible for control over the desired behavioural changes. This might explain the lack of correlation between the changes induced in the trained EEG signal and the modification of the targeted behaviour. It might also explain the lack of correlation between the remaining analyzed factors and training successes.

Needless to say, they failed to define what constitutes a "healthy human being." Healthy in what way? Who is to determine "healthy" in mental health to begin with? Who is to judge whom?

Do you still want to entrust your body and your mind to those enticing you to do so? That includes the NC *for* PTSD trained and brainwashed individuals to the psycho-the-rapists who make mince meat of you? Please yourself. At least now you know what you allow to possibly be done to you, regardless of the Helsinki Declaration. They urinate on the Hippocratic Oath; they urinate on the Helsinki Declaration, as well, I assure you.

To give the responsibility away is your decision, but if you do, you must just as lightheartedly accept the consequences. Before you do, however, have you considered that it might just be another lie sold to you, the PTSD journeyer. That it's a lie to hide the truth from you, that you have the power to heal your Self all by yourself? To hide from you that you have the power to do so without outside interference of dubious intention and quality? Without the possibly sinister and nefarious manipulation of your brain and consequently your body by others? Do you remember, that you are merely a replacement for Rattus and nothing else? But suit yourself. Your time of death is set. But, after all, it is heal your Self or die in accordance with your wishes in a pleasant or unpleasant way. You are the one creating paradise or hell for yourself while on this earth, you truly are.

Whichever way you choose, EEG neurofeedback and cognitive behavioural therapies go hand in hand. They are *the* primary methods in the PTSD stabilization process to ensure that veterans' anxiety is brought to a level where memory processing can begin. The Headstrong Project uses the purportedly evidence-based

practice of eye movement desensitization reprocessing (EMDR) for memory processing. That's the cornerstone therapy of the program. It allows veteran and clinician to work as a team through each traumatic event. It is not a regimented or an aggressive form of therapy, we read on its website. Rather, it is a method that works into the tailored model of the program. Results from EMDR work were used around the world for a variety of trauma victims from rape and abuse to natural disasters, we learn. Once veterans' traumatic memories have been processed, reintegration begins with clinicians as "life coaches". Veterans begin to again become part of a community, redeveloping work skills and their next passion in life, according to Headstrong.

The final piece of clinical practices' prose advocated by Headstrong Project's program takes the mind-body therapy approach. They say on their website: "We understand that there are certain activities that will put the mind at ease, keep the brain focused at a correct level, and physical activity is part of healing body and mind." What the brain's correct level of focus is may be debatable from the clinician versus the patient's point of view. But who cares when these wholesome activities include, but are not limited to yoga, canoeing and rock climbing. "We have seen tremendous strides in our veterans in the areas of stabilization and reintegration when they participate in such activities," Headstrong asserts.

Furthermore, Headstrong affiliates understand that veterans' PTSD can affect their family. So, they educate spouses cost-free on what their veteran is going through. They give them a community that is going through similar issues at home. That gives spouses access to advice on how to handle certain situations occurring with their beloved and originating from PTSD. There appears to have been tremendous increases in trust, communication and commitment to one another amongst the couples. The spouse group therapy is said to empower couples to become a team again. That is wonderful news. But might it be appropriate if Headstrong presented scientific, empirical and statistically documented evidence of treatment methods, results and financial arrangements to substantiate their assertions? I'm just asking, considering the $10,000.00 spent on each couple annually, plus, of course, yoga, canoeing and rock-climbing?

In July 2015, the Headstrong Project followed the advice, guidance and strategic direction of Morgan Stanley, one of the last two US major investment banks. The American multinational financial services corporation Goldman Sachs is the other. The advice was to expand clinical services to San Diego and Riverside Counties in Southern California. That is one of the largest veteran populations in the country.

Since then, the Project has been expanded to Houston, Texas. It plans to add outlets in Los Angeles, Chicago and Washington, DC. That's quick business since 2012, when Iscol founded it in partnership with Weill Cornell Medical College, one of the nation's leading mental healthcare centers.

It is with the help and direction of top clinicians in the country that Headstrong developed its comprehensive treatment program. The program deals with PTSD, Military Sexual Trauma, addiction, anxiety and depression, trauma, grief and loss, and anger management. It serves people throughout the U.S. by providing cost-free, bureaucracy-free, and stigma-free treatment for the hidden wounds of war without wait times and extensive forms. And so, it eliminates hurdles patients experience with existing VA programs, we learned. But still, and curiosity inspiring, between 2012 and 2018 only about 450 veterans have been treated. Those 450 people were served from facilities in the New York Metro area, Buffalo, Rochester, Ithaca, San Diego and Riverside County, L.A., Houston, Chicago, Washington DC, Denver, Boulder and Colorado Springs. There are plans to expand to additional cities by end of year and nationwide within the next three years.

Could the translational research we were mentioning earlier, and perhaps the EEG treatment modality, have something to do with it? What does that incur and why is their interest in it at the Headstrong Project? Why are there such masses of directors with such masses of money involved in its operations, but only such a very few number of veterans willing to enroll? Why, in particular when reading on Headstrong's Guidestar website:

> "Mental health is a highly stigmatized arena in this country (USA). This stigmatized feeling is exponentially higher in the veteran community because in a combat zone, service members must "tough it out" and this is what they were trained to do. Many veterans have learned that one doesn't discuss symptoms of PTSD, that physical injuries you can see are more "real". They fear being labeled crazy, or that having a diagnosis of PTSD will impact on employment opportunities. Warrior culture can prevent veterans from wanting to talk about their experiences; many fear overwhelming and upsetting themselves and others. Often veterans find it difficult to mourn fallen brothers and sisters, and they may expend much of their energy keeping thoughts and feeling at the perimeter of their consciousness. Many veterans self-

> medicate with alcohol and other drugs, resulting in such consequences as loss of employment, loss of relationships and sometimes loss of their life."

One should think PTSD-affected veterans and soldiers would flock to their offices and clinics en masse, should one not? In particular, people should jump for joy that Headstrong Project's leaders purport to have recognized that there are evidence-based effective mental health treatments and protocols, which can immediately impact returning combat veterans for the better. They should be drawn to the fact that Headstrong's first goal allegedly is to enhance the mental health of wounded service members. Sign-ups should be through the roof to get that help to foster healthy readjustment to civilian life, should it not?

They say they reduce PTSD and emotional symptoms and increase mental wellness. They nobly intend to help veterans regain that part of themselves feared left behind on the battlefield. It's an honorable goal, indeed. Veterans must be banging down the doors! But still, between 2012 and 2018 only about 450 veterans enrolled. That's such a paltry number, considering the enormous amounts of money raised and the board of directors' education, rank, file, qualifications, earnings and prestige. Why, or rather why not?

Perhaps their intuitive fear of something like the study released on January 4, 2017? It was entitled "Endogenously Released Neuropeptide Y Suppresses Hippocampal Short-Term Facilitation and Is Impaired by Stress-Induced Anxiety". It was conducted by Qin Li, Aundrea F. Bartley and Lynn E. Dobrunz and published in the *Journal of Neuroscience*. It announced that the neurobiologist Lynn Dobrunz, Ph.D., had discovered a novel mechanism for how stress-induced anxiety affects circuit function in the hippocampus. Stress-induced anxiety is the type of experience that is said to possibly produce post-traumatic stress disorder, or PTSD. The hippocampus is the area of the brain where aversive memories are formed. Could that have something to do with it?

The study shows, we are told, how stress blocks the release of an anti-anxiety neuropeptide in the brain. This could pave the way for new therapeutic targets for PTSD. Neuropeptides are small protein-like molecules (peptides) used by neurons to communicate with each other. They are neuronal signaling molecules that influence the activity of the brain and the body in specific ways. Yes, and then what? Inject PTSD affected veteran with neuropeptides. Then implant them with chips. Put them on enhancing medication for neuropeptide production, together, of course, with the mandatory pharmaceutical drugs. Could they be playing with

translational procedures using veterans instead of Rattus for the experiments, pray? Let's have a look, shall we?

Translational Research, Precision Medicine & PTSD

Cornell University's Weill Medical College runs a comprehensive, not-for-profit outpatient program for the evaluation and treatment of chemically dependent people. It also runs free confidential mental health service programs for Iraq and Afghanistan veterans, their spouses, and their significant others living in the New York and Tri-State area. They do this in conjunction with the Headstrong Project we are told on its website. It does all this at its New York, NY, Midtown Center for Treatment and Research.

This service is offered through Cornell's Department of Public Health. That's a

division of Community and Public Health Programs licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) as a medically supervised ambulatory substance abuse treatment program. The Center's clinical team members are said to reflect rich and diverse academic backgrounds from the fields of medicine, psychology, social work and counseling. They have a special interest and certification in alcoholism and substance abuse treatment. Center employees take part in and are exposed to cutting-edge research exploring the mechanisms and treatment of substance abuse and, we assume, PTSD.

Dr. Ann B. Beeder, Headstrong's medical director, is also associate professor of clinical public health and clinical psychiatry at Weill Medical College. Her interests lie in translational medicine in viral hepatitis, alcohol and substance abuse and psychiatric illness. She also serves as medical director of the Vincent P. Dole Institute for Opiate Dependency Disorders of the Department of Public Health at Weill Cornell Medical College and New York-Presbyterian Hospital, and as medical director of the Vincent P. Dole Institute Treatment and Research at its Midtown Center. As mentioned earlier, Beeder's research interests lie in translational medicine in viral hepatitis, alcohol and substance abuse, and psychiatric illnesses. But what precisely is translational research? How is it conducted, what is it used for and how is it applied? But most of all, for whom and for what is it beneficial?

> "Translational research includes two areas of translation. One is the process of applying discoveries generated during research in the laboratory and in preclinical studies to the development of trials and studies in humans. The second area of translation concerns research aimed at enhancing the adoption of best practices in the community. Cost-effectiveness of prevention and treatment strategies is also an important part of translational science."

According to this definition, team Rubio opines translational research forms part of a unidirectional continuum. Research findings move from researchers' bench to patients' bedside and then into the community. In other words, in this schemata of continuum the first stage of translational research (T1) leads to the transfers of knowledge from the conception of an idea to the basic research of that idea. This is presumably done with Rattus and other non-human animals. This leads to its clinical research. The second stage (T2) transfers the findings from clinical studies or clinical trials to practice settings on human beings within human communities. There, it is assumed that its applications, experimentations and subsequent findings

will improve human health.

Steven H. Woolf is a professor at the Department of Family Medicine and Population Health at Virginia Commonwealth University. He received his medical degree in 1984 from Emory University and underwent residency training in family medicine at Virginia Commonwealth University. He is a clinical epidemiologist, trained in preventive medicine and public health at Johns Hopkins University (M.A. 1987). He is board certified in family medicine, preventive medicine and public health. He has published more than 150 articles in a career that has focused on evidence-based medicine and the development of evidence-based clinical practice guidelines. His special emphasis has been on preventive medicine, cancer screening, quality improvement and social justice. He wrote "The meaning of translational research and why it matters" (JAMA Jan. 2008, Apr. 2016). In it, he points out, however, that "translational research means different things to different people." He argues that the different types of translational research are too narrowly defined. He in particular asserts that T2 research will result in the knowledge needed to improve public health and quality of life only if T1 research includes sciences related to populations. Those sciences include epidemiology, psychology, economics and behavioural sciences. Mind you, psychology is a science only in the minds of those practicing it on their human subjects but never on themselves, where it may be needed most.

Translational Research, The Journal of Laboratory and Clinical Medicine is the official journal of the Central Society for Clinical and Translational Research. Its editor-in-chief is Jeffrey Laurence, MD. The journal prides itself on delivering original investigations in the broad fields of laboratory, clinical and public health research. Published monthly since 1915, it keeps readers up-to-date on significant biomedical research from all subspecialties. It states under the description of requirements for publications:

> "Translational Research delivers original investigations in the broad fields of laboratory, clinical, and public health research. Interdisciplinary and cross-disciplinary in scope, it keeps readers up-to-date on significant biomedical research from all subspecialties of medicine. Aiming to expedite the translation of scientific discovery into new or improved standards of care, it promotes a wide-ranging exchange between basic, preclinical, clinical, epidemiologic, and health outcomes research. It encourages submission of studies describing

> preclinical research with potential for application to human disease, and studies describing research obtained from preliminary human experimentation with potential to refine the understanding of biological principles underpinning human disease. Also encouraged are studies describing public health research with potential for application to the clinic, disease prevention, or healthcare policy."

In other words, translational research involves investigations into the broad fields of laboratory, clinical and public health research. It is interdisciplinary and cross-disciplinary in scope. It incorporates significant biomedical research from all subspecialties of medicine. And it aims to expedite the translation of scientific discovery into new or improved standards of care with the potential for application to clinical disease prevention and healthcare policies. All of it sounds rather benign, at least to me.

But for some humans educated in the field, translational medicine is deeply involved with trans-humanism. This topic is explored by Erin Barton in her article "Beyond human: Researchers explore transhumanism". Barton, a Master of Science student in the field of natural resources and environment at the University of Michigan, asks:

> "What do pacemakers, prosthetic limbs, Iron Man and flu vaccines all have in common? They are examples of an old idea that's been gaining in significance in the last several decades: transhumanism. The word denotes a set of ideas relating to the increasing integration of humans with their technologies. At the heart of the transhuman conversation, however, lies the oldest question of all: what does it mean to be human?"

At the Arizona State University (ASU), where Barton previously studied, a diverse set of researchers has been critically examining trans-humanism since 2004. Professor Hava Tirosh-Samuelson of ASU's School of Historical, Philosophical and Religious Studies at the forefront of this work. He also fulfills his duties as the university's Center for Jewish Studies director. In his view, trans-humanists seek to transcend human biology through techno-genetic enhancements. Their ultimate goal seems to be *Singularity,* leading to a supposedly inexorable turning point. After that, humans as we understand them will become obsolete. This might be because super-intelligent machines have replaced us. Or it might be because techno-genetic

enhancements have rendered us unrecognizable as humans. That would be the death of the individual, the sui generis, a new phase or death of human evolution driven by exponential technological growth. "Homo sapiens will give rise to Robo sapiens" expresses Tirosh-Samuelson. Have you looked around you lately?

Professor Brad Allenby of ASU's School of Sustainable Engineering and the Built Environment, however isn't worried. He says the idea that trans-humanism will end humanity is just one of many trans-humanist narratives. He describes trans-humanism as either a superficial cultural meme or a suite of technological projects. Views supporting the cultural meme of trans-humanism see human enhancement as inherently good. But they disregard that enhancing a murderer, for example, might have grave negative consequences, he says. As well, he notes that one person's enhancement might impact other persons.

The National Institutes of Health seems of a similar opinion. In 2006, it had already awarded Case Law School in Cleveland, Ohio, a $773,000 grant to develop guidelines "for the use of human subjects in what could be the next frontier in medical technology – genetic enhancement."

Maxwell Lehman, is the Arthur E. Petersilge professor of law and director of the Law-Medicine Center at the Western Reserve University School of Law. He is a professor of bioethics in the Case School of Medicine. He is leading a team of law professors, physicians, and bioethicists in the two-year project to develop standards for these tests on human subjects. The research would involve the use of genetic technologies to enhance "normal" individuals, to make them smarter, stronger or better-looking. Thomas R. Horn also covers this in his book *Nephilim: Stargates: The Year 2012 and the return of the Watchers*.

And who better to use for those conversion-experimentations than the populations' brightest and fittest, the PTSD-experiencing soldiers and veterans, to mold them into genetically and technologically modified super-humans?

But never mind. The Law-Medicine Center is perennially ranked among the nation's top ten programs. It is the U. S.' oldest law school-based centre for the study of legal, not necessarily lawful, medicine and health law. The field of health law in itself effectively began with the centre's creation in 1953. If you are in the field, you might even have attended the October 30th, 2017, pre-Halloween lecture and discussion.

Dean Ali S. Khan, MD, MPH, spoke on the current state and future outlook of American healthcare. He is retired assistant surgeon general, United States Public Health Service (USPHS). He titled his speech "*Witchdoctors, Zombies and Wizards:*

Rethinking Health in America", perhaps reflecting precisely what is done in the country to those allowing it? Other law schools, including Stanford and Oxford have also hosted "Human Enhancement and Technology" conferences. Trans-humanists, futurists, bioethicists and legal scholars gather to discuss ethical and legal ramifications of post-humans as envisioned and aspired to by the rulers of Kurzweil et al.

The US Defense Advanced Research Projects Agency (DARPA) is an agency of the U.S. Department of Defense. It is responsible for developing new technologies for use by the military, the Pentagon and other deep state US military agencies. It has already spent trillions of American tax dollars to create the Frankensteinian dream of "super soldiers" and the "Extended Performance War Fighter" program. It has injected young soldiers, men as well as women, with hormonal, neurological and genetic concoctions. It has implanted microchips and electrodes into their bodies to control their internal organs and brain functions. It has plied them with drugs that deaden some of their normal human tendencies such as the need for sleep, the fear of death and the innate reluctance to kill their fellow human beings.

The manifestations of these treatments may be, however, that 30 percent of soldiers who returned home from US theatres of war in 2017 suffered with PTSD according to Dr. Steve Pieczenik, (1943–) a former United States Department of State official, psychiatrist and publisher.

Mind you, according to Tom Horn, the internationally renowned American journalist Chris Floyd, for counterpunch, was quoted the Daily Telegraph and the Christian Science Monitor when stating:

> " . . . some of the research now underway involves actually altering the genetic code of soldiers, modifying bits of DNA to fashion a new type of human specimen, one that functions like a machine, killing tirelessly for days and nights on end . . . mutations [that] will revolutionize the contemporary order of battle and guarantee operational dominance across the whole range of potential US military employments."

Regardless, 20 veterans still commit suicide daily according to Michael Rivero of *What really happened* (July 3, 2018) fame. So no one and nothing has helped those poor souls overcome their PTSD. Treatment modalities are unchanged in the past 30 years, despite billions of dollars spent on the topic by the VA and the NC for PTSD.

Still want to join the military for the fatherland's freedom, defense and glory, when you know it is all for the glory and enrichment of the world's elite and your

destruction in accordance with the Georgia Guide Stones premise?

Leon R. Kass, MD, is the Addie Clark Harding professor emeritus in the Committee on Social Thought at the University of Chicago. He also served on the President's Council on Bioethics from 2001 to 2005, among many other positions held in high places. His 2002 book *Life, Liberty, and the Defense of Dignity: The Challenge for Bioethics* provides a status report on where we stood at that time regarding trans-humanism. It warns in its introduction that human nature, the sui generis itself, lies on the operating table ready for alteration, for eugenic and psychic enhancement, for wholesale redesign.

In his book, Kass publishes a series of meditations on cloning, embryo research, the Human Genome Project, the sale of organs and the assault on mortality itself. He evaluates the ongoing effort to break down the natural boundaries given to us by our Creator. These efforts would remake the human body into an instrument of will, not necessarily our own. What does it mean to treat nascent human life as raw material to be exploited, Kass asks? What does it mean to blur the line between procreation and manufacture? What are the proper limits to this project for the redesign of human nature, if any? These are questions we should be asking ourselves to prevent runaway scientism. Its utopian longings and inactions could reshape us in their image, including into chimeras, the mixture of humans with beasts as in antiquity.

At the same time, Kass does believe that technology has done and will continue to do wonders for humanity's health and longevity. The key is to protect the ideals and practices that give us dignity and keep us human. *Life, Liberty and the Defense of Dignity* purports to challenge us to confront the post-human future that may await us. It urges us to think deeply about the momentous issues we face today, unless we stop it. Ignorance is bliss, however, and the vast majority of the cell-phone-loving, television-watching, must-call-all-those-I-know-for-feedback-before-I-can-make-a-decision, functionally illiterate and unable-to-count public is clueless about the play being played or the actors involved. No one seems even to have noticed the truth revealed by literally calling those who call the shots "actors" instead of politicians. That is a step further to the truth mentioned by Francis Bacon, aka Shakespeare, 500 years ago. It finally was revealed, sank in or was surfaced or disclosed to the masses, the laity, the peons. The present play thus seems to be to change those on earth created in the image of God, human beings. We would become the image of those reviling God by means dreamt up by their neuroscientist and geneticists, under the guise of prolonging life and health.

All About the Human Genome Project says this on the topic:

> "The Human Genome Project (HGP) was one of the great feats of exploration in history — an inward voyage of discovery rather than an outward exploration of the planet or the cosmos; an international research effort to sequence and map all of the genes — together known as the genome — of members of our species, *Homo sapiens.* Completed in April 2003, the HGP gave us the ability, for the first time, to read nature's complete genetic blueprint for building a human being. In this section, you will find access to a wealth of information on the history of the HGP, its progress, cast of characters and future (genome.gov)."

Casts of characters all right. One of the main-characters involved, Francis S. Collins, MD, Ph.D., a former director of the National Human Genome Research Institute. He is now director of the National Institutes of Health. In his testimony before the Subcommittee on Health of the Committee on Energy and Commerce of the United States House of Representatives on May 22, 2003, he ventured forth to exclaim about the project's aim:

> "Genomics to Biology: The human genome sequence provides foundational information that now will allow development of a comprehensive catalog [sic] of all of the genome's components, determination of the function of all human genes, and deciphering of how genes and proteins work together in pathways and networks.
>
> Genomics to Health: Completion of the human genome sequence offers a unique opportunity to understand the role of genetic factors in health and disease, and to apply that understanding rapidly to prevention, diagnosis, and treatment. This opportunity will be realized through such genomics-based approaches as identification of genes and pathways and determining how they interact with environmental factors in health and disease, more precise prediction of disease susceptibility and drug response, early detection of illness, and development of entirely new therapeutic approaches.
>
> Genomics to Society: Just as the HGP has spawned new

> areas of research in basic biology and in health, it has created new opportunities in exploring the ethical, legal, and social implications (ELSI) of such work. These include defining policy options regarding the use of genomic information in both medical and non-medical settings and analysis of the impact of genomics on such concepts as race, ethnicity, kinship, individual and group identity, health, disease, and "normality" for traits and behaviours." (genome.gov)

This foundational and far from proven information derived from the HGP mapping could determine the function of human genes. It could decipher how they work together with proteins, in pathways and networks. It could help us understand the role they play in health and disease to reach more precise p*redictions.* Needless to say, this would need other than Rattus as test-subjects. And what better ones to choose than destitute PTSD journeyers' lounging on the streets of New York, San Diego or anywhere in between, eh?

Such superb material for translational medicine and genetic enhancement experimentation they make. Generally speaking, trans-humanism refers to the transfer of genetic material intended to modify non-pathological human traits into a healthy specimen. That's what PTSD experiencers in essence are, until they get in contact with the NCforPTSD trained practitioners and their pharmaceutical drugs. Those turn them into pliable, no-longer-able-to-reason, easily manipulated subjects, in their desperation and ignorance seeking help in all the wrong places.

Commonly, the term "translational medicine" is used to describe efforts to make someone not just well, but better than well. Those efforts optimize his or her attributes and capabilities by, perhaps, raising their standard to peak levels of a [non-described] performance. When the goal is enhancement, a gene might supplement the functioning of normal genes. Or it might be superseded with genes that have been engineered to produce a desired enhancement. Furthermore, gene insertion might aim to affect a single person through somatic cell modification. Or it might target the gametes, in which case the resulting effect could be passed on to succeeding generations. So we read in *science and health policy consultant* Kathi E. Hanna's, M.S, Ph.D.,'s article "Genetic Enhancement" (National Human Genome Research Institute, 2006).

Gametes are reproductive cells (sex cells) that unite during sexual reproduction to form a new cell called a zygote. If one considers genetically engineered drug products used to alter physical traits as genetic enhancements, the concept of genetic

enhancement has been around for a while. Human growth hormone (HGH), for example, before 1985 only obtainable in limited quantities from cadaveric pituitary glands, is now produced using recombinant DNA technology. When its supply was more limited, HGH was prescribed for children with short stature caused by classical growth hormone deficiency. But with the advent of recombinant DNA manufacturing, some physicians recommend its use for non-hormone-deficient children below normal height, Hanna states.

Animal models and possibilities for human application? Hanna says that animal experiments to date have attempted to improve such traits as growth rate and muscle mass. This research is focused on developing approaches to treat human diseases and conditions. But it is certainly conceivable that developments from such research could be more broadly applied to enhance traits rather than correct deficiencies, she says.

Recently, *Schwarzenegger mice, which are thus far only laboratory animals,* have been bred. Their bodies have expanded rapidly after the injection of a gene that causes muscles to grow. These mice are the first stage in the development of treatments intended to coax the bodies of seriously ill patients with degenerating diseases to recreate damaged tissue in those suffering muscular dystrophy. In the world of sports, this technology can potentially be used to improve athletic performance without being detected.

Other gene interventions could help delay the aging process. For example, a gene called Mechano-Growth Factor (MGF) regulates a naturally occurring hormone produced after exercise that stimulates muscle production. Levels of MGF fall as we age, which is one of the reasons why muscle mass is lost as humans grow older. A treatment to build up muscle mass would allow people to remain able-bodied and independent much longer. IGF-1, another muscle-building hormone, also produced increased muscle mass in laboratory mice. Therefore, theoretically, gene insertion of IGF-1 could produce an equally impressive effect in human beings, so beneficial for a super-soldier, right?

Efforts to genetically improve the growth of swine have involved the insertion of transgenes encoding growth hormone. Nevertheless, despite the fact that growth hormone transgenes are expressed well in swine, Hanna relates, increased growth does not occur. Scientific efforts are also made to enhance muscle mass in cattle. When the gene transfer was accomplished, the transgenic calf initially exhibited muscle hypertrophy. However, it then developed muscle degeneration and wasting soon afterwards and had to be destroyed. Whose dinner table it graced was

undisclosed.

Gene transfer at the embryonic stage through a technique called pronuclear microinjection is another approach being tested, purportedly thus far only in animals. Current knowledge from animal experiments suggests, however, that embryo gene transfer is unsafe at present. Its use is said to result in:

- random integration of donor DNA
- significant rearrangements of host genetic material
- lack of control of the number of gene copies inserted
- a five to 10 percent frequency of insertional mutagenesis, the mutagenesis of DNA, by the insertion of one or more bases

This process is associated with a low birth rate and a very high rate of late pregnancy loss or newborn death in at least two animal models. Thus, according to Hanna, many believe that the use of gene transfer at the embryonic stage for enhancement would reach far beyond the limits of acceptable medical intervention.

In humans, the limitations for gene-manipulation are more pronounced. There are more complex traits, such as intelligence and behaviour, and the genome provides only a blueprint for the brain's formation. Despite the technical limitations, it is possible that enhancements using techniques initially intended to restore deficiencies could eventually be redirected to or:

- increase longevity
- reduce the need for sleep
- increase musical capacity
- attain desirable personality traits
- improve memory and problem-solving
- protect against cardiovascular disease or cancer

Or "enhancements" could reverse such factors into the opposite. *One flew over the Cuckoo's Nest* and *Dr. Moreau's Island* spring to mind. Regardless, a large quantity of PTSD-afflicted and unsuspecting soldiers and veterans would be ideal specimens for the undertakings. The military in particular has evolved closely with this technology, claims the earlier mentioned Professor Brad Allenby of ASU's School of Sustainable Engineering and the Built Environment. This could raise the question: "Have some soldiers out there in the field of battle, the theatre of wars, already been

doctored with trans-humanistic, translational technology?"

Obviously, genetic enhancement raises a host of ethical, legal and social questions as simple as, for example:

- What is meant by normal?
- When is a genetic intervention "enhancing" or "therapeutic?"
- How should the benefit from a genetic enhancement be calculated in comparing its risks and benefits?
- Would people who have been genetically enhanced enjoy an unfair advantage in competing for scarce resources?
- Will genetic enhancement be available to all who desire it, funded by society, as trans-gender operations are for US military personnel at present, or only to the barely one percent sitting on the world's natural resources and wealth who can afford to purchase it using their personal fortunes?

So, what about the two very major concerns presented by genetic enhancement: the principle of social equality and the problem of creating an unfair advantage that would be enjoyed by enhanced individuals? Mind you, there is not and has never been equality. Nor is there or has there ever been fairness or justice. Just watch it surfacing blatantly through the purported "draining of the swamp". It has asked to be drained throughout the world for thousands of years. Is it an impossibility, an illusion invented by the Matrix? We shall explore it later.

Some researchers, scientists and philosophers are said to have speculated that genetic enhancement may affect human evolution. That is, if the Darwinian concept of evolution even existed to begin with in this holographicly induced reality. Philosophical and religious objections against translational medicine have also been raised. Many believe that to intervene in these fundamental biological processes is "playing God" or attempting to place humans above God.

Peoples from various perspectives and perceptions of life seem to maintain that any interference with the purportedly random offerings of nature are inherently wrong. Thus, they question humans' right to toy with the product of years of natural selection, albeit it is doubtful the latter ever existed, either. In general, however, ethical and social concerns centre not on the improvement of traits for alleviation of deficiencies or on the reduction of disease risk. Rather, they concern the augmentation of functions that would be considered entirely normal without

intervention.

Albeit distinctions between cure and enhancement may be obvious to some, they can lose meaning in medical practice or in formulating health policy, Hanna says. For example, interventions that begin in an effort to cure could slide quickly toward interventions thought to enhance But who is doing the thinking, and who is dictating what is and is not permissible? Who dictates when I can print my own gun, or if I can't at all. If there is a will, there is a way, and no law can prevent it. Furthermore, laws that cannot be implemented throughout society should not be passed at all, at least in my opinion. But, first and foremost in our case, who is applying control, when gene-altering kits are available to the public and used in peoples' garages for experimentation, pray. Sodom and Gomorra repeated and well, as Steve Quayle yells? Should they prohibited speedily, perhaps, to protect the human race in its original pre-humanistic state?

The questions then arise: What and where is the line between curing and enhancing? Who says? How much influence and capabilities do governmental regulatory agency have over the topic? Are patients, in particular PTSD experiencing soldiers and veterans, ideal for such experiments to replace Rattus told beforehand that genetic enhancement is used to "cure" them of their humane sensibilities?

In September 1997, the National Institutes of Health (NIH) convened a conference on genetic enhancement. It was prompted by a request to approve a protocol for conducting gene therapy experiments on healthy volunteers rather than on patients, in an effort to develop treatments for cystic fibrosis. This was the first proposal to use healthy subjects who had everything to lose instead of sick ones with nothing to risk. It raised the questions of whether and in what circumstances it was appropriate to use gene insertion technology in healthy volunteers.

Exactly how to regulate this potential use of genetic technology remains just as unclear as the printing of guns. The NIH is an agency of the United States Department of Health and Human Services. Primarily located in Bethesda, Maryland, it is the US government's main agency responsible for biomedical and health-related research. It conducts its own scientific research through its Intramural Research Program (IRP). It also funds major biomedical research in non-NIH research facilities through its Extramural Research Program.

The IRP has 1,200 principal investigators and more than 4,000 postdoctoral fellows in basic, translational and clinical research. It is the largest biomedical research institution in the world. Its extramural arm provides 28 percent of

biomedical research funding spent annually in the U.S. alone. That's about US$26.4 billion as of 2003, the latest figure I could find. It is hard to comprehend the size and scope of this massive translational, e.g. trans-humanist, operation and agenda. The NIH comprises 27 separate institutes and centres, conducting research in different disciplines of biomedical science.

The IRP is responsible for many scientific accomplishments, including the discovery of fluoride to prevent tooth decay. Yes, really, they do brag about it, obviously unaware it calcifies the pineal gland, dulls the brain and destroys the teeth into a decreasing level of functioning by the day if swallowing your toothpaste instead of spitting it out when finished brushing. Using baking soda instead of toothpaste would, of course, be even better. They also invented the use of lithium with its side-effects to manage bipolar disorder as a wonderful remedy. They also came up with the vaccines against hepatitis, Haemophilus influenza, *H. influenza,* which is responsible for a wide range of localized and invasive infections. And they created the vaccine against the human papillomavirus, the most common sexually transmitted infection globally.

The National Center for Advancing Translational Sciences (NCATS) was conveniently established close to the NIH in 2012 as one of its 27 creations. Its mission? To transform the translation of scientific discoveries so that new treatments and cures for diseases can be delivered to patients faster. In other words, to further the advancement and implementation of the trans-humanist agenda as rapidly as possible it seems. Tom Horn and Steve Quayle's February 11, 2018 you tube broadcast "Extinction Level – As in the Days of Noah" gives more insight into the topics.

Researchers outside of the NIH, those working at universities or other institutions, can apply for research project grants (RPGs). There are numerous funding mechanisms for different project types (e.g. basic research, clinical research, etc.) and career stages (e.g. early career, postdoc fellowships, etc.). The NIH regularly issues requests for applications (RFAs) for timely medical problems such as Zika virus research in early 2016.

In addition, researchers can apply for investigator-initiated grants. The subjects are completely determined by the scientist's individual desires. They follow the same process as the one used at the Brain & Behaviour Research Foundation's NARSAD. NIH's total number of unique applicants has increased from about 60,000 investigators applying between 1999 to 2003 to slightly less than 90,000 between 2011 and 2015. The "cumulative investigator rate," however, the likelihood that

unique investigators are funded over a five year window, has declined from 43 percent to 31 percent.

But then, everything changed for the much better for the trans-humanist-agenda advocates on January 20, 2015. That's when all ethical and humane consideration went out the window with President Obama's Precision Medicine Initiative (PMI) announcement in his State of the Union address. In consequence, and as part of PMI, the NIH is leading the effort to build a national, large-scale research enterprise. It will have one million or more volunteers to extend precision medicine to all diseases. That's the *All of UsSM* Research Program, we read about in the NI's *About the Precision Medicine Initiative: All of Us: the future of health begins with you.*

The *All of Us* Research Program is a historic effort to gather data over many years from one million or more people living in the United States. The ultimate goal is to accelerate research and improve health. Most research studies focus on a specific disease or population. *All of Us* will serve as a national research resource to inform thousands of studies, covering a wide variety of health conditions. Researchers will use data from the program to learn more about how individual differences in lifestyle, environment and biological makeup can influence health and disease. Participants might be able to learn more about their own health and contribute to an effort that might advance the health of generations to come.

It purportedly is a participant-engaged, data-driven enterprise. It supports research at the intersection of lifestyle, environment and genetics to produce new knowledge. Its goal is to develop more effective ways to prolong health and treat disease. To reflect the US population's diversity, the program will enrol participants from diverse backgrounds. That includes social, racial/ethnic, ancestral, geographic and economic backgrounds, as well as different age groups and health statuses.

Information from the program will be a broad, powerful resource for researchers working on a variety of important health questions. More importantly, the program will also focus on ways to increase an individual's chances of remaining healthy throughout life. It has begun building infrastructure and capacity through a series of funding awards and began recruiting participants in 2017. On August 2, 2018, Benjamin Ross of Clinical Informatic News (clinicalinformaticsnews.com) shared on the project, that it was in May 2018 that the National Institutes of Health (NIH) launched national open enrollment for their *All of Us* Research Program. This precision medicine initiative's ultimate goal is building a national research cohort of one million or more participants in the US.

"Our mission is not just to find one million or more people to

> volunteer to share medical information with the program," Dara Richardson-Heron, chief engagement officer of the *All of Us* Research Program, said during the launch event in New York. "Our mission is to find one million or more people who reflect the rich diversity of our nation, who will not only participate in the program, but partner with us and help us create an opportunity to change health and healthcare for the benefit of everyone."

We can be certain that PTSD-affected Iraq and Afghanistan soldiers and veterans will be welcomed with open arms. And there are masses of them available for experiment-repetitions, in case some researchers goof and subjects have to be "destroyed."

Funding is certainly going splendidly as proven by the following Columbia University Newsroom release "Four NYC Medical Centers Receive New NIH Precision Medicine Grant".

> "$4 million grant gives Columbia, Weill Cornell Medicine, New York-Presbyterian, and NYC Health + Hospitals key role in precision medicine cohort program. Columbia University Medical Center (CUMC) and Weill Cornell Medicine, in collaboration with New York-Presbyterian and NYC Health + Hospitals/Harlem, have been awarded a grant from the NIH for approximately $4 million in fiscal year 2016 to enrol participants in the Cohort Program of President Barack Obama's Precision Medicine Initiative (PMI), a large-scale research effort to improve our ability to prevent and treat disease based on individual differences in lifestyle, environment and genetics, we learn from the NIH publication *About the Precision Medicine Initiative: All of Us: the future of health begins with you*. The five-year award is estimated to total $46.5 million, pending progress reviews and availability of funds."

Columbia University Medical Center (CUMC) is one of four centres that have been designated as a regional PMI Cohort Program Healthcare Provider Organization (HPO). As such, CUMC and its partners seek to enrol at least 150,000 volunteers by 2021. CUMC plans to engage with a number of community organizations in New York City. In so doing, this multicentre collaboration will help

ensure that participants in the PMI Cohort Program represent the geographic, ethnic, racial and socioeconomic diversity of the country that the NIH is hoping to achieve. We can assume Cornell University has similar aspirations, Hunter R. Rawlings III, its interim president stating:

> "Cornell University has a distinguished legacy of leading scientific discoveries that address our greatest healthcare challenges. The launch of this collaboration marks a turning point in our effort to conquer disease and to translate research discoveries into life-changing impact for communities in New York and around the world."

Overall, this research aims to improve the ability to advance precision medicine, we read in CU's press release. But why the denomination "precision medicine" (PM) and what precisely is *that*?

According to Google, it is medical care designed to optimize efficiency or therapeutic benefit for particular groups of patients. It especially uses genetic or molecular profiling. It is a medical model that proposes the customization of healthcare. So, medical decisions, practices and/or products are tailored to the individual patient, often based on diagnostic testing. The tests help select appropriate and optimal therapies chosen by a computer, based on the context of a patient's genetic content and other molecular or cellular analysis. Tools employed can include molecular diagnostics, imaging and analytics/software. Yes, precisely as Headstrong's PTSD-curing therapy modality proposes.

The question is: "When is it applied without diagnostic testing, and is it done with or without clients' knowledge?"

The National Research Council also claims PM refers to the tailoring of medical treatment to each patient's individual characteristics. Should we presume that to be the individual's sui generis, perhaps? We don't know. What we do know, however, is that it does not literally mean the creation of drugs or medical devices unique to a patient. It does mean the ability to classify individuals into subpopulations that differ in their susceptibility to a particular disease. Or that differ in the biology and/or prognosis of those diseases they may develop. Or that differ in their response to a specific treatment. Rattus among Rattuses.

Preventive or therapeutic interventions can then be concentrated on those who will benefit, while sparing expense and side effects for those who will not. Although the term 'Personalized Medicine' is meant to convey this meaning, the term is sometimes misinterpreted as implying that it is the application of unique treatments

designed for each individual. That's the clincher. It sounds as if it were tailor-made to an individual. Headstrong even advertises that it is just that, whereas in fact it is a generic application for human population "subgroups." To me, it sounds like another perversion of the truth to shuffle down humanity's throat under the guise of benevolent action.

On the other hand the term "precision medicine" can well extend beyond treatment selection. It could also cover the creation of unique medical products for particular individuals. For example, it could include patient-specific tissue or organs to tailor treatments for different people. Hence PM in practice has so much overlap with "personalized medicine" that they are often used interchangeably.

Often, though not necessarily, PM involves the application of panomic analysis. This is defined by the American Society of Clinical Oncology (ASCO) as referring to the interaction of all biological functions within a cell and with other body functions. It combines data collected by targeted tests and global assays, such as genome sequencing, with other patient-specific information.

Systems biology is a computational and mathematical modeling of complex biological systems. It might also be used to analyze the cause of an individual patient's disease at the molecular level. It can then be used to create targeted treatments, possibly in the right combination to address that individual patient's disease process.

The theoretical basis of precision medicine is the "unique disease principle." This emerged to embrace the ubiquitous phenomenon of heterogeneity of disease etiology and pathogenesis. Precision medicine became intertwined with molecular pathological epidemiology (MPE), a discipline combining epidemiology, the patterns, causes and effects of health and disease conditions in defined populations and pathology. In this case, it is most likely the "general pathology," which includes a number of distinct but inter-related medical specialties that diagnose disease. Most of them do so through analysis of tissue, cell and body fluid samples.

MPE research is capable of identifying potential biomarkers for precision medicine. This in turn will tailor PTSD sufferers' experimental medical precision treatment and modalities. This will happen with whatever practicing practitioners of any of those above fields or all of them working together on some particular human specimen deem appropriate and in line with the "unique disease principle." Their own career-furthering and Nobel-prize-aspiring pharmaceutical drugs of choice, a bit of ecstasy thrown in, the marijuana at hand for emergencies, ganglion therapy and God only knows what else when they are at it should give joy to their

heart. And their pocket books with IRP funding swell, allowing them to play harder in Hell's kitchen a la Faust.

That there is nothing wrong with PTSD-affected people is never considered. That there are just changes in their vibrational energy and consequent elevation to higher vibrational levels is ignored. That this comes with a change in world view, which resulted in an existential crisis doesn't enter the equation. It's anathema, because none of it can be scientifically and empirically proven or documented. Their pre-PTSD brains and way of thinking are no longer available for studies.

But who cares, when the aspirations are to map it all? So we, the transhumanistic scientists, can create creatures in accordance with our own scientific atheistic will and our own aesthetic views rendering God, check mate. Let's create the Robo-Sapien as pointed out by Professor Allenburg, and MP and MPE seem to be the finest pathways to achieve the goal in this battle for human souls.

The blessing? That few of the massive US PTSD suffering soldier and veteran population signed up for the program. The rest are obviously smarter than to allow physical and mental health practitioners and scientist to fiddle around with their brains, their genes their psyches, their sui generis. Should they hand in an application, however, they are screened and assessed before veteran and clinicians begin. They will work together to craft a course of treatment tailored to the individual veteran's needs. Then they'll start the fulfillment of what Headstrong promises to be:

> " . . . tailored and consistent mental health treatment with the result to enjoy improvement in emotional wellbeing, to sleep better, to have better home and work relationships, and to experience a reduction of harmful behaviours including excessive substance use."

And what is going to be done to them to achieve those promises, remembering that soldiers are trained to obey orders unquestioningly?

Dr. Beeder and her colleagues have developed a Psychiatric Assessment and Individual Psychotherapy scheme for veterans. They will be conducting the enrolment interview. This can result in and include phases of behavioural cognitive treatment modality applications in accordance with the Pavlonian dogs, rattus and Skinnerian human research. For instance:

- stabilization
- family treatment

- substance use treatment
- traumatic memory processing
- re-integration, including work readiness and socialization

Also on the agenda might be modalities and treatments that work best for the individual to take place. Best for and by whom is unspecified, but gene therapy enters my feeble mind.

The enrolled veterans will be thrilled by this approach. They most likely have already been through *that* mill a hundred times with VA's employees and a multitude of its mental health practitioners. They've probably also been through it with other self-professed and inane PTSD mental health psycho-the-rapists PTSD experts.

There apparently are over one thousand different PTSD psychotherapy treatment hallucination-illusion-ideas to choose from. Some are minor variations, while others are based on very different concepts of psychology, ethics and/or techniques of the individual psychotherapist. They run the gamut from the Kumbaja humming ad nauseam to imagining yourself in heaven or hell because of your previous life – probably.

Choosing the right treatment for any PTSD-affected person might be rather tedious. Most of these treatments involve one-to-one sessions between client and therapist. But some are conducted with groups, including one's own family members, we read on Headstrong. Psychotherapists conducting these sessions could be psychiatrists or psychologists or come from a variety of other backgrounds. Depending on the jurisdiction, they might or might not be legally regulated, voluntarily regulated or unregulated. So anyone is actually at liberty to call himself a psycho-the-rapist. They can go ahead and treat whoever appears at their doorstep for whatever reason. Most, PTSD sufferers included, will be none the wiser to the rip-off they experience.

I think of the greatest losers, con-artists, drug addicts and drunks I ever met in my life, some of whom I met in the spiritualist church. They graduated from psycho-the-rapist schools to make an easy buck off the desperate. As Steven King says in one of his books: "The trust of the innocent is the liar's most useful tool." So is the trust of the desperate. That the psyche can truly be raped with psychotherapy has been proven a thousand times by such projects as MK Ultra. It has also been and portrayed in the Manchurian Candidate. But it is also used in seemingly much more benign institutions, as I briefly experienced during my ten years of unadulterated hell.

32

Three Days In The Nuthouse

I was still taking Ativan, liberally prescribed by both my GP and psychiatrist after the recurrent PTSD diagnosis. Then someone at the WCB, doubtlessly inspired by NorAm, thought they had a brilliant idea. They demanded I participate for at least six weeks in a program at a government-run mental health daycare facility for the mentally impaired: Developmental Disabilities Mental Health Services Institute (DDMHS).

Its mandate? First, to provide specialized mental health services for people living with co-existing developmental disabilities, a mental illness and/or other challenging behaviors. Second, to render individualized assessment, treatment and education to adolescents and adults with such developmental disabilities and other

complex mental health needs.

Inmates also receive psychiatric and behavioral assessments, diagnoses and psychiatric treatment, combined with clinical counselling and speech and language assessment. Music and art therapy was part of the treatment, and other therapies dealing with behavioral disorders were also imposed. One-to-one support at home or in hospital for people in crisis was also provided. So was individual case management, as well as educational-, training and consultative services. The institution, we read, works in collaboration with unnamed existing community resources and support networks.

Who was eligible?

- Anyone aged 12 years or older.
- Anyone who had a mental illness and/or challenging behaviors.
- Anyone whose psychological assessment indicated an IQ of 70 or below.
- Anyone who had developed an intellectual disability before the age of 18.
- Anyone with Concurrent (Dual Mental Health and Substance Use) Disorders.
- Anyone who met the governmental Children and Family Development Administration criteria.

The disorders justifying enrolment included, but were not limited to:

- Grief, the feeling that comes with the loss of a loved one.
- Insomnia, an inability to sleep, regardless if the is the problem is falling or staying asleep, or both.
- Anxiety Disorders manifested by constant feelings of anxiety and fear that interferes with daily life
- Eating Disorders manifested by irregular eating habits and concern about body-weight, shape or form.
- Dementia and Alzheimer indicated by decline of mental processes, memory, judgment and functioning.
- Concurrent Mental Health and Substance Use Disorders, if people experienced both substance use and mental health issues.
- Depression, as it could sap one's energy, motivation and ability to

experience joy, satisfaction, connection and meaning in life.
- Pregnancy-related Depression and Anxiety, which can begin during pregnancy, right after birth or any time within the first year of birth.
- Bipolar Disorder indicated by periods of depression and mania, great excitement, fantasies and over-activity as well as periods of stable mood.

Getting the munchies too often? Don't despair. Help can be had, as Obsessive Compulsive and Hoarding Disorder, a form of anxiety involving the combination of obsessions and compulsions that interfere with daily life, also qualifies for treatment at the Development Disabilities Mental Health and Substance Use nuthouse.

Suffering from psychosis, an inability to determine what is real and what is not? This often occurs with all kinds of pharmaceutical and naturally growing drug use, and it is a prime cause for admittance to the nuthouse. So are general personality disorders and other continuous and longstanding impairments of the mind reflected in a wide range of situations and relationships. So is schizophrenia, portrayed as a form of psychosis affecting perceptions and thinking, emotions and behavior.

If one is in a state of overwhelming desire to injure or harm the self, one too is gladly admitted to the minimum six weeks behavioral adjustment-training nuthouse described in *Broken Wings*. Stress-affected people will also be joyfully admitted, as stress is deemed to possibly be eliminated by daily proper self-care, healthy meals, exercise and sleep. Those with suicide ideation or suicidal thoughts were then, and remain, prime candidates for admittance, an ideal environment, indeed, for a PTSD-affected flight attendant.

Enrolment procedures went by an open referral-service, and applications were accepted from organizations such as Community Living. This was a non-profit society providing individualized, flexible and creative support for people with mental disabilities. Applications were also accepted from general practitioners, hospitals, mental health centers, families, caregivers, schools and the WCB.

Mind you, all referrals required prospective clients' general practitioners' approval. But that, too, could be circumnavigated with as small an effort as mine was. The demand, the order of enrollment, was sprung on me one Friday afternoon. I was told to start treatment the following Monday at 9.00 a.m. precisely. The demand was made at a time when my primary caregiver, the Irish psychiatrist, was in Ireland. My general practitioner was on vacation. I, consequently, was left with little choice but to obey WCB's command or face financial cut-off. How was it that

NorAm and the WCB were so exquisitely well-informed about my GP's and psychiatrist's vacation schedule? That question did not dawn upon me until years later. The husband of Annemarie informed me of her role in the entire *Broken Wings* staging, as if it mattered at this point, when I know so well that what goes around comes around.

Who is Annemarie? Don't worry . . . you'll meet her later.

The mental health institute idea conceived by the airline, the WCB and the union obviously reflected what they thought about my predicament, even though that insight escaped me at that time. How could it have dawned upon me? After all, after almost 20 years, I was still employed as a flight attendant by one of the world's 10 largest airlines. I had maintained an immaculate work-record. I had over 40 passenger recommendations, including one from the airline's president himself. I was conversant in five route languages. And I still wanted nothing more than to return to the work I adored more than life itself, despite so many near-misses under my belt when PTSD hit, that no one wanted to fly with me anymore, if they could possibly avoid it. Although that was rather hard to do under an anonymous bidding system of flight schedules. My own blindness, however, arose from my own ignorance and stupidity. At that point, I still believed in the goodwill of men.

So, ignorant to the point of ridiculous, when that Monday morning arrived, I trooped up at the nuthouse at 9.00 a.m. after a harrowing journey through rush-hour traffic seldom experienced in my flying career.

I had done no research on the Institution. Nevertheless, within the first hour, I suspected I had landed in the land of *One flew over the Cuckoo Nest*. By dismissal at 5.00 p.m., I knew I had. Somehow, I survived next day. By Wednesday, after the resident psychiatrist demanded my blood — I refused — my anxiety and stress level rose and I became rather distraught. Arriving home, I called a friend. Her response:

> "Get the hell out of there now before they destroy you. Get out NOW. Get a hold on Courtney to get his consent, get your stuff tomorrow, and leave. Don't say a word. Just leave. Never go back, regardless of the pressure they'll put on you."

I swung into action. I tracked down my Irish psychiatrist and got his consent to skip the program. Then I awaited the WCB's fall-out, full well knowing that I had narrowly escaped being further psychologically damaged by the facility's psycho-the-rapists practitioners. But nothing happened. They accepted my withdrawal as if it was the most natural thing in the world to do, at least in my deranged condition.

It would take years for me to find out why the one urging me to skip the program

knew about the danger I was in. She knew what can be done to a person's mind in those places. Years' earlier, on duty and homebound on an overseas long-haul, someone had spiked her coffee with an unknown substance. That made her rotate out of proportion and control of herself. Upon landing on Canadian soil, an ambulance picked her up at the aircraft and she was admitted into a psychiatric hospital. Her family approved.

With the help of a fellow inmate, she escaped three months later while on an institutional day-pass. She knew what those considering themselves qualified to judge the mental health of other human beings were capable of inflicting on healthy ones, if given the power. They also have the power to commit an inmate to a more "secure" institution, including a permanent asylum for the insane. How and why?

Empirical evidence gathered by academically well-papered mental health practitioners shows how, after they voluntarily enrolled themselves into mental institutions for research purposes they found it almost impossible to get themselves released. Once admitted to a psychiatric institution, an asylum, a nuthouse of whatever distinction, it's almost impossible to get out again. The Rosenhan experiment *On being sane in insane places"* (Science 1973) attests to it.

It was a lecture given by R.D. Laing, one of the world's most renowned psychiatrists. He was at the time associated with the anti-psychiatry movement, which inspired Stanford University Professor of Law and Psychology David Rosenhan (1930–2012) to conduct the study. After the lecture, Rosenhan began to wonder if there was a way to experimentally and empirically test the reliability of psychiatric diagnoses to determine their validity.

Rosenhan's study was done in two parts. The first part involved the use of healthy associates or "pseudopatients", three women and five men including Rosenhan himself. He briefly feigned auditory hallucinations in an attempt to gain admission to 12 psychiatric hospitals in five states in the United States. All were admitted and diagnosed with psychiatric disorders. All were given antipsychotic drugs.

After admission, the pseudopatients acted normally and told staff that they felt fine and had no longer experienced any additional hallucinations. All were forced to admit to having a mental illness and had to agree to continue to take antipsychotic drugs as a condition of their release. The average time that the patients spent in the hospital was 19 days. All but one were diagnosed with schizophrenia "in remission" before their release.

The second part of his study involved an offended hospital administration

challenging Rosenhan to send pseudopatients to its facility, which the staff would then set out to detect. Rosenhan agreed. In the following weeks, out of 250 new patients the staff identified 41 as potential pseudopatients, and 2 more viewed as suspicious by at least one psychiatrist and one other staff member. In fact, Rosenhan had sent no pseudopatients to the hospital.

Upon its completion Rosenhan concluded:

> " . . . it is clear that we cannot distinguish the sane from the insane in psychiatric hospitals"

The study also illustrated the dangers of dehumanization and labeling in psychiatric institutions. It suggested that the use of community mental health facilities which concentrate on specific problems and behaviors rather than psychiatric labels might be a solution. And it recommended educating psychiatric workers in the social psychology of their facilities.

Rosenhan's observations reflect the treatment and hypotheses applied to PTSD-affected people by the NC*for*PTSD, viewed as experts in the field. From them, it filters through to the WCB, Union and employers treatment ideas of the four high risk PTSD occupations — aircrew, fire-fighters, police officers, and soldiers and veterans — or anyone else incurring PTSD in the line of duty. Rape victims, including homosexual rape in the military (apparently the major cause of PTSD in that setting), are to my knowledge from two of those experiencers, treated with kid gloves. But pharmaceutically drugged to the hilt.

Furthermore, Rosenhan's recommendation of education tailored to enhance psychiatric workers' awareness the social psychology roles played by their facilities appears to hitherto have been graciously ignored by those in power to follow through.

Needless to say, Rosenhan's peers were in the uproar of righteous indignation, viewing his experiment as an attack on the efficacy of psychiatric diagnostic practices. After all, it did endanger mental health practitioners' credibility and omnipotence in judgment of the other's mental health. More importantly, it was a threat to their golden goose, never mind their normally monumental egos.

When in the PTSD condition, anything can happen, and self-protection is called for. Trusting in and depending on interpersonal relationships during the time of PTSD vulnerability through possibly well-meaning but ignorant wives, husbands or significant others, or even ranking officers or superiors? If you do, it might be detrimental to both health and freedom, as we shall see later on. But what to do to protect the Self from landing in a mental health asylum, despite vigilance? And

what on earth to do to get out of it is the question to ask? Take note!

How To Get Released From A Psychiatric Hospital

The following rights connected to the release from a mental facility are taken mainly from *Disability Rights Ohio.* These rights are designated under federal law as the system to protect and advocate for the rights of people with disabilities and as the Client Assistance Program under the Rehabilitation Act. The mission of Disability Rights Ohio is to advocate for the human, civil and legal rights of people with disabilities in Ohio. Presumably, similar rights for the disabled have been legislated in all other states, considering it is federal law. We might see different financial arrangements, but the premise will differ little: to protect the disabled's

rights to a larger or lesser degree, as there may be distinct differences.

Read Arkansas' protection premise, for example:

> "Disability Rights Arkansas has a vision that people with disabilities are equal members in their communities and dictate the course of their own lives through self-determination.
>
> "Advocacy services provided by DRA are client focused. The person with disability is DRA's client; DRA provides services to, and takes direction from, this individual. People with disabilities are treated with dignity, respect and compassion regardless of their disability.
>
> "DRA's Board of Directors, PAIMI Advisory Council and staff members are held accountable for ensuring the agency mission and vision are adhered to and all services are provided with integrity and equality."

As you can see, if ending in their clutches of benign-sounding vision and mirages as a severely physically handicapped human being, you are up the creek without a paddle. If living with PTSD, you are too, unless you thoroughly educate yourself on your rights and your government's federal mandate to assist you and insist they indeed do.

The State of New York's DRNY vision statement reads:

> "DRNY envisions an inclusive world that provides equal opportunity for individuals with disabilities — one that is free from discrimination, abuse and neglect."

Their mission?

> "DRNY provides free legal and advocacy services to individuals with disabilities. Working tirelessly to protect and advance the rights of children and adults with disabilities, DRNY is committed to enabling those we serve to exercise their own life choices and fully participate in community life."

It is, in my opinion, equally as vague as Arkansas'. So let's stick with Ohio, as they seem to be most detailed and comprehensive in their outline of what to do when danger of nuthouse admittance looms, as it certainly does for PTSD journeyers. You can read it verbatim under *The Right to Be Told Your Rights, http://www.disabilityrightsohio.org/when-person-wants-released-psych-hospital.* It begins with the disclaimer:

"This publication is intended to provide information only, and is not intended as legal advice. You should consult a lawyer if you need legal advice."

It can vividly be imagined that it may be a tad difficult to make contact with a lawyer once in the nuthouse. If not, watching the almost documentary-grade *One flew over the Cuckoo Nest* with Jack Nicholson is in order. Should you get the nagging, sinking feeling in the stomach that something untoward may be in the cards, making a couple of copies of the above might be a good idea. So may finding a lawyer well versed in human rights through the Lawyer Referral Service and arrange a 30 minutes meeting for very little money to discuss the issue at hand. Remember, Dharma extinguishes Karma. Take your best and brightest buddy along, if you have one left willing and capable to assist you in your drive to protect yourself.

This should not be your wife or significant other. Why not? Too emotionally fragile, too easily influenced and swayed by doctors, physicians, girlfriends, mothers, fathers, in-laws, brothers and sisters. It's far too dangerous for your wellbeing at loss as s/he is about your changed personality and disinterest in all and sundry. Your odd behavior will throw them off. It is so distinctly different from the time you first married and loved each other so desperately for years thereafter when you were the perpetual ray of sunshine and joy in bed and out of it! Keep quiet about your inquiries.

Put the lawyer's name and phone number on the two copies you made of your rights and also memorize both. Keep one copy on you if your intuition yells that something is amiss, and the other at hand. Should you be forced to enter the nuthouse, hand it to staff the moment you step on their premises. The idea that you might know your rights will put them on guard and make them more cautious about committing human rights violations against you.

These Are Your Rights

If you are not charged with a crime, but have been taken to a psychiatric hospital against your wishes, hospital staff must give you the following information verbally and in writing:

1. YOU MAY IMMEDIATELY MAKE TELEPHONE CALLS IN ORDER TO GET HELP WITH LEGAL, MEDICAL AND MENTAL HEALTH ISSUES.

   It is now that you call your dearest, brightest, most stalwart and trusted friend, the one you took to the lawyer with you, if you had one left. Why? Your future depends on it. Everything you say from now on can and will be held against you. You have no voice. They can hold you forever, as we shall see. Therefore

you want someone who is emotionally detached from the situation, someone who has some knowledge about your rights, thanks to the lawyer visit. Furthermore, at this point it is likely that psych staff has drugged you to the gills by injection or got you to liberally swallow antipsychotic drugs, putting you in limbo, so you'll need someone to speak on your behalf.

2. YOU HAVE THE RIGHT TO HIRE YOUR OWN LAWYER. IF YOU CAN'T AFFORD A LAWYER, THE COURT WILL APPOINT ONE TO WORK WITH YOU.

Your friend will do this for you, as you will most likely be drugged too heavily. They will probably allow you to surface only briefly for the assessment interviews conducted by mental health practitioners. Expect to be pushed under again with another pharmaceutical drugs treatment — for your health. Hiring a lawyer on your own may, under these circumstances, be a rather tedious undertaking.

3. YOU HAVE THE RIGHT TO AN INDEPENDENT EXPERT EVALUATION OF YOUR MENTAL CONDITION. IF YOU CAN'T AFFORD THIS EVALUATION, IT MUST BE PROVIDED TO YOU AT NO CHARGE.

This, of course, is breathtaking in its generosity, but how will you arrange it? Again you need the trustworthy friend whom you briefed in advance on the nuthouse possibility. This friend must be intelligent and gutsy enough to spring into the breach and jump into action should his intuition tell him you are in danger. Like when he is unable to get ahold of you for more than a day. Or when the significant other refuses to speak with you or let her beloved come to the phone. Or when the cellphone is mute for hours on end.

4. YOU HAVE A RIGHT TO A HEARING WHERE A JUDGE OR REFEREE WILL DECIDE WHETHER OR NOT YOU WILL BE LABELED MENTALLY ILL AND FOUND TO BE IN NEED OF HOSPITALIZATION BY COURT ORDER. THIS IS CALLED A "CIVIL COMMITMENT HEARING.

You most likely will neither have time nor wherewithal to arrange this matter on your own. In the environment and state of mind in which you'll find yourself, you might not even understand the concept at this point. But your trusted friend is there again to aid you, perhaps.

If not you should despite it all try to:

> "*Find Out Whether You are a Voluntary or Involuntary Patient*: Your rights in the hospital can depend on whether you are a voluntary or involuntary patient. If you do not know whether you are a voluntary or involuntary patient, you can ask the hospital clients'

rights officer to find out for you."

Avoid ever to be persuaded to commit yourself as voluntary patient. If you do, to get yourself out is almost impossible. Far brighter souls than you and I have tried and almost failed for the following reasons:

> Voluntary Patient: "Voluntary" patient means that you or your court appointed guardian, if you have one, want to admit yourself into a psychiatric hospital. If you have admitted yourself into a psychiatric hospital, you cannot simply sign yourself out and leave when you decide to do so. There is a process that must be followed in order for you to leave. The hospital staff can try to keep you by asking the court to commit you. If the court orders you to stay at the hospital you become an "involuntary patient."

However, as a voluntary patient you do have the right to *request* your release from the hospital by writing a "three-day letter." The hospital must inform you of your right to ask to be released from the hospital. You write a three-day letter by asking in writing for your release from the hospital. If you ask for help, the hospital must provide you with help in making this request. Your letter can be short. Write your letter to the hospital Medical Director and state that you want to leave. Hospital staff, with approval from your county Mental Health Board, will decide whether or not to release you or to ask the court for an order to keep you at the hospital.

Always remember you are their meal ticket, their bank account, a more than valid reason in their mind to keep you in for as long as possible. After handing in your three-day letter the hospital has three working days, Monday through Friday — not weekends and holidays — to tell you whether or not you *should* leave. It is important to know that even if you signed yourself in voluntarily, hospital staff can keep you if they think you should stay by filing papers to try to commit you. Consequently, one of three things can happen after you signed the three-day letter:

1. The hospital agrees you should leave. If they do, you get to leave;
2. The hospital wants you to stay. If they do, they must file an affidavit within three working days of receiving your letter, and your request for release turns into a request for a court hearing.
3. If the hospital does not file an affidavit within three workdays, you

must be released immediately.

If you are an Involuntary Patient, the following applies: You are placed and kept in the hospital against your wishes by a court order. Anyone can sign an affidavit saying you are "mentally ill and in need of hospitalization by court order." The court will decide whether or not you meet the legal definition of mental illness and whether you are an immediate danger to yourself or others.

If the court finds you mentally ill and presenting a danger, you can be ordered committed to your county's Mental Health Board, which can then place you at the hospital. Involuntary patients, however, can also request their release from the hospital. I assure you that a PTSD experiencer will never be able to live through such traumatization and anxiety. The intense pressure and stress, together with pharmaceutical drug traumatization, is far too much to escape sane in mind and healthy in body. Mental health practitioners and WCB et al employees, as well as union bosses and employers know this, I believe. But for them, PTSD journeyers are considered human debris anyway, and view the local insane asylum befitting their condition.

Involuntary patients are also given the opportunity to request becoming voluntary patients and have the right to ask to become so at any time. If you have been involuntarily committed to the nuthouse by a court and want to try to leave the hospital, you can ask to change from an involuntary to a voluntary patient by making an application for voluntary admission.

If you do, the hospital must convince the court that you meet the legal definition of mental illness They must also convince the court that because of mental illness, you are an immediate danger to yourself or others. That's easy enough, as we know from the Rosenhan experiment. If the court finds you are mentally ill and present a danger to yourself or others it can order you to be hospitalized against your wishes for 90 days. Then see what happens, as the hospital then can ask the court to keep you for more than 90 days. If that occurs the agency or hospital to which you are committed must file with the court an application for continued commitment. This application must be filed at least 10 days before your period of commitment is over. If the application is not filed at least 10 days before your 90 days is up, you must be discharged immediately. After 90 days, you most likely have no clue whether you are coming or going at any time of the day or night. Watch the *Cuckoo Nest* for education.

Should you, by sheer miracle and divine intervention, still be with it, however, a

full court hearing must be held. Hospital staff must prove to the court that you are a danger to yourself and others. If the court decides to commit you anyway, it may order you held for up to 2 years. A hearing must then be held at least every 2 years without your request, but you can request a hearing every 180 days during which the hospital must examine you at least every 30 days. When the hospital finds that you are no longer mentally ill and no danger to yourself or others the hospital must discharge you. Remember or write down these rights:

- You have the right to request voluntary admission.
- You have to right to a court appointed attorney at the court hearing.
- You have the right to ask for help from hospital staff to make sure that your rights are carried out.
- You have the right to file a grievance with the hospital if you feel your rights have been violated. You can ask the hospital's clients' rights officer for help in filing your grievance.

Take note that there is a *hospital clients' rights officer*, which may or may not be useful to you. You should find out by having a meeting with the person, should hospital staff allow you to surface from their drugging.

You should also bring these issues up with the evaluating psychiatrist who may or may not be sympathetic to your plight. Timidity in this situation would be lethal, even though the situation is intimidating, as it would be detrimental to your health. Anger and hostility would be just as detrimental.

The only way to get out of this truly awful situation is by maintaining your honor, your integrity and your graciousness throughout the ordeal, even if it kills you. If you lose it, they will never set you free. The result? You will be killed, or they'll kill your Self in one way or another, as they will kill your spirit and your will to live. And they know very well how to go about it.

Also know why those employed in the nuthouse milieu do this kind of work. It's because they love being surrounded by mental patients in the style of Miss Ratchet of *Cuckoo Nest* fame, due to their own mental flaws and fragilities. Many, I believe, have psychopathic tendencies, hate themselves and thrive on misery. They entered this field first and foremost to figure out what's wrong with themselves, what makes them tick the way they do.

Unable to fix themselves, they decided to escape their own deficiencies by trying and practicing to analyze others in accordance with their own ideas and ideologies.

It is that simple. In regards to PTSD, the vast majority of mental health practitioners of all genres have furthermore been brainwashed into thinking and believing that it is a mental illness, when it is in fact one colossal existential crisis, as R.D. Laing, Loren Mosher and others so poignantly documented.

Again, then, the way to PTSD self-preservation and recovery is to vigorously learn to recognize the signs of losing it. Observe your thinking like a hawk. Learn to control yourself before flying off the handle, regardless of who puts on the pressure in the conscious attempt to make us lose it. It would mean joy and financial relief to watch us digging our own grave that way.

That alone should entice one to keep one's lid on, because controlling our temper and educating ourselves really is an all-empowering exercise towards PTSD healing. All other treatment modalities merely mask the wound and prolong the PTSD agony.

35

High Risk PTSD Occupations

Mental health practitioners nowadays diagnose clients with PTSD because of hangnails or childbirth. That gets as many humans as possible on mind-altering pharmaceutical drugs, leading to addiction within hours, to invoke the Matrix zombie society. Yet, there are only four occupations where this existential crisis typically occurs, other than rape victims. These are fire fighters, police officers, soldiers and veterans, and aircrews. According to William B. Mount's June 2018 report, rape of military men by other military men is rampant and the main cause of PTSD in the military. These are men and women who are by nature disciplined. They love their careers, and managed them beautifully until the manure hit big time with the PTSD-causing incident due to no fault of their own. They carried

themselves well throughout their lives until that point. They are suddenly dependent on strangers to declare them mentally ill and defective since birth, almost literally.

Think about it! And you still think strangers can heal you? Can change how you view yourself? Can repair your soul, your conscience? Can create peace within yourself? Really? Can strangers absolve us from the guilt we may feel about actions taken in the past? Again, look at what strangers pretending to be humane people are doing to the Honourable Judge Kavanaugh and his family. There you have the template of what is being done against you when in the PTSD situation. Only you yourself can free your heart and soul and heal it. Only the development of a deep and genuine desire to educate yourself in the field can save your sanity. If ignored due to ignorance and belief and trust in physicians and the like, the outside leading to healing when it can only come from within, it leads to a slow and tedious death until the natural preset clock runs out. We have the choice. We are able to make that decision, if we are free of drugs. If on drugs, we are unwittingly mentally disabled to make any decisions whatsoever.

Only soldiers' and veterans' PTSD assistance programs have sprung up in recent years. The non-profit Headstrong Project Inc.'s is one of them. The Guide Star website is one of the first central information sources on U.S. nonprofit corporations, founded in Williamsburg, Virginia, in 1994. It has tax-exempt status, and in 1996, it began to post nonprofit organizations' financial reports to the World Wide Web. Guide Star reports that Headstrong's mission is to provide cost-free, stigma-free, bureaucracy-free mental healthcare to post-September 11, 2001, combat veterans. Their PTSD numbers are said to be a staggering 300,000, or more than Iraq and Afghanistan veterans alone. The VA estimates that at least 22 veterans a day commit suicide. The Department of Defense reports that somewhere between 30 and 50 active duty troop members take their lives every month. Guide Star also reports an increase in dangerous and destructive behaviors among veterans, manifested by domestic violence and substance abuse.

Just listen to world famous psychiatrist Peter R. Breggin for a moment, whose biography states in part:

> "Peter R. Breggin MD is a Harvard-trained psychiatrist and former Consultant at NIMH [National Institute of Mental Health] who has been called 'The Conscience of Psychiatry' for his many decades of successful efforts to reform the mental health field. His work provides the foundation for modern

criticism of psychiatric diagnoses and drugs, and leads the way in promoting more caring and effective therapies. His research and educational projects have brought about major changes in the FDA-approved Full Prescribing Information or labels for dozens of antipsychotic and antidepressant drugs. He continues to educate the public and professions about the tragic psychiatric drugging of America's children.

"Dr. Breggin has authored dozens of scientific articles and more than twenty books, including medical books and the bestsellers "Toxic Psychiatry and Talking Back to Prozac." Two more recent books are "Medication Madness: The Role of Psychiatric Drugs in Cases of Violence, Suicide and Crime and Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients and their Families.

"Dr. Breggin has unprecedented and unique knowledge about how the pharmaceutical industry too often commits fraud in researching and marketing psychiatric drugs. He has testified many times in malpractice, product liability and criminal cases, often in relation to adverse drug effects . . . "

Here is an excerpt from Dr. Breggin's recent column at *Mad In America*: "Psychiatrist Says: More Psychiatry Means More Shootings":

"In the early 1990s, a federal court appointed me to be the scientific expert for all of the combined product liability cases that were brought against Eli Lilly throughout the country concerning Prozac-induced violence, suicide and crime. Since then I have been involved in many cases in which judges and juries, and even prosecuting attorneys, have determined that psychiatric drugs have caused or substantially contributed to violence. For a lengthy list, see the Legal Section on my website (www.breggin.com).

"In 2003/2004, I wrote a scientific review article about antidepressant-induced suicide, violence and mania which the FDA distributed to all its advisory committee members. This took place as the FDA Advisory Committee members prepared to review new warnings to be put in the Full Prescribing Information for all antidepressants.

"In my peer-reviewed paper [about the effects of antidepressants], I wrote: 'Mania with psychosis is the extreme end of a stimulant continuum that often begins with lesser degrees of insomnia, nervousness, anxiety, hyperactivity and irritability and then progresses toward more severe agitation, aggression, and varying degrees of mania.

"In words very close to and sometimes identical to mine, the FDA one year later required the manufacturers of every antidepressant to put the following observations in the Warnings section of the Full Prescribing Information:

"'All patients being treated with antidepressants for any indication should be monitored appropriately and observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric'."

"These adverse drug effects — including agitation, irritability, hostility, aggressiveness, akathisia, and impulsivity — are an obvious prescription for violence. Akathisia, which I also described in my article, is a psychomotor agitation that is strongly associated with violence.

"The FDA Medication Guide for antidepressants warns clinicians, patients and families to be on the alert for the following:

- acting on dangerous impulses
- acting aggressive or violent
- feeling agitated, restless, angry or irritable
- other unusual changes in behavior or mood

"This list (above) of antidepressant adverse effects from the Medication Guide should make clear that antidepressants can cause violence.

"The FDA also acknowledges the risk of both psychosis and aggression from the stimulant drugs used to treat ADHD . . . .

"In the study of violence reports to the FDA, any predisposition toward violence in the patients themselves was largely ruled out because some of the most violence-inducing drugs were not psychiatric drugs, and were being given to a more general population. Some of the violence-inducing drugs were antibiotics, including Lariam (Mefloquine), which Sgt. Robert Bales was taking when he slaughtered 16 helpless, innocent villagers in Afghanistan.

"[The authorities] do not foresee that the psychiatric strategy for treatment will sometimes lead to tragic outcomes like the school shootings. Nor do they realize that the overall evidence of harm from psychiatric drugs is infinitely greater than the evidence for good effects, as scientist Peter Gøtzsche has confirmed in Deadly Psychiatry and Organized Denial.

"Calling for more spending on mental health and on psychiatry will make matters worse, probably causing many more shootings than it prevents.

"Not only do psychiatric drugs add to the risk of violence, but psychiatric treatment lulls the various authorities and the family into believing that the patient is now 'under control' and 'less of a risk.' Even the patient may think the drugs are helping, and continue to take them right up to the moment of violence.

"Even when some of their patients signal with all their might that they are dangerous and need to be stopped, mental health providers are likely to give drugs, adding fuel to the heat of violent impulses, while assuming that their violence-inducing drugs will reduce the risk of serious aggression."

Dr. Breggin himself issues this warning:

"Most psychiatric drugs can cause withdrawal reactions,

> including life-threatening emotional and physical reactions. So it is not only dangerous to start psychiatric drugs, it can also be dangerous to stop them. Withdrawal from psychiatric drugs should be done carefully under experienced clinical supervision. Methods for safely withdrawing from psychiatric drugs are discussed in Dr. Breggin's book: Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients and Their Families."

This is the truth. The public and PTSD experiencers are in the middle of a psychiatric locust plague. Better wake up and heal yourself or die a gruesome death because of those pretending to know how to heal you. Learning the truth, after all, is the first step towards recovery. It is also the beginning on the path of Dharma over Karma.

Dr. Breggin has managed to break through this code of silence. He is one of the only psychiatrists who has been able to testify in court about the true effects of psychiatric drugs. The FDA is the US agency tasked with approving every medical drug as safe and effective before it can be released for public use. But it will never admit its role in the mass shootings and violence across America. The Agency views the pharmaceutical industry as its partner, says Jon Rappoport.

Placing warnings on informational drug inserts as described by Dr. Breggin escapes the attention of patients prescribed psychiatric drugs. The warnings are also in such small print as to be generally unreadable. Furthermore, in a land where illiteracy is becoming rampant, comprehension of the written word is also becoming an issue. And lets face it, even physicians prescribing the drugs don't always read the warnings. Why should they, when part of their lucrative income depends on issuing the prescriptions, and when the drugs are advertised as solution to "mental" disorders?

The military seems to have a fairly accurate account of the number of its PTSD-affected members. There are a multitude of papers written, based on assumptions and presumptions of their overall purportedly PTSD-caused symptoms and behaviors. But I could find only one paper written on PTSD in commercial pilots, other than what I presented in *Broken Wings.*

Written by a Marcello Leoni, this 85-page paper entitled *Post Traumatic Stress Disorder in commercial aircraft pilots, a research of different methods of management and intervention submitted as part of the requirements for the award of Master of Science (msc) in air safety management at City University London* hypothesizes on commercial pilots'

PTSD possibilities. Its author is seemingly unfamiliar with aircrew way of life in its entirety.

I know for a fact that PTSD development in pilots is almost an impossibility, no matter how hard they tried. The reasons are given in *Broken Wings* — the book as current today as when first published in 1999. Leoni did show, however, that in a comparison between captain and first officer, first officers were more susceptible to PTSD than their superior and so were younger pilot generations overall.

This could indicate a possible reduction in the number of mentally healthy young pilots in the long run, the author claims. Leoni is unable to grasp that PTSD is not a mental illness, but the result of an extremely life-threatening event beyond the scope of any normal human life experience. He doesn't see that it traumatizes the person and causes an existential crisis. That is regrettable, but it cannot be held against him. After all, he is a Master of Science with little or no life experience in aviation and going out on a limb, I venture to opine. Lucky for him that his supervisory committee seems to be equally as ignorant; the blind leading the blind.

His left side brain dominance may furthermore make it difficult for him to grasp that it is difficult to scientifically and empirically provide best evidence to document PTSD. But he tried very hard, indeed. This is in the same vein as the ludicrous hypothesis perpetually proposed by the self-proclaimed PTSD VA's National Center *for* PTSD experts to the detriment of PTSD journeyers. They refuse to acknowledge that certain aspects of human and humane functioning cannot be documented by scientifically inspired experiments. If they admitted that, they would lose their lucrative jobs, as well as their experimentation subjects. Without the bright and fertile human minds of their otherwise mentally fit and healthy military PTSD sufferers, their experiments for trans-humanistic purposes would suffer.

As for PTSD-affected flight attendants, there is the documentation of my own experiences in *Broken Wings.* Beyond that, no research has to my knowledge been conducted since the profession's inception in 1930, when United Airlines hired the first stewardess. The job description changed when political correctness slowly came in vogue. Men, hitherto hired as assistant pursers, were engaged for stewardess jobs, forcing the generic description. Thus in North America, the flight attendant configuration was created similar to that of the toilet or washroom attendant, whereas in Europe and other more gracious societies, people still use "stewardess" and "steward" to describe the occupation.

Between 1930 and 1999, not even a word about the possibility of PTSD in flight attendants' had been breathed. Not by academia. Not by the airlines themselves,

never mind passengers. No research on the phenomenon existed even though innumerous crashes and incidents with survivors occurred.

The Gimli Boeing 767 ran out of fuel at 36,000 feet altitude in the middle of nowhere over Manitoba, Canada. You would think that would have elicited some interest in someone to research the crew's wellbeing after the ordeal, but no one could be bothered. All six flight attendants, playing sitting ducks in a locked barrel, suffered PTSD. None of them ever returned to their previous Self or health. Two of them were apparently driven to suicide. Of the 67 passengers, many of them most likely suffering the same sentiments, nothing is known. The number of commercial airlines' PTSD-afflicted flight attendants and their fate is thus unknown.

Air Transat Flight 236 bound for Lisbon from Toronto on Aug. 24, 2001 crash-landed in the Azores after gliding powerless over the ocean for 30 minutes. Some of the 306 passengers and crew on board developed PTSD as a result. In June 2015, almost 14 years later, the Canadian Broadcasting Corporation reported on a study by researchers at Baycrest Health Sciences' Rotman Research Institute in Toronto. The study had been published in the journal Clinical Psychological Science (August 2014). Brain imaging of eight of Air Transat's 236 passengers nine years after the event showed the memories of the experience "retained a rich vividness" that they "lit up" areas of the brain related to memory, emotion and visual processing. This traumatic incident still haunts passengers, regardless of whether they have PTSD or not, said lead researcher Daniela Palombo, now post-doctoral researcher at Boston University's School of Medicine.

The Canadian Press elaborated on what Dr. Margaret McKinnon, a postdoctoral psychology student at Baycrest Health Sciences in Toronto, did. At the time of the near-miss, a passenger on Flight 236, she and her colleagues had recruited 15 other passengers for the PTSD study. It compared details recalled by passengers with PTSD with passengers without PTSD and with a control group. The researchers concluded that the result of their findings helped psychologists uncover new clues about PTSD vulnerability. The aircrew, the ones on duty on the Transat flight's back-end and front-end, were left out of the study. Only passengers were included. "What our findings show is that it is not what happened but *to whom it happened* that may determine subsequent onset of PTSD," said the study's senior author Dr. Levine, without given further details why and how. On June 24, 2017, I wrote to Dr. M. McKinnon, copying K. Connelly at Baycrest and M. Hayes at the Canadian Press. I asked whether the researchers had read *Broken Wings*. My letters went unanswered.

Be it as it may, "One in five police officers are at risk of PTSD — here's how we

need to respond". That was the headline of an article written by an unnamed author and published in the August 2016 Australian journal *The Conversation*. This publication is owned by an independent, non-profit media outlet that prides itself on using content from the academic and research community. Launched in March 2011, the website since then went global, publishing all content under a Creative Commons (CC) License. This allows free distribution of otherwise copyrighted work, states the journal's editor-in-chief Andrew Jaspan.

Policing, we are told, is undoubtedly a stressful occupation. Officers often face potentially traumatic situations. They may, without warning, be exposed to disaster, hostage situations, sexual and physical assaults, shootings, mutilations, death and threats to their life. So, police and emergency services workers have elevated PTSD rates, depression, and suicidal thoughts and actions. ABC's August 2, 2016, *Four Corners* program "Insult to Injury" reveals and highlights how police officers' claims for compensation and psychiatric treatment for PTSD are being met with scepticism, resistance and lengthy delays. Perceived stigma, failure to seek help, and the policing organizations' own failure to support officers' seeking help have created a melting pot of despair for some members.

As I portrayed in *Broken Wings*, the modus-operandi for PTSD-affected people's treatment is the same across large corporations (governmental or otherwise), WCB and Unions, without exception and with the following aim:

- First, do everything to entice the PTSD claimant to commit suicide. Use all avenues, including engaging sufferers' colleagues for perks and monetary remuneration into action leading to his or her complete downfall and consequent demise and death.
- If that doesn't work, put all efforts into landing him or her on skid row.
- If unsuccessful after ten years of vigorous attempts of claimant destruction, settle for the most pitiful monetary compensation possible.
- That seems to be the truth for all PTSD prone occupations, unless one is a member of a so-called secret society, such as the Eastern Star or a Freemason.

How common is PTSD among police officers? We are told that "dose," the number of routine and repeated exposures to potentially traumatic events, directly

impacts their PTSD rates worldwide. In Australian police, it is as high as 20%, far beyond the 1–3% prevalence expected in the general population. "Normal" PTSD symptoms include hyper-arousal or hyper-vigilance, numbing or depression, intrusions, "flashbacks" or nightmares, and avoidance or withdrawal. In policing, PTSD is, as in the other three occupations, characteristically accompanied by rage and alcohol abuse, the report claims ("One in five police officers are at risk of PTSD — here's how we need to respond", August 2, 2016, 1.06am EDT; *The Conversation; ABC's Four Corners* program "Insult to Injury"). Key factors to recover from trauma exposure for any person are stability and safety. With emotional support, some empathy, and peace and quiet, PTSD is a temporary and manageable condition. This has been already pointed out several times in this book. It has been extensively covered and documented in *Broken Wings.* And psychiatrists Loren Mosher, R.D. Laing and others in their field have documented these factors, as well.

That is why PTSD claimants, whether veterans, soldiers, aircrew, police officers or fire fighters, are haunted to death by those purporting to support them. They are haunted even as the professionals hide the fact that they are viewed merely as disposable human debris, more cost-effective dead than alive. They are worth even less when new ones stand in line praying to be hired as replacements by the hundreds, if not thousands.

By "Adding insult to injury," states the *Four Corners* author, insurance companies impede injured police officers' recovery by, he alleges, prolonging the claims process. They create unjustified delays. And they fail to act on psychiatrists' recommendations even when the claimant is clearly suicidal. The WCB put me on a starvation diet at one point, owing me $56,000.00, meaning I had received no income whatsoever for months and months on end. The aim? Destroy me?

Each person interviewed in *Four Corners* reported multiple exposures to suicides, homicides, mutilation, dismembered body parts, family homicides and corpses of children and infants. The ex-officers were visibly distressed even when recounting incidents more than a decade ago. As time is merely a figment of human imagination, it depends on an individual's mental acuity how and if events, some going back to the cradle and even before, are recalled. The police officers, however, were not upset and stressed due to the incidents they had witnessed in the line of duty, I assure you. They were stressed from the treatment they had and were receiving from their corporation, their Union, their insurance corporation and most likely their peers. All of them were unaware that only the brightest will incur PTSD. All were unaware that it is not a mental disorder, but "merely" an existential crisis

of immense proportion and unimaginable unless one has lived through it.

The *Four Corners'* author put his finger right on it. He stated first that it might be difficult to discern where the responsibility for mental health lies. And second, he pointed out that all parties involved in the *Four Corners* case study, from the individuals to the policing organizations to the insurance companies, failed to seek or provide adequate support. They created circumstances that made the problem worse. Of course, they did. It's their role. Their job depends on it, as profits rule and PTSD-affected human lives value zero. Shareholders' profits dictate the operation.

Research compares people seeking financial compensation for PTSD incurred in the line of duty with those who can survive without. Those seeking financial compensation are more likely to have a poorer recovery prognosis, more severe symptoms and a longer recovery time. Yes, of course. The latter can create relative peace and quiet for themselves, if able to afford an unpaid leave of absence to solve their PTSD problem. If they continue to work with PTSD they will surely be destroyed by their colleagues and by their own volition.

But how many working stiffs can afford an unpaid leave of absence? In my case, I was under the insane illusion that NorAm would be delighted to help me return to work. I was unable to envision the Hell in which I was going to be immersed quasi voluntarily by seeking my employer's assistance. This was due to my lack of knowledge about the system and its detrimental effects on my health. So, I almost caused my own destruction. Only when I stopped taking Ativan did I awaken to the fact and see the light of day–slowly. Why slowly? Because the scheme or the meme is so sinister, so evil as to defy any humane imagination, so alien it is to the psyche of a well-adjusted human being.

The *Four Corners'* documentary states that there are three plausible reasons for this pattern of human abuse (delaying the claims process):

- People seeking compensation do so because their psychological injury is more severe.
- People seeking compensation exaggerate or prolong their symptoms, a practice known as malingering, to maximize their payout.
- People whose claim process is prolonged, thus triggering further stress and exacerbation of symptoms or otherwise hindering recovery.

I believe, from my own experience, that the prolonged claims progression is

engineered purposely to inspire claimant-suicide or disappearance from the scene. To give an indication how perfectly this is engineered, remember the $56,000.00 the WCB owed me? It was months and months and months of back-payments. I was paid only after numerous battles in the rigged and nerve wrecking WCB court systems, with 33 percent of it payable to my lawyer. It is but one of their many tactics. It is enhanced by sending a multitude of mental health practitioners to practice their craft on the seen or unseen claimant. In my case, 23 of them spewed forth their by and large ludicrous hypothesizations on my health and well-being or lack thereof. All of their theories were unrelated to the extraordinary multitude of near misses I had experienced before the PTSD-causing event. Hard on the psyche? This, too, is standard operating procedure. I learned from another flight attendant. She was the only survivor in a fatal crash one year after my incident, whose treatment for 10 years was a carbon copy of mine.

As is recognized in *Four Corners*, any self-respecting insurance company's main duty is to protect its own interests. That includes the employer's insurance agency, the WCB. However, the author conveys, an ethical compensation system must deliver timely evaluation and warrant assessments and outcomes for claims in a way that protects those who are distressed and psychologically unwell. What he does fail to acknowledge or even recognize is that ethics went out the system light-years ago. No morals. No graciousness. No honor and integrity, if it ever existed at all in large corporations and insurance compensation systems.

Changing attitudes to seeking help might also help the PTSD affected, the author feels. Of course, feeling is not fashionable in the field of any of the professions analyzed, including the mental health profession. It is just not in style, as the presumption there was something wrong with the PTSD affected claimant long before their career began is a forgone conclusion by the powers that be. The same presumption is held by their peers as well. That applies to military, police, firefighters and aircrew, their brutality and viciousness almost unimaginable, as so vividly portrayed in Tim Kennedy's diatribe.

The author thought the cultural shifts in Australia would also permeate the country's law-enforcement agencies. He expected a shift in attitudes from "Toughen up, Princess" toward "Are you OK?" But he realized that that was his illusion only. Of course it was, as PTSD judgments have nothing to do with race, color, religion, nationality or gender, as demonstrated by the US Army and its multitude of everyone in those who suffer PTSD. It has to do with intelligence, morals, and yes, ethics, of PTSD-affected people, as it results in the existential crisis. Ignorance is

thus proven to be bliss, stupidity a blessing of the highest degree. Mind you, an individual officer's attitudes towards PTSD can prevent someone from seeking help. It is not the individual officer *per se* preventing PTSD sufferers from seeking help. It is their advancement record, which concerns PTSD experiencers. A PTSD incident on one's record is said to stall advancement forever and a day across the field of PTSD-prone occupations. In our Matrix world of fierce, ego-centered competition, that may be hard to swallow for many in the PTSD situation.

Another common feature of each case highlighted by *Four Corners* was the lack of recognition that there indeed was a problem. There was a lack of support for treatment from the organization. There was a lack of independent treatment-seeking or personal responsibility for health and wellbeing. The reduction of stigma and the removal of individual barriers to seeking treatment were viewed as crucial for early intervention, treatment and, ultimately, recovery and health. People who are proactive about seeking timely treatment apparently have far better outcomes than those who hide the symptoms and self-medicate for years or even decades.

I sought help early, the idea of stigma never even occurred to me, and still I was almost hounded to death during those 10 years of pure hell.

My reward? Indescribable. I came into my true power, and also helped a few others, I think. Even some Saskatchewan, Canada, iron-workers injured in the line of duty thanked me for the book, *Broken Wings*. They said they and their families would have landed in the gutter without it as a guideline in what to expect from the powers that be, the Union, the WCB and their corporation. That the book also gets me into cockpits of foreign carriers when a pilot who has read the book spots my name on the passenger manifest. They want to meet the woman who wrote it. I admit, to me it is welcome acknowledgement for work well done. That writing it helped me to survive is a given.

A first step to make progress in PTSD treatment, the *Four Corners'* author opines, would be to reduce barriers to seeking treatment. Related to that would be instigating a cultural change in a multi-level, organization-wide program of education for law-enforcement agencies. This would require a supportive framework in which officers were instructed from recruit school and throughout their careers onward about chronic stress, mental health and how to be robust officers. It should include PTSD-prevention strategies, as well as viewing assistance-seeking as a normal practice. Such programs have now been trialed in recruit schools at the Department of Fire and Emergency Services in Western Australia and the Queensland Police Service with promising results. The details can be viewed at

PLOS ONE, a journal of the worldwide community of researchers – from Nobel laureates to early career researchers. You'll find it under *The Primary Prevention of PTSD in Firefighters: Preliminary Results of an RCT with 12-Month Follow-Up* published in July 6, 2016, by Petra M. Skeffington, Clare S. Rees, Trevor G. Mazzucchelli and Robert T. Kane.

Matthew Tull, Ph.D., wrote his article "The Link Between Trauma and PTSD: Some Traumatic Events Are More Likely to Lead to PTSD Than Others" *in* May 2016. He pointed out that the numbers may be higher than in other, non-stated professions. He says:

> "See, many people will experience a potentially traumatic event at some point in their life. But just because you have experienced a traumatic event does not mean that you will definitely go on to develop PTSD. However, people who have experienced multiple traumatic events have been found to be at greater risk for developing PTSD."

Tull is an associate professor and director of anxiety disorders research in the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center in Jackson. He is said to have conducted many studies examining the ways in which humans manage emotions such as PTSD.

Tull gives no information on how non-humans deal with PTSD. Nor does he quote statistical data substantiating his findings. In my opinion, he furthermore omitted to point out that we live in an ABC documentary, in a drug- and television-manipulated, brainwashed, and thus weakened and spoiled, population. That being a victim appears to be high fashion and illnesses are a *cause celebre*. That hang-nails and child-birth now qualify for PTSD diagnosis, the DSM-5 facilitating it. So, a distinction should perhaps be made between high risk PTSD occupations, namely soldiers and veterans, fire-fighters, police officers and aircrew of the world, and the considered normal, hum-drum through and through, Matrix-generated population. But I digress.

Tull is now professor in the Department of Psychology at the University of Toledo. These days, he broadly focuses his research on the role of emotion regulation in the anxiety disorders, with an emphasis on post traumatic stress disorder. His research also looks at how emotion regulation contributes to self-destructive and health-compromising behaviors. Those would be substance abuse, risk-taking behaviors, and suicidal and non-suicidal self-injury among people with PTSD.

In January 2017, Tull and some of his colleagues published *The Cognitive Behavioral Coping Skills Workbook for PTSD Overcome Fear and Anxiety and Reclaim Your Life* (New Harbinger Publications). How anyone who never lived through PTSD can be so presumptuous as to publish how to deal with it is merely another manifestation of practitioner-arrogance and hubris. It is my well-founded view that the mostly catastrophic outcomes for PTSD afflicted are generated by mental health practitioners, because their treatment modalities are detrimental to PTSD recuperation. Thus, when engaging with any of them, it would be useful to remember that you are the object and subject of their practice in a hit or miss fashion, 99% of the time missing the mark

36

It's Criminal, But We Allow It

What would it take to develop a warped, mentally disturbed and physically disabled, zombie-like population, as portrayed in the movies *The Matrix* and *The Hunger Games*, One would have to make the public at large believe that drugs, any drugs, will enhance their lives. They would have to believe that those drugs would have no consequences to their mental and physical acuity and well-being.

To label normal life-events as PTSD-causing, is the first step. Then to claim that it arose as the result of a personality disorder harbored in the individual's psyche since birth, or even inception, is the second step. From a physician's view, this is the perfect way to achieve that goal and justify the use of pharmaceutical and other

drugs. The DSM-5 reclassifies many behaviors previously viewed as:

- natural human characteristics
- natural human behavior patterns
- natural human reactions to life and living in general

These have basically been classified as Personality Disorders (PD). They are considered to be a class of mental disorders characterized by enduring maladaptive human patterns of behavior, cognition and inner experience. They are considered PD when exhibited across many contexts and deviating markedly from those accepted by a person's culture.

That the few distinct cultures left around the globe are seemingly being systematically destroyed to kill individuality is nowhere mentioned. That thought patterns of possible personality disorders are developed early in life, is never mentioned. That they are viewed as inflexible and associated with significant distress or disability is never heard of in the field of PTSD. That definitions of mental disorders might vary according to the source of the distress and individuals' perception of distress, is also kept quiet. It is logical to conclude, however, if one is taught logic and reason, that what may be distress to one human being may not at all cause distress in another. But logic and reason are an art form unpracticed in North American governmental educational institutions, better termed internment camps, for the past 80 years or so.

As we learned earlier, there are official mental health criteria to diagnose personality disorders. They are listed in the American Psychiatric Association's creation, the *Diagnostic Statistical Manual Of Mental Disorders* (DSM). This is widely known as the Psychiatrists' and Psychologists' Bible. The DSM's origin, however, dates back to 1840, when the United States government in its census began to collect data on mental illness. In accordance with Article One of the United States Constitution (section II), the population should be enumerated at least once every 10 years. Whereas between 1790 and 1840 marshals of the judicial districts took the census, The Census Act of 1840 established a central office known as the Census Office. That same year, the terms "idiocy" and "insanity" first appeared in the US census. Forty years later, the census had been expanded to "mania", "melancholia", "monomania", "paresis", "dementia", "epilepsy", and "dipsomania". That last one is a historical term describing a medical condition involving an uncontrollable craving for alcohol.

The United States Census Bureau is the U.S. Federal Statistical System's principal agency responsible for producing data about the American people and economy. In 1917, it embraced the *Statistical Manual for the Use of Institutions for the Insane.* In 1917, three organizations began collaborating to gather uniform statistics across mental hospitals:

- the Census Bureau
- the National Commission on Mental Hygiene
- the Committee of Statistics of the American Medico-Psychological Association, renamed the American Psychiatric Association (APA) in 1921

The APA then worked with the New York Academy of Medicine to create a nationally acceptable psychiatric nomenclature. This was for the first edition of the American Medical Association's Standard Classified Nomenclature of Disease, which separated mental illness into 22 groups. *They wanted to minimize diagnostic confusion and create consensus as to what did and did not constitute mental illness. So they streamlined the system's classifications, to help* mental health practitioners communicate using a common diagnostic language in 1952. This resulted in the Diagnostic Statistical Manual DSM-I. It featured the descriptions of 106 disorders referred to as "reactions."

The term was invented by Swiss psychiatrist Adolf Meyer (1866–1950). It showed his view that mental disorders represented an individual's reactions to psychological, social and biological factors. As a matter of fact, Meyer's main theoretical contribution to the mental health field is said to be his idea of ergasiology. He derived this term from the Greek for "working" and "doing". Working from this term, he focused on addressing all biological, social and psychological factors and symptoms pertaining to a patient. One of his ideas was that mental illnesses were a product of a dysfunctional personality and not from the pathology of the brain. He also stressed that social and biological factors that affect someone throughout their life should be heavily considered when diagnosing and treating a patient.

Meyer was also one of the earlier psychologists supporting occupational therapy. He thought there was a connection between the activities of an individual and their mental health. Taking this into consideration, he looked for community based activities and services to aid people with everyday living skills. This brought

together all the biological, social and psychological factors and symptoms pertaining to a patient. It considered mental illnesses to be a product of dysfunctional personality, not a pathology of the brain. After immigrating to America, Meyer rose to prominence as Johns Hopkins Hospital's first psychiatrist-in-chief, from 1910 to 1941.

The Johns Hopkins Hospital (JHH) is a teaching hospital and biomedical research facility of the Johns Hopkins School of Medicine. It is located in Baltimore, Maryland, U.S. It was founded in 1889, using money from a bequest by Johns Hopkins, a Baltimore merchant and banker. When he died on Christmas Eve, 1873, at the age of 78, he left an estate of $7 million. It would be worth US$134.07 million in 2016. In his will, he asked that his fortune be used to found two institutions that would bear his name:

- Johns Hopkins University
- The Johns Hopkins Hospital

Johns Hopkins Hospital and its School of Medicine are the founding institutions of modern American medicine and the birthplace of numerous medical traditions including rounds, residents and house-staff. Many medical specialties were formed at the hospital including neurosurgery, cardiac surgery and child psychiatry. It is still regarded today as one of the world's greatest hospitals. When Meyer took over, he oversaw the building and development of its Henry Phipps Psychiatric Clinic. It opened in April 1913, to make sure it was suitable for scientific research, training and patient treatment.

Meyer is considered one of the first half of the 20th century's most influential figures in psychiatry. His detailed case histories on patients are considered one of the most prominent of his contributions to the field. He also briefly acted as APA's president (1927 and 1928), 40 years before the advent of the DSM-II publication in 1968. It differed from the first edition only by increasing the number of mental health disorder to 182 and eliminating the term "reactions." The reason? Because it implied causality and referred to psychoanalysis. This is a system of psychological theory and therapy that aims to treat mental disorders by investigating the interaction of conscious and unconscious elements in the mind. It brings repressed fears and conflicts into the conscious mind by techniques such as dream interpretation and free association.

Free association is a technique used in psychoanalysis and in psychodynamic

theory. It was originally devised by Sigmund Freud out of the hypnotic method of his mentor and colleague, Josef Breuer. Freud described it as such:

> "The importance of free association is that the patients spoke for themselves, rather than repeating the ideas of the analyst; they work through their own material, rather than parroting another's suggestions".

A psychodynamic theory is a view that explains personality in terms of conscious and unconscious forces, such as unconscious desires and beliefs. It was Freud who also proposed the psychodynamic theory, according to which personality consists of:

- the id, responsible for instincts and pleasure-seeking
- the superego, which attempts to obey the rules of parents and society
- the ego, which mediates between them according to the demands of perceived or learned reality

Psychodynamic theories commonly hold that childhood experiences shape personality. Such theories are associated with psychoanalysis, a type of therapy that attempts to reveal unconscious thoughts and desires.

Both were extremely undesirable concepts. The attempt was to instigate and permanently install into the public's psyche the idea (the perception and deception) that pharmaceutical drugs could and would cure mental disorders. This was reflected somewhat in the DSM-III 1980 publication. This edition ballooned to 494 pages and 265 diagnostic categories. It dropped the psychodynamic perspective in favour of empiricism, the purportedly philosophical school of thought that real knowledge comes from the senses. This ludicrous aspect of human beings was refuted by Socrates et al, who hugely begged to differ.

Granted, information gained in all sorts of study gives us knowledge. Is all of our knowledge based on empirical observations, though? That is what Moya K. Mason asks in *Socrates, the Senses and Knowledge: Is there Any Connection?* (moyak.com). Most would argue that the joys of learning and knowledge come from combining human sensory abilities with our brain's ability to compute and understand information. The more we try to learn and internalize, the better our brains seem to get with the series of actions and reactions that bring us wisdom. Are our senses an integral component in the search for wisdom, though? Plato and Socrates are two people who would differ in opinion.

The ancient Greek philosopher Plato wrote the *Phaedo*, a dialogue of Socrates'

execution. In it, Socrates argues that the senses do not grasp reality in any way. He believed that a philosopher's "concern is not with the body but . . . [with] the soul." Mind you, for the ancient Greeks, the word 'philosopher' denoted a lover of wisdom or knowledge. Nowadays it is used to describe a multitude of concepts, such as a person who offers views or theories on profound questions in ethics, metaphysics, logic and other related fields. Or someone who establishes the central ideas of some movement, cult, etc. Sometimes we use it for a person who regulates his or her life, actions, judgments and utterances by the light of philosophy or reason. It can also mean someone who is rationally or sensibly calm, especially under trying circumstances. It can even refer to an alchemist or occult scientist. Go figure — almost all of us human beings could thus describe ourselves as philosophers.

Socrates, however, was a philosopher who spent his entire life searching for the truths — the simple, uncomplicated and indestructible truths that make up knowledge. He believed that there was a division between the body and the soul, and that the body played no part in the attainment of knowledge. But hey, today's mental health practitioners and academics in general shun the concept of the God-given soul like it was molten gold dripping down their throats. Thus, out with psychodynamics, the attempt to solve human reactions to human problems with logic and reasons. And in with empiricism, the human being ruled solely by its senses, by its emotions, by its: "You hurt my feelings". Combine that with the trauma of political correctness, and one can't utter the truth at any time. That political correctness is a farce in itself, prohibiting truthful expression, and that no one has the power to hurt the other with words, unless the other allows it, is also swept under the rug.

In Socrates' opinion, the body is only concerned with pleasures such as food, drink, sex, material acquisitions and wealth. To him, the body, with all its needs, was an obstacle in the "search for knowledge," that never gave anyone an accurate account of anything. That no two people will ever hear or see the same thing in an identical way and, consequently, will never perceive sensory information in the same way, either, is also kept silenced. In other words, Socrates stated that human beings could not rely in any way on their senses as a source for knowledge, because information varied. To Socrates, knowledge was concrete, eternal, never changing. If relying on our senses, one would never learn the reality and truth of anything. To prove his point, he gave this example: He put a straight stick halfway into the water; it will look bent. Take it out, it looks straight again. What is it? Straight or bent? Our

senses tricking us? Another perception-deception of the senses by the senses?

But the latter is what formed the basis for the foundation of modern science, namely the reliance on what is termed *empirical evidence*, or evidence that is observable, generated by and combined with investigators'/researchers' senses. Is it therefore that scientific research results differ when observed versus unobserved? But what generated, and is the purported reason, for this big shift in the field of mental health from psychodynamic and free association to empiricism?

Was it that the public's perception of psychiatry at the time was far from favorable and that suspicion and contempt about it started to brew in America? Was it that psychiatric diagnosis was seen as unclear and unreliable, or even, perhaps, unpolished? Who knows, but mental health practitioners hastened to revise the DSM-II to publish a revised third edition in 1987. The new edition advocated German psychiatrist Emil Kraepelin's (1856–1926) hypotheses that biology and genetics played a key role in mental disorders, if not *the* role.

While proclaiming high clinical standards of gathering information by means of his own expert individual case-analysis, he also drew on reported clinical observations done by individuals untrained in psychiatry. After all, he grew up in the theatrical milieu. His father Karl Wilhelm was a former opera singer, music teacher, and later in life, a successful storyteller.

Even his lifelong interest in experimental psychology is reflected in today's PTSD treatment therapies. This was based on his theories, employing human participants and animal subjects to study and verify numerous topics. Some of those topics were:

- emotion
- learning
- memory
- cognition
- sensation
- motivation
- perception
- social psychology
- developmental processes
- the neural substrates of all of these

Pavlov's dogs and B.F. Skinner's caged two-year-old daughter spring to mind.

Thus, the authorities practice with enthusiasm on the afflicted, in complete disregard of the latter's health and wellbeing, both physical and mental. The H. J. Eysenck's Encyclopedia of Psychology identifies Kraepelinas as the founder of modern scientific psychiatry, psychopharmacology, and psychiatric genetics. Kraepelin's senses told him that the chief origin of psychiatric disease had to be the human's biological and genetic malfunction. His theories, which had dominated psychiatry at the start of the 20th century, enjoyed a tremendous revival at its end.

In the United States, Kraepelin's influence on psychiatry re-emerged in the 1960s. A group of Washington University St. Louis, MO, psychiatrists, Eli Robins, Samuel Guze, and George Winokur, were called the Neo-Kraepelins. They sought to return psychiatry to its medical scientific experimental state, as practiced in the Middle Ages. Why? Because of their dissatisfaction with the lack of clear diagnoses and classification. Because of low inter-rater reliability among psychiatrists. And because of the blurred distinction between mental health and illness.

Inter-rater reliability determines the extent to which two independent parties, each using the same tool or examining the same data, arrive at matching conclusions. Many health care investigators analyze graduated data, not binary data. In an analysis of anxiety, for example, a graduated scale may rate research subjects as "very anxious", "somewhat anxious", "mildly anxious", or "not at all anxious." Meanwhile, a binary method of rating anxiety might include just the two categories "anxious" and "not anxious." If the study is carried out and coded by more than one psychologist, the coders may not agree on the implementation of the graduated scale: some may interview a patient and find him or her "somewhat" anxious; another might assess the patient as being "very anxious." The congruence in the application of the rating scale by more than one psychologist constitutes its inter-rater reliability.

In statistics, *inter*-rater reliability (also called by various similar names, such as inter-rater agreement, inter-rater concordance, interobserver reliability, and so on) is the degree of agreement among raters. It is a score of how much homogeneity, or consensus, there is in the ratings given by various judges. In contrast, *intra*-rater reliability is a score of the consistency in ratings given by the same person across multiple instances. Inter-rater and intra-rater reliability are aspects of test validity. Assessments of them are useful in refining the tools given to human judges, for example by determining if a particular scale is appropriate for measuring a particular variable. If various raters do not agree, either the scale is defective or the raters need to be re-trained.

Inter-rater reliability is measured by a statistic called a kappa score. A score of 1 means perfect inter-rater agreement; a score of 0 indicates zero agreement. In psychosocial research, a kappa score of 0.7 or above is generally considered good. The neo-Kraepelins wanted to address these fundamental concerns and to avoid speculating on etiology. So, they advocated for descriptive and epidemiological work in psychiatric diagnosis. Such work is found in Kraepelin's textbooks, said to contain detailed patient-case histories and mosaic-like compilations of typical statements and behaviors from patients with a specific diagnosis. Therefore, he has been described as a scientific manager and a political operator who developed a large-scale, clinically oriented, epidemiological research program. (Engstrom, E. J. September 2007. On the Question of Degeneration by Emil Kraepelin [1908]. *History of Psychiatry* 18 [3]: 389–398. PMID; Shepherd, M. August 1995. Two faces of Emil Kraepelin; *The British Journal of Psychiatry* 167 [2]: 174–183.)

American psychiatrists changed their theoretical orientation toward an empirical foundation a la Kraepelin. This was reflected in the 1987 DSM-III, which in the process, revolutionized North American psychiatry. Ever since that time, nowhere can it been seen better than in the treatment modalities and therapies applied to PTSD-affected soldiers and veterans, fire fighters, police officers, and aircrew. They are experimented on from the get go, if in their infinite trustfulness and ignorance consenting to whatever is demanded of them by mental health practitioners. From vigorous pharmaceutical psychotropic and opioid drug consumption to ecstasy. Whatever their treating psychiatrist can dream up and concoct in ever-fertile hyper-active, left-side, scientific-dominating human and humane emotion-devoid minds. These get shuffled down their throats. Most obey, the numbers of homeless on the streets and of suicides proving it.

DSM-IV and -5 were merely DSM-III's ever more perfected versions. Inconsistencies in the system and instances of unclear diagnostic criteria were corrected. The DSM-IV involved more than 1,000 mental health practitioners and numerous professional organizations. They conducted comprehensive reviews of the literature to establish a firm empirical basis for making modifications before it was published in 1994. Numerous changes were made to classifications, new disorders were added, old ones deleted, and diagnostic criteria sets and descriptive text was re-organized.

Furthermore, the developers of the DSM-IV worked closely with those of the 10th edition of the ICD. The ICD is the World's Health Organization's (WHO) International Statistical Classification of Diseases and Related Health Problems.

They coordinated their efforts to increase congruence between the two systems and assure fewer meaningless differences in wording.

ICD is the foundation to identify health trends and statistics globally, and the international standard for reporting diseases and health conditions. It is the diagnostic classification standard for all clinical and research purposes. ICD defines the universe of diseases, disorders, injuries and other related health conditions, listed in a comprehensive and hierarchical fashion.

Its uses include:

- keeping track of safety and quality guidelines
- monitoring of the incidence and prevalence of diseases
- observing reimbursements and resource allocation trends

They also include the counting of deaths as well as:

- injuries
- diseases
- symptoms
- reasons for encounter
- external causes of disease
- factors that influence health status

The ICD's first international classification edition was known as the International List of Causes of Death. It was adopted by the International Statistical Institute in 1893. Its latest edition, the 11th Revision (ICD-11), sprung forth on June 18, 2018, in numerology calculation, another 666 publication-date.

I have not surveyed the ICD. I have surveyed the DSM-5, for the first time carrying a numerical rather than Roman letter description. It is a priceless piece of art of unimaginable human proportions in assumptions, presumptions, warped perceptions, deceptions, allusions, illusions and hallucinations. Such is its rendering of the human psyche by at least 1000 mental health practitioners of the highest educational and peer-reviewed calibers and standards.

As we shall see later, with the DSM-5's assistance, every natural God-given and innate human and humane emotion can with ease be twisted into a personality disorder. That includes anger, fear, disgust, contempt, joy, sadness, surprise, love, concern, empathy, happiness, compassion and mere contentment. This is contrary

to the DSM-III and -IV, by the way.

All DSM-5 diagnoses encourage and leave room for the possibility to, with clear conscience, declare any PTSD living, humane emotions a mental or psychiatric illness, as the wind blows. These can be applied to unsuspecting subjects at leisure. They can be applied based on the practicing mental health practitioner's individual perception, education, life-philosophy, like or dislike for the patient, or financial benefit and perks to be reaped from patient-treatment, There are 299 mental disorder classifications to facilitate human beings' destruction. Hundreds of self-proclaimed experts in all aspects of mental health worldwide contributed to create this poisonous, authoritative volume of destruction. It claims to define and classify humans' mental disorders to what end? To improve and streamline *their* diagnoses, their treatment and their research — all of them, I understand, psychiatrists of renown.

They devised innumerous diagnostic options to choose from. A multitude of them can be thrown at PTSD journeyers during the 10-year countdown few ever survive, before a pitiful settlement is offered. The leitmotiv? "If one diagnosis doesn't fly, let's try another." Ram it down their throats and see if that gets them to throw in the towel and walk away, out of our sight and off our books, as in mine and other WCB cases. Why? It ensures PTSD claimants' constant emotional upheaval and keeps them on perpetual guard and alert, a sure-fire way to prevent PTSD healing.

Ten classified PDs established in the DSM-5 are:

- Antisocial Personality Disorder
- Avoidant Personality Disorder
- Borderline Personality Disorder
- Dependent Personality Disorder
- Histrionic Personality Disorder
- Multiple Personality Disorder, see Dissociative Identity Disorder
- Narcissistic Personality Disorder,
- Obsessive-Compulsive Personality Disorder
- Paranoid Personality Disorder
- Schizoid Personality Disorder and Schizotypal Personality Disorder.

What is a personality disorder?

The website Psych Central is an independent mental health social network

created in 1995. It is overseen by mental health professionals. It states that personality disorders form a class of mental disorders characterized by long-lasting, rigid patterns of thought and behavior. Due to the inflexibility and pervasiveness of these patterns, they could cause serious problems and issues in a person's life. We further read that mental health practitioners and researchers view personality disorders as an enduring pattern of inner experience and behavior deviating markedly from the expectations of the culture of the individual exhibiting it.

To be diagnosed as a personality disorder:

- the onset of such deviant behavior pattern must be traceable back to at least the beginning of adulthood.
- A behavioral pattern must cause significant distress or impairment in personal, social and/or occupational situations.
- These features must be relatively stable across time and consistent across situations, and not solely be present due to the direct effects of a substance or general medical condition.

Nevertheless, in PTSD cases, pre-morbidity, co-morbidity, and inherent susceptibility for PTSD development since birth, in my case and that of others, is documented in this book as well as in *Broken Wings*. In my view, it is used consistently to destroy PTSD claimants' reputation, credibility and confidence in the Self.

Those 10 DSM-5 personality disorders are said to be more the product of historical observation than of scientific study. So, they are considered rather vague and imprecise constructs. As a result, they are said to rarely present in their classic "textbook" form, but instead tend to blur into one another. Neel Burton, M.D., explains this in his May 29, 2012, Psychology Today article "*The 10 Personality Disorders A short, sharp look into the 10 personality disorders*." Burton is a psychiatrist, philosopher, writer and wine lover living and teaching in Oxford, England.

The study of human personality or "character" as such is nothing new in acknowledged human history, he says. It dates back at least to antiquity. The word itself is derived from the Greek word *charaktêr*, the mark impressed upon a coin. Tyrtamus (371–287 BC) was nicknamed Theophrastus or "divinely speaking" by his contemporary, Aristotle. It was he who already had divided the people of Athens into 30 personality types, including categories of arrogance, irony and boastfulness.

Most people today recognize traits of themselves in many of the different

personality disorders seen by Tyrtamus. Many an individual qualifies for a personality disorder, Burton states.

It helps little, in his opinion, that the 10 DSM-5 mental health disorders are further categorized into three groups of Disorder Characteristics Clusters sharing common themes or elements. Cluster A encompasses odd, bizarre, eccentric, paranoid, Schizoid and Schizotypal Personality Disorder. It's worth looking at the diagnostic possibilities encased in the DSM-5. So, let's take Cluster A's Schizotypal Personality Disorder to see its endless delights for the usually imaginative mental health practitioner:

> "It is one of a group of conditions informally thought of as 'eccentric' personality disorders. People with these disorders often appear odd or peculiar. They also may display unusual thinking patterns and behaviors. People with schizotypal personality disorder may have odd beliefs or superstitions. These individuals are unable to form close relationships and tend to distort reality. In this respect, schizotypal personality disorder can seem like a mild form of schizophrenia — a serious brain disorder that distorts the way a person thinks, acts, expresses emotions, perceives reality, and relates to others. In rare cases, people with schizotypal personality disorder may eventually develop schizophrenia.
>
> "Symptoms of Schizotypal Personality Disorder? Display of a combination of odd behavior, speech patterns, thoughts, and perceptions. Other people often describe these individuals as strange or eccentric. Additional traits of people with this disorder include the following:
>
> - Dressing, speaking, or acting in an odd or peculiar way
> - Being suspicious and paranoid
> - Being uncomfortable or anxious in social situations due to their distrust of others
> - Having few friends and being extremely uncomfortable with intimacy
> - Tending to misinterpret reality or to have distorted perceptions (for example, mistaking noises for voices)
> - Having odd beliefs or magical thinking (for example, being

overly superstitious or thinking of themselves as psychic)
- Being preoccupied with fantasy and daydreaming
- Tending to be stiff and awkward when relating to others
- Coming across as emotionally distant, aloof, or cold"

You get the idea. This mouthful alone can sink a battleship of dynamic proportions. I trust no further examples of the DSM-5's ambiguity are needed to get my point across. You get the drift. But let's briefly quote the other Clusters to do due diligence to ourselves.

Cluster B signals dramatic, erratic, antisocial, borderline, histrionic and narcissistic PD.

Cluster C encompasses anxious and fearful behavior patterns.

All of these traits, of course, clarify the employability of firefighters, police officers, aircrew, soldiers and veterans and their success in their chosen occupations pre-PTSD-causing event, right?

The division into the three clusters is intended to reflect specific tendencies. In any given personality disorder, these most likely blur with other personality disorders within its cluster, Burton claims. He adds that the majority of people with a personality disorder never come into contact with mental health services. Those who do, usually do so in the context of another mental disorder. Or they do at a time of crisis, commonly after self-harming or breaking the law. As is easily ascertained even by laypersons, the categories are highly subjective. This explains the huge difference in psychological evaluations imposed on PTSD journeyers by mental health practitioners.

Only one thing is certain: in the course of the 10 years from beginning to end of the trip through hell, any and all of those 10 categories will be pinned on the PTSD afflicted. They'll be pinned on soldiers, veterans, police officers, fire fighters and aircrew members. Which they pin depends on the multitude of practitioners doing the evaluation and their individual mood, imagination, idea of how a PTSD living individual ought to feel or not feel, personal like or dislike for the claimant, and their own country of origin, religion, race and color of skin.

The initial PTSD evaluation is normally conducted by a psychiatrist or a psychologist, hovering in a high chair in the shadows. The PTSD afflicted more or less crouches much closer to the floor. Natural or lamp light beams into the eyes to establish whether or not the patient fits the basic DSM PTSD. Here Cluster A, encompassing odd, bizarre, eccentric, paranoid, Schizoid And Schizotypal

Personality Disorder, is often favored. It fits PTSD experiencers' feelings shortly after the PTSD causing event, the strangers-in-a-strange-land symptom.

The DSM-5 allows the application of all three clusters. So, reaction to a PTSD-causing event is also blamed on previously existing personality susceptibility before the event ever occurred. This is the intention from the onset. I, for example, was deemed to be a feeble, scared kind of pussy from the moment of my birth, if 22 of the 24 evaluating my character and personality could have managed it. That my life's track record proved distinctly otherwise was inconsequential.

The way out for PTSD subjects? Awakening to their modus operandi, their intentions, they should be on high alert at all encounters. They must distinctively distrust all of them, regardless if working for the VA, the WCB, the airline, the police, the firefighters corporations or their respective unions. They should even distrust their own colleagues. Always presented as "S/he will help you get better," it is all bovine manure, deviation tactics throwing sand into PTSD claimants' eyes. These tactics tire them out, rattle them consistently between hope and despair, all for one purpose. Make them go away or, preferably, die fast.

Exaggerated? Not a bit. Only self-education on the avenues open to one's self-defense, calling their bluff, outwitting them, and proving them wrong in their assertions so detrimental to health and self-esteem — only those tactics lead to the path of recuperation, recovery and healing. Confirmation? Phil Hickey, in his March 2013 write-up entitled "DSM-5 Inter-Rater Reliability is Low", spoke about it. He raised the topic in relation to an article published by Jack Carney, DSW, on "Mad in America" earlier that year in the *American Journal of Psychiatry*. Only *one* DSM-5 "diagnosis" was higher than 0.7 (good) in the field trials. This was major neurocognitive disorder — essentially dementia.

- Major Depressive Disorder was 0.32.
- Antisocial Personality Disorder was 0.22.
- Obsessive-Compulsive Disorder was 0.31.

Even schizophrenia, the flagship "diagnosis," scored only 0.46.

Other values are also available in Jack's article. This means if one psychiatrist "diagnosed" a person with major depression, for instance, another psychiatrist was quite likely to come up with another "diagnosis." They were neither compatible nor consistent. Hickey also notes that people participating in field trials are on their best behavior, probably having studied the new criteria and conscious of the fact that

their findings were being checked and scrutinized.

This is important, because the American Psychiatric Association (APA) continues to push the notion that the DSM-5 manual is based on solid science. In fact, it isn't, and never has been. Its purpose is to create the *appearance of science*, and to provide an umbrella under which psychiatrists can do pretty much whatever they like. Here's a little known quote from the DSM-IV:

> "The specific diagnostic criteria included in DSM-IV are meant to serve as *guidelines* to be informed by clinical judgment and are not meant to be used in a cookbook fashion. For example, the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe." (p xxiii)

In lay circles this is known as: "Having your cake and eating it too." Or perhaps it could be called "fuzzy science," Hickey asks. It also means that any research based on the DSM-5 is fundamentally flawed, because the whole mental illness concept is fundamentally flawed. Furthermore, Hickey states, agreement-figures for the DSM-5 are also noticeably poorer than the figures for the DSM-IV, the likely reason for this being the APA's persistent desire to widen the net. One way to do this is to make the criteria less precise which inevitably means different inter-raters' will apply them differently.

So, will the APA scrap DSM-5 and start again? No, says Hickey, maintaining that the whole field has never been about *science* but about *marketing*. His prediction? They will either ignore the poor reliability matter or spin it somehow into a positive feature. For instance, they might try to promote the notion that psychiatrists are less concerned about excessive fastidiousness than with providing real help to real people, to add with aplomb: "If there's one thing the APA is good at (and it may well be the *only* thing), it's spin!" And you, the PTSD experiencer, trust them with your life after reading this? If you do, you deserve precisely what you get.

To prove my point, even before replacing the DSM-IV, mental health practitioners were highly concerned about DSM-5 criteria. This is clear from a 2011 *Letter to the DSM-5 Task Force and the American Psychiatric Association,* submitted by Brent Robbins on behalf of the Society for Humanistic Psychology. Robbins is associate professor of psychology at Point Park University in Pittsburgh, Pennsylvania. His areas of research include grief, humor, self-consciousness,

spirituality/religion, death, anxiety and body medicalization. His online petition garnered endorsements from:

- over 15,000 individuals
- 50 professional organizations
- 15 additional American Psychological Association divisions

Those endorsements addressed the following topics:

- " . . . clients and the general public are negatively affected by the continued and continuous medicalization of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation."
- "The putative diagnoses presented in DSM-V are clearly based largely on social norms, with 'symptoms' that all rely on subjective judgments, with little confirmatory physical 'signs' or evidence of biological causation. The criteria are not value-free, but rather reflect current normative social expectations."
- " . . . [taxonomic] systems such as this are based on identifying problems as located within individuals. This misses the relational context of problems and the undeniable social causation of many such problems."
- There is a need for "a revision of the way mental distress is thought about, starting with recognition of the overwhelming evidence that it is on a spectrum with 'normal' experience" and the fact that strongly evidenced causal factors include "psychosocial factors such as poverty, unemployment and trauma."
- An ideal empirical system for classification would not be based on past theory but rather would "begin from the bottom up — starting with specific experiences, problems or 'symptoms' or 'complaints'."

The APA by and large ignored all concerns. That includes the frequently voiced concern of the DSM-5's lower diagnostic threshold. The fear was that it might artificially inflate the prevalence of numerous disorders. This would increase the

number of people "qualifying" for a mental disorder diagnosis. That, in turn, would lead to excessive medicalization and stigmatization of normative or *transient normally occurring human emotional distress.* That's my "childbirth and hangnail" PTSD diagnose hypothesis manifested.

Other potential consequences of the DSM-5's lower threshold and new disorder categories would negatively impact children and the elderly. They are already at risk for excessive and inappropriate medications treatment and their dangerous side effects, Robbins stated. Furthermore, the overuse of medications raised concerns for:

- Mild Neurocognitive Disorder
- Generalized Anxiety Disorder
- Attenuated Psychosis Syndrome
- Disruptive Mood Dysregulation Disorder
- Attention Deficit/Hyperactivity Disorder

All can with ease be attached to PTSD-affected people and all lack empirical, scientific evidence substantiating their existence.

Unprecedented levels of criticism concerned Human Psychology Society members. They demanded an external review by scientists and scholars appointed by people unaffiliated with the APA.

Where did it all stand in June 2018? The Global Summit on Diagnostic Alternatives (GSDA) Global Platform for Rethinking Mental Health was convened online May 2013–February 2015, and in Washington, DC, August 5–6, 2014." It generated many new initiatives and having fostered a conversation that will no doubt continue in other professional venues for quite some time." Further activities are suspended, and the site, DX summit, was permanently archived as documentation of historical discussions. Participants are encouraged to continue envisioning the future of mental health. But the thrust for DSM-5 changes was silenced.

Henceforth, PTSD, depression, alcohol and substance abuse, panic disorder and other normal human life experience and anxiety causing disturbances are considered human mental disorders. They therefore need pharmaceutical drugging with oxycodone, fentanyl, Ativan, Prozac, and the like. This would *improve* "sufferers" pain while simultaneously enhancing acute and desperate desires of suicidal fits.

For PTSD experiencers, however, nothing changed. The assumption of their mental impairment long before the PTSD causing event continues to be advertised. This, despite or because of the lack of empirical scientific proof. Engaged in their own fantasies and fishing expeditions, mental health professionals continue to drug their PTSD patients. Often, if not always, having chosen the path of psychology as a profession because of their own mental deficiencies and warpedness, their lucrative judgment of others provides them with endless excuses for non-self-examination and superb financial rewards. Most of them are devoid of human emotions anyway. They are unable to fathom or even evaluate the consequences for those they brutalize. They are alien to the concept "What goes around comes around" or the maxim "as you do onto others, it shall be done to you." They seem to be equally alien to the concept of God's creation of humans' immortal soul.

But there is a clincher. In February 2017, Jon Rappoport wrote "The number-one mind-control program at US colleges; If you're a college student or have a child at college, read this, the unspoken secret in plain sight." He writes that the National Alliance on Mental Illness (NAMI) claims more than 25 percent of college students have been diagnosed or treated for a mental health condition within the past year. In other words, "Colleges are basically clinics. Psychiatric centers."

We are told by "NAMI on Campus Because Mental Health Matters" that those challenges are even more difficult for students. One in five in students face a mental health condition while on campus, because nearly three-quarters of human mental health conditions emerge by age 24. This means many college students face mental health concerns for the first time while on campus and may not know where to go for support. Mind you, it is now offered right there on campus by NAMI.

Age 24, therefore, is the age stipulated to be when innate human mental illnesses have manifested in human beings. At that age, most police force, firefighters, soldiers, veterans and aircrew have already been hired. In fact, we have worked for years, due to our stability and personality in relationship to the work we were performing to obvious satisfaction of our bosses. If suffering an innate mental disorder, it would have manifested shortly after starting our careers, considering the high-pressure jobs in which we engaged. If statistics were kept, it would also be clear that those incurring PTSD would do so beyond the age 24, not ahead of it. And those only after numerous near catastrophic events.

You want to know where violent aggressive behavior on campus and in PTSD voyagers originate? "You want to know why so many college students can't focus on their studies?" ask Rappoport. You want to know why many PTSD voyagers can't

focus on helping themselves? Pharmaceutical drugs affect their brains, which cease to function properly. As for the college student, so for PTSD-afflicted people. For the former, a healthy person suffering a little Lebenschmerz, the drug prescribed on campus may lead to ruination of their life. This is due to the trust they place in mental health practitioners out of pure ignorance and lack of knowledge. For PTSD journeyers experiencing the same treatment assigned by the VA, the WCB, and the Police or fire fighters, it most often means complete destruction. This is also due to ignorance, even though the knowledge is at our fingertips.

If I refuse to educate myself, I have to accept the results. No one else can be blamed for my laziness and lethargy, my feelings of victimhood and my sloth. It is I who, as a grown-up, am responsible for my actions. It is I who am responsible for the effects of drugs I voluntarily swallow. It is I who must suffer the consequences, I who refuse to see the light to help myself. I am the one who allows myself to become someone else's victim. I am the one who always finds excuses for not springing into action. It is I who refuse to take responsibility for myself and fan the fire in my soul into a high-shooting flame. As Rappoport states:

> " . . . the drug he's taking [the student, the PTSD experiencer] is disrupting his thoughts and his brain activity. But of course, the psychiatrist tells him no, it's not the drug; it's the condition, the clinical depression, which is worsening and making it harder to think clearly. He needs a different drug. The student [PTSD experiencer] is now firmly in the system. He's a patient. He's expected to have trouble coping. And on and on it goes."

A new joiner of the zombie society. Rings a bell?

Another weakness of using the DSM-5 in clinical practice is that it is highly likely to result in unreliable diagnoses. Associate professor of psychiatry, Ahmed Aboraya et al., pointed this out. One of the reasons was that practitioners simply do not have sufficient time to spend on the necessary patient interviews and rating scales to reach a proper diagnosis. It was also noted that these instruments interfered with the therapeutic rapport necessary for successful patient treatment. In other words, although it may in theory be possible with the help of the DSM-5 and rating scales to make a reliable diagnosis, in practice there are many reasons why this might be difficult.

Ahmed S. Aboraya, MD, DrPH, by the way, is the assistant professor/chief of psychiatry of William R. Sharpe, Jr. Hospital, located in Weston, West Virginia. It

operates under the direction of the West Virginia Department of Health and Human Resources. It's an acute care psychiatric facility with 150 beds and full accreditation from The Joint Commission on Accreditation of Healthcare Organizations. What's that, you may wonder?

It is another so-called independent, not-for-profit organization. It accredits and certifies nearly 21,000 health care organizations and programs in the United States. Its Joint Commission accreditation and certification are apparently recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain unmentioned performance standards. Its Mission: to continuously improve health care for the public in collaboration with other unmentioned stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. But of value to whom? Its Vision Statement: "All people always experience the safest, highest quality, best-value health care across all settings." Nice. Wonder how many PTSD-affected soldiers and veterans Sharpe hosts?

If any, do they, too, have experts turning a colossal existential crisis into a never existing mental illness. Are they also treating it in ways that make PTSD sufferers a hundred-fold sicker than they ever were before the PTSD causing event hit without them either knowing or wanting to know about it? Is it really, as Jon Rappoport claims in May 3, 2018, when stating:

> "Wherever you see organized psychiatry operating, you see it trying to expand its domain and its dominance. The Hippocratic Oath to do no harm? Are you kidding?"

Whichever way, it is a fact that the psycho-the-rapists, the psychologists, and the mighty psychiatrists with full DSM-5 approval now are empowered to find diagnoses to declare a PTSD patient completely mentally defective since the moment of birth. Or they can declare them as ineligible for financial assistance due to malingering, congenial lying or thieving. In fact, they can declare them ineligible for almost any reason suitable to the cause of the employing corporation or agency to boost shareholders profits and the bottom line overall. The PTSD claimant is thus successfully cut off at the knees. The powers that be live a bonanza.

For PTSD-afflicted humans, however, this literally means they have to decide their own fate. They must either sink or swim by way of their ability to maintain themselves financially. They must take up the battle cry: "Not with me!" They must adopt the Dharma versus Karma attitude to avoid sinking into the destitution of skid-row and shelter living, or to commit suicide in one way or another. Until

recently, that is. Then a bomb hit the world of psychiatry, unfortunately little reported by mass media. It would be devastating to the world of mental health practitioners. It is priceless, and good for a chuckle, as it all revolves around the DSM-5.

37

The Truth About DSM-5 Diagnoses

The greatest event in hitherto all mental health profession events was the admittance by one of their own about the invention of mental disorders. It was gloriously swept under the rug by mass media outlets. One of the great psychiatric stars of this century went public blowing the whistle on himself and his colleagues. His name is Dr. Allen Frances. In 1994, he headed up the project to write the DSM-IV defining, describing and labeling, as we have seen, every official mental disorder humanly possible. *New York Times* journalist Daniel Goleman wrote "*SCIENTIST AT WORK: Allen J. Frances; Revamping Psychiatrists' Bible*" April 1994. He called Frances "Perhaps the most powerful psychiatrist in America at the moment . . . ". Frances had been sculpting the entire canon of diagnosable mental disorders for his

colleagues, for insurers, for the government and for Big Pharma, who would sell tailor-made drugs to match DSM-IV diagnoses. The DSM-IV eventually listed 297 of them. But otherwise, for years, few others seem to notice.

Born 1942 in New York City, New York, Frances' early career was spent at, yes, the private Cornell University Medical College. He rose from the rank of professor to, in 1991, become Duke University's School of Medicine's Chair of the Department of Psychiatry. He was also the *Journal of Personality Disorders* and the *Journal of Psychiatric Practice* founding editor.

Frances chaired the task force that produced the fourth DSM-IV revision. But as time went by, he became distinctly critical of the DSM-5. He warned that the expanding boundary of psychiatry would cause a diagnostic inflation. It would swallow up normality. The over-treatment of the "worried well" would distract attention from the core mission of treating the more severely ill. In 2013, Frances already publicly claimed, "psychiatric diagnosis still relies exclusively on fallible subjective judgments rather than objective biological tests". But by that time it was, in a way, old news. The punch line already came in December 2010, long after the DSM-IV had been put into print.

In an interview with *Wired*'s Gary Greenberg, entitled "Inside the Battle to Define Mental Illness" Frances said:

> "There is no definition of a mental disorder. It's bullshit. I mean, you just can't define it. . . . these concepts are virtually impossible to define precisely with bright lines at the boundaries."

Why did he come out of a seemingly contented retirement? He launched a bitter and protracted battle with those who were creating the *DSM-5,* some of them his friends. He criticized them not just once, and not in professional mumbo jumbo that would keep the fight inside the professional family. He had his say repeatedly and in plain English in newspapers and magazines and blogs. He accused his colleagues not just of bad science, but of bad faith, hubris and blindness. He accused them of making diseases out of everyday suffering and, as a result, padding the bottom lines of drug companies.

These were not new accusations levelled at psychiatry, either. What was new is that Frances used to be their target, not their source, writes Greenberg, a practicing psychotherapist himself. He wrote" "He's hurling grenades into the bunker where he spent his entire career." Frances claims, however: "We made mistakes that had terrible consequences." Diagnoses of autism, attention-deficit hyperactivity disorder

and bipolar disorder skyrocketed. Frances thinks this was due to his manual inadvertently facilitating these epidemics. In the bargain, it fostered an increasing tendency to chalk up life's difficulties to mental illness and then treat them with psychiatric drugs.

As we saw, by 2011, the insurgency against the *DSM-5* had spread far beyond just Dr. Allen Frances. Psychiatrists at the top of their specialties, clinicians at prominent hospitals, and even some contributors to the DSM-5 edition expressed deep reservations about it. Most of the dissenters squealed about making their concerns public. It seems there was a surprisingly restrictive nondisclosure agreement that all insiders were required to sign. But they were becoming increasingly restive. Some even began to agree with Frances that public pressure might be the only way to derail a train that he feared would "take psychiatry off a cliff."

This book, this manual, this call-it-what-you wish, is the basis of psychiatrists' authority to pronounce upon human beings' mental health. It lets them command health care dollars from insurance companies for treatment and from government agencies for research. It is as important to psychiatrists as the Constitution is to the United States government and the Bible to Christians, Greenberg states. But the DSM rules outside the profession, too, serving as the authoritative text as well for psychologists and social and other mental health workers. It is invoked by lawyers in arguing over the culpability of criminal defendants. Parents seeking school services for their children refer back to the DSM. If the DSM-5 were the "absolute disaster" Frances deems it to be, it could cause a seismic shift in the way mental health care is practiced in the US. It could cause the APA to lose its franchise on humans' psychic suffering, the naming of rights to human pain. As already documented, all of it was of course rethought at the *Global Platform for Rethinking Mental Health* and peacefully put to rest. With it, mental health practitioners were granted license to destroy human lives at leisure. They could turn children into drug addicts in Kindergarten with or without parents' permission. And they could destroy PTSD travellers.

In 1986 already, the *International Journal of the Addictions* published a literature review by Richard Scarnati. It was titled "An Outline of Hazardous Side Effects of Ritalin (Methylphenidate)" [v.21 (7), pp. 837–841]. In it, he listed a large number of adverse effects of Ritalin and cited published journal articles reporting each symptom, often times as a consequence carried through life, such as the following:

- Toxic psychosis

- Paranoid delusions
- Paranoid psychosis
- Extreme withdrawal
- Visual hallucinations
- Amphetamine-like psychosis
- Aggressiveness and Insomnia
- Hypomanic and manic symptoms
- Activation of psychotic symptoms
- Terrified affect, Startled screaming
- Effects pathological thought processes
- Auditory hallucinations, Can surpass LSD in producing bizarre experiences

Ritalin is considered an amphetamine-type drug, so we are told to expect amphetamine-like effects. We also see

- psychic dependence
- decreased REM sleep
- high-abuse potential (DEA Schedule II Drug)

When used with antidepressants, one can see dangerous reactions, including hypertension, seizures and hypothermia. Convulsions and Brain damage can be seen with amphetamine abuse. In the US alone there are at least 300,000 cases of motor brain damage incurred by people prescribed so-called anti-psychotic drugs, aka "major tranquilizers." These are often prescribed for PTSD experiencers.

Risperdal, a drug given to people diagnosed with Bipolar, is one of those major tranquilizers (source: *Toxic Psychiatry*, Dr. Peter Breggin, St. Martin's Press, 1991). And the psychiatric drug plague seems to be accelerating across the land. As we will discover, every PTSD treatment modality favored by mental health practitioners, in particular those employed by the NC *for* the enhancement of PTSD, emphasizes the need to use pharmaceutical drugs. It is shortly to be augmented by marijuana, ecstasy and ganglion block to encourage PTSD recovery. According to a 2014 *JAMA Psychiatry* report, nearly one in four active military duty members showed signs of a mental health condition. With what do you think they are treated? Pharmaceutical drugs, of course. And that worsens the situation and the symptoms, not helps to heal them.

Another side-effect? The Centers for Disease Control and Prevention (CDC) in 2012 reported that drug overdose was the leading cause of injury and death. It kills 120 Americans every single day, 81.1 percent of them apparently unintentionally. In 2013, drug overdose accounted for nine out of 10 poisoning deaths. And 51.8 percent of all drug overdose fatalities were due to prescription drugs' nonmedical use. This inspired the CDC to label prescription drug abuse an epidemic as approximately 1.4 million people sought emergency treatment for pharmaceutical medication drug abuse in 2011 alone. Overdose deaths from illicit drugs seem also on the rise, mind you. The National Institute on Drug Abuse (NIDA) reported a 29 percent increase in cocaine overdose fatalities between 2001 to 2013 and a fivefold increase in heroin deaths between 2001 to 2013. Were PTSD journeyers among them? If so, who is to blame?

Mental health practitioners have an ever increasing right to rule society through their inane assumptions, presumptions and opioid drug distributions. This creates a sick-to-the-core society that refuses to, as Allan Frances suggested, apply public pressure to end the mental health practitioners' tyranny over the human population. But how can it, when drug consumption by its nature renders them docile and ignorant, turning whatever is good for it into bad, and what is bad good, killing all enthusiasm for life, the Mistake of the Intellect in full bloom? Combined with the lack of reason and logic, not taught in North American schools since the mid-1930s, it adds to the calamity. The ever increasing lack of reading and writing skills makes it worse. The general phlegmatic idea of holding Karma without recourse responsible for life's path grows popular, when nothing could be further from the truth.

The almost slavish trust in medical practitioners, regardless of genre, is another hindrance to turn this tide around. Doctors will not help you. Remember, true evil has a face you know and a voice you trust. Only you, and whoever is "out there" keeping an eye on you from the unseen, can help yourself. But, unless recognizing there is a problem, any problem, one cannot fix it. Most refuse, or cannot see a problem, neither with themselves nor with those purporting to treat, and thus help, them, even in their brightest moments.

Trust and ignorance, *the Doctor knows best syndrome*, laziness and refusal to educate the Self — that's what facilitates mental health practitioners' machinations. It allows anyone else of their league to destroy humans at leisure, and create the sixth root race: the Robo sapien, the soul or soulless human-hybrid AI creature. Dangling the trans-humanistic "You will be as God and never die" in front of our

noses, many are said to already engage in their own gene-therapy in their own garage-laboratories. But sooner or later, one will have to meet one's original Maker. Then, one will have to face up to how one waded, swam or sank through life in morass up through the nose or relatively love-imbued. At least, those with human souls will. For those journeying the PTSD path, however, this moment arises with the PTSD-causing event. The sink or swim moment of peacemaking with the life past in order to be able to begin a new one won't wait to the end. Were we to look for research on it, however, we would soon discover that this is the only path to a PTSD recuperation acknowledged in all its facets for thousands of years.

38

Gilgamesh's PTSD Epic

The best known of all ancient Mesopotamian heroes is Gilgamesh. Numerous tales have been told about him in the Akkadian language. The entire collection of his life has been described as the odyssey of a king who did not want to die. He was a king who feared death, a king seeking only immortality. I posit that it is an account of someone discovering the distinct possibility of death at any given moment of his life. The result is such an overwhelming feeling of meaninglessness of life and everything in it, such an overwhelming sense of futility of it all when one has to die anyway. Such meaninglessness strangles the Self into abject and indescribable despair and nothingness, other than robotic motion and the desire to just wait for death, as life has to end anyway regardless of one's endeavors in it. This

is the true essence of PTSD. This is what Gilgamesh experienced. This is when he went onto the quest to discover what this life, this existence, this earthly endeavor was all about, never mind the meaninglessness of it all, as he perceived it, or because of it.

As the semi-mythic 5th King of Uruk, Gilgamesh's life's story is known from *The Epic of Gilgamesh*. Uruk was one of the most important cities in ancient Mesopotamia. This region lies within the Tigris-Euphrates river system, roughly corresponding to most of Iraq, Kuwait, parts of Northern Saudi Arabia, the eastern parts of Syria, South-eastern Turkey, and regions along the Turkish–Syrian and Iran–Iraq borders. Uruk was founded by King Enmerkar sometime around 4500 BCE, according to the Sumerian King List. It was continuously inhabited until c. 300 CE when people began to desert the area. It lay buried until excavated in 1853 CE by William Loftus for the British Museum.

In the Aramaic language, Uruk was known as *Erech.* It is believed that this gave rise to the modern name for the country of Iraq, though another derivation may be *Al-Iraq*, the Arabic name for the region of Babylonia. Located in the southern region of Sumer, modern day Warka, Iraq, it is considered the first true city in the world. Writing and the wheel are said to have originated here. So did the first examples of architectural work of great stone structures in civilization. This includes the ziggurat, a type of massive stone structure with the form of a terraced compound of successively receding stories or levels.

The cylinder seal Mesopotamians used to designate personal property or used as a signature on documents was developed here. It stood for personal identity and reputation, thus recognizing the importance of the individual in the collective community.

Myths are traditional stories that address the various ways of living and being. The well-known myth of Gilgamesh has been cited in many sources as one of the first stories in recorded human history, originating from Mesopotamia, today's Iraq. The archaeologist Austin Henry Layard discovered the Epic's Akkadian version at Nineveh, in the ruins of the library of Ashurbanipal, in 1849 . The expedition was part of a mid-19th century initiative of European institutions and governments to Mesopotamia to find physical evidence to corroborate events described in the Bible. What these explorers found instead, however, was that the Bible — previously thought to be the oldest book in the world and comprised of original stories — actually drew upon much older Sumerian myths. One of those myths was the account of Gilgamesh written by a Middle Eastern scholar 2,500 years before the

birth of Christ.

For our modern accounts, it was only after the First World War that the Gilgamesh myth reached a wider audience. Only after the Second World War did it begin to feature in a variety of genres. This poetic work portraying the epic tale of his quest for the meaning of life and living is often regarded as the earliest surviving great work of Western literature. It pre-dates Homer's writing by 1500 years.

Some researchers maintained for the longest time that it was not just a fairy tale, but was based on elements of truth. This appears confirmed, since a 2003 German-led expedition discovered what is thought to be the entire city of Uruk. It included the last resting place of its famous King, where the Euphrates once flowed.

"I don't want to say definitely it was the grave of King Gilgamesh, but it looks very similar to that described in the epic," Jorg Fassbinder, of the Bavarian department of Historical Monuments in Munich, told the BBC World Service's *Science in Action* programme. In the book — actually a set of inscribed clay tablets — Gilgamesh was described as having been buried under the Euphrates, in a tomb apparently built when the waters of the ancient river parted following his death.

"We found just outside the city an area in the middle of the former Euphrates river the remains of such a building which could be interpreted as a burial," Fassbinder said (12160.info/forum/topics/gilgamesh-tomb-found-in-iraq-2003-giant-skeleton-found-retrieved; "Gilgamesh Tomb Found in Iraq, 2003 [Giant Skeleton Found & Retrieved]" Posted by 14300 on May 28, 2013 at 8:20am in Current News/Events).

James T. Kirk is a 12160 Social Network writer and journalist. He finds the discovery particularly interesting, as Gilgamesh was believed to be part human/part alien/angel, what we would call a hybrid. It is also interesting to note that Gilgamesh has been compared to and could very well be King Nimrod. He was the son of Cush, a descendant of Noah and the king of Babylon, says Kirk. This is the same Nimrod that built the Tower of Babel, also translated as 'Gateway to Heaven', to defy God.

Kirk mentions this because of the overwhelming amount of information that has recently come to light of DNA genetic manipulation and it's use in science and technology. He wonders if the Iraq "invasion" was a forward smoke screen to enable Western powers to gain ancient alien technologies. That might include DNA for future engineering and a possible resurrection/cloning of angels (Gilgamesh/Nimrod). Could US military PTSD-experiencing personnel be subjects of such experimentations?

Be it as it may, only a few tablets have survived from the original Sumerian texts. These date back to 2000 BC, and are written in cuneiform language. The Babylonian version is, however, two thirds complete and dates back to the 13th to 10th century BCE. Some of the very best copies were discovered in the 7th century in the library ruins of the Assyrian king, Ashurbanipal.

Gilgamesh's father is said to have been the Priest-King Lugalbanda. In the Sumerian language, this means young-fierce king who has magical abilities. He is listed in the postdiluvian period of the Sumerian king list as the second king of Uruk, ruling for 1,200 years. He is given the epithet of *the Shepherd*. Gilgamesh's mother was the goddess Ninsun or Ninsumun, known as the Holy Mother and Great Queen. Thus, Gilgamesh was a demi-god endowed with super-human strength. According to the Sumerian Kings List, he reigned for 126 years in the 26th century BCE.

Gilgamesh was seen as the brother of Inanna, one of the most popular, if not *the* most popular goddesses in all of Mesopotamia. She was the ancient Sumerian goddess of love, sensuality, fertility, procreation, and also of war. She later became identified by the Akkadians and Assyrians and many others as the goddess Ishtar, the Hittite Sauska, the Phoenician Astarte, and the Greek Aphrodite.

When the gods created Gilgamesh, they gave him a perfect body. Shamash, the glorious sun, endowed him with beauty. Adad, the god of the storm endowed him with courage. The great gods made his beauty perfect, surpassing all others, and made him terrifying like a great wild bull. Two thirds of him they made god, and one-third man, proclaim the Epic's opening lines (N. K. Sanders; Assyrian International News Agency, Books Online, www.aina.org).

Considered the strongest and most handsome man in the world, Gilgamesh was proud and arrogant. He is said to have spent most of his time in debauchery by engaging the city of Uruk's young men in endless athletic contests and sexually exploiting its maidens. Tired of his conduct, Uruk's citizens' appealed to the gods for help. Anu, Mesopotamians' god of the sky, belonging to the oldest generations of Mesopotamian gods and one of its supreme deities, heard their plea. The supreme deity in the Babylonian pantheon of gods, he allotted functions to other gods in heaven and conferred kingships on Earth. His decisions were regarded as supreme law.

In response to Uruk's pleas for help, Anu commanded the goddess Aruru to design a human match for Gilgamesh. Aruru was the surname of the Sumerian earth and fertility goddess, Ninhursag, in Mesopotamian mythology said to be

humankind's creator. Aruru created the one third human and two-thirds beast Enkidu as Gilgamesh's mirror image and placed him in the woods to live as one with the animals. A trapper met him at a watering hole. Terrified, he raced to Uruk seeking help from Gilgamesh, who advised sex therapy.

The temple-prostitute Shamhat was engaged to fulfill the task, zapping Enkidu's physical strength' during seven nights of sexual training. Taking a break, Enkidu, his mental horizon somewhat adjusted due to sexual exertions, we learn: " . . . drew himself up, for his understanding had broadened" (1.183–184), as he now expressed a desire for masculine companionship. Shamhat tells him about Gilgamesh, his strengths, his pursuits and activities. Enkidu enthusiastically exclaimed:

> "I will challenge [Gilgamesh] . . . Let me shout out in Uruk: 'I am the mighty one!' Lead me in and I will change the order of things; he whose strength is mightiest is the one born in the wilderness!" (1.200–204).

Gilgamesh, by way of his dreams, knew shortly before their first meeting took place, that a new friend would be entering his life. Nevertheless, when first meeting Enkidu, they engaged in a fierce battle in which neither was bested. Rather than continuing in their pissing contest, they became best friends and, the gods watching with disdain, embarked on adventures of mischief and destruction.

Their main offenses? They killed the monster Humbaba the Terrible, a demigod giant of immemorial age. He was a terror to human beings and guardian of the Cedar Forest, where the gods of the glorious realm of Mesopotamian mythology lived under his protection. Gilgamesh, in his quest for fame, decapitated him with his sword, Enkidu in tow. He also dared to cut down the forest's tallest cedar tree from the virgin cedar stands.

They killed the Bull of Heaven sent to Earth by Anu. The Bull was sent to destroy crops and people, after Gilgamesh had upset his daughter, the goddess Ishtar, whom he refused to marry. The Bull's killing was the final straw. It so infuriated the gods, that they convened a meeting to discuss Enkidu's and Gilgamesh's behavior. The Great Anu had decreed that either Enkidu or Gilgamesh would be punished for their deeds. All that remained was to decide which was to die for the killing and other havoc they had wreaked.

Enkidu, in a terrifying nightmare, saw it all unfolding as he cried to Gilgamesh:

> "O my brother, such a dream I had last night. Anu, Enlil, Ea and heavenly Shamash took counsel together, and Anu said to Enlil, 'Because they have killed the Bull of Heaven, and

> because they have killed Humbaba who guarded the Cedar Mountain one of the two must die.' Then glorious Shamash answered the hero Enlil, 'It was by your command they killed the Bull of Heaven, and killed Humbaba, and must Enkidu die although innocent?' Enlil flung round in rage at glorious Shamash, "You dare to say this, you who went about with them every day like one of themselves!"' So Enkidu lay stretched out before Gilgamesh; his tears ran down in streams and he said to Gilgamesh, ' O my brother, so dear as you are to me, brother, yet they will take me from you.' Again he said, 'I must sit down on the threshold of the dead and never again will I see my dear brother with my eyes."' (N.K. Sanders)

Shortly thereafter, Enkidu fell desperately ill. After another terrifying dream, he told the terribly distraught Gilgamesh that he saw him pleading Enkidu's case in front of the council of the gods. Enlil, the god of wind, air, earth and storms, however, had adamantly denied Gilgamesh's plea.

Then Enkidu himself began to cry out for mercy and assistance, appealing to the sun god Shamash to be sympathetic to their case. It was to no avail. The only response conveyed was that when Enkidu died, Gilgamesh would wander the earth undone by grief.

Another terrible dream followed.

> "As Enkidu slept alone in his sickness, in bitterness of spirit he poured out his heart to his friend. 'It was I who cut down the cedar, I who levelled the forest, I who slew Humbaba and now see what has become of me.'
>
> "Listen, my friend, this is the dream I dreamed last night. The heavens roared, and earth rumbled back an answer; between them stood I before an awful being, the sombre-faced man-bird; he had directed on me his purpose. His was a vampire face, his foot was a lion's foot, his hand was an eagle's talon. He fell on me and his claws were in my hair, he held me fast and I smothered; then he transformed me so that my arms became wings covered with feathers. He turned his stare towards me, and he led me away to the palace of Irkalla, the Queen of Darkness, to the house from which none who enters ever returns, down the road from which there is no coming

back.

"There is the house whose people sit in darkness; dust is their food and clay their meat. They are clothed like birds with wings for covering, they see no light, they sit in darkness. I entered the house of dust and I saw the kings of the earth, their crowns put away for ever; rulers and princes, all those who once wore kingly crowns and ruled the world in the days of old. They who had stood in the place of the gods like Ann and Enlil stood now like servants to fetch baked meats in the house of dust, to carry cooked meat and cold water from the water-skin. In the house of dust which I entered were high priests and acolytes, priests of the incantation and of ecstasy; there were servers of the temple, and there was Etana, that king of Dish whom the eagle carried to heaven in the days of old. I saw also Samuqan, god of cattle, and there was Ereshkigal the Queen of the Underworld; and Befit-Sheri squatted in front of her, she who is recorder of the gods and keeps the book of death. She held a tablet from which she read. She raised her head, she saw me and spoke: 'Who has brought this one here?' Then I awoke like a man drained of blood who wanders alone in a waste of rashes; like one whom the bailiff has seized and his heart pounds with terror.

"This day on which Enkidu dreamed came to an end and be lay stricken with sickness. One whole day he lay on his bed and his suffering increased. He said to Gilgamesh, the friend on whose account he had left the wilderness, 'Once I ran for you, for the water of life, and I now have nothing:' A second day he lay on his bed and Gilgamesh watched over him but the sickness increased. A third day he lay on his bed, he called out to Gilgamesh, rousing him up. Now he was weak and his eyes were blind with weeping. Ten days he lay and his suffering increased, eleven and twelve days he lay on his bed of pain. Then he called to Gilgamesh, 'My friend, the great goddess cursed me and I must die in shame. I shall not die like a man fallen in battle; I feared to fall, but happy is the man

> who falls in the battle, for I must die in shame.' And Gilgamesh wept over Enkidu.
>
> "He touched his heart but it did not beat, nor did he lift his eyes again. When Gilgamesh touched his heart it did not beat. So Gilgamesh laid a veil, as one veils the bride, over his friend. He began to rage like a lion, like a lioness robbed of her whelps. This way and that he paced round the bed, he tore out his hair and strewed it around. He dragged of his splendid robes and flung them down as though they were abominations."

Gilgamesh, all-powerful King of Uruk and its people, son of man and goddess — semi-god, thinking himself imbued with superhuman powers and abilities, suddenly recognized that his earthly powers lacked the jurisdiction over life and death, his own included. Unable to save Enkidu's life, he began to question his own mortality. He questioned the hegemony of the gods over his fate and destiny, which, I posit, leads him into an existential crisis of colossal proportions, nowadays termed PTSD. What did he do to heal himself, metaphorically speaking?

In the first light of dawn, he cried out to Enkidu:

> "I made you rest on a royal bed, you reclined on a couch at my left hand, the princes of the earth kissed your feet. I will cause all the people of Uruk to weep over you and raise the dirge of the dead. The joyful people will stoop with sorrow; and when you have gone to the earth I will let my hair grow long for your sake, I will wander through the wilderness in the skin of a lion."

For seven days and seven nights, Gilgamesh lamented and wept for Enkidu, until the worms fastened on him. Only then, he gave him up to the earth, for the Anunnaki, the judges, had seized him. Then Gilgamesh issued a proclamation throughout the land. He summoned them all, the coppersmiths, the goldsmiths, the stone-workers, and commanded them, "Make a statue of my friend."

The statue was fashioned with a great weight of lapis lazuli for the breast and of gold for the body. A table of hard wood was set out, and on it a bowl of carnelian filled with honey, and a bowl of lapis lazuli filled with butter. These Gilgamesh exposed and offered to the Sun. Weeping, he went into the wilderness, desolate with sorrow, and wondering about the reason and meaning of life. He questioned his own mortality, and grieved for what once was and never could be again. On his

perilous journey, he was forced to fight ferocious serpents and wild lions, whilst travelling through bitterly cold caves, across scorching deserts and over the fatal waters of the Sea of Death. It finally led him to the palace of Utnapishtim, the only human who knew the secret of immortality.

The name Utnapishtim means "He Who Saw Life," though "He Who Saw Death" would be just as appropriate. He had witnessed the destruction of the entire world as survivor of a mythological flood. Gilgamesh consulted him about the secret of immortality. Utnapishtim was the only man to escape death. He preserved human and animal life in the great boat he built, and he and his wife were deified by the father of the gods Enlil. Utnapishtim directed Gilgamesh to a magical plant, a flower of eternal youth. Before he could eat the flower, the goddess Ishtar ate it herself. In this way, she exacted her revenge for the deeds committed by Gilgamesh and Enkidu. At this moment, Enkidu finally surfaced from the underworld to show Gilgamesh true immortality: a king who will be remembered for his good deeds, courage and love for his people (The Epic of Gilgamesh; English version by N. K. Sandars, Penguin Classics, pp. 61–125, Chapter 3, p.20).

In time Gilgamesh's destiny decreed by Enlil was fulfilled:

> "In nether-earth the darkness will show him a light: of mankind, all that are known, none will leave a monument for generations to come to compare with his. The heroes, the wise men, like the new moon have their waxing and waning. Men will say, 'Who has ever ruled with might and with power like him?' As in the dark month, the month of shadows, so without him there is no light. O Gilgamesh, this was the meaning of your dream. You were given the kingship, such was your destiny, ever lasting life was not your destiny. Because of this do not be sad at heart, do not be grieved or oppressed; he has given you power to bind and to loose, to be the darkness and the light of mankind. He has given unexampled supremacy over the people, victory in battle from which no fugitive returns, in forays and assaults from which there is no going back. But do not abuse this power, deal justly with your servants in the palace, deal justly before the face of the Sun" (ibid: Chapter 7, p.33).

Like the PTSD-causing event in PTSD journeyers, the shock that higher entities, higher gods were ruling over him disrupted his psyche. He was a proud, arrogant,

debauchery- and violence-prone individual. He was terrifying and all-powerful, who sacrificed warriors whenever he felt like fighting. He raped his nobles' wives. He took whatever he wanted from his people. He trampled anyone who got in his way, harassing them like a wild ox. He was the King of Uruk, semi-god, yet unable to prevent Enkidu's death. The question of whether or not he, too, was mortal, forced Gilgamesh to make a choice. He had to either face himself and search for the meaning of life and everything in it, or cave in to perpetual misery, most likely expressed in more acts of brutality and terror against his subjects.

Gilgamesh's fear of death however, is, I venture to opine, a fear of the meaninglessness of life and everything in it. Consider that we die anyway, regardless of our travels through it. Thus, it is the quest itself that gives his life meaning, Joshua Mark contends. This theme has been explored by writers and philosophers from antiquity up to the present day. It is through his struggle to find meaning in life that Gilgamesh defies death. In doing so, he becomes the first epic hero in world literature. Gilgamesh's grief and the questions his friend's death evoke resonate with every human being who has wrestled with the meaning of life in the face of death and the refusal to accept what seemingly, unless closely examined, is meaningless. It is Gilgamesh's psychological odyssey against this apparent meaninglessness that defines him, just as it defines PTSD journeyers.

Like him, I chose to find answers to my questions, to pursue the course of helping my Self, rather than have others dictate their answers to my predicament to me.

As it did for Gilgamesh, my course changed my perception of life, its meaning, the role I could play or decline to play in it.

Like him, I questioned my attitude, my behavior, my purpose of actions and deeds committed in the past and present. I questioned my ideas for Self in the future. I examined and slowly discovered the enormous powers I have, or the lack thereof and why. I examined my possibilities for change within myself, and how my thinking had to change if I was to change. Every day, I examined who I wanted to be and how to get there. I still do.

Gilgamesh, like every PTSD experiencer, had to, unconsciously or otherwise, make the decision whether to live or die. It's not a physical death by laying hand on himself, but a death manifested by petrifying into stagnation, to become a victim by one's own decree and volition. The questions arising in his mind could be answered only by him, the one walking through the valleys of his own wilderness. Those were the abysses of the pre-PTSD causing event, perceived as misdeeds and debaucheries.

During this odyssey of the mind, this soul-searching exercise, through research and contemplations, the answers for absolution will present themselves. Gilgamesh recognized that honor, integrity, graciousness, kindness and goodwill towards all human beings and creatures alive is the way to live life. He saw that there truly is a reason for everything under heaven, including the PTSD experience. Only then did his healing occur.

For Gilgamesh, also known as "Bilgames" in the Sumerian and "Gilgamos" in Greek, the destiny decreed for him by the father of the gods, Enlil of the mountain, was fulfilled.

The result was profound. Later Mesopotamian kings would invoke his name and associate his lineage with their own to elevate their reign in the eyes of the people. Most famously was Shulgi of Ur (2029–1982 BCE), considered the greatest king of the Ur III Period (2047–1750 BCE) in Mesopotamia. He claimed Lugalbanda and Ninsun as his parents and Gilgamesh as his brother. In royal hymns of the Ur III period, Ur-Nammu of Ur and his son Shulgi describe Lugalbanda and Ninsun as their holy parents, and in the same context call themselves the brother of Gilgamesh. Sin-Kashid of Uruk also refers to Lugalbanda and Ninsun as his divine parents, and names Lugalbanda as his god.

The result for mere mortals? While walking through hell, we slowly gather strength. Almost imperceptibly, we discover and recognize the ever increasing power we have. This power comes when steadfastly applying discipline, determination, persistency and willpower to regain and retain it. We can stop those wanting to trap us in the victim status, which spells the end of our sui generis. Engage to beat PTSD by engaging Dharma over Karma as Gilgamesh did. Or live miserably to the end of our natural lives by trusting others to live that life in accordance with their perceptions, their rules and their ideas about a PTSD recovery. If we do, we squander away into nothingness our chance to create of ourselves an individual of our own liking. We squander away a chance of a lifetime. The choice is ours.

What is the result, if we succeed in overcoming the PTSD–overwhelmed Self, the futility and meaninglessness of it all?

We already lost the fear of death while awaiting the physical death that never came during the PTSD-causing episode. With it, and much later, arose the idea of being immortal, of being infinite consciousness. Could we have chosen this life's experience, perhaps even for our amusement? Our entertainment and spiritual growth? Could the choice have been for learning and understanding whatever it

might be. Did we need to realize that many a time true evil has a face we know and a voice we trust? Did we seek to understand that we are never alone, that there are guides, guardians, helpers, teachers and friends in the unseen and here on earth to help us? For Gilgamesh in his lofty heights of ancestry, they were the gods; for us, they are the *Touched by an Angel* beings. If we look, observe, think about it, we meet them anywhere in the world whenever we find ourselves in trouble.

Thus the PTSD journey in essence is an odyssey of learning. It can only be successfully travelled with twice-daily meditations, by listening to the small voice within guiding us, by observing and making notes of our dreams. We must listen to our intuition more than to our head. We must avoid taking pharmaceutical drugs, marijuana, ecstasy, stellar ganglion, or whatever else is suggested or advertised as PTSD healing. It might also help to cling to the thoughts expressed by Findhorn's Eileen Caddy in her March 2018 guidance:

> "All is well. Never accept seeming setbacks. Simply know the answer is there and leave no stone unturned to find it. Flexibility is very necessary. So be very positive and know all is well for all is in My hands."

And in her August 2018 guidance

> "Never accept defeat over anything simply know you can do something about it. Look for the way and it will open for you . . . Seek within and become very, very still and find that infinite power within you. Then use that power and send it out into that dark and gloomy situation. Remember, it only takes a tiny spark to light a light and you can be that tiny spark . . . "

The decision is ours. We have the power to make this journey, this odyssey of PTSD, and heal heart and soul to live heaven on earth. Or we decline and wither in misery until our natural death. It is that simple, albeit at times tedious.

One has to kick the Self into action, I found. This may continue until time's up, when departure to heavenly realms occurs with a sigh of relief and joy. After all, one has done it. One has overcome the Self. One has regained one's stamina, one's confidence and trust in Self and one's abilities and much more. One needs to see, sooner or later, that it is all a joke, an illusion, a hallucination a la *The Truman Show* created by the Self in accordance with one's own thinking. It is manifested by one's behavior towards the Self, and consequently the Other in league with the honor, integrity and graciousness principles, the "Thoughts are things" theory.

If it indeed is so, we can create heaven or hell for ourselves all by ourselves, as Gilgamesh discovered. Prayers inscribed on clay tablets address him in the afterlife as a judge in the Underworld comparable in wisdom to the famous Greek three judges of the Underworld: Rhadamanthus, Minos and Aeacus.

They judged the heart of each soul that enters the Underworld. Souls deemed righteous were allowed to enter the Elysium Fields, while souls deemed as being evil were sentenced to the depths of Tartarus. They were the sons of Zeus and Europa.

They were originally mortal men, sons of the god Zeus, three demi-god ministers of Haides. They were granted their station in death as judges of the dead as a reward for establishing law and order on earth.

Aiakos was guardian of the keys of Haides and judge of the men of Europe. Rhadamanthys was the lord of Elysion (Elysium) and judge of the men of Asia. Minos was the judge who cast the tie-breaking vote. (Plato, Gorgias, 524A).

According to some, Triptolemos was a fourth judge who presided over the souls of Initiates of the Mysteries. Triptolemus was a demi-god of the Eleusinian mysteries who presided over the sowing of grain-seed and the milling of wheat. Be it as it may, King Minos declared:

> "By the Gods of Olympus and order of Zeus, we are the Three Judges. Face your final judgment, mortal. King Aeacus has found you wanting. King Rhadamanthus has found you worthy. It falls to me, King Minos, to make the final decision. Your future is cloaked in shadow. The realm of the afterlife is not yet ready for you. Beyond that door awaits your destiny."

Now, there's something to aim for in the next life, or not? More education is needed to reach that stage. We PTSD journeyers need more insight into what to do or not to do to heighten our state of awareness of our own predicament, never mind judging others. So let us take a look at other PTSD recovery treatment modalities and activities proposed by those purportedly in the know, shall we?

39

Most Prominent PTSD Treat-The-Mind Modalities

Now, whatever you do, remember that PTSD is one colossal existential crisis. It has nothing whatsoever to do with a mental illness. It was put in motion by an extraordinarily traumatic experience far beyond the scope of what are considered "normal" human life experiences and events.

It is the DSM-5 inauguration that enabled mental health practitioners to lower the PTSD diagnostic threshold to such extent that an ordinary hangnail, a burnt hand, a scratch on the nose, childbirth, a broken fingernail, a cut from peeling potatoes or slicing bagels, combined with the right histrionic attitude, can result in a

PTSD diagnosis. Why was the DSM-5 engineered that way? To land as many human beings as possible on mind-altering pharmaceutical drugs. To destroy their healthy thinking ability. To create the mistake of the intellect, and damage the body's vital organs in the process.

It is with the DSM inauguration that most of the western human population has been declared mentally ill. That's easy to do, with 300 mental disorder diagnoses from which to choose.

Perhaps a distinction ought to be made between PTSD of the household variety versus that incurred in the line of duty by fire fighters, police officers, soldiers, veterans, aircrew and rape-victims. After all, this is a society where victimhood is in fashion and stylish, something to be proud of and bragged about, the handicap sticker flashed with pride.

Thanks to Dr. Allan Frances' disclosure, we know about the huge efforts are made by the Matrix system, aka the NOW. These efforts are opposed by the Humanistic Psychology Division 32 of the American Psychological Association members, NAMI. That's the United States' largest grassroots mental health organization dedicated to building better lives for the millions of Americans said to be affected by mental illness. Many psychologists and researchers also object to a multitude of DSM-5 diagnostic criteria, including PTSD. The expanded criteria have a single goal: to declare as many people as possible as mentally incapable as possible. Or to declare us all unable to lead our lives without the aide of pharmaceutical, mind-altering drugs.

The fact that these drugs are highly addictive and make takers both suicidal and physically ill is rarely, if ever, mentioned. The knowledge, however, is easily available on the Internet and in the Compendium of Pharmaceuticals mandatory at every physician's office.

Some people are in occupations where beer-drinking as R&R is favored because pharmaceutical mind-altering drug consumption is officially prohibited. That includes aircrew and others who are exposed to the possibility of a true PTSD experience every time they troop to work. Most of them are consciously or subconsciously aware that they may not return home in the same condition in which they left. They are truly outside the DSM-5 PTSD criteria realm, as they are front-line warriors in their own way.

Why, for example, do commercial airline pilots, and perhaps military pilots as well, by the nature of their work fall outside of PTSD susceptibility? Pilots are trained to spring into instantaneous action should a system failure occur. The work

itself, as one of our captains explained, means endless hours of sheer boredom, interspersed by a few seconds of pure terror, before springing in a frenzy of activity to rectify the problem. The latter will keep pilots far too occupied and busy to even think about the possible consequences of failure, even in a life or death situation. They are trained to correct errors mid-air from the moment they begin to fly for commercial carriers. It's their duty. They are in control at all times. They know what is happening. They are not ducks in a barrel waiting to be shot.

If they live, and consequently everybody else on board, it's the greatest high of their lives; they have fulfilled their duty to perfection! If they die, well, they are dead without PTSD.

We got an idea of it with Air Canada's July 23, 1983, Flight 143. It was a Boeing 767 cruising at 12,500 metres (41,000 ft.), when the cockpit warning system sounded, indicating a fuel pressure problem on the aircraft's port side engine. Assuming a fuel pump had failed, the pilots turned the warning system off.

A few moments later a second fuel pressure alarm sounded for the starboard engine prompting the pilots to divert to Winnipeg. Seconds later the left engine failed. They began preparing for a single-engine landing. As they communicated their intentions to controllers in Winnipeg while trying to restart the port engine, the cockpit warning system sounded again with the "all engines out" sound. It was a long "bong" that no one in the cockpit could recall having heard before. It had not been covered in flight simulator training. After all, flying commercial aircraft with all engines out was something that was never expected to occur. Therefore, it had not been covered in training. Seconds later, the 767 lost all power and most of the instrument panels in the cockpit went blank.

The pilots immediately searched their emergency checklist for the section on flying the aircraft with both engines out. No such section existed. As fate would have it, Captain Bob Pearson was an experienced glider pilot familiar with flying techniques almost never used in commercial flight. To have the maximum range and therefore the largest choice of possible landing sites he needed to fly the 767 at the optimal glide speed. Making his best guess as to this speed for the 767, he flew the aircraft at 220 knots (410 km/h; 250 mph). First Officer Maurice Quintal began to calculate whether they could reach Winnipeg. He used the altitude from one of the mechanical backup instruments, while the distance was supplied by the air traffic controllers in Winnipeg. They measured the distance the aircraft's echo moved on their radar screens. In 10 nautical miles (19 km; 12 mi) the aircraft lost 5,000 feet (1,500 m), giving a glide ratio of approximately 12:1 (dedicated glider

planes reach ratios of 50:1 to 70:1).

At this point, Quintal proposed landing at the former RCAF Station Gimli, a closed air force base where he had once served as a Royal Canadian Air Force pilot. Unbeknown to Quintal or to the air traffic controller, a part of the facility had been converted to a race-track complex known as Gimli Motorsports Park. It included a road-race-course, a go-kart track and a drag-strip. A Canadian Automobile Sport Clubs' sanctioned sports car race hosted by the Winnipeg Sports Car Club was underway at the time of the event. Part of the decommissioned runway was being used to stage the race, and the area around the decommissioned runway was full of cars and campers.

Without power to lower the landing gear, the pilots used a gravity drop, which causes gravity to lower and lock it into place. The main gear locked into position, but the nose wheel did not. Later, this should prove advantageous. As the aircraft slowed on approach to landing, the ram air turbine generated less power, rendering the aircraft increasingly difficult to control.

A Ram Air Turbine (RAT) is a small wind turbine that is connected to a hydraulic pump, or electrical generator, installed in an aircraft and used as a power source. The RAT generates power from the airstream by ram pressure due to the speed of the aircraft.

As the runway drew near, it became apparent that the aircraft was coming in too high and too fast. That raised the danger of running off the runway. The lack of hydraulic pressure prevented flap/slat extension. Under normal landing conditions, that would have reduced the aircraft's stall speed and increased the lift coefficient of the wings to allow the aircraft to be slowed for landing. Briefly the pilots considered a 360-degree turn to reduce speed and altitude, but decided against it due to lack of altitude for the manoeuvre. Pearson instead decided to execute a forward slip to increase drag and lose altitude. The manoeuvre is commonly used with gliders and light aircraft to descend more quickly without increasing forward speed.

In other words, the forward slip changes the heading of the aircraft away from the down wing, while retaining the original *track* (flight path over the ground) of the aircraft. To execute a forward slip, the pilot banks into the wind and applies opposing rudder (e.g. right aileron + left rudder) in order to keep moving towards the target.

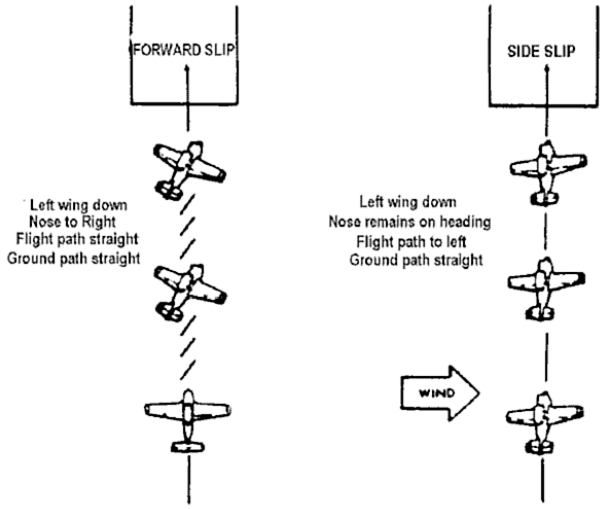

Figure 9–9 Forward Slip and Side Slip

Source: flighttrainingcenters.com

If you were the target, you would see the plane's nose off to one side, a wing off to the other side and tilted down toward you. If you were observing the landing from the ground, you would think the aircraft came in for landing sideways. You can see the last second correction to straighten it out for touch down by watching most dangerous landings on you tube.

The pilot must make sure that the plane's nose is low enough to keep airspeed up. However, airframe speed limits such as VA and VFE must be observed. V-speeds are standard terms used to define airspeeds important or useful to the operation of all aircraft. These speeds are derived from data obtained by aircraft designers and manufacturers during flight testing for aircraft type-certification testing. Using them is considered a best practice to maximize aviation safety, aircraft performance or both. VA stands for design maneuvering speed. This is the speed above which it is unwise to make full application of any single flight control (or "pull to the stops") as it may generate a force greater than the aircraft's structural limitations. VFE is known as Maximum Flap Extended Speed. This is the speed in which we can fly with flaps extended. Flaps are a type of high-lift device used to increase the lift of an aircraft wing at a given airspeed. Flaps are usually mounted on the wing trailing edges of a fixed-wing aircraft. Flaps are used for extra lift on take-off.

Assuming that the plane is properly lined up for the runway, the forward slip will allow the aircraft *track* to be maintained while steepening the descent without adding excessive airspeed. Since the heading is not aligned with the runway, forward-slip must be

removed before touchdown to avoid excessive side loading on the landing gear, and if a cross wind is present an appropriate sideslip may be necessary at touchdown.

In the United States, student pilots are required to know how to do forward slips before embarking on their first solo flight. The logic is that in the event of an engine failure, the pilot will have to land on the first attempt and will not have a chance to go around if the aircraft is too high or too fast.

Complicating matters on the 767 was the fact that with both engines out the plane made virtually no noise during its approach. People on the ground therefore had no warning of the impromptu landing and little time to flee. As the gliding plane closed in on the runway the pilots noticed two boys riding bicycles within 1,000 feet (300 m) of the projected point of impact. Captain Pearson would later remark that the boys were so close that he could see the looks of sheer terror on their faces as they realized that a commercial airliner was bearing down on them.

Two factors helped avert disaster: the failure of the front landing gear to lock into position during the gravity drop and the presence of a guardrail installed along the decommissioned runway's center to facilitate its use as a racetrack. As soon as the wheels touched down, Pearson braked so hard that he blew out two of the aircraft's tires. The unlocked nose wheel collapsed and was forced back into its well, causing the aircraft's nose to slam into, bounce off, and then scrape along the ground. This additional friction helped to slow the airplane down and kept it from careening into the crowds surrounding the runway.

After touchdown, the aircraft nose began to scrape along the guardrail in the center of the tarmac. Pearson applied extra right brake, which caused the main landing gear to straddle the guardrail creating additional drag that further reduced the speed. 17 minutes after running out of fuel, Air Canada Flight 143 came to a final stop. Reportedly, no serious injuries occurred among the 61 passengers or the people on the ground.

A minor fire in the nose area was extinguished by racers and race-course workers. As the aircraft's nose had collapsed onto the ground, its tail elevated. Some passengers sustained minor injuries when exiting the aircraft via the rear slides, which were not long enough for the increased height.

Following Air Canada's internal investigation, Captain Pearson was demoted for six months and First Officer Quintal suspended for two weeks for allowing the incident to happen. Three maintenance workers were also suspended. But the Aviation Safety Board of Canada, the Transportation Safety Board of Canada's

predecessor, reported that Air Canada management was responsible for "corporate and equipment deficiencies". Meanwhile, it praised the flight and cabin crews for their "professionalism and skill". That all flight attendants sustained PTSD is nowhere mentioned. The pilots lived the high of their lives. Gimli even named a street after Captain Pearson.

In 1985, the pilots were awarded the first ever Fédération Aéronautique Internationale Diploma for Outstanding Airmanship. Several attempts by other crews to replicate the event when given the same circumstances in a simulator at Vancouver resulted in crashes. In 1989, First Officer Quintal was promoted to captain. He died at age 68 in 2015 in Saint-Donat, Quebec.

Captain Pearson remained with Air Canada for another 10 years before moving on to fly for Asiana Airlines. He retired in 1995. By its 35th anniversary, the "Gimli Glider" story had gained the interest of Hollywood producers for a potential feature film. I wonder if the backend-crew will play a role in it, as they are not mentioned at all in any media reports. As far as I know, none of them ever fully recovered from the experience.

Swissair 111's fate was far worse. The aircraft slammed into the ocean with a force of impact "in the order of at least 350 *g*" after the following scenario evolved:

- The first that air traffic controllers heard of the problem was 16 minutes before the crash.
- The pilot announced: "Swissair 111 is declaring pan pan pan — we have smoke in the cockpit."
- "Pan pan pan" is the expression used when an emergency is less acute than a mayday signal, which indicates imminent disaster. But the situation rapidly deteriorated.
- The pilot suggested landing at Boston, but was told Halifax was closer, so he began heading in that direction.
- However, the plane was at an altitude of around 10,000 metres and needed to lose height.
- Air traffic controllers also gave the pilot permission to dump at least 30 tons of fuel to land safely.
- The pilot's next words on the radio were that he was declaring an emergency.
- "We have to land immediately," the pilot said, the last words the controller heard from the plane.

- Radar signals showed that the airliner began flying off course in a rapidly descending loop over the sea.
- Six minutes later, it hit the water.

Had these pilots been able to get the aircraft on the ground and survived in more or less one piece, however, they would have been thrilled. They would have been jubilant almost to death and for the rest of their lives just thinking about it. And rightfully so. It would have been a gargantuan deed to accomplish the task under such enormous pressure. Most of their passengers would have been PTSD affected, but that again would have been unmentioned. It could dangerously impair the bottom line if it were.

And then, of course, occurred the Miracle on the Hudson on January 15, 2009. US Airways Flight 1549 an Airbus A320-214 was in climbout after take-off from New York City's LaGuardia Airport. It struck a flock of Canada geese just northeast of the George Washington Bridge and consequently lost all engine power. Unable to reach any airport, pilots Chesley Sullenberger and Jeffrey Skiles glided the plane to a ditching in the Hudson River off Midtown Manhattan. All 155 people aboard were rescued by nearby boats and there were few serious physical injuries.

A National Transportation Safety Board official described it as "the most successful ditching in aviation history," not that there had been many ditchings of airliners before it.

According to a report in *Flight International Magazine* in 1964, one occurred in October 1963. An Aeroflot Tupolev 124 on a flight from Estonia to Moscow had a landing gear problem leading to a diversion to Leningrad. While holding prior to landing and about 13 miles (20.8 km) from Leningrad airport, the aircraft ran out of fuel. The crew managed to land the aircraft on the nearby Neva River, where it remained floating on the surface. The aircraft was towed to shore and all 52 occupants survived.

Another one involved an ALM Antillean Airlines DC9-33CF departing JFK airport in New York for St. Maarten in the Netherlands Antilles on May 2, 1970. After three missed approaches, the crew diverted to St. Croix. While en route, the aircraft ran out of fuel and the crew ditched the aircraft. While the flight crew made specific preparations for ditching, the imminent ditching was not communicated to the cabin crew. As a result, several occupants were not belted in at the time of the ditching. The aircraft remained afloat for five to six minutes before sinking in waters about one mile (1600 meters) deep. One of the six crew members and 22 of the 57

passengers were killed. The accident was investigated by the NTSB and the details are available in NTSB report NTSB-AAR-71-8 dated 31 March 1971. An Ethiopian Airline B767 ditched into the Indian Ocean during a hijacking on November 23, 1996. The hijackers would not allow the crew to land the aircraft and refuel. The crew ditched the aircraft near a beach in the Comoros Islands. This was only the third time that a passenger jet transport aircraft had in intentional ditching with survivors.

An intentional ditching is defined here as a case where the flight crew makes a deliberate decision to land the aircraft in some body of water. This definition excludes cases such as runway overruns into water, accidental controlled flight into water, or cases where the crew is unable to control the aircraft's descent. The two previous intentional ditching cases before the Ethiopian Airline involved the ALM DC9 in the Caribbean in 1970 and an Aeroflot Tupolev 124 in the River Neva in Leningrad in 1963. You can read more on these ditching issues of the *AirSafe Journal* and also review the video of the 767 event taken by Mariana Gouws ("Intentional Ditchings of Jet Airliners" *28 November 1996. Revised 7 September 2001; The AirSafe Journal*, Issue 6).

Of the three, only the Miracle on the Hudson is documented in detail, and still is discussed widely and viewable over the Internet today. This morning I viewed it for the first time, and it shook me profoundly. I now understand why my peers resent reading *Broken Wings* before their retirement. As to the investigation, the Board rejected the notion some extraordinary soul had made that the pilot could have avoided ditching by returning to LaGuardia or diverting to nearby Teterboro Airport. We can assume that the suggestion came from someone who had never experienced intense life-threatening catastrophic pressure.

The National Transportation Safety Board (NSTB) investigators used flight simulators to test the possibility that the flight could have returned safely to LaGuardia or diverted to Teterboro. Only seven of the thirteen simulated returns to La Guardia succeeded, and only one of the two to Teterboro. Furthermore, the NTSB report called these simulations unrealistic: "The immediate turn made by the pilots during the simulations did not reflect or account for real-world considerations." A further simulation, conducted with the pilot delayed by 35 seconds, crashed. In testimony before the NTSB, Sullenberger maintained that there had been no time to bring the plane to any airport. He testified that attempting to do so would likely have killed those onboard and more on the ground.

The Board ultimately ruled that Captain Sullenberger had made the correct

decision. It reasoned that the checklist for dual-engine failure is designed for higher altitudes, when pilots have more time to deal with the situation. It noted that simulations showed that the plane *might* have just barely made it back to LaGuardia. But it recognized that those scenarios assumed an instant decision to do so, with no time allowed for assessing the situation.

The NTSB concluded its investigation on May 4, 2010. It identifyed the probable cause as "the ingestion of large birds into each engine, which resulted in an almost total loss of thrust in both engines." The final report credited the outcome to four factors:

- good decision-making and teamwork by the cockpit crew (including decisions to immediately turn on the APU and to ditch in the Hudson)
- the fact that the A320 is certified for extended overwater operation (and hence carried life vests and additional raft/slides) even though not required for that route
- the performance of the flight crew during the evacuation
- and the proximity of working vessels to the ditching site

Contributing factors were good visibility and a fast response from the ferry operators and emergency responders. The report also made a range of recommendations to improve safety in such situations.

The pilots and flight attendants were awarded the Master's Medal of the Guild of Air Pilots and Air Navigators in recognition of their "heroic and unique aviation achievement".

As far as I know, no one bothered to check for PTSD in either crew or passengers. But there is enough evidence in the videos I viewed this very day. Those interviewed with the near-miss had a life-changing awakening through what for many was surely a PTSD-incurring incident. No better evidence for their actions at this present day can otherwise explain it.

All of it is still ignored by the National Center for PTSD and other agencies praising themselves for wanting to help those suffering from genuine PTSD. By those, I mean the previously mentioned PTSD prone employment occupations and the rape-victims. I am also convinced at this time that the attempt to kill or at least destroy them mentally and physically, and me at that time, is indeed a fact. Many of my peers and those working for the Union spit on me to the day for this. Otherwise,

so-called mental health professionals' PTSD treatment modalities, therapies, and proposals cannot be explained by anyone with a grain of logic and reason in their being. Unless, that is, that they are mentally insane, as Jon Rappoport suggests.

Here are the YouTube videos I viewed to reach that conclusion:

- US Airways Flight 1549 New York City Hudson River Crash
- Air Traffic Controller of USAirways Flight 1549 Hudson River Landing "the Lowest Low I've Ever Felt"
- *60 Minutes*: "Saving 155 Lives," Katie Couric, you tube
- "How do you evacuate 155 people from an Airbus 320 sinking in just off the Manhattan shoreline? The crew of U.S. Airways Flight 1549 described how they were able to get every passenger back on dry land."
- CBS: "An Emotional Reunion.150 people might not be alive today if it weren't for Capt. Sullenberger and the crew of U.S. Airways Flight 1549. 60 Minutes invited some of the passengers to reunite with them in, of all places, Charlotte N.C."
- CBS: "Captain Sullenberger's Moment: Flight 1549 Captain Chesley Sullenberger spoke with Maggie Rodriguez and Harry Smith about the moments before he landed the airplane safely in the Hudson River. In their Own Words."
- "Flight 1549 Interview with Charles Gibson: NY Waterway Captain and Crew Interviewed!", May 25, 2012.
- NYCredcross January 2014: "Remembering Flight 1549. On January 15, 2009, U.S. Airways Flight 1549, en route from LaGuardia Airport to Charlotte, North Carolina, landed on the Hudson River in sub-zero temperatures. The American Red Cross responded immediately with blankets, hot drinks, sweat suits, socks and health and mental health support for passengers and crew members who evacuated to the New York Waterways Terminal in Manhattan."
- Marie Mercer, The Aviation Speakers Bureau: Cactus 1549 Flight Attendant Doreen Welsh Dec. 2012. Note that Ms. Welsh is out of uniform in many of the above interviews indicating that she quit the airline.
- Speakers.com: "Jeffrey Skiles on The Miracle on the Hudson." Published on Apr 7, 2014. "US Airways Flight 1549 New York City

Hudson River Crash" Air Crash Investigation 2018 published on Feb 12, 2017.

- US Airways Flight 1549 New York City Hudson River Crash "Should Sullenberger have tried to turn back to LGA?"

Many a commercial cockpit crew accomplishes near-miracles in the line of duty, but we seldom hear about it. Nor do we hear about their cabin crew who in such situations has time on their hands for endless speculations whilst the struggle to solve whatever it may be is ongoing on the flight deck leaving no time to inform the back-end. Often times, such a situation can last hours, two in the event that broke my back, figuratively speaking, to consciously or subconsciously contemplating what could or would happen if they — the pilots — would fail to make it out of the dilemma. Depending on flight attendants' personal IQ, this is, I think, the catalyst for the subsequent existential crises exacerbated by the absence of a debriefing. Most flight attendants' thrown into such predicament without recourse as in my case will never recover from it. They merely disappear from the system, shafted by the airline as the human debris the airline considers them to have become, when nothing could be further from the truth.

But Many a commercial cockpit crew accomplishes near-miracles in the line of duty, but we seldom hear about it. Nor do we hear about their cabin crew, who in such situations has time on their hands for endless speculations. The struggle to solve the problem is on the flight deck. The captain has no time to inform the back-end. If an announcement from the flight deck to passengers is made, you will always hear that everything is honky dory, no need for concern. We'll keep you updated. Moments later it may be followed by a "Boom!" and game over. Often times, the situation of not knowing can last hours — two in the event that broke my back, figuratively speaking. That's a lot of time to consciously or subconsciously contemplate what could or would happen if they — the pilots — would fail to make it out of the dilemma. Depending on a flight attendant's personal IQ, this is, I think, the catalyst for the subsequent existential crisis, exacerbated by the absence of a debriefing. Most flight attendants thrown into such predicament without recourse, as in my case, will never recover from it. They merely disappear from the system, shafted by the airline as the human debris the airline considers them to have become, when nothing could be further from the truth.

I met 25 or so PTSD-affected US Army veterans for 50 minutes on the "Norwegian Star'. It was that meeting that propelled me to write this book. And it

was that meeting that confirmed my hypothesis. It is the unconscionable treatment dished out by the powers that be, including mental health practitioners, that causes PTSD journeyers' deteriorating condition and often suicide. It is not their purportedly genetically defective and before-the-PTSD-causing-event-miswired-and–disturbed-from-birth dilapidated psyche. Questions such as: "What can we do for you? What do you think may work for you?" are never asked. It is OBEY our commands or go to the dogs. Human debris. Useless eaters.

So, when you enter their system, know that clinical psychologists educated in clinical psychology usually conduct your interviews and evaluations. This is the branch of psychology concerned with the assessment and treatment of mental illness, abnormal behavior and psychiatric problems. It is done by integrating the *science* of psychology with the treatment of complex human problems. This supposedly makes it an exciting career choice for people who are looking for a challenging and rewarding field.

Science of psychology? How can it be a science? Human emotions, stress levels, life experiences, educational and social backgrounds, races, religions and nationalities vary wildly throughout humanity and from individual to individual. These are scientifically unmeasurable, empirically and evidence-based undocumentable.

Those entering this challenging field of analyzing and passing judgment on others are most likely in it because they are severely flawed themselves. Who else would enter such a field? The old adage, "Physician, heal thyself" springs to mind. Each seems to have their own theory of favorite modalities to traumatize their already PTSD-traumatized subjects between their caring hands, according to their education and tendencies. Are they Freudians, Jungians, Heideggers or Hegelias, Skinnerians, Pavlovians, Trans-Humanists or something in between? And if so, which one is the actual "science"? It takes off from there.

Headstrong Projects' ideas of PTSD rehabilitation again gives us a fine theatre of knowledge to exemplify. Again, as in the NC for PTSD, the Cognitive Behavioral Theory Therapy (CBT) is emphasized. This is followed by EEG Neuro-feedback. These are the alpha and omega, the primary methods, in their PTSD *stabilization* process. Also used are the purportedly evidence-based Eye Movement Desensitization Reprocessing (EMDR). This one is actually considered their program's cornerstone for memory processing because, we read, it allows veteran and clinician to work as a team through each traumatic event. This fits wonderfully well into their non-regimented, non-aggressive, individually-tailored PTSD rapid

recovery program, we are told.

The adaptive information-processing model governing EMDR practice is said to invite the therapist to address a client's overall clinical picture. This includes past experiences that, in the therapist's opinion, might do two things. They might contribute to the client's current difficulties. And they might trigger the present events' maladaptive responses. The goal of EMDR, then, is to develop more adaptive *neural* memory networks in order to enhance positive responses in the future. Dr. Roland G. Benoit, leader of the German Max Planck Institute for Human Cognitive and Brain Sciences Research Group for Adaptive Memory (GMPIHCBSRGAM, for short), has this explanation on the topic:

> "Humans possess the remarkable capacity to vividly remember a plethora of experiences from their lives. They can voluntarily reminisce about cherished moments but also be haunted by intrusive memories of unpleasant experiences. At the heart of the research in the *Adaptive Memory Group* is the insight that memory is not merely a passive capacity but a constructive process. As such, memories, on one hand, are malleable to change and disruption but, on the other hand, can also be recombined into novel experiences. We seek to understand the nature of adaptive memory by using behavioral, fMRI, and neuromodulation methods. In particular, we focus on three intertwined research areas: Memory suppression: The work on voluntary forgetting seeks to understand the different neurocognitive mechanisms underlying the ability to suppress unwanted memories. We have reported evidence for two opposing mechanisms that can achieve memory suppression (Benoit & Anderson, 2012): one by effectively inhibiting hippocampal retrieval processes and the other by guiding hippocampal retrieval towards the recollection of alternative memories that then keep the unwanted memory out of awareness. Our research group examines how these mechanisms can be adaptively recruited to purge intrusive memories from consciousness (Benoit et al., 2015), and whether they may be compromised in people who suffer deficits in controlling unwanted thoughts (e.g. Kupper, Benoit, et al., 2014). In recent work, we have

> established that a mechanism akin to direct suppression can also be engaged to control persistent imaginings of future fears." (Benoit, Davies, & Anderson, in 2016)

Present research being sought at the Research Interests in the Adaptive Memory Group seeks to understand the neural and cognitive mechanisms that operate on our memories of the past to help us live in the future. The Available Ph.D. projects in the field currently are focused on two lines of research, with a particular interest in prefrontal cortex functioning. We read:

> "First, we investigate how people suppress unwanted memories. By this, we study a process that may be deficient in individuals suffering from intrusive thoughts. Second, we investigate how people imagine possible future episodes. We examine how such imaginings are constructed based on recombinations of disparate memories, and how they motivate future-oriented decisions."

The now is unimportant, it seems. That it is the now creating the future is also ignored. That human emotions may play a role is of no consequence, either, it seems.

So, the EMDR psychotherapy method emphasizes that *disturbing memories* are the cause of the apparent PTSD psychopathology. It is applied to eliminate the potential for growth in PTSD-afflicted people. It seeks to return them to the ignorant status from whence they rose. So, would PTSD voyageurs then be spared the need to investigate the meaning of their human lives and therefore to heal themselves?

But EMDR is only part of this advertised as structured and *manualized treatment*. It is combined with elements of Cognitive Behavioural Theory Therapy (CBT), mindfulness, body-based approaches and person-centered therapies, we read.

Manualized treatment means a treatment that has exact steps. Each person has the relatively same treatment, with pre-set expectations. The Adaptive Information Processing Model clinically guiding EDMR proposes that traumatic memories in PTSD are unprocessed. In other words, they are not stored as memories, but treated as if they were new sensory inputs.

Sensory input describes the response in a sensory organ when it receives stimuli. In human beings there are five sense organs: eyes, ears, tongue, skin and nose. These contain receptors that relay information through sensory neurons to the appropriate places within the nervous system. Each sense organ contains different

receptors, and anything perceived using our senses — smell, sight, touch, taste, and hearing — can be called sensory input.

As a distinct form of psychotherapy, EMDR's treatment emphasis is on directly processing the neuro-physiologically stored memories of events said to set the foundation for pathology and health. The adaptive information-processing model that governs EMDR practice invites therapists to address clients' overall clinical picture. These include past experiences that contribute to a clients' current difficulties. They also include present events seen as triggering maladaptive responses. EMDR hopes to develop more adaptive neural networks of memory in order to enhance positive responses in the future. The clinical application of EMDR is elaborated through a description of eight phases of treatment. These illustrate the convergences with psychodynamic, cognitive-behavioral and systemic practice.

The most unique of those eight are termed desensitization and reprocessing. This is said to happen when clients are said to hold distressing images in their mind while simultaneously following or tracking the clinician's rhythmic finger movements. Positive cognitions are put in a client's mind during sessions in which fingers are tracked while thinking those positive cognitions, as well as by journaling.

EMDR has been deemed efficacious by the International Society for Traumatic Stress and is recommended in the VA/DoD (2010) treatment guidelines. However, these same guidelines question the theoretical and empirical grounding of some of the more novel components of EMDR. We learn this from Brian A. Sharpless and Jacques P. Barber's paper *A Clinician's Guide to PTSD Treatments for Returning Veterans.*

When the WCB touted EMDR as the most lauded treatment to cure my PTSD three decades ago, I declined. I could not see any value in moving my eyes around to the direction of someone I had never met. This person would most likely be without a clue about PTSD. Miraculously, no one forced me into compliance. That was good, as I always liked my brain the way it is.

In my view, EMDR is designed to cut PTSD journeyers off from the introspection required to heal and not just mask PTSD symptoms. It attempts to lure the journeyer into the belief that it works. In essence, it just prolongs the agony of doubt about life and living, its purposes and its reasons. These can be resolved only by the connection with the Divine, the exploration of the spiritual aspects of human existence. On a sub-surface level, in my view, it is even more sinister than denying us the peace, quiet and financial stability necessary for the PTSD recovery. But let's move on to the equally well-lauded Cognitive-Behavioral Theory therapy or CBT.

CBT is in a similar vein as EMDR, and pioneered by psychologists Aaron Beck and Albert Ellis in the 1960s. It assumes that maladaptive behaviors and disturbed mood or emotions are the result of inappropriate and/or irrational thinking patterns called *automatic thoughts*. This means that instead of reacting to the reality of a situation, the clinician assumes that an individual reacts to his or her own distorted views of the situation at hand. The aim of cognitive therapies is to attempt to make patients' aware of what the therapist thinks is their distorted thinking patterns causing cognitive distortions. Then the therapist entices them to change those thoughts by a process termed cognitive restructuring.

In turn, behavioral therapies are based on the theory of classical conditioning a la Pavlov and Skinner. The premise there is that all behavior is learned. Faulty learning, i.e. conditioning, therefore is the cause of abnormal behavior. Therefore, people have to learn correct and acceptable behavior. Who and what dictates correct, incorrect, acceptable or non-acceptable behavior is nowhere to be found.

Another feature of behavioral therapy is its focus on clients' current problems and behaviors and to remove those that patients find troublesome. PTSD experiencers, however, have yet to find the Self lost with the PTSD-causing event. They haven't created a new structure for it, never mind recreating the brain's cognitive and behavioral structure. That structure is invented and created in accordance with and to the liking of a clinician of whatever field of schooling. That clinician has no knowledge in, but only of, PTSD, and no interest in the client's well-being. On the contrary. Logic dictates that it would be much more beneficial for the therapist's financial well-being to have clients linger ad nauseam. Easy to do for someone who most likely has as much knowledge about an existential crisis as a hole in the ground. They are probably completely unaware that the self-same clients would be perfectly able to resolve this crisis on their own, were they given peace, quiet and financial stability to do so.

We hear that, in theory, a clinician can employ the "action-oriented" form of psychosocial CBT therapy in any situation of unwanted behavior patterns. It is therefore recommended for a slew of perceived mental disorders other than PTSD such as

- Affective (mood) disorders
- Personality disorders
- Borderline personality disorder
- Histrionic personality disorder

- Sociopathic personality disorder
- Narcissistic personality disorder
- Social phobia
- Obsessive-compulsive disorder (OCD)
- Eating disorders
- Substance abuse disorder
- Anxiety or panic disorder
- Agoraphobia, attention-deficit/hyperactivity disorder (ADHD)

The enthusiastic mental health practitioner can also use it as a tool to help patients deal with chronic pain, rheumatoid arthritis, back problems, cancer, sleep disorders and insomnia, we read.

When in the PTSD situation, clinicians of course assert that faulty thinking patterns are the cause of PTSD afflicteds' maladaptive, incorrect, socially unacceptable behavior and negative emotions. If we can just make them forget the whole thing and turn them into unempathetic, emotionless robots, they'd be perfect in no time flat, seems to be the theme. That the treatment received from the powers that be is causing the maladaptive, incorrect, socially unacceptable behavior and negative emotions goes unacknowledged. So does the imposition of pharmaceutical mind-altering drugs, leading to suicide.

The CBT treatment I received from the first psychiatrist was the greatest irritant of all. That one worked for NorAm without my knowledge. That one focused on CBT to change my thoughts and cognitive pattern, also without my knowledge . It was pure senselessness to regurgitate the PTSD causing event ad nauseam in his presence. But, I thought this Santa Claus look-alike was the expert helping me to recover. So I trusted him in his efforts, and still overwhelmed by the situation overall, I just cruised along, "Doctor knows best" idiot that I was at that time. Doing so almost landed me on skid-row.

I believe that mental health clinicians are acutely aware of the futility of their CBT efforts. But admitting it would lose them the justification for their existence and purpose. After all, it is so useful for control. Just look at Aleksandr Isayevich Solzhenitsyn's (1918–2008) work. One of his quotes precisely reflects their attitude and reasoning:

> " It is not because the truth is too difficult to see that we make mistakes. It may even lie on the surface; but we make mistakes because the easiest and most comfortable course for

> us is to seek insight where it accords with our emotions — especially selfish ones ("Peace and Violence" (1973)."

Especially the pocket book. Enormous amounts of money are made all around from the PTSD calamity. The only people not raking it in are PTSD journeyers. That's just as the system wants it, as it is so lucrative to their bottom line. So it makes perfect sense to go on with EMDR and CBT treatments, enhanced by psychotropic and hallucination-causing drugs, pushing claimants into suicidal actions against themselves and violence against others.

And who can really gauge and heal another's emotions, thinking, desires, aspirations, inner conflicts and distresses? Who? The Self, and only the Self. Therefore the PTSD, the existential crisis problem, is merely the unrecognized and/or purposely ignored rattling of the conditioned cognitive behavioral psyche from the moment of conception onwards into the PTSD-event-caused nothingness. The meaninglessness and futility of life situation, this psyche, this tabula rasa is ready to be rewritten by the PTSD journeyer to his or her own liking. It is not ready to be rewritten to that of attending "practitioners" trying to destroy the process.

Only the PTSD journeyer through introspection, reflection, acceptance of the Self and peace-making with the Self can heal the Self. And that only when with the grace of the Divine, gradual rebuilding and restructuring of the new Self, and thus life itself, occurs. Perpetual outside interference and imposition of ideas and treatment modalities concerning PTSD, as well as drugging, is anathema to the healing process. Marijuana, ecstasy, pharmaceutical drugs or anything else of that nature are life threatening to PTSD journeyers.

Are we ever told about it? No? Who's fault is it? Our own. Too lazy to educate ourselves? Too distraught? Or is it because of the way I thought: "Whoever deals with me in this knows best and will do whatever it takes to heal me." I could laugh myself half silly reading my own innocence and ignorance, my trust in the Other. Not having read other than Solinitzyn's *Gulag Archipelago* when all this went down, a few years later in *One Day in the Life of Ivan Denisovich* (1962), bibliotherapy at its finest, this one crossed my path:

> "Here, lads, we live by the law of the taiga. But even here people manage to live. D'you know who are the ones the camps finish off? Those who lick other men's left-overs, those who set store by the doctors, and those who peach on their mates." Kuziomin, in the Ralph Parker translation (1963).

Are PTSD journeyers ever told by clinicians about PTSD's natural healing

process? I was not. With the exception of two mental health practitioners out of 24, I was only directly or indirectly made to doubt my own sanity. This feeling was enhanced by my Ativan consumption, I am sure. I was steadfastly encouraged to believe in my own mental defectiveness, my own warpedness from the cradle and long before the PTSD-causing event. I was perpetually made to feel guilty about my unusual and inappropriate slowness of recovery. I was made to feel guilty because of its development in the first place, caused as it was by those imaginary, innate birth-defects that unfortunately blossomed after a successful career and successful life hitherto the event. Once that vicious cycle is in motion, one is being ground to a pulp, too exhausted to continue with the charade. And by participating in CBT, we unwittingly participate in our destruction

Mind you, Dr. Nilamadhab Kar, a consultant psychiatrist in Black Country Partnership NHS Foundation Trust, begs to differ. NHS is a semi-autonomous organisational unit within the National Health Service based in the West Midlands, United Kingdom. He wrote an article "Cognitive behavioral therapy for the treatment of post-traumatic stress disorder: a review", published by Dove Press in 2011 under *Neuropsychiatric Disease and Treatment*. Kar claims that reviews suggest CBT to be an effective treatment for both acute and chronic PTSD, with both short-term and long-term benefits. This follows a range of traumatic experiences, as it had been used with positive outcomes in preschoolers, children and adolescents suffering from PTSD.

CBT, Kar asserts, had been found to be at least as effective as various other [unnamed] psychological PTSD interventions. He should know, as he previously worked at:

- Kasturba Medical College, in Manipal, India
- the Central Institute of Psychiatry, Ranchi, in the State the Mental Health Institute, Cuttack, Odisha State of Jharkand
- the National Institute of Mental Health and Neurosciences, Bangalore

His research interest lies in the field of disaster mental health with a focus on post-traumatic *psychiatric* disorder and preventive psychiatry.

But even he admitted that, in spite of reports of CBT's efficacy in many studies, the CBT nonresponse for PTSD can be as high as 50%. This, the learned psychiatrist opines, was attributable to various factors, including comorbidities, the nature of the

study population, and the group of people participating in these particular studies. In other words: "Your warped psyche is the reason why CBT doesn't work for you."

To its credit, the mental health industry itself does admit that some of its PTSD treatment modalities may be non-conducive to clients' wellbeing. S. Dingfelder, Ph.D., for example, wrote the article "A psychodynamic treatment for PTSD shows promise for soldiers" published by the American Psychologist Association in March 2012 (Vol 43, No. 3). In it, he quotes Russell B. Carr, MD, an Army psychiatrist, as saying that this was especially true for service members who were both perpetrators and victims of violence. "It's a much more complicated experience, and they often feel a lot of shame in addition to the usual PTSD symptoms," Carr states. His PTSD treatment is rooted in the *inter-subjective systems theory.* This modern take on psychoanalysis, pioneered by George E. Atwood, Robert D. Stolorow, and Donna M. Orange, posits that the heart of trauma is shame and isolation.

Atwood et al. are the core theorists of inter-subjective systems theory. This form of psychoanalytic practice focuses on the relational origins of mental distress. It does so through the interpersonal and inter-subjective relationship of the analyst and the analyzed.

Theorists applying this theory, all of whom are practicing psychoanalysts, have rejected the Cartesian version of self as a unitary, isolated entity. They have likewise rejected mental illness as an intrapsychic dysfunction. In the Cartesian self, Descartes proposes a radical dualism in life where there is the subjective, inner mind on one hand and the objective, outer world on the other.

Their model relies heavily on phenomenological philosophy as its explanatory foundation. The patient's troubles, other than organic disease or physical trauma, exist only within the experiential and relational contexts in which they developed. Phenomenological philosophy or method of inquiry is concerned with the perception and experience of objects and events as the basis to study reality. It originated with Edmund Husserl around 1905. The principal founder of phenomenology, Husserl thus was one of the most influential philosophers of the 20th century. He made important contributions to almost all areas of philosophy. He also anticipated central ideas of its neighbouring disciplines such as linguistics, sociology and cognitive psychology.

In their book *Working Intersubjectively: Contextualism in Psychoanalytic* (Routledge Taylor & Francis Group New York, London, 2001) Orange, Atwood and Stolorow begin with an overview of the basic principles of intersubjectivity theory. They proceed to contextualists' critiques of the psychoanalytic technique concept and of

the myth of analytic neutrality. Then, they examine the inter-subjective contexts of extreme states of psychological disintegration. They conclude by examining what it means philosophically and clinically to think and work contextually.

How is an inter-subjective field created? Simply by the interplay between the subjective inner worlds of both the patient and the therapist. Thus the inter-subjective psychoanalysis suggests that all interactions must be considered contextually. For example, interactions between the patient/analyst or child/parent or infant/caretaker cannot be seen as separate from each other. Rather, they must always be considered as mutually influencing each other, as their interactions result in subsequent empathic appreciation of each other's subjective realities. When George Atwood and Robert Stolorow introduced the term in 1984, they considered it a "meta-theory" of psychoanalysis.

Meta-theory? Metatheory, or meta-theory, is a theory whose subject matter is some theory. All fields of research share some meta-theory regardless of whether this is explicit or correct. We could add in regards to psychology, if not other fields of research, inexplicit and incorrect. In general, meta-theoretical investigations are part of the philosophy of science.

Philosophy of Science? Philosophy of science is a sub-field of philosophy concerned with the foundations, methods and implications of science. Its central questions ask what qualifies as science, the reliability of scientific theories and the ultimate purpose of science. It's an attempt to explore the relationship between science and truth. Just as in the science of psychology, cognitive dissonance possibilities, hypotheses, hallucinations, imaginations, assertions, assumptions and consequent PTSD treatment modalities arise from the selfsame premise.

Dr. Carr, however, had been working with soldiers not responding to CBT. He was ingenious enough to consequently develop a PTSD treatment rooted in the inter-subjective systems theory. But not everyone agrees with this approach. Psychiatrist and psychoanalyst D.H. Frayn wrote "Inter-subjective processes in psychotherapy", published in the *Canadian Journal of Psychiatry* of June 1990. He opines that Carr's approach is not necessarily dependent on an acceptance of a self-psychology model. Self-psychology, an offshoot of Freud's psychoanalytic theory, forms much of the base of contemporary psychoanalysis. It was the first large psychoanalytic movement to recognize *empathy* as an essential aspect of the therapeutic process of addressing human development and growth.

The theory of Self-psychology and its clinical applications was conceived in Chicago in the 1960s, 70s and 80s by Heinz Kohut. It is still developing as a

contemporary form of psychoanalytic treatment. In it, the clinician tries to understand people from within their subjective experience via vicarious introspection. Thus, they base interpretations on the understanding of the Self as the central agency of the human psyche.

The essentials of contemporary Self-psychology for practitioners are given in Kindler's List as follows:

- "Self Psychology privileges the patient's subjective experience. To this end it maintains a perspective that at all times privileges the patient's point of view. The therapist's goal is to engage and illuminate subjective experience so that aspects of it may be transformed.
- "Rather than attending solely to the subjective world of the patient, contemporary Self Psychology appreciates that the subjectivities of both patient and therapist, along with their impact on one another, must be considered to fully comprehend the therapeutic process.
- "The focus on understanding subjective experience has given rise to two fundamental concepts to capture its essential elements. These are the "Self" and the "Selfobject experience". The Self, (or subjective sense of self), refers to the person's experience of their own unique subjectivity which may vary in its qualities of cohesion, agency, continuity and vitality. A selfobject experience is one in which the person experiences themselves to become more cohesive and enlivened.
- "Selfobject experiences are of various kinds, including mirroring (affirming, approving), idealizing (strengthening, calming), or twinship (sameness, like-mindedness). Many other kinds have been described and the possibilities are endless. These experiences may exist in the foreground (conscious) or background (non-conscious unless disrupted) of the relationship with the therapist. They may be healthy (development enhancing) or pathological (development restricting) in nature; e.g. drug addiction.
- "To apprehend the subjective experience of an individual at any time, we pay particular attention to affect. Hence, affect is key to our understanding of subjective experience. This includes the affect actually being experienced and the affect being sought.

- "In addition to recognizing and exploring beneficial effects of selfobject experiences, the therapist also explores the patterns of aversiveness when selfobject needs are not met.
- "Emphasis is placed on positive (leading edge) strivings that are found alongside maladaptive or problematic (trailing edge) patterns.
- "We attend closely to the self-regulating and self-righting qualities of problematic behavior for the individual while still recognizing its problematic impact on others.
- "Disruption-repair sequences are explored in an experience-near manner (empathically) because they provide opportunities to understand the patient (and therapist and their relationship) in greater depth. This often includes the precise nature of the selfobject needs being frustrated and the repetitive patterns of response to these frustrations (selfobject failures).
- "Careful attention is paid to the sequence of events in the patient-therapist interaction (the "what happens next?" in the therapeutic process), particularly as it applies to the patient's subjective experience, (sense of self). This provides an essential guide to the effect of the therapist's participation at any moment.
- "Knowledge of past "lived experiences" is used to help understand present clinical experience (exchanges, events, enactments, etc.) rather than the opposite as has been the practice in more traditional models. Hence there is a strong developmental perspective in which the co-construction of 'model scenes' (prototypical lived moments in development) makes past experiences alive and current.
- "In order to explore who we have become to the patient (precisely how we evoke the patient's experience of us) the therapist tries to accept the patient's attributions as a point of departure for inquiry.
- "Contemporary self psychology acknowledges a wide range of shifting motivations (needs for attachment, physiological regulation, sensual and sexual experience, assertion and exploration, and aversiveness) all contributing to the fundamental need to sustain, protect and strengthen the vulnerable self."

This work in progress was initiated by Alan Kindler, Joe Lichtenberg and Frank Lachmann at a Sunday breakfast in Toronto in 2005. Self-psychology also recognizes

certain drives, conflicts and complexes present in Freudian psychodynamic theory. They are understood within a different framework. Self-psychology was seen as a major break from traditional psychoanalysis and considered the beginning of relational approaches to psychoanalysis. It rejects Freudian ideology of the role sexual drives play in the psyche's organization. It focuses on the development of empathy toward the person in treatment. And it thrives on exploring fundamental parts of healthy development and growth, as reflected in Dr. Carr's treatment module.

Dr. Carr's therapy described in the October 2011 issue of *Psychoanalytic Psychology* has shown much promise. It can help soldiers by addressing the existential dread dredged up by trauma. It can address the feeling that their entire world has lost its meaning. Carr should know. He is a naval psychiatrist heading up inpatient psychiatry at the National Naval Medical Center in Bethesda, Maryland, USA. Since September 11, 2011, he has spent a decade in military campaigns, both in Iraq and Afghanistan. With his experience, if anyone can empathize with and develop ways to effectively treat PTSD in military personnel, it is he. So states Helen Davey, Ph.D., in her 2011 *Psychology Today* article "Inside the Mind of a War Vet. There is new hope for treating combat-related trauma."

But before he was able to do that, he first had to look for ways to help himself in an attempt to survive and to tolerate his own shattering experiences with war. He understands what Kohut explained in 1977 when saying in all he wrote on the psychology of the Self, that he purposely did not define the Self. He explained his reasoning this way:

> "The self . . . is, like all reality . . . not knowable in its essence . . . We can describe the various cohesive forms in which the self appears, can demonstrate the several constituents that make up the self . . . and explain their genesis and functions. We can do all that but we will still not know the essence of the self as differentiated from its manifestations" (*Siegel, Allen (1996). Heinz Kohut and the psychology of the self (1st ed.). New York: Routledge. p.140).*

Therefore when in the PTSD condition, the Self is the only one that can heal the Self.

One of the key parts of inter-subjective PTSD therapy is helping patients put their feelings around traumatic experiences into words, says Carr. These feelings are not always negative. One patient mentioned by him found he enjoyed the smell of

burning human flesh and was later horrified and ashamed of his reaction. By expressing empathy rather than rejection, Carr helped the soldier process the experience and reconnect with the civilian world.

Convincing soldiers that a therapist, friends and family understand a little of what they are going through also lessens PTSD symptoms, Carr found. In some cases, soldiers even learnt from the experience, he observed. "Recognizing the fragility of life, you can refocus on what's important to you, and not waste time on things that aren't," he states. The dominant cognitive-behavioral therapy for PTSD might be unsuitable for patients without specific behavioral issues they wish to address. They might be better served by psychodynamic therapy. This is even admitted by the mental health industry itself, we learn.

But consider the well-adjusted and successful-before-the-PTSD-causing-event experiencers in the four PTSD susceptible occupations. Why won't they apply it to them, one wonders?

What else is there to traumatize the traumatized? The earlier-mentioned Headstrong project views itself as the most advanced in PTSD treatment and recovery for Iraq and Afghanistan soldiers and veterans. It also advocates electroencephalography (EEG), the study of brain waves using an instrument that amplifies and records them.

Said to detect abnormalities in the electrical activity of human brains, its neurofeedback addresses problems of brain disregulation, such as:

- Attention deficits
- Behavior disorders
- Various sleep disorders
- Headaches and migraines
- Anxiety-depression spectrum
- PMS and emotional disturbances

It is also considered useful for organic brain conditions such as seizures, the autism spectrum and cerebral palsy. We learn this from *EEGinfo,* whose slogan is *Unlock your brain's potential*.

The test detects abnormalities in brain waves or in the electrical activity of the human brain. During the procedure, electrodes consisting of small metal discs with thin wires are pasted onto the scalp. The electrodes detect tiny electrical charges resulting from brain cell activity. The charges are amplified, appearing as graph on a

computer screen or as a recording printed out on paper, which the healthcare provider interprets. The aim of EEG is to bring the veteran's anxiety to a level where memory processing can begin, we read on Headstrong's website.

Interestingly enough, the EEG neurofeedback and rearrangement of brainwaves proposed to PTSD-affected people doesn't happen right away. It appears to begin after they have been persuaded to believe that their brain was warped by the PTSD-causing event. Thus, they need rewiring to cure the PTSD. At least, they are so persuaded, even though it is merely a hypotheses that the brain indeed has changed. Without a "before" reading, there is no scientific and empirical evidence.

Something else also seems odd. These self-proclaimed PTSD experts perpetually claim PTSD journeyers' brains were warped long before the PTSD-causing event. In fact, they say their brains were warped since birth. So, isn't it odd that they now claim to be able to rewarp it into the originally warped and undetected condition for a cure?

And isn't it odd to perpetually claim that pre-conditions and comorbidity predate PTSD symptoms. Yet without them, the PTSD condition could and would never have occurred?

So then, for what purpose are the best and brightest, the PTSD-affected Iraqi and Afghanistan soldiers and veterans, the youngest generation of USA men, really sought to have their brains rewired?

And what can EEG really do?

Siegfried Othmer, Ph.D., attended the now well-known-to-us Cornell University, Ithaca, New York between 1962 and 1970. He received a Ph.D. in experimental physics with minors in theoretical physics and mathematics. He has been developing research-grade instrumentation for EEG feedback since 1985.

Since 1988, he has also researched and managed the clinical applications of EEG biofeedback. He has been doing this as president of EEG Spectrum, Inc., and more recently as Chief Scientist of EEG Spectrum International and of the EEG Institute. He provides training for professionals in EEG biofeedback and presents research findings in professional forums. His website *Unlocking Brain Potential* gives insight into the topic.

Othmer believes that our intellectual abilities and emotional resources can be considerably enhanced with neurofeedback training.

The Canadian Dr. Graves Penfield, OM CC CMG FRS, (1891–1976) was, the founder of the Montreal Neurological Institute and one of the greatest neuroscientists who ever lived. Penfield explored the function of the brain by

electrically stimulating different regions of cerebral cortex in conscious patients undergoing surgery with local anesthetic for focalized seizure disorders. Penfield described the activation of motor cortex, an area of the brain responsible for transmitting all willed conscious movement to the appropriate levels of brain stem and spinal cord.

His scientific contributions on neural stimulation expanded across a variety of topics, such as hallucinations, illusions and déjà vu. Penfield also devoted a lot of his thinking to mental processes, including whether or not there was scientific basis for the existence of the human soul. This is, sadly, so vividly ignored by most of those in the PTSD treatment modality field.

The Torah, as Penfield most likely discovered, exquisitely explains that life and consciousness are provided by a spiritual entity. This entity enclothes itself in and is operator of the sophisticated computerized machine that we call the body. Torah is replete with information on the nature of souls. Interestingly, the existence of a non-material conscious entity responsible for operating the material body has also been demonstrated scientifically. The observations on which this conclusion is based are numerous, and some are rather complicated, we read in Neurology and the Soul by Shamir at borhatorah.org.

The only valid conclusion from Penfield's experiments and observation is that the will to move the body and the movement itself are not one and the same. The conscious will to move emanates from something that is aloof from the brain. It is able to observe objectively the operation of what is nothing more than a computer made out of flesh. But tell that to the experts in trans humanism, EEG, CBT and EMDR.

What no one furthermore talks about, at least not openly, are instruments based on EEG principles but entirely controlled without outside interference. I bought the BioTuner in the middle of my journey through hell and believe it helped me immensely to survive cruising through it.

SOTA Instruments: Your Personal EEG Neurofeedback Healing Devices

"It is no measure of health to be well adjusted to a profoundly sick society."
— Jiddu Krishnamurti

Jiddu Krishnamurti (1895–1986), an Indian philosopher, speaker and writer was groomed early in his life to be the new World Teacher, the Maitreya or Lord Maitreya. He is described in Theosophical literature of the late 19th-century and subsequent periods as an advanced spiritual entity. He is thought to be a high-ranking member of a hidden spiritual hierarchy, the so-called *Masters of the Ancient Wisdom*.

According to Theosophical doctrine, one of the hierarchy's functions is to oversee the evolution of humankind. In accordance with this function, the Maitreya is said to hold the *Office of the World Teacher*. The purpose of this office, Theosophical texts posit, is to facilitate the transfer of knowledge about the true constitution and workings of its existence to humankind. Humanity is thereby assisted on its presumed cyclical but ever progressive evolutionary path. One way the knowledge transfer is accomplished is reputedly by Maitreya occasionally manifesting or incarnating in the physical realm. Here, the manifested entity assumes the role of *World Teacher* of Humankind.

The Theosophical Maitreya concept is similar to the Maitreya doctrine in Buddhism. The Maitreya in Buddhism is described as a transcendent bodhisattva named as the universal Buddha of a future time. The name is taken from the Sanskrit *maitri* (in Pali, *metta*), which means "loving kindness." In Mahayana Buddhism, Maitreya is the embodiment of all-encompassing love (Barbara O'Brien: *Maitreya Buddha*, updated April 13, 2018). The Theosophical Maitreya concept is said to have been appropriated by a variety of quasi-theosophical and non-theosophical new age and esoteric groups and movements. They have advanced their own interpretations, ideas and commentary on the subject.

Be that as it may, Krishnamurti rejected the role of new World Teacher later in life, and withdrew from the Theosophy organization. As a philosopher, however, he continued to ponder and publish his thoughts. His topics of interest were:

- meditation
- the nature of mind
- human relationships
- psychological revolution
- how to bring about radical change in society

He constantly stressed that to bring such radical change about, a revolution in the psyche of every human has to occur. And such change, such revolution in the human psyche, cannot be brought about by any external entity, be it religious, political or social. It must be done by individuals themselves. PTSD subjects received the shortcut to such inner revolution by way of the PTSD-causing event.

Russ Torlage and Lesley Punt were a husband and wife team. They wanted human beings to be better adjusted to what Krishnamurti already in the early 20th century called a profoundly sick society. So in the early 1990s, they funded a small

company, SOTA, dreaming big dreams. Their mission?

> "First, we are committed to offering you great products for health at a fair price. Second, we are committed to providing outstanding customer service. If you ever have a question or comment, we would love to hear from you. Our most valuable feedback comes from our customers. Working together, we continue to learn and grow."

Before long, customers began spreading the word about their products to people all over the world. And 22 years later, SOTA is still thriving.

What do they produce? Easy-to-use micro-currents, colloidal silver, pulsed magnetic fields, ozone, light and healthy frequencies instruments for personal use. The Silver Pulser, Magnetic Pulser, Water Ozonator, Bio Tuner, LightWorks and YumaLite all offer the benefits of micropulsing, harmonic frequencies and light for health, we read on their website sota.com.

What is Micropulsing? It helps to stimulate the body's natural electricity for greater energy and wellbeing. What does it do? As we saw in the previous chapter, research today recognizes how our bodies operate electrically. As a matter of fact, our bodies depend on our natural electrical system. Some folks even know that we are nothing but electrical vibration and all seemingly solid, including our bodies, is nothing but illusion. SOTA is an energy-giving system that enhances this electrical system, and can be used at home, at work or at play. How so?

The SOTA products use nature's own technologies — electricity, magnetic fields, ozone, harmonic frequencies, color and light — to help us enjoy a healthy lifestyle. The Silver Pulser, for example, is uniquely designed to apply a gentle pulse of electricity — microcurrents — to the body. The gentle flow of electrons helps restore the body's natural electricity. Many people report an increase in energy within days of applying the Silver Pulser for microcurrents.

How does it work? The Silver Pulser offers a unique way to deliver microcurrents. Electrodes are placed on the wrist over the two pulse points. The physicist who developed the original unit carefully calculated the Micropulsing function to deliver microcurrents. It is recommended to use the unit for two hours daily for at least six to eight weeks. For more detailed instructions, watch the how-to video or read *The SOTA Products User Guide* and the product manual.

The Magnetic Pulser by SOTA offers the benefit of a pulsed magnetic field to help balance the body's natural electricity for health and wellbeing. It can be used anywhere on the body in one of two modes: regular and fast. It also has an

automatic timer.

The Water Ozonator by SOTA is designed to produce a glass of fresh ozone water for drinking by increasing the water's oxygen content and giving it a fresher taste. Independent laboratory tests show the SOTA Water Ozonator "sterilizes drinking water that is heavily contaminated with several different micro organisms." The SOTA Water Ozonator is portable, as it operates using 12 Volts. Ozone output is greater than 200 mg/Hr.

My personal favorite it the Bio Tuner, my first SOTA purchase. It is a super easy-to-use relaxation product designed for stress relief. It outputs harmonic frequencies to promote health. It supports the mind-body connection by offering the benefits of harmonic frequencies to help create an inner sense of calm, balance and tranquility. The unit features an automatic built-in timer for 20-minute sessions. I seemed to level out considerably after my first few days of using it and still use it today when times get a bit hectic. To me, it is a blessing.

Then there is SOTA's LightWorks, which offers the benefits of LED light combined with healthy frequencies. These frequencies gently stimulate the body electric for more energy, health and well being, we read. LightWorks combines the ancient wisdom of color and light with the frequencies and LEDs of modern technology. It gently awakens the body's natural tendency towards health and wellbeing. It also offers the benefits of LED light combined with healthy frequencies gently stimulating the body electric for more energy, health and wellbeing. Either red or near infrared (NIR) light can be readily applied by placing the paddle anywhere on the body. A built-in timer automatically cycles through healthy frequencies. Individual settings can also be chosen.

And last but not least, there is SOTA's newest product, the YumaLite®, which delivers gentle light to the eyes, giving us the benefits of natural sunlight. It is natural sunlight that affects our mood, sleep-patterns and energy levels, gives us an overall sense of wellbeing, and helps us to enjoy life.

YumaLite® offers the benefits of LED light to gently stimulate the body electric for more energy, health and wellbeing. Its easy–to–use visor design allows to select either white or red LED light. The light helps balance the effects many feel during times of decreased exposure to natural sunlight. Many of us suffer from this, due to long hours spent in an office, shift work, jet lag, seasonal changes or dark winter days.

The red light further helps to balance the constant blue light we are exposed to from staring at computer and cell phone screens. The overabundance of blue light

tends to stimulate. It affects circadian rhythms and sleep patterns, whereas the red light helps to bring balance to the blue. Both white and red light use the modern technology of light emitting diodes (LEDs).

The light is applied gently to the eyes by wearing an easy-to-use visor to help balance the effects many feel during times when they have less exposure to natural sunlight. Whether it is a change of time zones, short daylight hours in winter, working indoors or working night shifts, lack of exposure to natural light can impact both mood and energy levels.

YumaLite does help to re-synchronize our body's internal rhythms, elevate our mood and revitalize our energy. In addition, the red LED light further helps to balance the constant blue light we are exposed to from long hours of staring at computer and cell phone screens as well as flat screen TVs.

Many forms of artificial white light contain more light in the blue spectrum than in the red. This over-stimulates us, affecting our circadian rhythms and sleep patterns. The red light helps to bring balance to the overexposure to blue light, helping to restore our natural circadian rhythms and sleep patterns. Using the YumaLite visor with the red light, especially in the evening, helps to balance the ill effects from excessive blue light.

Thus the SOTA YumaLite® helps to balance the effects of decreased exposure to natural sunlight as well as helps to balance overexposure to blue light from cell phone and computer screens. It can be our very own personal sunshine.

SOTA's website has a very useful products user guide, offering tips and suggestions for each SOTA Unit:

- Just starting out? . . . See *Recommendations Before You Begin.*
- Using more than one Unit? . . . You'll find tips to help.
- Wondering how to Integrate the Units for your Wellness? . . . There are recommendations for a *Basic Wellness Program* and a *Focused Wellness Program.*
- Embracing Wellness? . . . You'll find tips for an *Ongoing Wellness Program.*

It's like they were made for PTSD journeyers. And no, I get no payment for praising them, nor a discount for the products I bought. I used and use those products to heal and maintain my health and wellbeing. I consider it my duty to spread the word about SOTA, as I consider it my duty to write this book. I will be

able to lie on my deathbed satisfied with having done due diligence to myself.

What does "due diligence" mean? "Required carefulness" or "reasonable care." In general usage, it has been used in that sense since at least the mid-15th century. It became a specialized legal term, and later a common business term, due to the United States' Securities Act of 1933, where the process is called "reasonable investigation" (section 11b3).

In legal and business use, the term was soon abbreviated and thus perverted in its meaning. Used for the process itself instead of how it was to be performed, the original expressions such as "exercise due diligence in investigating" and "investigation carried out with due diligence" were shortened to "due diligence investigation" and finally "due diligence".

In essence, however, it means the actions considered reasonable for people to be expected to take in order to keep themselves or others and their property safe. Keep *themselves* safe. Taking responsibility for Self is the essence of due diligence. The legal implications are huge, but not in the realm or scope of this book to discuss.

I daily apply due diligence to my life by investigating and researching everything that mighty influence and impact it. The reflections of it are found in this book, which would not be written without due diligence to myself for my protection.

But back to SOTA. PTSD journeyers' in the four PTSD prone occupations had no problems unlocking their brains before the PTSD-causing event. Nor was insufficient brain function an issue for them. Therefore, SOTA should do the trick just fine by soothing the brain into a calm state helping to create peace and quiet and relaxation. In that state, it can harmoniously begin the work of building its new life-structure. Why allow others to apply neurofeedback, the direct training of brain function, by which the brain learns to function more efficiently — or, perhaps, differently — to the one owned, when one can do it oneself without risks of malevolent interference involved?

Why does the Headstrong Project, for example, apply neurofeedback to PTSD experiencers at all? Is it part of Synthetic biology research, an interdisciplinary branch of biology and engineering? The subject combines disciplines from within those two domains. It encompasses biotechnology, genetic engineering, molecular biology, molecular engineering, systems biology, biophysics, electrical engineering, computer engineering, control engineering and evolutionary biology. Synthetic biology applies these to build artificial biological systems for research, engineering and medical use.

The European Medical Association just announced that they will begin

genetically modifying humans to meet their health standards. Scientists at the CRISPR Biotech Company have been doing this type of modification for over 30 years. Professor Robin Lovell-Badge, Group Leader at London's "CRISPR" Institute told the London newspaper Sunday Telegram: "We look back and think this is the beginning of real gene therapy." Doctors dispense purportedly "missing" DNA from damaged cells to increase their effectiveness. How and with what one is replacing something that's missing is unclear.

That actual genes can be removed from humans and others by adding and subtracting whatever one desires is also drifted over lightly. This type of genetic modification of humans is being presented as "therapy" for human diseases. To play with the brain with equal enjoyment by way of neuro-feedback would merely be an addition to the project, would it not? And what better subjects to recruit than the PTS afflicted? (Dr. W. Blount: Modification of Human DNA now Occurring; You Tube, April 17, 2018)

Remember, information on how my thoughts and my brain functioned pre-PTSD-causing event is unavailable. But it functioned mighty well then, just as well as that of those of the other professionals in the PTSD-susceptible occupations. They are living PTSD at present. But before that, we oft times held our work positions exquisitely well for many, many years before PTSD hit.

In my view today, the professions' entire estimation of PTSD is based on trickery and speculation. And so are the effects of any given PTSD treatment modality foisted upon unsuspecting PTSD sufferer for experimental purposes on human beings and, with great vigor I might add. This suppresses all self-help remedies available, including SOTA's instruments.

According to Dr. William Mount on August 21, 2018, there is only one way for veterans, regardless of type of injury, will get help or treatment of any kind, from tooth implants to operations. They must declare themselves mentally defect and content to go on heroin and opium drugs such as oxycodone or LSD-produced Prozac (CIA False Flag against China Set). Murdering the veterans, PTSD journeyers among them, on purpose, killing them and get away with it, the US president does nothing about it, states Mount. They are lead to believe by NCfor PTSD employees and affiliates that only pharmaceutical drugs, together with the above mentioned treatment modalities, will improve their PTSD condition. Most PTSD journeyers' are too distraught to apply due diligence. For both these reasons, they swallow everything whole unaware that they are voluntarily complicit in creating hell for themselves — if they survive rather than shooting a bullet through their head. The

only way out is to heal the Self or die in heart and soul. There is no other way. SOTA is one of the ways to assist this healing.

And whatever you do, do not enlighten the powers that be or anyone else that you are engaging in SOTA or anything else of that nature. Don't bring up any metaphysical aspects of life you may be investigating, the guardian angels and the like. Unless, of course, you want to be declared totally off your rocker, nuthouse-ready. That would give the WCB et al. the excuse to proclaim that your tendencies of believing in the airy-fairy world of life's holistic and spiritual aspects were the cause of your PTSD.

That they certainly are off their rocker is evident. After all, they think the cure for PTSD can be found by wiping the PTSD experience from the experiencers' minds. In effect, it is like asking Neo a few days after having swallowed the red pill to throw it up again and go back to his slumbering-in-ignorance matrix existence. Awareness once gained cannot be returned to unawareness. Can a genie released be returned to the bottle?

Therefore, the path might be painful. It starts at the pre-PTSD causing event's state of ignorance on the meaning of life and everything in it. It leads to the post-event acquisition of insights and discoveries necessary to heal from this existential crisis. Do you want to engage in a drawn-out and gruesome dance towards death by trusting those in authority? If not, you must show due diligence towards your Self, by investigating neurofeedback, SOTA, daily meditation, introspection, soul-searching, yoga, bibliotherapy and things that are anathema to most mental health practitioners.

The earlier-mentioned, empathy-promoting psychodynamic method applied by Dr. Carr seems the humane way to treat human beings in peril. But EEG neuro-feedback treatment modalities and pharmaceutical, marijuana and ecstasy drugging are in vogue. So let us continue to look at other PTSD hypotheses, illusion, hallucinations and implementations concocted by the cabal to prolong PTSD journeyers' agony.

What Else Do They Use To Pervert Our Minds?

Options for PTSD interventions are manifold. That gives everyone making a living in the field of psychology or as a psychic viewer ample opportunity to make a killing. Or, at least, it assures them a steady and handsome income.

The vast majority of pharmacological and psychological PTSD amelioration attempts originate with government-funded research. These are conducted throughout the land by National Center *for* PTSD affiliates and employees of all stripes and colours, many closely associated with VA hospitals. They in turn try out their PTSD treatment ideas and modalities on combat-related trauma sufferers of all

ranks and categories and in the US Veteran population. These by and large constitute their guinea pigs.

An effort was made to present mental health providers with the multitude of pharmacological and psychological interventions available to help prevent and treat PTSD. In 2011,, thoughts by mental health practitioners on the topic gathered and analysed by Brian A. Sharpless and Jacques P. Barber in "A Clinician's Guide to PTSD Treatments for Returning Veterans" (Prof Psychol Res Pr. 2011 Feb 1; 42(1): 8–15).

Sharpless is a clinical psychologist and associate professor of psychology at the American School of Professional Psychology (ASPP) at Argosy University, Northern Virginia, USA. He was trained as a generalist in anxiety disorders, depression, sleep disorders and personality disorders. But he takes particular interest in working with people suffering from disorders that are uncommon or not yet well-understood. To him, thus, PTSD seems to be one of those disorders.

A generalist practice is a social services practice that operates with a broad array of skills, professional roles, methods and settings to help and empower clients. Based on the same values and ethics as social work, this type of practice lends itself to multi-level practices in both the private and public sectors. An example of this are state agencies that combine child protective services, adult protective services, elderly assistance, adoption and foster care, etc.

Jacques P. Barber was professor emeritus of psychiatry at the University of Pittsburg, Pennsylvania, USA. His research focuses on the efficacy of psychotherapy in uncovering the mechanisms of change in different psychotherapies. For the most part, those include psychodynamic and cognitive therapies of patients with depression, panic disorders, personality disorders, cocaine dependence and interpersonal problems.

Due to his work at the VA, Barber also became interested in the efficacy of various PTSD treatments, including prolonged exposure.

He is now dean of the Derner Institute of Advanced Psychological Studies at Adelphi University, founded in Brooklyn, NY in 1896. It is Long Island's oldest private coeducational university, with centers in Manhattan, Hudson Valley and Suffolk County. Its tuition fees average around $20.000 per semester. Professor Barber continues his studies of outcome and process of psychodynamic and cognitive therapies for depression, panic disorder and personality disorders.

He also researches the impact of therapeutic alliances, theoretically relevant interventions, therapist competence, and relational and technical models of

therapeutic changes. Also of interest to him are core conflicts, relationship personality and meta-cognition. A special interest is children of holocaust survivors from Waco to September 11, from Parksville to other recent holocausts regularly occurring in the United States of America, we surmise.

In Sharpless' and Barber's view, strong evidence supports the use of several PTSD therapies, including:

- prolonged exposure (PE)
- cognitive processing therapies (CPT)
- eye movement desensitization and reprocessing (EMDR)

PE shows the most empirical evidence in favour of its efficacy, they claim.

There were fewer studies of non-exposure based modalities, such as psychodynamic, interpersonal, and dialectical behavior therapy perspectives. But there was no evidence that these treatments were less effective than any of the others, we are told. Pharmacotherapy — drugging PTSD voyagers to the hilt — was also promising, especially when influenced by paroxetine, sertraline and venlafaxine. However, more research comparing the relative merits of medication versus psychotherapy alone, and the efficacy of their combined treatment, was needed.

Several pharmacological approaches to prevent of PTSD with ketamine and cortisol had already been assessed, they state. The most promising of those was with propranolol, a beta-adrenergic antagonist (beta-blocker) often used to treat headaches, performance anxiety, and hypertension. Four efficacy studies reviewed in Stein et al. (2007) and McGhee et al. (2010) had shown mixed results. However, only two cases showed reduced PTSD symptoms to an unknown degree.

Given the recent influx of combat-related traumas due to the ongoing Iraq and Afghanistan conflicts, more study was needed. There clearly was still an urgent need to conduct more randomized clinical trials and effectiveness studies in military and VA PTSD research samples.

It's called "feed the wolves". You are the food, the sacrifice. In your misery, you are lead to ruin and destruction by their well-disguised PTSD treatment modalities and prescription drugs. These are administered for their own benefit whilst caring nothing for those for whom they pretend to care. Rather, they feed to the wolves anyone they can use for their experiments and financial gain and worldly fame.

Sharpless wrote *Unusual and Rare Psychological Disorders: A handbook for Clinical*

Practice and Research (Oxford University Press, 2016). In it he asserts that many fascinating and important psychological disorders are either omitted from the current PTSD diagnostic systems or are rarely covered during physicians' graduate and medical training. We could, of course, comment on many fascinating and important psychological disorders mentioned in the DSM-5, to which Sharpless may be referring. We might suggest that they are nothing other than natural human emotional reactions to temporary human life-event-upheavals. We could wonder if they will heal naturally with time, unless mental health practitioners intervene. As Barber and Sharpless point out, psychology students and trainees stumble across these humane human reactions. But most of these, future mental disorder analysts are never taught how to identify, diagnose or treat them. This lack of attention, Sharpless insists, has real-world consequences for patients and basic science, the science of psychology, the science of guessing.

At last count, Professor Barber has published his views and ruminations about the human psyche in more than 225 publications. His ideas of human psychotherapy and human personality publications span from papers and chapters to books. Some of his musings, with effortless vigor and purported expertise, evaluate and estimate the purported effects and efficacy of PTSD treatment modalities. He looks at how they are applied and imposed on soldiers and veterans. Therefore, by extension, he looks at how to apply them to the human PTSD-affected world population, Krishnamurti's profoundly sick society. We do not know if Barber or Sharpless ever soldiered or visited theaters of tar for any length of time. Neither do we know if they ever suffered the experiences and perils police officers, fire fighters and aircrew face in the line of duty. Nor do we know if they were ever raped or otherwise severely assaulted. All this leads to the question: Have their life experiences given them the right to pass judgment of treatment for PTSD-affected people? In particular when we know they have yet to discover — officially at least — that PTS has nothing to do with a mental illness or disorder. In other words, how are they qualified to know that PTSD is 'merely' is a colossal existential crisis?

But let's go on with looking at their findings for our own amusement and education, shall we?

Existing psychological PTSD approaches began as psychological debriefings developed to prevent long-term negative sequelae in the wake of traumatic events, we are told. In clinical medicine, "sequalae" means the consequences of a particular condition or therapeutic intervention. This included elicitations of negative emotional reactions, normalizing reactions and preparing for PTSD responses.

Barber and Sharpless found little evidence that psychological debriefing prevented PTSD. Interestingly enough, though, they report that evidence does exist of such psychological debriefings being detrimental to asymptomatic people, meaning those not reporting PTSD symptoms. Therefore, they state, there appears to be growing hesitation in the field to employ emotional processing interventions during early post-traumatic stages.

Barber and Sharpless also gave Cognitive Behavioral Therapy techniques (CBT) such as relaxation and exposure to memories and reminders of trauma a great deal of scrutiny. From them, we learn about current research reviewed in VA and Department of Defense (DoD) 2010 publications. The research shows that with acute trauma, only PTSD symptomatic clients will likely benefit from such early interventions. In fact, consonant with the literature on psychological debriefings early intervention on non-symptomatic trauma survivors, CBT might also be both ineffective and harmful.

Some inroads had apparently been made towards understanding which clients might benefit from the preventative use of 4 to 5 CBT sessions. But according to Barber and Sharpless, no other preventative recommendations had been included in current CBT practice guidelines. Just CBT for symptomatic trauma survivors and using several techniques of psychological debriefing and "psychological first aid" such as safety education, are included.

And then there is the behavioral-cognitive inhibition theory. It assumes that PTSD and other psychopathology disorders develop when dysfunctional respondent-functional-appraisal memories develop (Nenad Paunović: Behavioral-Cognitive Inhibition Theory: Conceptualization of Posttraumatic Stress Disorder and Other Psychopathology Disorders; *Psychology 2010*. Vol.1, No.5, 349–366). Psychopathology disorders remain due to a continuous retrieval of dysfunctional respondent-functional-appraisal memories. They remain due to inhibition of incompatible respondent-functional-appraisal memories. And they remain due to current dysfunctional appraisals and behaviors. Dysfunctional and incompatible respondent-functional-appraisal memories consist of respondent, discriminative, behavioral response, appraisal and consequence memory elements.

There are three situations where recovery from PTSD and other psychopathology disorders are said to happen:

- when strong enough matching incompatible respondent-functional-appraisal memories are retrieved in the same circumstances as

dysfunctional respondent-functional-appraisal memories

- when dysfunctional respondent-functional-appraisal memories become inhibited by incompatible respondent-functional-appraisal memories
- when new incompatible or functional contingencies are encoded, stored and become effective incompatible respondent-functional-appraisal memories

Concrete examples of respondent-functional-appraisal memory elements in emotional and personality disorders are presented. So are incompatible respondent-functional-appraisal memory elements.

How to accomplish this hypothesized task with the PTSD afflicted? In the 2014 abstract to Paunovic's hypothesization, published in 2014, we read:

> "A first outline of a new cognitive-behavior therapy program for posttraumatic stress disorder (PTSD) is presented with regards to its underlying theories and treatment components. It is based on the behavioral-cognitive inhibition (BCI) theory for PTSD (Paunović, 2010) and is named *Behavioral-cognitive inhibition* (*BCI*) *therapy*. The treatment program is presented descriptively session by session. The program rests on the following main blocks: (1) overview of the whole treatment program and normalization of PTSD symptoms in terms of the BCI-theory, (2) the development of narrative stories of valued life event memories, (3) emotional processing of valued life event memories, (4) cognitive processing of dysfunctional trauma-, pre-trauma and posttrauma beliefs central in the maintenance of PTSD, (5) exposure inhibition that consists of (i) emotional processing of valued life event memories, (ii) a single imaginal exposure to central trauma memory details, and (iii) repeating the emotional processing of valued life event memories, and (7) identifying current most valued life areas and *utilizing* valued narrative stories, emotional processing of valued life event memories and behavioral activation *in valued directions*." (Nenad Paunovic, Behavioral-Cognitive Inhibition Therapy for Posttraumatic Stress Disorder: A Cognitive Behavior Therapy Developed

from the Behavioral-Cognitive Inhibition Theory, *International Journal of Applied Psychology*, Vol. 4 No. 6, 2014, pp. 229–239. doi: 10.5923/j.ijap.20140406.04).

What life has been experienced by Paunovic thus far is unknown.

Barber and Sharpless did furthermore observe that drugs affecting mind, emotions and behavior are commonly prescribed for PTSD-affected people. Although they are meant to effectuate PTSD healing, they are prescribed because it is less time consuming than psychotherapy. They can be administered by any physician of any field of expertise. They can be taken with ease in the combat theater, where it is so much easier to administer than talk therapy. Nothing is mentioned about simultaneous body and mind destruction.

The NCforPTSD fervently encourages combined CBT and pharmacotherapy for PTSD healing. According to Dr. William B. Mount, no veteran trooping up at a VA hospital without consenting to psychotropic drug intake gets treatment for anything (William B. Mont, August 2018). At the same time, of course, any veteran declaring himself or herself mentally defect by consenting to take psychotropic drugs is consenting to give up the 2nd Amendment right to bare arms.

Where is the scientific empirical first evidence that mind-altering drugs alleviate PTSD? Barber and Sharpless state that at least 35 randomized controlled trials (RCT) examining pharmacological agents and their effects on PTSD symptoms exist.

RCT are research studies in which people are allocated at random and by chance to receive one of several clinical interventions performed to bring about change in people. Generally it means any activities used to modify human behavior, emotional states or feelings. In RCT one of these interventions is the standard of comparison or control. The control may be a standard practice, a placebo or "sugar pill", or no intervention at all. RCTs seek to measure and compare the outcomes after trial-participants received the interventions. Because outcomes are measured, RCTs are called quantitative studies. In sum, RCTs are quantitative, comparative, controlled experiments, in which researchers study two or more interventions in a series of individuals who receive them in random order. In clinical research, RCTs are touted as one of the simplest and most powerful tools.

Ranked as first-line treatments in at least four different PTSD practice guidelines were two selective serotonin reuptake inhibitors. One was paroxetine [Paxil] and the other was sertraline [Zoloft]. Also ranked in at least four different PTSD practice guidelines was the serotonin-norepinephrine reuptake inhibitor venlafaxine [Effexor, Trevilor]. (American Psychiatric Association, 2004; VA/DoD, 2010;

Davidson et al. 2005, and the National Center *for* PTSD, 2009) Paroxetine and Sertraline had FDA approval to treat PTSD, with the former possessing the strongest level of overall empirical support. Per VA/DoD 2010 guidelines, the following were recommended as second-line agents:

- imipramine (Tofranil)
- nefazodone (Serzone)
- mirtazapine (Remeron)
- two tricyclic antidepressants (amitriptyline, Elavil)
- one monoamine oxidase inhibitor (phenelzine, Nardil)

It is worth noting, however, that the Institute of Medicine (2007) concluded that there was insufficient evidence for the efficacy of medications for PTSD. Their use is indeed recommended in many current treatment guidelines, convey Sharpless and Barber. We will present/explore drug side-effects and other repercussions in a later chapter.

Adjunctive pharmacological agents for treatment are also recommended, we hear. This has prompted the use of polypharmacy strategies, including multi-target pharmacotherapy. That is treatment using one or more add-on psychotropic medications and supplements. Try one, try all together, with or without psychotherapy. Thus, some PTSD experiencers voluntarily swallow 18 different psychotropic drugs daily, in the belief it will help heal their PTSD.

The most widely used drugs for that purpose are:

- prazosin (Minipress)
- atypical antipsychotics
- D-cyloserine (Seromycin)

Prazosin is often used to treat hypertension. It may be very useful in reducing nightmares and other sleep disturbances commonly associated with PTSD, said Raskind et al. in 2007. At that time, a large-scale study of prazosin was to be conducted by Raskind, due to its relatively mild side effect profile and its apparent utility against nightmares. The new study was run over six months at 12 VA medical centers with about 300 participants. Half were given a placebo and half were given prazosin. The result? Prazosin did not improve sleep-associated problems in patients with chronic PTSD. But the placebo response rate was quite high. Could prazosin

have been effective if patients with psychosocial instability, expected to have a low placebo response rate, had been included in the trial, one wonders? Furthermore, patients received relatively high doses of prazosin, which had hypotensive effects. Could the authors rule out the possibility that chronic night-time PTSD symptoms might even have been aggravated by the nightly hypotension caused by prazosin? After all, orthostatic panic attacks are a known potential coexisting condition in these patients, points out Ion Anghelescu, M.D., and Carsten Moschner, M.D., of Clinic Dr. Fontheim, Liebenburg, Germany. (*N Engl J Med* 2018; 378:1648–1650).

Andrew Joseph of STAT reported on prazosin in February 2018 that "*This drug has been used to treat PTSD symptoms. What happens when it fails a trial?*" Patients in both arms of the study saw mild improvements in sleep quality and in the frequency and severity of nightmares. But there was no significant difference between the improvements in the different study groups.

Mind you, enrolment was limited to PTSD-affected people who were clinically stable. In other words, they were not drinking heavily, facing family conflicts or experiencing suicidal or violent thoughts, Raskind said. Because of the long duration of the study, researchers didn't want to risk exposing such patients to a placebo. Some psychiatrists didn't want their patients enrolled in the study at all for that same reason. But in Andrew Joseph's view, by focusing on stable patients, Raskind and his colleagues may have set themselves up for a negative result. It could be that only patients experiencing some distress would have responded to prazosin.

Be it as it may, some researchers not involved with the study were quick to say that clinicians should still prescribe prazosin for some patients. Raskind, who is director of the VA's Northwest Network Mental Illness Research, Education and Clinical Center, agreed. There are few other treatment options, we hear, and there is evidence supporting the use of the drug. It was a generic, originally approved to treat high blood pressure, but prescribed off label to control nightmares and improve sleep quality in PTSD patients. "I don't think it should change clinical practice — there are six positive studies and one negative study," said Raskind. He described the research team as "humbled" by the results. He estimated that 15 to 20 percent of PTSD affected veterans in the VA system were currently prescribed prazosin. He did not expect that to change.

The study had some impact, though. The VA and Department of Defense wrote in 2017 that there was insufficient evidence to recommend for or against the use of prazosin to treat PTSD-related nightmares or sleep disturbances. It should be up to clinicians and their patients to decide whether to stop or continue its use, the

officials said. If patients who stopped taking it re-experienced the symptoms they should just start the therapy again, as it appeared to be very promising.

Many things and situations in life appear to be promising, while instead spelling further disaster if not thoroughly researched. About prazosin's short- and long-term repercussions on body and mind, we hear not one word.

D-cyloserine, Seromycin, the other drug touted as marvellously benevolent to PTSD journeyers, is a broad-spectrum antibiotic. It also serves as a cognitive enhancer, as well as a facilitator of extinction learning in anxiety disorders (Cukor, Spitalnick, Difede, Rizzo, & Rothbaum, 2009), we learn from Barber and Sharpless.

Studies clearly show that naturally occurring psychedelics, from which all mind-altering drugs derive, can produce life-altering feelings in anyone at any time. In a trial at Johns Hopkins University with healthy volunteers, most participants reported that taking psilocybin, for example, was among the five most meaningful experiences of their life.

Only a few hundred patients have been treated in this array of studies. But even cautious voices see a potential shift that could overhaul the practice of psychiatry. "It raises all sorts of interesting issues about neuroscience," says Dr. Paul Summergrad. He is chair of the psychiatry department at Tufts Medical School and a former president of the American Psychiatric Association. He says,

> "It goes back to spirituality and meaning. An experience of oneness, purpose, holiness, sacredness, these things are very powerful, and in these studies they seem to be highly correlated to people's improvement. You have to ask what this says about the power of these states as part of human experience and about what we think of as mental health."

Summmergrad warns: "The history of mental health treatments is littered with things that look good at first, but eventually don't turn out to be so helpful." (Caleb Hellerman: *Hitting the Brain's Reset Button*; pbs.org 2016).

Another pet PTSD treatment modality mentioned by Barber and Sharpless is extinction learning. This is a major mechanism to reduce fear by means of exposure and neurogenesis. Extinction of maladaptive conditioned responses or behaviors is a process of active learning. It requires to learn new stimulus-response and action-outcome relationships and to form new associations between previously trauma-related cues and contexts and appropriate cognitive and behavioral responses.

Knowledge about the neural substrates that underlie extinction processes comes from studies of fear conditioning. Adult neurogenesis is an ongoing process that

occurs in most mammalian species, including humans (Richard M. Cleva, Kelly C. Wischerath & M Foster Olive: Extinction Learning and Adult Neurogenesis; Neuropsychopharmacology volume 36, pages 360–361 (2011) Current research targets innovative strategies to enhance fear extinction. Thereby, they can optimize exposure-based treatments for anxiety disorders by way of novel behavioral strategies that may provide cutting-edge clinical implications, we hear.

Summary behavioral strategies to enhance fear extinction may further make exposure-based interventions more effective. However, future replications, mechanistic examinations and translational studies are needed to verify its long-term effects

the authors assert. Future study is needed on the interplay of optimized fear extinction with (avoidance) behavior and motivational antecedents of exposure (Pittig, Andre; van den Berg, Linda; Vervliet, Bram: "The key role of extinction learning in anxiety disorders: behavioral strategies to enhance exposure-based treatments"; *Current Opinion in Psychiatry*: January 2016, Volume 29, Issue 1, p 39–47; journals.lww.com).

An enduring question in the study of mental health is to what extent the changes a patient experiences are the result of new "thinking", as opposed to more primal shifts. One area of PTSD research focuses on the latter. It is speculated by armchair experts that, in the wake of a life-threatening incident or extended abuse, a person "learns" to avoid stimulus appears dangerous. Up to a point, they hypothesize, this kind of conditioning may be normal and crucial to evolutionary success. But with PTSD, they suggest that such conditioning goes beyond what they considered healthy. They feel the brain overreacts to stimuli that do not in fact signal a threat.

Common symptoms include hypervigilance, nightmares, shame and guilt, and a sense of being emotionless. Even a faint reminder of the trauma can evoke a strong physical response, like a panic attack. Severely-affected war veterans or sexual assault survivors might avoid even small crowds, cutting themselves off from friends or even simple shopping expeditions. Again, PTSD is one colossal existential crisis, which no one understands unless having lived it. All else is nothing but B.S., creating a delightful income stream for a many mental health practitioners. They practice with vigour, making sufferers suffer forever and a day, until death do them part.

Some say avoidant behavior is at the heart of PTSD. For one thing, it's self-reinforcing.

Dr. Kerry Ressler, a psychiatrist and neuroscientist at McLean Hospital and Harvard Medical School, says:

> "If people have an intrusive disturbing thought and then do everything they can to shut it down, that probably trains the brain that this is still a scary thing you have to avoid and run away from . . . Successful avoidance effectively reinforces the fear memory . . . If people can be really engaged but not over-engaged or overwhelmed by emotion, that's when the therapeutic change happens."

Treatment often centers on the fear response. "You can look at recovery from trauma as a form of extinction learning," says Ressler. He adds that the goal of therapy is to reconstruct neural pathways to disconnect a traumatic memory from its overwhelming emotional charge.

I beg to differ, as I proved him wrong. So would many others in the PTSD situation, were they allowed to heal rather than being destroyed due to their own ignorance and laziness, and pharmaceutical drugs and dreamed up treatment modality and trusting their treaters. True evil has a face you know and a voice you trust . . . .

As we learn from Barber and Sharpless, extinction learning looked promising, but more research sample data were needed before determining its PTSD usage. Combined with the adequate dosage of psychotropic drugs, such as the atypical antipsychotic Risperdal, it held promise. The VA and DoD recommend it as adjunctive treatment.

What are atypical drugs? Older, first generation antipsychotic drugs are considered typical antipsychotics. Newer, second generation drugs, which have different chemical structures, are considered atypical.

Atypical antipsychotics have some different side effects than older typical antipsychotics. Both typical and atypical antipsychotics are dopamine antagonists, meaning they block dopamine in the brain, though this action is briefer with atypical antidepressants. Atypical antidepressants also block serotonin.

What function do dopamine and serotonin perform in the human brain? They are neurotransmitters associated with the pleasure centers of the brain. They are responsible for feelings related to love, joy, pleasure, reward and motivation. Serotonin gives humans a feeling of calmness and a sense of general wellbeing. By increasing the serotonin level we maintain calmness under stress, regardless of external or internal factors. Serotonin enables us to deal with stressful situations

much more constructively. It keeps us feeling good regardless of problems coming our way. It helps regulate and most likely control irritability, impulse, obsession and memory.

Dopamine is the pleasure chemical responsible for making humans feel elated or euphoric. It may slow down the aging process by making us feel both happier and younger. It also assists with libido. However, prescription medication is not needed to boost dopamine and serotonin levels. Several natural exist to do this in a much safer way than using artificial medications (Jennifer Johnson: *Dopamine and Serotonin–Brain Chemicals and Your Happiness*; anxietyreliefstress.com). Draw your own conclusion when considering that mind-altering drugs block the brain's natural dopamine and serotonin production.

Barber & Sharpless in their *Clinician's Guide to PTSD Treatments for Returning Veterans* go on to talk about the International Psychopharmacology Algorithm Project (IPAP). This not-for-profit corporation was established in or about 1993. Its purpose was to bring together experts in psychiatry, psychopharmacology and algorithm-design. Together, they could enable, enhance and propagate the use of algorithms for the systematic treatment of major Axis I psychiatric disorders.

The approach is polythetic with a central psychiatric focus using other relevant fields. Those fields include data modeling, information science (informatics), cognitive science and general medicine. (polythetic: relating to or sharing characteristics common to members of a group or class, but none of which is essential for membership of that group or class). Psychiatrist Kenneth O. Jobson graduated from the Emory University School of Medicine in 1968 He has been in practice for over 50 years, and he founded the project. He works in Knoxville, TN. You can watch him in action on you tube's Dr. Bob Show.

The IPAP receives funding from the Dean Foundation, a non-profit medical charitable trust. The Foundation's prime objective is to provide palliative care for those suffering from incurable illnesses with competence and compassion and to end unnecessary suffering, indignity and fear. The IPAP organized and supported several international conferences on psychopharmacology algorithms. It also supports the creation of several algorithms based on expert opinion. It released schizophrenia and PTSD algorithms in July 2005. Now, it is creating "evidence-based algorithms," created by experts and annotated with the evidence that leads to these algorithms.

The word algorithm can also be used to describe certain medical procedures. In this context, the algorithm is similar to a recipe with ingredients and processes. However, it is the kind of recipe that specifies what to do under alternative

conditions. For example a cooking recipe might contain alternatives for high altitude cooking or ingredient substitutions. Thus, a medical algorithm might describe or prescribe a procedure. The algorithm might have a deterministic or a stochastic orientation. In other words, it might emphasize cause and effect or the probabilities of various possible results or coincident conditions. The word *stochastic* in English was originally used as an adjective with the definition "pertaining to conjecturing."

It has various origins, such as from the Greek *stokhastikos*, loosely translated as capable of guessing. And from stokhazesthai, to aim at, conjecture. And from stokhos a target, it is by some translated into "to aim at a mark, guess", the Oxford English Dictionary giving the year 1662 as its earliest occurrence. The Swiss mathematician Jacob Bernoulli (1655–1705) probably first used the phrase in his *Ars Conjectandi sive Stochastice*, Latin for "The Art of Conjecturing". It is a book on combinatorics and mathematical probability. Combinatorics is an area of mathematics primarily concerned with counting, both as a means and an end in obtaining results, and certain properties of finite structures. It is closely related to many other areas of mathematics and has many applications ranging from logic to statistical physics, from evolutionary biology to computer science.

Apart from many combinatorial topics, Bernouille in this work consolidated many central ideas in probability theory, such as the very first version of the law of large numbers: indeed, it is widely regarded as the founding work of that subject. It also addressed problems that today are classified in the twelvefold way and added to the subjects; consequently, it has been dubbed an important historical landmark in not only probability but all combinatorics by a plethora of mathematical historians. The importance of this early work had a large impact on both contemporary and later mathematicians; for example, Abraham de Moivre.

Bernoulli wrote the text between 1684 and 1689, including the work of mathematicians such as Christiaan Huygens, Gerolamo Cardano, Pierre de Fermat, and Blaise Pascal. He incorporated fundamental combinatorial topics such as his theory of permutations and combinations (the aforementioned problems from the twelvefold way) as well as those more distantly connected to the burgeoning subject: the derivation and properties of the eponymous Bernoulli numbers, for instance. Core topics from probability, such as expected value, were also a significant portion of this important work.

Bernoulli also reviewed work of others on probability, in particular those by his contemporaries van Schooten, Leibniz and Prestet. Many examples are given on

how much one would expect to win playing various games of chance. The term Bernoulli Trial resulted from this work. In the theory of probability and statistics, a Bernoulli trial (or binomial trial) is a random experiment with exactly two possible outcomes, "success" and "failure", in which the probability of success is the same every time the experiment is conducted. Incomplete at the time of his death, the work is still of greatest significance in the theory of probability.

And what really is probability or Stochastice?

> ". . . probability as a measurable degree of certainty; necessity and chance; *moral versus mathematical expectation*; a priori an a posteriori probability; expectation of winning when players are divided according to dexterity; regard of all available arguments, their valuation, and their calculable evaluation; law of large numbers . . . " (*Ars Conjectandi*)

Thus, it is the law of stochastics in which the NC for PTSD perpetually engages by experimenting with new theories, hypotheses, modalities and therapies on PTSD experiencers.

The phrase "Ars Conjectandi sive Stochastice", was used with reference to Bernoulli by the Russian economist and statistician of Polish ancestry Ladislaus Josephovich Bortkiewicz (1868–1931). He lived most of his professional life in Germany, where he taught at Strassburg University (1895–1897) and Berlin University (1901–1931). In 1917, he wrote in German the word *stochastik* with a sense of meaning random.

Stochastischer Prozeß was also used in German by Andrey Nikolaevich Kolmogorov (1903–20 October 1987). He was a 20th-century Russian mathematician who made significant contributions to the mathematics several fields. Those fields include probability theory, topology, intuitionistic logic, turbulence, classical mechanics, algorithmic information theory, and computational complexity.

Another Russian mathematician, Aleksandr Yakovlevich Khinchin (1894–1959), one of the most significant people in the Soviet school of probability theory, also used the term.

In the English language, the term *stochastic process* is said to have first appeared in a 1934 paper by the American mathematician Joseph L. Doob (1910–2004), who specialized in analysis and probability theory and developed the theory of martingales. In probability theory, a martingale is a sequence of random variables (i.e. a stochastic process) for which, at a particular time in the realized sequence, the expectation of the next value in the sequence is equal to the present observed value

even given knowledge of all prior observed values.

But back to algorithms, which might be presented as a time-oriented flow or as a time-isolated procedure. Regardless of the variations in purpose or orientation, an algorithm is a succinct expression of the elements of the procedure, and its language of expression should support the communication of the algorithm's meaning.

One of the flaws observed in IPAP's web conference was the difficulty connecting the algorithm to the best medical evidence. IPAP resolved to restructure the process by creating evidence-based algorithms rather than expert-based algorithms. During 2004 and 2005, IPAP enlisted two groups of prominent psychiatrists to create flowchart algorithms for Schizophrenia and PTSD. The complete algorithms on the IPAP website include copious notes for each of the nodes and additional reference material for the education of physicians.

Barber and Sharpless opine that these algorithms represent an ongoing effort by the psychiatric profession to improve the communication of knowledge about treating mental disorders. The schizophrenia faculty, for example, is currently addressing new research to determine what, if any, impact it has on the schizophrenia algorithm. As we can see, schizophrenia and PTSD are mentioned in the same breath. In fact, schizophrenia accusations are gladly hung on PTSD experiencers at any given opportunity. But Barber and Sharpless merely state that the IPAPs PTSD algorithm presents little guidance when medications fail to produce significant changes in PTSD subjects. IPAP's algorithm is for medical practitioners, what IBM's supercomputer Watson is for computing. It combines artificial intelligence (AI) and sophisticated analytical software for optimal performance as a "question answering" machine.

However, they do reveal that work has begun to address this all-too-common treatment problem. The very detailed treatment algorithm makes explicit recommendations for sequencing medications in order to maximize response when a first-line drug fails to achieve treatment goals. Although built on the best available evidence, and seemingly face valid, the PTSD guidelines have yet to be empirically supported. In other words, it is purely stochastice/conjecture.

Barber and Sharpless note, however, that some PTSD clients are reluctant to take medications for a number of reasons. One reason is fear that their PTSD symptoms will merely be masked but not healed. No data for military personnel on their reticence to take medications is yet available; nor if other PTSD journeyers' prefer talk therapy. Be it as it may, psychotherapy in Barber's and Sharpless' opinion continues to remain an important PTSD treatment option. We may be well to

remember that treatment modalities are considered theories only. They are the often times trans-humanistic-oriented practitioner practicing his theorized — stochastic — practices on live human subjects for better or for worse.

Barber and Sharplessnote that many forms of psychotherapy have been used for PTSD. They contend, however, that approaches derived from the CBT traditions have undergone the most extensive evaluation thus far. These are more widely disseminated throughout the VA system than other approaches. Many others, the researchers convey, also hold promise and warrant additional consideration and testing.

PE, CPT, WET, EMDR, Stress Inoculation Training (SIT) Hypothesis

PROLONGED EXPOSURE (PE)

Take the Prolonged Exposure (PE) PTSD treatment modality, for example. This approach aims to reduce PTSD through by modifying the memory structures' underlying emotions, such as the ubiquitous fear said to be found in PTSD. PE is a manualized treatment, typically consisting of eight to 15 weekly, 90-minute sessions. The main components of PE include the imaginal revisiting of the clients' traumatic memories, termed imaginal exposure. This is done by recounting them aloud and discussing the experience immediately after the recounting, termed "processing". It

is also done by *in vivo* exposure to safe but trauma-related situations the client fears and avoids.

PE also includes psycho-education and training in slowed breathing techniques. Psycho-education aims to help people with a mental illness or anyone with an interest in mental illness to access the facts about a broad range of mental illnesses in a clear and concise manner. It is also a way to access and learn strategies to deal with mental illness and its effects (Royal Brisbane and Women's Hospital, 2009).

Exposure therapy in general and PE in particular had been found to be highly effective in reducing PTSD symptoms, assert Barber and Sharpless. In fact, they say, of all the pharmacological and psychological PTSD treatment in nature, PE likely possessed the most evidence in favour of its efficacy. Furthermore, we hear, PE was one of only two psychotherapies selected by the VA and military for widespread circulation. Evidence for its efficacy in military and VA samples were beginning to emerge, as two small studies in VA settings surfaced. On the basis of these two small studies and the assertion that extensive support existed for PE in the civilian population, Barber and Sharpless vigorously supported it. They opined that PE could be effective in the military setting and for both PTSD afflicted male and female veterans. Effective, yes, but with the appropriate psychotropic drugs as adjunctives, of course.

COGNITIVE PROCESSING THERAPY

Cognitive processing therapy (CPT) shares many of CBT's concepts. The rattus principle is one, in particular challenging automatic thoughts and self-blame on which, we are told, it focuses special attention. Typically administered in a 12-session format, CPT contains an exposure component, but one quite different from PE. Specifically, clients are instructed to:

- write about their traumatic events in detail, revealing their sensory memories, thoughts and feelings
- read their accounts to themselves daily
- to read them aloud during sessions

Therapists — the rapists of the mind — help clients label their feelings and work through "stuck points" in their narratives.

Six studies, four of them RCTs, have found CPT effective in both military and civilian samples (Cahill et al, 2008). To provide evidence of its PTSD efficacy, a

recent dismantling study (Resick et al., 2008) showed that while both CBT and CPT were effective. But they also showed that the cognitive components of CPT were more effective than written exposure techniques. In summary, CPT had very good data supporting its use in PTSD. It was chosen as the other psychological treatment to be extensively "rolled out" through the VA system.

On what basis was its efficacy in PTSD treatment for soldiers and veterans in the US Armed Forces and thus PTSD afflicted worldwide determined? On the Information Processing Theory's basic idea that the human mind is like a computer or information processor rather than based on behaviorists' notions that humans merely respond to stimuli (learning-theories.com). These theories equate thought mechanisms to that of a computer. The brain gathers information from the senses (input) stores it and processes it, finally bringing about a behavioral response (output).

In 2002 Patricia A. Resick, Pallavi Nishith, Terri L. Weaver, Millie C. Astin, and Catherine A. Feuer of the University of Missouri — St. Louis published a study. It was entitled "A Comparison of Cognitive-Processing Therapy With Prolonged Exposure and a Waiting Condition for the Treatment of Chronic Posttraumatic Stress Disorder in Female Rape Victims" (*Journal of Consulting and Clinical Psychology* 2002, Vol 20, No. 4, 867–879) They ran with the concept.

Resnick is professor in psychiatry and behavioral sciences, psychiatry & behavioral sciences, translational neuroscience at the School of Medicine. She is also professor in the department of psychiatry and behavioral sciences at Duke University and a member of the American Board of Professional Psychology. In the course of her career, she served on the faculties of the University of South Dakota, the Medical University of South Carolina, the University of Missouri-St. Louis, where she held an endowed professorship, and Boston University. For a decade, she was the NC *for* PTSD Director of the Women's Health Sciences Division at VA Boston Healthcare System.

Resick has received numerous grants from NIH, NIJ, CDC, SAMHSA, VA and DoD. These have generally been to provide services and conduct research on the effects of traumatic events in particular on women, and to develop and test therapeutic interventions for PTSD. Specifically, she developed and tested the Cognitive Processing Therapy (CPT), considered an effective short-term treatment for PTSD and related symptoms. She is a prolific writer, having published nine books and over 250 journal articles and book chapters. Resick and Schnicke introduced the Cognitive-processing therapy (CPT) as a possible PTSD treatment

some years back. You can read about it in *Cognitive Processing Therapy for PTSD: A Comprehensive Manual;* (Patricia A. Resick, Candice M. Monson, and Kathleen M. Chard Copyright © 2017).

Specifically designed to treat PTSD resulting from sexual assault, it consists of two integrated components: cognitive therapy and exposure in the form of writing and reading about the traumatic event (Resick, 1992; Resick & Schnicke, 1992, 1993). I could find no information on M.K. Schnicke. Their 2002 study's purpose was to compare cognitive-processing therapy (CPT) with prolonged exposure and a minimal attention condition (MA). They randomized 175 female rape victims into 1 of the 3 conditions; 121 completed the treatment. Participants were assessed with:

- the PTSD Symptom Scale
- the Beck Depression Inventory
- the Trauma-Related Guilt Inventory
- the Clinician-Administered PTSD Scale
- the Structured Clinical Interview for DSM-IV

Independent assessments were made at pre-treatment, post treatment, and 3 and 9 months post treatment. Analyses indicated that both treatments were highly efficacious and superior to MA. The 2 therapies had similar results, but CPT produced better scores on 2 of 4 guilt subscales, according to their research.

The therapy focuses initially on assimilated, distorted beliefs, such as denial and self-blame. Then the focus shifts to overgeneralized beliefs about oneself and the world. Beliefs and assumptions held before the trauma are also considered. Clients are taught to challenge their beliefs and assumptions through Socratic questioning and the use of daily worksheets. Once dysfunctional beliefs are deconstructed, more balanced self-statements are generated and practiced. The exposure component consists of having clients write detailed accounts of the most traumatic incident(s), which they read to themselves and to the therapists. Clients are encouraged to experience their emotions while writing and reading and the accounts are then used to determine "stuck points," which are areas of conflicting beliefs, leaps of logic or blind assumptions.

This traumatizing concept was or is sprung on PTSD warriors and other humans in similar conditions as the PTSD afflicted. In fact, it drives them further into the abyss. Since 2006, Resnick has been a leader of a national VA plan to disseminate Cognitive Processing Therapy throughout the VA system. She is working on five

clinical trials in San Antonio and Ft. Hood, Texas, one at Duke, a large cooperative study in VA comparing CPT with PE, and consulting on several grants overseas. Pray, what are her life-experiences thus far?

But never mind, as the CPT concept leads us right to the next PTSD healing assumption on the block. It's the *Written Exposure Therapy,* presented by the rapists of the mind, therapists, as the alpha and omega for PTSD healing. Or, as they phrase it, a treatment modality non-inferior to the Cognitive Progressive Theory (CPT) therapy. As rattus has yet to learn to write, human subjects were needed.

WET was originally part of a technique in behavior therapy thought to help treat anxiety disorders. It involves exposing the target patient, the human being whose mind is to be manipulated into disbelieving what he or she saw and experienced, to the anxiety source or its context without the intention to cause any danger or harm. Pay attention to "intention". Doing so was thought to help PTSD journeyers' overcome their anxiety *or* distress. Procedurally, it is similar to the fear extinction paradigm developed by studying laboratory rodents.

K.M. Myers & M. Davis are with the Department of Psychology, Emory University, Atlanta, Georgia, USA. They both seemingly work for the National Center for Biotechnology Information. They wrote the article "Mechanisms of fear extinction" (*Molecular Psychiatry* vol. 12, p. 120–150, 2007). In it, they express that excessive fear and anxiety are hallmarks of a variety of disabling anxiety disorders that affect millions of people throughout the world. The brain mechanisms involved in inhibiting fear and anxiety is being studied with great interest in the molecular biology research society. This is done by exploring and studying the structures and functions of human cells on a molecular level. Presumably, all cell functions take place on that level. Supposedly, the sophisticated interconnection and cooperation of biological molecules is what makes life possible. The notion that human heart and soul emotions may influence cell structure development is ignored. But for the sake of exploring motivation and purpose behind this research and its possible connection and application to PTSD experiencers, let's continue.

In the laboratory, fear inhibition most often is studied through a procedure in which a previously fear-conditioned organism — rat or mouse — is exposed to a fear-eliciting cue in the absence of any aversive event. Much of this progress can be attributed to the use of Pavlovian fear conditioning as a model system. In this paradigm, there is an initially innocuous stimulus, the to-be-conditioned stimulus (CS). It is paired with an innately aversive unconditioned stimulus (US), such as a foot-shock. The subject, typically the rat or mouse, comes to exhibit a conditioned

fear response (CR) to the CS. In rodents, fear is defined operationally as a cessation of all bodily movements except those required for respiration. They freeze. Other reactions to the the conditioned stimulus include:

- increase in blood pressure
- changes in respiration
- emission of ultrasonic distress calls
- avoidance of the place where shock occurred
- increase in the amplitude of an acoustically elicited startle response
- any of a number of other measures .

The same Pavlovian fear conditioning described above is used to study inhibition of fear. It is typically studied through a procedure in which a previously fear-conditioned organism is exposed to the fear-eliciting CS in the absence of the aversive US. This procedure results in a decline in conditioned fear responses that is attributed to a process called fear extinction. It occurs when there is a reduction in the predictive measurements or values of the CS as to the occurrence of the US. The same fear extinction is lauded for the PTSD afflicted.

In 2002, Myers & Davis published a comprehensive review of the neural literature on extinction, which, they say, at the time was relatively modest. The extensive empirical work of behavioral psychologists has revealed basic behavioral characteristics of extinction. Theoretical accounts, we read, have emphasized extinction as a form of inhibitory learning as opposed to an erasure of acquired fear. What is inhibitory learning? Inhibitory learning is learning that inhibits previous learning. According to psychological jargon, it means that when we learned something that competes with other information it inhibits that previous learning from being expressed.

To give an example, someone may have learned that if they have a panic attack they will have a heart attack and die. As that is not necessarily the truth, if they were to successfully complete exposure therapy, they would learn something new, namely that they can have a panic attack without a heart attack and death. This new learning competes with the previous learning and inhibits it. So now when the individual gets anxious, this new learning will inhibit the previous belief of having a heart attack from being expressed.

The original belief — or thought — about having heart attacks when under a panic attack might not go away entirely. It might not be unlearned. But it is

theoretically assumed that it will be somewhat inhibited by new learning.

Yes, and in the same vein is mind over matter, thoughts are things, Dharma, over Karma, knowledge is power. Control over the Self is the ultimate goal. It can inhibit previous learning like the *trust your doctor* to be expressed and adhered to. Thus inhibitory (or extinction) learning, as part of expansion learning per se, fits right into PTSD journeyers' goals. The expansion of knowledge helps heal the Self without neurobiological, pharmacological, the-rapist inhibition and extinction learning intervention. It heals solely by and with the innate God-given power of the Self.

Let's look at Myers' and Davis 2002 abstract *Behavioral and neural analysis of extinction* (Neuron. 2002 Nov 14; 36(4): 567–84). In it, they exclaim that the neural mechanisms by which fear was inhibited were poorly understood. Although, by 2007, literature on the issue had grown substantially and a number of advances had been made. Consequently, behavioral investigations of fear extinction had been extended and *theoretical* accounts developed by psychologists. Yes, they now guided neurobiological studies — with you as rattus, if you allow it.

And how did the idea of CPT come about originally? It began as a mode of therapy in the 1950s. At the time, the psychodynamic approach, which saw human functioning based upon the interaction of drives and forces within the person dominated Western clinical practice. Those drives were seen as particularly strong in the unconscious and between the different structures of the personality. That's when behavioral therapy first emerged.

The South-African psychiatrist Joseph Wolpe (1915–1997) was one of the first who sparked interest in it. He treated psychiatric problems as behavioral issues during his enlistment as a medical officer in the South-African army. He worked at a psychiatric hospital, treating soldiers diagnosed with what was then called "war neurosis" and now termed PTSD.

Wolpe spent a year at Stanford University's Center for Behavioral Sciences in the mid 1950's. He then moved to the USA, accepting a position at the University of Virginia in 1960. In 1965, he took up an engagement at Temple University, a public research university in Philadelphia, Pennsylvania, USA, and founded in 1884 by Baptist Minister Russell Conwell.

Wolpe's most famous idea is known as *systematic desensitization*, where the client is exposed to the anxiety-producing stimulus at a low level. Once anxiety is no longer present, a stronger version of the anxiety-producing stimulus is given. This continues until the individual client no longer feels any anxiety towards the

stimulus. His systematic desensitization involves developing a hierarchy of anxiety-provoking situations and learning relaxation techniques. They then associated the anxiety provoking situations with relaxation, beginning at the bottom. Or least they associate the anxiety-provoking part of the hierarchy after the initial formulation of what Wolpe originally called, "behavior analysis."

His relaxation and stress relationship originated with the American physician in internal medicine, psychiatry and physiologist, Edmund Jacobsen (1888–1983). He was the creator of Progressive Muscle Relaxation and of Biofeedback. Wolpe ran with the idea and modified Jacobsen's muscle relaxation techniques to take less time, reasoning one could not be simultaneously relaxed and anxious.

The second step in Wolpe's therapy was for client and therapist to create a hierarchy of anxieties. The client makes a list of all the things that produce anxiety in all its different forms. The therapist and the client then make a hierarchal list, from what produces the lowest level of anxiety to what produces the highest anxiety. Next, the client is to be fully relaxed while imaging the anxiety-producing stimulus. Depending on patient reaction, no anxiety or great anxiety, the stimulus will be changed to a stronger or weaker anxiety-provoking stimulus. Mind you, systematic desensitization, though said to be successful, has its flaws. We read that the patient might give misleading hierarchies, have trouble relaxing or be unable to adequately imagine the scenarios. Despite this possible flaw it seems to be most successful, claim practitioners.

Behavioral psychologist James G. Taylor (1897–1973) of the University of Cape Town, South Africa, Psychology Department is known to be the first to use Wolpe's exposure therapy treatment for anxiety. This includes methods of exposure with response prevention, a common exposure therapy technique still used today. Hence we see the multitude of exposure therapies developed over time including:

1. flooding
2. implosive therapy
3. in vivo exposure therapy
4. imaginal exposure therapy
5. prolonged exposure therapy

How is this a case of proposed PTSD treatment modality? In 2011, Myers, W.A. Carlezon Jr. and Davis published "Glutamate receptors in extinction and extinction-based therapies for psychiatric illness" (*Neuropsychopharmacology*: 2011 Jan; 36(1):

274–93; Erratum in 2011 Mar; 36(4): 910), in which they state:

> "Some psychiatric illnesses involve a learned component. For example, in posttraumatic stress disorder, memories triggered by trauma-associated cues trigger fear and anxiety, and in addiction, drug-associated cues elicit drug craving and withdrawal. Clinical interventions to reduce the impact of conditioned cues in eliciting these maladaptive conditioned responses are likely to be beneficial. Extinction is a method of lessening conditioned responses and involves repeated exposures to a cue in the absence of the event it once predicted. We believe that an improved understanding of the behavioral (sic) and neurobiological mechanisms of extinction will allow extinction-like procedures in the clinic to become more effective. Research on the role of glutamate-the major excitatory neurotransmitter in the mammalian brain-in extinction has led to the development of pharmacotherapeutics to enhance the efficacy of extinction-based protocols in clinical populations. In this review, we describe what has been learned about glutamate actions at its three major receptor types (N-methyl-D-aspartate (NMDA) receptors, α-amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid (AMPA) receptors, and metabotropic glutamate receptors) in the extinction of conditioned fear, drug craving, and withdrawal. We then discuss how these findings have been applied in clinical research."

In translation? Drug some willing, ignorant, trusting PTSD experiencers up to the hilt under the guise of healing and see what happens next.

The question to ask, then, is how such treatment modality would influence other ones like CPT and WET? Drugged and spaced out writing should make for some good reading, but for whom and for whose benefit? *A Brief Exposure Based Treatment vs. Cognitive Processing Therapy for Post Traumatic Stress Disorder: A Randomized Noninferiority Clinical Trial* (Sloan DM, Marx BP, Lee DJ, Resick PA; JAMA Psychiatry. 2018 Mar 1;75(3):233–239) may give some insight.

This randomized clinical trial was conducted at a Veterans Affairs medical facility between February 2013 and November 2016. They took 126 adult veterans and non-veterans of unknown origin and background. There were 66 men and 60 women of

mean age of 43.9, who were randomized to either WET or CPT. Inclusion criteria were a primary diagnosis of PTSD and "stable medication therapy". According to *Medication Therapy Management in Pharmacy Practice*, this means a participant who follows their healthcare team's prescription drug dictates to optimize medication use for maximum outcome.

Exclusion criteria for participant-applicants included:

- had a high risk of suicide
- had an unstable bipolar illness
- were diagnosed with a psychosis
- received psychotherapy for PTSD

The reason for this exclusion, we surmise, is that Randomized Controlled Trials (RCTs) often suffer from two major complications: noncompliance and missing outcomes. One potential solution to this problem is a statistical concept called intention-to-treat (ITT) analysis. ITT analysis includes every subject who is randomized according to randomized treatment assignment. It ignores noncompliance, protocol deviations, withdrawal, and anything that happens after randomization.

It includes all randomized patients in the groups to which they were randomly assigned. It includes them, regardless of their adherence with the entry criteria. It includes them, regardless of the treatment they actually received. And It includes them, regardless of subsequent withdrawal from treatment or deviation from the protocol. In other words, ITT analysis includes every subject who is randomized according to randomized treatment assignment. It ignores participants' or anyone else's noncompliance, protocol deviations, withdrawal, and/or anything that happens after randomization. ITT analysis is usually described as "once randomized, always analyzed."

Mind you, it allows the exclusion of some randomized subjects in a justified way. For example, patients who were deemed ineligible after randomization or certain patients who never started treatment. However, the definition given to the modified ITT in randomized controlled trial, has been found to be irregular and arbitrary because there is no consistent guidelines to apply it. The modified ITT analysis allows a subjective approach in entry criteria. This can lead to confusion, inaccurate results and bias.

Mind you, in the same breath we are told that ITT analysis avoids overoptimistic

estimates of the efficacy of an intervention. The overoptimism can result from the removal of non-compliers. ITT accepts that noncompliance and protocol deviations are likely to occur in actual clinical practice.

Team Sloan's *Brief Exposure Based Treatment vs. Cognitive Processing Therapy for Post Traumatic Stress Disorder: A Randomized Noninferiority Clinical Trial* study's structure?

CPT participants received 12 sessions; WET participants received 5 sessions. Why the difference in time spent on each? The CPT protocol that included written accounts was delivered individually in 60-minute, weekly sessions. For the first WET session, participants were given 60 minutes to write whatever came to mind. For the remaining 4 sessions, only 40 minutes of writing were allowed. The question was whether a brief, exposure-based treatment would be non-inferior to the more time-intensive cognitive processing therapy in treating posttraumatic stress disorder. According to Sloan et al., the findings were:

> "In this randomized noninferiority clinical trial of 126 adults who received a diagnosis of posttraumatic stress disorder, those treated with written exposure therapy, a 5-session treatment, and those treated with cognitive processing therapy improved significantly, with large effect sizes observed. Despite the substantial dose difference, written exposure therapy was noninferior to cognitive processing therapy.
>
> "The findings provide evidence that written exposure therapy and cognitive processing therapy are effective for treatment of posttraumatic stress disorder, and that posttraumatic stress disorder can be effectively treated with a 5-session psychotherapy."

Already in December 2012 Dr. James Hawkins of Goodmedicine.org.uk presented an article entitled "One of the most exciting therapeutic writing studies for years". The article was by Denise Sloan, now psychologist and professor, Department of Psychiatry, Boston University School of Medicine, and since 2006 National Center for PTSD and NC*for*PTSD associate director. It introduced fascinating new research, as he phrased it, showing an augmented approach to the traditional expressive WET an effective treatment for PTSD ((Sloan, Marx et al. 2012). The outcomes they achieved were startlingly good, said Hawkins. He found that the effect sizes and drop out rates seemed even better than those achieved with current, much more time consuming *state of the art* PTSD treatments

Subjects using WET are asked to write for half an hour on five occasions at weekly intervals about a specific memory that is particularly upsetting for them. As is usual when using expressive writing more generally, the instruction is to write continuously without being concerned about spelling or grammar. This is more to combat 'writer's block' than because it necessarily makes the writing itself more therapeutic.

Written exposure challenges the tendency to avoid thoughts and feelings about the memory so that they can now be adequately processed, we read. Subjects are asked to write about:

- the details of what happened
- the feelings that occurred at the time and afterwards
- especially the "hot spots," the sections of the event where emotional distress was strongest and memory often most disorganized

This is a tough thing to be asked to do, so it's really important that participants understand why they are being asked to do it. The quote on the handout given to participants in the beginning of WET stating: *"Courage is not the absence of fear, but rather the judgement that something else is more important than fear."*

Quoting the key Sloan et al research paper, Hawkins shares:

> "Participants were instructed to write about the same . . . event during each writing session. The importance of delving into their deepest emotions and thoughts (at the time of the event) was emphasized, as well as the importance of providing detailed information (about the event e.g. the participant was asked to describe what he/she saw, heard, and smelled). The participant was instructed to repeat the detailed account (of the event) during the second session, with a reminder to also include information on what he or she was thinking and feeling as the event was happening. At the end of the writing instructions for each session, the therapist reminded the participant that the event was being recounted, not relived. For the remaining four sessions, participants were instructed to focus on providing a detailed description of the part of the event that was most distressing to them ('hot spot'), as well as to describe how the event had affected their

> lives (e.g. how the event changed the way the person interacts with others, how the event has changed the way in which the person views his/her life). During each of the five treatment sessions, the therapist read the writing instructions to the participant, made sure that the participant understood the instructions, and answered any clarifying questions that the participant had. The therapist then exited the room, leaving a printed copy of the writing instruction for that session with the participant so that he/she could refer to them, if necessary, while completing the writing exercise. The therapist returned to the room after 30 min and inquired whether the participant experienced any difficulties during the writing session and address any problem or concerns that may have arisen. The therapist also checked the written narrative to make sure that the instructions were followed. The session ended with the therapist instructing the participant to allow him/herself to experience any trauma-related memories, images, thoughts or feelings, whatever they might be, in the week between sessions. This instruction was provided to reiterate the importance of confronting trauma memory, rather than engaging in avoidance."

Immediately after each session, participants were asked to rate the quality & intensity of their feelings while writing. They were to use the following scales from 1 to 9:

- very pleasant to very unpleasant
- very calm to very aroused

Remember that the writing instructions are to confront one's deepest thoughts & feelings. Therefore, it's likely to be therapeutically important that — at least for significant sections of the writing — scores on these scales should be high. In the olden days, we called it journaling, known to be therapeutic for the longest time. Why do you think our ancestors were such prolific writers during their lives? In Hawkins' opinion, though, Sloan & colleagues discovered the most wonderful PTSD remedy since Christ was a cadet. They worked hard to make sure that subjects in their PTSD research trial understood and really felt that the writing approach had

a very good chance of helping them. Much more relevant background information on the "PTSD assessment, images, memories & information" and "Life review, traumatic memories & therapeutic writing" pages are accessible on Good Medicine's website. They are downloadable from the "PTSD assessment" page we are told (goodmedicine.org Dr. James Hawkins, 2012). In fact, I read, written exposure therapy may well be helpful more generally whenever one is tackling experiential avoidance. As Wikipedia neatly explains:

> "Experiential avoidance has been broadly defined as attempts to avoid thoughts, feelings, memories, physical sensations, and other internal experiences — even when doing so creates harm in the long-run."

Therefore the CPT versus WET result was predestined. It had to be that way, even though only 4 participants dropped out of WET, whereas 25 kissed the CPT bye-bye. That was an indication in itself that WET was hugely more helpful to PTSD journeyers' than CPT.

Sloan et al.'s conclusion? Although WET did involve fewer sessions, it could not be denied that it was *non-inferior* to CPT in reducing PTSD symptoms. Therefore, if wanting to maintain some credibility, Sloan et al. had to recognize WET as an efficacious and efficient PTSD treatment. Of course, they that applies to those regularly consuming psychotropic medication according to prescription. So WET *might* reduce attrition and transcend previously observed barriers to PTSD treatment of hitherto unknown specifications for both patients and mental health administrator/providers.

If subject improvement was in any way related to the company they kept during the trial, researchers did not investigate or take it into consideration. That the outcome of Sloan et al.'s study objective paid for by your tax dollars could not possibly be different was a given. Why?

Consider if WET proved to be not only *non-inferior*, but superior to Cognitive Processing Treatment in patients' steadily and regularly consuming mind-altering pharmaceutical drugs. That would reveal PTSD experiencers' capability to heal themselves without mental health practitioners' assistance. That in turn would ruin the entire PTSD healing/treatment modality scam, would it not? Remember that any treatment modality with the term *cognitive* in it presumes you as being on equal, non-inferior nor superior, footing with animals simia, rattus and canis in particular, and even mus, the mouse. Thus Pavlov and Skinner's ideas on human cognitive abilities are applied. The conditioned human being acts, according to cognitive

psychology, solely from pre-conditioned reflexes, with little or no individual thought and reasoning. The contrary was expressed in and proved by this WET research participants. Sloan et al. would cut their own financial throat and that of their thousands of collaborators if admitting WET's immense superiority to CPT. It is that simple. Never mind that the purported result is still hypothetical, pure assumption and presumption. And with the undisclosed amount of money spent on the study, thousands of PTSD afflicted soldiers and veterans could have been helped to heal themselves to live productive and delightful lives, without pharmaceutical drugs, until their natural death.

One laughs or cries, in particular, at Myers and Davis claim in their previously mentioned Cognitive Processing Therapy spiel. They talk about *abnormal fears* or *excessively compulsive behavior,* both encouraged by psychotropic drugs. They say that when these begin to rule a person's life, three quarters of cooperative patients can be restored to normal functioning through a form of therapy based that I'm sure you find disquieting. They suggest exposing the patient continually to the stimuli that evoke symptoms until they can be tolerated. They claim that the phobic or compulsive behavior would dissipate.

WET would blow that theory out of the sky. When writing down/working through such theoretical hypotheses presented by their the-rapists, PTSD journeyers' would recognize the idiocy of such rattus-in-the-maze reasoning. Furthermore, we will see later how detrimental CPT can be to PTSD voyagers. It is also rather interesting how events like these would be replayed:

- mid-air engine explosions five feet away
- the theatre of war scenarios
- gun-fires in the streets
- murders in homes
- September 11 events

These are to be replicated with ease by the CPT modality cure, as PTSD journeyers have been exposed to such incidents.

It merits repeating that to face one's fears and the Self and through it heal the Self takes courage. Molecular psychiatry and neuro-psycho-pharmacology is presently so very much in style to accomplish the task. It is also ins tyle to flaunt and be proud of engaging and depending on it to heal the Self. But it is just as imbecilic as flaunting the handicap sticker in the car and being proud — even arrogant — of it.

Look at the parking spot I get; borrowed it from my mother. The sense of entitlement shines brightly, even though it is a sign of weakness and dependence, an admission of having given one's power away to others. Oft times the true evil with the face one knows and the voice one trusts.

And you still want to fall into that trap by believing that the PTSDS treatment modalities thus far mentioned in this book will cure the colossal trauma you find yourself in? When their instigators depend on your failure to heal to continue this colossal farce or tragedy of human manipulation for their financial gain? Dream on, then, as you are on your own to either be destroyed or to heal yourself. Perhaps Timothy Alberino's *Coast to Coast* February 4, 2018 interview "Transhumanism and Biohacking" might be healthy for your education. It might just serve as a wake-up call to rattle you out of your lethargy and towards healing.

Many research studies have shown the dangers of experiential avoidance of facing anything unpleasant within the Self. They show how it increases the likelihood and severity of a whole string of psychological problems, including:

- PTSD (Leiner, Kearns et al. 2012)
- depression (Shallcross, Troy et al. 2010; Newby and Moulds 2011)
- panic & agoraphobia (Gloster, Wittchen et al. 2011)
- generalized anxiety disorder (Stapinski, Abbott et al. 2010)
- social anxiety (Kashdan, Breen et al. 2010)
- anxiety disorders in general (Marques, Kaufman et al. 2009)
- effects of child abuse (Shapiro, Kaplow et al. 2012)
- binge eating (Lillis, Hayes et al. 2011)
- psychotic illness (Goldstone, Farhall et al. 2011)
- general mental health & level of wellbeing (Kashdan, Barrios et al. 2006; Barber, Bagsby et al. 2010; Fledderus, Bohlmeijer et al. 2010)
- academic performance (Sullivan, Worth et al. 2006)
- persistent pain problems (Chou and Shekelle 2010)
- possibly even Alzheimer's Disease (Wilson, Boyle et al. 2011)

To get a sense of how one rates on experiential avoidance, you can take the brief seven-item "Acceptance & action questionnaire (AAQ-II)". Or you can complete the more detailed sixty-item "Multidimensional experiential avoidance questionnaire" (Gamez, Chmielewski et al. 2011). That psychological upheaval and avoidance behavior does create physical illness is also a well-known fact. That both avoidance-

behavior, psychological upheaval and physical illnesses are enhanced by pharmaceutical drugs prescribed by mental health practitioners to purportedly aid in PTSD healing, is also a fact almost never mentioned anywhere.

Keeping WET and CPT in mind, it seems that all those theories of successful PTSD therapies show one thing. They show that those engaged in PTSD healing treatment modalities are solely drawing on the ways their since-departed-into-the-netherworld peers went about solving the war-neurosis non-conundrum. War-neurosis is nothing other than a humane, human-emotion-caused existential crisis. It is sparked by the innately humane attitudes of empathy, compassion, honour, integrity, ethics and morals.

Jon Rappoport, David Icke, Steve Quayle, Jordan Maxwell and others indicate that our rulers, the deep state, or whatever one may cherish to call it, not only love to deny the existence of the human soul, but also frown and ignore innate human sentiments. It even crossed my feeble mind that it might be trans-humanism might be in league with the AI agenda. It's the New Man driving PTSD research for their manipulation of our minds and bodies.

I by and large circumnavigated the institutionalized WET therapy, but I did keep my own journal, enabling me to trace my tracks. Therefore I know that two of the 24 mental health practitioners I was forced to deal with over the course of 10 years were honourable men. They would be my Irish psychiatrist, who out-papered them all, and one of his colleagues at UBC. They knew that no PTSD treatment would work as long as I was consistently and perpetually traumatized by NORAM, the WCB and the Union. They said in writing that no improvement, never mind healing, from my PTSD condition could occur under that condition. They wrote that the traumatization of the traumatized had to stop before PTSD healing could occur. Peace had to be granted for a recovery. I am the proof, not the exception, as I discovered on the Norwegian Star. I owe my survival to my outstanding psychiatrist. It is to him I owe my health, my sanity, my life, my contentment and the ability to write this book and *Broken Wings*.

Do you still believe in the assistance of mental health practitioners as the panacea and salvation from your PTSD troubles and tribulations? Do you refuse to believe that you are nothing other than a rat-replacement, a research subject, a rodent-or dog specimen in the trans-humanistic agenda? Then dream on and God speed on your chosen path, because part of institutionalized WET is part of it. Its danger? On the surface it seems innocuous. It's like a rewarmed concept of the vigorous correspondence in which our forefathers engaged to unburden themselves

from worries and concerns within their hearts and souls. But the danger for the PTSD journeyer to do so with a therapist could be deadly.

It is here they will begin to restructure your thinking, their thought inhibition learning. It is here the will begin to pile on you their criticism, because of your present state of mind. All done to stop the colossal perception change out of the deception you hitherto lived, a deception those ruling humanity depend on for their survival. The awakening through PTSD to the existence of this colossal human perception deception has to be stopped by all means possible. Thus the effort to, under the ruse of benevolence, destroy PTSD experiencers' mind and sui generis through drugs and created confusion by way of the multitude of treatment modalities thrown at you. Because of my psychiatrist, I contributed little to fatten the golden goose of PTSD treatment applications. I did not even do the Eye Movement Desensitization and Reprocessing (EMDR), another one of at least 155 known purported PTSD remedies known to exist.

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

In January 2001, Bunmi Olatunji was a graduate student in the clinical psychology program at the University of Arkansas. He found the Eye Movement Desensitization and Reprocessing (EMDR) theory, as treatment for a variety of psychological disorders to be highly conspicuous and controversial. Empirical evidence both supported and negated its effectiveness and efficacy. EMDR appeared to be aligned with the meaning of science, but lacked the methodological and empirical validation necessary to substantiate the claim, he quipped. Olatunji noted the enormous popularity of EMDR at the time. He also noted the tendency to embrace what he viewed as the false comfort of non-scientific mental health treatment interventions. For example, psychodynamic therapy considering heart, soul, and mind in unison with EMDR as treatment. He felt this certainly necessitated a most careful EMDR component examination. Whereupon he set out to critically analyze the available 2001 empirical EMDR data. His aim was to ultimately determine if EMDR fitted the definition of a true science, or rather presented pseudoscience (Bunmi O. Olatunji: EMDR: Science or Pseudoscience, theness.com 2001).

Olatunji stated that EMDR had been labeled as scientific intervention with claims of being the most effective treatment for both Post Traumatic Stress Disorders — *plural* — and equally as effective for other psychological disorders. He noteds that a number of studies had *proposed* that EMDR was an unproven

pseudoscientific treatment intervention (Lohr, Lilienfeld, Tolin, & Herbert, 1999). This apparent disagreement on EMDR's efficacy as a scientific treatment applicable to human problems inspired Olatunji. He found it vital to critically examine and analyze EMDR's purpose and procedure for scientific and pseudoscientific content.

The expression "pseudoscience" derives from the Greek root "*pseudo*" or false and the English word "science" from Latin "*scientia*" or knowledge". The term has been in use since at least the late 18th century. English historian and antiquary James Pettit Andrews first used it in reference to alchemy in 1796. But it took another 50 years before the concept of pseudoscience as distinct from real or proper science began to become more widespread. One of the earliest uses was in the 1844 *Northern Journal of Medicine* issue 387:

> "That opposite kind of innovation which pronounces what has been recognized as a branch of science, to have been a pseudo-science, composed merely of so-called facts, connected together by misapprehensions under the disguise of principles."

Ambiguity at its finest? Be it as it may, can psychology not be viewed as pseudo science in and of itself, if the world's Neumeisters had eyes to see and ears to hear? Olatunji, generally defines pseudoscientific manifestations as a set of theories presented as scientific concepts, when in fact they may not be. One vital element of a scientific theory, he says, is its ability to explain a wide range of empirical phenomena, which can be validated or tested empirically in some meaningful manner (Carroll, 2000). Empirical validation of scientific theories demands, he states, the deduction of empirical predictions from those theories. To be meaningful, such predictions must, at the very least in theory, possess the potential to be falsified, a scientific characteristic known as falsifiability (Herbert, Lilienfeld, Lohr, Montgomery, O'Donohue, Rosen, Tolin, in press 2000). Are not the falsifiability components and possibilities in and of the science of psychology as good as endless, I ponder?

But Olatunji states:

> "A pseudoscientific theory claims to be scientific, or in actuality claims to be falsifiable. The reality is that theories that are pseudoscientific in nature are not falsifiable or they have already been falsified but modifications are made to the theories to discount the negating evidence (Carroll, 2000). Pseudoscientific theories are also allegedly based on empirical

> evidence, and may often appear to utilize scientific methodology, when in fact the rationale of pseudoscientific theories are based on misconceptions and its employment of controlled experimentation are often insufficient.
>
> "The 'pseudoscientific misconception' is the notion that it is adequate to simply highlight the consistencies of its theory with data (Carroll, 2000). Certainly consistency with factual data is a scientific necessity, however it is not a sufficient attribute to be considered a scientific entity. Not only is it vital that a scientific theory be predictive by nature, it is also important that a truly scientific theory provide empirical means of testing those predictions. A theory that is challenged by factual data is clearly not a good scientific theory, however that does not imply that a theory, which is consistent with the facts, is correspondingly a good scientific theory (Carroll, 2000)."

Consider consistencies in human emotions, actions, reactions, attitudes, aptitudes, inclinations and basic characteristics. Some of these are dictated (or not) by the stars, e.g. the time and place of birth and so on and so forth. How can they temporarily and overall be scientifically measured, when human emotions, feelings, heart and soul are consistently involved in a non-translationally manipulated human? This remains unclarified, opaque and nebulous. In the 2001 EMDR world, it had proven rather difficult for its advocates to sufficiently explain the functional mechanism behind its proposed effectiveness, says Olatunji. It seems the leading justification of its effectiveness was generally based on its apparent integration of psychological and neurological processes. Seeming recovery occurred after eye movements and other EMDR components unlocked pathological conditioning within a person's information-processing system, he writes (Lohr, Kleinknecht, Tolin, & Barrett, 1995) But how did Olatunji reach his conclusion? And how, in fact, did the idea of this form of using an individual's eyes as psychotherapy for resolving and healing symptoms of traumatic and other disturbing life experiences, including PTSD, originate?

The American psychologist Francine Shapiro recalls a leisurely stroll in a park in 1987. It was then that she discovered her own rapid eye movements easing and decreasing the negative emotions associated with her own distressing and painful memories. Experimenting with the idea further, she discovered that other humans

felt the same kind of response to their own eye movements. A single session of the procedure was sufficient to desensitize subjects' traumatic memories as well as dramatically alter their cognitive assessments, she maintained. But she also stated that, while the EMD procedure served to desensitize anxiety, it did not eliminate all PTSD-related symptoms and complications. Nor did it provide coping strategies for the victims, with an average treatment time of five sessions to comprehensively treat PTSD. Furthermore, it became apparent that by themselves eye-movements were not enough to create any documentable positive therapeutic effects. That minor problem Shapiro amended with ease, by adding cognitive behavioral components to her eye-movement therapy model. She developed a standard procedure for the whole schischkekabudle she called Eye Movement Desensitization (EMD). And — voila! With nothing to lose and everything to gain financially, she proclaimed the birth of a new PTSD treatment modality. Thus a new golden goose was born.

In 1991 Shapiro changed the therapy's name to Eye Movement Desensitization and Reprocessing (EMDR). She did this to reflect the insights and cognitive changes that she maintained occurred during treatment and to identify the information processing theory she developed to explain its treatment effects. Because it appeared as if clients achieved therapy results very quickly, Shapiro also felt ethically obligated to teach other clinicians in rapid succession, so that PTSD sufferers could find relief.

Initially Shapiro taught an experimental EMDR procedure. This was in line with the American Psychological Association's (APA) Ethical Principles of Psychologists and its Code of Conduct's mandates of responsibilities as an innovator. This was particularly important because at that time no PTSD designated, well established and empirically validated PTSD therapies purportedly existed. Her peers considered her treatment ideas and success-assertions experimental. There had been no independently controlled and researched studies confirming EMDR's efficacy and effectiveness. To face and resolve what she perceived as her ethical dilemma, she opened the EMDR Institute offering quality training in EMDR™ methodology in 1990. In 1998, APA's Clinical Psychology Division's independent reviewers agreed with her when identifying only three PTSD treatments with *probable efficacy*. EMDR was one of them. Exposure therapy and stress inoculation therapy were the other two. How *probable efficacy* could be aligned with scientific empirically validated first evidence proving treatment efficacy remained unexplained. But over 24 randomized trauma victim studies were said to have empirically validated EMDR.

By and large, EMDR is espoused as a psychotherapy enabling people to heal from symptoms and emotional distresses resulting from disturbing life experiences. The

claims are that by using EMDR therapy, psychotherapeutic benefits once taking years *to surface* can now be felt much faster. In fact, EMDR therapy seems to document, we learn, that the human mind heals from psychological trauma much the same way as the human body recovers from physical trauma. Supposedly, the brain's information processing system automatically moves toward mental health. Practitioners trained to use EMDR's detailed protocols and procedures are able to help clients active their mind's natural healing processes and abilities, we read. But of what does the EMDR treatment modality actually consist?

In 2011, the Clinical Social Work Journal published Shapiro and Laliotis' "EMDR and the Adaptive Information Processing Model: Integrative Treatment and Case Conceptualization". *The* abstract states:

> "EMDR is a comprehensive psychotherapy approach that is compatible with all contemporary theoretical orientations. Internationally recognized as a frontline trauma treatment, it is also applicable to a broad range of clinical issues. As a distinct form of psychotherapy, the treatment emphasis is placed on directly processing the neurophysiologically stored memories of events that set the foundation for pathology and health. The adaptive information processing model that governs EMDR practice invites the therapist to address the overall clinical picture that includes the past experiences that contribute to a client's current difficulties, the present events that trigger maladaptive responses, and to develop more adaptive neural networks of memory in order to enhance positive responses in the future. The clinical application of EMDR is elaborated through a description of the eight phases of treatment with a case example that illustrates the convergences with psychodynamic, cognitive-behavioral, and systemic practice (Shapiro, F. & Laliotis, D. Clin Soc Work J (2011) Volume 39, Issue 2, pp 191–200)."

Without doubt, we note that no fingers moving in front of faces resulting in PTSD healing is mentioned. And we do note that EMDR, too, uses CBT elements. Those so successfully get Rattus and Cani in line to obtain empirical and scientifically provable evidence of efficacy and effectiveness. Then evidence came that the rapists were getting similar results to standard EMDR with blind patients whose therapists used tones and hand-snapping instead of finger-wagging. So,

Shapiro softened her stance a bit and admitted that eye movement was not an essential part of desensitization processing, feeling that attacks on her were *ad hominem* and without merit (Carroll). *"Ad hominem"* is Latin for "to the person. It is short for "*argumentum ad hominem*." It's a fallacious argumentative strategy, whereby genuine discussion of the topic at hand is avoided by instead attacking the character, motive or other attributes of the person making the argument or persons associated with the argument rather than attacking the substance of the argument itself.

Regardless, Shapiro stuck to her guns, maintaining that altogether 8 phases constituted the EMDR treatment:

In Phase 1, the patient's history and an overall treatment plan are discussed and the therapist identifies and clarifies potential EMDR targets. A target is a disturbing issue, event, feeling or memory for use as an initial focus for EMDR. Maladaptive beliefs are also identified, such as "I can't trust people" or "I can't protect myself."

Phase 2: Before beginning EMDR for the first time, it is recommended that the patient identify a "safe place". This would be an image or memory that elicits comfortable feelings and a positive sense of self. This safe place can be used later to bring closure to an incomplete session or to help a client tolerate a particularly upsetting session, we learn.

Phase 3: In developing a target for EMDR prior to beginning the eye movement, a snapshot image is identified that represents the target and the disturbance associated with it. That image is said to help the client focus on the target. A negative cognition (NC) of self is identified, a negative statement about the self that feels especially true when the client focuses on the target image. A positive cognition (PC), a positive selfstatement, that is preferable to the negative cognition is also identified.

Phase 4: The therapist asks the patient to focus simultaneously on the image, the negative cognition, and the disturbing emotion or body sensation. Then the therapist usually asks the client to follow a moving object with his or her eyes. The object moves from side to side so that the client's eyes also move back and forth. After a set of eye movements, the client is asked to report briefly on what has come up. This may be a thought, a feeling, a physical sensation, an image, a memory or a change in any one of the above noted topics. In the initial instructions, the therapist asks the client to focus on this thought and begins a new set of eye movements. Under certain conditions, however, the therapist directs the client to focus on the original target memory or on some other image, thought, feeling, fantasy, physical sensation or memory. From time to time the therapist may query the client about

her or his current level of distress. The desensitization phase ends when the SUDS (Subjective Units of Disturbance Scale) reach 0 or 1.

SUDS is a scale of 0 to 10 for measuring the subjective intensity of disturbance or distress experienced in the present moment. The patient self assesses where they are on the scale.

The SUDS-level was developed in 1969 by the South African psychiatrist Joseph Wolpe, one of the most influential figures in behavior therapy. It is used in cognitive-behavioral treatments for anxiety disorders, exposure practices, hierarchy and research purposes (*The Practice of Behavior Therapy*, New York: Pergamon Press). There is no hard and fast rule by which a patient can self-assign a SUDS rating to his or her disturbance or distress, hence the adjective *subjective*.

However, some guidelines are:

- The intensity recorded must be as it is experienced now, in this very present moment.
- Constriction or congestion or tensing of body parts indicates a higher SUDS than that reported.

Scales may differ slightly in terminology, but in essence convey the following:

[10] Feels unbearably bad, beside the self, out of control as in a nervous breakdown, overwhelmed, at the end of the rope. One may feel so upset that one does not want to talk because one cannot imagine how anyone could possibly understand one's agitation.

[9] Feeling desperate. What most people call a 10 is actually said to be a 9. Feeling extremely freaked out to the point that it almost feels unbearable and one is getting scared of what one might do. Feeling very, very bad, losing control of one's emotions.

[8] Freaking out. The beginning of alienation, the feeling of separation or estrangement of human beings from some essential aspect of their nature or from society, often resulting in feelings of powerlessness or helplessness.

[7] Starting to freak out, on the edge of some definitely bad feelings. One maintains control with difficulty.

[6] Feeling bad to the point of beginning to think something ought to be done about the way one feels.

[5] Moderately upset, uncomfortable. Unpleasant feelings are still

manageable with some effort.

[4] Somewhat upset to the point that one cannot easily ignore an unpleasant thought. One can handle it but it does not feel good.

[3] Mildly upset. Worried, bothered to the point that one notices it.

[2] A little bit upset, but not noticeable unless one took care to pay attention to one's feelings and then realizes, "yes, there is something bothering me".

[1] No acute distress; feeling basically good. If one took a special effort one might feel something unpleasant but not much.

[0] Peace, serenity, total relief. No more anxiety of any kind about any particular issue.

SUDS utility does not require precision, we learn. Therefore when using SUDS in a therapeutic setting the therapist does not necessarily define the scale, because one of the benefits of asking a patient or client for a SUDS score is that it is simple. Typically, the client is asked: "On a scale of one to ten, where 1 is the best you can feel and 10 is the worst, how do you feel right now?"

The question's purpose is to enable the patient or client to notice improvements. The inherent difference between one person's subjective scale and that of another is viewed as irrelevant to therapy with either individual. Our brains are sophisticated enough that they can usually summarize a large amount of data very quickly and often accurately, we are told.

Interestingly enough, though, there is the possibility that in some forms of therapy the patient will want to see progress. The patient might therefore report progress that isn't objectively present — a type I error from a statistical point of view — is acknowledged to exist.

A type I error is the rejection of a true null hypothesis also known as a "false positive" finding. A type II error is, failing to reject a false null hypothesis, also known as a "false negative" finding.

While both type I and type II errors are important in research situations, type I errors can have a therapeutic utility in clinical situations. They can provide an indirect opportunity for positive auto-suggestion, much like the indirect suggestions employed in Ericksonian hypnosis. Thus, since the main use of SUDS is for clinical rather than research purposes, the imprecise nature of the scale is relatively unimportant to its main users: patients and clinicians.

In statistical hypothesis testing, however, a type I error or a type II error can skew results.

As to Ericksonian Hypnosis, it is a method of indirect hypnosis named after Dr.

Milton Erickson. He was a prominent American psychiatrist and psychologist widely regarded as the "father of hypnotherapy". His discoveries have influenced a wide spectrum of therapy, from strategic family therapy to neuro-linguistic programming. Erickson found that indirect suggestion could result in therapeutic behavioral change. Thus, he preferred to converse with clients using metaphors, contradictions, symbols and antidotes to influence their behavior rather than by direct orders.

He suffered extreme pain after contracting polio at an early age. So, he thought it critical to put himself in the patient's shoes and truly try to understand the client's present situation. Unlike Freud, who encouraged self-exploration, Erickson adopted a form of brief therapy where a patient's past history was not the focal point of change.

He recalled one conversation with a patient with Obsessive Compulsive Disorder who showered a dozen times a day. He asked the patient about the present rather than the past. Specifically he asked about the process: "Do you wash from the neck down, or do you start with your feet and wash up? Or do you start with your head and wash down?" He made it a point to show the patient that he was really, *really* interested. The patient, who had undergone five years of traditional psychoanalysis prior to consultations with Erickson, was quickly cured with this treatment modality. But I digress. Back we go to EMDR's remaining treatment phases:

Phase 5 is called the "Installation Phase" in which the therapist asks the client about the original positive cognition (PC) and if it is still valid. After Phase 4, the client's view on the treatable event, the initial snapshot image stated in phase I, might have changed dramatically. Another PC may be needed. If that is the case, the client is asked to "hold together" the snapshot and the new PC. The therapist then inquires: "How valid does the PC feel, on a scale from 1 to 7?" New sets of eye movement are issued at his point.

Phase 6 is called the body scan, where the therapist asks if pain, stress or discomfort is felt anywhere in the client's body. If so, the client is asked to concentrate on that body part, the sore knee or whatever it may be. Again, a new set of eye movements is issued.

Phase 7: Debriefing: the therapist gives appropriate information and support.

Phase 8: Reevaluation: At the beginning of this session the client reviews the week, discussing any new sensations or experiences. The level of disturbance arising from the experiences targeted in the previous session is assessed. An objective of this

phase is to ensure the processing of all relevant historical events. The End.

All in all, the most unique of EMDR techniques is termed desensitization and reprocessing. That is followed by mindfulness, body-based approaches, and person-centered therapies such as journaling. To elaborate further, the clinician first determines which memory to target first. She or he then asks the client to hold different aspects of that event or thought in mind and to use the eyes to track the therapist's hand as it moves back and forth across the client's field of vision. This is followed by the client's holding in mind the positive cognitions (PS's) of Self following the therapist's finger in motion. That is followed by the client holding positive cognitions of the Self in mind or distressing images while tracking the clinician's rhythmic finger movements. But eye movements or other bilateral stimulations are only used during one part of a session, we read, as journaling also takes place.

As this happens, internal associations supposedly arise and clients begin to process the memory and disturbing feelings while in successful EMDR therapy. The reasons are believed to be connected with the biological mechanisms involved in Rapid Eye Movement (REM) sleep. With it, we hear, the meaning of painful events is transformed on an emotional level. For instance, a rape victim shifts from feeling horror and self-disgust to holding the firm belief that, "I survived it and I am strong." Unlike with talk therapy, the insights clients gain when in EMDR therapy don't result mostly from the clinician's interpretation. The come from the client's own accelerated intellectual and emotional processes, it is claimed. The end effect, we hear, is that clients who conclude EMDR therapy feel empowered by the very experiences that once debased and distressed them. Their wounds are closed and they themselves are transformed.

Thus, we read, clients' thoughts, feelings, and behaviors are robust indicators of emotional health and resolution. This is the natural outcome of the EMDR therapeutic process. All of it is accomplished without speaking in detail or doing homework as in other therapies. The PTSD experiencer doesn't have to do a thing other than to listen, follow a clinician's finger and advice, scribble a few words here and there when asked to do so . . . aimed at what? The healing of my soul?

Perhaps unsurprisingly, 2008 meta-analyses feedback indicated that EMDR outcomes in both civilian and military populations differed little from other exposure-based therapies. Reviews of the available dismantling studies also found that none of them incrementally added to result outcome. Not finger tracking. Not other forms of kinesthetic stimulation, a person's awareness of the position and

movement of the parts of the body by means of sensory organs (proprioceptors) in the muscles and joints. Not kinesthetic learning through a physical activity.(Spates et al; UMASS: Department of Medicine, Division of Preventive and Behavioral Medicine).

A dismantling design is one type of therapy outcome study. This design investigates therapies that have multiple components. The goal is to identify those features of the therapy that don one of two things. Either they are the active mechanisms of change or they identify the degree to which specific components add to the magnitude of change attributable to other components (A. Papa; W. C. Folette: *Dismantling Studies of Psychotherapy*; January 2015; onlinelibrary.wiley.com).

Regardless, EMDR was deemed efficacious by the International Society for Traumatic Stress. It was therefore recommended in the VA/DoD 2010 PTSD treatment guidelines. This happened even though it was thought that some theoretical and empirical grounding of EMDR's components were questionable. Presently, more than 30 positive controlled outcome studies on EMDR therapy have apparently been conducted. Some of them claim that 84%-90% of single-trauma victims no longer have PTSD after only three 90-minute sessions. One study funded by the Health Maintenance Organization (HMO) Permanente found amazing results. Fully 100% of single-trauma victims and 77% of multiple trauma victims after only six 50-minute EMDR sessions were no longer diagnosed with PTSD. And naturally so! Why?

Well? What is Kaiser Permanente (KP)?

It is an integrated managed-care consortium founded in 1945 by industrialist Henry J. Kaiser and physician Sidney Garfield, and based in Oakland, California. It is made up of three distinct but interdependent groups of entities:

- Kaiser Foundation Health Plan, Inc. (KFHP) and its regional operating subsidiaries
- Kaiser Foundation Hospitals
- The regional Permanente Medical Groups

As of 2017, Kaiser Permanente operated in the US states of Hawaii, Washington, Oregon, California, Colorado, Maryland, Virginia, Georgia, and the District of Columbia. It is the largest managed care organization in the United States. And what is *managed care* or *managed healthcare*? They are terms used to describe activities ostensibly intended to reduce the cost of providing health care. By simultaneously

improving the quality of that care, they term it "managed care techniques." It has essentially become the exclusive system of delivering and receiving American health care since its implementation in the early 1980s, and is said to have been largely unaffected by the now rather infamous Affordable Care Act of 2010, also known as Obama care, which intended to:

> " . . . reduce unnecessary health care costs through a variety of mechanisms, including: economic incentives for physicians and patients to select less costly forms of care; programs for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of high-cost health care cases. The programs may be provided in a variety of settings, such as Health Maintenance Organizations and Preferred Provider Organizations." (Public Law 111–148, 111th Congress; An Act Entitled The Patient Protection and Affordable Care Act).

In essence, managed care is a system of healthcare in which patients agree to visit only certain doctors and hospitals. The cost of treatment is monitored by a managing company. In the U.S., where managed care is nearly ubiquitous nowadays, it has attracted controversy because of mixed results in its overall goal of controlling medical costs. Proponents and critics are also sharply divided on managed care's overall impact on the quality of U.S. health care delivery. It ranks among the worst and most expensive in the developed world. The World Health Organization places it 37th, right between Costa Rica (36) and Slovenia (38).

As to Kaiser Permanente, it had 11.7 million healths plan members in October 2017. It also had 208,975 employees, 21,275 physicians, 54,072 nurses, 39 medical centers and 720 medical facilities. In December 31, 2016, the purportedly non-profit Kaiser Foundation Health Plan and Kaiser Foundation Hospitals reported a combined $3.1 billion in net income on $64.6 billion in operating revenues. Mind you, each of KP's Medical Groups operates as a separate for-profit partnership or professional corporation in its individual territory. While none of them publicly reports its financial results, each is primarily funded by reimbursements from its respective regional Kaiser Foundation Health Plan (KFHP) entity. We could thus deduce that KFHP is one of the largest not-for-profit organizations in the United

States, making huge profits for its equally non-profit partners. The trend seems to be standard operating procedure for US-based, so-called "non-profit" operations or corporations. Perhaps they would be better called "*All for US*" entities. After all, no benefit seems to be reaching those supposed to benefit from the donations given to such operations, wit Kaiser and Clinton foundations as examples.

Nevertheless, KP's quality of care has been highly rated. This is attributed to three key factors:

- a strong emphasis on preventive care
- salaried doctors, rather than paid on a fee-for-service basis
- attempts to minimize the time patients spend in high-cost hospitals, by carefully planning their stay

KP was among the health insurance companies evaluated by Top Ten Reviews (toptenreviews.com), a company for the past 14 years reviewing consumer products. One of the largest product review sites on the web, they have tens of thousands of reviews and rankings in categories that include services, software, electronics, business, computers, home appliances and more. They found KP to have some of the lowest insurance rates and a substantial breadth of choices compared to others. However, we read that it does limit their clients to the Kaiser Permanente system. Top Ten Reviews says that one should check out KP's reputation in one's area, in particularly if needing special healthcare.

How PTSD experiencers fare with Kaiser Permanent is unknown. It acknowledged PTSD as a mental disorder, however, stating under: "How is PTSD treated?"

"The most effective treatments for PTSD are:

- "Counselling, which can help you understand your thoughts and learn ways to cope with your feelings. This can help you feel more in control and get you back to the activities in your life. A type of counselling called cognitive-behavioral therapy has been shown to be the most effective form of counselling for PTSD.
- "Antidepressant medicines, especially selective serotonin reuptake inhibitors (SSRIs). These can help you feel less sad and worried. SSRIs include fluoxetine (such as Prozac), paroxetine (Paxil), and sertraline (Zoloft).

- "You may need to try different types of treatment before finding the one that helps you. Your doctor will help you with this. These treatments may include other types of medicines and other forms of counselling, such as group counselling. If you have other problems along with PTSD, such as overuse of alcohol or drugs, you may need treatment for those also.
- "Treatment can help you feel more in control of your emotions, have fewer symptoms, and enjoy life again."

Because the Insurer has its own medical system of doctors, hospitals and specialists, it does not cover outside specialists. Nor will Kaiser doctors refer to anyone outside of their network. Nonetheless, Top Ten found the breadth of KP plan options to be about average of the health insurance companies tested. They also found it above average for their hypothetical *THIRTY FIVE YEAR OLD* human specimen used as test case. That's right, any older and *Watson* will jump in to eliminate patients at leisure, especially, we presume, if suffering PTSD or anything else of considered psychosomatic nature. Who was used in the KP funded EMDR PTSD study with the splendid result of 100% of single-trauma victims and 77% of multiple trauma victims no longer being diagnosed with PTSD after only six 50-minute sessions is unknown.

As late as in the winter of 2014, in an article published in *The Permanente Journal*, Shapiro spoke about adverse life experiences. She maintained that a substantial amount of research indicated that they *might* be the basis for a wide range of psychological and physiologic symptoms. She asserted that EMDR therapy research had shown that processing memories of such experiences resulted in the rapid amelioration of negative emotions, beliefs and physical sensations. She states that EMDR has potential applications for patients with stress-related disorders, as well as those suffering from a wide range of physical conditions. In her view, the medical community can also benefit from the use of EMDR therapy for prevention and rehabilitative services to support both patients and family members. A thorough assessment of potential experiential contributors can be beneficial. If relevant, EMDR therapy can allow medical personnel to quickly determine the degree to which distressing experiences are a contributing factor and to efficiently address the problem through memory processing that can help facilitate both psychological and physical resolution. Rigorous research of the use of EMDR therapy with patients suffering from the conditions identified in the ACE Study would be needed. They

could further contribute to our understanding of the potential for both remediation and preventive care.

The ACE report is a 1998 ground-breaking public health study co-authored by Dr. Vincent Felitti and Dr. Robert Anda. It used a 10-question screen on over 17,000 patients at Kaiser Permanente.

What are Adverse Childhood Experiences (ACE)? They are events that occur in the home, and include household dysfunction, substance abuse, parental separation and divorce or early death of a parent. Also identified as ACE are: mental illness, spousal or partner violence and criminal behavior resulting in incarceration of a household member. Thus again we see the aim to declare PTSD voyagers as mentally defect from the moment of birth, or basically all human beings, if we want to call a spade a spade.

And who is *The Permanente Journal*? Purporting to advance knowledge in scientific research, clinical medicine and innovative health care delivery, the Permanente Journal is sponsored by the National Permanente Medical Groups. It is a peer-reviewed journal of medical science, social science in medicine and medical humanities. The Permanente Presspublishes it in print quarterly and continuously online, the journal of record published at www.permanentepress.com.

As to Peer review, it is the evaluation of work by one or more people of similar competence as the work's producer — the peers. Therefore it constitutes a form of self-regulation by considered-to-be-qualified members of a profession within the relevant field of the work. Peer review methods are purportedly employed to maintain standards of quality, improve performance and provide credibility. In academia, scholarly peer review is often used to determine an academic paper's suitability for publication. The possibilities of human manipulation and control are huge. Nothing of quality *they* don't want published will ever be published, unless this system is changed by the masses for the masses, but dream on . . . .

The Centers for Medicare & Medicaid Services created the Medicare Star quality rating system in 2008. It would give beneficiaries a way to assess Medicare plans based on quality of care and service delivery. They gave KP consistently high ratings in all states in which they operate. It is also acknowledged in their evaluation, however, that Kaiser had disputes with its employees' unions. They, repeatedly faced civil and criminal charges for falsifying records and patient dumping. And they faced action by regulators over the quality of care it provided especially to patients with mental health issues, most likely PTSD insured among them. They also faced criticism from activists and action from regulators over the size of its cash

reserves.

Jamie Court, president of the Foundation for Taxpayer and Consumer Rights doesn't like Kaiser's retained profits. They say this evidence that Kaiser policies are overpriced and that health insurance regulation is needed. State insurance regulations do require that insurers maintain certain minimum amounts of cash reserves to ensure they are able to meet their obligations. The amount varies by insurer based on its risk factors, such as its investments, how many people it insures, and other factors. A few states also have caps on how large the reserves can be. But both activists and state regulators have criticized Kaiser for the size of its cash reserves. As of 2015, it had $21.7 billion in cash reserves, about 1,600% the amount required by California state regulations. In Colorado at the end of 2010 Kaiser held $666 million in reserves, about 1,300% of the minimum required under state law. Those funds were in Kaiser's risk-based capital account held to pay for disasters or major projects. In 2008 Colorado's regulator required Kaiser to spend down its reserves. After negotiations Kaiser agreed to spend $155 million of it by giving credits to its clients and building clinics in under-served parts of the state.

Kaiser Permanente: Not-for-Profit or "Not for Patients"? Nearly 1 in 3 people in the nation are now dependent upon an HMO for their health care needs, according to the California Nurses Association. Health care mergers and acquisitions over the last five years total nearly $200 billion. Meanwhile, health care CEO compensation continues to set historic highs. This is a time of drive-through mastectomies and 8-hour maternity stays. It is a time of 24-hour "emergency room" waits and of 41.3 million uninsured patients waiting until the last possible moment to go to a hospital. They wait out of fear of an inability to pay or of being treated as second-class citizens by the new "bottom-line" medicine of corporate health care.

The leader among the nation's 765 HMOs is $13.2 billion Kaiser Permanente with:

- nine million members
- $3.3 billion in profits in the past five years
- 12% of the current national HMO membership
- 36% of the California HMO market

And, KP is the subject of numerous federal and state quality care investigations, both in and out of California.

Kaiser has taken advantage of a legal technicality to attain market dominance

— it is a non-profit corporation — which means it is exempt from paying any federal income taxes. The Internal Revenue Service requires a non-profit organization to contribute services to the community as a condition of its non-profit status. Kaiser's corporate bylaws reflect those requirements:

> "This corporation's principal purpose is to provide hospital, medical and surgical care, including emergency services, extended care and home health care, for members of the public, without regard to sex, race, religion or national origin, or physical or mental handicap or to the individual's ability to pay."

Kaiser lives up to none of these requirements maintains the California Nurses Association corps ("*Corporate Healthcare–For Profit, Not for Profit, or Not for Patients: Kaiser Permanente; Watch Kaiser;*" www.kaiserpapershawaii.org).

Patients with mental health issues, in which KP insured PTSD experiencers are included, add wholesomely to that profit, I assume. If their PTSD isn't cured after six EMDR sessions, KP will have an excuse. KP will state it is their own innate pre-PTSD mental deficiency combined with their Adverse Childhood Experiences causing their lack of improvement, never mind healing, and stop paying compensation. Human debris. All your own doing.

What did Prof Olatunji conclude in 2001 about EMDR whilst still a graduate student? Despite the theoretical inconsistencies, the enthusiasm and support of EMDR had increased significantly. More and more clinicians were receiving training applicable in the clinical setting, wrote he. This was premature acceptance by psychologists of this, in his view, pseudoscientific intervention. It appeared to suggest a shift on their part in the basic necessity of scientific validation prior to clinical application. Although a consensus had yet to be achieved in regards to a universal definition of pseudoscience, he writes, it was, in his, opinion no coincidence that EMDR fitted the non-categorical and prototypical definitions of pseudoscience. These had been proposed by a variety of philosophers, such as Herber, Lilienfeld, Lohr, Montgomery, O'Donohue, Rosen, Tolin. In in 2000, they wrote in the abstract of their article about EMDR:

> "The enormous popularity recently achieved by Eye Movement Desensitization and Reprocessing (EMDR) as a treatment for anxiety disorders appears to have greatly outstripped the evidence for its efficacy from controlled research studies. The disparity raises disturbing questions

> concerning EMDR's aggressive commercial promotion and its rapid acceptance among practitioners. In this article, we: (1) summarize the evidence concerning EMDR's efficacy; (2) describe the dissemination and promotion of EMDR; (3) delineate the features of pseudoscience and explicate their relevance to EMDR; (4) describe the pseudoscientific marketing practices used to promote EMDR; (5) analyze factors contributing to the acceptance of EMDR by professional psychologists; and (6) discuss practical considerations for professional psychologists regarding the adoption of EMDR into professional practice. We argue that EMDR provides an excellent vehicle for illustrating the differences between scientific and pseudoscientific therapeutic techniques. Such distinctions are of critical importance for clinical psychologists who intend to base their practice on the best available research (*Science and pseudoscience in the development of eye movement desensitization and reprocessing: implications for clinical psychology.* Clin Psychol Rev. 2000 Nov;20(8):945–71)."

It would be splendid, said Olatunji in 2001, if EMDR advocates could empirically support the exaggerated claims they put forth regarding the efficacy of EMDR treatment. Nevertheless, at that time it was exceedingly clear to him that EMDR lacked the theoretical foundation necessary to be considered a scientific method. It was also clear to him that the empirical evidence purportedly supporting its efficacy was also flawed and inconsistent. In other words, in his opinion it had not yet been validated convincingly by any controlled study that any of EMDR's therapeutic effects did not just occur due to random chance. Or that they occurred from other aspects of the treatment, such as patient expectancy or placebo effects, besides the eye movement procedure. Based on those and numerous other inconsistencies, it was without question that extreme caution was advisable in the clinical application of EMDR, Olatunji asserts. He had no doubt that both in theory and practice EMDR fell way short of scientific standards. How he feels about it in 2018 we do not know.

We do know, however, that the American Psychiatric Association, the World Health Organization, and the Department of Defense nowadays recognize EMDR as an effective form of treatment for trauma and other disturbing human life

experiences. Shapiro herself is a senior research fellow emeritus at the Mental Research Institute in Palo Alto, California. She is also executive director of the EMDR Institute in Watsonville, CA. And she is founder and president emeritus of the Trauma Recovery EMDR Humanitarian Assistance Programs Trauma Recovery EMDR Humanitarian Assistance Programs. That's a non-profit organization that coordinates disaster response and low fee trainings worldwide. Its mission statement is: "To increase the capacity for effective treatment of psychological trauma in under-served communities anywhere in the world." Another person kept very busy due to PTSD existential crisis experiencers.

Shapiro is also a recipient of the *International Sigmund Freud Award* for distinguished contribution to psychotherapy, presented by the City of Vienna in conjunction with the World Council for Psychotherapy. She received the American Psychological Association Trauma Division *Award for Outstanding Contributions to Practice in Trauma Psychology. And she also received* the *Distinguished Scientific Achievement in Psychology Award,* presented by the California Psychological Association.

She was also designated as one of the "Cadre of Experts" of the American Psychological Association & Canadian Psychological Association Joint Initiative on Ethnopolitical Warfare. She has served as advisor to a wide variety of trauma treatment and outreach organizations and journals. She has been an invited speaker at psychology conferences worldwide and has written and co-authored more than 60 articles, chapters, and books about EMDR, including:

- Getting Past Your Past: Taking Control of Your Life with Self-Help Techniques from EMDR Therapy (Rodale)
- *EMDR*: Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures (Guilford Press)
- EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress and Trauma (Basic Books)
- EMDR as an Integrative Psychotherapy Approach: Experts of Diverse Orientations Explore the Paradigm Prism (American Psychological Association Books)
- Handbook of EMDR and Family Therapy Processes (Wiley)

And her own distressing and downright traumatizing life-experiences, which lead her to discover the impact of eye-movement on the human psyche? I could find

nothing.

As to PTSD, Olatunji teamed up with Rebecca C. Fox i in 2017. She was a graduate student at the Clinical Science Program in Psychological Sciences at Vanderbilt University program (annual tuition fee roughly $45,000.00). They claimed that deficits in attentional control and rumination were linked with PTSD. Attentional control, also known as endogenous attention or executive attention, refers to a person's ability to choose what they pay attention to and what they ignore. In lay terms, attentional control can be described as one's ability to concentrate. Although deficits in attentional control have been linked to PTSD, the mechanism that may account for this association had not been fully elucidated, we are told.

The present study examined rumination as a mediator of the relationship between attentional control and PTSD symptoms. Veterans with PTSD and trauma-exposed veterans without PTSD completed measures of attentional control, rumination and PTSD symptom severity. As predicted, the findings showed that veterans with PTSD reported significantly *lower* levels of attentional control than veterans without PTSD. Veterans with PTSD also reported significantly *higher* levels of rumination than veterans without PTSD.

Subsequent analysis of the total sample revealed that the relationship between attentional control and PTSD symptom severity was accounted for by excessive rumination. So, excessive rumination might be an important target for PTSD interventions. Cox and Olatunji suggest creating another golden goose of hypostatical PTSD treatment modality. (Rebecca C. Fox, Bunmi O. Olatunji: Linking attentional control and PTSD symptom severity: the role of rumination; *Journal of* Cognitive Behaviour Therapy Volume 46, 2017, Issue 5 p.421–431)

It seems to have been that self-same rumination that inspired Francine Shapiro in the 1980s. That's when she dreamed up and created her EMDR treatment hypothesis. You will recall that she was ruminating in the forest somewhere in the middle of nowhere, as she tried to get a grasp on her own emotional distresses and traumas of unknown quality and quantity. So perhaps the same ruminations could inspire PTSD travelers to find their own solutions rather than being incessantly subjected to those thought up by people who make a living off of them? After all, what is there to lose? It's being touted as effective in treating low self-esteem, feelings of powerlessness and the myriad of other purported human problems in earlier times attributed to living life to the fullest, picking self up and getting going againThat's what PTSD journeyers aim to do until the moment they seek help.

Then, they enter the journey that ends up in the clutches of the mental health cabal's pharmaceutical drug-doused treatment. Game over. Forthwith, a slow, tedious journey towards death, due to destruction of mind and body, is voluntarily traveled — unless self-awakening occurs.

30 years after inception, EMDR still causes most PTSD afflicted the same distress as all other PTSD remedies appear to do. It causes more rumination than the ruminations it is said to be able to alleviate, ameliorate or eliminate, other than in the Kaiser Permanente funded study. *EMDR Research News* reported that in January 2018 alone 29 new articles related to EMDR therapy surfaced. Business is swift, despite an economic crisis. 18 articles had links to the open access full text articles. Wonderful how much empirical scientific confirmation of EMDR's effectiveness is sought with such outstanding determination and persistency. And all this not only to prove that it is effective, but also to justify the role of mental health practitioners administering it. PTSD prolongation due to rumination since 2017 also ranks high on research funding agendas.

And Bunmi O. Olatunji, now a full professor at the Clinical Science Program in Psychological Sciences at Vanderbilt University? His primary research interest lies in cognitive behavioral theory assessment and therapy for anxiety disorders. He is particularly interested in the role of basic emotions other than fear in the etiology of anxiety pathology. His current research employs basic descriptive and experimental psychopathology methodology. He uses it to examine the relationship between the experience of disgust and specific anxiety disorder symptoms including in pediatric chronic abdominal pain.

Olatunji isVanderbilt's director of the Emotion and Anxiety Research Laboratory. In that role, his primary research interest involves multilevel examination of cognitive behavioral theory, assessment and therapy for anxiety disorders. He is currently adopting an experimental psychopathology framework to examine the role of basic emotions, especially disgust, as they relate to the assessment, etiology, and maintenance of anxiety-related disorders. The National Institute of Health and the Anxiety Disorders Association of America funds his research.

Olatunji, certainly did well for himself in the past 17 years. In the Department of Psychology and Psychiatry at Vanderbilt University, he also serves as director of clinical training. He also is the associate editor of the *Journal of Consulting and Clinical Psychology* . He currently serves on the editorial boards of:

- *Behavior Therapy*
- *Psychological Bulletin*
- *International Journal of Cognitive Therapy*
- *Psychological Assessment, and Psychotherapy*
- *Journal of Obsessive-Compulsive and Related Disorders*

He has published more than 160 journal articles and book chapters, and has participated in more than 100 conference presentations. He is co-author of the book *10-minute CBT: Cognitive behavioral interventions for the brief medication visit,* published by Oxford Press. He is also co-editor of the book *Disgust and its disorders: Assessment, theory, and treatment,* published by the American Psychological Association. A very busy man indeed.

But before Olatunji ever analyzed EMDR in his 2001 graduate paper on his way to become a renowned man in his field, famous skeptic Robert Todd Carroll (+2016) wrote this about it in his "eye movement desensitization and reprocessing (EMDR)" article of around 1999:

> ". . . what is new in EMDR does not appear to be helpful, and what is helpful is what we already know about relaxation, education, and psychotherapy.
>
> "Although the research regarding the necessity of the eye movement component is currently inconclusive, EMDR is a psychological treatment for PTSD which has received considerable empirical validation However, in spite of the empirical validation, confusion still exists in the literature regarding EMDR. Some of the confusion is theoretical and due to the current lack of empirical validation of Shapiro's (1991b, 1995) information processing model and the continued inability of other models (e.g. exposure) to convincingly explain EMDR methods and effects."

Whereupon Carroll dives right in, describing EMDR as a therapeutic technique in which the patient moves his or her eyes back and forth, hither and thither, while concentrating on "the problem". The therapist waves a stick or light in front of the patient, and the patient is supposed to follow the moving stick or light with his or her eyes. Yes, that's the therapy discovered by therapist Dr. Francine Shapiro while on a stroll in the park. At least, that's her version, he proclaims.

John Grinderis one of the founders of Neuro-linguistic Programming (NLP). He

claims he taught the eye movement part to her when she worked for his office as an administrator in the 1980s. NLP is an approach to communication, personal development and psychotherapy he and Richard Bandler created in California, United States, in the 1970s. The term neuro-linguistic programming has 3 components:

- Neuro: the neurology or brain system. The neurological system regulates how our brains function.
- Linguistic: The linguistics define how we interface/communicate with others and ourselves. The linguistic also refers to unconscious communication, like body language, eye patterns, etc, which are not in our conscious control.
- Programming: The strategies (i.e. programs) which we use to create our individual models of the world or run our behaviors. These programs can be improved, strengthened or altered as we may like using existing NLP Processes or by modelling new processes.

NLP's creators claim there is a connection between neurological processes and behavioral patterns learned through experience *(programming)* and that these can be changed to achieve specific goals in human life. Bandler and Grinder also claim that NLP methodology can "model" the skills of exceptional people allowing anyone to acquire those skills. ("What is Neuro-Linguistic Programming? or What is NLP?" nlpminds.com)

They claim, as well, that, often in a single session, NLP can treat problems such as:

- allergy
- phobias
- depression
- tic disorders
- common cold
- learning disorder
- near-sightedness
- psychosomatic illnesses

Shapiro's doctorate was earned at the now defunct and never accredited

Professional School of Psychological Studies, enlightens Carroll. She holds a bachelor's degree (1968) and MA (1974) in English Literature from Brooklyn College, City University of New York. In 1974, while employed full-time as an English teacher, she enrolled in a Ph.D. program in English Literature at New York University. In 1979, having completed all but her dissertation, she was diagnosed with cancer. Her post-recovery experiences shifted her attention from literature to the effects of stress on the immune system. Her focus was based on the work of the American political journalist, author and professor Norman Cousins (1915–1990) and others believing that human emotions were the key to success in fighting illness.

By osmosis, she thus made the discovery of EMDR. She claims it can "help" with "phobias, generalized anxiety, paranoid schizophrenia, learning disabilities, eating disorders, substance abuse, and even pathological jealousy" (Lilienfeld 1996). But she says that its main application is treating PTSD.

After extensive research notes, however, no one has been able to adequately explain how EMDR works. Some think it works something like acupuncture, which allegedly unblocks chi, while rapid eye movements allegedly unblocks "the information-processing system." Some think it works by a sort of ping-pong effect between the right and left sides of the brain, which somehow can restructure memory. Or perhaps it works, as one unnamed therapist suggested, by the rapid eye movements sending signals to one part of the brain. That part might somehow tame and control the naughty part of the brain causing the psychological problems. Others apparently think EMDR works by activating a healing process in the brain. Painful memories are re-processed and beliefs that sprang from them are eliminated and replaced by new, healthy beliefs. Whichever way it may be, it all was but pure speculation for Carroll, if not humbug.

Empirical scientific evidence for EMDR's eye movement component's effectiveness is not much stronger than the theoretical explanations for EMDR's alleged workings. Unlike the theoretical explanations, the evidence has the virtue of being consistent, but it is mainly anecdotal and very vague, we learn. No controlled studies have established beyond a reasonable doubt that any positive effects achieved by an EMDR therapist's eye movement techniques are not likely due to chance. Nor to the placebo effect. Nor to patient expectancy or posthypnotic suggestion. Nor to other aspects, such as the cognitive behavioral rattus and cani therapy (CBT), also used as part of EMDR treatment modalities beside the eye movement aspect, we read.

A Cochrane Collaboration report on psychological treatment of PTSD opines that there was no significant difference between EMDR and cognitive behavioral therapy. This is not to say that there have not been controlled studies of EMDR. Shapiro cites quite a few, including her own, writes Carroll. The reader is invited to look at her summaries of the research. The reader can then determine for himself or herself just how adequate the evidence is in support of EMDR's eye movement component as the main causal agent in PTSD recovery. One study was by Wilson, Becker and Tinker, licensed psychologists in private practice for the past 35 years. They specialize in EMDR treatment for adults and children, family and marriage therapy, phantom limb and pain memories. and motor vehicle accident treatment. Their study was to be published in The Journal of Consulting and Clinical Psychology. *I*t reported a "significant improvement" in PTSD subjects treated with EMDR, Carroll noted. The study also provided significant evidence that spontaneous healing cannot account for this improvement. Nevertheless, the study is unlikely to convince critics that EMDR's eye movement component is the main cause of measured improvement of PTSD subjects. Carroll suspects that until a study is done to isolate the eye movement part from other aspects of the treatment, critics will not be satisfied. It may well be, he says, that those using EMDR are themselves effecting the cures they claim. That might thereby be benefiting many victims of horrible experiences such as rape, war, terrorism, murder or suicide of a loved one and so on. It may also well be that those using EMDR are directing their patients to restructure their memories. The result would be that the horrible emotive aspect of an experience is no longer associated with the memory of the experience. *EMDR Evaluated Clinical Applications* can be read up on the Eye Movement Desensitization and Reprocessing Therapy Institute, Inc.'s website.

Regardless, for Carroll the question still remained whether the rapid eye movement part of the treatment was essential. In fact, one of the control studies cited by Shapiro seemed counter-indicative to him:

> "In a controlled component analysis study of 17 chronic outpatient veterans, using a crossover design, subjects were randomly divided into two EMDR groups, one using eye movement and a control group that used a combination of forced eye fixation, hand taps, and hand waving. Six sessions were administered for a single memory in each condition. Both groups showed significant decreases in self-reported distress, intrusion, and avoidance symptoms (Pitman et al.

1996)."

Would hand taps will work just as well as eye movements? According to one EMDR practitioner, Dr. Edward Hume:

> ". . . taps to hands, right and left, sounds alternating ear-to-ear, and even alternating movements by the patient can work instead. The key seems to be the alternating stimulation of the two sides of the brain."

According to Carroll, Dr. Hume also noted that Shapiro now called the treatment *Reprocessing Therapy* saying that eye movements were not necessary for the treatment! Maybe *none* of these movements are needed to restructure memory. In short, EMDR was a scientifically controversial technique. But controversy had not prevented thousands of practitioners from being certificated to practice EMDR by Shapiro and disciples.

EMDR still is controversial. And although at the time of Carroll's writing it was not approved by the American Psychological Association (APA), it did not disapprove of it either. Mind you, according to the APA Public Affairs Office spokeswoman Pamela Willenz, the APA rarely approves or disapproves of therapies:

> "We don't approve or disapprove of EMDR as a therapy. APA does recognize therapies and does recognize EMDR as a type of therapy. We offer CE [continuing education] credits for psychologists wanting to learn EMDR."

In Carroll's opinion, this APA practice to neither approve nor disapprove of therapies tells us more about the APA than it does about EMDR. It might be useful to consumers, if the APA would at least distinguish between therapies proven to be effective and those that are controversial. He spews forth: "One does not need to be an expert in anything to recognize that EMDR is *a type of therapy*."

Advocates of EMDR claim that it is "a widely validated treatment for PTSD and other ailments such as traumatic memories of war, natural disaster, industrial accidents, highway carnage, crime, terrorism, sexual abuse, rape and domestic violence." (David Drehmer, Ph.D., Licensed Clinical Psychologist & Director, Performance Enhancement Laboratory, Associate Professor of Management, DePaul University, personal correspondence.)

Carroll thunders:

> "What is needed is not proof that PTSD subjects are being helped by the treatment, but that it is the eye movement part of the treatment that is essential to its success. Once that is

> established, a theory as to how it works would be most gratifying. At present, we are being given theories to explain something that we can't yet be sure is even occurring: that eye movements are restructuring memory. If it turns out that that claim is true, I suggest it will have significance far beyond the treatment of PTSD subjects."

Carroll in a December 2000 update added:

> "Ranae Johnson has founded the Rapid Eye Institute on a blueberry farm in Oregon where she teaches Rapid Eye Technology. This amazing new therapy is used 'to facilitate releasing and clearing of old programming, opening the way to awareness of our joy and happiness.' It helps us 'find light and spirituality within us that has always been there.' Apparently, people are paying some $2,000 for the training and all the blueberries you can eat."

No doubt EMDR and PTSD are big business. The American Psychological Association on its website sells videos about it. The DVD *EMDR for Trauma: Eye Movement Desensitization and Reprocessing*, for example, sells for a list price of US $109.95. For a Member/Affiliate the price drops to $82.46 (© 2018 American Psychological Association). Its description?

> "Dr. Francine Shapiro demonstrates her approach to working with clients still experiencing the effects of past traumatic experiences. EMDR is an integrative psychotherapy designated by the American Psychiatric Association as highly effective and empirically supported. The approach is based on an information-processing model of pathology, directly addressing the stored memories of events that cause clinical complaints, the present situations that are disturbing, and experiences necessary for appropriate future functioning. In this session, Dr. Shapiro works with a 42-year-old retired police officer who is having panic attacks. She uses EMDR to help the client process the images, emotions, feelings, and thoughts associated with his job-related trauma. This video features a client portrayed by an actor on the basis of actual case material."

The WCB proposed EMDR to me, soon after Shapiro's stroll in the park. They

lauded it as the foremost treatment to cure my PTSD. I declined laughing, ready to declare them for insane. As said earlier, for the love of my life could I see value in moving my eyes around to the direction of someone's finger at any given time, but in particular not when this somewhat was a complete stranger most likely without only an academic and theoretical clue about PTSD. Miraculously, no one forced me into compliance. That was almost three decades ago, and the war of opinions on EMDR's merit or dismerit wages on.

Could it be that EMDR is designed to cut PTSD journeyers off from the introspection required to heal, and not just mask PTSD symptoms? Is it an attempt to lure them into the belief that it does work? Does it simply prolongs the agony of doubt about life and living, its purposes and its reasons? These can be resolved only by finding the connection with the Divine, the exploration of the spiritual aspects of human existence. Is it on the sub-surface nothing but another avenue to cradle us in the illusion of hope of healing without doing anything for and by ourselves? Does it thus indirectly deprive us of the peace, quiet and financial stability necessary for recovery?

That was all I needed at that time, plus the willingness to educate myself on PTSD and a willingness still five years in the future. In my infinite wisdom and stupidity, I fully trusted those pretending to help me make a full recovery to return to flying for the rest of my working career. There is good news for voyagers sick and tired of having their brains picked by anyone who never lived their temporary predicament. With the Internet in most people's hands these days, studying PTSD and, EMDR is easy as there are sites galore to be explored. These would make a good start.:

- Efficacy of EMDR
- Summary of PTSD Studies
- Eye Movements and Alternate Dual Attention Stimuli
- What has research determined about EMDR's eye movement component?

But let us now move on to the next modality dreamed or not dreamed up by the mental health league. This one is touted as beneficial for PTSD experiencers, namely the Cognitive Behavioral Modification technique or CBM for short.

COGNITIVE BEHAVIOURAL MODIFICATION(CBM)

The Cognitive Behavioural Modification hypothesis is the brainchild of Donald Meichenbaum (1940–). He, who is known in his field for his role in the development of cognitive behavioural therapy (CBT), is also known for his contributions to the treatment of posttraumatic stress. Born and raised in New York, NY, USA, he began his undergraduate career at City College of New York. From there, he went to the University of Illinois in Champaign where he obtained his Ph.D. in clinical psychology. In graduate school, he started out as an industrial psychologist. After he was hired as research assistant to conduct group observations at a local veteran's psychiatric hospital, however, he became so fascinated with the patients that he decided to switch to clinical psychology instead. After his graduation in 1966, with the US Vietnam draft (1964–1973) in full swing, he accepted to teach as assistant professor at Ontario's University of Waterloo, and remained there for over 30 years before taking early retirement.

In addition to cognitive psychology, Meichenbaum has studied anger, posttraumatic stress and education. He is considered to be an expert in the treatment of PTSD, and has presented workshops on PTSD in several parts of the world. Before his retirement from the University of Waterloo in 1998, he was the most-cited researcher in his field at a Canadian university. A 2002 survey found him to be one of the 10 most influential North American therapists of the 20th century.

The University of Waterloo is located in Southern Ontario about 60 miles west of Toronto *on the traditional territory of the Attawandaron, Anishinaabe and Haudenosaunee peoples.* It is consistently ranked as the most innovative among the top three Canadian universities. Its world class Department of Psychology includes 42 faculty members, approximately equally divided over six major research areas: clinical, cognitive, cognitive neuroscience, developmental, industrial/organizational and social, with over 800 undergraduate students pursuing a Bachelor's degree in psychology and over 400 pursuing a psychology .

The University of Waterloo gets extensive grant support from Canada's tri-council agencies of the :

- Canadian Institutes of Health Research (CIHR)
- Social Sciences and Humanities Research Council of Canada (SSHRC)
- Natural Sciences and Engineering Research Council of Canada (NSERC)

These funds, as well as funds from other granting agencies world-wide, outfit the laboratories in the Department of Psychology with state of the art equipment That includes eye movement trackers, suites, and event-related potential (ERP) systems. An event-related potential (ERP) is the measured brain response that is the direct result of a specific sensory, cognitive or motor event. More formally, it is any stereotyped electrophysiological response to a stimulus. The study of the brain in this way provides a non-invasive means of evaluating brain functioning. The latter is in league with the Neumeisters of the world, the neuroscientists viewing humans as soulless entities, as machines with nuts and bolts, easily replicable and repairable, as earlier mentioned.

And what are virtual reality suites? The Queen's University at Kingston, Ontario, Psychology Department's website states the primary purpose in venturing into the field of virtual reality. That is to bring their knowledge of multisensory perceptual mechanisms to the technical advancement of virtual and artificial perceptual environment research (VAPER). This is done by exploring the perceptual consequences of various types of stimuli and body motion constraints in humans. These suites are also involved in research into basic perceptual mechanisms using human and animal models behaviour and physiology. Much of the work focuses on the distinctions between self-motion and object motion, and the segregation of objects using motion cues.

The German Max Planck Society Department of Social Neuroscience's Virtual Reality Laboratory is more open about the state of affairs regarding reality suites when unveiling:

> "We live in a complex and dynamic world that provides a wealth of opportunities for experience, exploration, and interaction. Nevertheless, psychology and neuroscience traditionally rely upon paradigms with pared down-stimuli and extremely limited constraints on action and attention.
>
> "While these paradigms provide experimental control, they often lack ecological validity. Immersive virtual environments (IVEs) bridge this gap by placing participants in 3D digital simulations that mimic the complexity and freedom afforded by the physical world while maintaining laboratory-level control.
>
> "Over the past several years the Virtual Reality Lab of the Social Neuroscience Department, headed by Dr. Cade

> McCall, has developed "The Wunderkammer", a suite of virtual worlds that evaluates several facets of cognition, affect and behaviour. Using a head-mounted display and digital motion tracking equipment, participants enter visually and aurally complex worlds. There they encounter humanoid avatars, explore a virtual museum, or become immersed in anxiety-provoking scenes.
>
> "Meanwhile we measure autonomic activity, subjective experience, motor behaviour, gaze, and performance on various tasks. Together these data allow us to assess individual differences in the kinds of stimuli participants choose to approach or avoid, the degree to which they observe their environment, their nonverbal behaviour toward others, and how they physiologically and subjectively respond to anxiety."

A force in sciences, the Max Planck Society is a world leader in the physical sciences. It has 18 Nobel Prizes to its credit. In 2018, it was on the Annual Tables of the ten institutions that dominated science, ranking third in the world after the Chinese Academy of Sciences, China, and Harvard University, USA.

The Max Planck Society for the Advancement of Science (German: *Max-Planck-Gesellschaft zur Förderung der Wissenschaften e. V.*; abbreviated MPG) is a formally independent, non-governmental and non-profit association of German research institutes. It was founded in 1911 as the Kaiser Wilhelm Society. It was renamed the Max Planck Society in 1948, in honour of its former president, theoretical physicist Max Karl Ernst Ludwig Planck whose discovery of energy quanta won him the Nobel Prize in Physics in 1918.FIt is funded by the federal and state governments of Germany. According to its primary goal, the society supports fundamental research in the natural, life and social sciences, the arts and humanities. Since its formation 100 years ago, the Society has established 84 institutes and research facilities, five of which are located outside Germany. (In 2017, Max Planck Society researchers were part of a global effort that pinpointed a supermassive black hole with a mass 800 million times larger than the Sun. Described in *Nature*, the black hole is the most distant of its kind ever observed and formed just 690 million years after the presumed Big Bang. Mind you, Meichenbaum's former Waterloo's Psychology Department ranks number sixth for 2018 out of the 20 best psychology programs in Canada's universities. It has recently been touted as the country's most productive, a testament to the cutting edge research conducted at the facility, we are told.

Now professor emeritus, it was his work in the field of cognitive psychology that led Meichenbaum to develop cognitive behavioural modification (CBM) at the tail end of the cognitive revolution. The result was his 1977 publication *Cognitive Behavior Modification: An Integrative Approach. This is* considered a classic text in the field of CBT, the Pavlov/Skinner rattus/cani PTSD treatment methodology so favoured by the NC for PTSD.

CBM empowered clients to take charge of their own negative self-talk and beliefs. It put clients in the driver seat to change their own behaviours simply by changing their inner dialogue. This considered revolutionary therapeutic approach continues to be a powerful and effective tool for therapists today, we understand. In fact, in 2002 Meichenbaum was voted by his peers as one of the top 10 influential psychotherapists' of the 20th century.

CBM, of course, is nothing new. It has existed throughout time and is well known to those in the know, the sages, meditators and philosophers of the ages. How does it work? As in everything else, with Self-awareness, which is half the battle won. *Know thyself, know thy enemy. A thousand battles, a thousand victories* (Sun Tzu). Win over the Self by observing one's thinking like a hawk. Change it to one's liking, as mirrored in the Cognitive Behavioral Modification theory and process. A client's awareness of negative self-talk and narrative is imperative for CBM to work. It is also said to be necessary in order to move on to the next phase of treatment. That would be changing negative self-talk by focusing on identifying dysfunctional self-talk in order to change unwanted behaviours. In other words, Dr. Meichenbaum recognizes human behaviours as outcomes of their individual inner self-verbalizations.

How, then, does his Cognitive Behaviour Modification work? Sheryl Ankrom, answers the question in her verywellmind.com 2018 article "How Cognitive Behavior Modification Works."

A licensed clinical professional counsellor and nationally certified clinical mental health counselor specializing in the treatment of anxiety disorders, Ankrom received her undergraduate degree from St. Xavier University in Chicago, Illinois and her master's degree in counseling psychology from Capella University in Minneapolis, Minnesota. She is part of a team of forensic mental health experts performing evaluations for disability companies, school systems and employers and also works with individuals and families. She has extensive experience in assessment, diagnosis and treatment of anxiety disorders we read on verywellmind.com. She presently is director of Clinical Services at Lifeline

Behavioral Healthcare, Ltd./Benchmark Mind + Health, Ltd., a company offering counseling, psychotherapy, and life coaching services (www.lifelinebehavioralhealthcare.com).

She observes that panic disorder, agoraphobia, or other anxiety disorders often result in certain thought patterns and behaviors hindering recovery. She asks: "But, what if we were able to change our thoughts?" And, what if by changing our thoughts we were able to attend to endeavours and overcome apprehensions previously thought insurmountable? But how? According to her, using CBM to change thoughts and avoidance-behaviours, including panic responses, is a three-phase process:

Phase 1: Self-Observation

This phase involves listening closely to our internal dialogue or self-talk and observing our own behaviour. We want to be especially aware of any negative self-statements that contribute to our anxiety and/or panic symptoms.

To help us become more aware of our negative self-talk, it might be beneficial to write it down as it happens. Tracking this type of dialogue in writing helps to become more aware when it is happening. One might jot it down in a notebook as soon as possible after it occurs, to look at it later. O one might journal at the end of the day. It might be surprising to discover just how often we set ourselves up for anxiety throughout the day, says Ankrom.

Phase 2: Begin New Self-Talk

Once we recognize our negative self-talk, we can catch ourselves in a negative thought pattern. We can begin to change it by creating a new and positive internal dialogue. "I can't" turns into "I can, of course, I can." One can scratch off the negative statements in the journal and replace them with the positive, then practice saying them until one starts to believe.

Better still, go on watching Self think, continuously, endlessly, every moment of waking hours until it becomes a habit and an amusement. Some dreadful thoughts of hilarity can pop forth out of nowhere at the most unexpected times. It might be accompanied by gratitude that mind-reading has yet to come into vogue. Sooner or later — there is no time and everything occurs at the right time — one discovers that one's awareness to negative thought patterns heightens to such a degree that they diminish more and more. With it the desire for self-defeat, which negativity in essence signifies, also diminishes. Meanwhile, the power of Self increases exponentially with it, with increasing control over the Self. All of it is fascinating to

watch and behold in the Self, as it is created by the Self. So are the miracles associated with and accompanying the process.

But I digress — again. Here more from Ankrom about Meichenbaum's theory. He assumes rightly that these new self-statements or affirmations by the Self now guide new, or should we call it different, behaviour. Rather than using avoidance to cope with panic disorder and/or anxiety, one becomes willing to experience anxiety-provoking situations to see and gauge how one copes. This leads to better coping skills and admiration of the Self, actually. When one has kicked Self, to at least give it a try to overcome the Self. and succeeds in the endeavour, success begins to build upon success and superb gains in one's PTSD recovery become visible to the Self.

Phase 3: Learning New Skills

Each time we are able to identify and restructure our negative thoughts, through it change our response to panic and/or anxiety. We learn that we indeed have the power to control our anxiety, our panic, our behaviour associated with it. That includes the anger and rages associate with PTSD, not because of the crises itself, but because of the impositions of others occurring adjacent to it. When acutely aware of our thinking, we are able to gauge our anxiety and thus control our reaction to it. As Ankrom states, react "in a more useful manner." For whom? Ourselves, as we are in damage-control mode rather than causing the damage.

Why? As one controls one's behaviour one takes back one's power. As one gains power over the Self, one becomes less vulnerable. As one becomes less vulnerable, one becomes more balanced. As one becomes more and more balanced, one thinks better. As one thinks better and more clearly, one deals much better and easier with what the day throws at one. Then, everything one undertakes flows better, and on and on it goes. Needless to say, however, that a "Go for it" attitude, guts, gumption and courage, is part of this self-change in thinking. That part is nowhere mentioned. But without it, nothing will occur within — nothing at all, as nothing comes from nothing. Thus the goal of therapists using CBM technique is to change clients' narrative or life story from negative to positive by focusing on their strengths and resilience.

The "Word From Verywell?" When negative thoughts control us, it becomes difficult to control our behavioural responses to unpleasant situations, but CBM can give us back some lost control. As our thoughts change from negative to positive, we humans start to behave differently in many situations. As an added bonus, it is likely that others react differently to your new "positive", actually awakened, Self.

CBM is also said to help humans forgive themselves for misdoings in the past and move forward with hope and positivity for the future, the must in PTSD. With a favourable change of perspective and life narrative a client's actions and behaviours are expected to follow suit (Karin Gonzales: Cognitive-Behavior Modification Approach by Meichenbaum; study.com). Meichenbaum's CBM therapy approach is said to have contributed significantly to the development of CBT. In essence, however, is CBM perhaps nothing other than the ancient Greek aphorism "know thyself"? This was one of the Delphic maxims, which, according to the Greek writer Pausanias, was inscribed in the Temple of Apollo forecourt at Delphi. It was later expounded upon by Socrates, who taught "The unexamined life is not worth living?" (Pausanias: Description of Greece, 10.24)?

Be it as it may, the same mental health practitioner who sought and found fame and fortune with CBM, Donald Meichenbaum, also gave us the Stress Inoculation Training (SIT) technique. It is purported to prevent the possibility of PTSD in subjects of all stripes and colours. SIT hypothesis or theory revolves around a psychotherapy method intended to help humans prepare themselves *in advance* to handle stressful events, including PTSD-inducing-situations, successfully and with a minimum of upset. They would do so by living in perpetual anxiety while awaiting an event which might never come to pass. But never mind that part, as some people truly enjoy perpetually living on the edge. Mind you, they might indeed not be genetically and MK Ultra manipulated, unsaturated, or unaltered humans.

THE STRESS INOCULATION TRAINING (SIT) HYPOTHESIS

Even though Meichenbaum claims fame for the SIT hypothesis, it was American psychiatrist Aaron Temkin Beck pioneered the idea who in the 1960s. He did this after practicing psychoanalysis at the University of Pennsylvania for a number of years. Now professor emeritus in the department of psychiatry at the University of Pennsylvania, he is regarded as the father of cognitive therapy. Beck also developed self-report measures of depression and anxiety, notably the Beck Depression Inventory (BDI). This is one of the most widely used instruments for measuring depression severity PTSD journeyers probably come across in their journey through the mental health system.

Beck is noted for his research in psychotherapy, psychopathology, suicide and psychometrics. His pioneering theories in the treatment of clinical depression are said to be widely used. He has published more than 600 professional journal articles and authored or co-authored 25 books. In July 1989, The American Psychologist not

only named him one of the Americans in history who shaped the face of American Psychiatry, but also one of the five most influential psychotherapists of all time.

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Nowadays, professor emeritus Beck is president emeritus of the non-profit Pennsylvania-based *Beck Institute for Cognitive Behavior Therapy*. He and his psychologist daughter, Judith S. Beck, set up the Institute in 1994.

His Beck Depression Inventory (BDI, BDI-1A, BDI-II), a 21-question multiple-choice self-report inventory, however, is used all over the world. The two most critical factors clinicians use to determine whether or not clients, including PTSD-experiencing ones, suffer from clinical depression are:

- The degree to which symptoms interfere with their daily life and functioning
- How long their symptoms have lasted.

In order to determine the severity of someone's depression, for example, the symptoms are compared with those of other people by way of the completion of a standardized questionnaire test such as the Beck Depression Inventory. There are other scales, too, such as:

- Hamilton Depression Rating Scale
- Zung Self-Rating Depression Scale
- Center for Epidemiologic Studies Depression Scale
- Geriatric Depression Scale (if 65 years of age or older)

These psychometric tests measuring the state of our psyche or depression are useful for screening purposes and as research instruments. But they are not the only source of information used to diagnose PTSD or any other condition.

Beck's invention, the first one of its kind, marked a shift among mental health professionals. Until then, they had viewed depression from a psychodynamic perspective, instead of it being rooted in patients' own thoughts.

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Adelphi University of Garden City, Nassau County, New York, USA. It has centers in Manhattan, Hudson Valley. His research is funded by the National Institute of Mental Health and National Science Foundation. He says that the psychodynamic perspective, originating in the work of Sigmund Freud, emphasizes unconscious psychological processes, such as wishes and fears, of which humans are partially unaware. He also contends that childhood experiences are crucial in shaping adult personality. Freud's psychodynamic perspective has evolved considerably with innovative new approaches such as the object relations theory and neuro-psychoanalysis.

Object relations theory in psychoanalytic psychology is the process of developing a psyche in relation to others in the environment during childhood. Based on psychodynamic theory, the object relations theory suggests that the way people relate to situations and to others in their adult lives is shaped by family experiences during infancy. For example, an adult who experienced neglect or abuse in infancy would expect similar behavior from others who remind them of the neglectful or abusive parent from their past. These images of people and events turn into *objects* in the unconscious that the Self carries into adulthood. The human unconscious can use these objects to decide how to behave in social relationships and interactions. I would have thought it has always been so throughout humanity's existence, those familiar to us from first drawing breath being the role-models of ours. But the mental health league appears to differ with my assumption. No doubt, the next thing PTSD voyagers will hear is that their PTSD actually originated with their infancy experiences with their working mother, their absentee father, their non-Christian, Muslim, Russian Orthodox, Khazarian, African, Jewish Hawaiina immigrant nanny from the moment of their birth or at conception, and off the wall.

After all, the object relations theory in itself is ancient, made public as early as originating with Oedipus and his mama. It was warmed up again, with the initial line of thought re-emerging in 1917 and later in the 1920s. That was by Ferenczi, coiner of the term "pre-Oedipal" and considered one of Freud's most gifted disciples. And who was Oedipus? He's right out of Greek mythology, the body of myths originally told by the ancient Greeks. These tales told of the origin and the nature of the world, the lives and activities of deities, heroes and mythological creatures. They told of the origins and significance of the ancient Greeks' cult and ritual practices. Initially propagated in an oral-poetic tradition starting in the 18th century B.C., the myths of the heroes of the Trojan War and its aftermath became part of oral tradition. Homer's epic poems the Iliad and the Odyssey, Hesiod's the Theogony

and the Works and Days contained accounts of the genesis of the world, the succession of divine rulers, the succession of human ages, the origin of human woes, and the origin of sacrificial practices. Myths are preserved in the Homeric Hymns, in fragments of epic poems of the Epic Cycle, in lyric poems, in the works of the tragedians and comedians of the fifth century B.C., in writings of scholars and poets of the Hellenistic Age and in texts from the time of the Roman Empire by writers such as Plutarch and Pausanias.

Aside from object relations theory evidence in ancient Greek literature, pictorial representations of gods, heroes, and mythic episodes featured prominently in ancient vase-paintings. These and the decoration of votive gifts and many artifacts back up their personalities' factual existence. Present day findings from deep-sea oil excavations and land sights on the earth including giants life in Afghanistan and bones all over Sardinia and the USA also have something to say. They present scientific, empirical evidence of a hidden story never told slowly surfacing in relation to object relations theory, which will always be associated with it.

Geometric designs on pottery of the eighth century BC depicting scenes from the Trojan cycle as well as the adventures of Heracles might speak volumes to some right brain thinkers. In the succeeding Archaic, Classical and Hellenistic periods, Homeric and various other mythological scenes also supplemented the existing literary evidence, and thus the object relations theory. That the German Heinrich Schliemann's excavations of Troy in the latter part of the 1800s also mirrors object relations theory is fervently ignored as well. And that all of humanity throughout its purported history has been and is engaged in object relations is thoroughly ignored by all and sundry, it seems. That Troy and its history are just one *prime face* proof of scientific, empirical evidence, substantiated by literature and artefacts of such object relations, is of no value whatsoever to the mental health cabal.

Yes, we will return to the stress inoculation training in a few moments. This is all inter-related, as all human psychology is being warped out of proportion by those claiming to be experts in the field.

The tale or fact of Oedipus and Mama is just such an example of the object relations theory. In Greek mythology, he was the son of King Laius and Queen Jocasta, ruling over the city of Thebes. He unknowingly married his mother and had four children with her, Polynices, Eteocles, Antigone and Ismene. Freud's disciple was obviously well familiar with this tale.

Otto Rank né Rosenfeld (1884–1939) was an Austrian psychoanalyst, creative theorist, therapist writer and teacher born in Vienna. In 1905, at the age of 21, he

presented Freud with a short manuscript on the *artist*, a study that so impressed Freud that he invited Rank to become secretary of the emerging Vienna Psychoanalytic Society. Rank thus became the first paid member of the psychoanalytic movement and Freud's secretary and right-hand man for almost 20 years. Thought of by Freud as the most brilliant of his Viennese disciples, Rank was a prolific writer on psychoanalytic themes, the editor of two eminent analytic journals of the era, as well as the managing director of Freud's publishing house. In 1926, Rank left Vienna for Paris and for the remainder of his life lead a successful career as a lecturer, writer and therapist in France and the United States.

To ordinary readers, he may probably be best known for The Myth of the Birth of the Hero, initially published in 1909, then revised and amplified in 1922. In the 1909 version, Rank explores the significance of hero myths, finding in them variations on the infantile fantasy to kill the father, take his place and possess the mother. In the later edition, Rank retains much of this initial Oedipal interpretation, but enlarges his scope to examine more closely the hero's actual birth, usually closely associated with water (Michael Dirda: The Letters of Sigmund Freud and Otto Rank. www.washingtonpost.com 2012). It might be imagination at its best, craving a breathtaking and vivid imagination almost alien to relatively straight-thinking humans. Albeit again it shows object relation at its finest, or does it? To form an opinion, one must read the synopsis, as nothing else demonstrates and mirrors present day's psychology and psychologists' principles, premises, thought-perversion, sickness and object relations by way of covering for each other better – in my view.

The concept of the Oedipus complex, in psychoanalytic theory, is the belief of a desire for sexual involvement with the parent of the opposite sex. It comes with a concomitant sense of rivalry with the parent of the same sex. This is seen as a crucial stage in the normal human developmental process. The Oedipus complex was officially introduced to the Western world by Freud in his Interpretation of Dreams (1899). As we saw, the term derives from the Theban king Oedipus, who unknowingly slew his father and married his mother. Its female analogue, the Electra complex, is named for another mythological figure who helped slay her mother.

Freud attributed the Oedipus complex to children around three to five years of age. He said the stage usually ended when the child identified with the parent of the same sex and repressed its sexual instincts. If previous relationships with the parents were relatively loving and non-traumatic and if parental attitudes were neither

excessively prohibitive nor excessively stimulating, the stage would be passed harmoniously, he assured. In the presence of trauma, however, an "infantile neurosis" would occur, which would be an important forerunner of similar reactions during the child's adult life.

He also surmises that the superego, in his view the moral-factor dominating the conscious adult mind, also has its origin in the process of overcoming the Oedipus complex. The reaction against the Oedipus complex was, in his opinion, the most important social achievement of the human mind. But does how the concept of an Oedipus complex evolved in his mind to begin with perhaps somewhat inspire curiosity? Again, the answer to that question requires reading the tale's synopsis. It also provides further food for thought of the object relation theory as a new or not so new concept.

During the 1940s and 1950s, British psychologists Melanie Klein, Donald Winnicott, Harry Guntrip, Scott Stuart and others thought to further extend the object relations theory. They were joined in 1952 by William Ronald Dodds Fairbairn FRSE. This Scottish psychiatrist and psychoanalyst was a central figure in the development of the object relations theory as a theory of psychoanalysis.

While Fairbairn popularized the term "object relations", Melanie Klein's work tends to be most commonly identified with the terms "object relations theory" and "British object relations", at least in contemporary North America. But the influence of what is known as the "British independent perspective", arguing that a child's primary motivation is object-seeking rather than a drive for gratification, is increasingly recognized.

While some psychodynamic concepts and perspectives have apparently held up well to empirical scrutiny, others have not. That includes all theories in psychology that see human functioning based upon the interaction of drives and forces within a human, including the unconscious and the different structures of the personality. Freud's psychoanalysis is viewed as the original psychodynamic theory. But the psychodynamic approach as a whole includes all theories based on his ideas. That inludes those of Carl Gustav Jung, one of his contemporaries, as well as Adler and Erikson. But almost all aspects of the theory remain controversial, even as they continue to influence many different areas of contemporary psychology. Might that be a reflection of the impossibility to empirically, scientifically extract with one hundred percent certainty and as first evidence the psychic functioning of all human beings? And does it really matter, as long as one is outside of the system? As a PTSD journeyer, however, it might be of vital importance to know about these theories,

including the Oedipus complex, as all of it will be used against us, unless we disappear from the radar.

Freud, in his famous psychoanalytic theory of personality, expressed that at the heart of human personality and psychological processes are three elements. He remarkably envisions that with these elements, humans are constantly battling or working to create and explain their complex human behaviours. These are:

- The id
- The ego
- The super-ego

Each component not only adds its own unique contribution to personality, but all three elements interact in ways that have a powerful influence on each individual, he asserts. Each of these elements of personality might or might not emerge independently at different points in life. Freud's theorizes that certain aspects of one's personality are more primal. This would pressure us to act upon our most basic urges, while others might counteract those urges, striving to make us conform to demands of reality.

And what does all this have to do with Stress Inoculation Training (SIT) you again ask? This is why:

How can we, the PTSD experiencers thrust into the mental health cabal's hands and trusting them to help us to free ourselves from the PTSD condition and its overall miseries, protect ourselves from them when we do not have a clue of their conduct and concoctions? So let's just carry on educating the Self in accordance with Dharma over Karma, and do it in good humor and with interest, although it seems tedious at times, shall we? As Sun Tzu said:

> "If you know the enemy and know yourself you need not fear the results of a hundred battles."

Or you can play this game:

> "Victorious warriors win first and then go to war, while defeated warriors go to war first and then seek to win."

And if you think nothing comes from nothing, think again. As Sun Tzu knew and practiced:

> "The general who wins the battle makes many calculations in his temple [the temple of his inner Self] before the battle is fought. The general who loses makes but few calculations

beforehand."

Which one is it going to be? If choosing to be victorious in our PTSD battle, self-education by investigation is the only way to protect ourselves. We must accompany this with conversation and contemplation within our own inner temple with whatever is out there to help us. It is our duty to self. It is no one else's. So, unless we want to stay in supreme ignorance, we owe to ourselves to educate ourselves. Unless we want to continuously be exposed to and experimented on with psychology's hypothetical, theoretical, phantasm-inspired fantastic and imagined ideas and theoretic treatment modalities we owe to ourselves to educate ourselves. Unless we want to be pushed into pharmaceutical-and other mind-altering drugging used against us at leisure, we owe to ourselves to educate ourselves. In particular, when by way of self-education understanding that each of these theoretical derived-at PTSD treatment theories in essence teach us that there is nothing wrong with us other than our own reluctance or downright refusal to figure out who and what we are and why we are on earth. Thus, through the academic knowledge we acquire in the field, we not only overcome our adversaries but also experience the Dharma versus Karma principle life in action unfolding for us. This is the way to heal ourselves, This is the path to live contented, prosperous, immensely satisfying lives with an almost incomprehensive gratitude rather than scorn for the PTSD experience. Why? Because it made us to who we are today, a much more aware, broadminded, tolerant, delightful human being in all aspects of the words, a human being living in peace with the self and thus with all around us. By that alone we change the world. Nothing else will do, as quoted by Mahatma Gandhi: "*If you want to change the world*, start with *yourself*." To heal PTSD it is a must.

It is therefore that we once more will briefly return to Freud. Let's look at his id, ego and super-ego, the three distinct yet interacting agents in the human psychic apparatus he defines in his structural model of the psyche. According to his model, the id is the set of uncoordinated instinctual trends. The super-ego plays the critical and moralizing role. And the ego is the organized, realistic part, mediating between the id and the super-ego's desires.

Although the model is structural and makes reference to an apparatus, the id, ego and super-ego are said to be purely psychological concepts. They do not correspond to somatic structures of the brain, such as the kind dealt with by neuroscience. The super-ego is observable in how someone can view self as guilty, bad, shameful or weak, and feel compelled to do certain things. Freud in The Ego and the Id (German: *Das Ich und das Es*), published in 1923, presents an analytical

study of the human psyche. He outlines his theories of the id, ego and super-ego, and the psychodynamics of fundamental importance to develop psychoanalysis, using his own meticulous research. He explains:

> "The functional importance of the ego is manifested in the fact that normally control over the approaches to motility devolves upon it. Thus in its relation to the id it is like a man on horseback, who has to hold in check the superior strength of the horse; with this difference, that the rider tries to do so with his own strength while the ego uses borrowed forces. The analogy may be carried a little further. Often a rider, if he is not to be parted from his horse, is obliged to guide it where it wants to go; so in the same way the ego is in the habit of transforming the id's will into action as if it were its own." (*Freud, Sigmund (1978).* The standard edition of the complete psychological works of Sigmund Freud. Volume XIX (1923–26) The Ego and the Id and Other Works. *Strachey, James; Freud, Anna, 1895-1982; Rothgeb, Carrie Lee, 1925-; Richards, Angela; Scientific Literature Corporation. London: Hogarth Press* p.19).

In psychology, motility means "of or relating to mental imagery that arises primarily from sensations of bodily movement and position rather than from visual or auditory sensations."

The id is viewed as the unconscious reservoir of libido, the psychic energy that fuels instincts and psychic processes, we learn. The ego serves as the general manager of personality. It makes decisions about the pleasures that will be pursued at the id's demand, the person's safety requirements and the moral dictates of the superego that will be followed. The superego refers to the repository of an individual's moral values, divided into the conscience (the internalization of a society's rules and regulations) and the ego-ideal (the internalization of one's goals).

When talking about the id, the ego and the super-ego, it is important to remember that these are not three totally separate entities with clearly defined boundaries. These aspects of personality are dynamic and always interact within the individual to influence overall personality and behaviour.

Freud thought of the id, ego and super-ego as competing forces, often in conflict with each other. He used the term "ego strength" to refer to the ego's ability to function, despite these duelling forces. Ego-strength in psychotherapy is the term

used for the ability to maintain the ego by a cluster of traits that together contribute to good mental health. The traits usually considered important include:

- vitality and power in the activities of life
- persistence and perseverance in the pursuit of goals
- openness, flexibility, and creativity in learning to adapt
- acceptance of substitutes and ability to defer gratification
- tolerance of the pain of loss, disappointment, shame or guilt
- forgiveness of those who have caused an injury, with feelings of compassion rather than anger and retaliation

A person with good ego strength is able to effectively manage these pressures. Those with too much or too little ego strength can become too unyielding or too disrupting.

Freud asserts that the key to a healthy personality is a balance between the id, the ego and the superego. If the ego is able to adequately moderate between the demands of reality, the id and the superego, a healthy and well-adjusted personality emerges. If not, Freud believed, an imbalance between these elements leads to a maladaptive personality.

He hypothesized, for example, that a person with an overly dominant id might become impulsive, uncontrollable or even criminal. This individual would act upon most basic urges, with no concern for whether the behaviour is appropriate, acceptable, lawful or legal.

An excessively dominant ego can also result in problems. An individual with this type of personality might be so tied to reality, rules and appropriateness that they are unable to engage in any type of spontaneous or unexpected behaviour. This individual might seem very concrete and rigid, incapable of accepting change and lacking an internal sense of right from wrong.

An overly dominant superego, on the other hand, might lead to a personality that is extremely moralistic and possibly judgmental. This individual might be unable to accept with ease anything or anyone perceived as “bad” or “immoral.”

Freud’s theory, and remember that it is a theory, provides one man’s conceptualization of how personality is structured and how these different elements of personality function. In his view, a healthy personality results from a balance in the dynamic interactions of the id, ego and superego. Hence, basic psychodynamic therapy models focus on these dynamic id, ego and superego interactions. They try

to explain and/or interpret behaviour or mental states in terms of innate emotional forces or processes.

Freud later in life (1933) hypothesizes different levels of ego ideal or superego development, with increasingly greater ideals occurring in the human psyche, as he said:

> ". . . nor must it be forgotten that a child has a different estimate of [its] parents at different periods of [its] life. At the time at which the Oedipus complex gives place to the super-ego they are something quite magnificent; but later they lose much of this. Identifications then come about with these later parents as well, and indeed they regularly make important contributions to the formation of character; but in that case they only affect the ego, they no longer influence the super-ego, which has been determined by the earliest parental images." (*New Introductory Lectures on Psychoanalysis*, p. 64)

Whichever way it might be, the question remains why the German "Ich" was translated into "Ego". In fact, it is the first person singular in the German language? Could it be argued that the Ich in fact is the sui generis, the soul essence, the infinite conscious Self journeying to earth for a performance, as Michael Newton describes? Was it not Freud himself who viewed the Id, the sui generis, as the unconscious reservoir of libido, the psychic energy that fuels instincts and psychic processes? We it not he who viewed the Id as the only component of human personality present in the body from birth, but entirely unconscious in all aspects, including its instinctive and primitive behaviours? Was it not also Freud who viewed the Id as the source of all psychic energy, thus making it the primary component of personality? Could the Id or Ich, then not be the soul essence, as all psychic energy originates from the source, the Divine Creator of all there is in all of creation, God, infinite Spirit, or whatever one may wish to call it?

And why was the "Es", the neutral second person singular in the German language, translated into "Ego"? It could indeed be the tabula rasa upon which scene for the Ich's (id), the sui generis' play is developed and unfolds in accordance with the Ich's free will decisions. This, in turn, mirrors the influences of fellow actors, the object relations, encountered in the course of its life from the moment of birth until its end. And what of these object relations, the main protagonist's (Ich's) side-kicks in supporting roles presented in the Es. Have they been chosen by and with the Ich to influence the sui generis for better or for worse, depending on the decisions made

by the Ich? Could they thus result in the person's ego and super-ego personality, reflected in his or her behavior and actions?

Consider, however, that the ego is said to function in the conscious, preconscious and unconscious mind. And these three levels of mind are thought of often as representing an iceberg. So, we can get a visual idea of how this hypothesis looks like. Everything above water represents conscious awareness, while everything below the water represents the preconscious and unconsciousness. Only 10% of an iceberg is visible (conscious) whereas the other 90% is under the water (preconscious and unconscious). The preconscious mind covers 10%–15% whereas the unconscious is allotted to 75%–80% (Mausumi Dutta, "Three Levels of Consciousness by Sigmund Freud").

Which question presents itself? Which conclusion could we reach? Do accredited mental health practitioners have a different set of brain and psyche functioning than human beings, perhaps? If not, how are they able to assume, presume, assert, define, determine and steadfastly dictate to know with certainty how and why I think differently? Or why I function differently. Or why I heal differently or feel differently from them and their hypothesizations, 99 percent of the time derived only from their academic hearsay regurgitated psychology education? Or are they really as sick as Jon Rappoport claims in his reports?

There is no scientific, empirical, provable evidence on my human functioning that can be obtained. So, is it any wonder the thought and question arises within that all is done to destroy our human base of knowledge about ourselves and to belittle our intuition. Does this tell us that the whole industry of psychology is nothing other than a racket, a for financial gain business enterprise, a farce, except that the farce at this point in world history endangers all human existence to the point of extinction?

Whichever way it may be, only one thing is certain. Freud's theories about human psyche functioning and reasons for behaviour are important today. They form part of most theories and hypothesis of treatment modalities created by a multitude of mental health practitioners of all ranks and file to purportedly cure mental health disorders. Freud, for example, compared the Id to a horse and the ego to the horse's rider. The horse provides the power and motion, yet the rider provides the direction and guidance. Without its rider, the horse may simply wander wherever it wished and do whatever it pleased. The rider instead gives the horse directions and commands to guide it in the direction he or she wishes to go. Does it appear as if those imagining PTSD treatment only aim to replace the rider,

the sui generis, rather than help him or her to repair it to get back into the saddle?

In psychology, psychoanalytic and psychodynamic are two words that can be confusing, as they are often used interchangeably. But there is a key difference. Psychoanalytic refers to the perspective and theoretical ideas that were originated by Freud. Psychodynamic refers to the ideas and perspective that came from Freud and his followers. Thus, psychoanalysis is the term used for Freud's original creation of a psychological perspective, which, it is assumed, enables psychologists to focus and analyze the human mind. Psychodynamic theories and modalities are still drawing inspiration from Freud's theory of psychoanalysis.

Psychoanalysis refers to the theoretical basis that includes a specific approach, theories and techniques that help the psychologist comprehend the human mind. Freud spoke of many important concepts. Some of the key concepts he emphasized were the role of the unconscious, defense mechanisms, dreams, the id, ego and superego. He specifically believed that the unconscious was important when understanding the human mind. He believed that all our fears and desires are restrained in the unconscious. This idea was also used in his psychoanalytic therapy to treat patients suffering from depression and anxiety disorders. Freud emphasized that by making the unconscious thoughts known, the patients can be treated.

With help from the therapist, the patient is encouraged to speak freely about anything that comes to mind, including current issues, fears, desires, dreams and fantasies. The goal is to experience a remission of symptoms. But other benefits might be increased self-esteem, better use of their own talents and abilities, and an improved capacity to develop and maintain more satisfying relationships. The patient might experience ongoing improvements after therapy has ended. Although short-term therapy of one year or less might be sufficient for some patients, long-term therapy could be necessary for others to gain lasting benefits. Psychodynamic therapy is primarily used to treat depression and other serious psychological disorders, especially in those who have lost meaning in their lives and have difficulty forming or maintaining personal relationships. But studies have found that other effective applications of psychodynamic therapy include addiction, social anxiety disorder and eating disorders.

What theories and techniques distinguishing psychodynamic therapy from other types of therapy? A focus on recognizing, acknowledging, understanding, expressing and overcoming negative and contradictory feelings and repressed emotions in order to improve patients' interpersonal experiences and relationships. This includes helping patients understand how repressed earlier emotions affect

current decision-making, behaviour and relationships. Psychodynamic therapy also aims to help those aware of and understanding the origins of their social difficulties, but unable to overcome their problems on their own. Patients learn to analyze and resolve their current issues. They learn to change their behaviour in current relationships through this deep exploration and analysis of earlier experiences and emotions.

Barber and Sharpless expressed that psychodynamic therapies encompassed myriad treatment approaches which shared common assumptions:

- that symptoms are meaningful
- that psychopathology is situated in prior developmental events
- that there are multiple levels of mental life, conscious as well as unconscious
- that aspects of the therapeutic relationship, such as transference, countertransference, and the alliance between patient and therapist, are important agents of change

One RCT conducted for PTSD found that trauma desensitization, hypnotherapy and psychodynamic therapy were more effective than a waitlist control group. In the opinion of Barber and Sharpless, the available empirical base of psychodynamic therapy while often lacking in empirical controls, appeared compelling enough to warrant its use. This may, they proclaim, be especially the case with PTSD clients unwilling to undergo exposure techniques early in treatment or in complex cases where interpersonal — the famed pre-morbidity — themes predominated.

Human emotions play little or no role in PTSD recovery treatments by NC for PTSD affiliated mental health practitioners. This is clear by their vigorous search for scientific neurological documentation of brain defects before the PTSD causing event. It is clear by their similar search for wrong wiring after the event. And it is clear by their perpetual, persistent pharmaceutical drugging to repress any humane emotions that should, God forbid, jump out of the PTSD-human's brain. And it is clear that psychodynamics is obviously not heralded as a possible PTSD cure. It would take away the opportunity for neurologists, researchers and practitioners to form the PTSD patient into a creation of their own making. It would halt pharmaceutical drug disbursement. It would strangle all the opportunity of experimentation so much better afforded by the Cognitive Behavioral Theory treatment. The CBT's results are so wonderfully mirrored in the Beck Depression

Inventory (BDI) mentioned in the beginning of this chapter. It would put an end to regularly shuffling that down PTSD journeyer's throat.

Nowadays there are three versions of the BDI:

- the original BDI, first published in 1961
- the BDI-1A, revised in 1978
- the BDI-II, published in 1996

The BDI is widely used as an assessment tool by health care professionals and researchers in a variety of settings. It was also used as a model to develop the Children's Depression Inventory (CDI), published in 1979 by clinical psychologist Maria Kovacs. In its current version, therefore, the BDI-II is designed for people aged 13 and over. It is composed of items related to symptoms of depression, such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss and lack of interest in sex.

At the time, Beck fully expected his research to validate the fundamental concepts of psychoanalysis. To his surprise, he found the opposite. He found that depressed patients experienced streams of negative thoughts that seemed to arise spontaneously. He called these cognitions "automatic thoughts." He found that patients' automatic thoughts fell into three categories: negative ideas about themselves, the world and/or the future.

As a result, he began to look for other ways of conceptualizing depression. He began by helping patients identify and evaluate these automatic thoughts. By doing so, he found that patients were able to think more realistically. As a result, they felt better emotionally and were able to behave more functionally. When patients changed their underlying beliefs about themselves, their world and other people, therapy resulted in long-lasting change.

Beck called this approach "cognitive therapy," which has become known as "cognitive behaviour therapy." In the years since its introduction, it has been studied and demonstrated to be effective in treating a wide variety of disorders. More than 1,000 studies have demonstrated its efficacy for psychiatric disorders, psychological problems and medical problems with a psychiatric component. Further information on the concept is available on beckinstitute.org, worthwhile studying as part of the PTSD afflicted's bibliotherapy curriculum. Whichever way, it is clearly visible that when used on PTSD voyagers, the Beck Depression Inventory, combined with the MMPI, affords examining mental health the-rapists a splendid way to see how well

they are traumatizing traumatized clients.

In 1977, Meichenbaum published *' Cognitive Behaviour Modification: An Integrative Approach.* This is considered a classic text in the field. By the time he conceived the Stress Inoculation Training (SIT) idea, he had studied anger, posttraumatic stress and education. That is in addition to cognitive psychology. He had also pioneered self-instructional training, an evidence-based treatment designed to help people modify their behaviour. This method is typically used as part of cognitive behavioural treatment approaches. His research is said to have helped change the way mental health care professionals and researchers view depression and other mental health conditions. And his proposition brought him recognition as a leader in the treatment of PTSD.

The use of the term "inoculation" in SIT is based on the idea that a therapist is inoculating or preparing patients to become resistant to the effects of stressors. This is similar to how a vaccination works to make patients resistant to the effects of particular diseases, we read on mentalhelp.net. How fitting, knowing that vaccines impair, and at times kill, their receivers, rather than prevent the diseases for which a person is inoculated. If in doubt, view VAXXED.

SIT is a package of techniques from relaxation to thought-stopping and *in vivo* exposure to feared situations, initially developed to manage anxious symptoms. With SIT, you are thus welcome to prepare for your own individual warfare and catastrophes in the comfort of your own home. In short order, it was adapted to prevent PTSD and specific other ailments considered disorders. It had been shown to be effective in eight studies (four of them RCTs) with groups of male veterans and female sexual assault victims (Foa et al., 1991, Cahill et al., 2008). Evaluated by Barber and Sharpless, they espouse SIT as very promising treatment modality for PTSD journeyers. However, more RCTs assessing the full treatment package were needed. This includes exposure components, which, we read, are sometimes omitted when SIT is used as a control condition. They were urgently needed to officially establish SIT's efficiency and efficacy for PTSD clients.

In 1996, Meichenbaum helped found The Melissa Institute *for* Violence Prevention and Treatment. It was founded a year after Melissa Aptman was murdered in St. Louis in May 1995. A Miami native, she was just two weeks away from graduation from Washington University. Melissa's parents Lynn and Michael Aptman and family, as well as friends and violence prevention experts, established the institute to honour Melissa's memory and make a difference by working to prevent violence and assist victims. It became a non-profit organization dedicated to

the study and prevention of violence through education, community service, research support and consultation. The institute's mission is to prevent violence and promote safer communities through education and applying research-based knowledge.

Meichenbaum is a research director for the Institute. Considered to be an expert in PTSD treatment, he has also presented workshops on the topic in several parts of the world. It is unknown whether he ever in his own life faced colossal existential traumas such as PTSD represents. Nor is it known if he participated in the Vietnam War, US drafts raging when he entered Canada. Nor do we know if he participated at all in any other theaters of war. Nothing private is ever made public about these people's individual life-experiences or their lives in general. Only their curriculum vitae, a brief account of their education, qualifications and previous experiences typically sent with job applications is made public. That gives us an idea that they spend and spent most of their lives in academic schooling, oft times in private institutions, from cradle to their assured graves. So we move on to another of their dreamt-up-as-beneficial PTSD treatment modalities, the Exposure Therapy, which uses virtual reality (VR) to heal the PTSD experiencer.

Virtual Reality exposure therapy is a type of treatment modality increasingly used to treat a variety of anxiety disorders and specific phobias. Before learning how VRET treats PTSD symptoms, however, it's important to have a handle on what VR and exposure therapy is (Matthew Tull, Ph.D.: How Virtual Reality Exposure Therapy (VRET) Treats PTSD, 2018); verywellmind.com)

VR first emerged in the late 1980s, and then all but disappeared due to the stratospheric cost of components at the time. Its resurgence has been led by the Oculus Rift, a headset designed by a wunderkind VR enthusiast Palmer Luckey, who built its prototype in a garage using mobile phone parts. In 2014, Facebook bought Luckey's company for $2 billion. Now, as consumer headsets from PlayStation, Google and HTC flood the market, the cost of these headsets falls and the potential to use VR in PTSD treatments rises (How Virtual Reality Is Helping Heal Soldiers With PTSD by Simon Parkin, Mar.16.2017 7:41 AM ET www.nbcnews.com 2017).

Albert "Skip" Rizzo is a research professor at the USC Davis School of Gerontology. He has worked with veterans suffering from PTSD since the mid-1980s. The disorder can lie dormant for years, especially if sufferers are otherwise occupied, he says. According to Rizzo, approximately 69,000 brand new cases of PTSD were diagnosed in veterans from Afghanistan and Iraq in 2013. That same year, 62,000 Vietnam veterans, who more than thirty years earlier had left that

chaotic front, were newly diagnosed with the condition. "As people get older and they retire, they're not as busy," Rizzo says. "They get more emotionally vulnerable. That can bring it out."

Treatment for PTSD has varied over the years, from medication to psychotherapy to simple exercise. Most now agree that exposure therapy, a treatment pioneered in the 1950s, though many doctors disagree. Exposure therapy seeks to relive a sufferer's trauma in a controlled, often imaginary environment, is usually the most effective prescription. The idea is to take a patient back to the memory of their trauma over and over again until their triggers no longer produce anxiety. Psychiatrists call this process habituation. Through repetition, the memory is slowly robbed of its power.

Such was the success of the program that, following the September 11 terrorist attacks on New York's World Trade Center (WTC), one of Rizzo's collaborators, JoAnn Difede, Ph.D., began using VR to treat burns victims suffering with PTSD. She explains:

> "People saw the buildings, saw the plane fly into the buildings, heard the sounds and watched the explosion. We did not know if it would work. It did. Better than I ever expected."

Difede is a professor of psychology in psychiatry at Weill Medicine of the to-us-now-familiar Cornell University. She is also an attending psychologist at the New York Presbyterian Hospital. And she is director of the Program for Anxiety and Traumatic Stress Studies (PATSS), a specialized program within Weill Cornell Medical College's Department of Psychiatry. She is internationally recognized for her pioneering work using virtual reality to treat PTSD following the WTC attack of September 11, 2001, and more recently to treat combat-related PTSD. Dr.

JoAnn Difede serves as the lead Principal Investigator of a large multi-site Department of Defense funded clinical trial contract. The project is called "Enhancing Exposure Therapy for PTSD: Virtual Reality and Imaginal Exposure with a Cognitive Enhancer." It is investigating how the use of virtual reality and the pharmacologic agent D-Cycloserine might speed recovery from combat-related PTSD among U.S. service members deployed to Iraq and Afghanistan. Difede has served as the PI of several NIH-funded treatment studies seeking innovative treatments for PTSD. She has also received many grants and corporate medical contracts for projects aimed at delivering optimal care for trauma survivors and their families. These have come from both private foundations and publicly held Fortune

500 corporations. Her treatment research spans survivors of burn injuries, terrorism and occupations at-risk for PTSD, including U.S. soldiers deployed to OIF/OEF/OND, firefighters, police officers, and disaster rescue and recovery workers.

Difede has advised many corporations, non-profit organizations and governmental agencies in the U.S. and internationally. Her advice has been on how to implement best practices to screen, evaluate and treat trauma and PTSD. She has served on NIH special emphasis review panels on occupations at risk for trauma PTSD and CDMRP, among others. She serves on the scientific advisory board of the Anxiety Disorders Association of America (ADAA). She also serves on the advisory board of the Jericho Project, a non-profit foundation serving homeless veterans. She recently completed a four-year term on the editorial advisory board of the Journal of Traumatic Stress.

In addition to her scholarly endeavours, her work has been featured in many popular media venues. These include publications like the *New Yorker*, the *New York Times*, *Newsweek*, the *Washington Post*, *Scientific American. They also include* television programs, including a recent appearance on *Charlie Rose: The Brain Series'* episode on PTSD and ABC's *World News Tonight* with Peter Jennings, as well as shows on CNN and NBC. Notably, she was featured in *New York Magazine's* Best Doctors issue in 2005 for her work developing a virtual reality-based treatment for WTC-related PTSD. And she was profiled in *The Lancet* in September 2011, for the tenth anniversary of the WTC attacks, for her work developing innovative treatments for PTSD.

Now director of the Program for Anxiety and Traumatic Stress Studies, Difede expanded her research to look at how the tuberculosis drug D-Cycloserine might be combined with VR to accelerate treatment effectiveness. Working on glutamate receptors in the brain, the drug was shown to enhance learning in rats and mice. Difede's idea was that, if patients were given the drug right before the VR treatment it would increase the effectiveness of the VR in helping the patient to "relearn. "We had a 70 percent remission rate within six months," she says.

But VR as such is nothing new to her. In 2009 already, Albert Rizzo and JoAnn Difede praised the marvels of VR in their paper "Emerging treatments for PTSD." They were working with together with Judith Cukor, Josh Spitalnick and Barbara O. Rothbaum. The three researchers were respectively employed by:

- Weill Cornell Medical College, New York, NY, USA working in

conjunction with the Virtually Better, Inc. of Decatur, GA, USA
- the University of Southern California Institute for Creative Technologies, Marina del Rey, CA, USA
- the Emory University School of Medicine, Atlanta, GA 30306, USA.

So let us check it out in detail, shall we?

Virtual Reality Means & Ways In Detail

Cukor et al.'s abstract states:

> "Recent innovations in posttraumatic stress disorder (PTSD) research have identified new treatments with significant potential, as well as novel enhancements to empirically-validated treatments. This paper reviews emerging psychotherapeutic and pharmacologic interventions for the treatment of PTSD. It examines the evidence for a range of interventions, from social and family-based treatments to technological-based treatments. It describes recent findings regarding novel pharmacologic approaches including

> propranolol, ketamine, prazosin, and methylenedioxymethamphetamine. Special emphasis is given to the description of virtual reality and D-cycloserine as enhancements to prolonged exposure therapy (© 2009 Elsevier Ltd.; ict.usc.edu)."

You can read the entire write-up on Virtually Better Inc. System, known as VBI in the trade, at this point stating on their website:

> "At this time, many of our products are sold only to qualified mental health professionals and are not designed to be used as self-help tools. If you're unsure of whether they are appropriate for you, please contact your mental health professional or us at sales@virtuallybetter.com to discuss your options. We are currently developing several applications for a number of mental health conditions. Please check back with us often. Thank you."

Their products?

Phone VR Therapy System: $699, encompassing:

Bring your own iPhone and PC*

- Premium iPhone holder (Head Mounted Display headset)
- VR Navigation Controller
- Router
- Software for PC or Apple laptop
- General setup manual
- Fear of flying clinician's manual
- Clinical apps for treating phobias:
    1. Acrophobia (fear of heights, elevators)
    2. Arachnophobia (fear of spiders)
    3. Astraphobia/astrapophobia/brontophobia (Fear of storms, hurricanes, tornadoes)
    4. Aviophobia (fear of flying)
    5. Glossophobia (fear of public speaking)

The Complete iPhone VR Therapy System for $1395 consisting of:

- Premium iPhone holder (head mounted display headset)
- VR navigation controller
- Software for PC or Apple laptop
- General setup manual
- Fear of flying clinician's manual
- iPhone 5 or better (with 64/128/256 GB memory)
- PC laptop with WiFi and necessary specifications
- Router
- Clinical apps for treating phobias:
    1. Acrophobia (fear of heights, elevators)
    2. Arachnophobia (fear of spiders)
    3. Astraphobia/astrapophobia/brontophobia (fear of storms, hurricanes, tornadoes)
    4. Aviophobia (fear of flying)
    5. Glossophobia (fear of public speaking)

Custom VR Solution whose configuration includes all of the following programming:

Phobias Suite:

1. Fear of bridges
2. Fear of flying
3. Fear of public speaking
4. Fear of spiders
5. Fear of storms
6. Fear of tall buildings

Relaxation Suite

e. 6-4-6 paced breathing
8. Aquarium
i . Autogenic training
10. Deep breathing relaxation
11. Imagery-guided relaxation
12. Mindfulness
13. Pediatric 5×5 breathing relaxation
14. Progressive muscle relaxation (eight muscle groups)
15. Progressive muscle relaxation (12 muscle groups)

Addictions Suite:

16. Bar
1e. Convenience store
18. Home alone
1i . Party

Last but not least:

Comprehensive VR Solution, whose custom configuration includes any or all of the following:

Phobias Suite:

1. Fear of bridges
2. Fear of flying
3. Fear of public speaking
4. Fear of spiders
5. Fear of storms
6. Fear of tall buildings

Relaxation suite:

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8. Aquarium
i . Autogenic training
10. Deep breathing relaxation
11. Imagery-guided relaxation
12. Mindfulness
13. Pediatric 5×5 breathing relaxation
14. Progressive muscle relaxation (eight muscle groups)
15. Progressive muscle relaxation (12 muscle groups)
16. Addictions Suite
1e. Bar
18. Convenience store
1i . Home alone
20. Party

PTSD Suite:

21. Bravemind
22. Military sexual trauma (MST)

* Calm Craft is available upon request

For pricing and purchase, email or call 404-633-2506, we read. I tried, but got only an answering machine.

But what is Calm Craft, the only one I could access on VBI for a closer look?

It is a biofeedback-based interactive application for relaxation and distraction. The application involves navigating a virtual submarine and capturing photos of unnamed ocean creatures along the way. Calm Craft teaches the end user a breathing technique and uses data from a supplied respiration monitor to provide feedback, including modeling calm breathing. That's all we are told.

But can that not be achieved by engaging in creative activities of all sorts, from pranayama breathing to arts and crafts, one may wonder? Maggie O'Shannon is author of the do-it-yourself-guide to piece of mind *Crafting Calm: Projects and Practices for Creativity and Contemplation* (Viva edition of Cleis Press Inc. 2013). She seems to think so, maintaining in her book that we can achieve calmness within ourselves all by ourselves. She explores crafts and creativity as a means to achieve that goal with enormous physical, menta, and spiritual benefits. By immersing ourselves in a craft, we can quiet those voices around us and within us. We can enter sacred stillness, she asserts in her own way. The nature of the craft matters little. It could be reading, writing or arithmetic. It could be to petite point needlepoint, studying the wing-structure of the tsetse fly or leaning to build your aircraft with your own hands. What counts is the intention and mindfulness – the determination, willpower, discipline and persistency.

Needless to say, when we enter stillness, we become more peaceful. When we are more peaceful, we can think better. When we think better, we think more clearly. When we think more clearly, we are able to rationalize. When we rationalize, we can begin to analyse. When we analyse and rationalize, we can begin to overcome our fears and phobias, proven results of a PTSD experience. O'Shannon shows through interviews, personal stories and 40 suggested activities how creative processes can become spiritual practices. Her crafts and how-to ideas include contemplation candles, visual journals, prayer shawls, collage mandalas, intention beads, finger labyrinths, personal prayer flags, spiritual toolkits and tabletop altars. One can easily make it part of the PTSD mandate of education to heal the self, part of the Dharma versus Karma doctrine.

"Unless we are Creators, we are not fully alive," said American writer Madeleine l'Engle (1918–2007). It is the starved-to-death right brain that is the main force in our creative endeavours. That's what is quenched throughout academic schooling,

from Kindergarten until whenever we see the light, our humanity being strangled with it. It's our right side of the brain that creates our own virtual reality. It all begins with what we think, how we think and what we do with our ideas conceived by way of our thinking. It ranges from what to engage in to how to do it, with anger and self-oppression, or with joy and creative accomplishment.

In virtual reality applications, however, the brain seems to shut down. The projection takes over, being super-imposed upon the brain. Virtual Reality fools the human brain by linking the movement of the camera to your head's movements. Look up and you'll see the virtual sun wheeling in the virtual sky. Look down and you'll see the steel-capped toes of your boots. VR creators refer to the mystical effect as "presence." No matter how crude or abstract the virtual world around you, your mind is tricked into believing that you're there, in mind and body and soul. It's this trickery that is leveraged by the PTSD treatment (NBC).

"Exposure therapy is an ideal match with VR," explains Rizzo, who in 2015 received the Pioneer in Medicine Award from the Society for Brain Mapping and Therapeutics. "You can place people in provocative environments and systematically control the stimulus. In some sense, it's the perfect application. We can take evidence-based treatments and use it as a tool to amplify the effect of the treatment."

"My mission is to drag psychology kicking and screaming into the 21st century," Rizzo said. He noted that virtual reality offers a unique opportunity for clinicians and clients alike: to be immersed in the environment that evokes the original trauma, rather than relying on the patient's imagination.

Rizzo himself says he created 14 virtual "worlds" for patients, and clinicians can add custom elements, including helicopters, clouds, small-arms fire and missiles (Treating PTSD With Virtual Reality Therapy: A Way to Heal Trauma By Justine Quart, *ABC News* Jul 18, 2016).

Already in 1997, researchers from Georgia Tech linked exposure therapy with the emerging technology of virtual reality. Ten volunteers, veterans suffering from PTSD who had not responded to multiple treatments, signed up for the pioneering clinical trial. It was dubbed Virtual Vietnam (NBC). As it seemed to have been rather successful and effective with Vietnam vets, some bright soul in 2011 changed it to Virtual Iraq. According to new study published in *The Journal of Traumatic Stress*, virtual reality exposure therapy holds promise for soldiers returning from Iraq and Afghanistan (fastcompany.com).

The findings were part of a four-year study conducted by the Department of

Defense National Center for Telehealth and Technology. It partnered with the Defenses Center for Psychological Health and Traumatic Brain Injury and the Department of Psychology at Madigan, Tacoma, Washington. VR exposure therapy (VRET), according to the army, used 360-degree interactive computer-generated environments to run the Virtual Iraq. Patients wear a head-mounted display while the doctor orchestrates the relevant stimuli — helicopters overhead, gunfire or even a Muslim call to prayer. A typical session lasts 90 minutes. After just seven sessions, soldiers reported reductions in their PTSD symptoms, almost two thirds of them finding the change to be reliable and meaningful.

The system was perfected further, and presently VR is fast becoming one of the most affordable treatments available. But while PTSD treatments are said to evolve, the understanding within the military of PTSD's effects is still in the dark ages, say some living within the system. "In the military, PTSD is almost synonymous with weakness," says Jimmy Castellanos, the son of undocumented immigrants who fled El Salvador in 1980 on the eve of civil war. Born in Chino, California, as a teenager, he wanted to give back to the land that his family usurped as their home.

In boot camp on September 11, while on active duty in Iraq one march day, an experience so rattled him that he declared himself a conscientious objector. Although the Marines ultimately denied his conscientious objector claim, Castellanos said he served the remainder of his military service in non-combatant roles. "When I came back from Iraq, I was very lost," Castellanos said. "I didn't understand my experience as a Marine in a war zone; I didn't understand my experiences as a conscientious objector. I started reading war literature and realized that so many people in previous wars have felt the same way I did. I had to write — I had to continue that long history of American war writing."

He decided to pursue a Masters of Fine Arts in creative writing at the University of Arizona, all the while working part-time in a research laboratory and a B.A. in biology at Claremont, California He enrolled in Weill Cornell's Medical College in New York, entering a M.D. and Ph.D. immunology program shortly thereafter. Now he is in his third year as a student and assistant physician at Weill Cornell. He is one of at least six veterans and reservists enrolled at the medical college — three medical students, two M.D.-Ph.D. students and one physician assistant student — whose dedication to service led them from the military to medicine.

Luis Villegas, 33, of Miami, Florida, USA, enlisted in the U.S. Army after high school and now is a fourth year medical student. He said:

"There are a few of us in school. The reality is that most

veterans who return from service don't go back to college. They may be struggling with post-traumatic stress disorder, a service-related injury or the simple readjustment to civilian life. But pursuing an education is one of the best ways to readjust and get started on the next part of life.

"I would like veterans to know that a lot of places — medical schools in particular — are really open to what veterans have to offer. "I definitely wanted to go to medical school before I joined the military, but after serving in Iraq, the reasons for doing it became a lot more real. During war, you witness some very unfortunate things, but at the same time you witness incredible acts of bravery and compassion. When I think back to my time in service, my best memories are of times when I got to help."

The Weill Cornell Graduate School Master of Science in Health Sciences for Physician Assistants (MSHS PA) aims to educate those recently released from voluntarily accomplished military service. It is a 26 months long program, comprised of two phases of study: a classroom intensive pre-clinical phase and a clinical phase.

In its earliest model, the MSHS PA Program began at The New York Hospital-Cornell Medical Center in 1973 to train qualified people as surgical assistants (SA) in care of surgical patients. While the surgical focus remains strong, primary care training prepares students for practice in any area. The Program offers students the opportunity to apply foundations of medicine learned in the classroom to patient care in a variety of practice settings, by using abundant academic and clinical resources. In addition, students nowadays learn and develop research skills that allow them to incorporate new medical methodologies and progress into clinical practice. The result? Students participate as integral members of surgical and medical patient care teams. To graduate, all students must to satisfactorily complete all curriculum components as well as a present a Master's thesis and attend to orally defend their thesis. After successful completion, graduates are eligible to take the National Certifying Board Examination administered by the National Commission on Certification of Physician Assistants (nccpa.net).

At Weill Cornell, the tuition for the most recently enrolled class is $29,250 for each of the three academic years. Students are eligible for financial aid for each phase. They also pay a graduation fee. This tuition cost is set for the current

academic year and is subject to change. With the average undergraduate education debt prior to PA school at $36,300 and the average anticipated debt load from PA school at $75,000-$124,000, the Yellow Ribbon program may come in handy for those veterans wanting to enrol at Weill (www.thepalife.com).

Approximately 90 percent of its students are recipients of financial aid, Federal Direct Loan Program and/or Alternative Education Loans. Various scholarships are available through a number of Physical assistant (PA) organizations and state agencies. In addition, Weill maintains listings within the department regarding alternative scholarship programs available to students. Veterans of the Armed Forces may be eligible for tuition fees under the G.I. Bill. So, they are especially encouraged to attend Weill Cornell's medical college to share their unique perspectives on medicine, commitment and service. To help do just that, Dr. Laurie H. Glimcher, the Stephen and Suzanne Weiss Dean of Weill Cornell, earlier this year approved the medical college's participation in the VA's Yellow Ribbon Program. It is a component of the post-9/11 GI Bill and one of three funding streams at Weill Cornell that help veterans with tuition. The Post-9/11 GI Bill will pay:

- All resident tuition and fees for a public school
- The lower of the actual tuition and fees or the national maximum per academic year for a private school

Degree-granting institutions of higher learning such as Weill-Cornell participating in the post-9/11 GI Bill Yellow Ribbon Program agree to make additional funds for veterans' education programs available without an additional charge to their GI Bill entitlement. These institutions voluntarily enter into a Yellow Ribbon Agreement with the VA and choose the amount of tuition and fees that will be contributed. The VA matches that amount and issues payments directly to the participating institution.

Under the GI Bill, the federal government provides eligible veterans up to 36 months of education benefits, generally payable for 15 years following release from active duty. Those benefits cover tuition and fees for students who attend an in-state public college or graduate school, or up to $20,232.02 for a private institution, according to the 2014 payment schedule. The Yellow Ribbon Program is designed for students whose costs exceed that defined amount because they attend either out-of-state public or private institutions. Participating institutions provide eligible veterans with supplemental funding to cover the higher costs for tuition and fees,

and Veterans Affairs matches that amount.

According to the VA, Weill Cornell is one of three New York City medical schools participating in the Yellow Ribbon Program. Of the three, it provides the greatest financial support to veterans, allocating up to $20,000 for medical students and $24,000 for graduate students. Two physician assistant students qualified for the benefit in fiscal 2014. Glimcher in the Weill Cornell November 2014 "The Veterans Who Call Weill Cornell Home" said:

> "My son served as a captain in the U.S. Marine Corps, so it's particularly important to me to provide as much support as we can to all our brave men and women who serve in the military. I'm thrilled that we can offer this invaluable tuition assistance program to our veterans and empower them to deliver exceptional patient care and make ground-breaking research discoveries."

None of the veterans currently enrolled at the medical college were eligible for 2015.

Physician assistant student John Quigley knows first-hand the benefit of tuition-assistance programs for veterans. He qualified for the Army Tuition Assistance, the New York State Veterans Tuition Awards and the Yellow Ribbon Program approved at Weill Cornell for the final year of his program. When he graduated in March 2015, his student loan burden was cut roughly in half.

Quigley began his military career in 2001 with the U.S. Marine Corps, protecting U.S. embassies. He then spent six tours in Iraq and Afghanistan as a medic in the U.S. Army National Guard. He said:

"The Yellow Ribbon Program and other tuition assistance program like it make it easier and simpler for veterans to go to Weill Cornell, an Ivy League [private] school, and pursue a career in medicine. With so many people getting out of the military, I think that's very important."

As to Castellanos, he was in boot camp during Sept. 11, 2001 and later trained as an aviation ordnance technician responsible for handling and maintaining all weapons systems and ammunition on Marine aircraft. He was sent to Al Asad Airbase three years later. His military career influenced his decision to pursue medicine by of the Yellow Ribbon Program. It was his tutor, Dr. Olaf Andersen, who diagnosed PTSD in him after he heard that his student had served in Iraq. Dr. Anderson is professor of Physiology and biophysics at the Weill Medical College of Cornell University and director of the Tri-Institutional MD-Ph.D. Program in New

York City. He asked Castellanos about his experience, Castellanos broke down in a squall of unsettled grief and anxiety, we read, saying:

> "Nobody talks about it. Nobody gets evaluated. A lot of people don't understand what it feels like to come back from war. It's so hard for veterans to make it this far."

He participated in the previously-mentioned research study for Iraq and Afghanistan war veterans led by Difede. She is investigating how the use of virtual reality could help accelerate recovery from post-traumatic stress disorder among the nation's service members.

Castellanos' perception of his situation in 2014 was:

> "Weill Cornell is definitely a veteran-friendly campus. It's a big family here. The mentoring is phenomenal. They look after you professionally as well as personally and developmentally. They really want you to succeed. Everybody cares about each other and they care about you as both a person and as a scientist."

But for the average G.I., things might be a bit rougher, with statistics showing PTSD in the military is close to an epidemic. According to official figures between 11 percent and 20 percent of soldiers who fought in Iraq and Afghanistan between 2001 and 2010 experience PTSD in any given year. The RAND Corporation furthermore confirms the earlier made statement that almost half of veterans diagnosed with PTSD will not seek treatment — namely the really bright ones.

In Castellanos opinion, however, the military itself is at fault, as there is systemic failure to warn, address and treat PTSD sufferers. He says:

> "If they took a serious approach early in training, when the risks and treatments are ingrained during boot camp, it would change how the military views PTSD."

He's dreaming! He is apparently ignorant of the fact that if cadets were warned beforehand of the extreme perception changes of life and living most likely to occur whilst in the theatre of War, with PTSD a distinct possibility as a result, only the very desperate or those with psychopathic and sociopathic tendencies would enrol in the military.

In that case, most of the 50 clinicians around the U.S. now trained to use Virtual Reality on PTSD experiencers, for example, would have invested their time and money for nothing. Those conducting current research to demonstrate, document, scientifically and empirically prove that VR is more effective than having PTSD

patients simply describe their trauma from their own memory would be out of a job. The avenue to mind-manipulate human PTSD VR subjects to the agenda's liking is eliminated. The loss of opportunity to further screw up those demanded or agreeing to PTSD VR exposure treatment alone has to be prevented at all cost. Think about it. The guinea pig, rattus, cani, would be dead. But they are needed alive for the racket to continue, as yes, PTSD is a racket, the same as war. One feeds on the other.

With the elimination of PTSD-afflicted soldiers and veterans, the mental health industry of all ranks and file as a whole would suffer. Financially alone, it would be catastrophic to many. So Rizzo, and his cohorts, says:

> "The hypothesis is that we'll show that the VR version will help people to get better faster because of the sensory element. Remission will be more complete and you'll be less likely to have a relapse. We should know within a year." (NBC: The hypothesis!)

That VR is combined with everything else on the PTSD treatment modality market to alter experiencers' mind, most likely without them having a clue, is a given. Exposure Treatment is only one of them. It is considered a splendid behavioral PTSD treatment, because it targets PTSD journeyers' response to situations, thoughts and memories they view as frightening or anxiety-provoking. Avoidance, a conscious or unconscious defense mechanism by which a person tries to escape from unpleasant situations or feelings, such as anxiety and pain, is one of those responses (Matthew Tull: How Virtual Reality Exposure Therapy (VRET) Treats PTSD; verywellmind.com 2018).

If not addressed, avoidance behavior can become more extreme. Avoidance interferes with working through thoughts, memories and emotions. It can lead to shut-in syndrome. It can also make PTSD symptoms stick around longer. Furthermore, when avoiding certain situations, thoughts and emotions, one deprives the self of the opportunity to learn that situations are less dangerous or threatening than they look. Exposure therapy, then, is to help clients reduce fear and anxiety by eliminating avoidance behaviour and, as a consequence, enhance their quality of life. This is done by actively confronting feared situations, thoughts and emotions, thus learning that anxiety and fear lessen on their own with confrontation. One could call it systematic desensitization.

For exposure therapy (ET) to be effective, however, it is very important that a person confronts a situation that closely maps what they fear most, we read. However, this might not always be possible for someone with PTSD. For example, a

veteran who developed PTSD as a result of combat exposure would not be able to confront a combat situation again. It would unsafe to do so. The same holds true for PTSD-afflicted fire fighters, police officers and aircrew. This is where virtual reality technology comes in.

In VRET, a person is immersed in a computer-generated virtual environment. This is done either through the use of a head-mounted display device or by entering a computer-automated room, where images are present all around. This environment can be programmed to help a person directly confront feared situations or locations that may not be safe to encounter in real life.

There also is some evidence showing that VRET might be useful for treating anxiety-related problems such as claustrophobia, fear of driving, acrophobia (a fear of heights), fear of flying, arachnophobia (a fear of spiders), social anxiety, and I presume, agoraphobia, the shut-in syndrome. But only a couple of studies have apparently been done that tested how useful VRET might be for PTSD. Those looked primarily at using it on veterans from Vietnam, Iraq and Afghanistan missions. Therefore, the virtual environment in which a person is immersed has included imagery that soldiers would come into contact with during combat, such as helicopters and jungles. These studies found that it *appeared* as if VRET-treated soldier' experienced PTSD symptom reduction. Scientific, empirical first evidence appears to be absent.

Even the American Psychological Association (APA) determined VR to be "particularly well suited to exposure therapy." This dispelled whatever doubt or criticisms mighty be looming, says Yariv Levski of AppReal-VR. This Israeli software company specializes in Virtual and Augmented Reality, V R & AR. Virtual reality completely replaces the user's real world environment with a simulated one.

Augmented Reality (AR) is different. It is an interactive experience of a real-world environment. Objects in the real-world are "augmented" by computer-generated perceptual information. Sometimes these augmentations run across multiple sensory modalities, including visual, auditory, haptic, somatosensory, and olfactory. The overlaid sensory information can be constructive, i.e. additive to the natural environment. Or it can be destructive, i.e. masking of the natural environment. It is seamlessly interwoven with the physical world, such that it is perceived as an immersive aspect of the real environment. In this way, augmented reality alters one's ongoing perception of a real world environment, whereas virtual reality completely replaces the user's real world environment with a simulated one.

Despite APA's approval, Levski insists a solid understanding of VR therapy is

crucial if mental health care providers are to deliver the most effective treatments available today. For those seeking therapeutic solutions to restore their emotional wellbeing, however, virtual reality therapy in his view offers new hope. But what about the few research examples purportedly showing how fabulously well VR technology works? How do they prove that it indeed is the most effective therapeutic tool to come along in decades to rearrange the human psyche in a multitude of ways, including for PTSD? And who and what throws the switches to make such miraculous machinations and perception changes in the PTSD-affected human brain?

VR Purported Healing Machinations

Like conventional anxiety-treatment methods, VRET works by exposing patients to their anxiety triggers within a controlled environment. As with any exposure therapy, the objective is to condition patients to respond positively to events that bring about their particular anxiety. This would replace experiencing the physiological stress associated with the original trauma that caused their anxiety disorder. However, it is asserted that the immersive and interactive power of VR also offers numerous benefits beyond conventional treatment methods, such as:

- VR technology enables mental health practitioners to design highly individualized treatment plans, based on the unique needs of their

patients.

- VRET is superior to conventional treatment methods in allowing patients greater control over their own exposure. Virtual reality experiences can be designed to be highly interactive, allowing patients to maintain a sense of control even as they experience anxiety triggers.
- VRET offers a drug-free method of reducing trauma-related anxiety.
- A well-designed VR treatment program can offer improved cost-effectiveness over conventional treatment programs.
- The immersive power of VR provides a more engaging and more authentic experience, which results in greater effectiveness.
- Unlike conventional anxiety-treatment programs, VR apps empower patients to continue their own treatment at home. This significantly increases the long-term effectiveness of the treatment.

VR therapy may not in all cases replace conventional treatment methods, we learn. But even as an adjunct therapy, it offers exciting advantages over standard treatments alone, we are told.

VRET, for example, can do more than provide visual simulations of scenes that trigger patients' anxiety. Although the immersive aspect of VR alone is a powerful tool, more elements can be added to a treatment program. These might reduce its duration and improve its long-term effectiveness, by way of the Full Sensory VR Therapy. Who determines what, where and when to apply to the therapy programme, or to add or subtract from it, is a mystery.

In addition to life-like three-dimensional graphics, VRET can also expose the patient to a number of stimuli that simulate the user's real-life anxiety triggers — with or without their knowledge. Can they also insert them at leisure, is the question? We are told, however, that various combinations of the following triggers can be produced depending on the hardware used. These are:

- Sounds
- Tactile sensations
- Smells
- Wind
- Temperature extremes
- Acoustic effects

- Tilting/dropping
- Moisture or rain

No other technology or therapy method can match the realism VR offers. Of course, therapists monitor the patient's heart rate, respiration and other vital signs during treatment. If the patient becomes too anxious during the session, the therapist can cut the session short, or modify the exposure scenes.

Advanced treatment systems in the making will eventually monitor the user's physiological response and tailor the VR session in real time to achieve the most optimum result. Actually, the technology to support such treatment programs exists now, but developers need to innovate in this crucial area.

Dell, for one, is providing a $100,000 grant for the University of Southern California's Institute for Creative Technologies to advance Dell's virtual reality exposure therapy prototype called "Bravemind". The prototype focuses specifically on treating PTSD-suffering war veterans, we learn.

Virtual reality is an immersive technology in which the person wears a head mounted display (HMD), which displays 3D images. As the person moves in a particular direction these images change to reflect the shift in perception. This adds to the realism and sense of immersion. The person can also interact with objects in this virtual environment by means of a data glove or some form of input device, e.g. controller.

The use and relation of VR for PTSD? The affected person wears a pair of virtual reality glasses or HMD. This contains two tiny monitors displaying images of the source of their disorder, e.g. a battlefield. The rationale behind this is that exposing someone to the source of their condition, combined with relaxation skills, will enable them to cope and adapt. As they are exposed to this over time, the level of threat is removed, which then decreases their anxiety levels.

Their physiological and psychological responses are monitored and analysed as part of the treatment. Plus these are used to inform future developments in this technology.

The person is able to revisit painful memories, but with a view to developing new forms of behaviour that will challenge these and any other existing beliefs. *This will cause them to learn new ways of thinking and behaving*, which will positively impact upon their lives.

Soon, very soon, humans won't need to do other than vegetate on their couches with their virtual reality helmet on their heads. They'll have their sex AI's, soon to

be registered as their equal, wit Sophia, for fornication purposes on demand at their side for permanent pleasant, uncomplaining, un-nagging soulless and sterile companionship without arguments and complications. This seems confirmed when reading Professor Albert "Skip" Rizzo's journeys into the field past and present.

He received his Ph.D. in Clinical Psychology from the State University of New York at Binghamton. For years, he conducted research on the design, development and evaluation of Virtual Reality systems, including targeting the areas of clinical assessment treatment, and rehabilitation. His work spans the domains of psychological, cognitive and motor functioning in both healthy and clinical populations. In the psychological domain, his latest project has focused on the translation of the graphic assets from the Xbox game Full Spectrum Warrior. This real-time tactics videogame was developed by the Institute for Creative Technologies in association with Pandemic Studios in 2004. He was translating its graphic assets into an exposure therapy application for combat-related PTSD with Iraq War veterans.

Rizzo is USC's director for Medical Virtual Reality Institute for Creative Technologies and research professor at USC Davis School of Gerontology and USC Keck School of Medicine Department of Psychiatry & Behavioural Sciences. He is conducting research on VR applications that use 360 Degree Panoramic video. These would be for exposure therapy, to treat social phobia, for example, and for role-playing applications for anger management.

Rizzo also recently used this technology to capture news scenes for future multimedia journalism applications. In addition, he is working with a team creating artificially intelligent virtual patients, which clinicians can use to practice skills required for challenging clinical interviews and diagnostic assessments. Such skills would help them assess sexual assault, suicide lethality, resistant patients and so on and so forth.

Sigmund Freud defined resistant patients as those blocking memories from conscious memory. More generally, however, the term is used to describe the direct or indirect opposition of patients to the proposed therapeutic process. Those 50 percent of PTSD voyagers refusing treatment, for example, would be classified as resistant patients.

Rizzo's cognitive work addresses the use of VR applications to test and train human attention, memory, visuospatial abilities and executive function. In the human motor domain, he has developed VR Game systems addressing post-stroke physical rehabilitation, traumatic brain Injury and prosthetic use training. He is also

investigating the use of VR for pain distraction at Los Angeles Children's Hospital. He designs game-based VR scenarios for children and adults, addressing social and vocational interaction associated with autistic spectrum disorder.

His research furthermore involves designing and evaluating 3D user interface devices and interaction methods. For this purpose, he created a graduate level Industrial and systems engineering course at the University of Southern California (USC), entitled "Human Factors and Integrated Media Systems".

In the area of Gerontology, Dr. Rizzo has served as program director of USC's Alzheimer Disease Research Center. He is conducting a VR study of visuospatial and wayfinding ability of people with Alzheimer's. Visuospatial ability is the ability to visually perceive the spatial relationship between objects.

Rizzo is also currently examining the use of VR applications for training emotional coping skills, with the aim of preparing service members for the stresses of combat. He is senior editor of the MIT Press journal, *Presence: Teleoperators and Virtual Environments*. He also sits on a number of editorial boards for journals in the areas of cognition and computer technology (*Cognitive Technology*; *Journal of Computer Animation and Virtual Worlds*; *Media Psychology*) and is the creator of the Virtual Reality Mental Health Email Listserve (VRPSYCH). He served as General Chair for the IEEE VR2003 conference in Los Angeles and co-chaired this conference in 2004. He was also the Conference Chair of the 4th Annual Workshop on Virtual Rehabilitation on Catalina Island, Los Angeles, in 2005. And he chaired a military-sponsored conference on "Technological Approaches for the Treatment of Wounded Warriors" in November 2009.

In his spare time, the esteemed professor plays rugby, listens to music and rides his motorcycle. I am thrilled for him, amazed he finds time to breathe. Such vigour, such energy spent on remaking the human psyche and masking many issues arising from or out of it due to humanity's innate qualities of empathy, compassion, and kindness. And still he has time to ride bikes, play rugby and listen to music. Let's hope it's harp. Archons hate it.

According to James Lake, MD of *Psychology Today* February 2017, VR applications are presently being developed address PTSD. For instance, some aim to assess the risk of developing PTSD following trauma. Others would offer mental resilience training aimed at preventing PTSD in active duty soldiers and other, unnamed, high risk groups. Efforts are also ongoing to develop interactive Internet and smart-phone applications for VRGET protocols addressing PTSD in this population. Again, we hear that sub-threshold PTSD symptoms might be associated with pre-

morbid and hitherto undetected physical and mental health impairments in the GI across to generals. This would presumably develop into PTSD.

Health issues creep up on VR treatment participants in a pilot study. Some newly returned veterans with significant sub-threshold symptoms, but did not meet full criteria for PTSD. Nevertheless, their heart rates quickened in response to immersion into *Virtual Iraq,* designed to elicit fear.

Some people using VRET report mild transient symptoms of disorientation, nausea, dizziness, headaches and blurred vision. *Simulator sleepiness*, defined as feelings of generalised fatigue, sometimes following exposure to virtual environment, has also been noted. That virtual environments trigger migraine headaches, seizures or gait abnormalities is largely kept hidden. But people diagnosed with these problems arising from VR should be cautioned about possible adverse effects of exposure to virtual environments. That is, if one knows of it beforehand. If not, suffer the consequences with a smile. It was after all your choice to participate. Or did you participate because you wanted to maintain a modicum of income, and thus survival, off the streets of your treasured homeland?

Have you ever wondered what else might be implanted into you brain with VR apps? Ever think that VR perhaps is a means to desensitise and rob you of your human qualities of compassion and empathy? After all, the British Virtual Reality Society on its website comes right out and states that on the one hand, participants are able to revisit painful memories. But on the other hand, the aim of the game is to develop new forms of behaviour that will challenge these and any other existing beliefs they have. This, in turn, will cause them to learn new ways of thinking and behaving, which will positively impact upon their lives. VR subjects' physiological and psychological responses are also monitored and analysed as part of the treatment. These are then used to inform — and doubtlessly influence — future developments in this technology.

But what joy VR is for participating research patients having nothing other to do than show up for VR therapy. The-rapist of the mind chooses the program, according to his or her liking and idea of how the patient should feel and function. They spice it up a bit with pharmaceuticals, marihuana, stellar ganglione, D glycerinose and whatever else seems appropriate or in vogue at any given time. Voila, the patient is declared cured without having to lift a finger to help the Self. The patient remaINS completely ignorant of the fact that true evil has a face you know and a voice you trust. People pressured into participating by threatening financial cut-off don't know that all they need to do with graciousness and honour is

address the powers that be in writing, stating something to the effect of:

> "Yes, I will be delighted, thrilled, overjoyed, to do as I am told, if you will guarantee in writing that no harm will come to me from VR, VRET, VRGET or any of its derivatives to my mind, body, soul and spirit, and that if it does the VA, WBC, Insurer, will compensate me for my sufferings occurring after such treatment(s) for the pro-rated amount of money plus $10,000.00 annually for the remainder of my natural life."

If you did, I assure you that you would be free to use your own God-given force to heal yourself. If you dream, however, that VRET and VRGET will cure your PTSD without influencing anything else within your body, your soul or your mind, dream on then. But before you do, and if you think no such thing as the perversion of your mind through VR could take place, you may wish to listen to Steve Quayle's September 2018 interview *Everything will ramp up mid-September.*

The aim, one hears, is for PTSD affected soldiers to lose all feelings of anxiety caused by their condition so they can lead a normal life. But "normal" to whose perception? The definition of normalcy has been debated for centuries if not millennia. "Normal" by the shutdown, the exclusion, or the extinction of the human *sui generis*? Or "normal" in accordance with the world's Neumeisters?

The "Virtual Iraq" scenario was implemented in at least 19 military sites (Rizzo et al., 2009) in 2009 already. From Barber and Sharpless we learn that from a clinical standpoint, VR may be useful for people with difficulty vividly imagining their traumas or those resistant to talk therapy. Why one wants to vividly imagine the trauma lived to overcome it is beyond my comprehension. It will not change, it will merely desensitized. To absorb and resolve its consequences is the aim of the game, or is it? Apparently not to the mental health practitioner league.

However, in study of Army personnel entitled *Soldier attitudes about technology-based approaches to mental health care* (Wilson JA, Onorati K, Mishkind M, Reger MA, Gahm GA; Cyberpsychol Behav. 2008 Dec;11(6):767–9) offers hope. We read that technology-based treatments are promising approaches to reduce some barriers soldiers often face to receive necessary mental health care. Among those technologies are:

- such as video teleconferencing
- Internet-based treatments
- virtual reality

However, their knowledge and experiences with such technologies are unknown. In 2008, there was no research on their acceptability for use in military mental health care. The 2008 study looked at 352 U.S. soldiers' knowledge of and attitudes toward using technology to access mental health care.

Results showed that they were quite experienced with a wide variety of technology-based tools commonly proposed to facilitate mental health care. In addition, the majority of participants stated that they would be willing to use nearly every technology-based approach for mental health care included in the survey. Notably, 33% of Soldiers who were not willing to talk to a councilor in person were willing to use at least one of the technologies for mental health care. Twenty percent of those unwilling to seek traditional psychotherapy were also amenable to using a VR-based treatment (Wilson, Onorati, Mishkind, Reger, & Gahm, 2008). But the cost of VR systems (~$1,500) might have been prohibitive, *especially since it is unknown if the results of VR exposure would justify the expense.*

Thus, RCTs are needed, as are studies comparing the efficacy of VR exposure to more traditional modes of exposure. They are still needed, and again, what for, when you are barking up the wrong tree and have been doing so for decades?

These results suggest that technology-based approaches could help overcome barriers to care, the researchers concluded. That only 100,000 soldiers or veterans accessed the system in 10 years, however, seems to indicate otherwise.

What if, however, our whole perception is a deception, an holographic projection in accordance with our thinking. That would leave us as the producers and directors of our show, a VR production in perpetual motion a la *The Truman Show*? When contemplating that issue, may it rattle you enough to believe that rapists of the psyche enable you to regain your emotional stability lost with the PTSD causing event? Listen again: "True evil has a face you know and a voice you trust." Perhaps trusting only the Self and one's intuition could be a very good idea?

The Establishment On Relaxation Techniques & Training

There is nothing new under the sun, including the millennia-old knowledge that mind-and body relaxation by way of meditation is one of the most benevolent relaxation exercises in which humans can engage. It is free. All it takes is willpower, determination, discipline and persistency to do it daily and reap the benefits. Jacques P. Barber and Brian A. Sharpless, in "A Clinician's Guide to PTSD Treatments for Returning Veterans" (*Prof Psychol Res Pr.* 2011 Feb 1; 42(1): 8–15), contend that relaxation training might be the earliest behavioural PTSD treatment in existence.

First of all, however, they specify distinctly that the DSM-5 creators lowered PTSD diagnosis criteria to practically a hangnail. B & S firmly state that PTSD is the consequence of a terrifying event, either natural or man-made. They state that the event shocks the human psychological system and violates human core assumptions that life is predictable, safe and secure. B & S contend furthermore that such an event reveals to the experiencer the ultimate fragility of human existence. It can result in both immediate distress and long-term interruptions to normal functioning, which can have far-reaching consequences for the Self and one's loved ones.

Often PTSD also demonstrates a chronic course, with as many as 40% of people showing significant symptoms 10 years after onset. This according to the 1995 *Posttraumatic stress disorder in the National Comorbidity Survey* (Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB; Arch Gen Psychiatry. 1995 Dec;52(12):1048–60). The original survey was conducted in the early 1990s and comprised interviews of a representative national sample of 8,098 Americans aged 15 to 54 years.

In this earlier sample, the estimated prevalence of lifetime PTSD was 7.8% in the general population. Women (10.4%) were more than twice as likely as men (5%) to have PTSD at some point in their lives (ptsd.va.gov). The data were obtained on the *general population* epidemiology of DSM-III-R PTSD), including information on:

- estimated lifetime prevalence
- socio-demographic correlates
- the kinds of traumas most often associated with PTSD
- the comorbidity of PTSD with *other lifetime psychiatric disorders*

The duration of an index episode was of little concern to B & S. That soldiers and veterans played no role in "*the other lifetime psychiatric disorder*", B & S also accepted without blinking an eye. But never mind.

The National Comorbidity Survey Replication (NCS-R) was conducted between February 2001 and April 2003. It comprised interviews of a nationally representative sample of 9,282 Americans aged 18 years and older.

- PTSD was assessed among 5,692 participants, using DSM-IV criteria.
- The NCS-R estimated the lifetime prevalence of PTSD among adult Americans to be 6.8%.
- Current past year PTSD prevalence was estimated at 3.5%.

- The lifetime prevalence of PTSD among men was 3.6% and among women was 9.7%.
- The twelve-month prevalence was 1.8% among men and 5.2% among women (ptsd.va.gov).

Mind you, PTSD diagnosis criteria had already softened with the DSM-IV to get more people on pharmaceutical mind-altering drugs, predominantly SRRI's.

Naomi Breslau is an epidemiologist and doctor of philosophy at Michigan State University. In 2009, she wrote "The Epidemiology of Trauma, PTSD, and Other Posttrauma Disorders" This article states that epidemiologic studies reported that the majority of community residents in the United States have experienced posttraumatic stress disorder (PTSD) level traumatic events, as defined in the DSM-IV. However, only a small subset of trauma victims develops PTSD (<10%). Increased incidence of other disorders following the trauma exposure occurred primarily among trauma victims with PTSD.

Female victims of traumatic events are at higher risk for PTSD than male victims. Direct evidence on the causes of the sex difference in the conditional risk of PTSD is unavailable, though available evidence suggests that the sex difference is not due to (a) the higher occurrence of sexual assault among females, (b) prior traumatic experiences, (c) preexisting depression or anxiety disorder, or (d) sex-related bias in reporting (journals.sagepub.com).

In 2017, the National Center for PTSD in the USA published their own *Epidemiology of PTSD.* It was written by Jaimie L. Gradus, DSc, MPH, epidemiologist at the VA's Women's Health Sciences Division and assistant professor of psychiatry and of epidemiology at Boston University School of Medicine, Boston. What is epidemiology? It is the study and analysis of the distribution — who, when and where — and risk factors of health and disease conditions in defined populations. Epidemiology is the cornerstone of public health, and shapes policy decisions and evidence-based practice by identifying risk factors for disease and targets for preventive healthcare. The "public" in question can be as small as a handful of people, an entire village or it can be as large as several continents, in the case of a pandemic. In this case, it was the US military veteran public participating in their wars.

The National Vietnam Veterans Readjustment Study (NVVRS), conducted between November 1986 and February 1988, comprised interviews of 3,016 American Veterans who served in the armed forces during the Vietnam era. The estimated

lifetime prevalence of PTSD among those Veterans was 30.9% for men and 26.9% for women. Of those, 15.2% of men and 8.1% of women were still diagnosed with PTSD at the time of study conduction.

Veterans deployed to the Persian Gulf War from 1990 to 1991 seem to have fared even worse. They reported a constellation of symptoms and medical conditions, including PTSD, during their deployment and since their return home. Epidemiologic studies compared veterans who were deployed to the Gulf War with veterans who were in the military during the Gulf War but were not deployed. These studies have confirmed that deployed veterans have a greater prevalence of a number of medical conditions, illnesses and symptoms. This increased reporting of symptoms and prevalence of medical conditions has also been seen in deployed veterans from many of the countries that formed the coalition forces, including the United Kingdom (UK), Australia, Canada and Denmark. Recently, French forces deployed to the Gulf War have also been under study, but as yet few results have been published on this cohort (Gulf War and Health: Volume 8: Update of Health Effects of Serving in the Gulf War; ncbi.nlm.nih.gov).

The Longitudinal Health Study of Gulf War Era Veterans examining the health status over time of Veterans who deployed to the Gulf War and Veterans who served elsewhere during the same time period. Researchers conducted an initial survey in 1995 and a second survey in 2005. They used the PTSD Checklist (PCL; 9) rather than interviews in this sample. PTSD in these Veterans was 12.1% with the prevalence of PTSD among the total Gulf War Veteran population estimated at 10.1%.

The PTSD CheckList (PCL) is a standardized self-report rating scale for PTSD, comprising 17 items that correspond to PTSD's key symptoms. Two PCL versions exist: 1) PCL-M is specific to PTSD caused by military experiences and 2) PCL-C applied generally to any traumatic event. Within the Veterans Administration (VA), the PTSD Checklist (PCL) is required as an outcome measure for Veterans in active treatment for PTSD. PCL items map directly onto PTSD symptoms in the Diagnostic and Statistical Manual of Mental Disorders [DSM-IV-TR; 8]. They ask respondents to rate the degree to which they were bothered by symptoms related to a stressful experience in the past month on a 1–5 scale (ncbi.nlm.nih.gov).

In 2008, researchers also used the PCL to evaluate Operation Enduring Freedom/Operation Iraqi Freedom participants' PTSD percentage. It was conducted by the RAND Corporation Center for Military Health Policy Research. They published a population-based study to examine the prevalence of PTSD

among those forces. They determined that among the 1,938 participants, the prevalence of current PTSD was 13.8% (Invisible Wounds of War Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery;

Terri Tanielian and Lisa H. Jaycox, editors).

To my knowledge, no money has ever been spent to conduct research on how PTSD experiencers successfully healed themselves. That relaxation techniques and the absence of pharmaceutical drugs may have been instrumental in turning the ship around is totally ignored.

That comorbidity is high, with only 17% of Veterans with PTSD diagnosed solely with PTSD (Seal et al. 2007) is a given, as alcohol often becomes a part of self-medication practice and healing. A risk factor for suicide (Kotler et al., 2001) is also present under certain conditions, according to Kotler et al.'s 2001 research in the abstract revealing that

> "An emerging literature suggests that posttraumatic stress disorder (PTSD) patients are at an increased risk for suicide. The objective of this study was: a) to reexamine the relationship between PTSD and suicide by comparing suicide risks of persons with PTSD, to persons with anxiety disorder and to matched controls; and b) to examine the relationship between anger, impulsivity, social support and suicidality in PTSD and other anxiety disorders. Forty-six patients suffering from PTSD were compared with 42 non-PTSD anxiety disorder patients and with 50 healthy controls on measures of anger, impulsivity, social support, and suicide risk. Persons with PTSD had the highest scores on the measures of suicide risk, anger, and impulsivity and the lowest scores on social support. Multivariate analysis revealed that in the PTSD group, impulsivity was positively correlated with suicide risk and anger was not. PTSD symptoms of intrusion and avoidance were only mildly correlated with suicide risk at the bivariate level but not at the multivariate level. For the PTSD and anxiety disorder groups, the greater the social support, the lower the risk of suicide. For the controls, social support and impulsivity were not related to suicide risk, whereas anger was. These findings suggest that persons with PTSD are at higher risk for suicide and that in assessing suicide risk

> among persons with PTSD, careful attention should be paid to levels of impulsivity, which may increase suicide risk, and to social support, which may reduce the risk." (Kotler, Moshe M.D.; Iancu, Julian M.D.; Efroni, Ravit M.A.; Amir, Marianne, Ph.D.: Anger, Impulsivity, Social Support, and Suicide Risk in Patients with Posttraumatic Stress Disorder; The Journal of Nervous and Mental Disease: March 2001, Volume 189, Issue 3, p 162–167)

That mind-altering pharmaceuticals assist in suicidal ideation is nowhere mentioned.

As we have noted, social and mental health support in the military has largely being replaced by the PTSD Coach On Line and the Mobile App as well as the VR treatment modalities. PTSD Coach purportedly provides facts and self-help skills based on research. By 2018, it had been downloaded over 100,000 times in 74 countries around the world, a paltry number considering PTS in soldiers returning from America's theatres of war is skyrocketing.

It has been noted that society has frequently suffered from bouts of "amnesia" over the importance and prevalence of PTSD (van der Kolk & McFarlane, 1996). But interest in it by the medical professions is climbing exponentially. The APA even saw fit in 2016 to publish *History of trauma in psychiatry.* It stated that from the earliest involvement of psychiatry with traumatized patients, there have been vehement arguments about trauma's etiology, meaning its cause, set of causes, or manner of causation. The arguments continue, the farce of it all either infuriating or inspiring uproarious hilarity. Pick and choose!

Neuroscientist Bessel van der Kolk, MD, is one of them. He has spent his career studying how children and adults adapt to traumatic experiences. He has translated emerging findings from neuroscience and attachment research to develop and study a range of potentially effective treatments for traumatic stress in children and adults. He has focused on studying treatments that stabilize physiology, increase executive functioning and help traumatized people feel fully alert to the present. This has included an NIMH-funded study on EMDR and an NCCAM-funded study of yoga. In recent years, it has included the study of neurofeedback. That was to investigate whether attentional and perceptual systems (and the neural tracks responsible for them) can be altered by changing EEG patterns (besselvanderkolk.net).

His efforts resulted in a "Trauma Center" specializing in treating children and adults with histories of child maltreatment. The Centre applies treatment models

that are widely taught and implemented nationwide. It has a research lab that studies the effects of neurofeedback and 3,4-Methylenedioxymethamphetamine (MDMA), commonly referred to as "Ecstasy," on behaviour, mood, and executive functioning. MDMA is a ring-substituted phenethylamine that is structurally similar to both mescaline and methamphetamine. MDMA is characterized by its unique subjective effects, including euphoria, a feeling of love for others and a sense of being at peace with the world, while not significantly affecting visual perception or cognition (ajp.psychiatryonline.org). But MDMA has an undeniably checkered history, and its use is not without risks. However, its unique subjective effects, when paired with psychotherapy, hold promise as a novel therapeutic intervention for PTSD, and potentially for other psychiatric disorders. We read this in Michael Cooper and Anna Kim, M.D.'s *MDMA in Psychiatry: Past, Present, and Future* published Online in February 2018

That Ritalin is an MDMA derivative turning them into drug addicts possibly for life, is kept secret. Ritalin is prescribed in North-American schools to bright children bored to hell and, due to their brightness, unable to stand the much-less-so teacher.

Van der Kolk unfortunately gives numerous training seminars across the USA. He preaches to a variety of mental health professional, educators, parent groups, policy makers. and law enforcement personnel. His message? The benefit of drugging the human population from cradle to grave into oblivion to create the SOMA society in the process. Like most Neumeisterians, he largely seems to disbelieve the God-given, innate, delightful human ability to heal the Self. Furthermore, like most of his cohorts, including those affiliated with the National Center FOR PTSD ("for" meaning its enhancement, not its cure), he certainly does not wish to advertise those human self-healing capabilities in any form. He doesn't want to find the so cherished empirical scientific first evidence that it works splendidly in PTSD. He won't conduct studies on those who healed the Self from it through the by-then-maligned relaxation techniques and by treading the spiritual path.

Exceptions always make the rule, and the exception of that rule is neuroscientist Dr. Edward. He graduated from Stanford University in 1957, earned his MD from Yale University in 1962, and did his residency in neurology at the University of California in 1967. He was in private practice in Petaluma, California, until his retirement in 2012.

Edwards' wake-up call came in 1996, when he read the book *Maps of the Ancient*

Sea Kings, by Charles H. Hapgood. The 1966 paperback documented that the entire earth had been mapped during the ice-age, and that megalithic structures were all over the earth's coastlines (Covert Harassment Conference, 2014). Nowadays, and as a neuroscientist, he is convinced that humanity is slotted for extinction by a big brain species with cone heads. Their IQ is hugely superior to humans and they are devoid of empathy and compassion. Dr. Ed Spencer: *We Are Victims Of Another Species: Large Brain Hominids*, You Tube Jun 16, 2014 is recommended.

The knowledge he conveys means the world. It helps understand why all relaxing self-healing techniques, including meditation, is suppressed. It explains why all things detrimental to the health, from psychotropic drugs to food, aerial chemical spraying, vaccinations and so on and so forth, is promoted as salvation of humanity. Once you have listened to Spencer's address, you will understand that you, in this case the PTSD journeyer, are truly on your own. More importantly, you will know why. Once we know why, we can help ourselves. As long as we are unaware, we can't. The problem? As Morpheus says in the Matrix:"

> "The Matrix is a system, Neo. That system is our enemy. But when you're inside, you look around, what do you see? Businessmen, teachers, lawyers, carpenters. The very minds of the people we are trying to save. But until we do, these people are still a part of that system and that makes them our enemy. You have to understand, most of these people are not ready to be unplugged. And many of them are so inured, so hopelessly dependent on the system, that they will fight to protect it."

Under those circumstances, future hypothesis about PTSD are actually rendered null and void by and through that knowledge. But we will go on anyways, as I put all this work into exploring the topic, at this point almost ad nauseam.

But what can I say, when at this point those purportedly procuring the cure for PTSD are debating whether or not it is organic or psychological? Is trauma the event itself or its subjective interpretation? Does the trauma itself cause the disorder or do pre-existing vulnerabilities cause it? Are these patients malingering and suffering from moral weakness? Or do they suffer from an involuntary disintegration of the capacity to take charge of their lives? (PsycINFO Database Record (c) 2016 APA, all rights reserved)

Does one laugh or cry? That PTSD is "merely" a colossal existential crisis, according to Jung, Mosher and other untold eminent psychiatrists, is absolutely

non-acceptable to them. Now, thanks to Dr. Spencer and others, we know why not. The love of money, nothing but the love of money, the root of all-evil, strangles humanity's love of life and our empathy and compassion towards each other. Relaxation techniques are benevolent not only for a PTSD recovery, but for all humans, regardless of state of mind. To hinder our rediscovery, these techniques are suppressed with sheer might. Why? Humanity's awakening and uprising against those ruling it may otherwise result, destroying the scam of the 6th root race.

What does it take to heal the Self with the help of relaxation techniques? Discipline and persistency. Nothing else.

Relaxation techniques are practiced in order to reduce fear and anxiety associated with traumatic responses. So say D. Scotland-Coogan and E. Davis in their research *Relaxation Techniques for Trauma* (J Evid Inf Soc Work. 2016 Sep-Oct; 13(5): 434–41). They reduce physiological PTSD symptoms manifesting as increased arousal and reactivity, anger outburst, irritability and overall reckless behaviour with little or no concern for consequences. Hyper-vigilance, sleep disturbance and problems with focus are other problems. In seeking the most beneficial treatment for PTSD, consideration must be given to the anxiety response. Relaxation techniques are shown to help address the physiological manifestations of prolonged stress. The techniques addressed by these authors include mindfulness, deep breathing, yoga and meditation. These techniques can complement traditional therapies, they say.

In addition, relaxation techniques are alternative interventions that might help maintain the human body's healthy or normal functioning and lessen physiological PTSD manifestations. This is especially true for PTSD journeyers averse to the "traditional," purportedly evidence-based, practices: the exposure-, cognitive behavioral- and EMDR-treatment modalities combined with the mandatory pharmaceutical of all kinds treatment. It is equally true for those who have unsuccessfully tried all that.

It should come as no surprise that being in a constant state of mental arousal is hard on the cardiovascular system. Stress increases heart rate and blood pressure. When common stimuli such as a car horn or a dish dropping elicit this response, PTSD patients often find themselves in aroused states. Studies consistently show that PTSD victims — and specifically war veterans — have an increased risk of dying from coronary heart disease.

In constant upheaval, the hearing becomes acute and the eyesight diminishes as well.

Long-term PTSD effects can also influence lifestyle choices, such as indulging in

prescription drugs that in turn destroy physical health. Feelings of depression, encouraged by such drugs and constant anxiety, can cause sufferers to turn to illegal substances or smoking to alleviate the symptoms. It has also surfaced that PTSD sufferers tend to smoke more than non-PTSD sufferers.

PTSD also seems to have implications for the immune system, as journeyers typically have more inflammation within the body and a higher white blood cell count. That in turn can lead to blood disorders and serious infections (Joanna Fishman: *"What are Some of the Physiological Manifestations of PTSD?"* (psychcentral.com).

Multiple studies have shown that patients suffering from PTSD have these responses to traumatic slides, sounds and scripts, in particular increased startle reaction, increased resting heart rate, increased heart rate and blood pressure.

Some researchers studied the sympathetic nervous system even further by looking at plasma norepinephrine and 24-hour urinary norepinephrine. They found them to be elevated in veterans with PTSD as compared to those without PTSD. PTSD is also associated with hyper functioning of the central noradrenergic system. Hyperactivity of the sympathoadrenal axis might contribute to cardiovascular disease through the effects of the catecholamines on the heart, the vasculature and the platelet function.

A psychobiological model based on allostatic load has also proposed that chronic stressors over long durations of time lead to increased neuroendocrine responses. These, in turn, have adverse effects on the body state researchers Updesh Singh Bedi and Rohit Arora in *Cardiovascular manifestations of posttraumatic stress disorder* (J Natl Med Assoc. 2007 Jun; 99(6): 642–649). They found that physiological responses, increase in heart rate, blood pressure, tremor and other symptoms of autonomic arousal, to reminders of the trauma are a part of the DSM-IV definition of PTSD. Multiple studies have shown that PTSD patients have increased resting heart rate, increased startle reaction, and increased heart rate and blood pressure as responses to traumatic slides, sounds and scripts. Some researchers have studied the sympathetic nervous system even further by looking at plasma norepinephrine and 24-hour urinary norepinephrine and found them to be elevated in veterans with PTSD as compared to those without PTSD. PTSD is associated with hyperfunctioning of the central noradrenergic system. Hyperactivity of the sympathoadrenal axis might contribute to cardiovascular disease through the effects of the catecholamines on the heart, the vasculature and platelet function. A psychobiological model based on allostatic load has also been proposed and states

that chronic stressors over long durations of time lead to increased neuroendocrine responses, which have adverse effects on the body. They also mention that PTSD has also been shown to be associated with an increased prevalence of substance abuse, the overindulgence in or dependence on an addictive substance, especially alcohol or drugs. Of course, a necessity to calm the PTSD affected nervous system down, in particular when knowing that pharmaceutical concoction destroy body and mind.

When the body is kept in a constant state of fight or flight, the immune system automatically keeps turned on overactive alert. This is true even when not caused by the PTSD-causing event due to the consequent treatment by the powers that be. They create the fear of loosing one's subsistance to live reasonably secure with a roof over one's head, No wonder, then, that PTSD sufferers miss more workdays than those who do not suffer it, if they can work at all. They most likely see higher risk of cancer and autoimmune disease as well as early mortality, we hear, as the constant emotional upheaval creates physical illness. This too, however, has been known for thousands of years, but is rather successfully suppressed.

But here, too and again, future research studies assessing the benefits of treatment modalities, including relaxation techniques, are needed. These would provide scientific, empirical evidence to support the efficacy of these treatments, tout Scotland-Coogan et al. If just 10 percent of the money spent annually by the American taxpayers were allocated to PTSD-experiencing human soldiers and veterans, the problem would be solved in no time flat. That money flows through e the VA and the NC for PTSD and associates, as well as the US Department of Defence. It would also lessen the multitude of difficulties created by them for the world's legitimate civil PTSD journeyers, not the one's created by the DSM-5, with their PTSD diagnosis criteria turning everyone into opioid drug-addicts.

Coogan is an associate professor in the School of Social Work at Saint Leo University, Florida, USA. As a sideline, she counsels many veterans with PTSD. She also helps at K9 Partners for Patriots, a non-profit organization in Brooksville that helps veterans with PTSD manage their lives better with the help of service dogs. That's a whole other screwed-up can of worms we shall open later. Her perception of PTSD, evidently not having lived it herself, is portrayed in her June 2017 article written for the *Tampa Bay Times*: "To deal with PTSD, one must first understand it." As usual for most in her league, she pushes drugs and exposure therapy rather than relaxation techniques. B & S recommendations are in accordance with it.

PROGRESSIVE MUSCLE RELAXATION

Relaxation training is possibly the earliest *behavioural* treatment for PTSD in the 1900s. According to B & S, it has been used as a standalone treatment, often as a control, and as a component of broader PTSD treatments. The only one mentioned by them in detail is the progressive muscle relaxation mode. You'll find it under Veterans Employment Toolkit on the VA's website, where we read that tense muscles are a common reaction to stress. Indeed, we hear, many people experience some tension in the neck and shoulders in a normal workday. I never did, as I loved my job. I never had headaches, either. But did I experience excruciating neck pain for months on end. This was not because of muscle tension, but because the nerve ran through the scull muscles in the neck, which gets caught under tension. No painkiller will relieve the pain. Nothing helps but to lie down and remain still. Very, very still.

As a relaxation exercise, however, progressive muscle relaxation involves tensing and relaxing human body muscles one muscle group at a time. This can reduce the tension. Other reactions to stress, such as rapid breathing and heartbeat, stomach problems and headaches can also be lessened with this technique, they say.

It has been used in 4 RCTs, and while it certainly proved to be effective, it was not nearly as effective as other more comprehensive treatment packages, claim B & S. We assume that includes the pharmaceutical treatment package. These are always mandatory if one wants to participate in VA PTSD treatment modalities, as asserted by Dr. William Mount again in September 2018. The NC for PTSD employees seem to dislike with fervour that PTSD-afflicted might educate themselves and then heal themselves. Reflecting the establishment view on relaxation and self-help, no more on it was said by B & S. Unless PTSD journeyers' minds can be destroyed and mind manipulation techniques can be applied, it is of no interest. The Cognitive Behavioural Group Therapy (CBT) is constantly touted as beneficial and is again pushed to the fore, this time in a group setting.

So is anything else related to Cognitive Behavioural — Theory? That means the Pavlovian Skinnerian rattus cani training to learn standing at attention and do as told at all times, the slave in action.

COGNITIVE BEHAVIOURAL GROUP THERAPY (CBT) & TRAUMA-FOCUSED GROUP TREATMENT FOR PTSD

Denise M. Sloan, Ph.D., and J. Gayle Beck in 2016 published the article "Group Treatment for PTSD" in the National Center for PTSD journal's *PTSD Research Quarterly* (VOLUME 27/NO. 2, 2016. They state that despite the rich history of PTSD group treatments, there was a surprising lack of methodologically rigorous

studies in this domain. Thus, they in unison conceived to launch an investigation.

At one point "rap groups" were seen to be the treatment of choice for Vietnam Veterans, they trumpet (Foy et al., 2000). Such support groups, the noted, still played a significant role in many agencies serving trauma survivors, including in the VA. (Hundt, Robinson, Arney, Stanley, & Cully, 2015). Despite the popularity of such support groups, the group treatment research literature was only characterized by open trial (e.g. Ready et al., 2008) or non-randomized designs (e.g. Resick & Schnicke, 1992). Therefore, they were considered as helpful only in the beginning stages of PTSD treatment development. Due to this very limited number of randomized clinical trials (RCT) and no recognized, evidence-based group PTSD treatments, they maintained, none were currently offered by the VA (VA & Department of Defense [DoD] 2010). To earn their keep, Beck and Sloane then thought of summarizing the scanty current group PTSD treatment research available. They highlighted areas, which in their valuable opinion, deserved empirical focus. That means research based on, concerned with, or verifiable by observation or experience rather than theory or pure logic.

Sloan, Beck, et al.'s 2013 meta-analysis of RCTs of group PTSD treatment studies came in handy for the purpose. As they had already noted three years earlier, no significant differences for cognitive behavioural group interventions relative to other active PTS treatment modalities existed. Since its publication, only a handful of additional RCT group trials for PTSD had been conducted. This inspired them to proclaim: "Clearly, this is an area ripe for needed study."

There were indeed a number of protocols that held promise and deserved further investigation, they orated. It was then that they began to examine group formats of currently available, first-line, individual PTSD treatment approaches. They deemed that studying the Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) would be one obvious path to pursue PTSD improvement.

As a matter of fact, they state, the first PTSD CBT efficacy study conducted in 1992 and a second one in 2005 had used a group format. By 2008, at least 14 CBT studies had been concluded, four of them random control trials (RCTs). Another was a large study of Vietnam War Veterans. In it, 360 male Veterans were randomized to either trauma focused group therapy or non-specific treatment controls, most likely versus single treatment protocols. Even though clients had improved significantly, no differences between the groups were found. Subsequent analyses nevertheless suggested that numbing and avoidance symptoms were reduced more in the trauma focused group therapy than in the nonspecific [most

likely single treatment control] group. After reviewing the literature further, they state, researchers concluded that there was significant support for group CBT approaches for PTSD.

Several additional studies with CPT were administered in group format in 2013. Variations included a cognitive only version, referred to as CPT-cognitive only, and a group CPT-C modified for cultural considerations. In 2014, Resick et al. investigated the CPT-C group format relative to group present centered therapy (PCT). They worked with a cohort of active duty service men and women diagnosed with military-related PTSD ("Comparing effectiveness of CPT to CPT-C Among U.S. Veterans in an interdisciplinary residential PTSD/TBI treatment program"; *Journal of Traumatic Stress* 27(4) August 2014). Both group treatments consisted of 12 90-minute sessions. Findings indicated significant reductions in PTSD severity for both conditions. A significant reduction in depression was observed in CPT-C participants only. Without a no-treatment comparison, however, it could not be known whether significant PTSD reductions were the result of treatment or other factors. For instance, such as the passage of time or nonspecific group support might influence the improvement (PTSD Research Quarterly Vol. 27/No 2 Issn: 1050-1835, 2016). All *PTSD Research Quarterly* publications are available at ptsd.va.gov.

The sensation of spending time with comrades who lived through similar experiences as one's own would surely be uplifting for the individual experiencing it. Is it perhaps somewhat extraordinary or abnormal, even paranormal, to leave this more or less unrecognized and unacknowledged? Does it seem abnormal to leave unrecognized and certainly unconsidered for future use that these indeed had been the catalyst for the improvement? Could the ignorance towards it perhaps even indicate that signs of PTSD recuperation and their pursuit are non-desirable to those running the PTSD research show? Let's investigate, shall we?

Sloan is a psychologist and associate director in the Behavioral Science Division of the National Center for PTSD. She is also a professor of psychiatry at Boston University School of Medicine. Her research expertise is in psychosocial treatments for PTSD and emotion in psychopathology. She has received funding for her research from organizations such as the National Institute for Mental Health and the Department of Veterans Affairs.

She is also member of several editorial boards, among them the *Behavior Therapy*, *Behaviour Research and Therapy* and the *Journal of Abnormal Psychology*. *Behavior Therapy* is an international journal devoted to applying the behavioral and cognitive sciences to the conceptualization, assessment and treatment of psychopathology and

related clinical problems. Published six times annually, it is a vehicle for scientist-practitioners and clinical scientists from all related disciplines to report the results of their original empirical research. Although major emphasis is placed on empirical research, it also publishes methodological and theoretical papers, as well as evaluative reviews of the literature. Controlled single-case designs and clinical replication series are welcomed, as well.

The *Behaviour Research and Therapy* journal takes an experimental psychopathology approach to understanding emotional and behavioral disorders. They look at their prevention and treatment using cognitive, behavioural, psychophysiological and neural methods and models. This includes laboratory-based experimental studies with healthy at-risk and subclinical people that inform clinical application. It also includes studies with clinically severe samples. The following types of submissions are encouraged:

- theoretical reviews of mechanisms that contribute to psychopathology and that offer new treatment targets
- tests of novel, mechanistically focused psychological interventions, especially ones that include theory-driven or experimentally-derived predictors, moderators and mediators
- innovations disseminating and implementing evidence-based practices into clinical practice in psychology and associated fields, especially those that target underlying mechanisms or focus on novel approaches to treatment delivery

In addition to traditional psychological disorders, the scope of the journal includes behavioural medicine such as chronic pain.

The journal will not consider manuscripts dealing primarily with measurement, psychometric analyses and personality assessment. Its Editor-in-Chief, Michelle G. Craske, (1959–) is a professor of psychology, psychiatry, and biobehavioral sciences at the University of California, Los Angeles. She is known for her research on anxiety disorders, including phobia and panic disorder, and the use of fear extinction through exposure therapy as treatment. Her other research focuses on anxiety and depression in childhood and adolescence and the use of cognitive behavioral therapy as treatment. Craske served as the past president of the Association for Behavioral and Cognitive Therapy. She was a member of the DSM-IV work group on anxiety disorders. She also served on the DSM-5 work group on

anxiety, obsessive compulsive spectrum, posttraumatic, and dissociative disorders while chairing the sub-work group on anxiety disorders. Editors and associate editors of any journal decide whether or not submissions fall within the scope of its publication or are of sufficient merit and importance to warrant a full review by the editorial board.

As noted, Sloan is also on the editorial board of the peer-reviewed *Journal of Abnormal Psychology,* published eight times annually beginning in January. The journal has been in publication for 110 years and is considered to be a preeminent outlet for research in psychopathology. To be all on the same page, psychopathology is purported to be the scientific study of mental disorders. It includes the efforts to:

- investigate potentially effective treatments
- more fully understand the manifestations of mental disorders
- understand their genetic, biological, psychological and social causes
- understand the course of psychiatric illnesses across all stages of development
- develop classification schemes (nosology) which can improve treatment planning and treatment outcomes

At least conceptually, psychopathology is a subset of pathology, which is the ". . . scientific study of the nature of disease and its causes, processes, development, and consequences." (*American Heritage Dictionary of the English Language (6th ed.). Houghton Mifflin Harcourt. 2016.)*

The *Journal of Abnormal Psychology* exclaims to focus on the following major areas:

1. Psychopathology (etiology, development, symptomatology, and the course)
2. Normal processes in abnormal disorders
3. Pathological or atypical features of behavior of normal individuals
4. Experimental studies (with human or animal subjects) relating to the abnormal emotional behavior or pathology
5. Sociocultural effects on pathological processes (gender, ethnicity)
6. Tests of hypotheses from psychological theories that relate to abnormal behavior

But then, what indeed does abnormal psychology mean? Purportedly, it is a

division of psychology that studies people considered "abnormal" or "atypical" compared to the members of any given society. The definition of the word abnormal, however, in itself is rather complex, as it depends largely on who determines what is normal? Like psychology itself, the concept of abnormality is thus as imprecise and difficult to define as the concept of psychology itself. Examples of abnormality can take many different forms and involve many different features. At first sight, this might seem quite reasonable, but turns out to be quite problematic on closer examination. PTSD is a prime example.

Abnormal psychology thus involves the study of what whoever decides are unusual patterns of behaviour, emotions and thought precipitating mental disorders. The field of abnormal psychology attempts to identify multiple causes for different conditions viewed as abnormal. It uses diverse theories from the general field of psychology and elsewhere to prove its points.

But first and foremost is to determine what exactly is meant by "abnormal". Traditionally, there has been a divide between psychological and biological explanations reflected in the philosophical dualism in regard to the mind-body problem.

This philosophical problem concerns the relationship between thought and consciousness in the human mind and the brain as part of the physical body. Attempts to solve this perceived problem dates back millennia. The Buddha (480–400 B .C.E) already tangoed with it, so did the Greek philosopher of Athens Socrates (469–399 B.C.), generally regarded as one of the wisest people of all time. He himself left no writings, but his most famous pupil Plato (427–347 B.C.) widely discussed the mind-body problem most likely reflecting Socrates' sentiments on the topic. Descartes, Kant, Jung, Freud, Unamumo, Popper and Allan Watts are other prominent philosophers to discuss it, too. Watts in *The Book: On the Taboo Against Knowing Who You Are* (Random House Inc., 1966) states, as all the others did before him, that:

> "At the root of human conflict is our fundamental misunderstanding of who we are. The illusion that we are isolated beings, unconnected to the rest of the universe, has led us to view the "outside" world with hostility, and has fuelled our misuse of technology and our violent and hostile subjugation of the natural world."

He might have added, "and of each other," as indeed is being done by mental health practitioners of all genres worldwide. Watts provides a way to absolve the

problem of personal identity by distilling and adapting the ancient Hindu philosophy of Vedanta to help understand that the Self is in fact the root and ground of the universe and nothing else. His revelatory work is an eye-opener and a mind-opener on what it means to be human and, some opine, a manual of initiation into the central mystery of existence.

In gallops the American Rhodes scholar and philosopher John Roger Searle (1932–), currently Willis S. and Marion Slusser Professor Emeritus of the Philosophy of Mind and Language and professor of the Graduate School at the University of California, Berkeley. He takes the price on the human psyche and behavior question, when recently declaring that the mind-body problem is a false dichotomy, a false dilemma. He says it occurs when an argument presents two options, ignoring either one purposefully, other alternatives or out of ignorance.

Searle's other alternative is his joyous observation that the mind is a perfectly ordinary aspect of the brain. To him there is no more a mind-body problem than there is a macro-microeconomics problem. But Searle is said to be careful to maintain that the mental — the domain of qualitative experience and understanding — is autonomous and has no counterpart on the micro-level. Any re-description of these macroscopic features amounts to a kind of evisceration (*Joshua Rust (2009)*. John Searle. *Continuum International Publishing Group.* pp. 27–28).

And what does that mean? To eviscerate means to remove the entrails of a creature. A vulture eviscerates — takes out — the guts of a dead animal, the word itself originating from the Latin eviscerates, "to disembowel." Does Searle's parable-like opinion on the human's brain and mind perhaps signal that the profession's intent is to disembowel human beings. Is the intent perhaps, to eviscerate all aspects of innate humane characteristics and qualities, such as compassion and empathy, love and caring for Self and others, from their minds and or brains?

Are psychiatrists and psychologists together with the world's neuroscientists already eviscerating as abnormal everything outside of Searle's brain and mind paradigm? Are the mental health practices' mental health concoctions, including PTSD treatment modalities, becoming the new gospel for "normal" human behaviour, a behaviour generated by brain without conscious awareness?

If that is so, what of the findings of Billy Carson, Nassim Harameins and others in their fields? What of their research stating that the universe seems to be consciousness, pure consciousness, nothing but consciousness? What of their findings that consciousness is the only thing really existing throughout the universe?, All that must either be steer manure or Searle et al. are ignoring the

essence of life itself. If everything we see or hear or feel or touch or sense is an illusion originating in our own heads, where does it leave Serle et al.? If our own human consciousness can indeed change matter by changing our own thinking, where does that leave their abnormal versus normal or paranormal ways of thought reminding us most oftentimes of delusional and deranged imaginations? David Icke's latest book *Everything You Need To Know But Have never Been Told* (David Icke Books, College business Centre, Derby, DE223Wz, UK, 2017) is highly recommended to to broaden their horizon or even inspire a change in perception.

Spending 27 minutes listening to GAIA's Billy Carson: *You Might Question Everything After Watching This* (2018–2019, YouTube) might also serve as an awakening and a perception-changer. So could insight into the long history of laboratory experiences presenting scientific, empirical, first evidence. This is documented in Dean Radin's classic, *The Conscious Universe: The Scientific Truth of Psychic Phenomena* (HarperCollins, 1997).

For genuinely PTSD-afflicted humans the change of perception is forced upon us by the PTSD-causing experience. If we refuse to take the opportunity to educate the Self on why, what, who, how and where we really are, we will indeed linger in limbo while dying a slow and tedious death. Note the hundreds of thousands who are made to unwittingly decline the inquest into themselves through the means forced upon them by the VA, the NC for PTSD, and the Department of Defense. Their means and ways to treat PTSD reverberate world-wide. The results mirrored by the PTSD wrecks on the streets or, if they are fortunate, on the world's Norwegian Stars or Puerto Vallarta's hotels.

Searle's posturing about the human brain ruling the human being in its entirety thus bodes rather unwell for the human population; all hitherto considered normal in the species will soon be considered an abnormality. But how and what should be considered normal to begin with?

Normal. What is normal and how does it affect society and curriculum asked David Dalton in a 2014 Curriculum Theory Project. The Project provides a digital place where educators and graduate students can converse, contribute and showcase ongoing provincial, national and transnational curriculum theory projects. The question of what is what and what is not normal had bothered him for quite a while, he writes. Being of a mathematical mind, he looked for a solidly understood definition of the term, giving the concept great thought. But the question "What is normal?" remained. In Dalton's view, the answer to the question depends on what situation is talked about. For instance, he says, in mathematics and physics the

definition of normal is "perpendicular; especially perpendicular to a tangent at a point of tangency," and in psychology it can mean "free from mental disorder" (Merriam-Websters Dictionary). Thus in these contexts, the term is clearly defined.

In a "society" context, the definition is a little more complicated. According to the Merriam-Webster's Dictionary, normal is "according with, constituting, or not deviating from a norm, rule, or principle", "conforming to a type, standard, or regular pattern", or "occurring naturally." Each of these definitions can lead to different (and contradictory) interpretations of what normal could really mean.

The *first* two of those definitions imply conformity to set guidelines established by whoever sets the rules/principles. In our society, the individuals who make the rules are those in power or in control of the direction of society. This means we have a group of people who set the direction of what is "normal." Just for a moment here, Dalton suggests, think about what would be "normal" if different people were in power. It might be "normal" to have blue hair or to walk on all fours or for children to pilot space ships. From this definition, "normal" is something that can be dictated by a group of people, and is set to change as the people in charge change. This means the definition of "normal" changes as situations change. This also implies that "normal" means different things to different groups of people, depending on the rules of the group.

The third of the above noted definitions is different from the others and in some ways contradictory. The definition in question states that normal means to "occur naturally". This implies a number of things, Dalton observes, such that anything that occurs naturally is normal. Normal in this definition is much less restrictive, indicating the only thing that is not normal is something that is unnatural. Normal behaviour is simply behaviour that we feel is natural. This could be something as simple as saying "breathing is normal because it is natural" or "living in a house is normal because it feels natural". These things are straightforward. It means our human nature defines what is normal. This can, however, become misinterpreted. People could argue a number of things, including that it is human nature to kill those who oppose us, as animals often fight to the death when in conflict, as humans are really just animals, for example. It could also be argued that using a computer is abnormal, because computers are not natural. The third definition therefore is a dangerous definition, as the interpretation of what is natural depends on who is doing the interpretation.

Furthermore, the definitions contradict each other as the first definitions states that "normal" is conforming to a set of rules, whereas the third states it is something

occurring naturally. That is all fine, if the definitions and rules state precisely what is considered to occur naturally, like gravity, say. The problem comes into play when people in control of others, the ruling class in the field, decide and set rules on what is and is not naturally occurring. Consider the following situation: A rule that states doing something natural is wrong. Following the rule is normal, by the first definition, but not following the rule is also normal by the third definition. Both actions are contradictory, so both actions are "against the normal", but yet both actions can be considered normal by the definitions above. Both thus mutually exclude each other. This is at the center of the confusion surrounding the term "normal." Says Dalton:

> "At many points in my life, the pressures to be "normal" have dictated what I have done. As I look back I feel these pressures forced me to take the longer path to get to where I am now. I got to the point where I am today by eventually forgetting about and ignoring the pressures to feel normal. As I grew up, I reached a point in my life where it became much less important to fit in and be normal, and much more about being myself. I realized it was much more important to become who I wanted to be, not what society wanted me to be, and not what was "normal". I am now at the point in my life that I accept and encourage that "normal" is not always best for people. As a teacher I live my life and teach my students that it is alright to not fit in with what society's "normal". I like to show my students that it is much more important to be doing something that you enjoy and being who you want to be rather than doing and being who society (and other people) would prefer. It is perfectly acceptable (and encouraged in my mind) for students to live and be "not normal". I encourage my students to take the road less travelled, to not give into the pressures of society, and to become who they want to become, not who society wants them to become."

If we cannot define what "normal" is without contradicting ourselves, Dalton asks how we can possibly know what it means to be normal? Well, mental health practitioners certainly crave and usurp the right to do so over humanity, which in itself is a manifestation of abnormality, in my view. Never mind thinking of

paranormal experiences, in league with a PTSD-causing event, such as Jon Rappoport dwells on in his September 27, 2018, article "The taboo against paranormal experience is a taboo against freedom".

Rappoport claimed that 20th-century life was shaping up in a world of National Security States. It was all about citizen behaviorism, repression, operant conditioning and various forms of mind control. He said it was in essence aimed at curtailing human freedom to experience whatever might lie beyond the prescriptions and slogans of governments, the experiences judged to be abnormal by the American Psychological Association *Journal of Abnormal Psychology* editors.

But what indeed does exists outside the psychic human prison, he asks. This prison is defined by rabid consumerism, limited and false science, pressure from peers to accept idealized and cartoonish middle-class imagery without question, without deviation.

The truth is, paranormal experiences are everywhere, and people have them. The experiences exceed the ordinary boundaries of material reality, such as the PTSD journey. They tend to lead to a new view about life, and they certainly go beyond societal tenets about what one is supposed to know and feel, says Rappoport. This acknowledges the limits to what the vast majority of mental health practitioners, in their infinite blindness, can perceive.

And yes, the waters are muddied by people who feel compelled to chime in and report experiences they only wish they had, hoping for badges of honor, Rappoport asserts. In certain respects, this is in fact a prison planet. Through upbringing, education, peer pressure, training, indoctrination and propaganda, citizens are expected to maintain "normal status." People gratuitously condition themselves, with the goal of fitting in. As Shakespeare mentioned: "It's a grand stage play, and one picks a role and lives it out." Which role to pick then, in the PTSD situation? Victim or Conqueror in this APA created inversion, this new paradigm of normal, abnormal and paranormal? To gain mastery over and win by overcoming the massive obstacles and opposition to ones healing by mental and moral power, discipline, willpower, determination and persistency? Or take the easy way out by caving in to destruction and mayhem created by powers that be?

Like paranormal experiences, anything psychological can, Rappoport says, only be overridden when something happens if you admit it to yourself that everything has changed. This is what happens to the genuinely PTSD experiencer, not the hangnail variety. This is the blessing or the curse of PTSD. What then? Do you continue to obey and subscribe to what your lord and masters dictate? Or do you

awaken to the fact that something truly extraordinary and abnormal, has occurred in your life and that you must face up to it or perish in your own misery? Do you confess to yourself that the true normal is actually paranormal?

Do you tighten your grip on the card that identifies you as a citizen of the realm? Or do you drop it in the wastebasket saying, "Screw you. I'll do my own, humane and human thing?"

Do you cling to the old? Or do you opt for possibilities wider than you previously imagined and trade in all your chips on a new life? Do you have the guts, or are you happy in your state of mind dictated to you from the cradle until this blessed moment of your perception change, your awakening, if you dare to accept it?

The taboo against the non-ordinary is as old as the hills, in Rappoport's opinion. In many cases, the establishment was a state religion and the priest-class labeled paranormal experiences heretical witchery. Why? Because, of course, free consciousness unburdened of church doctrine was a threat to priestly power, nowadays the mental health practitioners' power.

Modern science, with ridicule as its primary modus operandi, attacks the paranormal because it cuts too close to home. It tends to expose what science cannot explain, landing their empirical, scientific evidence dead in the water.

Take freedom, for example, suggests Rappoport. Like "normal" or "abnormal", nowhere in the lexicon of conventional physics is there room for such a concept as freedom. The predetermined and inexorable flow of tiny particles is assumed to be everywhere at all times, even in the composition of the brain. Therefore, all thought, feeling and action stemming from the brain are predetermined and inexorable as well. Thus, there is no freedom. The absurdity of this notion is plain to anyone who can think, he claims. He explains that

if the human brain and the human body are just another collection of sub-atomic particles, as suggested indirectly by Serle, then the capacity to make a free and independent choice about anything is null and void. Free choice would exist only if the entity doing the choosing, YOU, is beyond those particles, beyond matter and energy.

It takes a considerable amount of indoctrination and mind control not to recognize this fact.

The notion that various key political documents established freedom is extremely shortsighted. Heroic though the efforts were, they only purported to uncover what was already there in a natural state. But the human natural state is anything but normal, claims Rappoport. It speaks of the human ability to move out

of the chain of cause and effect and make choices, changing lives, thus changing futures.

Mind you, for most people most of the time, the sense of their own freedom is a rather dull given. There is nothing thrilling about it. They choose A or B within a grossly limited context and call it freedom. This fact alone is an indication that a monitor has been tightly placed on their own life-experience and emotions. But this cover could be blown by a miracle like the PTSD-causing event transformation. Then, if allowed to recuperate in a "natural way", they would know what freedom is and is supposed to be, leading to the most natural kind of ecstasy in the world.

Be it as it may, normal, abnormal or paranormal, it takes a conscious effort to control one's thoughts to obtain and attain the guts, gumption and consequently power to run one's own life. In many, that alone seems to inspire the fear factor. This, in turn, means giving one's power to those seemingly intent on destroying human beings rather than helping them live healthy and successful lives. Such is viewed in the treatment of genuinely PTSD-affected human beings.

The question at this very minute is why Sloan and Co-author Gayle Beck are merely documenting for untold amounts of money if or if not CBT group therapy works better for PTS affected than single treatment. Why do they refuse to acknowledge the most eminent of all humanity's substance, its infinite consciousness and awareness as empirical and scientifically proven beyond a shadow of a doubt? Should this lack of investigation and acknowledgment perhaps be considered rather abnormal, nay even paranormal, beyond normal?

As it stands right now, all judgments of the human psyche with all its delightful quirks, nooks and crannies are tightly bound up and controlled, normal, abnormal and paranormal. They are controlled by "them," the Serles, Neumeisters, Sloans and Becks of North America, if not he world. Nothing of their life-journeys from cradle to present was accessible to me. Only that Beck appears to have a much more low-keyed position with the Department of Psychology, University at Memphis, her research interests spanning from adult anxiety disorders to PTSD treatment development and experimental psychopathology.

As to Barber & Sharpless' investigation of most favourable PTSD treatment modalities their summary by and large concurres with Sloan & Beck They agree that Cognitive Behavioural Group Therapy (CBT) & Trauma-focused Group Treatment for PTSD needed further investigation. They also agree that PTSD psychotherapies that had undergone the most empirical testing, the PE, CPT and EMDR, had the most evidence of efficacy and utility. A need for larger comparative PTSD trial

studies involving combat veterans were needed to find "the cure." B & S also informed us that Acceptance and Commitment Therapy (ACT) and individual mindfulness techniques were excluded from their review, as no empirical study samples of those approaches were available. But what is ACT?

ACCEPTANCE AND COMMITMENT THERAPY (ACT)

While many people maintain a strong interest in psychoanalysis, the movement has slowed dramatically. In the United States, only a relatively small percentage of therapists are said to engage in psychoanalysis as their primary mode of treatment. Most adopt contemporary approaches to psychoanalysis that have modified Freud's version in obvious ways. For example, brief, time-limited versions of psychoanalysis are becoming more popular, and the therapeutic relationship tends to be more interactive, according to goodtherapy.org. More emphasis is also placed on current problems rather than early childhood experiences, we are told. In other words, most psychoanalysis has been overtaken in popularity by other approaches, although it is still considered a valid form of treatment for most anxiety and personality issues. The Acceptance and commitment therapy (ACT), typically pronounced as "act", is one of them.

A branch of clinical behavior analysis, it is, purportedly, an empirically-based psychological intervention that uses acceptance and mindfulness strategies mixed in different ways with commitment and behavior-change strategies to increase psychological flexibility.

Steven C. Hayes (1948–) developed Acceptance and Commitment Therapy in 1982. He wanted to create a mixed approach, which integrates both cognitive and behavioral therapy. Hitherto Western psychology had typically operated under the "healthy normality" assumption. This states that humans, by their nature, are psychologically healthy. With ACT, Hayes rather assumes that psychological processes of a normal human mind are often destructive.

Mind you, Hayes also seems to believe that human beings created this world. He thinks that human beings ought to adapt to it, namely to create modern human minds for this modern world (Dr. Steven Hayes on ACT, OCD and living a meaningful life; Ep. 4 2016). For him, to learn to control the mind, to put it on a leash, as he puts it, is beyond humans' control. It's an impossibility. The arrogance of the human mind is what interferes with a person gaining control over the mind. That there is no scientific empirical first evidence that the human mind exists in the brain or in the body anywhere is apparently inconsequential.

Hayes received his Ph.D. in clinical psychology from West Virginia University in 1977. He is a Nevada Foundation professor and chair of the Reno Department of Psychology at the University of Nevada. His interests cover basic research, applied research, methodology and philosophy of science. He maintains an active laboratory focused on language pragmatics and semantic relations. His recent applied research has focused on the analysis of emotional acceptance methods in psychotherapy, where he has a million dollar grant to assess their impact on drug abusers. In 1992, the Institute for Scientific Information and the American Psychological Society listed him as the 30th "highest impact" psychologist in the world during 1986–1990. This was based on the citation impact of his writings.

He has also played key roles in starting two scientific societies:

- the American Psychological Society
- the American Association of Applied and Preventive Psychology

Hayes is Past-President of the APA's Division 25 (behaviour analysis) and of the American Association of Applied and Preventive Psychology. He is president of the Association for Advancement of Behaviour Therapy. He is also co-organizer and co-chair of the Practice Guidelines Coalition. This national effort brings together over 600,000 professionals and insurance companies covering nearly half the nation's population. Their partnership is trying to develop empirically-based clinical practice guidelines.

Other than knowing he spent his first 29 years in educational pursuit, nothing of his private life seems to be known. Be it as it may, we can surmise something rattling him mightily in those 29 years. Otherwise he would be in a different line of life-occupation.

At the University of Nevada, he runs the leading Ph.D. program in behavior analysis. He coined the term clinical behavior analysis, also called third-generation behavior therapy, the clinical application of behavior analysis (ABA).

But what were the first two generations or waves of behaviour therapy?

As such, all three of them became popular with the dominant psychoanalytical model of the early 20th century, developed mostly from the clinical interactions of Freud and his patients.

The very first wave of basic behavior therapy emerged from the experimental psychology of John Broadus Watson (1878–1958). This American psychologist established the psychological school of behaviourism. He promoted a change in

psychology through his address *Psychology as the Behaviorist Views,* given at Columbia University in 1913. (Hooper N., Larsson A. (2015) *The Three Waves. In: The Research Journey of Acceptance and Commitment Therapy* (ACT). Palgrave Macmillan, London).

Watson had come into contact with Pavlov's dog and pony show experiments. At first, he believed that Pavlov's results were more physiological than psychological. In fact, he viewed psychology as "a purely directive experimental branch of natural science." Nevertheless, he began to use Pavlov's experimental conditions in his work in the USA (Watson, 1913, p. 158). Richard F. Rakos, professor of psychology and associate dean for faculty in the College of Sciences and Health Professions at Cleveland State University addressed this. His "Behaviorist Manifesto: Setting the Stage for behaviourism's social action legacy (rmac-mx.org Publicado: Miércoles, Enero 15th, 2014 at 5:20 AM | Categoría: Vol. 39, No. 2 Número monográfico (2013)) explains in the abstract:

> "John B. Watson's 1913 article 'Psychology as the Behaviorist Views It' is widely known as the 'behaviorist manifesto' that initiated behaviorism as a discipline and academic field of study. While the intent of the paper was to present behaviorism as psychology's path to becoming a natural science, Watson also insisted that empirical data and principles generated by such a natural science must be applied to solving human and social problems if the science was to have substantial meaning and validity. He suggested several areas of social interest (education, medicine, law, business) that were ripe for an application of behavioral principles. In subsequent writings over the next decade, Watson expanded his focus on social problems and their behavioral remedies, culminating in his 1924 book Behaviorism, which aggressively confronted the eugenic fervor sweeping the United States during the first quarter of the century by espousing an extreme and at times polemical environmentalism. Watson's environmentalism and advocacy of social interventions reflected his comfort with the Progressive ideology of the time — a heritage that embodied Skinner's work and the rise of operant interventions in the 1960s, and now is found in the work of the many contemporary behavior analysts who are applying scientific principles to increasingly complex social

problems."

Watson's manifest, apparently, was much debated over time (Barrett, 2012). The predominant interpretation was that he refused to allow any information not available to the outside observer to be used in psychology. His notion and reasoning was that psychology should look at covert behavior, not bother itself with introspection and the experience of consciousness (Watson, 1913). Watson's importance in behavior therapy is twofold. First was his initial formulation of behaviorism. And second was his experiment with "Little Albert", a nine-month-old child, who was experimentally conditioned to fear a white rat ("*CONDITIONED EMOTIONAL REACTIONS"* By John B. Watson and Rosalie Rayner (1920). First published in *Journal of Experimental Psychology*, *3*(1), 1–14.).

The experiment was criticized both for ethical concerns and methodological flaws. But it had clear implications for the development of psychopathology. It could be explained by principles of classical conditioning, which could be undone by developing means to help clients shed unhelpful associations.

In galloped South African psychiatrist Wolpe and his systematic desensitization idea, based on the classical Pavlovian and Skinnerian conditioning paradigm. Said to be so eminently successful in the treatment of his South African PTSD-affected soldier patients, it was still used by NorAm's psychiatrist in the late 1980s. It did SFA for me, but then, I wasn't a soldier. But Watson surely set the course, as Rattus and Cani cognitive behavioral theories and treatment modalities are still fervently applied to humans in emotional distress, including the PTSD affected. The carrot and the stick are applied wherever we look, if we care or dare to look.

From this first purely behavioral psychotherapy theme wave, evolved the so-called psycho-social intervention. This second wave was termed cognitive-behavioral therapy (CBT), purportedly aimed at improving humans' mental health. In other words, now the human mind was being involved, as cognition and cognitive means relating to or involving the processes of thinking and reasoning. CBT, if effective, is done in relationship and cooperation with a good clinical psychologist and requires real work on the patient's part. It proclaims to focus on challenging and changing cognitive distortions. Or should we call it perception-deceptions, in thoughts, beliefs, attitudes and behaviors? It purports to improve their emotional regulation, and develop personal coping strategies, solving current problems. The decision-makers about what constitutes human warpedness in thoughts and views are, of course, the treating clinicians.

Look at the Russian writer Alexander Solzhenitsyn's (1918–2008) work for

further information on the topic. He writes from his own experiences with the powers that be, making such decisions in particular in "The Cancer Ward." He not only fought in World War II, but also was arrested for criticizing Joseph Stalin, and spent 11 years in labor camps and exile. He has a good idea what is played in the mental health field. He was awarded the Nobel Prize for Literature in 1970 and the Russian State Prize in 2007 for his sufferings.

But what is emotional regulation in psych-jargon?

It is the ability to respond to life events with emotions socially tolerable and sufficiently flexible to permit spontaneous reactions. It is also the ability to delay spontaneous reactions, we read in the official translation of the expression on the web. Road-rage, thus, is out; self-control and constraint are in. Both our external and internal processes are, of course, responsible for monitoring, evaluating and modifying our emotional reactions at any given time.

Therefore, observing our thoughts like hawks comes in handy. It is especially handy when in the PTSD situation, where flying off the handle and losing emotional self-regulation, and thus control over the Self, can very fast become second nature. All this falls under the category of cognitive behavior, behavior generated by our thinking and ability to emotionally regulate it so as to avoid running ourselves into losing control.

Originally, however, CBT was merely designed to treat depression. But with time, and most likely the discovery of how lucrative it would be to the mental health practice, its use expanded. It began to include treatment of a slew of purportedly mental health conditions, including anxiety and PTSD. With the DSM-5, it now has reached hitherto unknown and most likely unexpected heights. We, the human being of this Earth, have been declared through and through sick people, mentally impaired from the get go, as wit by the ACT premise. But, because it is based on the combination of behavioral and cognitive psychology principles, CBT therapy has been termed the second wave, and ACT the third one.

Why? Because it contains the mindfulness-based therapies.

And what's that?

Mindfulness approaches have their roots in ancient Buddhist traditions such as Vipassana and Zen meditations. These are almost a given in any East Asian culture. In the West, however, there at present seems to be a void for the concept, no specific definition. The term, just as PTSD, seems to prove difficult to define due to:

- differing beliefs of what exactly mindfulness is

- varied views about the purpose of mindfulness
- differing opinions on how to achieve mindfulness
- the challenge of describing the concept using medical and psychological terminology

Mindfulness can be fundamentally understood as the state in which one becomes more aware of one's physical, mental and emotional condition in the present moment without becoming judgmental. People may be able to pay attention to a variety of experiences, such as bodily sensations, cognitions and feelings, and accept them without being influenced by them. Mindfulness practices are believed to be able to help people better control their thoughts, rather than be controlled by them.

CBT methods can collaborate with East Asian psychological strategies, such as mindfulness meditation. When they do, the focus is on becoming aware of all incoming thoughts and feelings and accepting them, but not attacking or reacting to them. This process, known as "decentering", is said to aid in disengaging from self-criticism, rumination and dysphoric moods that can arise when reacting to negative thinking patterns, we read (Hayes, Steven C.; Villatte, Matthieu; Levin, Michael; Hildebrandt, Mikaela (2011-01-01), "Open, Aware, and Active: Contextual Approaches as an Emerging Trend in the Behavioral and Cognitive Therapies". *Annual Review of Clinical Psychology*. 7 (1): 141–168.)

Mind you, in the Western world, mindfulness-based interventions such as yoga and meditation are becoming widely accepted to address symptoms of mental health challenges and emotional concerns. I have practiced meditation and yoga for over 30 years. I am certain that without it, I would have been dead a long time ago. In America, the following four recognized mental health therapy models incorporating mindfulness practices are:

Mindfulness-based stress reduction program. In the 1970s, Jon Kabat-Zinn, founded the mindfulness-based stress reduction program. He was one of the first people to try to integrate Buddhist principles of mindfulness into his work in science and medicine.

- DBT. Also in the 1970s, Marsha Linehan developed DBT with the aid of certain Western and Eastern spiritual influences.
- ACT. This was introduced in the late 1980s by Steven Hayes, Kelly Wilson and Kirk Strosahl, also incorporating Eastern ideas and

techniques.
- MBCT. At the beginning of the 21st century, Zindel Segal, Mark Williams and John Teasdale built upon Kabat-Zinn's work to develop MBCT.

Though these approaches all involve mindfulness techniques, there are slight differences between each modality. MBSR and MBCT actively teach mindfulness meditation, but MBCT also integrates cognitive behavioral therapy techniques as a part of treatment. DBT and ACT do not teach mindfulness mediation, but instead use other mindfulness exercises to promote awareness and focus attention. Additionally, while MBSR and MBCT focus on the process of developing mindfulness, as well as any associated thoughts, DBT and ACT focus primarily on the cognitions experienced during the state of mindfulness. But never mind. We will detail this line of ideas a bit later and focus on Hayes' ACT for the moment.

These are commonly grouped under "third wave of cognitive behaviour therapy":

- dialectical behavior therapy (DBT)
- functional analytic psychotherapy (FAP)
- acceptance and commitment therapy (ACT)
- mindfulness-based cognitive therapy (MBCT)
- other acceptance- and mindfulness-based approaches

They are different from the historical psychoanalytic CBT approach. Historically, the therapist looked for the unconscious meaning behind behaviours, then made a diagnosis and tailored the therapy to it. The second wave is based on the belief that thought distortions and maladaptive behaviours played a role in developing and maintaining psychological disorders like PTSD. For example, they would play a role in the "you were defective from birth" theme. And they might play a role in the "we can fix you or reduce your symptoms and associated distress by teaching you new information-processing skills and coping mechanisms to mould you after our idea of you" theme. This is the Pavlov-Skinner-cani-rattus model of treatment. And the above third wave treatments modalities are nowadays used to treat specific problems related to a diagnosed mental disorder a la the DSM-5. Still you are viewed as equal to rattus and cani. Though, if the bright cockroaches could be educated to their liking, they'd throw them in for good measure. But then, what

truly is behavior analysis?

Behavior analysis and therapy is a broad term referring to clinical psychotherapy using techniques derived from behaviorism. That is the theory that human and animal behaviour can be explained in terms of conditioning. Such conditioning would be without appeal to thoughts or feelings, and with the conviction that psychological disorders are best treated by altering subjects' behaviour patterns. According to the Association for Behavior Analysis International (ABAI) 2018 website, behavior analysis is a natural science, as Watson wanted it to be. It seeks to understand human behavior, rather than accepting and having a good time with it, when expressing:

> "That is, behavior analysts study how biological, pharmacological and experiential factors influence the behavior of humans and nonhuman animals. Recognizing that behavior is something that individuals do, behavior analysts place special emphasis on studying factors that reliably influence the behavior of individuals, an emphasis that works well when the goal is to acquire adaptive behavior or ameliorate problem behavior. The science of behavior analysis has made discoveries that have proven useful in addressing socially important behavior such as drug taking, healthy eating, workplace safety, education, and the treatment of pervasive developmental disabilities" (abainternational.org).

Note again that the ABAI also equates humans with animals, like rattus and cani, and to be experimented on and drugged at leisure. Rings a bell within you, PTSD journeyers? Note also that ACT freely admits to be based on the Pavlovian and Skinnerian philosophy of the radical behaviourism premise. ABAI prides itself on being the primary membership organization for those interested in the philosophy, science, application and teaching of behavior analysis since 1974. As a matter of fact, it considers itself the home of the science and practice of the behavior analysis craft.

Those who practice behavior therapy look at specific purportedly learned behaviors and how the environment influences them. Behavior therapy spans a wide range of techniques that presumably can be used to treat human beings' psychological problems. We can see it in PTSD treatment modalities, where everything, including the kitchen sink, is thrown in to "heal" it. "Qui bono," of course, is the question to ask. We know the answer.

Behavioural treatment outcomes are presumably objectively measurable. After all, it is called a natural science, so it must be measurable and empirically validated and substantiated with first evidence, right? That fundamental aspects of behavior therapy have been identified in various ancient philosophical traditions, particularly stoicism, is swept under the carpet. As Donald Robertson in his 2010 book *The Philosophy of Cognitive-behavioural Therapy (CBT): Stoic Philosophy as Rational and Cognitive Psychotherapy* (Karnac Books, 2010) exclaims:

> "Why should modern psychotherapists be interested in philosophy, especially ancient philosophy? Why should philosophers be interested in psychotherapy? There is a sense of mutual attraction between what are today two thoroughly distinct disciplines. However, arguably it was not always the case that they were distinct."

No. It is the "need to know" concept at work, the compartmentalization, so human beings never find out who they really are and whence they came. By reconsidering the generally received wisdom on the history of these closely related subjects, we certainly would learn a great deal about both philosophy and psychotherapy, Robertson ventures to opine. As a matter of fact, in my view it would spell the end of psychotherapy. Thus it must be suppressed with sheer might.

As to stoicism, it is a school of Hellenistic philosophy founded in Athens, Greece, by Zeno of Citium (334–c. 262 BC), whose teachings were heavily influenced by Socrates. The school taught that virtue was the highest good. Based on knowledge, wise individuals lived in harmony, with divine Rrason, fate and providence governing nature. Stoics learn to react with indifference to vicissitudes of fortune, accepting endurances of pleasure, pain and hardship with little display of feelings and complaint. Their leitmotiv thus is patience, forbearance, resignation, fortitude, endurance, acceptance, tolerance and calmness — emotional self-regulation at its best.

Two other people acknowledged the merit of ancient day psycho-therapeutical knowledge when writing in the 1960s. South African short-term military physician and psychiatrist Joseph Wolpe, to whom we owe systematic desensitization, was one. His peer, the South African-born clinical psychologist and researcher Arnold Allan Lazarus (1932–2013), who specialized in cognitive therapy and is best known for developing the multimodal therapy (MMT), is the other. They wrote:

> "While the modern behavior therapist deliberately applies principles of learning to this therapeutic operations, empirical

> behavior therapy is probably as old as civilization — if we consider civilization as having started when man first did things to further the well-being of other men. From the time that this became a feature of human life there must have been occasions when a man complained of his ills to another who advised or persuaded him of a course of action. In a broad sense, this could be called behavior therapy whenever the behavior itself was conceived as the therapeutic agent. Ancient writings contain innumerable behavioral prescriptions that accord with this broad conception of behavior therapy (Wolpe, J. & Lazarus, A. (1966) *Behavior Therapy Techniques: A Guide to the Treatment of Neuroses*, pp. 1–2).

Lazarus is the first on record to use the term "behaviour therapy". His multimodal therapy (MMT) is based on the idea that humans are biological beings that think, feel, act, sense, imagine and interact. Therefore, in Lazarus' view, their psychological treatment should address each of those human modalities or, rather, sentiments, a fragment of the human psyche at a time rather than the Whole. In that vein the multimodal treatment assessment follows seven reciprocally influential dimensions or modalities of personality, known by the acronym BASIC I.D: behaviour, affect, sensation, imagery, cognition, interpersonal relationships and drugs/biology.

- B represents behavior, which can be manifested through the use of inappropriate acts, habits or gestures, or the lack of appropriate behaviors.
- A stands for affect, which can be seen as the level of negative feelings or emotions one experiences.
- S is sensation, or the negative bodily sensations or physiological symptoms, such as pain, tension, sweat, nausea, quick heartbeat, etc.
- I stands for imagery, which is the existence of negative cognitive images or mental pictures.
- C represents cognition or the degree of negative thoughts, attitudes or beliefs.
- The second I stands for interpersonal relationships, and refers to one's ability to form successful relationships with others. It is based

on social skills and support systems

- D is for drugs and biological functions, and examines the person's physical health, drug use and other lifestyle choices (Dwyer, K. K. (2000). *The Multidimensional Model: Teaching Students to Self-Manage High Communication Apprehension by Self-Selecting Treatments, Communication Education*, 49, 72–81).

MMT presumes that each person is affected in different ways and in different amounts by each dimension of personality, a product of interplay among genetic endowment, physical environment and social learning history. Therefore all reactions are a combination of how the seven dimensions work together in a person. The idea is that the therapist must address one's multiple modalities to successfully identify and treat their mental disorder. Once the problem's source is found, treatment can be used to focus on that specific dimension more than on the others. By the way, classical conditioning, the Pavlovian dog-concept, and operant conditioning, are central MMT concepts (Skinner, 1938). Operant conditioning is the Skinnerian method of learning through rewards and punishments for behavior, to teach people to associate a particular behaviour with a consequence

That clarified, it was in the early 1980s that the second wave's empirical limitations and his personal philosophical misgivings inspired Steven C. Hayes to create his ACT theory. He was 30-something at the time and freshly graduated from West Virginia University. The clinical psychologist is now Nevada Foundation Professor at the University of Nevada, Reno,

The ACT theory modified the focus of abnormal behaviour away from the content or form of it towards the context in which it occurred, he stipulated. His motivation?

ACT research had apparently suggested that many of the emotional defenses humans use to try to solve their mental problems in fact entangled them into greater suffering. It was their rigid ideas about themselves, their lack of focus on what was important in their lives, and their struggle to change their sensations, feelings and thoughts, that were troublesome to them, he opined. All of these only served to distress them further. How he knows is a secret. As usual with these characters, we know nothing about his life from cradle to grave and beyond, other than his academic schooling and accomplishments within the league.

All we know is that Hayes' interests, according to his website, lie in integrating behavioral and biological science and nesting contextual behavioral psychology into

modern evolution science. Nesting? Neumeisterian, AI and human nesting?

But, Hayes maintains, his core conception of ACT is that psychological suffering is indeed caused by three things:

- experiential avoidance
- cognitive entanglement
- their resulting psychological rigidity, which leads to the failure of taking needed behavioural steps in accord with core values

He figures the core of many human problems is represented in the acronym "FEAR". Therefore, cards used as therapeutic activity in ACT treatment read:

- Fusion with your thoughts
- Evaluation of experience
- Avoidance of your experience
- Reason-giving for your behavior

And the healthy alternative according to Hayes is ACT:

- Accept your reactions and be present
- Choose a valued direction
- Take action

ACT is said to differ from traditional cognitive behavioural therapy (CBT). It helps to notice, accept and embrace clients' private events, especially those previously unwanted ones. Traditional CBT, on the other hand, tries to teach clients to control their thoughts, feelings, sensations and memories. ACT thus advocates the "it is what it is" theme, when nothing except for broken bones is ever the way it seems to be.

ACT also claims to help people contact a transcendent sense of self, known as "self-as-context". This self would always be there, observing and experiencing and yet distinct from one's thoughts, feelings, sensations and memories. It also claims to help people clarify their personal values and take action on them. This would bring more vitality and meaning to their lives. And it would increase their psychological flexibility, the ability to adapt to situational demands, balance life demands and commit to certain unclarified behaviors. In Hayes' view, absence thereof predicts

many forms of psychopathology, which manifest in poor general mental health, depression and anxiety.

Six core ACT principles are advocated to develop psychological flexibility:

- **COGNITIVE DEFUSION:** learning methods to reduce the tendency to reify, meaning to give definite content and form to a concept or idea, thoughts, images, emotions and memories.
- **ACCEPTANCE:** allowing unwanted private experiences, in ATC considered to be thoughts, feelings and urges, to come and go without struggling with them.
- **CONTACT WITH THE PRESENT MOMENT:** awareness of the here and now, experienced with openness, interest, receptiveness and mindfulness.
- **THE OBSERVING SELF:** accessing a transcendent sense of self, a continuity of consciousness which [to Hayes] is unchanging.
- **VALUES:** discovering what is most important to oneself.
- **COMMITTED ACTION:** Setting goals according to values and carrying them out responsibly in the service of a meaningful life.

ACT also encourages the pragmatic utility of cultivating a transcendent sense of self — a higher power — within an unconventional, individualized spirituality. Finally, ACT also accepts the paradox that acceptance is a necessary condition for change, and encourages a playful awareness of the limitations of human thinking. Yet again, we see complete ignorance in the latter statement. Humans have infinite thought capacity, strangled only by the earlier mentioned perception-deception. PTSD experiencers are so acutely aware of this. If not, they would never incur PTSD to begin with.

Needless to say, after Hayes introducted ACT in the early 1980s, some of his colleagues chimed in to give their views on his brainstorm. One of them was Brandon A. Gaudiano, Ph.D., of the Department of Psychiatry & Human Behavior, Alpert Medical School of Brown University Psychosocial Research Program, Butler Hospital. He stated in the abstract of his "Evaluating Acceptance and Commitment Therapy: An Analysis of a Recent Critique":

> "Acceptance and commitment therapy (ACT) is a newer psychotherapy that has generated much clinical and research interest in recent years. However, the approach has begun to

> receive strong criticism from proponents of traditional cognitive-behavioral therapy (CBT). Hofmann and Asmundson (2008) recently compared and contrasted ACT and traditional CBT. They concluded that ACT's criticisms of traditional CBT are inaccurate; both ACT and CBT can be understood using a similar theoretical model; and there is no evidence that ACT represents a "third wave" of behavior therapy, as is sometimes claimed by its proponents. In the current article, I further analyze Hofmann and Asmundson's critique of ACT to determine its evidential merit and to attempt to clarify potential points of misunderstanding between CBT and ACT proponents."

By 2009, however, a substantial number of controlled trials investigating the efficacy of acceptance and commitment therapy (ACT) had accumulated. A meta-analysis combined multiple well-controlled studies to help clarify the overall impact of ACT relative to waiting lists, psychological placebos, treatment as usual and established therapies. It showed that the average ACT-treated participant improved more than 66% better than participants in the control conditions. Analyzed separately, ACT was superior to waiting lists and psychological placebos. But findings still concluded that it was not significantly more effective than established treatments. Nor was it superior to control conditions for distress problems, such as anxiety and depression, never mind PTSD.

The conclusion? ACT was more effective than control conditions for several problem domains, but there was no evidence that ACT was more effective than established treatments (Powers MB, Zum Vörde Sive Vörding MB, Emmelkamp PM (2009). "Acceptance and commitment therapy: A meta-analytic review". *Psychotherapy and Psychosomatics*. 78: 73–80).

Nothing is mentioned about pharmaceutical drug consumption by RTC participants.

The controversy in the ranks about the empirical status of ACT and its presumably different characteristics relative to traditional CBT continued. Meanwhile, another enterprising mental health practitioner undertook another meta-analysis with his research grant. This one aimed to shed light on ACT, by conducting a systematic review and meta-analysis of the 16 studies that empirically compared ACT versus CBT outcomes in diverse problems. Suddenly, it showed that mean effect sizes on primary outcomes now significantly favored ACT. However,

mean effect sizes were not significant with anxiety symptoms, though at post-treatment a positive trend for ACT was obtained in depression and quality of life. Overall, ACT seemed to work through its proposed processes of change, but CBT did not (Ruiz, F. J. (2012): "Acceptance and commitment therapy versus traditional cognitive behavioral therapy: A systematic review and meta-analysis of current empirical evidence"; *International Journal of Psychology and Psychological Therapy*. 12 (3): 333–358).

A 2013 paper comparing ACT to cognitive therapy (CT) concluded: "Like CT, ACT cannot yet make strong claims that its unique and theory-driven intervention components are active ingredients in its effects." The authors suggested that many of ACT and CT assumptions were "pre-analytical, and cannot be directly pitted against one another in experimental tests" (Herbert, James D.; Forman, Evan M. (June 2013); "Caution: the differences between CT and ACT may be larger (and smaller) than they appear"; *Behavior Therapy* 44 (2): 218–223).

A meta-analysis by Lars-Göran Öst in 2008 concluded that ACT did not qualify as an "empirically supported treatment". Apparently, the research methodology for ACT was less stringent than for cognitive behavioral therapy, and the mean effect size was moderate. In 2014, Öst published an update entitled "The efficacy of Acceptance and Commitment Therapy: an updated systematic review and meta-analysis" (Behav Res Ther. 2014 Oct; 61:105–21). He concluded again two things about ACT. First, it had attracted lots of interest during the last 10–15 years, with a strong increase in the number of randomized controlled trials (RCTs). Second, it had shown no significant improvement in methodological quality and deterioration on psychiatric disorders, somatic disorders and stress at work, when compared to various forms of cognitive or behavioural treatments. An evidence-based evaluation had shown that ACT was not yet well-established for any disorder, although it was probably efficacious for chronic pain and tinnitus. It was also possibly efficacious for depression, psychotic symptoms, OCD, mixed anxiety, drug abuse and stress at work. For the remaining disorders, Öst termed it "experimental".

He should know. After all, he is one of the most eminent clinical researchers in the field of cognitive behaviour therapy (CBT) and a founder of CBT in Sweden. He recently retired from his position as professor in clinical psychology at Stockholm University. Examples of his innovative and pioneering new treatment methods include the one-session treatment for specific phobias, as well as applied relaxation for a range of anxiety disorders and health conditions (Andersson, G; Holmes, EA; Carlbring, P: Lars-Göran Öst. *Cogn Behav Ther*. 2013; 42(4):260–4).

A few more enterprising others in the field of psychology took a kick at the ACT can, good money in it, and by 2015 ACT's status had risen to an acceptable level. That year, a meta-analysis was made of 39 randomized controlled trials on ACT's efficacy, including 1,821 patients with mental disorders or somatic health problems. It did actually seem to document that it was better than placebo and typical drug-treatment for anxiety disorders, depression and addictions. Its effectiveness was now deemed to be similar to traditional treatments, such as cognitive behavioural therapy treatment modalities (A-Tjak, JG; Davis, ML; Morina, N; Powers, MB; Smits, JA; Emmelkamp, PM (2015): "A Meta-Analysis of the Efficacy of Acceptance and Commitment Therapy for Clinically Relevant Mental and Physical Health Problems"; *Psychother Psychosom* 2015; 84:30–36).

By 2016, the Association for Contextual Behavioural Science (ACBS) claimed that there had been:

- 20 meta-analyses
- 171 randomized controlled ACT trials
- 45 mediational studies of ACT literature

Mediating variables are prominent in psychological theory and research. A mediating variable transmits the effect of an independent variable on a dependent variable (David P. MacKinnon, Amanda J. Fairchild, Matthew S. Fritz: "Mediation Analysis"; *Annu Rev Psychol*. 2007; 58: 593).

Mediational processes are mental (cognitive) factors that intervene in the learning process to determine whether a new behavior is acquired or not. Four mediational processes were proposed by Albert Bandura (1925). He is a Canadian-American psychologist and the David Starr Jordan Professor Emeritus of Social Science in Psychology at Stanford University. He is known as the originator of social learning theory (renamed the social cognitive theory) and the theoretical construct of self-efficacy of:

- our attention (whether we notice the behavior)
- retention (whether we remember the behaviour)
- reproduction (whether we are able to perform the behavior)
- motivation (whether the perceived rewards outweigh the perceived costs)

Mediation analysis is meant to facilitate a better understanding of the relationship between the independent and dependent variables when the variables appear to not have a definite connection.

The above mentioned ACBS, founded in 2005, has its headquarters in New York City. Its membership includes researchers, psychologists, psychiatrists, physicians, social workers, marriage and family therapists and other mental-health practitioners, nurses, researchers, and nationally- and internationally-based students working with behavioral and cognitive therapy modality approaches from around the world. Among its past presidents were Michelle Crasske, Nathan Abramowitz, Marsha M. Linehan, Linda C. Sobell, Kelly D. Brownell and Alan E. Kazdin.

By and large, ACBS purports that through CBT, including ACT, cognitive and behavioural therapists help humans learn to actively cope with, confront, reformulate, and/or change their maladaptive cognitions, behaviours and symptoms that:

- cause them emotional distress
- limit their ability to function
- accompany the wide range of at least 297 mental health disorders from which they, according to the DSM-5, suffer.

Goal-oriented, time-limited, research-based, and focused on the present. Such is ACT's cognitive and behavioural approach, which is termed "collaborative", as it apparently values client feedback. It also encourages clients to play an active role in setting goals and direct the overall course and pace of treatment. Behavioural interventions are characterized by a direct focus on observable behaviour, we read. Psychotherapists teach clients concrete skills and exercises from breath-retraining to keeping thought records. From behavioural rehearsals to practice at home and in sessions. All this with the goal of optimal functioning and the ability to engage fully in life. Nice.

Cognitive-behavioural treatments have been subjected to more rigorous evaluation using RCTs than any of the other mental health treatment modalities. It is therefore viewed as the present gospel of the craft, it appears. Needless to say, ACT is now called a "commonly used treatment with empirical support" within the APA-recognized specialty of behavioural and cognitive psychology.

Some major theoretical concerns about ACT were that its primary authors

recommended their approach as the proverbial holy grail of psychological therapies. Psychologist James C. Coyne in a discussion of disappointments and embarrassments in the branding of psychotherapies as evidence-supported said: "Whether or not ACT is more efficacious than other therapies, as its proponents sometimes claim, or whether it is efficacious for psychosis is debatable." (The textbook Systems of Psychotherapy: A Transtheoretical Analysis provides criticisms of third-wave behaviour therapies including ACT from the perspectives of other systems of psychotherapy).

Psychologist Jonathan W. Kanter concluded that Hayes and colleagues:

> "argue that empirical clinical psychology is hampered in its efforts to alleviate human suffering and present contextual behavioral science (CBS) to address the basic philosophical, theoretical and methodological shortcomings of the field. CBS represents a host of good ideas but at times the promise of CBS is obscured by excessive promotion of Acceptance and Commitment Therapy (ACT) and Relational Frame Theory (RFT) and demotion of earlier cognitive and behavior change techniques in the absence of clear logic and empirical support."

Nevertheless, Kanter concluded that:

> "the ideas of CBS, RFT, and ACT deserve serious consideration by the mainstream [mental health practitioner] community and have great potential to shape a truly progressive clinical science to guide clinical practice (Kanter, Jonathan W. (June 2013). *"The vision of a progressive clinical science to guide clinical practice"* (PDF). Behavior Therapy 44 (2): 228–233)."

Overall, it could seem as if ACT failed to separate from CBT on effect sizes for depression, anxiety or quality of life. In other words, ACT and associated brainchildren dreamt up by Hayes et al. throughout the field could be interpreted as nothing but ego-driven air to get fame and acceptance and more elbow room at the trough.

About PTSD nothing is mentioned anywhere, other than by Barber & Sharpless, whose investigative study carries the title *A Clinician's Guide to PTSD Treatments for Returning Veterans.* It's their effort to present mental health providers with many of the pharmacological and psychological interventions available to help prevent and

treat PTSD. It places particular emphasis on combat-related traumas and veteran populations. Why they even mention it is a conundrum. Or is it a manifestation, an acknowledgement, that for PTSD everything and anything goes?

After ACT, however, B & S carry on with touting their opinion on interpersonal psychotherapy. That's the next PTSD treatment modality with which to possibly traumatize the traumatized — or not, once PTSD journeyers recognize the power of their own thoughts, when free of pharmaceutical drugs, and begin to use it.

It is the only way to begin the journey of recovery, the only way to heal the Self simply and without outside interference. Watch your thinking like a hawk and change it to your liking. Make it a hobby. Make it your favourite entertainment. Make it your favourite amusement! You have no idea how much fun and laughter you can derive from watching what you think. It's hilarious, in particular when we read in the science magazine Wonderpedia:

> "Every second, 11 million sensations crackle along these [brain] pathways . . . The brain is confronted with an alarming array of images, sounds and smells which it rigorously filters down until it is left with a manageable list of around 40. Thus 40 sensations per second make up what we perceive as reality (David Icke, Everything you need to Know, But Have Never Been Told p. 6)."

One of those 11 million we eventually choose can create havoc or bliss for us. Mind you, we have enough time to make a good choice, as one second is an eternity, as we well know from our PTSD-causing event moment. Once we make it a hobby to learn to watch what we think and act upon it, it is an eternity! It is obvious that even without having tried it yet, the difference in life's unfolding can be deduced with ease just by visualizing the choosing process. So give it sincere thought and effort. What you can discover once you try is indescribable, the progress of a PTSD recovery phenomenal; but I repeat myself.

And you still want to allow the Neumeisters, Hayes et al. to interfere with your-thought dictated choices? Investigate, learn, prosper and thrive with your discoveries through personal thought selection, and you will see miracles unfold every single moment of your day. But on to the next manifestation of mental health practitioners' insanity, the interpersonal psychotherapy (IPT).

As we learned, cognitive exposure based therapies (CBT) dominate PTSD treatment. But many patients and therapists refuse to use them because of the grueling requirement to face and relive traumatic memories in order to become used

to them. IPT prides itself to jump in the breech.

IPT is advertised overall as a time-limited, evidence-based mental health treatment, focusing on patients' social and interpersonal functioning, affect, and current life events. It was initially formalized to treat major depression, bulimia and other conditions. Some bright researchers, however, viewing PTSD as a psychiatric illness triggered by a traumatic rather than traumatizing event, saw their chance and recently adapted IPT for PTSD treatment. Their central tenet:

> "Trauma impairs the individual's ability to use the social environment to process environmental trauma, shattering perceived environmental safety and poisoning trust in interpersonal relationships." (Markowitz, Milrod, Bleiberg, & Marshall, 2009, p.136)

So we'll fix it with counselling and pharmaceuticals.

As the excuse for doing so, they give two rationales. First, IPT does not use exposure-to-trauma reminders. Thus, it offers an alternative to patients refusing exposure techniques or not responding to them, as highly traumatized patients might fare better receiving affect-focused — loving, tender, personal care-based — therapy. Secondly, IPT works by improving patients' interpersonal functioning and emotion regulation, commonly impaired in PTSD patients. Therefore, important targets for behavioural change through interpersonal therapy are advocated. Social support is also sought, which IPT helps patients to mobilize. It has also been shown to be a key factor in preventing and recovering from PTSD.

The above conclusion was apparently reached in 2005 after Bleiberg and Markowitz conducted an open trial of IPT for 14 PTSD clients reasoning:

> "Interpersonal psychotherapy is a life-event-based treatment, and PTSD is a life-event-based disorder. Patients with PTSD manifest significant interpersonal difficulties, depressive symptoms, and affect dysregulation, all problems that interpersonal psychotherapy has been shown to alleviate. Interpersonal difficulties associated with PTSD include difficulty trusting others, low self-esteem, problems establishing boundaries, and fears of intimacy and of vulnerability in social interactions. Interpersonal psychotherapists encourage patients to focus on current life events and their relationship to mood and help patients make interpersonal changes that provide a renewed sense of

> mastery over their present situations while reducing PTSD symptoms. The medical model of interpersonal psychotherapy that employs defining PTSD as a medical illness may help patients relinquish guilty self-blame for their symptoms. The authors hypothesized that solving current interpersonal problems in interpersonal psychotherapy would yield generalized symptomatic improvement for PTSD subjects even in the absence of exposure techniques."

Of the 13 who completed the protocol, 69% were "responders" and 36% remitted. Anger and depressive symptoms improved as well. However, although the results were promising, there were several limitations to this open study. These included a small group size, heterogeneity of the traumas, the use of only two therapists, the lack of a comparison/control group and rater blindness to treatment. Nevertheless, self-report Posttraumatic Stress Scale scores mirrored scores on the Clinician-Administered PTSD Scale. This reminds us of how the Beck Depression Inventory scores did the Hamilton depression scale scores, and formal treatment-adherence monitoring. This group of PTSD patients may furthermore have had a better prognosis than others who abuse substances or take medication. Consequently, the preliminary results of this study awaited replication with random assignment and controls, we are told.

IPT's limitations for PTSD were yet unknown, but the study yielded a treatment manual that would be used in future controlled trials. Follow-up of the subjects was ongoing. Conclusions: treating interpersonal sequelae of PTSD appears to improve other symptom clusters. Therefore, IPT could be an efficacious alternative for patients who refuse repeated exposure to past trauma. This represents an exciting extension of interpersonal psychotherapy to an anxiety disorder, we are told. Nothing is mentioned anywhere about pharmaceutical drugging throughout this trial. (Kathryn L. Bleiberg, Ph.D. John C. Markowitz, M.D. : "A pilot study of interpersonal psychotherapy for posttraumatic stress disorder"; *Am J Psychiatry*. 2005 Jan;162(1):181–3).

And ongoing trials there are.

As of October 2018, ClinicalTrials.gov was looking for military volunteers in a study entitled "Comparative Effectiveness of Two Treatments for Veterans With PTSD" (Identifier: NCT02586064). Sponsored by the VA Office of Research and Development, in collaboration with the Georgetown University and the Southeast Louisiana Veterans Health Care System, we read the following:

> "Interpersonal problems such as relationship conflict and social isolation are common among Veterans with PTSD and serve as barriers to successful posttraumatic adjustment. The main interventions for PTSD at VA facilities, i.e. Prolonged Exposure, Cognitive Processing Therapy, and Trauma-Focused CBT, do not directly target these relationship difficulties and many Veterans do not complete these treatments. Couple and family approaches for PTSD address relationship problems, but logistical problems make it difficult for couples to attend sessions and these approaches do not involve Veterans who are socially isolated or unmarried. There is accumulating evidence that Interpersonal Psychotherapy (IPT) for PTSD may be effective in reducing symptoms and improving interpersonal functioning. This study, a randomized controlled trial, aims to provide evidence regarding whether IPT for PTSD could be a useful addition to current treatments delivered at the VA."

The detailed description states:

> "The strong relationship between posttraumatic stress disorder (PTSD) and interpersonal problems is well documented. PTSD is highly associated with relationship discord, increased intimate partner violence, and difficulties in connecting with others, leading to social isolation. These types of conflicts, as well as the social withdrawal that is common among Veterans with PTSD, diminish the Veteran's opportunities for interaction with supportive others, and serve as a barrier to successful posttraumatic adjustment. Treatments that have been "rolled out" nationally in VAMCs, e.g. Prolonged Exposure, Cognitive Processing Therapy, and Trauma-Focused CBT, do not directly target these relationship difficulties. Furthermore, data show that only a limited number of Veterans has fully engaged with these interventions. Evidence-based interventions of couples therapy are available, but are not logistically feasible for many couples and do not address the problems of those who are socially isolated."

It goes on to state:

> "This application proposes a randomized clinical trial of interpersonal psychotherapy (IPT-PTSD) as a treatment for veterans with PTSD and relationship problems. Pilot data suggest that this type of treatment might provide a useful alternative strategy for Veterans who would prefer an individual, relationship-focused approach. The investigators propose comparing IPT-PTSD with prolonged exposure (PE), an evidence based treatment for PTSD used in the VHA system. The investigators hypothesize that IPT-PTSD will be statistically equivalent to PE in reducing PTSD symptom severity, and superior to PE in improving interpersonal functioning. IPT-PTSD is also hypothesized to be more effective than PE in improving social adjustment and quality of life. Exploratory analyses will examine whether IPT-PTSD is more effective than PE in reducing suicidal ideation, and will examine hypothesized mediators of improvement in PTSD symptoms in IPT-PTSD."

But buyers beware. ClinicalTrials.gov continues:

> "The safety and scientific validity of this study is the responsibility of the study sponsor and investigators. Listing a study does not mean it has been evaluated by the U.S. Federal Government. Know the risks and potential benefits of clinical studies and talk to your health care provider before participating. Read our disclaimer for details." (ClinicalTrials.gov)

I suggest you do, so you know what you get yourself into. Estimated recruitment in 2015 was for 176 participants, but as of October 15, 2018, they were seemingly still recruiting. Scheduled to end on December 31, 2019, no news could be found on the ClinicalTrials.gov site, either. Are PTSD soldiers and veterans awakening to the detriment of it all, including ITP? Are they getting leery of the threat of AI content in PTSD treatment, the archontic rather than artificial intelligence content? (Nag Hammadi Library; *The Hypostasis of the Archons (The Reality of the Rulers)* thelostbooks.org).

But first and foremost, how did IPT spring forth to begin with, and what was its original premise?

It originated with the theoretical work of the American Neo-Freudian psychiatrist and psychoanalyst Herbert "Harry" Stack Sullivan (1892–1949). He held that the personality lives and its being is in a complex of interpersonal relations. Having studied therapists Sigmund Freud, Adolf Meyer and William Alanson White, he devoted years of clinical and research work to helping people with psychotic illness. He viewed interactions with others as the most profound source of understanding one's own emotions.

It was at the Sheppard and Enoch Pratt Hospital in Maryland (1923–30), while engaged in clinical research, that Sullivan became acquainted with Swiss psychiatrist Adolf Meyer (1866–1950). Meyer's practical psychotherapy emphasized psychological and social factors, rather than neuropathology, as the basis for psychiatric disorders. The first psychiatrist-in-chief of the Johns Hopkins Hospital (1910–1941), Meyer also was president of the American Psychiatric Association in 1927–28, and one of the most influential figures in psychiatry in the first half of the twentieth century. It was Sullivan, who, as Pratt's research director from 1925 to 1930, showed that it is possible with sufficient personal contact to understand schizophrenics, no matter how bizarre their behavior. He consequently concluded that by appropriate psychotherapy, the sources of human behavioral disturbance could be identified and eliminated. Developing his ideas further he applied them to the organization of a special ward for the group treatment of male schizophrenics (1929). During the same period, he first introduced his concepts into graduate psychiatric training through lectures at Yale University and elsewhere.

It was Sullivan who developed a theory of psychiatry based on interpersonal relationships where cultural forces are largely responsible for mental illnesses (see also social psychiatry). In his words, one must pay attention to the "interactional", not the "intrapsychic". This search for satisfaction via personal involvement with others led Sullivan to characterize loneliness as the most painful of human experiences. He also extended the Freudian psychoanalysis to the treatment of patients with severe mental disorders, particularly schizophrenia.

Sullivan was also the first to coin the term "problems in living" to describe the difficulties with Self and others experienced by those with so-called mental illnesses. As much of his work centered on understanding interpersonal relationships, his research became the basis for a field of psychology known as interpersonal psychoanalysis. This suggests that the way people interact with others provides valuable clues into their mental health. It also suggests that mental health disorders could stem from distressing interpersonal interactions. And, while Klerman et al.

stipulate that PTSD is a psychiatric illness triggered by a traumatic event, Sullivan drew no such conclusion. He steadfastly tried to avoid stigmatizing mental health patients preferring to refer to mental health disorders as "problems in living."

It is he who developed a theory of psychiatry based on interpersonal relationships He believed that anxiety and other psychiatric symptoms arise in fundamental conflicts between individuals and their human environments. It is he who concluded that personality development also takes place by a series of interactions with other people. He made substantial contributions to clinical psychiatry, especially in the psychotherapy of schizophrenia. He suggested that the mental functions of schizophrenics, though impaired, are not damaged past repair and can be recovered through therapy.

The term therapy derives from the Greek therapeutikos, meaning "inclined to serve." The term "psychiatry" was first coined in 1808 by the German physician Johann Christian Reil and literally means "medical treatment of the soul" (psych- "soul" from Ancient Greek psykhē "soul." The "iatry" means medical treatment, from the Greek iātrikos "medical" and from iāsthai "to heal."

Thus, Sullivan espoused the idea that a true psychotherapist would be able to help solve their problems of living, as he communicated with them and described their behavior with clarity and insight. None of it is applicable today, when clearly "psychotherapist" in essence means psycho-the-rapist, as that is what pharmaceutical drugs do to the human psyche.

The "problem of Living" view of mental emotional disturbance became a catchphrase. It was a preferred method of referring to mental health disorders among those involved in the anti-psychiatry movement, such as the world's R.D. Laings and Lauren Molchers. It was later picked up and popularized by Thomas Szasz, whose work was a foundational resource for the antipsychiatry movement. "Problems in living" went on to become the movement's preferred way to refer to the manifestations of mental disturbances or life-created emotional upheavals, as manifested by genuine PTSD experiencers.

As to Sullivan himself, he became one of the William Alanson White Institute founders. It was considered by many to be the world's leading independent psychoanalytic institute. He also helped found the journal *Psychiatry* in 1937. And he headed the Washington (DC) School of Psychiatry from 1936 to 1947.

The British developmental psychologist and psychiatrist John Mostyn Bowlby (1907–1990) also played a role in the IPT development theory. He was best known as the originator of attachment theory which posits an innate need in very young

children to develop a close emotional bond with a caregiver. Bowlby's understanding of emotional attachment and the consequences of interpersonal loss and separation was crucial. In PTSD voyagers, it is the separation of the physical Self and its soul during the PTSD-causing event (Bowlby 1973, 1998)). This crucial understanding also played a role in Klerman et al.'s IPT development theory. It is from these premises, outlook or knowledge that they constructed a purportedly time-limited, supportive, patient-friendly intervention that helped depressed patients to link affects to life circumstances, namely:

- to name their feelings
- to understand them as social cues
- to learn to express them effectively, in order to improve their social situations

The hope was that this intervention would not only improve patients' social functioning, but thereby relieve their depressive symptoms with the help of pharmaceutical drugs.

How many PTSD afflicted journeyers are diagnosed as schizophrenics and landed in psychiatric hospital thanks to treatment they receive from the powers that be is unknown. No statistics appear to be available. Go to the VA and see how much time is allotted to those of PTSD plight before prescriptions drugs start flowing en masse, purportedly to heal them.

Be it as it may, Sullivan's observations of people's interpersonal relationships resulted in the foundation of interpersonal psychoanalysis. This stressed the detailed exploration of the nuances of patients' patterns of interacting with others, including the therapist. In 1969, his observations inspired Gerald L. Klerman, Myrna M. Weissman and Eugene Stern Paykel to run with the idea, by enhancing it with pharmaceutical drugs. The medical mafia's bonanza had started.

Klerman was a 1959 Cornell University graduate and a member of its Quill and Dagger senior honor society. This was recognized as one of the most prominent and legendary collegiate societies of its kind, along with Yale's notorious Skull and Bones. To belong was "the highest non-scholastic honor within reach of undergraduates" (www.nytimes.com). In 1954, he graduated from the New York University School of Medicine. After a year-long medical internship at Bellevue Hospital Center in New York he went on to complete his psychiatry residency at the Massachusetts Mental Health Center in Boston. He did his residency at Harvard

and worked two years as a researcher at the National Institute of Mental Health. From 1966 to 1970, he was a professor at Yale and also director of its mental health center. It was there that he developed and added pharmacotherapy as an experiment to an eight-month randomized controlled psychotherapy trial for patients with major depressive disorder. He did this together with his grad student Myrna M. Weissman, and with Eugene Stern Paykel, a British psychiatrist known for his research work on depression, clinical psychopharmacology and social psychiatry, now in practice for over 40 years,

Klerman's expertise at the time included depression, schizophrenia and anxiety disorders. He sketched his first randomized controlled IPT trial based on the principles of a medical model defining major depression as a diagnosable and treatable psychiatric illness, and on empirically derived interpersonal factors related to depression. Results indicated that this therapy relieved depressive symptoms and improved social functioning. He also noted that the additive effects to pharmacotherapy contained forward-looking features, meaning clients can get used to them, and depressive symptoms. A psychosocial functioning assessment had also been conducted. Due to the treatment's intensity, one weekly session, Klerman et al. initially described it as "high contact" counseling.

This first treatment trial compared the tricyclic antidepressant amitriptyline, a pill placebo, IPT on its own, a "low contact" alternative to IPT, and combined IPT and amitriptyline. It is of value to understand that at that time, many clinicians held strong ideological beliefs in either medication or psychotherapy favoring one and disparaging the other. But it was unknown whether combining psychotherapy and antidepressant medication was tolerable and efficacious, and it was also unknown whether the psychoanalytical therapy that became IPT worked at all.

Klerman et al. treated 150 depressed women who had shown some response to four-to-six weeks of amitriptyline alone. They found that random assignment to eight months of their methods resulted in both improved symptoms and better social functioning. Next, they compared 16 weeks of IPT with 16 weeks of amitriptyline, combined amitriptyline with IPT, and tried a low contact condition for acutely depressed patients. The result? Amitriptyline and IPT were each more efficacious than the control condition, and the combination of medication and IPT had greater benefit than either one on its own. Moreover, on follow-up a year later patients who had received IPT reported improved social functioning whereas patients treated with the tricyclic antidepressant alone did not (John C. Markowitz and Myrna M. Weissman: "Interpersonal Psychotherapy: Past, Present and Future";

Clin Psychol Psychother. 2012 Mar-Apr; 19(2): 99–105).

IPT a la Klerman et al. consequently defined major depressions as not due to problems of living, but as a treatable medical condition not of patients' doing. The method of psychotherapy itself was as empirically derived as possible on the basis of what was then known about psychosocial aspects of depression, Weisman et al. exclaim. There are as follows:

- that social supports protect against psychopathology
- that whatever the "cause" of a depressive episode, it occurs in an interpersonal context and usually involves disruption of significant attachments and social roles that the death of a significant other (grief), antagonistic relationships (role disputes), life disruptions or losses (role transitions), and isolative lack of social support (interpersonal deficits) are negative life events or circumstances that place vulnerable individuals at risk for a depressive episode
- that it is useful to work on change in social functioning in the "here and now" to improve symptoms (John C. Markowitz and Myrna M. Weissman: Interpersonal Psychotherapy: Past, Present and Future; *Clin Psychol Psychother*. 2012 Mar-Apr; 19(2): 99–105)

When all had been said and done, the combination of medication and psychotherapy was found to be the most efficacious therapy for depression treatment. As a result, these initial IPT studies led to its inclusion in the NIMH Treatment of Depression Collaborative Research Program. IPT was compared to imipramine, placebo and CBT for acute depression treatment. The original IPT manual, *Interpersonal Psychotherapy for Depression*, published in 1984, served as a manual for the project.

Thus Sullivan's "problems with living" amelioration by way of counselling had been turned into "let's fix it with pharmaceuticals," and that is where it stands today.

While all this transpired, Klerman, highly energetic, also served as head of the US Alcohol, Drug Abuse and Mental Health Administration under the Carter administration (1977–1980). He taught at Harvard's medical school and was the director of psychiatric research at Massachusetts General Hospital and director of the Eric Lindemann Mental Health Center. After his federal service, he became professor of psychiatry and vice chairman of research at Cornell Medical College and New York Hospital. He was a psychiatrist at the affiliated Payne Whitney

Psychiatric Clinic (www.nytimes.com/1992/04/05). He departed Mother Earth in 1992.

His and Weisman's roaring success, however, sparked innumerous studies to prove empirically and scientifically without leaving a shadow of a doubt that IPT does anything for any patient whatsoever. Paykel was apparently out of the picture by then. But, as there are no scientific empirical tests to prove any mental health related successes or failures, we are still waiting. There is no best evidence. But what does Amitriptyline HCL administered to depressed patients do to body and mind? We do know what, almost to perfection, although no mention of it is made in any of ITP's publications.

Amitriptyline HCL belongs to a class of medications called tricyclic antidepressants. It works by affecting the balance of certain natural, chemical neurotransmitters in the brain, such as serotonin. Used to treat mental/mood problems, such as depression, it might, just might, we hear, help improve mood and feelings of wellbeing, relieve anxiety and tension, help to sleep better, and increase our energy level. The dosage, somewhere from one to four tablets daily, is based on one's medical condition and response to treatment. To reduce the risk of side effects, such as drowsiness, dry mouth and dizziness, our doctor might direct us to start this medication at a low dose and gradually increase it. Doctor's instructions are to be followed carefully, we are told on WebMD.

What is graciously ignored? That it comes with an FDA warning, stating:

> "Suicidal thoughts and behavior: This drug has a black box warning. This is the most serious warning from the Food and Drug Administration (FDA). A black box warning alerts doctors and patients about drug effects that may be dangerous. Amitriptyline can increase the risk of suicidal thoughts and behavior in children, adolescents, and young adults. Your doctor and family members should watch you closely for signs of changes in your behavior or worsening depression when you start taking this drug."

Other warnings on the label:

> "Worsening depression warning: You might experience an initial worsening of your depression, thoughts of suicide, and behavioral changes when you first start taking amitriptyline. This risk may last until the drug starts working for you.
>
> "Withdrawal symptoms warning: If you've been taking

> this medication for a long time, you shouldn't stop taking it suddenly. Stopping it suddenly may cause side effects such as nausea, headache, and tiredness. Don't stop taking this drug without talking to your doctor. They will tell you how to slowly lower your dosage over time." (healthline.com)

And what is written as direction for consumption?

> "Take this medication regularly in order to get the most benefit from it. To help you remember, take it at the same time(s) each day. Do not increase your dose or use this drug more often or for longer than prescribed. Your condition will not improve any faster, and your risk of side effects will increase."

The punch-line?

> "It is important to continue taking this medication even if you feel well. Do not stop taking this medication without consulting your doctor. Some conditions may become worse when this drug is suddenly stopped. Also, you may experience symptoms such as mood swings, headache, tiredness, and sleep change. To prevent these symptoms while you are stopping treatment with this drug, your doctor may reduce your dose gradually. Consult your doctor or pharmacist for more details. Report any new or worsening symptoms right away."

Does this write-up make it implicitly clear that human beings are considered imbecilic entities? Should one perhaps recognize and accept it as a valid concept for every drug prescribed by one's caring physician before purchasing and swallowing it? If not, does one deserve everything one experiences as a result of the drug, considering that we all, every one of us human beings, are responsible for our own well being, not anyone else who tries to usurp such responsibility for financial gain? Yes, financial gain, and your destruction in a slow and tedious way is what it seems to boil down to.

You have a cellphone? Why not use it to educate yourself, apply your power to investigate rather than chat endlessly with god and sundry about your feelings and your ailments and the responsible parties for it — never yourself, as you refuse to take responsibility for your own life adventure? Why trust someone who makes money off maintaining you in ill health by way of your prescription drug

consumption? It was my stupid gullibility and ill-placed trust that did me in. It was, my overwhelming laziness, sponsored by and originating with Ativan consumption that compromised me. It was my ignorant or innocent belief that those in power wanted my best that turned me away from living my life and from learning the truth about PTSD through research. That true evil is a face you know and a voice you trust had yet to dawn on me. Thus indeed, at least for a while, I unknowingly was my own true evil, perhaps?

You still think at this point that Big Brother and cohorts have your best interests at heart? Really? If you do, you belong where you already are in your mind, an insane asylum. But how did your gullibility arise? Television ads saying that "Doctor knows best?"

When you read about the side-effects of any given pharmaceutical prescribed to enrich themselves, do you see something like:

> "This medication might not work right away. You could see some benefit within a week. However, it might take up to four weeks before you feel the full effect. The side effects are your liver's destruction, etc. . . . "

Does knowing this and still failing to investigate signal a loss of reasoning power and marbles? Does it also signal an addiction to the drug consumed, in association with the failure of physical health beginning with malfunctioning brain activity? It took me 42 months after swallowing the first Ativan tablet to investigate. By that time, it was almost too late, as I could my physical health had deteriorated to a point where I could barely walk. And I took it only when the powers that be hit me united, all at the same time, and never regularly.

"Tell your doctor if your condition persists or worsens, such as your feelings of sadness get worse, or you have thoughts of suicide" the small print normally states on all psychosomatic prescriptions. But, it is unimaginable to your thinking that your doctor would actually prescribe something that would worsen your symptoms and eventually kill you slowly but surely, or rapidly depending on your choice. So you never bother to read it, do you? Doctor knows best, eh?

As my GP stated one day, when I told him about that push the pedal to the metal episode in my T-Bird 1966 with the 428 hp engine flying out to the airport in record time under the influence of three Ativans swallowed all in one swoop: "One of my patient's took eight a day and was dead within six months," chuckling away as he said so. I was too far gone into distorted and limited Ativan perverted thinking to even to ask: "Why?" or "How come?"

By the time I got around to feeling extraordinarily suicidal, my thinking was so perverted that I thought it normal to feel that way. When a friend came around to see if I was alive, I had turned the phone off and cut connection with all and sundry. She smelled death in my house. I also felt guilty about my lack of improvement and so did not tell anyone of that concern, afraid the blame for it would be put on me, as well. It took four more months for me to reason that Ativan was the culprit of my ailing health. But it took me much, much longer to see the light and understand that what was done to me had nothing to do with healing me. How sinister and well-planned my treatment was for my destruction. This dawned on me only in the course of writing this book. True evil . . . .

But Klerman, Weissman and colleagues, meanwhile, found their IPT pharmacotherapy breathtakingly exciting. They were spellbound, awaiting replication of their findings by other research groups, whose IPT results were promising. However, even in 2004, Weisman and Markowitz wrote in their *World Psychiatry* article "Interpersonal psychotherapy: principles and applications" about its limitations. They noted that the relatively young IPT psychotherapy was targeted to particular psychiatric diagnoses, with its characteristics well defined and its efficacy well understood relative to other psychotherapies. (World Psychiatry. 2004 Oct; 3(3): 136–139) But they admitted that there were far more unknowns about its indications for various conditions, its optimal dosing, its combination with pharmacotherapy, its utility in different formats, and so on and so forth.

IPT was already one of the best-studied interventions in outcome research, particularly for mood disorders. But we read that IPT was only then spreading into clinical practice, its fairly simple treatment easy to learn for already experienced psychotherapists. Its effectiveness in the hands of less trained therapists was nevertheless moot. Therefore the spread of this still relatively "pure" treatment, as they termed it, carried both opportunities and dangers.

Hence it was adapted for depressed patients with differing characteristics and for depressive subtypes, such as adolescents, post-partum, geriatric and medically ill. It was adapted for use on patients with major depression and patients with dysthymic disorder. It was used on patients with sub-threshold depression and as an adjunctive treatment to pharmacotherapy for bipolar disorder. IPT is now used to test patients for bulimia and substance abuse to see how briefer treatment and maintenance treatment work, and there is couples IPT, group IPT and IPT by telephone. That it was of little benefit for patients with anorexia nervosa and substance abuse matters little, as ITP demonstrated efficacy in treating major depression and bulimia. That

led to its entry into professional and national treatment guidelines, such as those of the American Psychiatry Association.

Geographically, it also expanded, from the northeast USA to other parts of the country, to Europe, South America and Uganda. Research continued to expand to patients from these different cultures and with different diagnoses. People with social anxiety disorder and dysthymic disorder were studied. They benefitted only from pharmacotherapy, we hear. The cash-cow of all cash-cows, PTSD, was recently added graciously and mentioned in conjunction with borderline personality disorder.

Nothing ventured, nothing gained, as we view them as psychiatric patients anyway, mental health IPT practitioners scream, as they dream money, money, money. So they defined IPT for PTSD as these problem areas:

- grief (mourning the death of a significant other)
- role dispute (a struggle with a significant other, which the patient is inevitably losing)
- role transition (any major life change, including having suffered a traumatic event or events) (Markowitz, et al, 2009)

ITP's idea of psycho-therapeutic IPT practitioner-assistance?

The IPT therapist's stance is relaxed and supportive. The goal is to be the patient's ally. The acute time limit pressures the patient to take action. No formal homework is assigned, but the goal of solving the focal interpersonal problem area provides an overall task. Treatment centers on the patient's outside environment, not on the therapy itself.

The scheduling of weekly sessions accentuates that the emphasis is on the patient's real life, not the office. The therapist and patient review the past week's events. When the patient succeeds in an interpersonal situation, the therapist acts as a cheerleader, reinforcing healthy interpersonal skills.

When the outcome is adverse, the therapist offers sympathy and helps the patient to analyze what went wrong in the situation. They brainstorm new interpersonal options, and role-play them together in rehearsal for real life. The patient then tests them out. Given this emphasis on interpersonal interaction, it is not surprising that depressed patients learn new interpersonal skills from IPT that they have not seen with pharmacotherapy. It's a con-game, guys, a con-game, beginning with changing your role in your own life. It's not the psycho-the rapist's

life, whose idea it is for a role transition. That life change costs PTSD-affected patients their old role and substitutes them with a new, unwanted one.

It is the treatment rendered by ITP-versed psychotherapists that will help PTSD patients mourn the loss of their former role. That same treatment will help them develop skills, interpersonal opportunities and confidence in their new unwanted role, we read in Rafaeli et al. ("Interpersonal Psychotherapy (IPT) for PTSD: A Case Study", *Am J Psychother*. 2011; 65(3): 205–223.) They reached the conclusion based on their observations of a 48-year-old man working from home as a freelance software engineer. He held a master's degree in computer science and had worked successfully for many years as a computer programmer, but was currently working sporadically and struggling financially. He requested psychotherapy to address current symptoms of "irritability, sleep disturbance, and interpersonal conflicts."

That was in 2011. Meanwhile, that IPT has most likely made a phenomenal number of humans dependent on psychotropic drugs is swept under the carpet. In 2018, IPT courses at psychiatric and psychological conferences having fanned clinical interest in it. The International Society of Interpersonal Psychotherapy was holding increasingly well-attended meetings in North America and Europe, mushrooming growth in IPT research. All of this trendy fandom based on an open trial of 14 participants, with no empirical scientifically proven evidence of IPT's efficacy. And, of course, a 48 year old software engineer. Nevertheless the NC *for* PTSD accepted it. Why? Because they hadn't accepted anything in a while and needed to be seen to be doing something? No. They purportedly did it because the central tenet of IPT for PTSD, you'll recall, is asserts that:

> "Trauma impairs the individual's ability to use the social environment to process environmental trauma, shattering perceived environmental safety and poisoning trust in interpersonal relationships." (Markowitz et al. 2009, pg. 136)

One of the newest IPT observations in conjunction with PTSD was spewed forth in 2015 by Lorenzo Lorenzo-Luaces in his article "Breakthroughs in the treatment of PTSD" (*Society for Psychotherapy Research* 2015). He is assistant professor in the University of Indiana Bloomington's Psychological and Brain Sciences Department. His research interests span from psychotherapy for depression and personalized medicine for depression, to history and classification of major depressive disorder and treatment of bipolar II depression. Calling PTSD one of the most disabling and common mental disorders in human beings, he asserts:

> "Most of the leading psychotherapies for fear and anxiety

> disorders share as a common features that they encourage patients to 'face their fears' by engaging in 'exposure' to things they are afraid of. That is why Markowitz et al. in 2015 adapted interpersonal psychotherapy (IPT) for PTSD. The PTSD-focused IPT does not focus on exposure to the trauma and related fear cues, but instead on the effect that trauma has had on a person's interpersonal relationships."

The authors compared IPT to prolonged exposure (PE), which has a high response rate, but also a high risk of dropout. The treatments were also compared to applied relaxation, which has been found to decrease symptoms of PTSD, but not as much as exposure-based treatments. Although exposure was slightly more effective than IPT, this difference did not meet a minimum clinical significance threshold set by the authors. Both treatments were more effective than relaxation. Interestingly, IPT had a lower rate of dropout than exposure, especially for patients who were depressed.

If replicated, these findings suggest that IPT should be considered an evidence-based therapy for PTSD. It would be especially useful for patients who are depressed or who are unwilling to engage in exposure. The study authors concede that even for patients who receive IPT, some exposure to their fears might be necessary. However, they argue that a focus on interpersonal relations might help patients "improve in a way that later motivates them to face their fears."

I wanted to voice my opinion about his view on the Society for Psychotherapy Research website. It said:

> "Welcome to the online community. Because of the built-in security features, you must first register and be approved before accessing many site sections. If you are not a member of the site yet, please register – we'd love you to be part of our online community."

When I tried to register, this alighted on my screen: "That username and password combination was not found! Please try again." A tight-knit community alright. Everything stays in the mental health practitioner family. Outsiders are prohibited from participation.

Head to head studies with other psychotherapies might further develop differential therapeutics, exploring what factors mediate and moderate the efficacy of IPT, we read. Are there environmental moderators or biomarkers that could distinguish if and when IPT is likely to benefit a PTSD-influenced person? A

depressed or bulimic one? What aspects of IPT are "active" ingredients and which ones might prove to be inert? How can IPT be bolstered to work more effectively for particularly difficult patients? For example, those who fit the "interpersonal deficits" category so gladly hung on PTSD journeyers?

These are Weissman et al.'s dreams, as they continue to loudly roll the IPT drum. For instance, they published *The Guide to Interpersonal Psychotherapy Updated and Expanded Edition*. The authors call this new, expanded edition "The definitive guide on IPT from the originators of the treatment" (Oxford University Press, 2017). It apparently gives guidelines on how to learn to effectively use IPT to treat depression and bipolar ideation, anxiety, and eating and borderline personality disorders.

IPT is also taught in some psychiatric residency programs and is spreading into clinical practice, but no official sanctioning body or "diploma" for training or certification exists.

Barber & Sharpless view it as a time-limited therapy, adapted to PTSD, so they say. IPT for PTSD is intended to:

- increase PTSD experiencers' social skills
- reduce feelings of helplessness and demoralization
- increase agency (psychology jargon for enhancing a feeling of getting ahead, of making progress)

The psycho-the-rapist is to facilitate corrective emotional experiences and responses and to help generate adaptive coping strategies in accordance with his or her liking, we assume. In essence, the corrective emotional experience is a psychoanalytical idea. It suggests that patients get significant and intensive change via new interpersonal affective events with their therapist. These relate specifically to events that patients are presumed to have been unable to perfect in their formative years, we read. (Nugent, Pam: *Corrective emotional experience*; Psychology Dictionary, 2013).

Thus, IPT is just what genuine PTSD journeyers need to drive them over the brink. They get to enhance their social and interpersonal affective skills, of which they had no lack prior to the PTSD-causing event. Plus, they get this bonus training while figuring out what happened to them in that moment. And all of it administered by folk whose only life-experiences seems to be their academic schooling, worthless for being based on nothing but hypothesis and speculation. It has all been regurgitated for decades by other psychics, originating with Madame

Blavatsky and her ilk, mentioned in the Nag Hammadi scrolls. Unless, of course, they were mentally ill to begin with, which is most likely the reason why they engaged in the field in the first place.

Nevertheless, they now profess to have the PTSD cure, for two reasons. First, IPT for PTSD claims to offer a non-exposure-based approach to PTSD, by acknowledging the impact of trauma on the PTSD affected's life. Second, rather than trying to reconstruct the traumatic events, IPT aims to repair the damage trauma does to interpersonal trust and social functioning. This would help, as trauma can isolate patients from the social supports that protect against developing PTSD and then help in recovery from PTSD.

Not only that, they also claim to know the results of the PTSD-causing event moment to a T. Among the consequences are affective numbing, interpersonal hyper-vigilance and social withdrawal. In their view, numbness, an avoidance particularly of negative affect, makes it hard to read one's interpersonal environment. By adapting IPT for PTSD, the IPT-trained psycho-the-rapists devote the early part of treatment to affective re-attunement. But re-attunement to what?

Re-attunement to the previous role played. IPT for PTSD tends to focus on role transitions, which are usually inherent in trauma, we are told? And how does he or she know which role that was, pray? Practitioners will also help PTSD patients to identify their emotions and to recognize them as helpful social signals, rather than as bad or dangerous. Once patients can read their own feelings, they can put them to use to handle relationships better and decide whom they can trust and whom they can't, we joyfully read.

Krupnick and colleagues showed that group IPT reduced PTSD and depression better in badly and repeatedly traumatized women than to a waiting list control. Campanini et al. reported that adding IPT to pharmacotherapy reduced PTSD symptoms more than pharmacotherapy alone. Markowitz and colleagues found 14 weeks of individual IPT non-inferior to prolonged exposure, the best tested exposure therapy. They also found that IPT had advantages for patients with comorbid major depression or sexual trauma. Dropout was non-significantly lower in IPT: 15% versus 29%. Apparent personality disorders often resolved with treatment of PTSD. Patients also preferred IPT to exposure therapy. Gains from IPT persisted at 3 months follow-up. Further research was needed to replicate these findings, particularly for military PTSD, they meekly admit.

But it does claim to increase social skills. It does claim to reduce feelings of helplessness and demoralization. It does claim to increase agency. It does claim to

facilitate corrective emotional experiences and help generate adaptive coping strategies. So, it was adopted by the NC *for* PTSD as appropriate PTSD treatment. Drive PTSD journeyers nuts, drive them off the wall? Drive them to suicide by any and all means in fashion. And if they don't comply to our treatment modality demands and they refuse participation, throw them onto the streets, human garbage they are. Let the dogs eat them!

In other words, IPT merely presents another avenue to drive genuine PTSD experiencers' into the abyss. None of them suffered IPT-related deficiencies before the PTSD causing event. Consequently, they still possess those humane qualities and characteristics that enabled them to do their work brilliantly pre-PTSD causing event. Those humane qualities will resurface in increased intensity with the heightened awareness and change of perception that the PTSD event brought to them. This will happen as soon as they resolve the colossal existential crisis in which they temporarily find themselves. That is, if they are allowed the peace needed to make the journey or odyssey of recovery. Thus, Sullivan's "problem of living" giving birth to the IPT concept has been perverted to the finest degree.

That the peace needed to heal is always denied is understandable when viewed from the other side. After all, the bright ones have to be destroyed to guarantee the Archontic Intelligence agenda will succeed. Throughout history, it has been the bright ones who created upheaval for the ruling class, the elite. And the elite's psychological practitioners — its priesthood — has to protect their Golden Goose by prolonging the income they derive from PTSD travelers' temporary "problem of living". This inevitably enhances their sufferings to the hilt. The dialectical behavior therapy (DBT) is another one of those modalities.

But first, I want to introduce the newest idea of PTSD treatment, the jackpot of all PTSD jackpots, Xenon Gas. Perhaps Xenon is even combinable with IPT or DBT or both?

Other Ways To Bend Our Minds

XENON GAS AND PROPRANOLOL FOR PTSD MEMORY EXTINCTION

Dr. Gregory J. Quirk is adjunct professor with primary appointment as professor at the department of psychiatry at the San Juan-based University of Puerto Rico Medical Sciences Campus. He researches the neural basis of fear memories. His interests are the prefrontal amygdala, fear conditioning and cognitive neuroscience.

On his RTRN-RCMI Translational Research Network web page, we read that his research focuses on the neural circuits of fear regulation using rodent and human models for fear conditioning, extinction and active avoidance. The RCMI Translational Research Network considers itself to be a groundbreaking consortium of biomedical, behavioral and clinical researchers working with healthcare

providers and the community to address health disparities through collaboration.

Quirk's laboratory has been in Puerto Rico for 18 years. It consists of about 14 students, post-docs and technicians from the U.S., Puerto Rico and other parts of Latin America. His long-term goal is to promote neuroscience research and training in Latin America (connect.rtrn.net/profilesweb). A variety of experimental techniques, including multichannel unit recordings, opto-genetics, immunocytochemistry, electrical stimulation and computational modeling, are used. His team focuses on how the prefrontal cortex influences fear-related activity in the amygdala, thalamus and striatum. This work, says Quirk, applies to PTSD and OCD (obsessive compulsive disorder), purportedly another PTSD side-effect that mental health hypothesists try to shuffle down genuine PTSD voyagers' throats. Some of them even call it a PTSD sub-type (*OCD and PTSD, and the relationship between the two*, www.ptsduk.org. and "Could it be OCD or PTSD?" *Current Psychiatry*. 2009 August;8(8): 55–55).

Whatever Quirk et al. are doing is funded by the National Institute of Mental Health in the name of research. To design, combine and apply more and more mental health problems to human beings is merely to force them to perceive themselves as thoroughly ill folk, the archontic perception-deception at work. What we believe we become. What we perceive we manifest.

In 2010, Quirk and colleagues wrote the article "Erasing Fear Memories with Extinction Training" (Gregory J. Quirk, Denis Paré, Rick Richardson, Cyril Herry, Marie H. Monfils, Daniela Schiller and Aleksandra Vicentic; *Journal of Neuroscience* 10 November 2010, 30 (45) 14993–14997). They said that decades of behavioural studies have confirmed that extinction does not erase classically conditioned fear memories. Mind you, that also seems debatable, as there are debates about it raging among them over Myers' and Davis' laboratory work with fear extinction in rodents. Let's stick with the familiar used for human species hypothesis. In rattus, we learn, the argument is that extinction involves "unlearning", which, as had been seen, is generally problematic. Data shows that extinguished fear responses reappear, but might be an accurate description of the mechanism under some circumstances. It suggests that multiple mechanisms could be at work, depending on the timing and circumstances in which the fear extinction occurs. The apparently conflicting observations were based on the use of treatments that could affect both principal neurons and interneurons. Finer dissection of the cellular processes involved in extinction would require cell type-specific manipulations. These were generally beyond the technical reach of the field at that time, but should be possible

through the advent of technology, such as laser capture microdissection (Myers; Davis (2007). "Mechanisms of Fear Extinction". *Molecular Psychiatry*. 12: 120–150).

Quirk's team, in collaboration with Dr. Karen G. Martinez's lab, uses a differential fear conditioning paradigm, where human subjects view pictures of different rooms (contexts) containing a variable colored light (cue). One color is paired with a mild electric shock (unconditioned stimulus) to their fingers (CS+), whereas a different color is not (CS–). The US delivery occurs at CS+ offset. We use skin conductance responses (SCRs) as our measure of the conditioned fear response. We are examining the correlation of learned fear responses with ethnicity, neuropsychological tests, beta-blockers, and genetic markers (SNPs). We study healthy volunteers as well as people with anxiety disorders. They decide what is healthy or unhealthy, and no PTSD volunteers are mentioned.

Creating fears is one thing. Extinguishing them is another. In the laboratory, fear inhibition most often is studied by exposing a previously fear-conditioned organism to a fear-eliciting cue in the absence of any aversive event, we read. This procedure results in a decline in conditioned fear responses that is attributed to a process called fear extinction. Extensive empirical work by behavioural psychologists has revealed basic behavioural characteristics of extinction. *Theoretical* accounts have emphasized extinction as a form of inhibitory learning, as opposed to an erasure of acquired fear. Guided by this work, neuroscientists have begun to dissect the neural mechanisms involved, including the regions in which extinction-related plasticity occurs and the cellular and molecular processes that are engaged. In other words, the Neumeisterian procedures in action.

There are competing views and difficult observations for the various accounts of memory extinction. That, of course, means that researchers have turned to investigations at the cellular level, most often in rodents, we hear. There, they tease apart the specific brain mechanisms of extinction, in particular the role of the brain structures — amygdala, hippocampus, prefrontal cortex — and specific neurotransmitter systems. A recent study in rodents by Amano, Unal and Paré, published in *Nature Neuroscience,* found that extinction of a conditioned fear response is correlated with synaptic inhibition in the fear output neurons of the central amygdala that project to the periaqueductal gray that controls freezing behavior. They infer that inhibition derives from the ventromedial prefrontal cortex and suggest promising targets at the cellular level for new treatments of anxiety (Amano, T; Unal, CT; Paré, D (2010). "Synaptic correlates of fear extinction in the amygdala". *Nature Neuroscience*. 13: 489–494).

In their Abstract, we read:

> "Anxiety disorders such as post-traumatic stress are characterized by an impaired ability to learn that cues previously associated with danger no longer represent a threat. However, the mechanisms underlying fear extinction remain unclear. Here we show in rats that extinction is associated with increased levels of synaptic inhibition in fear output neurons of the central amygdala (CEA). This increased inhibition results from a potentiation of fear input synapses to GABAergic intercalated amygdala neurons that project to CEA. Enhancement of inputs to intercalated cells required prefrontal activity during extinction training and involved a higher transmitter release probability coupled to an altered expression profile of ionotropic glutamate receptors. Overall, our results suggest that intercalated cells constitute a promising target for pharmacological treatments aiming to facilitate the treatment of anxiety disorders."

"See, it's all in your brain, stupid." At least they want to make us believe it is. To them, we are comparable with rodents, cani and simian, and fixable like a computer. Does that alone not get you into a hissy fit, by now knowing you are infinite awareness, having had a PTSD experience? Do you still refuse to help yourself when reading the above? Do you really wish to go on being treated like a rodent, a dog or a monkey for the rest of your life? If you do, you have to take responsibility for everything in store for you, as it is your own fault if you refuse to take PTSD as the gift it is and go on viewing it as a curse!

It is because of so many people's imbecility of not standing up and saying "No More" that PTSD research efforts have focused on the mechanisms underlying the development of extinction-induced inhibition within fear circuits. It is why the last decade has witnessed a resurgence of interest in the neural mechanisms of Pavlovian extinction, especially related to fear conditioning, say Myers and Davis.

Classically conditioned fear memories are those specifically tailored during fear-conditioning experiments to teach, in this case, rodents to fear a specific cue. This is oftentimes an electrical shock or a tone. It is paired with a fear-eliciting stimulus, such as a foot shock. After several pairings, the rodent learns that the cue (e.g. tone) means a shock is coming, and it shows a conditioned fear response to the cue, even when the shock no longer follows. The same principles appear to govern how

people develop fear/anxiety symptoms.

An analogue for treatment is also present within these studies in the form of trials focused on extinction learning. After presentation of the cue in a safe environment (i.e. without the presence of the shock), the rodent learns that the cue (tone) is no longer something to fear, and the stress response remits (i.e. extinction learning). Again, anxiety interventions are developed using this same principle.

Lovely. The conditionings and results are deemed to be comparable to police officers, firefighters, soldiers, aircrew and veterans who, from the moment of choosing the job and turning up at work, know that they might not return home the way they departed, or at all, right?

Their experimental analysis of fear extinction for Myers and Davis was a great success. There are plenty of intensely studied fear acquisition paradigms, for which the underlying neural circuitry was well understood. Therefore, they note, the literature on fear extinction has expanded at an incredible rate. The therapeutic interventions for fear- and anxiety-related disorders from "bench to bedside" occurred rapidly, as well. Thus, instead of treating the symptoms of anxiety pharmacologically, this strategy attempts to improve the extinction learning that occurs during cognitive behavioral therapy. In fact, they write that some of their own, we assume, have said that the use of cognitive enhancers to facilitate exposure-based psychotherapy could represent a paradigm shift in psychiatry.

But let's return to Quirk et al., pretending to be eager beavers to help the cure for PTSD and its possible consequences. Their living might be less lucrative without it, might it not? Farm work could be good for them for a few years, though. It would bring them close to the earth created by "The Father" according to Nag Hammadi scrolls, not by the Archons. They merely try to pervert it through inversion.

In Quirk's case, his Puerto Rican lab's mission is purportedly to:

- increase understanding of how the brain overcomes fear
- train effective scientific thinkers who value communication and collaboration
- increase neuroscience practice in historically underrepresented countries

Mind you, to him, nothing in this field seems new. As a matter of fact, he seems to be extraordinary in his aptitude for his apparently chosen calling. In 1992, he received the CIES Fulbright Award. This program was established in 1946 under

legislation introduced by Senator J. William Fulbright of Arkansas and sponsored by the U.S. Department of State's Bureau of Educational and Cultural Affairs. It awards approximately 8,000 grants annually, roughly:

- 1,200 to U.S. scholars
- 900 to visiting scholars
- 1,600 to U.S. students
- 4,000 to foreign students
- several hundred to teachers and professionals

In 1999, he received The Presidential Early Career Award for Scientists and Engineers, established by President Clinton in 1996. It is the highest honour bestowed by the United States Government on science and engineering professionals in the early stages of their independent research careers. Recipients are chosen for pursuing innovative research at the frontiers of science and technology, and for their commitment to community service through scientific leadership, public education or community outreach.

Even while obtaining his Ph.D. at Puerto Rico's Ponce University, the New York Academy of Sciences accepted his and D.R. Gehlert *Inhibition of the Amygdala: Key to Pathological States?* In this book, we previously discussed its pro and con opinions in detail. We mentioned Joseph E. Le Doux's, Ph.D.: "I Got a Mind to Tell You" being diametrically opposed to Quirk's assertions ("The Amygdala Is NOT the Brain's Fear Center. Separating findings from conclusions;" psychologytoday.com), which best reflects Quirk's Darwinian Archontic hypothesis on the issue.

Quirk and his assistants study the mechanisms of emotional regulation using the extinction of conditioned fear. Much of what is known about it comes from animal models, using Pavlovian fear conditioning. But already in 2011, in his expose *"Drug Regime May Erase Some Traumatic Memories"* (ptsdtreatment.org), he wrote that it soon could be possible to take a drug to permanently erase bad memories. He opined:

> "What's new and exciting about this is that you don't have to struggle your whole life with these terrible memories. You can alter them instead."
>
> He deduces that typical treatment involves learning how to react to the PTSD-causing event memory. These reactions are less emotional and with less of what he calls

> "inappropriate anger" and other associated symptoms. This assumes that all memories are permanent. It has yet to dawn on him that it is not the PTSD-causing event that caused what he considers inappropriate anger. It is the pharmaceutical drug consumption, combined with the treatment received from the powers that be, including the cognitive behavioural applications and the phenomenal ignorance and treatment as animals rather than human beings who are merely passing through a "problem of living", this one being an earth shattering experiential crisis. However, as with all of his ilk, he trumpets about a promising new drug regime, also known as reconsolidation blockade. This might help people with — now, pay attention — *PTS syndrome* by decreasing their physiological responses to the memory.

The process? Reactivating the memory and then providing several doses of Propranolol, a beta blocking drug available only as a generic drug without a brand-name version. It comes as an oral extended-release capsule, an oral liquid solution and as an injectable.

Why use it? The oral tablet reduces the heart's workload and helps it beat more regularly. After a heart attack. It is also used to treat high blood pressure, angina, atrial fibrillation and tremor. It is used to prevent migraines, and to help control thyroid and adrenal gland tumours. It is not fully understood how this drug works to treat those problems (healthline.com).

Propranolol's oral tablet side-effects? It could cause drowsiness. Don't drive, use machinery or perform any activities that require mental alertness until you know how this drug affects you.

Other more common side effects?

- nausea
- diarrhea
- dry eyes
- hair loss
- slower heart rate
- weakness or tiredness

If mild, these effects might go away within a few days or a couple of weeks. If

more severe or staying, talk to a doctor or pharmacist.

Serious side effects and their symptoms, including allergic reactions?

- hives
- itching
- vomiting
- skin rash
- hallucinations
- slow heart rate
- dry, peeling skin
- cold hands or feet
- breathing problems
- sudden weight gain
- changes in blood sugar
- muscle cramps or weakness
- swelling of your legs or ankles
- nightmares or trouble sleeping
- swelling of face, lips and/or tongue

Call your doctor right away if you have serious side effects. Call 911 if your symptoms feel life-threatening or if you think you're having a medical emergency. The disclaimer reads:

> "Our goal is to provide you with the most relevant and current information. However, because drugs affect each person differently, we cannot guarantee that this information includes all possible side effects. This information is not a substitute for medical advice. Always discuss possible side effects with a healthcare provider who knows your medical history."

About the loss of your memory, nothing is stated. And why should it be? After all, when you lose your memory, you don't know it, do you?

Does Propranolol interact with other medications? Sure it can, as all medications do. It may also interact with vitamins or herbs you take, thus changing the way it works, we read. To help avoid interactions between drugs and vitamins, the physician should carefully manage all medications prescribed and all vitamins and herbs taken. Dream on, yeah?

What are drugs that can cause interactions with propranolol?

Arrhythmia drugs

Taking propranolol with other drugs that treat heart rhythm problems might cause more side effects. These include lower heart rate, lower blood pressure or heart blockage. Your doctor should use caution if prescribing these medications together.

Other examples of these drugs include:

- digoxin
- quinidine
- bretylium
- flecainide
- encainide
- moricizine
- amiodarone
- propafenone
- disopyramide
- procainamide

Blood pressure drug

If switching from clonidine to propranolol, your doctor should slowly reduce your dosage of clonidine and slowly increase your dosage of propranolol over several days. This is done to avoid side effects, such as lowered blood pressure.

Blood pressure drugs

Don't use propranolol with another beta blocker. It can lower your heart rate too much. Examples of beta blockers include:

- sotalol
- nadolol
- esmolol
- atenolol
- carteolol
- nebivolol
- bisoprolol
- acebutolol
- metoprolol

Your doctor should use caution if prescribing angiotensin-converting enzyme (ACE) inhibitors with propranolol. Taking these drugs together can cause blood pressure that's lower than normal. Examples of ACE inhibitors include:

- lisinopril
- enalapril

Your doctor should use caution if prescribing calcium channel blockers with propranolol. Using these drugs together can cause severely low heart rate, heart failure and heart blockage. Examples of calcium channel blockers include:

- diltiazem

Your doctor should use caution if they're prescribing alpha blockers with propranolol. Using these drugs together can cause blood pressure that's lower than normal, fainting, or low blood pressure after standing up too fast. Examples of these drugs include:

- prazosin
- terazosin
- doxazosin

Anesthetics (drugs that block sensation)

You should use caution if you're taking these medications with propranolol. Propranolol might affect how these medications are cleared from your body, which can be harmful. Examples of these drugs include:

- lidocaine
- bupivacaine
- mepivacaine

Drugs used to increase heart rate and blood pressure

Don't use these medications with propranolol. These drugs cancel one another out. This means that neither of them will work. Examples of these drugs include:

- epinephrine
- dobutamine

- isoproterenol

Asthma drugs

You shouldn't take these drugs with propranolol. Doing so increases the amount of these drugs in your blood. This can increase your risk of side effects. Examples of these drugs include:

- theophylline

Nonsteroidal anti-inflammatory drugs (NSAIDs)

These drugs could decrease the blood pressure-lowering effects of propranolol. If you take these drugs together, your doctor should monitor your blood pressure. They might have to change your propranolol dosage. Examples of NSAIDs include:

- etodolac
- ibuprofen
- ketorolac
- naproxen
- oxaprozin
- piroxicam
- diclofenac
- ketoprofen
- fenoprofen
- meloxicam
- nabumetone
- indomethacin

Blood thinners

When taken with warfarin, propranolol can increase the amount of warfarin in your body. This might cause an increase in how long you bleed from any wound. Your warfarin dosage might need to be changed if you take these drugs together.

Drug to treat stomach ulcers

Taking cimetidine with propranolol can increase the levels of propranolol in your blood. This can cause more side effects.

Antacids with aluminum hydroxide

Taking these drugs with propranolol might make propranolol less effective. Your

doctor will need to monitor you and might need to change your dosage of propranolol.

And again the disclaimer:

> "Our goal is to provide you with the most relevant and current information. However, because drugs interact differently in each person, we can not guarantee that this information includes all possible interactions. This information is not a substitute for medical advice. Always speak with your healthcare provider about possible interactions with all prescription drugs, vitamins, herbs and supplements, and over-the-counter drugs that you are taking."

Further Propranolol warnings?

Propranolol can cause a severe allergic reaction. Symptoms may include:

- rash
- hives
- wheezing
- trouble breathing
- swelling of the mouth, face, lips, tongue or throat

If you develop these symptoms, call 911 or go to the nearest emergency room.

Don't take this drug again if you've ever had an allergic reaction to it. Taking it again could be fatal (cause death). If you've had severe allergic reactions to other agents causing anaphylaxis, your allergies could be more reactive when you take propranolol. The usual doses of your allergy medication, epinephrine, might not work as well while you take this drug. Propranolol might block some of epinephrine's effect.

ALCOHOL INTERACTION WARNING

Alcohol can increase levels of propranolol in your body. This can cause more side effects. You shouldn't drink alcohol while taking this drug.

WARNINGS FOR PEOPLE WITH CERTAIN HEALTH CONDITIONS

FOR PEOPLE WITH CARDIOGENIC SHOCK: Don't use propranolol. Propranolol reduces the force of your heartbeat, which could make this condition much worse.

FOR PEOPLE WITH SLOWER THAN NORMAL HEART RATE: You shouldn't use propranolol. This drug can slow down your heart rate even more, which could be dangerous.

FOR PEOPLE WITH HIGHER THAN FIRST-DEGREE HEART BLOCK: You shouldn't use propranolol. Propranolol reduces the force of your heartbeat, which could make your heart block worse.

FOR PEOPLE WITH ASTHMA: You shouldn't use propranolol. This drug can make your asthma worse.

FOR PEOPLE WITH SEVERE CHEST PAIN: Suddenly stopping propranolol can worsen your chest pain.

FOR PEOPLE WITH HEART FAILURE: You shouldn't take this drug. Propranolol reduces the force of your heartbeat, which could make your heart failure worse. Propranolol might be helpful if you have a history of heart failure, are taking heart failure medications, and are being closely monitored by your doctor.

FOR PEOPLE WITH WOLFF-PARKINSON-WHITE SYNDROME: This medical condition can cause a heart rate that's slower than normal. Treatment of this condition with propranolol might reduce your heart rate too much. Treatment with a pacemaker might be needed.

FOR PEOPLE WITH DIABETES: Propranolol can cause hypoglycemia (low blood sugar). It could also mask the signs of low blood sugar, such as a heart rate that's faster than normal, sweating and shakiness. This drug should be used with caution if you have diabetes, especially if you take insulin or other diabetes drugs that can cause low blood sugar.

FOR PEOPLE WITH HYPERACTIVE THYROID: Propranolol can mask the symptoms of hyperthyroidism (hyperactive thyroid), such as a heart rate that's faster than normal. If you suddenly stop taking propranolol and have hyperthyroidism, your symptoms can get worse, or you could get a serious condition called thyroid storm.

FOR PEOPLE WITH CHRONIC BRONCHITIS OR EMPHYSEMA: In general, if you have problems breathing, you shouldn't take propranolol. It can make your lung condition worse.

FOR PEOPLE WHO PLAN TO HAVE MAJOR SURGERY: Tell your doctor that you're taking propranolol. This drug can change how your heart reacts to general anesthesia and surgery.

FOR PEOPLE WITH GLAUCOMA: Propranolol might decrease the pressure in your eyes. This could make it hard to tell if your medications for glaucoma are working. When you stop taking propranolol, the pressure in your eyes might increase.

FOR PEOPLE WITH ALLERGIES: If you have had severe allergic reactions that cause anaphylaxis, your allergies might get worse when you take propranolol. Your usual doses of the allergy medication epinephrine might not work as well. Propranolol can block some of the effects of epinephrine.

FOR PEOPLE WITH UNCONTROLLED BLEEDING OR SHOCK: If you have hemorrhage or shock, a serious

problem where your organs don't get enough blood, drugs to treat these conditions might not work as well if you're taking propranolol. This is especially true if you're taking propranolol to treat pheochromocytoma, a tumor in the adrenal gland.

FOR PREGNANT WOMEN: Propranolol is a category C pregnancy drug. That means two things:

1. Research in animals has shown adverse effects to the fetus when the mother takes the drug.
2. There haven't been enough studies done in humans to be certain how the drug might affect the fetus.

Tell your doctor if you're pregnant or plan to become pregnant. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk. If you become pregnant while taking this drug, call your doctor right away.

FOR WOMEN WHO ARE BREASTFEEDING: Propranolol is passed through breast milk. The drug may be used while you're breastfeeding, but your child should be monitored. In your child, propranolol can cause a slower heart rate and low blood sugar. It can also cause decreased oxygen in the blood, which can cause cyanosis. This condition turns your child's skin, lips or nails blue. Of course, it also starves the brain, thus lowering the child's IQ.

FOR SENIORS: Seniors might have decreased liver, kidney and heart function, and other medical conditions. The doctor will take these factors and the medications you are taking into account when starting you on propranolol.

FOR CHILDREN: It hasn't been determined that propranolol is safe and effective for use in children younger than 18 years old. There have been reports of heart failure and airway spasms in children who have taken this drug.

SPECIAL DOSAGE CONSIDERATIONS?

- For people with kidney problems: your doctor should use caution when prescribing this drug for you.
- For people with liver problems: your doctor should use caution when prescribing this drug for you.

The disclaimer reads:

"Our goal is to provide you with the most relevant and

current information. However, because drugs affect each person differently, we can not guarantee that this list includes all possible dosages. This information is not a substitute for medical advice. Always speak with your doctor or pharmacist about dosages that are right for you."

TAKE AS DIRECTED? Propranolol oral tablet is used for long-term treatment. It comes with serious risks if you don't take it as prescribed. If you don't take it at all, your condition will get worse and you could be at risk of serious heart problems, such as heart attack or stroke.

IF YOU SKIP OR MISS DOSES? The condition you are treating could get worse. Pay attention that YOU suddenly are treating the condition, you are suddenly given responsibility for treating yourself with the drug, and so it should be. They are telling you in a round about way, but they are telling you. Wake up! You are responsible for your health. NO ONE ELSE is, and that includes YOUR PTSD!

IF YOU TAKE TOO MUCH? If you think you've taken too much of this drug, call your doctor or local poison control center. If your symptoms are severe, call 911 or go to the nearest emergency room right away.

WHAT TO DO IF YOU MISS A DOSE? If you miss a dose, take it as soon as you remember. If it's close to the time of your next dose, only take one dose at that time. Don't double the dose to try to make up for the missed dose. This can cause dangerous effects.

HOW TO TELL IF THE DRUG IS WORKING? Your symptoms should improve. For instance, your blood pressure and heart rate should be lower. Or you should have less chest pain, tremors or shaking, or fewer migraine headaches. We are admonished to keep these considerations in mind if our doctor prescribes propranolol for us.

REFILLS? Forever and a day as this is a refillable prescription. You should not need a new prescription for this medication to be refilled. Your doctor will write the number of refills authorized on your prescription.

SELF-MANAGEMENT? While taking propranolol, you need to monitor your:

- heart rate
- blood pressure
- blood sugar (if you have diabetes)

CLINICAL MONITORING? While taking this drug, your doctor will periodically do

blood tests to check your:

- liver function
- heart function
- kidney function
- electrolyte levels

AVAILABILITY? Not every pharmacy stocks this drug. When filling your prescription, be sure to call ahead to make sure your pharmacy carries it.

ARE THERE ANY ALTERNATIVES? There are other drugs available to treat your condition, we read. Some might be better suited for you than others. Talk to your doctor about other drug options that may work for you. Disclaimer:

> "Healthline has made every effort to make certain that all information is factually correct, comprehensive, and up-to-date. However, this article should not be used as a substitute for the knowledge and expertise of a licensed healthcare professional. You should always consult your doctor or other healthcare professional before taking any medication. The drug information contained herein is subject to change and is not intended to cover all possible uses, directions, precautions, warnings, drug interactions, allergic reactions, or adverse effects. The absence of warnings or other information for a given drug does not indicate that the drug or drug combination is safe, effective, or appropriate for all patients or all specific uses."

MY SUGGESTIONS? Yes. Propranolol is the way out for any PTSD-affected person. It is the cure-all of all PTSD cure-alls, as it will ensure the departure from life as one has known it within a very short time-span, if not in body then in mind, without even knowing about or being aware of it.

Professor Quirk, however, shares that after applying his propranolol regime, patients often return for follow-up visits. They tell their counsellors or psychiatrists that they simply do not remember the trauma-causing incident, none of it. What else they don't remember is also unknown. They can't remember.

But again, Quirk reiterates that traditional cognitive-behavioural PTSD

treatment is based on the premise that traumatic memory is permanent. And again, he reiterates that therapy should focus on learning to respond to it with less emotion. It goes without saying that he does not know what he is talking about. He has never been in and on a line of duty of any of the genuine PTSD susceptible professions. Nor has he been raped, either, we assume.

The learned "extinction" response he advocates changes the body's physiologic amygdala-based memory, he says, and teaches a cognitive hippocampal response to the memory instead. We know it does in rattus, simian, cani, we think he thinks, so therefore it must in humans:

> "With extinction, you reroute the stimulus so it does not go to the amygdala. You're teaching the brain — it's a learned thing — but the original memory is still in the amygdala somewhere. Extinction does not alter the original memory — we know that from Pavlov."

We should call it Pavlovian then, should we? Call a spade a spade? Recognize it, you PTSD affected human dog. Still, I find it notable that these scientific mental practitioners in their maze of archontic haze steadfastly refuse to see, with their impaired and deluded left side brain rationality, that PTSD is a humane spiritual experience, not a brain malfunction. But let us move on.

Whereas extinction works well in certain psychiatric conditions such as phobia, Quirk says, people with PTSD have hippocampal and prefrontal deficits. In his opinion, these frequently cause extinction failure (Kate Johnson: "PTSD research targets memory reconsolidation: treatment, which usually involves propranolol, erases emotional reaction to the traumatic memory"; *Expert analysis from the annual meeting of the International Society for Traumatic Stress Studies* (ISTSS) 2011; thefreelibrary.com). In contrast, he insists, reconsolidation blockade does not recruit — speak engage — the hippocampus, but instead targets the amygdala-dependent reaction. In rats, in simian or in PTSD affected humans, is the question? He quivers enthusiastically:

> "I am very excited about reconsolidation blockade. What's new and exciting about this shift is that you don't have to struggle your whole life with these terrible memories. You can alter them instead."

Now "Get in line so we can try it on you PTSD dogs" should come next. But wait, it's out there — in a moment.

That propranolol works in memory extinction is a fact, mind you. In one

experiment by Canadian psychiatrist Robert Menzies, 21 out of 31 patients had a 90% response rate to Propranolol that lasted up to 24 months. But here, too, whatever else they had extinguished in their memory bank could neither be explored nor was it touched upon. You've got to laugh or cry.

One result is for certain, however, from new research suggesting that propranolol and other medications combined with psychotherapy might be able to permanently erase "trauma" from traumatic memories. The field of psychiatry is facing a shift, said several experts present at the 2011 International Society for Traumatic Stress Studies (ISTSS) annual meeting in Baltimore, Maryland, USA.

ISTSS is another non-profit corporation. Established in 1985 in Washington, DC, it is also purportedly:

> "dedicated to disseminating the state of the science as it pertains to our understanding about the effects of trauma exposure, traumatic stress, evidence-based assessment of trauma and associated symptoms, and evidence-based prevention and treatment intervention approaches." (faceboook.com)

This particular non-profit society, as all the others in its league, also provides a forum for sharing research, clinical strategies, public policy issues and theoretical formulations on trauma, including PTSD, around the world. Members include psychiatrists, psychologists, social workers, nurses, counsellors, researchers, administrators, advocates, journalists, clergy and other professionals with an interest in the study and treatment of traumatic stress. Members come from a variety of clinical and non-clinical settings around the world, including public and private health facilities, private practice, universities, non-university research foundations, and many different cultural backgrounds. Their tax-free income must be enormous, their directors living well.

Its mission statement: "an international interdisciplinary professional organization that promotes advancement and exchange of knowledge about traumatic stress."

On ISTSS' Facebook site, we read that this knowledge includes:

- understanding the scope and consequences of traumatic exposure
- preventing traumatic events and ameliorating their consequences
- advocating for the field of traumatic stress

Is the propranolol experimental PTSD treatment benignly known as reconsolidation blockade there? It has been shown to interrupt the neuro-biologic process of memory formation in mus, cani and simian, and in a few humans, without ability to determine what else they've lost in the process. Yes, it is obviously one of ISTSS' accepted means to ameliorate the advertised PTSD consequences. to heal the mentally disturbed portrayed nutcases, the human debris. Let's destroy them before they decide to awaken to their potential because of their shift in awareness, their acknowledgment of their perception change. That, I now understand, seems to be their modus operandi.

Many of the ilk are in defence of such archontic treatment. One of them is Alain Brunet, Ph.D., associate professor, Department of Psychiatry, McGill University. He is also director of the Mental Health and Society research program at The Douglas Hospital Research Centre, the second largest mental health research center in Canada. Part of the Centre Intégré Universitaire de Santé et de Services Sociaux (CIUSSS) de l'Ouest-de-l'île-de-Montréal, it has more than 560 people onsite, including 64 principal investigators, 266 trainees, MSc and Ph.D. students, and postdocs. It also has eight Canada research chairs and 13 administrative staff. Grants to these investigators are $18M with a Research Centre budget (2014) of $22M from the non-profit Douglas Institute, the Fonds de Recherche du Québec, Santé (FRQS) and other sources. Furthermore, Brunet is the ISTSS's *Journal of Traumatic Stress* associate editor, so all research publications can be well controlled.

And, of course, Brunet supports propranolol treatment. He got his fame from it. For light-years, his main focus seems to have been the study of traumatic stress impact on mental health, characterizing its risk factors, and developing effective PTSD treatments. He is also interested in PTSD epidemiology and neurobiology, as well as uses of the Internet for research/intervention purposes (douglas.research.mcgill.ca). In 2001, he developed the first instrument designed to assess the recalled amount of distress experienced at the time of a traumatic event. This measure has been used by dozens of teams across the world, and has been translated into 12 languages.

His major interest in research is, however, said to stem from a breakthrough he and colleagues from McGill and Harvard University made when they used propranolol to treat PTSD. They discovered that when people recall their traumatic event under propranolol, the emotional strength of the memory was subsequently and durably reduced. This lead to reduced PTSD symptoms.

The discovery was published by Harvard Library Office for Scholarly

Communication in 2016 (Villain, Hélène, Aïcha Benkahoul, Anne Drougard, Marie Lafragette, Elodie Muzotte, Stéphane Pech, Eric Bui, Alain Brunet, Philippe Birmes, and Pascal Roullet. 2016. "Effects of Propranolol, a β-noradrenergic Antagonist, on Memory Consolidation and Reconsolidation in Mice." *Frontiers in Behavioral Neuroscience* 10 (1): 49). But at time of its publication, we still read in it:

> " . . . to date, *the effects of propranolol on human and animal memories remain to be clarified*. It is becoming increasingly important to understand the effect of propranolol on various types of memories in order to successfully guide treatment development for mental disorders including PTSD."

Studies on it have been ongoing since at least 1999 (Przybyslawski et al., 1999). Mind you, in September 2017, Brunet could be heard on radio station Europe 1, France, advertising: "Pilule de l'oubli" : "On obtient des résultats comparables à une psychothérapie" (roughly translated: "Take a pill to forget: the results will be comparable to psychotherapy"). If you want to swallow it, good luck!

The subjects in the above study turning the table in *propranolol's for PTSD* favour were 368 CD1 male mice (IFFA CREDO, Lyon, France). They were housed in groups of five in standard breeding cages, placed in a rearing room at a constant temperature under diurnal conditions (light-dark: 08:00–20:00), with food and water *ad libitum*. Every possible effort was made to minimize animal suffering and all experiments were performed in strict accordance with the recommendations of the European Union (86/609/EEC) and the French National Committee (87/848). All animal procedures were approved by the University Animal Care Committee of Toulouse (FRBT C2EA-01), we are told.

Through those experiments with rodents in labs across the system, researchers uncovered mechanisms that stabilize and destabilize fear memories. This opened the possibility that extinction might be used to erase fear memories. Moreover, extinction administered when fear memory is destabilized updates the fear association as safe. Therefore, it prevents the return of fear in rats, mice and humans, we are told. The use of modified extinction protocols to eliminate fear memories complements existing pharmacological strategies for strengthening the extinction.

The conclusion?

> "In this study, we have shown an action of propranolol administration on the initial consolidation but most importantly on the memory reconsolidation. Moreover, the

> observed amnesic effect was not related to the aversion level of the task. This effect *seems* due most likely to a modification of the emotional state of the memory, but leave the contextual component of the memory undisturbed. From a treatment perspective, and considering the ethical criticisms generated by such an innovative strategy affecting memory (Parens, 2010; Kass, 2003), this represents an ideal state of affairs. Most patients do not wish to have their memories "erased", but rather wish they were no longer bothered by them."

Most research results are based on rattus and mus, the little critters. Only team Quirk also uses simia, the monkey, dwelling on a small island off the south coast of Puerto Rico, Cayo Santiago. The NIH-funded Rhesus Macaque research facility contains 1,000 wild, free-roaming monkeys. His team is studying them for fear reactions, by exposing them to a rubber snake. They then correlate their fear responses with parameters such as age, sex, social behaviours and genetic markers. Nothing is known about propranolol or other drug consumption administration, and results for else seem to me still pending, while Brunet still maintains: "We do not erase people's memories."

Dr. Roger K. Pitman concurs. He is director of the posttraumatic stress disorder and psychophysiology laboratory at Massachusetts General Hospital and professor of psychiatry at Harvard Medical School, both in Boston, Mass. He explains that, rather than erasing an entire memory, the reconsolidation blockade *appears* to erase the emotional reaction to the memory. "Appears" is the operative word. Needless to say, what is good for mus, rattus, simia and cani, is good for homo sapiens, that Darwinian animal-evolved creature, although Darwin never said a word about it! But let's leave that can of worms closed.

Consequently, Pitman and Brunet studied PTSD patients treated with propranolol after memory reactivation. The results showed a significant decrease in physiologic response when they engaged in script-driven mental imagery of their traumatic event a week later, compared with placebo-treated patients (*J. Psychiatr. Res.* 2008;42:503–6).

But an even more recent study by Pitman's group found improvements in two separate propranolol-treated PTSD groups. One group was treated after memory reactivation, and one was treated without reactivation. This, Pittman opined, suggested that "there may be nonspecific effects of propranolol, which does not

support the theory of reconsolidation blockade." Really? Divine intervention, perhaps?

Not everyone agrees on the mechanism through which propranolol affects memory, either. Dr. Charles Marmar finds that propranolol treatment is "pioneering" in that it upends traditional theories about the permanence of memory. Propranolol normally involves two doses of the beta-blocker propranolol administered between 75 minutes and two hours apart, Marmar is professor and chair of the department of psychiatry and director of the Trauma Research Group at New York University.

Brunet, as already mentioned among the first researchers reporting results from propranolol treatment in PTSD patients, protests: "We do not erase people's memories." How he knows is unknown.

At a 2010 meeting of the Canadian Psychiatric Association, Menzies, the psychiatrist in private practice in Saskatoon, Sask., reported otherwise. His PTSD patients experienced fragmented memories, emotional distance and even amnesia after treatment with propranolol. This was not mentioned in the Kate Johnson article. Half truth, always half truth. In his 31 patients (21 men) treated over a two-year period, there was a 90% response rate, with the duration of effect continuing up to two years. The patients' duration of traumatic memories ranged from three months to 38 years, by the way.

Researchers at the center for neural science at New York University also reported a drug-free approach to reconsolidation blockade. It uses psychotherapy during the labile window to "rewrite" fearful memories (*Nature* 2010; 463:49–53). This approach is a variation of traditional extinction training. But because it is done during the window of biochemical lability, it is assumed to permanently alter the amygdala-dependent memory. These researchers furthermore wrote that they provide evidence that old fear memories can be updated with non-fearful information provided during the reconsolidation window. As a consequence, fear responses are no longer expressed. The effect lasted at least a year, and was selective only to reactivated memories, without affecting others, they say.

The discussion and debates rage on. Self-proclaimed PTSD experts, in the making of their fortunes, state that, although targeting the traumatic memory is an important part of PTSD therapy, it is not the only part. "We might have to go beyond simply looking at the traumatic memory piece of things," said Rachel Yehuda, Ph.D. She is director of the traumatic stress studies division at Mount Sinai School of Medicine and director of mental health at the James J. Peters VA Medical

Center in New York. There are other components to PTSD, such as loss, grief, sadness, inability to experience pleasure, anger and rage, and feelings of shame, she said in an interview. "Those are things that also have to be addressed." Finally a humane spirit voicing a sensible humane empathetic and compassionate opinion.

But Thomas C. Neylan vigorously opposes this. He is professor of psychiatry in residence at the University of California, San Francisco, and director of the posttraumatic stress disorder program at the San Francisco VA Medical Center. He trumpets:

> "This [propranolol extinction] is important work — I am excited about it — but cognitive work also has to happen. People who have been traumatized often have a whole new set of assumptions about their world and their place in the world, that are sometimes erroneous. That's cognitive work that has to be done, separate from reconsolidation or extinction work."

Yes, of course it has to. After all, propranolol should be a wonderful mix with Prozac and the like, shuffled down VA PTSD patients' throats. Combine it with CBT to keep those guys in business. So they assure patients of the healthiness of such consumption to cure them from their PTSD. All done so the therapist and his cabal can continue until his death with their lucrative PTSD voyagers-derived prescription drug-enhanced psychotherapy income. That way, patients won't see the perception-deception and gain their freedom from these psycho-the-rapists poisoning them to death.

Neylan's life-experiences? We know nothing of him, or any of the others, than what is written on Care Dash Review your doctor. There it says that he is a:

> "male psychiatrist in San Francisco, CA with over 34 years of experience. Dr. Neylan is affiliated with UCSF Medical Center in San Francisco. Public records indicate that he received $9,207 in payments from medical companies between 2014 and 2017, which is more than a majority (93%) of psychiatrists nationally. Dr. Neylan graduated from Rush Medical College of Rush University in 1984. He is licensed to practice by the state board in California."

Rush Medical College is the medical school of Rush University, located in the Illinois Medical District, just 2 miles west of the Loop in Chicago. Offering a full-time Doctor of Medicine program, the school was chartered in 1837. Today, it is

affiliated primarily with Rush University Medical Center, nearby John H. Stroger, Jr. Hospital of Cook County, and NorthShore University HealthSystem, Skokie Hospital (formerly known as Rush North Shore Medical Center). In 2018, Rush Medical College was ranked 69th among research institutions in the U.S. by *U.S. News & World Report*.

Many a therapist apparently believes that the propranolol approach will not be long-term effective.

Others object in a philosophical way, such as Kate Farinhold, executive director of the mental health support group NAMI Maryland. She sees memory as part of human identity and should never be erased. Actually, she finds deleting it a little scary, even. "How do you remove a memory without removing a whole part of someone's life, and is it best to do that considering that people grow and learn from their experiences?" she asks. Some do, many don't, but for PTSD experiencers growing and learning from it by making peace with the old Self and creating the new Self on a spiritual path is the only way out of this Odyssee. Both Dr. Yehuda and Farinhold seem to grasp it, small voices in a sea of scientific neurological PTSD treatment hawks.

Roger L. Redondo, Ph.D. of the pharmaceutical giant F. Hoffmann-La Roche AG, also espouses the possibility of PTSD trauma memories erasure following the administration of certain pharmacological agents. He should know. After all, he has access to all research conducted by this Swiss multinational "healthcare" cartel operating worldwide, with control of the American biotechnology company Genentech, the Japanese biotechnology company Chugai Pharmaceuticals, as well as the United States-based Ventana Medical Systems, Inc. The latter develops, manufactures and markets instrument reagent systems that automate tissue and slide staining in anatomic pathology laboratories.

Edward G. Meloni, Ph.D. is a Kaneb fellow in psychiatry and an investigator in the Behavioral Genetics Laboratory at McLean Hospital. Meloni's post-doctoral experience included research in the Psychiatry Department at Emory University and Neurology Department at Harvard University. He agrees with Redondo. Author of numerous journal articles, Meloni is also a recipient of McLean Hospital's Pope Award and an assistant professor of psychiatry at Harvard Medical School. Both Redondo and Meloni surmise that such erasure *might* mean that PTSD patients *might* be able to experience rapid relief of their symptoms, which would otherwise require *several* sessions of therapy. What about a lifetime of sessions and a slow and tedious death while they are ongoing with their methods of drugging and

brainwashing?

But now, finally, to the PTSD cure jackpot of all jackpots!

Meloni of McLean Hospital reported in 2014 that xenon gas had the potential to be a treatment for post-traumatic stress disorder (PTSD) and other memory-related disorders. Xenon gas is normally used in humans for anaesthesia and diagnostic imaging. "In our study, we found that xenon gas has the capability of reducing memories of traumatic events," he announced. "It's an exciting breakthrough, as this has the potential to be a new treatment for individuals suffering from PTSD."

Meloni teamed up with Marc J. Kaufman, Ph.D., director of the McLean Hospital Translational Imaging Laboratory and associate professor of psychiatry at Harvard Medical School for a study. They examined whether a low concentration of xenon gas could interfere with a process called reconsolidation. This is a state in which reactivated memories become susceptible to modification. In November 2014, Meloni explained:

> "We know from previous research that each time an emotional memory is recalled, the brain actually restores it as if it were a new memory. With this knowledge, we decided to see whether we could alter the process by introducing xenon gas immediately after a fear memory was reactivated." ("Can Post-Traumatic Stress Disorder be treated with Xenon Gas?" mghmcleanpsychiatry.partners.org).

In 2018, a *Newsweek* special edition regurgitated an *excerpt from its journalist Douglas Main's 2014* special edition article: "Vietnam War". They exposed the xenon gas PTSD proposition, this time entitling it "Can PTSD Be Treated With a Simple Gas?" The theory was then and is now that xenon gas prevents a memory from being re-encoded, which *might* allow it or its emotional significance to begin to fade. Proof? When researchers played a musical tone before giving rats a small electric shock, the animals learned to become fearful when they heard the sound. But when those rats inhaled air made up of 25 percent xenon for an hour after hearing the sound they became less fearful of the noise when it was played again, compared with rats not exposed to the gas. Thus, the authors insist, the study shows that xenon gas interferes with the re-encoding of the "fear memory or the emotional component of it."

"We really think we blocked this process of reconsolidation," Meloni announces without cracking a smile. And you believe this fairy tale, do you?

To hinder reconsolidation, xenon gas would be given to PTSD-experiencing

soldiers after they recalled a traumatic memory in a psychiatrist's office and thereby dampen that memory or its associated pain, he proposes. After all, the gas works in mice by interfering with a receptor in the brain called an NMDA receptor, thought to be involved in the reconsolidation process, writes Main. So why should it not work in humans, pray or become prey, perhaps? There certainly is reason to believe xenon would work similarly in humans, asserts Wendy Suzuki, a neuroscientist at New York University who wasn't involved in the work.

"The exciting thing about this research is that it's using a substance that's already used in humans," Suzuki told *Newsweek*. (Newsweek archive, 8/27/2014, by Douglas Main)

Yes, it may well be, but not to erase extraordinary experiences from their lives, right? Could it perhaps be that those extraordinary experiences resurface to give humans an opportunity to work through and learn from them, pray? But how could I even think that way? We are in their eyes rattus and cani, rattus and cani, rattus and cani, we need to keep repeating to ourselves. Researchers were planning to test xenon's effect on memory reconsolidation some more in rattus et al. beginning around 2016, although not yet on PTSD-affected humans, we were told.

But hold on. The xenon gas memory extinction gas idea did not need more research, it seems. It was implemented so fast you could see their heads spin. Nothing is better in the world for the ruling classes, the Elite, the archontic cabal, than making bright humans deficient of memory. Therefore, in June of 2017, Adriana Bobinchock, director media relations at The McLean Hospital Corporation of Belmont, MA, reported some stunning news. A patent allowance was issued to Meloni and Kaufman for their invention involving the use of xenon gas to help treat addiction and anxiety disorders, such as PTSD.

According to Meloni, "the invention may supplement traditional cognitive therapy or 'talk therapy' with xenon gas administered to help PTSD patients cope better with their traumatic memories." Sure, so they turn into obedient zombies. But that's not all. The invention could be used not only during a psychotherapy session in a clinician's office. It could be used not only during talk therapy, when the traumatic memory would be reactivated and the patient would inhale the gas, which "will interfere with a neurobiological process that re-stores or 'reconsolidates' the memory back into the brain." It could also be — wait for it — self-administered at leisure. Hallelujah. That should encourage a perpetual vegetal state of mind.

And all of it because these Harvard researchers, in one animal study with rattus, found that xenon gas blocks their memory process. What works for them works for

the rest of the homo sapien species as well, of course. Xenon gas thus turns into the ideal SOMA for the masses, easily disbursed through super malls' ventilation systems, aircraft, high-rises, public arenas, sports pavilions, and so on and so forth. You can render almost the entire human race amnesic with one swoop. Brother! Think about it.

Blocking or completely losing memories, or even the process of forming any, lessens the emotional impact of the memory of the traumatic – or any – event. It is better and easier applied than MKUltra, which still needs human intervention. Here you can traumatize en masse and erase en masse, another archontic perversion inversion carried through. Mind you, most humans are amnesic to begin with these days. TV, iphones, ipads, video games, virtual reality are all taking wonderful care of it. But I digress – again.

Even though Meloni believed the invention would mostly be used in clinical settings, he did exclaim:

> "We also envision having patients be able to self-administer the gas through a portable inhalation device when they experience flashbacks, cues that trigger the traumatic memory, or nightmares – all common symptoms of PTSD."

Needless to say, anyone in the takers environment can borrow the inhaler at leisure. Nay, how stupid of me. They will be distributed free of charge by the governments' respective Ministries of Social Services and Health, of course, worldwide.

Nobilis Therapeutics, a biotechnology company that develops inhalation-based treatments using inert gases has already licensed the patent. Nobilis is developing a hand-held medical device for self-administration of xenon outside of the clinician's office. It is working to advance the use of the invention to treat patient populations with neurological and psychiatric disorders beyond PTSD. McLean Hospital, the largest psychiatric affiliate of Harvard Medical School and a member of Partners Health Care, is thus complicit in drugging the population big time. And you still believe they will help with PTSD healing?

Partners HealthCare, by the way, is another non-profit health care system praising their commitment to patient care, research, teaching and service to the community locally and globally. "Collaboration among our institutions and health care professionals is central to our efforts to advance our mission" (partners.org). Whose mission might that be, I wonder. The Archontic evil you know in combination with xenon gas manifested, perhaps? Back to B & S's next superb PTSD

therapy, in their opinion at least, the DBT.

47

Dialectical Behavior Therapy (DBT) & PTSD as Systemic Disorder

What is DBT? Another cognitive behavioural treatment developed by another American, the psychologist and author Marsha Linehan (1943–), Ph.D., and ABPP. She created her style of psychotherapy by combining behavioural science with Buddhist concepts, such as acceptance and mindfulness.

Behavioural sciences includes two broad categories: neural *information sciences* and social, *relational sciences*. These areas are interrelated and study systematic processes of human and animal behaviour. But they differ on their level of scientific analysis of various dimensions of behaviour. Behavioural sciences explore the

cognitive processes within and the behavioural interactions between organisms in the natural world. They involve the systematic analysis and investigation of human and animal behaviour through the study of the past, controlled and naturalistic observation of the present, and disciplined scientific experimentation. They try to draw legitimate and objective conclusions through rigorous formulations and observation. Examples of behavioural sciences include psychology, psychobiology, anthropology and cognitive science. Generally, behavioural sciences deal primarily with human action and human behaviour as it relates to society.

Information processing sciences deal with information processing of stimuli from the social environment by cognitive entities. This processing would be to engage in decision-making, social judgment and social perception for individual functioning and survival of organism in a social environment. These include psychology, cognitive science, psychobiology, neural networks, social cognition, social psychology, semantic networks, ethology and social neuroscience.

In other words, neural information science ventures into visual reality information as behavioral science. However, let's consider our PTSD position, and our spiritual (not religious) view of the world. The whole undertaking might seem a bit ludicrous, as we, if we are off pharmaceutical drugs, discover sooner or later a couple things. First, that it is our own perception that dictates the choices we make of one of the 11 million sensations cruising through our minds per second. Second, that it is these choices we make that consequently dictate our lives in their entirety. As one reads in the *Course of Miracle* cards:

> "Your holy mind establishes everything that happens to you. Every response you make to everything you perceive is up to you, because your mind determines your perception of it (T168)."

Therefore, neural information science aimed at dictating human perception through computer technology is another archontic perversion scheme, as no experiment will be in accordance with experimenters' true human spirit or mind. It is an impossibility, as the researcher's mind will influence the results. That is well known in academic circles, but still the farce, the perception deception, is being carried on to the detriment of many, PTSD journeyers included.

On the other hand, relational sciences deal with relationships, interaction, communication networks, associations and relational strategies or dynamics between organisms or cognitive entities in a social system. We can almost deduce that these cognitive entities include AI Sophia, proud citizen of Saudi Arabia.

The idea for relational sociology sprang from the brains of Harrison White and Charles Tilly in the United States and Pierpaolo Donati and Nick Crossley in Europe. Relational sociology draws on a perspective or social ontology that Tilly and Donati refer to as relational realism or "the doctrine that transactions, interactions, social ties and conversations constitute the central stuff of social life." Donati argues:

> "Society is not a space 'containing' relations or an arena where relations are played. It is rather the very tissue of relations [as] society 'is relation' and does not 'have relations' (Pierpaolo Donati: *Birth and development of the relational theory of society: a journey looking for a deep 'relational sociology'* (PDF). Retrieved 18 October 2014.)

In the USA, theoretical ideas of relational sociology were consolidated under the banner of The New York School of relational sociology in the 1990s. The Canadian Sociological Association referred to it as the "relational turn" in social sciences spreading around the world. Fields under relational sociology are sociological social psychology, social networks, dynamic network analysis, agent-based model and micro-simulation.

Overall, then, behavioral sciences abstract empirical data to study the decision processes and communication strategies within and between organisms in a social system.

In contrast, social sciences provide a perceptive framework to study the processes of a social system through impacts of social organization on structural adjustment of the individual and of groups. They typically include fields like sociology, economics, public health, anthropology, demography and political science.

We see that many subfields of these disciplines cross the boundaries between behavioural and social sciences. For example, political psychology and behavioural economics use behavioural approaches, despite the predominant focus on systemic and institutional factors in the broader fields of political science and economics.

In other words, the field of behavioural sciences, where little seems to be science based, allows almost any proposal one may dream up as a PTSD amelioration idea. All it needs is a mental health practitioner with appropriate academic accreditation to propose it. Everything goes. It's the joker of any game. Whatever one dreams up as PTSD-efficient can be made to fit.

So it is with Linehan's DBT. The letters ABPP in her name, by the way, stand for the American Board of Professional Psychology, the primary organization for specialty board certification in psychology. The ABPP was incorporated in 1947 with

the support of the APA, the American Psychological Association. It is a unitary governing body of separately incorporated specialty examining boards. It was installed to assure the establishment, implementation and maintenance of specialty standards and examinations by its board members. Its stated mission? To increase consumer protection by examining and certifying psychologists demonstrating competence in approved professional psychology specialty areas. It provides certificates to those by their peers deemed competent to deliver high quality services in psychology's numerous specialty areas. Obviously everything goes, as long as it suits the majority of board members present.

The newest fashionable idea about PTSD, for example, is that it is a systemic disorder. That configuration, and new PTSD cure proposals in accordance with it, should be accepted by the ABPP very fast. It fits in well with the existing treatment modalities, all and everything in existence thus far. And everything yet to come into existence as cure proposal for PTSD, this most natural human and humane existential crisis calamity, can be made to fit into it. With the enormous money-making potential, ABPP certification can be accepted any day now, I assume.

It is the brain child of two people we met in the previous chapter. The first is Janine D. Flory, associate professor, Icahn School of Medicine, Mount Sinai, New York, NY. She is also director, trauma and recovery services clinic, James J. Peters Veterans Affairs Medical Center, Bronx. The second is Rachel Yehuda, professor of psychiatry, Icahn School of Medicine, Mount Sinai. She is also director, mental health care center, James J. Peters Veterans Affairs Medical Center. ("Is PTSD a Systemic Disorder?" *Psychiatric Times* Apr 18, 2018)

Systemic means affecting the entire body, rather than a single organ or body part. For example, high blood pressure and the flu are systemic disorders, as they affect the entire body. (medlineplus.gov) Nothing better to be dreamt up, except for xenon-gas, of course, than to destroy PTSD journeyers by way of with trans-humanistic means, fixing their systemic disorders of body and mind, is there?

Furthermore, Yehuda and Flory opine that in addition to PTSD's psychosocial problems, there is a growing realization it could lead to or exacerbate chronic medical health conditions. How, when, where and why these chronic medical health conditions arose is mute. Findings were consistent across civilian and veteran samples, assert Yehuda and Flory. Who are these civilians? We are not told. Could they be DSM-5 PTSD diagnosed snow-and-jelly flakes? Possibly. Remember . . . everything goes in this perception-deception game. If we are told over and over and over again how sick we are in mind and body, we will begin to feel sick in mind

and body. That's the aim. Now you know, now you can avoid falling into that trap.

However, several large cohort studies showed a prospective association between PTSD symptoms and cardio-metabolic disorders, such as myocardial infarction, stroke, type 2 diabetes mellitus and coronary heart disease. These associations generally persisted after adjusting for comorbid depression, which occurred in about half of all PTSD cases, we are told.

PTSD had also been linked with autoimmune disorders and neurodegenerative diseases. Epidemiologic research had suggested that it could increase the risk of rheumatoid arthritis, autoimmune thyroiditis, inflammatory bowel disease, multiple sclerosis, psoriasis and *lupus erythematosus. Lupus* is an autoimmune disease in which the immune system mistakenly attacks various parts of the body including the skin, joints and various other organs. It occurs when the immune system creates antibodies that attack and destroy healthy tissue causing pain, damage and inflammation. Mind you, the temporal association between PTSD and autoimmune disorders had not been studied extensively, Yehuda and Flory admit. But Andrea L. Roberts et al. did a longitudinal cohort study of 24 women. It showed that the onset of trauma exposure and PTSD symptoms preceded the development of *lupus erythematosus* (Andrea L. Roberts Ph.D., Susan Malspeis MS, Laura D. Kubzansky Ph.D., Candace H. Feldman MD, Shun-Chiao Chang ScD, Karestan C. Koenen Ph.D., Karen H. Costenbader MD, MPH: *"Association of Trauma and Posttraumatic Stress Disorder With Incident Systemic Lupus Erythematosus in a Longitudinal Cohort of Women";* onlinelibrary.wiley.com/).

These researchers disclose in their conclusion that the trauma and PTSD assessments had been done in 2008. They note that the 24 subjects may have experienced trauma and PTSD between 2008 and the end of the 2013 follow-up. Misclassification of trauma and PTSD likely also biased the results. Multiple analyses had been conducted to assess if their associations might be a result of SLE (Systemic *Lupus Erythematosus*) leading to trauma and PTSD. No evidence could be found to support this. The study design, however, could not definitively rule out the possibility. Although they considered their test-sample of 24 women large, the number of incident SLE cases was moderate. This limited the study's statistical power, they contended. Furthermore, the women who enrolled in the study were nurses, likely more interested in health-protective behaviours than women in the general population. This probably also biased the results. The study had a number of important strengths, at least in their view, as it was the first longitudinal study known to have examined the question of association of trauma and PTSD with

incident Systemic *Lupus Erythematosus* validated by medical record reviews. The authors opined that the results were more generalizable than those of clinic-based studies, as participants were not selected on the basis of trauma or PTSD status.

It is this study that seduced Yehuda and Flory to superimpose the PTSD systemic disorder verdict on 600,000 US soldiers and veterans, never mind the millions of others worldwide. It is such reports influencing the VA, the DoD, and the treatment of genuine PTSD experiencers overall. You have to laugh or to cry. And we, the PTSD journeyers, the general public, the media, fake or alternative, swallow it whole. We simply do not understand or recognize that it all boils down to a systemic perception-deception. We don't see that it is a systematic destruction of not only the PTSD affected's health, but the world population's health, by hook and by crook.

But in Flory's and Yehuda's opinion, the public health significance of understanding why and how trauma exposure/PTSD were linked to medical illness was enormous. Recent results from gene expression studies also offered some intriguing research possibilities for investigation, the Archontic trans-humanistic agenda at play again. But now that the link between PTSD and chronic illness had been established, the potential role of immune system markers in mediating this association was only beginning to be examined. As new psychotherapeutic and pharmacological treatments were developed, there was indeed an opportunity to examine the relationships between inflammatory markers and symptoms that, we learn, change over time.

I would be dead long ago had I followed the advocated mental health cabal's treatment modalities. Gruesome it would have been, had I continued to allow Ativan to warp my mind and body out of proportion, distort it to an unrecognizable shape. I know what would have happened to me. I recently met someone who had taken it like clockwork for over 30 years, albeit only three a day, she says. Now, she is more dead than alive, without knowing it. Her body is falling apart. Eye and brain cancer is ravaging her mind. All this is self-inflicted, trusting the evil with the face she knows and the voice she trusts. Does she know it? No. Her mind furthermore perverted by 24 hour *As the World Turns* television programming, the perception deception further renders her too blind to see and too deaf to hear anything, "my doctors know best" being her agenda.

Yehuda and Flory seemingly suffer in the same way. How else can they take the above research as justification for declaring military PTSD experiencers, and by extension fire fighters, police officers, aircrew and rape victims, as systemically ill? How can they justify ignoring that it is the PTSD treatment received by them that is

the culprit for the PTSD calamity continuance ad nauseam? Have they no shame, no grain of honor, no integrity?

No, they don't, as they serve another master. The "cure" for PTSD is not to be found other than within the Self. They know it, I know it, and now you know it. This is not to be advertised, as PTSD, or the perception-deception thereof in the DSM-5 configuration, is being used to get as many humans as possible on opioids, thus destroying their thinking ability. Those PTSD-affected soldiers and veterans stupid enough to enroll at Headstrong and the like for experimentation will be used to usher in the AI society. Welcome to the mixture between humans and Sophia fast-approaching, unless we awake fast, very fast. PTSD travelers have the awareness to change this rather grim prognosis for humanity, if they can just get off pharmaceuticals and opioids. If they dare to go there, meaning to free themselves from them, they can hugely help to turn the tide around by their awareness alone.

And this is why Yehuda and Flory and the vast majority of their ilk do everything in their power to stop them. The systemic disorder is just another in a long line of their scams. It is merely meant to rattle your confidence further, to make you doubt your sanity further, to throw–nay hurl–you into the abyss. It is up to you to disallow it. It is up to you to disallow them such victory over you, now that you know their game. You also know now that you have the power. Use it and prosper, or you might as well put your head down and die right now. As a matter of fact, it would be better for you and the world if you got it over with. There are enough cowards and imbeciles in it as it is. You don't have to be one.

Yehuda and Flory show unsurpassable acting or ignorance, however. They wonder whether it is possible that the growing interest in alternative therapies for PTSD, such as meditation, yoga, acupuncture and other interventions that increase physical activity or alter dietary intake, might indeed provide benefits. Oh, no, but the best part is that they wonder if those benefits are through their anti-inflammatory effects? I could of course assure them, manifest of all of it that I am, that without alternative interventions one can watch the Self die this slow and tedious death they so desire you to suffer. The latter is what they feed on, for heaven's sake (Janine D. Flory, Rachel Yehuda: *"Is PTSD a Systemic Disorder?"* Psychiatric Times. 2018, vol. 35, iss. 4). And it's not about anti-inflammatory effects.

It is also important to examine whether the association between PTSD and immune markers is part of a broader association between mental illness and poor health. Or is it specificity between trauma exposure and particular markers and disease outcomes, Yehuda and Flory wonder. I wonder whether they ever gave

thought to what in fact drives the body engine. Last I heard, nutrition played a role in it. What do most PTSD journeyers' loose after a few months of monetary cut-off by the powers that be shortly after the PTSD-causing event moment? Good nutrition, as they are made to be poverty-stricken as soon as possible afterwards — on purpose. It is all so simple to see, once we start looking.

But look we must. Nothing comes from nothing. Remember! Dharma overrules Karma. Learn, be frugal, be thrifty, be generous, be kind and prosper. Learn to use the PTSD journey for what it is meant to be used, for heightening awareness, personal education and spiritual growth — for the expansion of our infinite consciousness and awareness! Try to keep cool while learning, and prosper through learning. For me, sometimes that's very hard to do, as what I discover strikes me occasionally as almost overwhelming. But I refuse to feed the archontic wolves; I deny them power and go on. Nothing comes from nothing! And remember, as there is no time, no matter how long it has been that your PTSD-causing event occurred, you can begin now on your journey of discovery. You doubt it?

Why? If you truly wish to educate yourself on the topic, the Swiss psychiatrist Carl Gustav Jung can set you straight in his book *Psychology and the Occult,* stating:

> "The psyche's attachment to the brain, i.e. its space-time limitation, is no longer as self-evident and incontrovertible as we have hitherto been led to believe . . . It is not only permissible to doubt the absolute validity of space-time perception; it is, in view of the available fact, even imperative to do so (Routledge; New edition 1987).

Jung (1875–1961) was a most influential thinker in his time and the founder of analytical psychology known as Jungian psychology. Even today his radical approach to psychology is influential across the globe in the field of depth psychology. He is considered the first modern psychologist to state that the human psyche is "by nature religious" and to explore this spiritual part of our nature in depth. His many major works include:

- *The Red Book*
- *Man and His Symbols*
- *Memories, Dreams, Reflections*
- *The Collected Works of Carl G. Jung*
- *Analytic Psychology: Its Theory and Practice*

Poverty stricken you, the PTSD journeyer, most likely are, or at least financially very strapped, with the sword of poverty always hanging over your head. So, please be advised that if you live near a university or college, check out its library, to which you have access, even though you are not a student or alumni. Most likely you'll find many of Jung's work there, and you can spend all opening hours in the library to your heart's content. You can even pay for a photocopy card and make copies of the pages that touch your heart. Just mark them with a scrap of paper while you are reading and do it all in one swoop before going home to maintain your flow of thought.

The opposition, the NC *for* PTSD, the Yehudas and Florys will hate you for it, but who cares? Your burgeoning education will throw a stone into their cogwheels about declaring PTSD a systemic disorder. The ABPP and APA will hate you. And you may be instrumental in changing the public's perception deception of PTSD, and thus the perception of those in the same boat as you, just by reading Carl Gustav Jung. I am certain this will lead to your PTSD recovery, as it will persuade you to read more on the PTSD topic itself. When you do, your healing has begun. Kick yourself in motion, persuade yourself, as self-persuasion is part of recovery, any recovery, I think, but that's another topic.

Here is another thing that might get your hackles up about your imposed prolongation of PTSD. It is an observation posted on GreenMedInfo Saturday, April 14, 2018, written by Carey Wedler, trumpeting out to all and sundry yet able to read and think around the world: *Goldman Sachs Analyst: Curing Patients Not a Sustainable Medical Business Model*. He got that right. By beginning to educate yourself, you, your Self, you can change this tsunami of perception deception of the multitude of humanity, including that of your fellow PTSD journeyers. It is your Duty! Unless, that is, you want to end up as the guy Martin Luther King addresses in one of his speeches when saying:

> "You may be 38 years old, as I happen to be. And one day, some great opportunity stands before you and calls you to stand up for some great principle, some great issue, some great cause. And you refuse to do it because you are afraid . . . you refuse to do it because you want to live longer . . . Well, you may go on and live until you are 90, but you're just as dead at 38 as you would be at 90. And the cessation of breathing in your life is but the belated announcement of an earlier death of the spirit.

It is this that propelled me on May 22, 2016, to begin writing this book without knowing of King's words. I knew then that if I did not write it, I would be lying on my death bed saying: "I should have . . . " Over my dead body would I allow that, so I had little choice. My spirit still compels me. If I want to live in peace with myself, I have to finish the project. If I live in peace with myself, I live in peace with the world. It cannot be otherwise. That, too, is so simple.

But it does take discipline, determination, willpower and persistency. I also pray a lot to what the Nag Hammadi writers call *The Father* and to what I call my guides, guardians, helpers, teachers and friends in the unseen. I believe they have been given to me for assistance in walking through this life, and much fun and headaches I'm sure I gave them, and to complete this trilogy. What I can do, you, too, can do. Just meditate on it and ask for help. Then listen — to your inner Self! But let's move on now to where we began this chapter, Marsha Linehan's dialectic behaviour theory, or DBT.

Of one thing we can be certain. It will continue to grow and prosper, fitting as well into all the other mesh as it does, xenon gas and propranolol included. But, first and foremost, hats off to Linehan, the first of her cabal I stumbled across openly admitting to having been diagnosed with schizophrenia. It happened at the Hartford, Connecticut, Institute of Living where she was an inpatient. And we know how easy that part is when remembering Rosenhan et al.'s insane asylum experiences. What caused her to be submitted, we do not know. To purportedly cure her, Linehan was subjected to electroconvulsive therapy, Thorazine and Librium and seclusion treatments. She herself felt she suffered borderline personality disorder. In a 2011 *New York Times* interview, she said she could not remember taking any psychiatric medication whatsoever after leaving the institute at age 18. Just to remind you, a psychiatric medication is a licensed psychoactive drug taken to exert an effect on the chemical makeup of the human brain and nervous system.

She then, we don't know how, proceeded in 1968 to graduate *cum laude* from Loyola University Chicago with a B.S. in psychology, earning an M.A. in 1970 and a Ph.D. in social and experimental personality psychology in 1971. Nowadays, she is professor of psychology, adjunct professor of psychiatry and behavioral sciences at the University of Washington in Seattle. She is also a director of the Behavioral Research and Therapy Clinics, a research consortium that develops and evaluates treatments for multi-diagnostic, severely disordered and suicidal populations. That is a remarkable recovery. Her primary research lies in applying behavioral models to suicidal behaviors, drug abuse and borderline personality disorder. She is also

working to develop effective models for transferring science-based treatments to the clinical community. Another very busy woman indeed.

How she developed her dialectical behaviour therapy is nowhere disclosed. But the seed was apparently planted in 1967, while she prayed in a small Catholic chapel in Chicago. She says:

> "One night I was kneeling in there, looking up at the cross, and the whole place became gold — and suddenly I felt something coming toward me . . . It was this shimmering experience, and I just ran back to my room and said, 'I love myself.' It was the first time I remembered talking to myself in the first person. I felt transformed." (behavioraltech.org)

Her training in spiritual directions was purportedly conducted under the American psychiatrist and theologian Gerald "Jerry" Gordon May (1940–2005). He used to conduct workshops in contemplation and psychology and published books on how to combine spiritual direction with psychological treatment. The Episcopal priest and founder of the Shalem Institute for Spiritual Formation in Bethesda, Maryland, Tilden Edwards is another of her mentors.

In 2017, Edwards had served as Shalem's executive director for over 27 years. He is a nationally respected speaker, retreat leader and author. His most recent publication is called *Embracing the Call to Spiritual Depth.* He has designed and led contemplative programs since 1979, and continues to write and teach about spiritual life. (Rev. Tilden Edwards and the Shalem Institute. Pbs.org Nov. 1999)

Shalem is known as a center for the practice and teaching of the Christian contemplative tradition, a kind of worship usually associated with monks. We learn that at Shalem, mainline Protestants seek experience of God through, for example, practices of Tibetan Buddhists and Catholic saints. Linehan herself is a Zen master (Roshi) in both the Sanbo-Kyodan-School under Willigis Jaeger Roshi (Germany) as well as in the Diamond Sangha (USA). She teaches mindfulness workshops and holds retreats for health care providers. She has also dedicated her life and research to people whose lives are at-risk due to crippling and incapacitating psychological problems. (behavioraltech.org) Her DBT treatment seems to be one of her ways to assist those wishing help. But what does dialectic mean?

According to Merriam-Webster, the definition of dialectic in philosophy is in part based on logic and discussion and reasoning by dialogue as a method of intellectual investigation. The reasoning is specifically:

- the logic of appearances and of illusions
- the Platonic investigation of the eternal ideas
- the logic of fallacy, meaning a false, mistaken or erroneous idea
- the Socratic techniques of exposing false beliefs and eliciting truth

The term was used by the ancient Greeks to refer to various methods of reasoning and discussion to discover the truth. The term "philosopher", by the way, was coined by the Greek mathematician and founder of the Pythagorean brotherhood Pythagoras, (c. 570 BCE, c. 500–490 BCE). He formulated principles that influenced the thought of Plato and Aristotle, the development of mathematics and Western rational philosophy He interpreted it to mean "one who is attempting to find out." (Manly P. Hall: The Secret Teachings of All Ages; Pacific Publishing Studio, 2011, p.57)

More recently, German philosopher Immanuel Kant (1724–1804) applied the term to the criticism of contradictions arising from supposing knowledge of objects beyond the limits of experience, e.g. the soul or spirit. Kant, a central figure in modern philosophy, argued that:

- reason is the source of morality
- space and time are forms of human sensibility
- aesthetics arises from a faculty of disinterested judgment
- the human mind creates the structure of human experience
- the world as it is "in-itself" is independent of humanity's concepts of it

Could it be that he is talking about the deception-perception, perception-deception manifested by the cognitive-dissidence syndrome?

Experts in the field seem to concur that the fundamental ideas of Kant's "critical philosophy" especially lie in his three Critiques:

- the Critique of Practical Reason (1788)
- the Critique of Pure Reason (1781, 1787)
- the Critique of the Power of Judgment (1790)

He argues that human understanding is the source of the general laws of nature. He says that it is nature that structures all our experience. He goes on to say that it is

human reason that gives itself the moral law, which in turn is our basis for belief in God, freedom, and immortality. Therefore, scientific knowledge, morality and religious belief are mutually consistent and secure, because they all rest on the same foundation of human autonomy. This is also the final end of nature, according to the teleological worldview of reflecting judgment that Kant introduces to unify the theoretical and practical parts of his philosophical system.

Kant took himself to have effected a "Copernican revolution" in philosophy, akin to Copernicus' reversal of the age-old belief that the sun revolves around the earth. His beliefs apparently continue to have a major influence on contemporary philosophy, especially the fields of metaphysics, epistemology, ethics, political theory and aesthetics. His views confirm that the individual creates his or her own environment through personal autonomy of thought. Needless to say, personal autonomy of thought seems to be a rare quality these days, considering EMF radiation, pharmaceutical and other drugging, vaccinations, media influences, iphones, ipads, cellphones, video games and virtual reality entertainment all impacting the psyche, resulting in the perception-deception, nay perversion. Autonomy of thought is the true gift of PTSD. It presents to its voyagers the power to consciously reconstruct the Self to one's own liking. What one does with it is up to the Self, as it can also be stolen through the destruction of body and mind.

The German philosopher Georg Friedrich Wilhelm Hegel (1770–1831) also used the term dialectic. He applied it to the process of thought by which apparent contradictions, termed thesis and antithesis, are seen to be part of a higher truth, termed "synthesis" (oxforddictionaries.com). These terms originated with Hegel's contemporary Johann Gottlieb Fichte (1762–1814), another German philosopher. He became a founding figure of the philosophical movement known as German idealism, which developed from Kant's theoretical and ethical writings.

Recently, philosophers and scholars have begun to appreciate Fichte as an important philosopher in his own right. This is due to his original insights into the nature of self-consciousness and self-awareness. Like Descartes and Kant before him, he also was motivated by the problem of subjectivity and consciousness. Dialectic is manifest in the Hegelian process of change. In this process, a concept or its realization passes over into and is preserved and fulfilled by its opposite. Dialectic is also manifest by the critical investigation of this process and the theoretical application of this process, especially in the social sciences. The master-slave dialectic is the common name for a famous passage of Hegel's *Phenomenology of Spirit*, though the German title *Herrschaft und Knechtschaft* is more properly translated as

Lordship and Bondage. It is widely considered a key element in Hegel's philosophical system, which heavily influenced many subsequent philosophers.

DBT as PTSD treatment modality is destructive to PTSD experiencers. It presents a systematic reasoning, exposition and argument that juxtaposes opposed or contradictory ideas of the PTSD experiencer in order to resolve their (theoretical) conflict. It does this by examining and discussing these opposing ideas about the existential crisis termed by them as PTSD. The hope is to find the truth through an intellectual exchange of ideas with the psycho-the-rapist, the *Herrschaft*, who most likely has no clue about PTSD, as few if any of them have lived through it. In a nutshell, it would mean that PTSD-affected *Knechtschaft* voyagers in Bondage to their Lordships' fallacious views of a PTSD experience have to be changed by the treating psycho-the-rapist mental health practitioner into hypothetical entirely fallacious entities, in accordance with the Herrschaft's *Lordships* views. There you have it, written and deduced over 100 years ago. The Hegelian dialectic in motion daily, and humanity in its infinite laziness and gullibility gobbles it up, by and large without a murmur, just as the PTSD population gobbles up the treatment meted out to them, as if it were the gospel. You check out the rest.

In Linehen's view, DBT emphasizes individual psychotherapy and group skills training classes. It thereby helps people learn and use new skills and strategies to develop a life that they experience as worth living. Skills to adopt include mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness. A blend of CBT, DBT and mindfulness training was developed to treat borderline personality disorder, viewed as a serious mental illness and characterized by pervasive instability in moods, interpersonal relationships, self-image and behaviour. People with BPD were originally thought to be at the "border" of psychosis and neurosis. Now they are said to suffer from difficulties with emotion regulation as they exhibit high rates of self-injurious behavior, such as cutting, and significant rates of suicide. Impairment from BPD and suicide risks are greatest in the young adult years, and tend to decrease with age (psychologytoday). Obviously PTSD travelers are grouped in the same category.

DBT psycho-the-rapists wave between acceptance and tolerance of the client and attempts to change the client's behaviours, such as para-suicidal acts. Individual therapy sessions are supplemented with DBT skill groups. In addition, a peer supervision and support group for clinicians is built into this treatment model. The theory in itself has been evaluated as either a stand-alone treatment or as an adjunctive treatment. Evaluations have udes skills groups with exposure-based

therapies in 4 studies, none including Veterans.

Originally developed to treat chronically suicidal BPD people, it is now recognized as the gold standard psychological treatment for this population. Research has shown, we read, that it is effective in treating a wide range of other disorders. Thos include substance dependence, depression, post-traumatic stress disorder (PTSD) and eating disorders. Thus DBT appears to be a promising PTSD treatment, although it has been empirically tested only in limited types of PTSD clients. DBT's emphasis on suicidal/parasuicidal behaviors may make it particularly well suited for use with Veterans, a population with an elevated suicide risk we learn (Kotler et al. 2001). The reason why PTSD developed in the first place is not touched upon, obviously viewed as inconsequential. In mental health practitioners' feeble minds, they can distinguish between BPT and PTSD. On the one hand, there is borderline personality disorder — borderline between what, insanity and health? On the other hand, there is a colossal existential crisis due to an experience far exceeding what is considered a "normal human life experience", most likely following a number of previous similar experiences. Failing to make that distinction shows the dilapidated fraud of mental health practice at its finest — in my opinion.

Mind you, in 2018 DBT research into PTSD treatment modality was in its earliest stages. Studies were needed to explore how it compared to other cognitive behavioral theory (CBT) PTSD treatments wrote Matthew Tull, Ph.D., on verywellmind.com. That PTSD has nothing to do with borderline personality disorder or any other mental health disorder has yet to dawn on Linehan as well.

As a matter of fact, it might neither have dawned on her that the spiritual path is the only way to PTSD healing. Nor that her experience in the church chapel was the catalyst to both her academic development generated by a desire to help her and those in similar predicaments. That the path towards a PTSD recovery is a very solitary path to travel, or that we have no power over the Other is nowhere mentioned, either. Nevertheless, Linehan's heart appears to be in a place of humaneness seldom found in those engaged in the mental health field.

What is certain, however, is that DBT by and large means settling one's PTSD by argument with a psycho-the-rapist on a one-to-one or in a group setting. Arguments are deadly to PTSD experiencers. Deadly. Wear them down to bare bones by trying to shuffle the "experts'" beliefs down their throat and they will leave or wither further. No other choice in such a colossal existential crisis. We shall see some examples of it later, exactly as the powers that be desire. It's so much more conducive to their bottom line. But let's move on to the age-old treatment by

hypnosis, also recommended for the PTSD afflicted.

Hypnosis & Biopsychiatry

"The discovery of truth is prevented more effectively not by the false appearance of things present and which mislead into error, not directly by weakness of the reasoning powers, but by preconceived opinion, by prejudice."
— Arthur Schopenhauer, German philosopher (1788–1860)

So it is with PTSD, as with everything else in life these days, it seems. The perception-deception unfolds full force, wit PTSD and all its associated perception-deceptions presented to and believed by the public. The application of hypnosis to heal it may or may not be another one, as anyone can become a hypnotherapist. Montreal-based clinical hypnotherapist Pierre Benoit is a registered clinical

counseling hypnotherapist (RCCH), as he volunteered to register himself with the National Hypnotherapy Society. In Canada, it holds the first and only current hypnotherapy register to be accredited by the Professional Standards Authority under its Accredited Registers programme. The Canadian Health and Social Care Act 2012 amended the Health Care Professions Act 2002 to provide for the Professional Standards Authority to accredit Registers of health and social care practitioners, which meet the Authority's standards.

The programme was set up to provide assurance on the standards of voluntary registers, and is viewed as the best way to promote quality within the field of hypnotherapy (www.nationalhypnotherapysociety.org). Being accredited under the Accredited Register programme is said to offer enhanced protection to anyone looking for Hypnotherapy services which includes:

- Members of the public seeking a registered hypnotherapist
- Qualified hypnotherapists seeking to become registrants

One of those registered is Benoit, who claims to be an expert in the application of clinical hypnotherapy techniques to reduce or even eliminate PTSD symptoms. As a matter of fact, he swears to it. In 2018, he published the book *PTSD And Hypnosis: A Bulletproof Vest For The Mind,* claiming his "PTSD protocol" has helped hundreds of people reclaim their lives from the scourges of PTSD.

He feels that a fast, effective way to get to the bottom of the causes of PTSD, with or without a diagnosis, and to relieve or even eliminate its most troublesome symptoms, is clinical hypnotherapy. According to him, it allows people to delve into the recesses of their subconscious mind to seek the root source of any issue. Plus, it allows the mind to confront symptoms and causes at a pace the subconscious allows.

Benoit also claims that hypnosis is so PTSD-effective that psychiatrists and psychologists in the Great Wars used it extensively to treat war neuroses. They called it 'the original brief therapy', he says, because, in a relatively small number of hypnotherapy sessions, PTSD sufferers and their clinical hypnotherapists were able to identify past and present stressors causing the debilitating emotional and/or physical war neuroses symptoms and stop them. All this without the need for strong drugs or months and months of talk therapy, he asserts.

Ten percent of American troops deployed to Europe returned as 'psychiatric casualties', he states, which apparently mirrors the Canadian statistic of troops severely affected by service in Afghanistan. Canada now faces a PTSD epidemic,

Benoit says.

He might be right. Veterans Affairs Canada reports in March 2018 that only 18% of benefits that veterans, Canadian Armed Forces (CAF) members and Royal Canadian Mounted Police (RCMP) received from Veterans Affairs Canada were disability benefits for mental health conditions.

- Seventy-three percent (73%) of these received it specifically for post-traumatic stress disorder (PTSD).
- Fourteen percent (14%) of members who deployed to Afghanistan have received a Veterans Affairs Canada pension or award for a mental health condition.
- Fifty-two percent (52%) of Canadian Armed Forces veterans with a disability benefit related to service in Afghanistan received a Veterans Affairs Canada pension or award for PTSD (www.veterans.gc.ca).

If Benoit has any of them as clients, he does not say. We are told, however, that between 1977 and 1998 he worked as a specialized educator and child and family counselor in different government agencies in Montreal, Quebec, and Calgary, Alberta. From 1996 to 2004, he opened the *Institute International de Formation et de Ressourcement Inc*. (International Institute for Training and Resourcing Inc.), teaching intervention techniques to handle verbal and physical aggression in different agencies, cégeps and companies throughout Quebec.

It was Benoit's desire to better himself that lead him to become certified as a neuro linguistic programming master practitioner, to learn hypnosis as a modality for change and to help his clients better themselves. Making the decision to specialize in hypnotherapy in 2004, he opened the *Clinique d'hypnothérapie et de relation d'aide* (The hypnotherapy clinic and counseling), where he works full-time helping people reconnect with their potential for success (www.hypnotherapymontreal.com). Nothing is known about his personal life and first hand traumatic experiences.

Miss Hyman, the hypnotist performer on board the *Norwegian Star*, due to her generosity and kindness, had invited those on board with PTSD to a private gathering with her, free of charge. When she got ready to put those present under, I told her, "I don't believe in hypnosis. I think it only masks the symptoms, but doesn't heal the wound."

I could be thoroughly mistaken. Be it as it may, however, few empirical scientific first evidence studies have looked at whether or not hypnosis might be effective for PTSD recuperation. Nor whether it would be at least as effective as cognitive behaviour therapy (the cani-rattus-simia treatment), or psychodynamic psychotherapy. To recap, the primary focus of psychodynamic psychotherapy or psychoanalytic psychotherapy is to reveal the unconscious content of clients' psyche in an effort to alleviate their psychic tension. In other words, whereas hypnosis is to suppress such revelations, such as the desire for smoking, for example, psychodynamic therapy is to bring the most inner Self to the surface. Hypnotherapy is merely an addition, to see what goes in PTSD, and why not? It can't do more damage than pharmaceuticals, CBT, and all the other inane treatment modalities we analysed already. Plus, it has been endorsed by the British Medical Council, the American Medical Association and the American Psychological Association as a valid therapeutic procedure (*"How Hypnotherapy Can Be Used to Treat PTSD"*; Sian Ferguson, March 20, 2017 www.pastemagazine.com).

But most people might just view it as a party trick, the word "hypnosis" conjuring up the image of an old man swinging a pendulum in front of a patient's weary eyes. Perhaps you think of a show in which random audience members are hypnotized to think they're chickens or dogs, barking and cackling along.

Hypnosis certainly isn't something most people associate with mental health treatments. Hypnotherapy, however, prides itself in being a clinical practice that uses hypnosis techniques, but delves deeper into clients' psychology. In other words, Pierre Benoit is not the only one claiming that hypnotherapy is a valid therapeutic form, particularly effective for treating PTSD.

The evidence is more than anecdotal. Similarly, a 2008 RCT of combat Veterans found that adjunctive hypnotherapy reduced PTSD and insomnia symptoms more than adjunctive zolpidem (Ambien) ("Hypnotherapy in the Treatment of Chronic Combat-Related PTSD Patients Suffering From Insomnia: A Randomized, Zolpidem-Controlled Clinical Trial"; *Intl. Journal of Clinical and Experimental Hypnosis*, Volume 56, 2008, Issue 3). This study evaluated the benefits of add-on hypnotherapy in patients with chronic PTSD. Thirty-two PTSD patients treated by antidepressants and supportive psychotherapy were randomized to 2 groups: 15 patients in the first group received Zolpidem 10 mg nightly for 14 nights and 17 p in the hypnotherapy group were treated by symptom-oriented hypnotherapy twice-weekly for 1.5-hour sessions for 2 weeks, meaning for six hours in total. Apparently there was a significant main effect of the hypnotherapy treatment with PTSD

symptoms. This effect was preserved at follow-up a month later.

Additional benefits for the hypnotherapy group were decreases in intrusion and avoidance reactions and improvement in all assessed sleep variables. Taken together, these findings indicated that hypnosis might be useful in PTSD treatment (Abramowitz, Barak, Ben-Avi, & Knobler, 2008).

But what is Zolpidam supposed to do? It is used to help one fall asleep, stay asleep or treat insomnia. Its side-effects, in my opinion? Ruin your life!

- **DECREASED AWARENESS AND REACTION TIME WARNING:** If you take this drug and don't get a full night's sleep, you may have decreased awareness and slower reaction times the next day. This may cause trouble driving. You shouldn't drive or do other activities that require alertness if you take this drug and don't get a full night's sleep. If you're taking Intermezzo, you shouldn't drive or do activities that require alertness without getting at least 4 more hours of sleep after taking it.
- **ABNORMAL BEHAVIORS WARNING:** This drug may cause changes in behavior, such as increased agitation. You may act differently. You may act more outgoing, have hallucinations (see or hear things that aren't real), or feel like you're watching yourself from outside of your body. You also may sleep-drive or do other activities in your sleep that you can't remember later. Tell your doctor if any of this happens to you.
- **WITHDRAWAL EFFECTS WARNING:** Don't stop taking this drug without talking to your doctor. If you've been taking this medication for a while and stop taking it suddenly, you may have withdrawal. Symptoms can include muscle cramps, vomiting, sweating, flushing (reddening and warming of your skin), and emotional changes. These can include feelings of nervousness, panic attacks, and uncontrollable crying.

But now the real kicker:

Murder: Another Ambien side effect? This question was posed by John Gever, deputy managing editor, *MedPage on* May 07, 2014, after a presentation at the 167th APA annual conference in New York City. ("*Homicide and Zolpidem: What Do We Know and How Do We Know It?*" Cheryl Paradis, Psy.D.).

Forensic psychiatrists have found it challenging to unravel the role of zolpidem (Ambien) in several brutal murders committed against loved ones, and then to persuade attorneys, judges and juries to take their conclusions seriously writes Gever.

The cases could be the most extreme examples of an already known side effect of zolpidem. Even at recommended doses, people using the drug might get out of bed and do things while still effectively asleep and not remember it the next day. Numerous reports have described people fixing meals, having sex and even getting into their cars and driving away in the middle of the night with no later recollection. A few "Ambien zombies" have wrecked their cars and even killed people in accidents.

But in at least three cases, a person with no apparent motive and no history of violence brutally murdered a spouse or close friend in the wee hours after taking more than the recommended dose of zolpidem along with other psychotropic medications. A forensic psychologist and two psychiatrists who were involved in two of these cases discussed their experiences and how the law is evolving in this area at the APA meeting. Another task for the PTSD healing bibliotherapy, perhaps?

Zolpidan in combination with hypnosis could thus be a real doozy. But never mind.

There are more studies. One of them is "Hypnosis for PTSD: Evidence Based Placebo-Controlled Studies" by Professor Arreed and M. Barabasz of Washington State University, published in 2013 (*J Trauma Treat* S4:006. doi:10.4172/2167-1222.S4-006). Thirty-six patients in study #1 and 30 patients in study #2 who met PTSD criteria were exposed to either 5–6 hours of a manualized treatment or a placebo in a single session. The major findings of the two studies showed the value of a single 5–6 hour session of manualized abreactive ego state therapy (EST). It appeared to be an effective treatment at immediate post-treatment and over repeated follow-ups, using the most commonly accepted measures of PTSD symptoms. Instead of a repressed pain, the trauma event became a simple memory, resilient to re-traumatization.

EST is another psychodynamic approach proclaimed to be able to treat various behavioural and cognitive problems within a person. It uses techniques that are common in group and family therapy, but with an individual patient to resolve conflicts manifesting in a "family of self" within a single individual. The concept of segmentation of personality has been around for many years, and that of ego states was highlighted by psychoanalyst Paul Federn. The creation of EST, however, is

attributed to John G. Watkins, an analyst, and of Edoardo Weiss, who was himself analysed by Federn.

Distinct ego states in the most rigorous sense do not normally develop, except in cases of multiple personality disorder. However, EST identifies and names facets of a patient's personality, e.g. the "frightened child" or the "control freak". After the characteristics and function of each ego state are identified, the therapist uses various psychotherapeutic techniques, such as behavioural, cognitive, analytic or humanistic therapies, to achieve a kind of integration or internal diplomacy. EST may use hypnosis or instead employ conversational techniques.

Ego states exist as a collection of perceptions, cognitions and affects in organised clusters. An ego state may be defined as an organized system of behaviour and experience, whose elements are bound together by common principle. When one of these states is invested with ego energy, it becomes "the Self" in the here and now.

Through hypnosis, the therapist can focus on a single ego state or segment of personality and dissociate other parts. Many practitioners today are hypnotically activating covert ego states. They announce that they have discovered another multiple personality, when nothing could be further from the truth. So why not try to hang that one on the PTSD affected as well?

There has been over a century of careful scientific study of hypnosis. Researchers, typically in the fields of psychology and medicine, have been interested in finding out what hypnosis is, how it works and how effective it is as a clinical treatment. Some of the first scientists to become interested in studying hypnosis were doctors, notably Liebault and Coue at the Nancy school, and Charcot and Janet at the Salpetriere, who developed theories to explain what they saw.

In the twentieth century, there were teams researching hypnosis at top American universities, including Harvard and Stanford, as well as in top English and European universities. Modern hypnosis research tends to be more divided along academic and clinical lines, we learn on Hypnosis and Suggestion. The evidence of the effectiveness of hypnosis in the treatment of PTSD is scant, with single-case studies, which have integrated hypnosis, indicating promising effects. But larger studies have not shown the same level of support, we read.

Current evidence-based therapies for PTSD, including trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR), have origins in hypnotic techniques. The benefits that hypnosis might bring to the treatment of PTSD include a focus on feelings of safety and emotional regulation, as well as a framework & techniques for revisiting memories

(https://hypnosisandsuggestion.org).

One of the earliest PTSD academic studies on the topic I could find was published in the *Journal of Clinical Psychiatry* in 1990 (Spiegel D, Cardena E: *J Clin Psychiatry*. 1990 Oct;51 Suppl:39–43; discussion 44–6). Entitled "New uses of hypnosis in the treatment of posttraumatic stress disorder", authors Spiegel and Cardena declared that hypnosis was associated with PTSD treatment for two reasons:

- the similarity between hypnotic phenomena and the symptoms of PTSD
- utility of hypnosis as a tool in treatment

Physical trauma produces a sudden discontinuity in cognitive and emotional experience that often persists after the trauma is over, they say. This results in symptoms such as psychogenic amnesia, intrusive reliving of the event as if it were recurring, numbing of responsiveness, and hypersensitivity to stimuli. Dissociative symptoms during and soon after a traumatic experience predict later PTSD, they say.

Almost three decades later, in June 2018, Mathew Tull, Ph.D., of www.verywellmind.com updated his article "Using Hypnosis to Treat PTSD". He says that numerous mental health professionals attest to the successes of using hypnosis in treating the consequences of traumatic exposure including PTSD. Seemingly addressing the millennium and jelly generation in particular, he points out that PTSD is a mental health condition triggered by either experiencing or seeing a traumatic event, whatever that might mean. Symptoms, he specifies, can include flashbacks, nightmares and severe anxiety, as well as excessive thinking about the event.

Many people who experienced a terrifying event have a difficult time coping for a while, but they do not have PTSD, he says. What many people are, we do not know either, but so what? If the above-mentioned symptoms worsen or last for an unnamed number of months or longer and interfere with overall functioning, one might have PTSD. If PTSD symptoms develop, it is important to seek proper treatment, we are told, to reduce those symptoms. It has been suggested that hypnosis could help prevent or reduce dissociation following exposure to a traumatic event. It could also reduce symptoms of anxiety and help people get in touch with memories and feelings associated with their traumatic experience.

Hypnosis is a trance-like state in which you have heightened focus and concentration.

The magical or metaphysical attributes associated with hypnosis perhaps contribute to the scepticism of its use in the medical professions, including the mental health field. But then, at this point in writing, everything related to PTSD treatment by the mental health field has to be viewed with scepticism, unless one wants to declare oneself a complete idiot. Contrary to all other advocated ideas to cure or ameliorate PTSD symptoms, however, we at least know that hypnosis has helped humans to reach an altered state of consciousness. It has been used by humanity as a means of healing for thousands of years.

David Reeves of the Cuyamungue Institute wrote an article about "Hypnosis in Ancient Civilizations" (www.cuyamungueinstitute.com). He says that suggestion therapy can be traced back over 4000 years to ancient Egypt. Healing sanctuaries called "sleep temples" or "dream temples" were used to heal people with all sorts physical and mental problems, today most likely classed as psychological. In these temples, the sick were put into a trance-like sleep. Meanwhile, priests and priestesses interpreted their dreams to gain knowledge about and find a cure for their ailments.

The tradition of temple sleep dates from the time of the priest Imhotep (c.2667–2600 BCE), "He Who Comes in Peace". Imhotep was an Egyptian polymath, (someone who is an expert in many areas of learning), known for his aptitude as a poet, physician, mathematician, astronomer and architect. Best known for designing Pharaoh Djoser's step pyramid at Saqqara, he is the only Egyptian besides Amenhotep to be fully deified. Thus he became the god of wisdom and medicine or, according to some sources, the god of science, medicine and architecture. He was also Amenhotep's vizier and possibly also vizier to the succeeding three pharaohs of the Third Dynasty. He was also renowned for his medical treatises, which regarded disease and injury as occurring naturally, rather than as punishments sent by gods or inflicted by spirits and curses.

In Imhotep's temples, sleep was also used as a psychotherapeutic tool. Sick people were put under the influence of incantation and the performance of religious rituals. They were prepared psychologically for suggestion therapy by putting them into a "hypnotic state", in the hope of provoking dreams sent by the gods. Thus, by the use of suggestion and the help of gods, Imhotep priests cast out evil spirits from the mind and body of the sick. Still today in some parts of the Middle East and Africa, one encounters shrine sleep, where priests interpret the dreams of sick people. It is also regularly, and in ever increasing numbers, tried on purportedly

demon-possessed people by the Roman Catholic priesthood. See Father Malachi Martin et al. for further information. They call it exorcism.

In Greece, sleep temples were also known as places of great healing. They were dedicated to the healing god Æsclepius, son of Apollo, the god of healing, truth and prophecy, and of the mortal princess Coronis. It was said that the Centaur Chiron taught him the art of healing. Chiron, son of the Titan Cronus and Philyra, an Oceanid or sea nymph, lived at the foot of Mount Pelion in Thessaly (www.britannica.com). Unlike other Centaurs who were violent and savage, he was famous for his wisdom and knowledge of medicine.

Homer mentions Æsclepius in the *Iliad* only as a skillful physician and the father of two Greek doctors at Troy, his sons being Machaon and Podalirius. In later times, though, he was honored as a hero and eventually, beginning in Thessaly, one of the traditional regions of ancient Greece, was worshiped as a god. His worship spread to many other parts of the country. Because it was said that Asclepius affected cures of the sick in their dreams, the practice of sleeping in his temples became common.

Those looking for cures or insights to their problems, an ailment, a personal issue, an inner quest such as PTSD perhaps, were called "seekers". They came into the sleep temple to contact Æsclepius and get a vision that would heal, guide or provide comfort for them. After all, the path to the temple was lined with huge steles made of marble on which were carved inscriptions describing miracle cures and miraculous healings that had taken place there. Many a seeker had been cured of an incurable disease. The lame had begun to walk again. The blind had recovered their sight. They were all cured solely by the supernatural healing power of the divine dream.

Seekers did not just barge into the temple, by the way. Before being allowed to enter, they first had to learn the rituals and rites of purification to cleanse body, mind and soul. They meditated, fasted, took hot baths and made sacrifices to Æsclepius, looking for signs and symbols in their dreams. Only when omens looked right, and only when they had cleansed body, mind and soul with abundance, were they allowed to enter the temple's main part. This section had a large open floor area with sacred alcoves to the sides where seekers could sleep and dream of Æsclepius healing them. When they entered, the priests sprang into action to assist them in their endeavour.

The temple interiors themselves were places of spirits and of mysterious powers, places to find mental and physical healing. Healing would take place, it was believed, whilst the one seeking it was in a deep trance brought on by the power of

priests chanting and using magical spells. The trance, known as incubation from the Latin *cubare* (to lie down), was invoked while resting on a couch on a sacred skin called Klínè. Under auspicious circumstances, the god himself was believed to appear to the seeker during their dreams and heal their sickness directly. If not, the person could be kept in the dream/trance state for up to three days. During this time, priests used suggestions to help the person to communicate with Æsclepius through dreams, and find an answer on how to cure their ailment.

The priests used secret rituals, incantations and traditions for these therapeutic purposes. They knew of their power from ancient times and preserved this power through secrecy among their own. Part priest, part physician and part shaman, they were skilled in dream-interpretation and the use of medicinal herbs. In addition, other attendants and caretakers performed sacrifices and ritual activities. They would council new seekers and see to it that they were cleansed and purified. Skilled practitioners in their own right, they would offer advice and council dream interpretations once awaking from their trance. It was well known that seekers' dreams contained the seeds of their own healing. The attendants' job was merely to elicit the god's vision and to help seekers make sense of their own personal dream story. Through the incubation, the seeker was merely to awaken to his real self and, in so doing, be able to regenerate physically, mentally and spiritually.

Over time, priests began to develop greater understanding of herbs. They began to use them as unguents, tinctures and medicines, together with dream interpretation and suggestion therapy. Priests would make up herbal prescriptions in accordance with temple attendants' and assistants' dream interpretations. Sleep temples thus slowly over the past 4000 years degenerated from dream sleep trance healing into physicians with their compartmentalized knowledge of human health and function. They became hospitals and pharmaceutical drug centers, making the sick sicker and weaker. From dreams and awakening, we have come to a slow and tedious death for the sake of financial gain and overall perception deception of health and healing.

Nowadays, Æsclepius is surely rotating in his grave at a high rate of speed. He is frequently represented standing dressed in a long cloak with bare breast, holding his usual attribute, a staff with a serpent coiled around it. His staff is the only true symbol of medicine. A similar emblem, the caduceus with its winged staff and intertwined serpents, is unrelated.

The term caduceus originates from Greek κηρύκειον kērū́keion "herald's wand, or staff". It is the staff carried by Hermes in Greek mythology and consequently by

Hermes Trismegistus in Greco-Egyptian mythology. The same staff was also borne by heralds in general, for example by Iris, the messenger of Hera. It is a short staff entwined by two serpents, sometimes surmounted by wings. In Roman iconography it was often depicted being carried in the left hand of Mercury. He was the messenger of the gods, guide of the dead, and *protector of merchants, shepherds, gamblers, liars and thieves.* Some accounts suggest that the oldest known imagery of the caduceus have their roots in Mesopotamia. The Sumerian god Ningishzida whose symbol, a staff with two snakes intertwining, dates back to 4000 B.C. to 3000 B.C. There you have it.

It is that which is frequently used as a medical emblem. Nevertheless, it is without medical relevance, since it represents the magic wand of Hermes, the messenger of the gods and the patron of trade. It has nothing to do with the healing powers of Æsclepius (www.britannica.com). By using Hermes' caduceus as their emblem, however, physicians assure their protection by Mercury. Remember, he is the *protector of gamblers, liars and thieves,* regardless of choice of specialty. We were told all along, but in our humane innocence, we were blind to the enormity of such perception-deception, never even looking for it.

As to semi-god Æsclepius, he, like Imhotep before him, evolved into a full-fledged god. At the height of his fame in the 5th and 4th centuries BC, more than 420 healing dream temples had been built in then-Greece in his honour (www.britannica. com). One of them can still be visited today. You will find it close to the ancient city of Pergamum, Turkey, during the Hellenistic period (323–31 BC), one of the major cultural centers of the ancient world.

"Father of Medicine" Hippocrates (460–377 BC), for example, recognized the power of the subconscious mind. He also maintained that our feelings and emotions arose in the brain, which might not be the case at all. The jury is still out on that one, though it does seem to control our body. Nevertheless, he was aware that hypnosis is a state of focused mental concentration, self-awareness, watchfulness and heightened emotional sensitivity. We often move into this state spontaneously while watching a movie or reading or writing a book. Immersed in the storyline or research, focus and concentration deepens, time is suspended and everything happening around fades away. In other words, hypnosis is a meditative state we PTSD journeyers can enter at will and all by ourselves. No intermediary from the outside world is needed. It is within our own power to enter this state of mind and healing.

Hypnotism is a completely safe, noninvasive and effective tool. It allows us to

reach within ourselves and open up to our own inner wisdom and innate abilities and capabilities. It allows us to discover, resolve and release thoughts and emotions causing discontent and psychological upheaval in our spirit. These might show up as unwanted behaviors and habits, as well as illness, disease and disorder. Self-hypnosis or meditation thus gives us another avenue towards healing our PTSD. As Hippocrates said:

> "The natural healing force within each one of us is the greatest force in getting well." (Hippocrates, 460–377 B.C.)

Hippocrates during his lifetime thus already taught that our physical body has the inborn ability to correct itself, to grow whole and healthy when given a healing environment. He also taught that our mind rebalances when filled with healthy thoughts and emotions. But nothing comes from nothing, and when perpetually incapacitated by pharmaceutical drugs, logic and reason fly out the window without knowing it.

In 293 BC, Æsclepius' renown spread to Rome, where he was worshiped as Aesculapius. The Romans almost instantaneously adopted the use of healing sleep temples throughout their empire. Consequently, when visiting Lydney in Gloucestershire, one can see the sleep temple excavated by Sir Mortimer Wheeler in 1928. One of Sir Mortimer's assistants was Professor J.R.R. Tolkein, who went on to write *Lord of the Rings*. Even when Tiberius (42 BC–37 AD) and Claudius (10 BC–54 BC) were in power, Æsclepius was still popular and influential in the Roman Empire. Their temples, though, were inscribed with praise for god Imhotep's benevolence (Joshua J. Mark: *Imhotep*; www.ancient.eu 2016).

The ancient Hebrews used meditation with chanting, breathing exercises and fixation on the Hebrew letters of the alphabet that spelled their name for God to induce an ecstasy state called Kavanah. These ritualistic practices are said to be very similar to auto-hypnosis. In the Talmud, Kavanah implies relaxation, concentration, correct attention and motivation.

The Darkei Tshuva discusses it. He quotes the Bnei Tzion (Siman 67) who was asked if one was allowed to do a procedure that he called "magnetization". This is where one is put to sleep, and in his sleep, the person would tell of events occurring far away, and of events occurring privately (in other words, hypnosis). According to nature, it would be strange that such a thing could happen. So, the questioner wanted to know if this comes from "Kochos Hatumah" or not (judaism.stackexchange.com).

The Bnei Tzion answered that he asked scientists as to their opinion of the

nature of Hypnosis. He reported that there were some scientists who said that hypnosis was a fraud, and that all people see is in their imagination. Others tried giving a scientific explanation, but admitted that they did not know how it really works.

In the end, the Bnei Tzion said that hypnosis is permitted because it is possible that it does have scientific backing. He said that, even though we don't know how it works, we may just not have discovered it yet. Moreover, one is allowed to be cured by a non-Jew through magic, as long as he doesn't use idolatry, because it could just be a natural cure that we don't know about. So he ends off that to be cured through hypnosis is allowed, even if there is no danger. To do it for entertainment could be an issue, though.

People such as fire-walkers and priests who use the religious practices of laying on of hands to make people faint on to the floor are using auto-hypnosis to bring about an altered state of consciousness by the use of suggestion and expectation. But many people in many cultures throughout the world have long been able to enter into a hypnotic subconscious state at will.

In the 1800s, hypnosis re-emerged from a new awareness of meditation techniques. Some of the key figures of that time in the field were:

- Dr. Franz Anton Mesmer (1720–1792) — the first man to systematically use an altered state of consciousness (hypnosis) for curative purposes.
- Dr. James Braid (1795–1860) — responsible for naming this state "hypnotism" from Hypnos, the Greek god of sleep. He realized that hypnotism wasn't sleep at all and tried to rename it. However, as his books on the subject had already been published in so many languages, he wasn't successful.
- Dr. Hyppolyte Bernhiem (1837–1919) — whose contribution to hypnosis was in emphasizing the role of suggestion.
- Dr. Emile Couè (1857–1926) — whose work lead to the modern understanding of the laws of suggestion. According to Couè, it is not necessarily the suggestion given to the person that produces results. Rather it is how the suggestion is received. In other words, if the client does not accept the hypnotic suggestion as his or her own nothing happens. Therefore, any suggestion must be appropriate and congruent with what the person desires to change.

In the twentieth century, two figures stand out:

- Dr Milton Erickson – a doctor who used hypnotherapy with thousands of clients, often with remarkable effects. He used metaphors or stories to deliver suggestion.
- Dave Elman – trained doctors and dentists in the use of hypnosis and hypnotherapy in the United States. Elman developed and taught fast and easy methods for going into hypnosis.

It was reported that self-hypnosis, or meditation, was showing positive results in the East. How it worked was not truly known, despite many metaphysical, medical and psychological hypotheses about how and if it induces change in mind and body.

Equal scepticism exists over whether it works at all. Some say uses for hypnosis are plentiful and diverse. Others call it pure hogwash. As we just saw, however, it has been used to cure ailments, addictions, pain, mental health and a host of other concerns throughout millennia. In one of the very few purportedly scientific studies conducted on the subject, hypnosis was apparently shown to be effective in PTSD journeyers' flashbacks and hypervigilant fear responses (Talishenfield: "On Use of Hypnosis for Treatment of PTSD"; healthworkscollective.com, 2013).

But what in essence is hypnosis? It is said to be an intensely focused state, in which the human mind ignores outside stimuli and the person becomes tuned in and in control of their thoughts. If feeling the need to engage a hypno-the-rapist for assistance, he or she might during this time be able to help clients through their thoughts and fears in a so-called safe environment. This allows them to become aware of their considered dysfunctional behaviours and reactions and to minimize the effect of the traumatic event on their daily life. It lets them learn how to relax when the fear reaction is triggered, we are told.

The most important factors in the use of hypnotism in therapy form the safety-latch, so to speak. These are the patients' desire, their willingness to be hypnotized and the therapist's training and expertise in the use of this technique. Most of it seems to be lacking most of the time. Michael Newton, author of *Journey of souls,* is the rule's exception.

That going into a hypnotic state induced by a stranger makes individuals extremely vulnerable, is a given. After all, not only are they disconnected from their environment, they are also highly suggestible. Therefore, we hear that it is important to have a trusting relationship with the counsellor, so patients are able to

process feelings and progress appropriately, whatever "appropriately" means. It is equally important that a counsellor is able to effectively lead patients through hypnosis in clinically helpful ways. Determined by whom, my sceptical mind asks?

For PTSD treatment, hypnosis is first used to teach patients how to relax and regain control in situations outside of therapy. This is done by installing specific suggestions and coping strategies to quickly call upon when needed. These coping strategies are also used to find resolution in the trauma. During this time, patients will learn integration techniques to see the trauma in a new light. This step in hypnosis allows patients to dissolve self-blame and restructure the event in a way that decreases exaggerated recreations during flashbacks and allows for closure.

In the final step of hypnosis, patients learn to maintain stability and solidify coping and relaxation mechanisms. They learn how to distract their thoughts from the trauma and regain control over their daily lives. If used correctly, hypnosis, along with therapy, can alleviate the daily re-traumatizing symptoms patients might endure. When used shortly after the PTSD-causing event, effects of hypnosis can be seen in very few sessions, we read.

In the 1990s, hypnosis had been used as both an adjunctive and a stand-alone PTSD therapy technique. A meta-analysis indicated that it might be an effective adjunct for both psychodynamic and CBT PTSD treatment modalities. The reasoning behind it?

Physical trauma produces a sudden discontinuity in cognitive and emotional experiences that often persists after the trauma is over. This oftentimes results in psychogenic amnesia, intrusive reliving of the event, as if it were recurring, numbing of responsiveness, and hypersensitivity to stimuli, stated the researchers of the meta-analysis. Dissociative symptoms during and soon after traumatic experience also predicted later PTSD. New uses of hypnosis in the psychotherapy of PTSD victims involved coupling access to the dissociated traumatic memories with positive restructuring of those memories. Therefore, it was thought that hypnosis could be used to help patients face and bear a traumatic experience by embedding it in a new context. For instance, by acknowledging helplessness during the event, and yet linking that experience with remoralizing memories. It means to re-instill the PTSD experiencing human soldier or veteran with new aspects. A sense or a system of morality could be inserted. Their efforts at self-protection and their shared affection of friends who were killed could be added. Or the inability or ability to control the environment at other times could be made part of the memory. In this way, hypnosis could be used to provide controlled access to memories that were then

placed into a broader perspective. Patients could be taught self-hypnosis techniques that allow them to work through traumatic memories and thereby reduce spontaneous unbidden intrusive recollections. (Spiegel, D, Cardena, E: "*New uses of hypnosis in the treatment of posttraumatic stress disorder*"; J Clin Psychiatry 1990 Oct;51 Suppl:39–43; discussion 44-6.1990 Oct;51 Suppl:39–43; discussion 44-6).

Matthew Tull, Ph.D., noticed that few studies had been conducted actually examining whether or not hypnosis might be more effective in treating PTSD than cognitive behavior treatment or psychodynamic psychotherapy. He found one unnamed study, which stated that hypnotherapy on its own was at least as successful as some other treatments for PTSD, including psychodynamic psychotherapy. Another one claimed that hypnosis added to standard cognitive behavior therapy for PTSD might be just as effective as cognitive behavioral therapy alone in improving PTSD symptoms for up to two years following the hypnotic treatment. He also found that numerous mental health professionals thought hypnosis helpful when treating traumatic exposure consequences, PTSD included ("Hypnosis in Treating PTSD", verywellmind.com 2018).

After obtaining his Ph.D. in Clinical Psychology from the University of Massachusetts Boston in 2005, Tull completed his internship at the Boston Consortium in Clinical Psychology. He took rotations at the Outpatient Clinic, Substance Abuse Residential Treatment Program, and the National Center for Post-Traumatic Stress Disorder, Behavioural Sciences Division. He served as a research assistant professor in the Department of Psychology at the University of Maryland from 2006 to 2008, when he joined the Department of Psychiatry and Human Behaviour at the University of Mississippi Medical Center (umc.edu) in Jackson. He also serves there as associate professor with tenure and as the anxiety disorders research and Anxiety Disorders Treatment Clinic director of the Department of Psychiatry and Human Behaviour. And he is professor of psychology at the University of Toledo, Ohio, engaged in researching:

- emotion regulation within the anxiety disorders and posttraumatic stress disorder (PTSD)
- emotion-related factors underlying the relationship between PTSD and substance use disorders
- PTSD and risky behaviors (e.g. self-injury, suicide, risky sexual behavior)
- emotion-related vulnerabilities and negative outcomes (e.g. relapse,

suicide) associated with opioid use disorders
- development and evaluation of brief interventions for high-risk populations (e.g. medical populations, patients with substance use disorders)

Tull's particular theoretical expertise lies in treating generalized anxiety disorder and anxiety caused due to asthma and chronic pain, as well as PTSD. He looks at emotion regulation strategies that function to avoid emotion and internal experience in general. He examines the ways in which they are a vulnerability factor for the development and maintenance of posttraumatic symptoms. And he studies how an emotional approach and acceptance, such as mindfulness, might serve as a protective factor for anxiety disorder-related pathology. Pathology is the science of causes and effects of diseases. It especially refers to the branch of medicine that deals with the laboratory examination of samples of body tissue for diagnostic or forensic purposes.

His present investigations? Specific behaviours seemingly associated with emotion dysregulation and avoidance, manifested by substance use and risky sexual behaviour. He is looking at how these are mirrored by negative clinical outcomes among PTSD experiencers and other users of substances. Emotional dysregulation (ED) is mental health practitioners' jargon. It refers to patients who, in their view, demonstrate poorly modulated emotional responses, falling outside of a conventionally accepted range of human emotional response. It includes angry outbursts, destroying or throwing objects, aggression towards self and others, and threats of suicide. These emotion-generated reactions in true PTSD-affected experiencers, the fire fighters, soldiers, veterans, police officers and aircrew, are caused by the pharmaceutical drugs swallowed upon request. They are caused by the treatment received from employers, WCB, Unions and mental health practitioners. But that never gets studied.

Tull uses biological psychiatry (bio psychiatry) to gauge and evaluate his subjects' minds. It aims to understand mental disorders in terms of the biological function of the nervous system. It draws on neuroscience, psychopharmacology, biochemistry, genetics, epigenetics and physiology to discover the biological bases of human behaviours. There is some overlap between biological psychiatry and neurology. But the latter generally focuses on the study of the essential nature of diseases, especially where the structural and functional changes produced by the nervous system are apparent. Examples of this would be epilepsy, cerebral palsy, encephalitis, neuritis,

Parkinson's disease and multiple sclerosis.

There is some overlap with neuropsychiatry, the interface of psychiatry and neurology that deals with mental disorders, which in most cases can be shown to have their origin from an identifiable brain malfunction. Biological psychiatry, in contrast, explores functional neuro-anatomy, the structure and function of the nervous system. Magnetic resonance imaging (MRI) of the brain provides image quality for visualization and neuroanatomical classification of brain structure, and neuropsychology is the study of the relationship between behaviour, emotion, and cognition on the one hand and brain function on the other. Together, they are then used to explore the pharmacotherapeutic possibilities for depression, anxiety and mood disorders, substance abuse and eating disorders, schizophrenia and psychotic disorders, cognitive and personality disorders and, of course, PTSD, to drug humans out of their natural existence and misery, we presume.

Biological psychiatry has been particularly valuable in developing drug-based treatments for mental disorders. Whole industries have sprung up around it. In Richmond, Virginia, USA, a physician was sentenced to 30 years in prison in December 2017. He had been conspiring to distribute Oxycodone. According to court documents and evidence and testimony at trial, the physician was the supplier to a drug trafficking organization that, at various points in time, had more than 40 participants. The participants were recruiters, pill fillers, and dealers who sold to addicts. The physician dispensed 1,257 fraudulent prescriptions, amounting to more than 223,000 30-mg Oxycodone pills, distributed into the underground stream of commerce (Department of Justice, U.S. Attorney's Office, Eastern District of Virginia Dec. 18, 2017).

Also in December 2017, the U.S. Attorney's Office of the Middle District of Pennsylvania in Harrisburg, PA, announced a similar incident. A federal grand jury indicted a Mt. Carmel doctor for operating a "pill mill" and causing the death of five patients. The 19-count indictment charged the doctor with the unlawful distribution and dispensing of controlled substances. It charged him with causing the death of five patients by the unlawful distribution and dispensing of controlled substances. And it charged him with maintaining two drug-involved premises in Mt. Carmel and Shamokin, Pennsylvania. This physician prescribed approximately 2.7 million units of oxycodone, hydrocodone, oxycontin and fentanyl to approximately 2,838 patients from January 2016 through July 31, 2017. He was the top prescriber of those drugs in the Commonwealth of Pennsylvania in that time span, all enhanced by the knowledge of biopsychiatry.

Mind you, we again have to thank Hippocrates and his Hippocratic School of Medicine, which revolutionized medicine in ancient Greece and established medicine as a profession, for this drugging idea. He is credited with greatly advancing the systematic study of clinical medicine founded on the direct observation and examination of patients, in order to diagnose, treat and prevent disease. A medical interview in clinical medicine includes the following:

- chief complaint
- history of the complaint or illness(es)
- hobbies, occupation and other current activities
- medications taken in by the patient, including pharmacological drugs, home remedies, over-the-counter medication and alternative remedies
- past medical history including previous hospitalizations, surgeries, injuries, diseases, vaccinations, allergies, etc.
- social history such as birthplace, residence, etc.
- family history, and systems inquiry, such as recent and abrupt changes in weight, sleep quality, fevers, etc.

Physical examination is also carried out, using diagnostic medical devices such as stethoscope, tongue depressor, thermometer and so on. Relevant medical tests, such as blood and biopsy, might also be carried out. The physician prescribes treatments, including pharmacological drugs, in accordance with the information gathered from the tests and interview. The data collected are documented in the patient's medical record and kept in the physician's office.

Together, this is called "biological psychiatry", a term first used in scientific literature in the 1950s. The term "psychiatry", however, was already coined in 1808 by the German physician Johann Christian Reil. It literally means the "medical treatment of the soul" from the ancient Greek psykhē "soul"; -iatry "medical treatment" from iātrikos "medical" from iāsthai "to heal". The "biological" was added in the late 1950s, when the first chemical antipsychotic and antidepressant drugs were developed. Significantly, due to clinical observations of the above drug results, the seminal paper "The catecholamine hypothesis of affective disorders" by Joseph J. Schildkraut was published in 1965. He articulated the "chemical imbalance" hypothesis of mental health disorders, especially depression. It formed much of the conceptual basis for biological psychiatry, although it has scant

anything to do with biological.

Schildkraut, born in Brooklyn, NY, was a Harvard University and Medical School graduate (1959). As a young researcher at the National Institute of Mental Health in the early 1960s, he was among the physicians who witnessed a phenomenon that, in a way, was the birth of the era of antidepressants. "He saw patients who had been unresponsive to talk therapy suddenly come alive when drugs were introduced, and he got very excited about that," said his wife.

His enthusiasm flowed into his 1965 paper that inspired a significant shift in the field of psychiatry. It helped establish the biological basis for mood disorders, such as depression. It showed that the use of medications could provide a way to approach further research in clinical neuroscience.

"It crystallized a way of thinking about mood disorders. It provided a paradigmatic shift," said Dr. Alan I. Green, chairman of Dartmouth Medical School's psychiatry department. "I think he was a giant in the field. I think that initial paper, perhaps more than any other, defined the psychopharmacological era." It became the publication's most frequently cited article and one of the most cited ever in psychiatry. "It provided a bridge linking neurochemistry and clinical psychiatry for the depressive disorders," said Dr. John Mooney, an assistant professor of psychiatry at Harvard Medical School and a former research collaborator. Schildkraut's paper and subsequent research "really played a major role for setting the agenda for biological research on depression over the next quarter-century. His work was very important, particularly with respect to the depressive disorders."

"His work helped people understand that not all depressions were the same, and that you could subclassify depressions on the basis of different biology," Green said (Taimur.wordpress.com). Sure, just check out what people were fed from the moment of first drawing breath until present day, and you can easily see the consequence of biology. Combine that with attitudes and attributes of poverty stricken households often times riddled with alcohol and violence, and the "natural" result of mental instability and brain-development deficiency perhaps surfaces? Will pharmaceutical drugs cure it? Would hypnosis in sleep temples?

Schildkraut attributed an absolute or relative decrease in catecholamines to it. Catecholamines are any of a class of aromatic amines that include a number of neurotransmitters such as epinephrine and dopamine. Elation, conversely, could be associated with an excess of such amines, Schildkraut hypothesized. Evidence supporting his hypothesis was reviewed. Data from pharmacological studies, mainly

in animals, suggested that the actions of both major classes of antidepressant drugs were mediated through the catecholamines. The monoamine oxidase inhibitors increased brain concentrations of norepinephrine, while imipramine-like agents potentiated the physiological effects of norepinephrine. Whereas reserpine, a drug which, already known at that time, could cause clinical depression by depleting catecholamines, other amines might also be involved in its mechanism of action, Schildkraut wrote. A rigorous extrapolation from pharmacological studies to pathophysiology clearly could not be made.

Clinical studies relevant to the catecholamime hypothesis were limited, the findings inconclusive. It was therefore impossible to either reject or confirm the catecholamine hypothesis on the basis of data available. We read in the abstract:

> "In our present state of knowledge, however, the catecholamine hypothesis is of considerable *heuristic value,* providing the investigator and the clinician with a frame of reference integrating much of our experience with those pharmacological agents, which produce alterations in human affective states." (ajp.psychiatryonline.org; italics mine)

Nothing new under the sun. Still all speculation. To demonstrate the point:

> "A heuristic technique (/hjʊəˈrɪstɪk/; Ancient Greek: εὑρίσκω, "find" or "discover"), often called simply a heuristic, is any approach to problem solving, learning or discovery that employs a practical method not guaranteed to be optimal or perfect, but sufficient for the immediate goals. It also means that when finding an optimal solution is impossible or impractical, heuristic methods can be used to speed up the process of finding a satisfactory solution. Heuristics can also be mental shortcuts that ease the cognitive load of making a decision. Examples of this method include using a rule of thumb, an educated guess, an intuitive judgment, guesstimate, stereotyping, profiling or common sense." (parts.jspayne.com/php/SummaryGet.php?FindGo=Heuristics)

Schildkraut's hypothesis has been extensively revised since its advent in 1965. More recent research points to deeper underlying biological mechanisms as the possible basis for several mental health disorders.

We could speculate forever. Biopsychiatry in itself, however, has fervent critics,

among them Professor Alvin Pam and Dr. Colin A. More. They state unequivocally that it projects a stilted, uni-dimensional and mechanistic world-view of humanity's inherent functioning. Meanwhile, research in psychiatry is geared toward discovering which aberrant genetic or neurophysiological factors underlie and cause social deviance. The "blame the body" approach, which typically offers medication for mental distress, shifts the focus from disturbed behaviour to putative biochemical imbalances Pam states.

Mike Adam's *Natural News: Natural Health News & Scientific Discoveries* articles broadcast almost daily yet another sensational breakthrough in the search for the physical origins of mental illness including in PTSD. Not a shred of empirical best evidence to substantiate the existence of a gene causing alcoholism, schizophrenia, PTSD or anything else of that nature is presented. In their book *Pseudoscience in Biological Psychiatry: Blaming the Body*, Pam and More raise a more fundamental question. Is it even scientifically sound to limit the search for the roots of mental illness to processes occurring within the body, while dismissing socioeconomic, familial and experiential influences (wiley.com)?

Can clearer pictures of bio-psychiatry side-effects be seen than by the bio-psychiatry treatment modalities and applications practiced by the NC *for* PTSD employing the cream of the crop of that league on PTSD experiencers who drop like flies?

Some of Tull's research, however, originates from theoretical and empirical literature. This literature suggests a paradoxical effect of emotional avoidance and/or control and, conversely, the potential benefits of accepting and being mindful of one's own internal experiences. Perhaps it is therefore that he espouses and advocates hypnosis to mitigate dissociation after a traumatic event. Does he do this full well knowing that a major characteristic of all dissociative phenomena involves detachment from reality, rather than loss of reality? He wrote another verywellmind.com article, "Definition of Dissociation for People With PTSD: Learn About a Symptom That May Affect You" in 2018. In it, he explains that a useful definition of dissociation for people with PTSD is that it disrupts four areas of personal functioning, which usually operate together smoothly, automatically and with few or no problems. These are:

- identity
- memory
- consciousness

- self-awareness and awareness of surroundings

"Breaks" in this system of automatic function within ourselves cause the symptoms of dissociation manifesting in incidents like:

- having flashbacks to traumatic events related to our PTSD
- feeling that we are briefly losing touch with events going on around us, similar to daydreaming
- "blanking out" or being unable to remember anything for a period of time

The trance-like state of hypnosis with its associated heightened focus and concentration may be helpful in reducing those symptoms and states of anxiety.

Tull's academic career is filled with grants from a multitude of sources and a large variety of ways examining how human beings manage their emotions and develop and maintain anxiety disorders, including PTSD. Is it not surprising that a man like that fails to comprehend or acknowledge that PTSD is a colossal existential crisis? That it is unrelated to any and all mental disorders, bio-chemical deficiencies, neurological imbalances, pre morbid PTSDS tendency since birth or acquired before the PTSD-causing event moment or defects at its onset?

As to hypnosis? To repeat myself, I don't believe in it. I tried it with smoking and it did nothing for me. In my view, it merely masks PTSD symptoms and anything else, but heals nothing. Only work within the heart and soul of spirit, combined with willpower, determination, persistency and discipline works. It is that simple.

This completes our review of PTSD treatment modalities gathered and analyzed by Brian A. Sharpless and Jacques P. Barber in "A Clinician's Guide to PTSD Treatments for Returning Veterans" (Prof Psychol Res Pr. 2011 Feb 1; 42(1): 8–15). It was their effort to present mental health providers with pharmacological and psychological interventions available to assist in preventing and treating PTSD, particularly to combat-related traumas and veteran populations. Good luck! You'll need it if you engage in any of it, in my opinion.

I myself know that only I have the power to heal myself with the assistance of the infinite spirit, the Creator of all there is, and with my guides, guardians, helpers, teachers and friends in the unseen, standing by to help me the moment I holler. I holler often. Therefore I have the choice between heaven and hell. I have the choice between trusting the evil in the face I know and the voice I trust, or "do my own

thing." Unless, of course, one wants to end in complete mental and physical disarray and desperation. Then one should adhere to Dr. Nagy A. Youssef's proposal of ECT treatment to fulfill one's desire. It is normally suggested only to recalcitrant PTSD journeyers, the ones unwilling to obey orders or who outright refuse to do what in psycho-the-rapists' opinion should be done. Have fun deciding. As for me, I advocate the return to Sleep temples.

Electrical Shock Therapy For PTSD Recalcitrants?

Why not? After all, everything else plus the kitchen sink is thrown at despairing, and therefore gullible, PTSD journeyers. They aren't given a clue of being systematically destroyed, unless looking deeply at the inner Self. Everything one needs to know about PTSD to heal the Self is kept hidden there. But noone breathes a word about it.

The next thing you'll be asked to consent to by your friendly physician of the mental perversion, his not yours, is your participation in electroconvulsive therapy (ECT). Nothing else has helped you thus far, so why not try it? After all, Medscape's

New York correspondent Caroline Cassels even called it a potential lifesaver in 2014 (C. Cassels: "ECT a Potential Lifesaver in Comorbid PTSD, Major Depression"; Medscape, www.medscape.com). Its use in people with PTSD and comorbid major depression might even substantially reduce the risk for all-cause mortality, cardiovascular mortality and suicide in this patient population, she writes.

And who is she to know? Muck Rack, a journalist database, media monitoring and press coverage reporting platform says she has been a medical and health journalist for 20 years. She has also served as the national editor of the Canadian Heart and Stroke Foundation web site. Since 2005, she has covered Medscape's neurology and neurosurgery reporting and now is its executive editor. Her 2014 report on electro convulsive therapy originated with the American Psychiatric Association's 167th Annual Meeting, under the leadership of 2013–2014 APA President, Jeffrey Lieberman (1948–), MD. Lieberman is a psychiatrist specializing in schizophrenia and related psychoses and their associated neuroscience (biology) and drugs. He was principal investigator for CATIE from 2005 to 2008. CATIE was the largest, longest and most comprehensive purportedly independent trial ever done to examine existing therapies for schizophrenia. The study's aim was to determine which medications provided the best schizophrenia treatment. Previous studies had shown that taking antipsychotic medications was consistently far more effective than taking no medicine and that the drugs were necessary to manage the disease (www.nimh.nih.gov).

Classified as a brain disorder characterized by hallucinations, delusions and disordered thinking, it is often associated with PTSD, if the malevolent PTSD-treating mental health practitioners' can get away with it. As with PTSD, the course of schizophrenia is said to be variable. Usually it is said to be recurrent and chronic, however, and cause severe disability.

As with the National Center *for* PTSD, CATIE was funded by the NIH's National Institute of Mental Health. Participants included people with schizophrenia from 57 different clinical sites in 24 states. They were being treated in a variety of settings, from private clinics, academic centers and Veterans Administration hospitals to public mental health centers. The patients enrolled are said to have broadly reflected the three million people diagnosed with schizophrenia in the U.S. at that time. Those enrolled apparently suffered chronic schizophrenia and were in need of antipsychotic treatment. The only patients excluded were those in a first episode of psychosis, those with treatment-resistant schizophrenia, and those with serious and unstable medical conditions.

CATIE used clinical trials, comparing the effectiveness of older antipsychotic medications used to treat schizophrenia, first available in the 1950s, with newer ones available since the 1990s. That the newer medications known as atypical antipsychotics cost approximately 10 times as much as the older medications was of no consequence to the health care system. It might be of significance that no placebo treatments were used, a manifestation or confirmation of NIH agencies' disbelief in humans' self-healing abilities, perhaps? Patients were only randomly assigned to FDA-approved antipsychotic medications used to treat schizophrenia (www.nimh.nih.gov).

Lieberman was APA president and chair of its 167th Annual meeting in 2014. He is now, the Lawrence C. Kolb professor and chairman, Department of Psychiatry, Columbia University College of Physicians and Surgeons. He is also director, New York State Psychiatric Institute; and psychiatrist-in-chief at Columbia University Medical Center of the New York-Presbyterian Hospital. Under his auspices, a diverse educational program reflecting the presidential theme "Changing the Practice and Perception of Psychiatry" was offered among ECT discussions and revelations.

"How to make Healthy Humans Ill" might have been more accurate and to the point. The theme resonated well, with key forces impacting psychiatric medicine and mental health care today. Scientific discoveries about the human brain, human behavior, and human mental disorders and their treatment were chewed through. So was changing the way human health care in general, and mental health care in particular, was to be provided and financed.

Presentations from conference participants in their particular fields of interest or expertise spanned from ethics to military, from National Institute of Mental Health (NIMH) to psychosomatic medicine, to name just a few. The *Advances in Research* session featured psychotherapy and imaging [or imaginings, perhaps]. It also featured genetics, epidemiology, integrated care, therapeutic discovery, neuroscience and psychiatric services. Presenters discussed how research translated into clinical practice of today and for the future.

Participants were told that fields of psychiatric medicine and mental health care were poised on brinks of transformation. Advances were imminent in diagnostic methods and therapeutic modalities. Transformation was also on its way with the genetics and neuroscience underpinnings of schizophrenia, bipolar disorder, Alzheimer's disease, autism, addictions and other serious conditions. Neuro-imaging methodologies to examine behavioral and brain development would also

be discussed. The National Institute of Mental Health and APA's subspecialties of addiction, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry and psychosomatic medicine were on the agenda.

Military mental health also formed part of the conference. In particular, combat trauma and operational stress, the predictable part of combat deployments for U.S. troops, we are told, would also be discussed, we read. The U.S. military had been dealing with soldiers' ill mental health arising in current conflicts by embedding mental health providers within ground combat units. Their role was, and most likely still is, to prepare and educate troops and leaders (for battle and its potential consequences?).Their other roles are to identify and intervene early (in what?), and provide a consistent, credible, and accessible presence for troops (why and in what way?). A workshop presented U.S. Army and Marine Corps philosophies and practices, discussed their strengths and how to further develop them (J.C. West, Uniformed Services University of the Health Sciences, Ben Hershey: *Caring for those at the Tip of the Spear: Embedded Mental Health in the U.S. Military*; Conference Paper May 2014). Its weaknesses seem to be of no interest.

There was even a workshop on *Self-care Meditation Approaches Used Adjunctively in PTSD Management* describing PTSD evidence base for PTSD mindfulness interventions. It was conducted by Marina Khusid, MD, ND, MS of George Washington University, Jesse Brown VA Medical Center, and the University of Maryland School of Medicine. The program had been rapidly expanding, as reflected in the 2010 Veterans Administration/Department of Defense Clinical Practice Guideline, she said. Her view on PTSD soldiers and veterans?

> "Considering the high prevalence, and chronic, debilitating nature of PTSD among US Service members and Veterans, engaging patients in collaborative care and educating them on how to self-manage their *chronic mental illness [PTSD]* can lead to increased levels of functioning, reduced pain, improved health outcomes, and decreased health care costs." (Marina Khusid: *Self-care Meditation Approaches Used Adjunctively in PTSD Management (Workshop)Conference Paper,* May 2014*)*

Tell humans they are chronically ill, as Khusid does, and they will become chronically ill. They become healthy when told they are on the mend. How do you think placebo's function? In that way, precisely! Who and what inspired her to slot PTSD journeyers as chronically ill can be deduced from her academic education, I surmise.

Obama's Affordable Care Act had also been on the APA's 2014 agenda. So had the rise of accountable care organizations, ACOs. These are groups of doctors, hospitals and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal? To ensure patients get the right care at the right time, while avoiding unnecessary service duplication and medical errors. When an ACO succeeds, both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program. Needless to say, even when they save money by giving lousy care to their patients, they will share the savings thereby achieved. For them, it is a win-win situation. If applying ECT, for example, instead of psychotherapy, Medicare saves money and the healers of souls administering ECT earn some of it. Heaven — for them.

The renewed focus on patient-centered care affords psychiatrists and primary care providers unprecedented opportunities to work collaboratively to improve health, we learn. Whose health, was unspecified. Guided practical skills for leadership roles within collaborative care teams were also given, we read in the program guide, new research guide and exhibits guide. The convention highlight was, of course, that VP Joe Biden would be delivering the William C. Menninger Memorial Convocation Lecture.

William Claire Menninger (1899–1966) graduated from Washburn University in 1919 and went on to follow his father and brother into medicine. In 1924, he graduated from the Cornell University College of Medicine in New York State. After completing a two-year internship at Bellevue Hospital, he studied psychiatry at St. Elizabeths Hospital in Washington, DC, before returning to Topeka in 1927 to join his father and brother Karl in their medical practice.

The Menningers' philosophy was that psychiatry, a relatively new field in the USA, was a legitimate science. They held that the difference between a "normal" person and one with a mental illness was but a matter of degree. W.C. Menninger was an early innovator and advocate for the use of bibliotherapy in treating mental illness. He used it at the Menninger Clinic. Following the success of Karl's book, *The Human Mind*, W.C. presented a paper to the American Psychiatric Association in 1937 expounding on Karl's book:

> "The amount of satisfaction you get from life depends largely on your own ingenuity, self sufficiency, and resourcefulness. People who wait around for life to supply their satisfaction usually find boredom instead."

Another observation of his was:

> "Six essential qualities that are the key to [human] success? Sincerity, personal integrity, humility, courtesy, wisdom and charity."

In 1931, the Menninger Sanatorium became the first US institution to gain approval as a training facility for nurses specializing in psychiatric care. In 1933, it opened a neuropsychiatric residency program for physicians.

The formation of the Menninger Foundation in 1941 fulfilled two of the family's goals. The first was to combine medical practice, research and education on an international level. The second was to establish a group psychiatric practice.

In 1946, they also created the Menninger School of Psychiatry. It quickly became the country's largest training centre for psychiatric professionals, needed in increasing numbers to treat WW II veterans. About the same time, William Menninger also led a national effort to reform state sanatoriums. In 1948, he was featured on the cover of *Time* magazine, which hailed him as "psychiatry's U.S. sales manager." With his contributions, the Menninger Clinic evolved into the Menninger Sanatorium.

Needless to say, the Menninger Foundation is, of course, a non-profit organization. It provides clinical services to both inpatients and outpatients, and engages in research, as well as educational and social outreach. In 2003, the clinic moved from Topeka to Houston, where it continues to provide a range of diagnostic and speciality inpatient programs for various age groups and mental ailments, including PTSD-affected veterans. More of them later.

The Menningers might be rotating in their graves, observing present day psychiatry's on-goings, or not, but who cares? VP Joe Biden et al. would acknowledge them and everyone at the convention would have a ball.

A nice and colorful guide was the APA program, a shining green and red apple gracing its title page, and lots and lots of insights into the world's cream de la crop of mental health practitioners' workings' worldwide. Breathtaking, actually, who all were present to present on many topics. Bibliotherapy material for the PTSD journeyer for sure. But back to Cassels' exclusive *ECT as the miracle cure for PTSD* reportage and related observations.

She tells of a retrospective study conducted by investigators at Captain James Lovell Federal Health Care Center (FHCC), Rosalind Franklin University of Medicine and Science in North Chicago, Illinois. It had shown that among patients with PTSD and major depressive disorder (MDD), the death rate of those receiving

ECT was significantly lower than that of their counterparts who did not receive it. Lead investigator Naser Ahmadi, MD, Ph.D. presented the study at the meeting and told Medscape Medical News.

> "The finding that all-cause mortality was almost double in those with PTSD and major depression who did not receive ECT than of those who did, 18% vs. 9.7%, was very much a surprise to us,"

From whence sprang he? He is assistant professor of psychiatry, UCLA GLA VA, MD MS PHD, Medicare Psychiatry & Neurology in Los Angeles, CA. He earned his medical degree from Persia's Isfahan University of Medical Sciences, while simultaneously earning his Ph.D. in epidemiology/biostatistics. He also pursued a preventive medicine WHO EMR fellowship in Iran prior to completing a cardiovascular imaging fellowship at Harbor UCLA in Torrance, CA. He furthermore received a master of science degree in clinical and biomedical investigations from the University of Southern California. His psychiatry residency training took place at Chicago Medical School, Rosalind Franklin University of Medicine and Science in North Chicago, IL.

PTSD and MDD frequently coexisted, he and his team insisted. Up to 48% of PTSD patients have comorbid MDD and other comorbid psychiatric and medical conditions. The jury if ECT would help with any of it is still out, though, Cassels writes. Although numerous studies have shown ECT to be the most effective treatment for refractory depression, its long-term effects on PTSD and MDD are unclear. I, in my infinite wisdom and stupidity, thought it had gone out of fashion with the Cuckoo Nest era, except for MKUltra purposes.

To get the pro-ECT evidence, Ahmadi et al. dove into conducting a retrospective nested matched case-control study based on diagnostic and outcomes data from the Veterans Affairs' electronic medical records of 22,164 patients at FHCC. This showed 3485 veterans diagnosed with MDD and PTSD and 18,679 without either condition. 92 of those 3485 MDD and PTSD patients had received ECT whilst brief, light general anesthesia and succinylcholine had been administered for muscle relaxation. Remarkably, their PTSD and MDD symptoms had improved by 90 percent for ECT treated research participants compared with 50 percent for those who had received only antidepressants.

Cox's regression survival analyses, or proportional hazards regression, which allows analyzing the effect of several risk factors on survival, revealed that the relative risk (RR) for all-cause mortality was 85% higher in patients with PTSD and

MDD who did not receive ECT compared with those who did. In addition, RR for suicidal behaviour was 350% higher in patients without ECT treatment.

Ahmadi and his team espouse the *belief* that the positive long-term ECT effect in PTSD patients might, just might, be attributed to its anti-inflammatory effect. He asserted:

> "We know that ECT has an anti-inflammatory effect, and we also know from studies in cardiovascular disease that by reducing inflammation via statin therapy, we can decrease cardiovascular mortality by 20% to 30% across the board. ECT reduces inflammation, reducing cardiovascular mortality by 44%. This highlights that we should go beyond the conventional approach of addressing psychiatric symptoms of PTSD only and tackle the underlying inflammation pathway of PTSD by ECT."

The *statistical mortality* rate with ECT versus without had also improved, we hear, a huge factor in the equation, as every human is traded by the state corporation on the New York Stock Exchange for big bucks, depending on station in life. Thus the dog-tag or SIN, the Slave Identification Number. You are a slave, Neo. Face it! You are of monetary value to the USA Corporation.

The conclusion? On the basis of their findings, mental health practitioners should consider ECT as *first-line treatment* option for comorbid PTSD and MDD patients. Ahmadi added:

> "Assuming there are no ECT contraindications, there is no reason not to do ECT in PTSD, and patients will benefit. It has a rapid effect, and we currently offer it at our center to patients with PTSD and major depression."

Furthermore, he noted, with ECT treatment, improvement is often seen in just a few sessions. Though it had few [acknowledged?] side effects, the American Psychiatric Association was already recommending it as first-line therapy for major depression. What was there to be concerned about?

> "Patients with PTSD live on a daily basis, they don't have plans for future. Therefore, they tend to have not taken care of self well and have a poor compliance to treatment — so if patients with PTSD receive a therapy that is short, tangible, and effective, the chance of adherence, follow-up, and favorable outcome is much, much greater than giving them

medication," he said."

Splendid. Render them brain dead. That'll preserve our interests, he seemed to shout.

Iqbal Ahmed, MD, clinical professor of psychiatry and geriatric medicine at the University of Hawaii at Manoa, had commented:

> "PTSD and major depression both have been associated with medical comorbidity, partly because inflammatory markers are associated with both disorders. We know there are cardiovascular risks from depression itself, and the American Heart Association recently noted that it is one of the risk factors for poor outcomes in cardiovascular disease. There is less literature on PTSD, but there have been studies showing it increases inflammation and the risk for cardiovascular mortality and all-cause mortality, [but] maybe there is some inherent biological activity of ECT, which may reduce inflammatory markers and improve mortality rate. This is potentially a new frontier in the treatment of PTSD."

He did also say, however, that the study's retrospective design was its major limitation, as the phenomenon studied, its events and results, had long passed. Nevertheless, for what he calls a difficult-to-treat patient population, he found ECT a good first step toward investigating a promising treatment. (American Psychiatric Association's 2014 Annual Meeting. Abstract SCR14-4. Presented Monday, May 5, 2014).

That assistant professor of psychiatry Bradley V. Watts of the Geisel School of Medicine at Dartmouth College, Nova Scotia, already in 2007 thought electroconvulsive therapy the most effective, nay, choice treatment for PTSD and refractory major depressive disorder, had not been disclosed anywhere. Using a retrospective chart review, his team had examined the outcome of 26 patient cases by then. They had received a course of ECT, either supra-threshold right unilateral, bilateral, or a combination of both treatments. Comparing pre-treatment and post-treatment symptoms, they used the PTSD Checklist and the Montgomery-Asberg Depression Rating Scale (MADRS) developed by British and Swedish researchers in 1979. It is a 10-item, clinician-administered scale, designed to be particularly sensitive to antidepressant treatment effects in major depression patients. The combination of those two scales showed that patients receiving ECT had a significant reduction in major depression symptoms and some improvement in

PTSD symptoms. Therefore, Watts et al concluded that electroconvulsive therapy might be effective treatment for refractory depression and co-occurring PTSD patients ("*Electroconvulsive Therapy for Comorbid Major Depressive Disorder and Posttraumatic Stress Disorder*"; Journal of ECT 23(2):93–5 July 2007). If anything else, such as brainpower or memory, had been significantly reduced, it was kept secret.

In 2017, Tyler S. Kaster was a psychiatry resident at the University of Toronto with a passion for research into psychiatric illnesses and a particular interest in biological and epidemiological research into schizophrenia and PTSD. He was also the lead researcher in the study *Electroconvulsive therapy for depression with comorbid borderline personality disorder or post-traumatic stress disorder: A matched retrospective cohort study* (Tyler S. Kaster, David S. Goldbloom, Zafiris J. Daskalakis, Benoit H. Mulsant, Daniel M. Blumberger; sciencedirect.com). They compared clinical responses and adverse cognitive effects for MDE patients with comorbid BPD or PTSD to MDE only. They, too, concluded that ECT was the cat's meow, a most viable treatment option for a subset of patients with MDE and comorbid PTSD or BPD. They also claim the absence of cognitive adverse side-effects. They did, however, caution clinicians to be mindful of a weakened, diluted, thinned, reduced, and diminished response rate in admitted patients with these comorbidities.

To share their opinion with the world, they had already presented a portion of this work at the May 2017 Society of Biological Psychiatry 's (SOBP) 72nd Annual Scientific Convention, which took place in San Diego, California. Its audience? Clinicians, such as physicians, psychologists, nurses and anyone else directly involved in patient care, as well as neuroscientists, Ph.D.s and young researchers. The conference' goals and objectives?

- Identify biological mechanisms involved in the development, treatment and intervention of psychiatric illnesses.
- Describe new developments to use network and path approaches to understanding complexity in psychiatric neuroscience.
- Identify the pros and cons of network, pathway, parallel analytic, and 'big data' approaches compared to focused, candidate-driven, and serially organized scientific approaches.

The AI in action? The Neumeisters united in planning the New (Hu)man?

In August 2018, Dr. Nagy Youssef was a psychiatrist in Augusta, Georgia, affiliated with multiple hospitals in the area, including Augusta University Medical

Center and Charlie Norwood Veterans Affairs Medical Center. He took up and ran with the ECT baton with his article: "Treating recalcitrant PTSD with ECT: Are we there yet?" (*Psychiatric Times* Volume: 35 Issue: 8 Special Reports). He received his medical degree from Cairo University School of Medicine in 1995. He completed his Internship and his Residency at the University Of South Alabama Medical Center Internship Hospital from 2001 to 2004. His speciality is psychosomatic medicine, an interdisciplinary medical field exploring the relationships among social, psychological and behavioural factors on bodily processes and quality of life in humans and animals. In practice for 14 years, his personal life-experiences with trauma and psychosomatic illness are unpublished.

The title for his paper might say much about him, though, depending on who is analysing it. Could ECT truly be designed for the uncooperative, intractable, obstreperous, truculent, insubordinate, defiant, rebellious, wilful, wayward, headstrong, self-willed, contrary, perverse, difficult PTSD experiencers with an obstinately uncooperative attitude, unwilling to obey orders and difficult to deal with? Yes, those are the ones Youssef talks about, the Jack Nicholson s of the Cuckoos Nest.

Now that the risk of cognitive adverse effects, such as long disorientation duration or memory impairments, had been lowered, why not apply it to god and sundry? The Tasers had already proved that death rarely occurred with their use any longer, so who cared? It had almost been the only reason to have historically limited ECT use. As modern ECT parameter modifications nowadays also substantially limit cognitive risks to a much smaller portion of patients, all boundaries hindering its use had practically been removed. Tough luck if you were one of the smaller portion!

Further improvement of adverse cognitive effects had also been suggested Why not use lower current amplitude than standard ECT, thus creating more focal stimulation, as in low amplitude seizure therapy (LAP-ST). Further modifications in electrode shape and electrode placements could perhaps also be helpful for focal electrically administered seizure therapy (or FEAST), we are told.

Thus theoretical justification for ECT use on the PTSD population abound. Proposed mechanisms of action seem to exist. So there's another PTSD biblio-therapy project. Get those mental health practitioners, those psycho-the-rapists suckers should become the theme for all mentioned genuine PTSD experiencers. Why? Because human beings are not at all taken into consideration in these ECT tests. Only neurogenesis plays a role, and how it plays out in cani, rattus, mus, and

occasionally, we can surmise, simia.

Hippocampal neurogenesis, for example, has been shown to contribute to the clearances of artificially induced, long-term potentiation, a cellular model of learning and memory. Hippocampal long-term potentiation (LTP) is the primary model for investigating mechanisms and processes involved in establishing certain forms of explicit memory in the mammalian brain. During the last decade, much progress has been made in elucidating the cellular mechanisms underlying the induction and early expression of LTP. It was first discovered in 1966 by the Norwegian physiologist Terje Lømo (1935–). He specialized in neuroscience, the rabbit — lepus — being his mammalian subject of experimentation. Lømo was known for his studies on synapses, in particular synaptic plasticity. His discovery, together with fellow researcher Tim Bliss, of the long-term potentiation is still regarded as a fundamental work in neurophysiology. It has also remained a popular subject of research since, to better understand LTP basic biology. Others aim to draw a causal link between LTP and behavioural learning. Still others attempt to develop methods, pharmacologic or otherwise, of enhancing LTP to improve learning and memory. It is also a subject of clinical research, for example, in the areas of Alzheimer's disease and addiction medicine.

It is surmised that LTP mechanism might have a role in treatment-resistant PTSD and related memories, if clearance of hippocampal memory traces in the contextual fear conditioning can be accomplished. In other words, if memories could be erased. And, since ECT induces neurogenesis, it might just have a role in PTSD treatment, we learn. And it really goes on or takes off from there. Other mechanisms related directly to memory deconsolidation might also be possible where ECT could cause more improvement in PTSD symptoms, we hear, if delivered right after the traumatic memories reconsolidation. Perhaps Tasers could do the trick faster and more cheaply?

After all, in one study, patients with severe treatment-resistant PTSD were administered six sessions of ECT after retrieving either their traumatic or a neutral memory, Youssef has found. Findings did indicate ECT might have augmented effects if delivered right after traumatic memories reconsolidation. Given the preliminary evidence, however, and despite the plausibility of ECT use for PTSD hypotheses, it is stressed that these hypotheses need to be further tested in a well-powered, controlled clinical trial to be proven or disproven.

We are told that wider ECT availability in facilities would also be helpful, especially to treat a substantial number of treatment-resistant PTSD and depression

patients. At VA hospitals, for example, it would not only improve care for patients with disorders indicated for ECT in accordance with the Standard of Care act. It would also provide a chance to investigate ECT's potential role in treatment-resistant PTSD and depression. The number of patients needed for such trial would be hard to obtain by any one center or hospital alone.

In *Black's Law Dictionary, "standard of care"* refers to the degree of care a reasonable person will exercise under certain circumstances. It is an important element of many negligence cases, especially those involving injury or death. For instance, if someone's actions lead to the injury of another person, he or she might have acted negligently and failed to provide the standard of care he or she owes the other person. A standard of care, however, is not a fixed expectation. Consequently, standard of care refers to degree of attentiveness, caution and prudence a reasonable person in the given circumstances would exercise. Failure to meet the standard is negligence, and the person who fails to meet the standard is liable for any damages caused by such negligence. The standard is not subject to a precise definition and depends and is judged on a case-by-case basis (definitions.uslegal.com).

> "There are no US national laws on ECT leaving individual state governments to regulate treatment. Whereas some states have detailed restrictions on use, other states have no regulation at all. This variation applies to multiple areas of ECT practice including who can receive ECT, who can provide informed consent, who can prescribe or perform ECT, and what administrative requirements, (e.g. fees and reports), must be met by ECT practitioners. Knowledge of these state laws will help providers not only to be aware of their own state's regulations, but also to have a general awareness of what other states mandate for better patient care and utilization of ECT."(Livingston R, Wu C, Mu K, Coffey MJ: (*Regulation of Electroconvulsive Therapy: A Systematic Review of US State Laws."* J ECT. 2018 Mar;34(1):60–68).

In 2006, the *Journal of the American Academy of Psychiatry and the Law* enlightens its audience in the article "Electroconvulsive Therapy: Administrative Codes, Legislation, and Professional Recommendations" (September 2006, 34 (3) 406–411). Victoria Harris writes that in the United States including the District of Columbia and Puerto Rico there were 33 geographical jurisdictions where state laws and administrative codes did not comment on the use of ECT. In states where there were

no statutory law or administrative code concerning ECT and adults, a determination by only one physician was therefore needed to offer ECT to a patient. Arkansas codes outlined treatment restrictions for involuntary patients and required that the probate court find clear and convincing evidence that ECT was needed. Illinois, Pennsylvania, South Dakota and Virginia all require a court hearing and clear and convincing evidence as the standard of proof. They apply substituted judgment when a petition is made for a patient to receive involuntary treatment, she writes.

California's specific legislative requirement that three consenting physicians agreed to ECT treatment and agreed that the individual was competent to consent to ECT arose from the court's opinion in *Aden v. Younger.* Harris also states that the Colorado Revised Statutes, the Texas Health and Safety laws, and the New York Office of Mental Health were very specific with respect to the requirements of the treating physician. In California, these requirements included providing the patient with written information that specifically stated, " . . . that there is a difference of opinion within the medical profession on the use of [ECT]."

In summary, says Harris, the medical recommendations for ECT as proffered by the APA have been reiterated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Therefore, all hospitals across the country, in the District of Columbia and in Puerto Rico that accept Medicare payments should be following these minimal recommendations of the American Academy of Psychiatry and the Law. As the majority of states do not have administrative codes or legislation addressing ECT providers — meaning mental health cabal in all shapes and colours, would — she says WOULD — *theoretically* follow the APA/JCAHO recommendations. Almost as a warning she seems to add:

> "There are three states (California, New York, and Texas) where the legislative requirements are more stringent than the APA recommendations. In other words, we could translate it as 'Govern your self accordingly, whoever enters ECT therapy territory as a practitioner in whatever capacity. If the populace awakens to this brutality, you may be in hot water.'"

One could surmise, however, that this lack of ECT laws, rules and regulations would assist many a practitioner eager beaver to apply ECT to the desperate and ignorant PTSD journeyers, to be successful in the enterprise. On the other hand, though, this lack of the same might, just might, also result in the self-same practitioners being dragged into court for negligence and lack of standard of care.

Why? Because of the ECT-treated subject's loss of faculties while administering this draconian "therapy."

Now that the cat is out of the bag, it very well might happen, because what's happening in New Zealand could come to the USA and Canada, if it is not already tacitly here. What is being published there could be published here, as well, perhaps rattling the PTSD populace into some sort of awakening, starting to rise up and look out for themselves. Some already have. In April 2018, *Mad in America* journalist David Karen gave an update in the *ECT Shock Treatment Class Action Case* filed in September 2017 by the DK Law Group, LLP, against Mecta Corporation and Somatics, LLC. They are the only two manufacturers that make and deliver shock devices. The complaint? They wholly failed to comply with the FDA's requirements applicable to medical device manufacturers.

A manufacturer must meet these requirements and have a system in place for the timely investigation and/or reporting of adverse events (deaths or serious injuries). If it doesn't, it cannot manufacture or deliver the devices for use in the United States under 21 U.S.C. section 331. Defendants have encountered thousands of allegations of serious brain injury resulting from ECT, and know of the existence of entire support groups of ECT victims. Despite that, the defendants have never properly investigated, evaluated or reported a single adverse event allegation (madinamerica.com). Since 2011, debates have been raging whether or not the US Food and Drug Administration should continue to place ECT equipment in Class III, the highest of three risk categories for medical devices, or shift it to a lesser-risk category (Nancy Benac: *United States reviews safety of electroconvulsive therapy*; CMAJ March 22, 2011 183 (5) E269-E270).

At that time, *the U.S. Food and Drug Administration Neurological Devices Panel examined the reclassification of electroconvulsive therapy (ECT) devices from Class III to Class II.* The FDA consideration of ECT devices was part of the agency's ongoing effort to review high-risk medical devices in use before the Medical Devices Amendments of 1976 was enacted. The new Act allowed them to remain on the market without clearing a stringent review process. In 2009, the Government Accountability Office recommended that the FDA act expeditiously to ensure that grandfathered high-risk devices either met stringent review standards or be reclassified as lower-risk.

Class III medical devices have the most stringent regulatory controls. For Class III medical devices, sufficient information is unavailable to assure human safety and effectiveness through the application of General Controls and Special Controls. In 2015, Class III devices were deemed by the FDA to:

- usually support or sustain (human) life
- be of substantial importance in preventing impairment of human health
- present a potential unreasonable risk of illness or injury to the human patient (biologicalindicators.mesalabs.com)

A majority of committee members spoke in support of keeping ECT devices in Class III for the treatment of severe depression and a number of other conditions, according to FDA spokeswoman Karen Riley. The exception, she said, was catatonia, a condition for which there was no consensus on ECT classification.

Duke University Medical Center's Dr. Richard Weiner spoke on behalf of the American Psychiatric Association. His background? A professor in the Department of Psychiatry and Behavioural Sciences for decades, Weiner is recognized as an accomplished physician-researcher and educator with nearly four decades of service at Duke. His research has been funded for many years by the NIMH and the VA. His work was instrumental in developing newer, safe and effective types of electroconvulsive therapy (ECT) to treat people with severe depressive disorders, we read on Duke's website. He directs the Duke ECT Program. As a matter of fact, Duke has a whole clinic devoted to ECT, the Duke Electroconvulsive Therapy Clinic. That gave him ample material to author his over 150 publications in ECT research, while also serving as chief of the Mental Health Service Line at the Durham VA Medical Center for the past 21 years.

And splendidly qualified he is for this field. After all, he received a bachelor's degree in Electrical Engineering at M.I.T. and a master's degree in Systems Engineering and Operations Research at the University of Pennsylvania. He received his MD and his Ph.D. in Physiology in 1974, through the Duke Medical Scientist Training Program. He then completed his residency in psychiatry at the University of North Carolina, before joining the Duke faculty in 1977 (psychiatry.duke.edu). No wonder he is an expert in ECT functioning, never mind that of humans.

The evidence that ECT is effective for major depressive disorder and other conditions is "highly compelling," he surmises. He adds that "it's well understood that there are risks, particularly in the area of memory function." That is why it's critical that patients give informed consent before undergoing the treatment, he opined. He stressed, however, that the therapy was used sparingly, estimating less than 5% of patients with major depressive episodes got ECT. Even though ECT was

not a cure, he thought it an important treatment option "to bring somebody out of an acute episode" when not responding to other therapies.

Psychologist John Breeding, however, said it was unconscionable to subject people to ECT in the absence of rigorous testing demonstrating the treatment's safety and efficacy. He, also, calls attention to the movie *One Flew Over the Cuckoo's Nest,* when electroshock treatment was applied. "A lot more people get hurt than helped. I consider it just a really horrible thing to do to people," he said.

> "I've been a Texas psychologist for almost 30 years, and I'm a founding member of the Coalition for the Abolition of Electroshock in Texas. I've been active for 20 years in efforts to abolish or at least limit the use of electroshock because of its severe danger and lack of efficacy. Although we narrowly failed to accomplish a total ban on electroshock in Texas, the procedure is banned for children under age 16 and extra safeguards are in place for the elderly. In Texas at least, we know that electroshock is dangerous, and electroshock machines are very dangerous. So, of course, I'm strongly against the reclassification of the machines."

Contrary to Weiner, he knows of the human psyche's functioning, at least to some extent. Neurologist John Friedberg, author of *Shock Treatment is Not Good for Your Brain,* submitted written testimony saying:

> "The intentional induction of convulsions should be abolished. In my entire career, I never met an epileptic who benefited from their seizures. I never had a patient tell me a seizure leaves them feeling happier. ECT causes memory loss in all cases, dramatic damage in some."

In May 2001, he had already testified on the same topic before the Mental Health Committee of the New York State Assembly. At that time he said:

> "In view of the primitive simplicity of their minds, they (the masses) more easily fall victim to a big lie than to a little one, since they themselves lie in little things, but would be ashamed of lies that were too big." Adolph Hitler. Mein Kampf, Vol.1, Ch. 10, 1924 tr. Ralph Manheim, 1943.

Practicing in Berkeley, California, he was born in Far Rockaway, New York (1942–2012), and graduated from Lawrence High School, Yale University and the University of Rochester School of Medicine. For the past 20 years, he had been

seeing patients with every conceivable neurologic problem, from headaches to Huntington's, in his office and in hospitals. His book *Shock Treatment Is Not Good For Your Brain* was published in 1975. His peer reviewed article "Shock Treatment, Brain Damage and Memory Loss" followed in the *American Journal of Psychiatry* in 1979. "I do not believe in mental illness. Depression is no more "the same as diabetes" than heartbreak is the same as a heart attack," he voiced at that time.

I do not believe in hypothetical diseases of the mind, either, he asserted, but there is no mistaking damage to the brain. Psychiatric drugs and electroshock inflict real injury in the name of treating fictive maladies. Paul Henri Thomas was a high profile ECT case who had been a patient at Pilgrim Psychiatric Center in Central Islip for the past 22 months. There, he had received shock therapy between 30 and 50 times. He has tardive dyskinesia and hepatitis from psychiatric drugs and amnesia from the ECT, Friedberg stated.

Pilgrim Psychiatric Center is a state-run psychiatric hospital in Brentwood, New York. At the time of its opening in 1931, it was the largest hospital of any kind in the world. At its peak in 1954, it had 13,875 patients. Its size has never been exceeded by any other facility, though it is now far smaller than it once was.

His opinions were based on years of experience with patients and review of records from all over the country as an expert witness in electroshock malpractice cases, Friedberg stated. They are based on ECT statistics from the six states that mandate. And they are based on a lifetime following publications and statements issuing from the small but vocal minority of psychiatrists who believe in ECT and usually nothing but, he shared. "Fortunately for me, the believers don't always believe each other; their data frequently belie their conclusions; and what they actually do contradicts what they say they do. The truth slips out," he continued.

It is known since the 1950's, for example, that confining electroshock to the non-verbal hemisphere, usually the right, as in "unilateral non-dominant ECT," causes less verbal impairment and memory loss than bilateral ECT. But the recommendation to begin with non-dominant ECT is honoured mostly in the breech. Another example he gives is that the "grandfather" of ECT, Dr. Max Fink, claims the rate of memory loss is 1 in 200. He has repeated this so often it sounds like a fact. But Harold Sackeim, Ph.D., just as much an enthusiast and just as aggressive, says Fink's figure has "no scientific basis."

Whom to believe? "My view is that memory loss from ECT is no 'side effect'; it's the main effect, and the best studies find it in 100% of subjects. Incidentally, Dr. Fink didn't pick the number 1/200 out of thin air — 1/200 has consistently been the

death rate from ECT administration as far back as 1958, and as recently as Texas and Illinois in the 1990s."

THE FIVE BIG [ECT] LIES ACCORDING TO FRIEDBERG?

BIG LIE 1: Dr. Fink tells people that ECT is safer than childbirth. If one out of every 200 women were dying in delivery, it would be front-page news.

BIG LIE 2: ECT doesn't cause brain damage. One picture will refute that. The illustration below (MRI on the right, CT left, same patient) depicts a large hemorrhage from ECT. Haemorrhages, large and small, cause permanent seizure disorders in some patients.

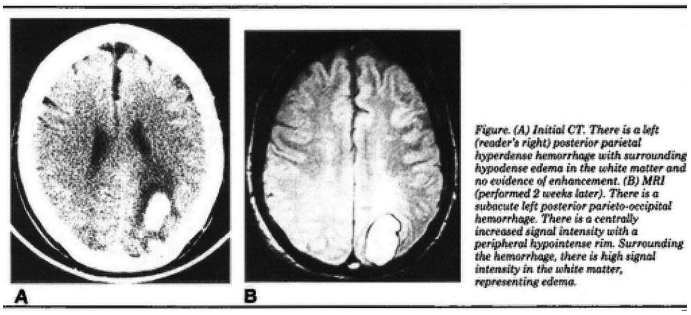

Figure. (A) Initial CT. There is a left (reader's right) posterior parietal hyperdense hemorrhage with surrounding hypodense edema in the white matter and no evidence of enhancement. (B) MRI (performed 2 weeks later). There is a subacute left posterior parieto-occipital hemorrhage. There is a centrally increased signal intensity with a peripheral hypointense rim. Surrounding the hemorrhage, there is high signal intensity in the white matter, representing edema.

Weisberg, L. Elliott, D and Mielke, D: "Intracerebral Hemorrhage Following Electroconvulsive Therapy (ECT)", November 1991, *Neurology,* v 41, p 1849.

Another MRI study documented a breakdown of the blood brain barrier and cerebral edema — brain swelling — after each and every shock. (Mander et al: *British Journal of Psychiatry*, 1987: V 151, p 69–71)

BIG LIE 3: ECT is new and improved. The whole point of ECT is to trigger a convulsion and there is simply no way around the brain's threshold: 100 joules of energy, a typical "dose," whether brief pulse, square wave, sine wave, AC or DC, unilateral or bilateral, with or without oxygen, equals the energy it takes to light up a 100 watt bulb for one second or drop a 73 pound weight one foot. And it's the energy that does the damage.

BIG LIE 4: ECT is a "Godsend" (Fink again). In March of this year, Dr. Sackeim published a study in JAMA showing a "relapse rate" of 84% within six months of stopping ECT. It is no coincidence that improvement ceases just as the concussive effects are finally waning. Sackeim's solution?: more ECT. Call it "maintenance" or call it "continuation," just don't stop. (*JAMA*. 2001;285:1299–1307).

BIG LIE 5: No one knows how ECT works. On the contrary, everyone knows how ECT works. It works by erasing memory and terrifying people.

Friedberg's conclusion?

ECT isn't back — it never went away. It's more common than appendectomy. What has happened is that its advocates have grown more arrogant and the number of patients forced to undergo ECT against their will is increasing. This was brought to public attention by Paul Henri Thomas fighting for his life and his mind at Pilgrim State Hospital on Long Island. Over the past two years, he has been subjected to 60 shocks and a judge just ordered 40 more. The newspapers stated that Mr. Thomas was born in Haiti, emigrated from oppression and was granted American citizenship.

To be held down, drugged and forcibly administered convulsive dose after convulsive dose of electroshock to the head — can anyone think of a greater assault on a human being's rights, short of death, in the whole world? And it's happening here in the land of the free. That's not acceptable.

> "We have had 60 years of poignant testimony from eloquent victims of electroshock. Ernest Hemingway complained it ruined his memory and put him out of business. He killed himself within weeks of concluding a second course of ECT. George Orwell ends 1984 with his protagonist being forced to love Big Brother on an electroshock table. I urge you to declare a moratorium on electroconvulsive therapy until it can be proven safe by evidence, not proclamation. I urge you to declare a moratorium on electroconvulsive therapy until patients can be guaranteed free and informed choice. Signed: John M. Friedberg, MD" (ectjustice.com).

What happens instead? ECT is advertised as the perfect PTSD cure!

Breeding completely agreed with Friedberg stating:

> "I've seen the research showing brain damage and memory loss, and I've sat with the victims of electroshock. I've witnessed their profound losses and disabilities. I personally know at least three people who have permanent seizure disorders now as a result of electroshock, including Diana Loper (ph.) who is one of the women I left in Charlotte. I know many more who are unable to work and on permanent disability. The other woman I left there, Evelyn Scogin, is unable to work as a teacher because of her disabilities."

Dr. Fred Baughman, MD, a neurologist in El Cajon, California, had this to say:

> "Throughout the more than three decades of my neurological practice, I have encountered patients treated with ECT who had permanent erasures of their memory. Psychiatrists may wish to call ECT therapeutic, but it never achieves anything but to diminish adaptability in the broadest sense and cannot be called therapeutic or medically justifiable. That my own mental health profession systematically inflicts brain damage is a shame and a disgrace."

He advises anyone serious about evaluating electroshock to read "Doctors of Deception, What They Don't Want You To Know about Shock Treatment" by researcher and electroshock survivor Linda Andre. The science is clear about the basic questions of ECT risks and benefits, he states. Electroshock is not safe. It is extremely dangerous. It always causes brain damage. The most obvious evidence of this is memory loss. It sometimes causes death. While the American Psychiatric Association argues that electroshock deaths are rare, a study published in 1993 reported 10 deaths among 37 patients 80 years and older who underwent electroshock. In the mid 1990s, the Texas Department of Mental Health and Retardation reported 21 deaths among an estimated 2,000 patients who were electroshocked. Imagine the brutality of it all, can you? These are psychiatrists applying such inhumane treatment, their denomination arriving from the Greek noun psychiatria, literally "a healing of the soul." By dispatching it into hell, more likely.

The electroshock machine industry has consistently ignored FDA requirements for evidence on the safety and efficacy of their machines, and the FDA obviously accepted their tardiness. Breeding assumes that it is a political question as to why the agency had consistently refused to apply the law and hold the industry accountable (psychcentral.com). But could it have been the AI agenda at work?

Amazingly enough, or not so, the National Alliance on Mental Illness (NAMI), the largest organization of people with major psychiatric disorders was the one recommending ECT equipment be reclassified as Class II, or medium risk, to ensure its treatment option. "Overly burdensome restrictions on ECT devices would very likely make this treatment difficult to avail for those who need and want it the most," the organization said in a statement submitted to the FDA. It said that, while the devices had not been through the rigorous research process typically required for high-risk devices, "in this instance, experience may be the best gauge for determining efficacy and safety." In a way this is not surprising as multiple

pharmaceutical companies fund NAMI. This was reported by the investigative magazine *Mother Jones* in 1999. At that time an Eli Lilly & Company executive was then "on loan" to NAMI working out of NAMI headquarters.

In 2009, during an investigation into the drug industry's influence on the practice of medicine, U.S. Senator Chuck Grassley (R-IA) sent letters to NAMI and about a dozen other influential disease and patient advocacy organizations, asking about their ties to drug and device makers. The investigation confirmed pharmaceutical companies provided a majority of NAMI's funding. According to investigators in Mr. Grassley's office and documents obtained by *The New York Times*, drug makers from 2006 to 2008 contributed nearly $23 million to the alliance, about three-quarters of its donations. The finding led to NAMI releasing documents listing donations over $5,*000 (Harris, Gardiner. "Drug Makers Are Advocacy Group's Biggest Donors"; New York Times* 2009).

The Canadian Institute for Health Information estimates that electroconvulsive therapy has been administered to about 15,000 Canadians annually since 2002. It is increasingly being administered to Canadian seniors as a treatment for depression (www.cmaj.ca/cgi/doi/10.1503/cmaj.080360). And few see that true evil is the face you know and the voice you trust. If they do, they are silent or silenced.

In that fair Commonwealth country a bit east of down-under, Mad Pride's Jessica Allen reported *Hundreds of Mental Health Patients Given Forced Electroconvulsive Therapy* in December 2017. The use of non-consensual electroconvulsive therapy had more than tripled in two years. Why are so many more mental health patients being shocked without permission, she wonders? ECT, a mental health treatment where electric currents are passed through the brain, triggering a seizure, she explains, had been administered without consent almost 1000 times last year — up 65 percent since 2015. The increasing ECT application trend, which occurred despite the New Zealand government's stated commitment to phase out coercive treatment, has left mental health advocates concerned about how dedicated the sector really is to respecting patients' rights.

In North America, roughly seven years after the United States reviewed ECT safety, it seems as if we are just entering such non-consensual ECT coercion without government commitment or law protection of any sort. PTSD-affected soldiers and veterans are in the front line of non-consensual ECT treatment, forget anyone else at this time. It is a neuroscientist's, mental health practitioner's and biological psychiatrist's dream come true. They already have wet dreams about it. Think about the glory they can obtain by rendering PTSD subjects imbecilic without anyone able

to prove it, while declaring it the PTSD cure? "Well, no, GI Joe was like this because of PTSD before we got him better with ETC, not worse," they will maintain about the brain-dead ducky. His family? They departed long ago and have neither voice nor interest.

Why? Professional mental health practicers, these purported *healers of the soul,* and their associated, above-mentioned ilk, have carte blanche to do whatever they please without any consequences whatsoever. Unless, that is, the PTSD subjects of their intended experimentations and others awaken to the ECT scams, lies and violations about to be perpetrated upon their brains and bodies.

What happens if they resent to awaken from their PTSD-treatment-induced lethargy and numbness associated with and accompanied by occasional outbursts of rage due to despair? What if they refuse to get off their pharma drugs, and instead engage in bibliotherapy to educate and arm themselves with material enabling them to give reasons to the authority why they decline ECT? Do they deserve to have it imposed on them? Why? They are more dead than alive, due to their own making anyway, so why not finish it off and go into oblivion in a body still only physically alive?

After all, anyone believing that when the brain is forced into seizures by way of electrical shocks, it will heal PTSD or anything else, for that matter, deserves what he or she gets. Anyone stupid enough to think that the brain, which since its creation naturally functions in a particular range of vibrational frequency, when forcefully rotated out of this frequency due to electrical convulsions will be coming out unscathed deserves everything received. Watching Dr. Emoto's results of what such shakings will do to *inanimate objects* gives a splendid idea of the results in human brains after just one ECT treatment administered. Never mind the six to 12 favored by those "standard of care"-adhering mental health psycho-the-rapists et al.s to their subjects.

What did New Zealand's Mental Health Foundation chief executive Shaun Robinson say to such loving tender care treatment? "Although ECT can be an effective treatment for some people it can have long term side-effects and should only be used in extreme cases." The country's mental health consumer advocate Mary O'Hagan echoed him when stating that ECT was still highly controversial, with some patients experiencing no benefits from the treatment and distressing side-effects such as losing large chunks of memory. "Compulsory ECT is a breach of human rights and should not be authorised in legislation. If the increase in compulsory ECT is based on accurate figures it is an outrage — it needs to be

investigated and stopped," she said.

We know of a few side-effects from the testimony given earlier, but what else is there in side-effects? Healthtalk.org gives insight in a somewhat detailed manner. The immediate post-treatment effects, reportedly only lasting a short while, some hours or sometimes a few days, apparently are:

- fatigue
- nausea
- drooling
- disorientation
- hallucinations
- inability to eat
- muscle stiffness
- intense sleepiness
- jaw ache feeling shaky
- fear, anxiety and confusion"
- looking like one "had a stroke"
- wooziness", "grogginess", dizziness
- problems thinking e.g. "they fried my brain"
- memory loss surrounding their treatment time
- headaches (which could be severe and "indescribable") feeling strange afterwards, e.g. light headed, dissociated, numbing, "mixing up emotions

The most common risks associated with ECT, however, are disturbances in heart rhythm. Broken or dislocated bones also occur, though rarely, we read on the free medical dictionary. Side effect severity seems to be influenced by ECT's strength of dosage. Headache and jaw ache can be so severe as to impede eating (healthtalk.org). Looking like someone who had had a stroke, as well as drooling, was part of the ETC aftermath scenario, we read.

As to the ubiquitous memory loss, the Mayo Clinic explains that following a treatment, a patient might not remember the moments before the therapy. These before-moments, however, can extend to weeks, months or even years of memories lost. The specific name for this ECT side-effect is retrograde amnesia, the source notes.

The positive, we hear, is that for most patients their memory bounces back

within a couple of months following the end of the treatment. However, that also suggests that some patients will permanently lose life events from their brain.

According to Health Talk, most ECT patients did experience memory loss following ECT. This seemed to be the case whether or not ECT had had any effect on their mental illness. Frequently the memory loss was judged to be relatively minor, such as forgetting people's names, or not being able to find their way back to their room or their local town, forgetting passwords, bank pin numbers or how to spell. These did come back in time or once they were reminded.

Patients worried about ECT's long-term effects on the brain, such as problems of thought processes, of thinking, were put at ease about it by their doctors, who denied long term effects were possible. However, many, especially those who had ECT over ten years ago, found they had lost memories of important events including the birth of a child.

For others the effects were more permanent. Some experienced long term "fogginess", which would go away but never cleared. Some have ongoing short-term memory problems, which are getting worse. Others suffer badly with memory loss and have overall difficulties using their minds. Long-term memory loss after having ECT seems to be the norm. Some watch repeats of television programs with no recollection of having seen them before. That's the risk you take. Still an eager-beaver?

If so, you might wonder if ETC is a safe alternative to medications? If you do so, at this point, you validate that you indeed are a complete idiot, but never mind that. WebMD views ECT as "among the safest and most effective treatments available for depression," benignly describing it as a brain stimulation. It sees ETC as a viable option indeed for patients unresponsive to medications or if allergic to a particular drug. Although used since the 1940s and 1950s, we read, it is still misunderstood by the general public. Many of ETC procedures' risks and side-effects were merely related to equipment misuse, incorrect administration or improperly trained staff, we learn, and never the treatment's efficacy in and of itself.

ECT's use as a "quick fix" in place of long-term therapy or hospitalization was also a myth, WebMD's advice to the ignorant asserts. In fact, we know very well that it is meant to be just that for PTSD journeyers. Another misconception mentioned by them is the public's belief that patients were painfully "shocked out of " their depressions. It arose out of ECT portrayal in movies such as the, equally ubiquitous, *One flew over the Cuckoo* Nest. A comforting: "Thanks to muscle relaxants and advances in anaesthesia, ECT may certainly be a viable treatment option for you or a

loved one in need," should put potential ECT clients at ease.

ETC can provide quick relief to severely depressed people, and is even effective for those showing suicidal tendencies, we hear. It is a marvellously effective treatment for overactive brain activity, known as mania. Soon it will be administered to ADHD suffering children, we can hear them chiming in the near future. Healthline.com even points out that ECT is safe for pregnant women, when the same cannot be said for all antidepressant medications.

By and large, though, all that negativity, all that controversy, all those misconceptions about ECT treatments, arose due to unfavorable news reports, media coverage and movie portrayals. All of it could be graciously ignored as hogwash, as ECT might certainly be the treatment option for you and your loved ones in case of need. It's either laugh or cry.

PsychCentral also praises ECT to the hilt, nevertheless noting though that considerable confusion about its treatment remains, resulting in many patients being frightened of the procedure. "One Flew Over the Cuckoo's Nest" was again mentioned as a culprit for such misapprehensions. Obviously, the writer never spent time in a mental health care facility or institution, or he would know better. Sites like PsychCentral, and others in general, harp away about in the earliest uses of electroconvulsive therapy. They point to the much higher ECT doses administered without anesthesia, resulting in much more severe physical harm and serious side-effects, never mind loss of brain-capacity. ECT today is a much safer treatment, at least for people who experience severe, debilitating and chronic depression, but at the cost of some memory loss. Most people also almost always need to get annual ECT treatment, as the effects of ECT appear not to be long-lasting. But after a few years, you won't notice anyway, as you can't remember, perhaps not even that you are depressed. Nice!

How much safer is it said to be, though? And what are considered serious ECT problems? Well, there is the one with memory, of course. But what so? Losing significant portions of past memories could for some be quite a blessing, could it not, in particular when they don't know they've lost it? In general, memory is transient, with many subjects having full memory functioning several weeks after the last session, as if they would know. That some never fully recover from this memory loss is an unexplained discovery. None of the ECT administering "professionals," these soul-healers, can tell ahead of time what kind of memory impairment subjects will suffer, how severe it will be and whether it will be temporary or permanent in nature. What they do know and admit to, however, is

that nearly everybody undergoing ECT will suffer from some sort of memory loss. But again, who cares, as subjects who underwent the procedure do not remember what there is to remember, or do they?

Following the miracle cure ECT procedure, many patients are given antidepressants and periodic maintenance ECT to help prevent depression relapse. Many patients seek annual relief from their depression at the cost of some memory loss, because ETC effects appear not to be long-lasting, according to John Hauser, MD (*An Overview of Electroconvulsive Therapy (ECT)*. Psych Central 2016).

In December 2012, under the title *History of ECT,* Recovery Ranch.com shared with the world that ECT, indeed, was a behavioral *health* treatment with a somewhat negative connotation in popular culture, but a wonderful treatment, especially for those with schizophrenia. "Viable" actually means "Capable of success or continuing effectiveness." That nothing about its efficacy is proven, is beside the point. The Ranch even opines that ECT was once a very popular mental health treatment. In this popular jelly culture of ours, it has merely been usurped by medications and unmentioned alternative therapies. Understanding its history would put it all into perspective. So here we go.

The ECT story officially began in the early 20th century for conditions like schizophrenia. That's when the Austrian psychiatrist Julius Wagner von Jauregg (1857–1940), for example, noted that mental health patients in asylums drastically improved after they survived fever-inducing diseases such as typhoid or tuberculosis. It won him the 1927 Nobel Prize in Physiology or Medicine for his discovery of the therapeutic value of malaria inoculation in the treatment of dementia paralytica, another name for general paralysis of the insane. A disease of the central nervous system due to late manifestation of syphilis, it often occurs up to 15 years after the original infection and is characterized by mental deterioration, speech defects and progressive paralysis. Jauregg's discovery on live humans was because lepus, cani, simia and mus were most likely insufficient as subjects. In particular, he had ready-made humans in his care for the project. They gave the first clue that the brain might be capable of healing itself, if presented with the right stimulus, in his hypothesis, the high fever treatment.

In 1927, Manfred Joshua Sakel (1900–1957), an Austrian-Jewish neurophysiologist and psychiatrist, followed suit. He induced a coma in a young woman by "shocking" her system with insulin. Her mental health symptoms practically disappeared, we hear. Sakel continued to try his "insulin shock therapy" on patients with schizophrenia and psychosis and, we are to believe, achieved a 70%

success rate.

Hungarian psychiatrist and neuropathologist Ladislas Joseph Meduna (1896–1964) chemically induced grand mal epileptic seizures as treatment for schizophrenia in 1934. This became the basis for modern convulsive therapy. He had sought ways to induce seizures with chemicals in animals, settling on camphor dissolved in oil as effective and reliable. His experiments on humans began at the psychiatric hospital at Lipotmező, outside Budapest, in January 1934. Soon after he replaced camphor with pentylenetetrazol (Metrazol), an intravenous agent that induced seizures immediately, compared with the long delay of 15 to 45 minutes after intramuscular camphor. He published *Die Konvulsionstherapie der Schizophrenie*– the convulsion therapy of schizophrenia — in 1937, describing results in 110 patients, half of whom recovered, in his opinion. Patients ill for less than a year fared much better than those ill for many years. Perhaps they were the ones suffering an existential crisis, PTSD, rather than anything else.

Meduna's results were quickly reproduced in centers around the world, always without patient-consent, of course, and recognized as the first effective schizophrenia treatment. Meduna, splendid soul that he was, also developed carbon dioxide therapy, where the patient breathes a gaseous mixture of 30% carbon dioxide and 70% oxygen, named carboxygen or carbogen. Designed to provoke a powerful feeling of suffocation, after only a few breaths, the client enters an unresponsive but intense altered state of mind. While usually unpleasant or even terrifying, the treatment proved very useful for revealing previously unconscious fears. In 1937, this piece of bovine excrement of the "They Live" variety immigrated to the US, and in 1938 became Professor of Neurology at Chicago's Loyala University. He was also founder of the *Journal of Neuropsychiatry* and a president of the Society of Biological Psychiatry.

Insulin coma therapy also came into vogue during that time. But Italian psychiatrists Ugo Cerletti and Lucio Bini thought of using the more facile form of seizure induction by electricity, instead of chemical induction, treating their first patient with ECT in 1938. By the mid-1940s, ECT had replaced Metrazol. That skin burns could now and today occur due to poor contact of electrodes with the skin surface, resulting in high impedance in the electrical circuit was of no consequence. It typically falls under "mild complications". As Hayward of active beat so soothingly says:

> "Presumably, your medical team will have some experience with the procedure and properly prepare for it — so burnt skin

> shouldn't be a big concern. Even when a burn from ECT does occur, the source says, it typically falls under 'mild complications' meaning the burns probably aren't severe. Conductivity gel may be used by your medical team to help prevent this problem."

That's soothing.

That ECT eventually declined in popularity had nothing to do with treatment's damaging and harmful side effects, asserts Recovery Ranch. It was merely because some mental institutions were using ECT in an abusive way. Patients would be administered ECT without sedation or anaesthesia, which made it an uncomfortable or painful experience. And those patients acting up might have been threatened with ECT even if it was not medically necessary. Some patients were given ECT multiple times per day, but what so? They'd get used to it. Somebody like nurse Ratchet and her cabal had a field day. Enough facilities misusing ECT were found guilty of abuse to spark public outrage, however, which caused part of ECT's decline in popularity. Mainly, it was because of new medications quickly replacing ECT to do the same damage in different ways. They could pervert the mind, sponsor addiction, destroy the human being in a slow and tedious way, while traveling towards death and dying.

Recovery Ranch, like the other websites, advertises ECT side effects as generally mild, nothing more than some post-treatment lingering muscle soreness, jaw pain, headache, nausea, confusion and memory loss. But Healthline.com outdoes them with the undocumented assumption that ECT helps up to 78% of clinical depression patients, compared to one source asserting antidepressant medications can eliminate depression symptoms in up to 65% of cases over a longer term treatment plan of six months. Each individual drug company may have its own statistics on this, they add, and one drug could be more effective than another, *depending on the patient*. Hayward then, in all his wisdom and expertise, adds, without blushing and under the pretext of fairness, honour and integrity: " . . . reported relapse rates for ECT are still quite high, meaning more treatments may be required beyond the initial plan, or a more comprehensive approach to managing mental health should come into effect." So brief yourself, genuine PTSD travelers. Your brain is the target of ECT destruction, and that of those suffering more or less nothing more than what they, too, can heal all by themselves. That is, if they get their shit together and acquire discipline, persistency, willpower and determination. But I am dreaming again, and what do I care, really? To each his own. I am merely giving myself the joy of writing

it down, putting it all together and making it available to those who still can read and reason.

But what does the aforementioned VA healer of the soul, psychiatrist Nagy Youssef of the Charlie Norwood Veterans Affairs Medical Center have to say to all of this? He, who loves the ECT for PTSD idea?

As standard therapeutics fall short of helping many patients with PTSD, ECT may be the answer, he proclaims. The literature that examined the role of ECT in treating PTSD in humans is scant, however, only totalling four preliminary studies. As a matter of fact, Youssef had recently done a synthesis of existing evidence of ETC's role in PTSD (Youssef NA, McCall WV, Andrade C. *The role of ECT in posttraumatic stress disorder: a systematic review*. *Ann Clin Psychiatry*. 2017;29:62–70). His opinion on PTSD overall? He finds it to be associated with a high burden of disability, mortality and frequent treatment resistance. He claims there is little to offer patients not responding to standard interventions, the rattus, cani, lepus, simia et al. variety treatment. The objective of his report was therefore to systematically review *human* data on whether ECT was or was not effective in PTSD. So on he and his two cohorts went to perform a systematic literature review from 1958 through August 2016 for clinical studies and case reports published in English examining the efficacy of ECT to improve PTSD symptoms. How and why those dates were chosen is undisclosed.

The search generated three retrospective studies, one prospective uncontrolled clinical trial and five case reports. Given the small sample size and lack of a large randomized trial, it was unclear whether favourable outcomes were attributed to improvement in depression, as opposed to core PTSD symptoms. Unfavourable outcomes are not mentioned.

The only clinical trial available in the literature for ECT in PTSD was an open-label, non-controlled trial. Participants had severe chronic and treatment-resistant PTSD, as evidenced by failure to respond to four or more adequate (in his opinion) antidepressant trials, as well as 12 sessions of cognitive behaviour therapy. It was also the only study that measured PTSD with the Clinician-Administered PTSD Scale (CAPS) as the primary measure. CAPS scores decreased by 34%, the authors reported. They also suggested that benefits for PTSD were independent from depression improvement (Margoob MA, Ali Z, Andrade C. "Efficacy of ECT in chronic, severe, antidepressant- and CBT-refractory PTSD: an open, prospective study". *Brain Stim.* 2010;3:28–35).

The conclusion was therefore reached that current ECT efficacy data did not

conclusively separate ECT effects on PTSD symptoms from those on depression. Randomized controlled trials were necessary to examine ECT use in PTSD patients, with and without comorbid depression, who did not respond to attempted forms of pharmaceutical drug treatment. Suggestion given? Subsequent studies could address response in PTSD subtypes and the use of novel techniques, such as memory reactivation before ECT.

In a way, it was all old hat to Youssef, who already in 2016 published with some of his own cabal *Electroconvulsive therapy for post-traumatic stress disorder: efficacy, mechanisms and a hypothesis for new directions* (Andrade C, McCall WV, Youssef NA. Expert Rev Neurother. 2016 Jul;16(7):749–53. Epub 2016 May 3). There, too, he said that a small body of literature suggested PTSD responded to ECT. Laboratory research had identified changes in the amygdala, hippocampus and prefrontal cortex that might explain the treatment response he and his cohorts claimed. After all, one randomized controlled trial in depressed patients in a laboratory setting had demonstrated ECT use to impair reconsolidation of reactivated, emotionally-aversive test memories. It could therefore with good conscience be hypothesized that ECT might be more effective in human PTSD patients, if their trauma memories were deliberately recalled immediately before each ECT session. After all, the hypothesis had received preliminary support in one single case report so a formal study in carefully designed clinical trials may be worth it, Youssef et al reasoned.

His reasoning was based on ECT generally having the advantage of working faster than medications and psychotherapy, with the effectiveness rate usually being at least twice as high as standard therapeutics. At least that is what Youssef asserted in his subsequent 2018 ECT for PTSD diatribe. How he surmised it is unknown. But he also liked the idea that it frequently worked in more severe and treatment-resistant cases. Jack Nicholson's ECT treatment in the Cuckoo Nest springs to mind. This was, of course, a huge benefit. If they don't obey, electrocute them into oblivion in their stupid ignorance, not knowing what we are up to anyway, seems to be the intended modus operandi. We are justified, as we tell them all the time what we are up to, as Cosmic Law demands. Not our fault that they can't see it.

Almost as if working in tandem, backing Youssef is Naser Ahmadi, who published the earlier mentioned *Efficacy and Long-term Clinical Outcome of Comorbid Posttraumatic Stress Disorder and Major Depressive Disorder after Electroconvulsive Therapy* in 2016 with Lori E. Moss. Many patients fulfill criteria for both PTSD and major depressive disorder (MDD), they assert. And, they say, as ETC is generally

acknowledged to be the most-effective treatment for refractory MDD, they, too, investigated the existent four or so studies on ECT efficacy on long-term clinical outcome of comorbid PTSD and MDD (Published 2016 in *Depression and anxiety*). Their conclusion? ECT is associated with a significant PTSD and MDD symptom reduction, as well as reduction in risk of suicidality, cardiovascular and all-cause mortality.

Thus ECT was declared a much more robust PTSD treatment than antidepressant-therapy alone. Dr. Lori Moss, by the way, is one of 21 psychiatrists in Waukegan, Illinois, affiliated with the familiar Captain James A. Lovell Federal Health Care Center. She received her medical degree from Chicago Medical School at Rosalind Franklin University and has been in practice for more than 20 years. Do they electrocute PTSD patients there, I wonder?

Youssef also reveals in his "ECT for PTSD: Are we There Yet" that 80% of PTSD veterans seen at the VA received pharmacologic treatment with or without psychotherapy. Of those, 89% were on prescribed antidepressants. Most of the studies he viewed had been positive for FDA-approved medications. But a 2016 large multicenter clinical trial did show no benefit for nightmares or other PTSD symptoms in veterans with chronic PTSD (Petrakis IL, Desai N, Gueorguieva R, et al.: "Prazosin for veterans with posttraumatic stress disorder and comorbid alcohol dependence: a clinical trial". *Alcohol Clin Exp Res*. 2016;40:178–186). Neither did another study that examined prazosin for PTSD, but no nightmares. Finally, it is officially confirmed what some of us have known all along: pharmaceutical drugs do sweet all for PTSD.

Trauma-based therapies such as cognitive processing therapy and prolonged exposure, considered PTSD gold standard treatments, did sweet all, as well, we hear from him. Despite all available standard therapeutics, a high percentage of PTSD patients did not achieve remission or response from multiple trials of both pharmacotherapy and psychotherapy. Hallelujah. The truth about the PTSD scam is beginning to surface.

As most humans living life know, traumatic memories are some of the most persistent and are the hardest to erase. Youssef concurs, though he seeks an explanation not in the human and humane psyche, its innate kindness and compassion, its integrity and humility contributing to the difficulty in erasing traumatic memories. He, as well as the vast majority of his fellow Healers of the Soul, seeks to explain the lack of loss of that memory, or the erasure thereof, by the cellular mechanism for encoding durable memories that also involves the brain's

structural change. At the intra-nuclear level, he says, a recent review suggested that the effect of these traumatic memories might even be passed to the next generations via epigenetic methylation effects.

A nucleus in biology is a dense organelle containing the genetic material. As to epigenetic methylation effects, this term is used to refer to heritable alterations that are not due to changes in DNA sequence, but rather alter DNA accessibility and chromatin structure, thereby regulating patterns of gene expression. You get the idea? If that is the case, we can deduce that all events from thriftiness to inclination to terror can be passed on by epigenetic methylation. Proof? None.

Youssef, however, thinks that these persistently encoded memories might be, at least in part, why so many patients with PTSD are treatment-resistant or partial responders. Prove of it? As usual, none!

Many PTSD patients with treatment resistance to the offered cognitive behavioural therapies suffer the burden of impairment, elevated risk of suicide and violence, and higher incidence of all-cause mortality, claims Youssef. As you have discovered by now, we are talking soldiers and veterans, more or less exclusively. Common PTSD psychiatric comorbidities, in addition to depression, include substance use disorders and physical illnesses, as well as hypertension and cardiovascular events. Of course they do. Impositions and maltreatment by the powers that be make it unavoidable.

But in Youssef's view, and in that of many of his ilk, preliminary evidence for the role of ECT in treating PTSD was certainly called for. After all, modern ECT had a high level of safety compared with older techniques. Not only were anaesthesia and muscle relaxation used during treatment, but improvements in electric parameter modifications and electrode placements had practically made it fool proof. And of course, paramount to it all, ECT generally did have the advantage of working faster than medications and psychotherapy, and its effectiveness rate was usually at least twice as high as standard therapeutics. It also frequently worked in more severe and treatment-resistant cases. I wonder why? Hike up the voltage until it does, should do it, eh?

But, as no randomized controlled clinical trials existed so far, routine ECT for PTSD clinical use could not be recommended yet. However, most available evidence was positive, although publication bias could not be ruled out and negative studies might not have been published. The disclaimer? The views expressed are those of Dr. Youssef and do not represent the Medical College of Georgia or the Department of Veterans Affairs.

New developments in using ECT to treat PTSD could soon get us to think about ECT as a tool to erase painful memories, like in the memory modification method in the film *Eternal Sunshine of the Spotless Mind*, writes Mona Han, a Harvard Ph.D. program in neuroscience (PiN) graduate student (Mona Han; figures by Abigail Burrus*:* "Can We Erase Painful Memories with Electroconvulsive Therapy?" sitn.hms.harvard.edu October 2017). In her view, ECT nowadays is a safe, quick and effective procedure with few side effects, used to achieve faster recovery in some patients with depression. It might have been an early sign of ECT utility for PTSD treatment, she muses. It could also be a manifestation of someone knowing the human body is an electrical construct that ETC exposure would rattle into a different vibrational configuration. Has she tried it? We don't know.

Be it as it may, rats were also indicative of ECT's PTSD potential, due to a 1968 study at Rutgers University, led by Dr. Donald J. Lewis ("Retrograde Amnesia Produced by Electroconvulsive Shock after Reactivation of a Consolidated Memory Trace"; *Science* May 1968: Vol. 160, Issue 3827, pp. 554–555). Rats experienced memory loss of a fear response when receiving an electroconvulsive shock 24 hours after the fear-conditioning trial preceded by a brief presentation of the conditioned stimulus. No such loss occurred when the conditioned stimulus was not presented. The memory loss in animals given electroconvulsive shock 24 hours after conditioning was, furthermore, as great as that displayed in animals given electroconvulsive shock immediately after conditioning. This result throws doubt on both the assertion that electroconvulsive shock exerts a selective amnesic effect on recently acquired memories and that electroconvulsive shock produces amnesia solely through interference with memory trace consolidation we read in the abstract. As rattus as homo sapien, remember?

When ECT was administered to human patients in the early 20th century, it did cause overall memory impairment, documents Laura Hirshbein, M.D., Ph.D., a clinical professor at the University of Michigan School of Medicine. Quoted by Ann Harbour In her *Historical Essay: Electroconvulsive Therapy, Memory, and Self in America,* she stated:

> "Electroconvulsive Therapy (ECT) practitioners and anti-ECT activists have divergent interpretations of both the treatment and its history. Despite claims by ECT opponents that practitioners do not acknowledge memory side effects, the published literature on the procedure demonstrates psychiatrists' awareness of this issue. And though current ECT

> practitioners claim that memory side effects were mostly the result of outmoded methods, investigators continue to publish studies that indicate ongoing memory problems (Laura Hirshbein: *Historical Essay: Electroconvulsive Therapy, Memory, and Self in America*; Pages 147–169; www.tandfonline.com)

Should PTSD be treated with ECT? Would you, the genuine PTSD experiencer, want to be treated with it? Perhaps reading Jonathan Sadowsky's book *Electroconvulsive Therapy in America: The Anatomy of a Medical Controversy* (Routledge Studies in Cultural History, 2016 1st Edition) may help in making the decision. Professor in history at Case Western Reserve University in Cleveland, Ohio, Sadowsky's main research interest is the history of medicine, especially psychiatry, in Africa and the United States. He teaches courses in African history, history of medicine and the body, and historical method and cultural studies.

Greg Eghigian, Ph.D., is associate professor of modern history and former director of the Science, Technology, and Society Program at Penn State University, University Park, PA, and section editor for *Psychiatric Times History of Psychiatry.* A 2017 interview with Sadowsky, published in the *Psychiatric Times*, points out that ECT has had and continues to have both champions and detractors. Historians who wrote on the subject also saw it either as a technology of social control or as an instance of unmitigated progress, he says (ECT: *History of a Psychiatric Controversy* Jun 23, 2017; www.psychiatrictimes.com).

In Sadowsky's view, ECT has been pressed into service as a proxy in wider struggles over the authority of medicine, what kind of psychiatry we should have, "biological" or "talk," for example, or even if we should have psychiatry at all, since ECT was a main target of the antipsychiatry movement. These debates touch deeply held, but often implicit, beliefs about the meaning of illness and wellness and even what a human being is. States he:

> "The human body is not a mass-produced machine, where given inputs such as therapies produce automatic and predictable results. Most clinicians and lay people know this but often act as if they don't. One result of this mechanistic conception is resistance to the variability of bodily experience. But this variability is easy to show. Any psychiatrist who reads this knows it is not completely random — a psychiatrist might hesitate to prescribe bupropion to treat depression comorbid

with extreme anxiety, for example — but there is a lot of mystery involved.

"In the case of ECT, there has been a reluctance by many partisans to recognize that the experience they have had or observed may not be universal or typical. We will have more productive discussions if we are more sensitive to variability."

He knows very well that electroconvulsive therapy is either demonized or idealized. Some detractors consider its very use to be a human rights violation, a remnant of a period of barbaric psychiatry, despite its reputation among many psychiatrists as possibly psychiatry's best treatment. Some promoters depict it as a miracle, the "penicillin of psychiatry." His book traces ECT's American history of this most controversial of procedures in medicine. It also seeks to provide an explanation of *why* ECT has been so controversial, juxtaposing evidence from clinical science, personal memoir, and popular culture. It is unknown who first thought of using it on humans, and used it is, every day somewhere in the form of Tasers. Thus, Sadowsky documents that the application of electricity to the brain to treat illness is not only a physiological event, but also one embedded in culturally patterned beliefs about the human body, the meaning of sickness and medical authority.

Historians of medicine have shown that illnesses symptoms and treatments like ECT have histories, for good and bad. In ETC, in particular, its adverse effects are memory loss. While the common short-term losses of memory of events close to the treatment are usually considered minor, permanent retrograde losses are possible. When they occur, they are a very disturbing effect of the therapy, even for patients who express deep relief because of symptom remission. This adverse effect has a history in at least two senses, says Sadowsky.

First, it has an intellectual history, in the clinical science, as the problem of memory loss has been studied virtually since the inception of ECT. That in itself is curious in his opinion, if the therapy is really as harmless as some of its strongest proponents claim. What struck him most about ECT's history was how inconclusive it is. Some advocates are convinced permanent retrograde losses are rare, and some critics are convinced they are very common. But many researchers have stressed how elusive certainty has been, meaning they are "practicing" their craft of hypothezisation on the cattle — the human beings.

The second sense is experiential, taken from the perspective of those who underwent the treatment. Here, memory loss complaints seem to appear more in

recent patient accounts than they do in earlier ones, even as techniques of treatment have supposedly been developed for the purpose of lessening that risk. He thinks, however, that narrative evidence shows permanent memory losses may be more common than some clinical manuals allow. Given how traumatic these losses are when they occur, clinicians should keep this in mind. Considering that ECT's public reputation is still precarious, downplaying the possibility of adverse effects could do it more harm than good. None of these hypotheses are easy to prove empirically. It's all speculation, a mystery.

Perhaps reading comments of those who tried or were forced into tasting ETC "therapy", including Taser treatment on the Internet, might help decide what to do or not to do, whether to engage or not engage in this purportedly PTSD curing proposal:

> "Should PTSD be treated with ECT when it was the experience of ECT that caused it? Following a bad reaction from an SSRI (overnight collapse no sign anything was unusual) that I was taking for stress in my professional life, in 2000–2002, 20 months) I had 66 ECT treatments. Whilst my memory for this time is very severely damaged, I do remember refusing the treatment many times. I was pulled off my bed, pushed through the door of the ECT room, even picked up and put on the table, held my arms over my head and begged them not to do it, I wept, I pleaded, I begged but they never stopped.
>
> "I still have severe memory and cognitive dysfunction. Others told me I often refused but they always did it. They stood over me to sign the consent, threatened to section me and send me to the public hospital. It was 2 years before I could drive down the street the Clinic was in. I was then treated for bipolar at 2 other private clinics.
>
> "I tried to tell the doctors that the mood swings, the bad depression, the rage, flashbacks, avoidance, hype-r-vigilance, etc. came from the ECT time, not before, but they wouldn't believe me. I spent 10 years at one clinic, I was unable to stay in a room near the ECT elevator, on ECT mornings I got all the meds I could, used earplugs and kept my head under the pillow so as not hear the squeaking wheelchairs. I had anxiety

attacks if I saw someone carrying the post ECT sandwiches. I had to run from any room when someone mentioned ECT & on and on.

"Surely this was enough for my doctor to see I had terrible fears of ECT. How did she not see me? ALL the nurses knew. They set things up to help me get through those mornings. In 2010, she somehow persuaded me to do ECT again. It took her 3 days but eventually I signed. I was told that it was new and improved, Ultra Brief ECT. That's the only way I can believe I did it. I wasn't told that the Ultra Brief was merely the pulse, not that there were 140 of them per second for 5 seconds, with 450 volts and BILATERAL? I would never have agreed to it if I'd known that. And for the first time I saw her admission notes about me and said "I had a difficult life with BAD", with "long periods of depression and SOCIAL withdrawal"

"NOT TRUE! I had a couple of spots in my 20s but never again. I was, according to my friends the most social of all of us. This LIE was used to get me 20 ECTs straight because of "HIPPOCAMPAL SHRINKAGE due to the "LONG" history that never happened.

"I am freaking out here. The nurse's notes said all along that I was terribly anxious about it but the doctor 's notes said once, `she [I] feels humiliated and violated but after a long talk agreed to continue.'

"After one I had to be locked up in the ICU because I was acutely suicidal. In fact the nurse's noted again and again that I was terribly worried about ECT and was talking about making a rope to hang myself. One time I said I couldn't afford the treatment so she fixed it that the doctors would cut their extra fees.

"I was desperately calling for help but every time I tried to get out she blocked the door. I do realise that I could have revoked consent but I couldn't, I don't know why. I was raped twice, at 13 and 24 and she knew that. I always said ECT was like that. You can't get away so you just grit your teeth. Maybe

it was that.

> "I now feel totally hopeless. I cannot ever talk to a psychiatrist again. I can hardly even talk to any doctor again. My diagnosis and terrible fear of further humiliation means I cannot sue them because she could get as many of her cronies to say I was "sick" which was why I was having the treatment in the first place. What my doctor did was wrong.
>
> "She told me for 7 years that she respected my feelings about ECT. I want to know what people who know about this condition think of my doctor's performance on this. And maybe how to get past this. I am very distressed and don't know what to do. I'm afraid that if I stand up and fight back, because of her lies, I could be pulled in off the street as an involuntary patient. I wouldn't put it past her. She watched me suffer horribly during that ECT, calm and determined to make me have it." (patient.info/forums/discuss/should-ptsd-be-treated-with-ect--62095).

The ECT pro and con debate rages on for those who care and those who want to force their will on PTSD journeyers even though no first evidence exists, documenting whether painful PTSD memories in humans can be permanently erased with ECT or not. No first evidence exists whether or not they will resurface after a while. No public first evidence exists on the severity of impact on the human brain. The question thus remains: "Do you want to run the risk with electro convulsive treatment to ruin your Self forever, or rather go holistic and look into the Self to heal the Self? The choice is yours. You have the power to do either or. What is it going to be? Perhaps biblio-therapy on the topic could be a fine way to start exploring the topic on your own? Or deviate to ART, the accelerated resolution therapy for PTSD, for improvement — or not — or doing your own thing and heal yourself?

Accelerated Resolution Therapy (ART) For PTSD?

The newest kid on the block flogging her rapid PTSD amelioration idea, the accelerated resolution therapy (or ART), is Laney Rosenzweig of the Rosenzweig Center for Rapid Recovery, LLC. Marriage and family therapy her specialty, she has been in the mental health field for 26 years and is familiar with its various therapies and treatment modalities, including those of PTSD. It is from her knowledge of EMDR that she evolved the accelerated resolution therapy. Since 2012, it has been accepted by the Substance Abuse and Mental Health Services Administration (SAMHSA) as evidence-based revolutionary trauma therapy, including for PTSD.

Congress established SAMHSA in 1992 to make information about substance use and mental disorder services and research more accessible to the American public. The agency is nested within the U.S. Department of Health and Human Services. It supposedly attempts to advance the nation's behavioural health by reducing the impact of substance abuse and mental illness on America's communities. Laney Rosenzweig entered that field soon thereafter. It took until 2011, however, before the *Connecticut Jewish Ledger* could announce "West Htfd. therapist develops treatment for trauma; says she can aid a client to erase the symptoms of Post-Traumatic Stress Disorder caused by trauma." Rosenzweig, you see, is a West Hartford, Connecticut, native who began her career in mental health at the Wheeler Clinic in Plainville, Connecticut, first as a crisis worker and then in the adult outpatient and substance unit.

Generosity, vision and hard work were the building blocks creating Wheeler Clinic's history. It began in 1960 with the generous bequest from prominent Plainville resident Bertha Wheeler. It continued with the support of many local and state-wide community and business leaders, as well as clinical health professionals. Vital construction and staffing grants from the National Institute of Mental Health helped establish the clinic in 1968. They led to the construction of the first facility in 1972, to develop more effective, less costly and more humane forms of care for children and adults with addictions, emotional disturbances and other behavioural disorders (wheelerclinic.org). Wheeler Clinic has grown and expanded significantly to respond to the changing and diverse needs of those it serves:

> "Our strong foundation supports the strategic choices that will define our future. As we continue to evolve, we know we will always be an integral part of the health and well-being of our communities."

After all, this is another non-profit society. It has the enormous amount of 875 employees, a substantial number of them sitting on the Board of Trustees. As members, they all draw multi-thousand dollar salaries annually, while purportedly serving the approximately 30,000 people gracing its premises in Bristol, Hartford, Manchester, Meriden, Middletown, New Britain, New Haven, Newington, New London, Plainville and Waterbury.

The leadership team in itself comprises of President and CEO Susan Walkama, LCSW, holding that position since 2007. Before attending such lofty heights she earned a Bachelor of Science degree in sociology from Central Connecticut State University. She then earned a Master of Social Work Administration and Case Work

Degree from the University of Connecticut, and in 1997, she completed the Executive Program in Managed Care through the University of Connecticut School of Business Administration Center for Health Systems Management.

Responsible for the overall operation of a $65.7 million Joint Commission-accredited organization, Walkama oversees Wheeler Clinics' activities. At the same time, she serves on numerous other non-profit organization boards, legislative task forces, committees and councils that focus on community mental health, human services and healthcare policy. A nice check she hauls home, considering the average income for sitting on non-profit board of directors is a minimum of $67,000.00 annually, as stated earlier in this book. Assisting her in her endeavours are four chiefs, one senior VP, seven VPs, five board of trustees officers and 10 members, including Walkama.

Mind you, Wheeler not only prides itself on a comprehensive continuum of mental health and substance abuse recovery services. It also provides primary care, child welfare, special education, early childhood development issues, community justice, foster care, behavioral health, dental and prevention services, wellness programs and employee assistance. In addition, it offers comprehensive solutions addressing complex health issues for individuals, families and communities, accessible innovative care that encourages recovery, health and growth at all stages of life. It also offers behavioural health, addiction and primary care services. These include treatment for mental illness, such as depression and anxiety, as well as opiate and heroin addiction, substance abuse, alcoholism, asthma, high blood pressure and diabetes for outpatients (wheelerclinic.org). Its types of treatments? Cognitive/behavioural therapy, dialectical behavioural therapy, substance abuse counselling, as well as approach and trauma-related counselling (cthealthcouncil.com).

It is here Rosenzweig got her feet wet as a psychotherapist and, always working in areas involving trauma, it is here she still serves in the employee assistance program. So it was unavoidable that sooner or later she should stumble across Shapiro's eye movement desensitization reprocessing (EMDR) and train in it. We examined it earlier. It's the finger-following form of modality, developed to address trauma-related disorders ("West Htfd. therapist develops treatment for trauma"; *Connecticut Jewish Ledger*, Sept. 2011; jewishledger.com).

While using EMDR on a client, she veered from the proscribed EMDR protocol. Instead of allowing to free-associate, meaning aimlessly bubble forth what came to mind, she focused the discussion between the patient and her on one specific

problem the client had. Free association is a technique used in psychoanalysis and psychodynamic theory. It was originally devised by Sigmund Freud out of the hypnotic method of his mentor and colleague Josef Breuer (1842–1925).

Breuer was an Austrian physician who made key discoveries in neurophysiology. His work in the 1880s with his patient Bertha Pappenheim, known as Anna O., developed the talking cure, also known as the cathartic method, thus laying the foundation to psychoanalysis. The "cathartic method" aimed to enable the hypnotized patient to recollect the traumatic event at the root of a particular symptom, and thereby eliminate the associated pathogenic memory through "catharsis." The term was derived from Aristotle's use of it to describe the emotionally purgative effect of Greek tragedies (encyclopedia.com)

Freud described it as such:

> "The importance of free association is that the patients spoke for themselves, rather than repeating the ideas of the analyst; they work through their own material, rather than parroting another's suggestions" (P. Thurschwell, *Sigmund Freud* (2009) p. 24).

In other words, Rosenzweig got patients to focus on a specific problem, rather than free-floating hither and dither in his or her own mind. The patients would vocalize it while their eyes followed her moving fingers across their faces. The use of eye movements enhances processing of information during therapy, Rosenzweig told the *Jewish Ledger*. Using eye movements with the more directive techniques she had developed in her opinion worked "amazingly well." After trying it on a number of clients she had found that she could often help them eliminate trauma-related symptoms in just one 60-minute session. When using it with children for trauma, anxiety and depression, it often even worked in half that time, she said, and even worked on a child with psychogenic seizure disorder. Psychogenic non-epileptic seizures (PNES), or "pseudo-seizures", are paroxysmal episodes that resemble and are often misdiagnosed as epileptic seizures; however, PNES are thought to be psychological, possibly emotion- or stress-related in origin. The child's seizures are said to have stopped after one ART session.

In 2011, ART was one of 5 therapies chosen for a two-year research study on PTSD. The study was funded by a $2 million Department of Defense (DoD) U.S. Army Medical Research and Materiel Command (USAMRMC) grant. It was supported in part by the Substance Abuse and Mental Health Services Administration (SAMHSA; Grant # 1H79SM060142-01) and Telemedicine and

Advanced Technology Research Center (TATRC) (Grant # W81XWH-10-1-0719) and a VA Career Scientist Award to DMD. The latter are for established, non-clinician, independent investigators, and initially provide up to five years of funding. Career Scientists at the RCS level must have a minimum of six years of independent research support (VA or other), and must have current VA/HSR&D project support (hsrd.research.va.gov). Rosenzweig obviously qualified for it all.

Administered by the University of South Florida (USF), she trained 12 therapists in ART. The therapists had worked with 10 PTSD-diagnosed soldiers. The results of this initial study showed that PTSD symptoms subsided after an average of three ART sessions. (Kevin E. Kip, Carrie A. Elk, Kelly L. Sullivan, Rajendra Kadel, Cecile A. Lengacher, Christopher J. Long, Laney Rosenzweig, Amy Shuman, Diego F. Hernandez, Jennifer D. Street, Sue Ann Girling, and David M. Diamond: *"Brief Treatment of Symptoms of Post-Traumatic Stress Disorder (PTSD) by Use of Accelerated Resolution Therapy (ART®)" Behav Sci (Basel)*. 2012 Jun; 2(2): 115–134).

In Kip's, Rosenzweig's et al.'s abstract we learn that PTSD under ART is viewed as a "prevalent/widespread disabling anxiety disorder". The 80 study participants aged 21–60 years were recruited from the Tampa Bay area. Of them, 77% were female and 29% were Hispanic. We assume that everybody else was one shade or another in between, and all purportedly diagnosed with PTSD symptoms of different shades and colors undefined. Their ART psychotherapy treatment was designed to minimize anxiety and body sensations associated with recall of traumatic memories. The purpose? To replace their distressing images of whatever happened to them with favorable ones. Of the 80 participants, 66 completed somewhere between one and five sessions with a median of three, and 54 of those 66, or 81.8%, even provided two-months follow-up data. No serious adverse events were reported. Thus, the team decided that ART appeared to be a brief, safe and effective treatment for PTSD symptoms (www.mdpi.com/2076-328X/2/2/115/htm), which SAMHSA then took for the Gospel of your choice.

Rosenzweig's 130-page manual with interventions for all types of problems should help to understand the concepts.

> "If you have a memory you don't want to live with, the use of ART can aid you in eliminating negative images usually within an hour. Our slogan is: 'Keep the knowledge, lose the pain.' You will have the full memory intact in the narrative side of the brain, so you will know what actually happened, but you will not have the images of the memory, and it's the

images which hold the pain."

The client can choose a different set of images to replace the distressing images. She likens what she calls "Voluntary Memory/Image Replacement" to what happens when one gets a tooth filled.

> "If you have a tooth that hurts and the dentist puts in a filling, you're not upset that the filling material isn't you. If you replace a nasty memory with a better one, all your symptoms often disappear because there's nothing to trigger them. You're not replacing the whole memory, but a subset of the memory — just the images. It's what happens during REM sleep: we're deleting and adding memories, and cleaning out our computer. I've found a way to trigger that process."

Rosenzweig claims to have used ART with victims of physical and sexual abuse, those suffering from depression, eating disorders and fibro-myalgia and phobias, as well as with parents of autistic children. She has trained numerous licensed therapists, and is presently seeking more trainees. Her dream is to bring ART to Israel to help PTSD affected Israeli soldiers and civilians suffering from the trauma of terrorism and rocket attacks. She is also currently discussing a therapist-training program with the director of an Israeli center for at-risk youth.

Elana Maryles Sztockman is contributing editor to the *Jewish Educational Leadership*, a professional journal for Jewish educators published by The Lookstein Center. She quotes Ashalim, the Association for Planning and Development of Services for Children and Youth at Risk and their Families, in her article "A Sampling of Programs for Youth At-Risk Youth in Israel". In it, she states that 350,000 children in Israel — or, one out of every six — are "at risk" (The Lookstein Center for Jewish Education 2018). Some of the risk factors?

- behavioral and emotional problems
- physical, sexual, mental/emotional abuse
- borderline criminal activity or delinquency
- physical, educational or emotional neglect
- alienation from the educational system leading to dropout

According to the 2005 *Report on the Child,* says Sztockman:

- 8% are raised by single parents

- 8% are known victims of neglect or abuse
- 4% have families that are dysfunctional or violent
- 30% of the children in Israel live below the poverty line
- 2,400 children are treated in emergency rooms each year for domestic violence

Geographic location and immigrant status apparently compound the risk. In the south, about 25% of the 112,000 youth (aged 14–21) are considered at risk and around 25% of all Israeli runaway youth come from the south. Nearly 36% of immigrant youth were not in any educational framework. The overall school dropout rate for all new immigrant children was about 36%. And 46% of immigrant youth arriving in Israel during the last five years did not finish 12th grade, according to the Ministry of Education and the Brookdale Institute statistics. Only 8% of native-born youth did not complete 12 years of education. Of immigrant youth, 22% were involved in crime. Of police files opened on charges of substance abuse among youth, 30% were for immigrant youth. And 30% of children and youth in protective care frameworks in Israel were immigrants.

Another growing group of youth-at-risk was among evacuees from Gush Katif (Hebrew: גוש קטיף, *lit.* Harvest Bloc). This bloc of 17 Israeli settlements is in the southern Gaza strip. In 2005, the Israeli army forcibly removed the 8,600 residents of Gush Katif from their homes as part of Israel's unilateral disengagement from the Gaza Strip. Many of those people suffered traumatic and post traumatic stress symptoms, such as anxiety, depression, regressive behavior, behavioral problems and lack of concentration, as well as difficulties coping with new and challenging situations. Significant learning gaps were noted among the children up to two to three years.

Mind you, everything is well taken care of, as Israel has hundreds of programs for at-risk youth. Ashalim alone supports 193 different programs. Many are in partnership with other organizations such as the Joint Distribution Committee, the Jewish Agency for Israel, various government ministries and private foundations. The Sacta Rashi Foundation alone, which works on a unique model of being both a foundation and a registered not-for-profit *(amuta),* is one of the most active advocates for at-risk children, spending tens of millions of dollars a year on programming, as well as capital support, we learn.

According to the Brookdale Institute, the plethora of programs does not necessarily mean that youth are getting timely access to best practices. The Myers-

JDC-Brookdale Institute (MJB) is a Jerusalem-based applied research institute on social policy and human services. It serves Israel, the Jewish world and the international community. Its mission is to identify and study key social issues, and contribute to shaping policy, designing programs and improving services for individuals, families and communities. Significant shifts in recent years have increased program effectiveness, including:

- parent child centers
- holistic approaches with schools
- comprehensive daycare centers
- the launching of major national initiatives
- development of innovative service models
- adoption of new approaches to intervention
- family-focused intervention that works with parents

The following general categories are:

- treatment programs
- family/community-centered programs
- special schools, para-school programs
- comprehensive residential programs (e.g. Sde Bar)

Programs differ according to area of focus. Some address the effects of poverty and the socio-economic gap and others the effects of drugs and alcohol abuse, issues cutting across class and ethnic boundaries, says Stztockman. Others focus on immigrants and residents of the geographic periphery. The goal, according to the Brookdale Institute, is to ultimately strike a balance between out-of-home and community and home-based care.

That none of it seems to help much is inconsequential. As Sarah Levi of the *Jerusalem Post* and *Israel News* in September 2017 reported in September 2017, in Jerusalem alone, some 30,000 teens falling on the spectrum of at-risk behaviour were "hanging about (*"The programs aimed at lifting up Jerusalem's at-risk youths"* www.jpost.com/israel-news/jerusalem-youth-at-risk-and-the-programs-trying-to-save-them-506312). Plain arithmetic tells us that the numbers since 2005 thus have changed little, even though it is said Jerusalem attracts troubled youth as well as those dedicated to helping them. But I digress, again. Those numbers will soon be

diminished if Rosenzweig has a say. ART will lower those numbers. That no conclusive, scientific, empirical first evidence of its effectiveness in anything exists, who cares. It keeps the Golden PTSD goose rolling, and that's what counts.

That SAMHSA, the Substance Abuse and Mental Health Services Administration, accepted ART as a PTSD treatment was based on one purportedly scientific empirical study, the only one in existence, as far as I know. To refresh our memory, SAMHSA purports to promote and implement prevention and early intervention strategies to reduce the impact of mental and substance use disorders in America's communities. As a matter of fact, it claims that promoting mental health and preventing mental and/or substance use disorders are fundamental to its mission. It says that the reduction of behavioural health condition impacts on American communities, forget Israeli ones. SAMHSA's rosy red ART for PTSD or PTSD for ART verdict used the above mentioned partially federally-, partially SAMHSA-supported study, conducted at the College of Nursing at the University of South Florida in Tampa, with Rosenzweig's active participation to reach its conclusion. Thus, millions of dollars were spent on PTSD research while its targets, those experiencing the PTSD existential crisis, were vegetating on skid row, starving in dismal conditions, while stewing in mental-health-industry-created PTSD toxicity. But who cares!

Theoretically, ART protocol is said to be grounded in and uses cognitive behavioural — the rattus, cani, simian, mus — treatment, along with experiential and psychodynamic psychotherapy, we read. Developed to treat both physiological and cognitive aspects of PTSD, it describes the PTSD crisis as a disorder developed as a consequence of failed memory processing. This would be a situation arising when the brain fails to appropriately consolidate and integrate *episodic* memory into the *semantic* memory system. Episodic memory is a person's unique memory of a specific event, and therefore different from someone else's recollection of the same experience. It is the recollection of biographical experiences and specific events in time in a serial form, from which we can reconstruct the actual events that took place at specific points in time in our lives.

People are usually able to associate particular details with an episodic memory, how it felt, the time and place, how we were dressed. But it is not really understood by neuroscientists, the Neumeisterians of the world, why we remember certain instances in our lives, while others go seemingly unrecorded in our episodic memory. It is believed and postulated, however, that human emotions play a key role in episodic memory formation (www.livescience.com).

Examples of episodic memory are

- your first kiss
- your wedding day
- your first day at a new job
- your skiing vacation last winter
- the name and breed of your first dog
- the first time you traveled by airplane
- neighbors on the block where you grew up
- your roommate from your first year in college
- the movie you saw on your first date with your spouse
- the details about how you learned of a relative's death
- fearing water because you were knocked over by a wave at the beach as a child
- where you were and the people you were with when you found out about the 9/11 attacks

Note there is no mention of a PTSD-causing event, though Rosenzweig et al. already in 2012 called it a "prevalent/widespread disabling anxiety disorder" definitively caused by an episodic memory, one deduces. It is sometimes confused with autobiographical memory, and while autobiographical memory involves episodic memory, it also relies on semantic memory. For example, most humans know the city of their birth and the date they were born, but have no specific memories of being born, we are told.

In contrast, we learn that semantic memory is the recollection of facts gathered from the time we are young. They are indisputable nuggets of information non-associated with human emotion or personal experience. Semantic memory thus refers to a portion of long-term memory purportedly processing common knowledge aspects, ideas and concepts. These include names of colors, sounds of letters, capitals of countries and other basic facts acquired in the course of life.

The semantic memory concept was introduced in 1972 as the result of collaboration between two professors. Toronto University's Professor Endel Tulving (1927–) was an Estonian Canadian experimental psychologist and cognitive neuroscientist. Wayne Donaldson was professor of psychology at the University of New Brunswick. They worked on the impact of organization in human memory. Noting that semantic and episodic memory differed in how they operated and in

the types of information they processed, Tulving outlined in 1985 the separate systems of memory conceptualization in his book *Elements of Episodic Memory* (Endel Tulving; OUP Oxford, Sep. 5, 1985). He described the critical role human memory retrieval processes play in remembering. He also proposed that the nature of human recollective experience, the use of one's memory to become aware or call something to mind, is determined by the interaction between the "episodic" trace information and the "semantic" retrieval information.

Examples of semantic memory are:

- remembering what a dog is
- knowing that grass is green
- knowing how to use scissors
- knowing how to use the phone
- recognizing the names of colors
- understanding how to put words together to form a sentence
- knowing that President John F. Kennedy was shot on Nov. 22, 1963
- recalling that Washington, DC, is the U.S. capital and Washington is a state

The postulated difference between semantic and episodic memory? Semantic memory encompasses the recollection of facts gathered from the time we are young, non-associated with or related to human emotions or personal experiences. Episodic memory is specific to every individual human being, as it is the recollection of biographical experiences and specific events in his or her time and space. Apparently presented in serial form, it is postulated that we, humans, can reconstruct from it events actually taking place at specific points in time in our lives.

But episodic and semantic memories are only two major types of memories. They constitute just part of our long-term memory. Long-term memory in itself, in turn, is often divided into two further main types: explicit or declarative memory and implicit or procedural memory (human-memory.net). Declarative memory — "knowing what" — is memory of facts and events. It refers to those memories that can be consciously recalled or "declared". It is sometimes also called explicit memory, since it consists of information that is explicitly stored and retrieved, although it is more properly a subset of explicit memory, we learn.

Procedural memory, the "knowing how", is postulated to be the unconscious memory of skills and how to do things. It is sometimes referred to as implicit

memory, because previous experiences aid in the performance of a task without explicit and conscious awareness of these previous experiences, although in essence, it is more properly a subset of implicit memory.

Procedural memory, in particular, includes the use of objects or the movements of our body, as well as activities such as tying shoelaces, playing the guitar or riding a bike. These memories are said to typically be acquired through repetition and practice. They are composed of automatic sensorimotor behaviours, apparently so deeply embedded in our brain that we are unaware of them. We are told that once learned, these "body memories" allow us to carry out ordinary motor actions more or less automatically.

Declarative memory differs from procedural implicit memory, as the latter is typically acquired through repetition and practice. Sometimes described as muscle memory or body memory, it enables us to carry out ordinary motor actions, essentially on autopilot. Take anterograde amnesia, for instance. This is the loss of ability to create new memories after the event that caused amnesia, leading to a partial or complete inability to recall the recent past, while long-term memories from before the event remain intact. This usually impacts declarative memory only, and has no effect on procedural memory. In other words, an amnesiac can remember how to talk on the phone, but cannot recall with whom they spoke earlier that day.

Procedural memory examples are:

- ice skating
- riding a bicycle
- shooting an arrow
- driving a motorcycle

These typically are tasks one can go for months or even years without performing, and quickly pick up again.

A breakdown of what is considered the "normal process" of memory transfer and integration has been proposed. It would lead to continued maintenance of the episodic memory and its affect in an inappropriately strong and affect-laden form (Stickgold, R.A. EMDR: "A putative neurobiological mechanism of action." *J. Clin. Psychol*. 2002, 58, 61–75).

According to ART protocol, meaning the postulation, hypothesization, illusory perception and fata morgana of ART theory by its inventor Rosenzweig and her

adherents, the repeated use of ART's sets of eye movements facilitates the separation or elimination of physiological sensations associated with the purposeful recall of episodic traumatic experiences prior to [behavioral] cognitive intervention. After that has taken place, the technique known as voluntary memory/image replacement (VMR/VIR) is used to "replace" the purportedly distressing images with more pleasing ones, without postulatively removing its narrative memory. Thus, it is again *postulated* that ART *aims* to transfer and integrate episodic memories from the hippocampus into the neocortex. This activity might efficiently occur after the heightened physiological responses invoked by exposure therapy — the behavioral cognitive "therapy" — have been minimized so that the subject is no longer in a "fight or flight" mode and the neocortical integration can occur.

The voluntary memory image replacement is only used, however, when clients are *very* clear about wanting to get rid of their traumatic images. And it is used only when they come to a session prepared to process out the old images and restore their mental health by replacing those disturbing images with more positive ones (acceleratedresolutiontherapy.com). In other words, if it doesn't work for PTSD experiencers, the blame can again be shifted to his or her SUBCONSCIOUS unwillingness to heal or faulty wiring from inception or birth. Rosenzweig et al postulate that, although clients know that the new image is not the actual memory, they nevertheless feel like it indeed is a new start for them, as the memory-story remains. Only the trauma images are erased or replaced. Once this happens, the trigger origin (T.O.) is removed, and clients affect changes, often in an instant, speaking of their old images as "like a distant dream." Even if the old scene does not fade completely, the new scene will firmly attach itself to it, so that clients move on easily to see the new scene they have chosen. At least that's the hypothesis.

A further beauty for the inventor and the mental health industry at large? If it doesn't work for PTSD experiencers, the blame can again be squarely placed on their shoulders as they lacked the willingness to improve and rid themselves of their PTSD condition and heal. Or perhaps their faulty wiring from conception or birth was present, thus impeding the miracle healing of ART to take place as it theoretically should. Isn't it all so quaint?

Mind you, imagery rescripting per se has long been part of cognitive behaviour therapy (CBT). But it has only surfaced in recent years to growing interest in CBT interventions, especially for patients struggling with distressing, intrusive imagery. Not surprising, then, that Rosenzweig's VIR parallels imaging rescripting (IR) ("Type A"), in which a pre-existing negative mental image is transformed into a

more benign one. These negative to positive image rescriptings have purportedly been successfully used on PTSD-experiencing survivors of traumatic industrial accidents, maintained Holmes and Grunert et al. in 2007. Insignificant reductions in the use of medications were also reported when comparing pre-treatment to the two-month follow-up. This included anti-anxiety, anti-depressant, pain and anti-seizure medications. No medication-specifics are given. (Holmes, E.A.; Arntz, A.; Smucker, M.R. "Imagery rescripting in cognitive behaviour therapy: Images, treatment techniques and outcomes". *J. Behav. Ther. Exp. Psychiatry* 2007, *38*, 297–305; Grunert, B.K.; Weis, J.M.; Smucker, M.R.; Christianson, H. "Imagery rescripting and reprocessing therapy after failed prolonged imaginal exposure for posttraumatic stress disorder following industrial injury". *J. Behav. Ther. Exp. Psychiatry* 2007, *38*, 317–328).

Kip, Rosenzweig at al. used Holmes and Grunert in their initial purportedly empirical scientifically substantiated ART presentation. They claimed to have observed substantial reductions in self-reported PTSD symptoms, such as depression, anxiety and other global physical and psychological PTSD symptoms. They noted splendid improvements in trauma-related growth, sleep quality and self-compassion after a median of four, previously three, treatment sessions. Favourable results were consistently observed among all subgroups examined and at the two-month post-treatment follow-up, we learn. In addition, no serious adverse effects were noticed. Thus, ART's initial assessment documented that ART appeared to be a brief, safe and effective treatment for symptoms of PTSD and related psychological comorbidities.

And why shouldn't it be? After all, the straightforward process uses relaxing eye movements high-jacked from EMDR and the VMR/VIR technique to change the way negative images are stored in the brain. The treatment is grounded in well-established psychotherapy techniques, and the end result is that traumas and difficult life experiences will no longer trigger strong emotions or physical reactions.

Future controlled studies with ART were warranted, however, particularly when given its short treatment duration. More studies could also reflect current heightened emphasis on health care cost constraints. And they could address the very large clinical burden of treating PTSD being experienced from the lengthy wars in Iraq and Afghanistan, Rosenzweig et al concluded with aplomb. SAMHSA gobbled it up and ran with it — or them, rather, facilitating millions of dollars of expenditures for further ART PTSD research. This was, of course, to the detriment of those suffering and trying to walk through it, by their perverted postulations

hindering the PTSD healing process, never mind exacerbating it.

RT's founder swears that not only will the PTSD trauma sensations disappear or show remarkable benefits. She also swears that it will improve, from the first session onwards, depression, anxiety, panic attacks, substance abuse, sexual abuse and many other mental and physical conditions. This is understandable. After all, why kill the golden goose, when it sounds so much better that ART dissolves such experiencers into nothing, nullifies them. Lo, her treatment eliminates all negative images from view and moves negative sensations into Neverland — or into the subconscious of never-end — thus never to be resolved by the humans whose psyches are experiencing it. What never lands in the conscious, or is eliminated from it (thus never ending), can of course stay in limbo forever, clouding the sub-conscience until death, and most likely beyond, without PTSD experiencers knowing of it. For all we know, might it perhaps even be carried over into a future life?

It has nothing to do with hypnosis either, we hear. Clients are said to always be in control of the entire sessions, with the therapist merely guiding the replacement process. It is admitted that some traumatic experiences such as rape, combat experiences or loss of a loved one can be very painful to think about or visualize. But it is also postulated that ART therapy rapidly moves clients beyond the place where they are stuck in those experiences and leads toward growth and positive changes. Thousands of mental health therapists and psychiatrists throughout the US A and on military bases, such as Walter Reed and Fort Belvoir, as well as at recovery centers, such as the Betty Ford Clinic, have apparently already been trained in ART. All of them report positive outcomes, we are told (psychologytoday.com).

Of course, ART, like all other PTSD imaginative treatment and healing hypotheses, is good business. Treatment, usually said to be completed within three weeks in one to five sessions of an hour each, 50 minutes in their jargon, costs US$200 a pop, paid by insurances of one sort or another. No one — no one — needs to get close, personal and cozy with anyone throughout, as no details about one's particular PTSD or other issues are to be conveyed to the in-charge psycho-the-rapist or anyone else. So everybody stays aloof and impersonal to the Other, and the treating mental health goon is safe from secondary PTSD by listening to the stories. And yes, the quick results are so healthy for the bottom line, never mind if it works or not. It gives the excuse to shaft those for whom it does not work. Splendid.

And how did the ART idea occur to Rosenzweig? Trained in multiple mental health treatment modalities, including Shapiro's previously discussed EMDR, she quickly appreciated eye movement's therapeutic value. Equally as quickly, she

recognized the need to modify their use and integration with other techniques. Into action she sprang, creating directive, standardised, easy-to-apply protocols to different conditions, including PTSD. Thus in 2008, the ART genesis occurred, integrating, like everything else in psycho-the rapists' treatment PTSD modalities, elements from different therapies in a unique (in her opinion) and more effective way (acceleratedresolutiontherapy.com). After all, she has been a licensed marriage and family therapist for over 30 years. She has worked with adults, children and families, treating a wide range of mental health and physical conditions. She knows what's good, she says.

Rosenzweig was engaged as assisting visiting professor at the University of South Florida whilst the ART's research there was conducted. She maintains a private practice in Connecticut. She is also an on-call trauma specialist for several employee assistant programs, besides training mental health professionals in ART. She is also "familiar" with the military population at Walter Reed Military Hospital, Fort Belvoir, Fort Benning, Fort Drum, Fort Hood, Fort Lewis and Fort Stewart (artherapyinternational.org), where ART seems to be on the up and up. So it seems to be in the Royal British Armed Forces, as well. After all, the *British Journal of the Royal Army Medical Corps* published another Rosenzweig et al. ART study in 2016, this time conducted with British Colonel Alan Finnegan of the RCDM (The Royal Centre for Defence Medicine), British Army, Birmingham, UK, as lead author of a study entitled "Accelerated resolution therapy: an innovative mental health intervention to treat post-traumatic stress disorder" (Finnegan A, Kip K, Hernandez D, McGhee S, Rosenzweig L, Hynes C, Thomas M: *J R ;Army Med Corps.* 2016 Apr;162(2):90–7).

This journal prides itself on publishing high quality research, reviews and case reports as well as other *invited* articles pertaining to the practice of military medicine *in its broadest sense.* It welcomes material from all ranks, services and corps, wherever they serve, as well as submissions from beyond the military. It intends not only to propagate current knowledge and expertise, but also to, with its invited articles, act as an institutional memory for the practice of medicine within the military, we are told (jramc.bmj.com).

Finnegan's home base is the Royal Centre for Defence Medicine, Queen Elizabeth Hospital, Birmingham. It provides medical and nursing care for injured and wounded military personnel on operational deployments, and secondary and specialist care for members of the armed forces overall. It is also a training centre for nursing, medical and support staff of the Queen Alexandra's Royal Army Nursing

Corps, QARANC, the Princess Mary's Royal Air Force Nursing Service, PMRAFNs.

He and his to-us-by-now-well-known ART research team, pronounced the usual. ART was an emerging psychotherapy that provided fast and lasting resolution for mental health problems such as PTSD. It had been shown to achieve positive results in one to five sessions, typically over a two-week period and required no homework, no skills practice, no repeated exposure to targeted events, nothing but to show up and try it. Initial research, including one randomised control trial, had demonstrated that ART interventions could significantly reduce symptoms of psychological trauma in both civilians and US service members and veterans. These results alone suggested that ART be considered as either a primary treatment option or for refractory PTSD in those with suboptimal, meaning "feeble", response to endorsed first-line therapies. In other words, all those treatment modalities with which we by now are well acquainted, one and all as useless as tits on a bull. Again, as usual, we hear that conservative estimates indicated substantial potential cost savings in PTSD treatment when using ART. Useless eaters deserve nothing else.

Admittedly, a need for more definitive clinical trials existed, we hear. But in the USA, interest in ART, including in the US Army, was on the rise. Its growing positive empirical evidence was compelling, insist Finnegan et al., the evidence appearing sufficient to warrant UK researchers to undertake ART research. That ART also appeared to have application in conditions such as depression, anxiety disorders and alcohol or drug misuse, justified and enhanced such research investment. It could furthermore, potentially, help military personnel traumatised by the unique challenges of war and conflict zones by providing brief psychotherapy in a readily accessible and culturally competent manner. Why? Because it facilitated interventions and resolutions in theatres of war, thereby enhancing soldiers' fighting capability. Remember that humans slaughtering humans is the main interest and objective in healing PTSD on the fields of battle and off. Nothing new in that either. It has been so at least since Troy and carried over and enhanced by the Romans, remnants of Troy.

So it went well for ART on foreign shores, and almost another year would pass before Dwight Norwood, Ph.D., LICSW, and a GoodTherapy.org Topic Expert in 2017 should ask: *"Accelerated Resolution Therapy (ART): Quick Fix for PTSD?"* And who is he? A master ART practitioner certified by the International Society of Accelerated Resolution Therapy (IS-ART) and a student at the Hartford Family Institute (HFI). Founded in 1969, the latter is considered a cutting edge psychotherapy and training center. The psychotherapy created and practiced there

purportedly is a combination of in-depth body emotional work, energy healing, shamanic spiritual healing and trauma work. Its training and certification programs conducted under the founding partners' and associates' directions include advanced psychotherapy training for established counsellors, therapists, healers and practitioners in the healing arts. It also includes a master's degree, and a full range of healing and psychotherapy modalities. Founding partners, partners, associates and independent practitioners involved in this enterprise are numerous. HFI's tentacles, in addition to its primary location in West Hartford, Connecticut, reach to educational and training sites in Kansas City, Missouri, New York, New York, and Germany (hartfordfamilyinstitute.com).

In 2001, the Hartford Family Institute developed a partnering resources in ministry education (P.R.I.M.E.) relationship with the Graduate Theological Foundation (GTF). This is another 501(c)(3) not-for-profit ecumenical and interreligious institution, providing advanced educational opportunities to practicing ministry professionals, including online, on-site and distance learning opportunities, since 1962. Needless to say, any and all not-for-profit religious institutions fall under state control, and therefore are no longer institutions serving the Creator of All there is, the infinite intelligence and Spirit, God, or whatever you may wish to call this Supreme entity who created us humans.

GTF's degree programs are designed for ministry professionals unable or disinclined to leave their current place of employment in order to pursue full time residential educational opportunities. It strives to provide quality education to professionals from a variety of faith backgrounds, by providing a plethora of study options and opportunities to study at GTF-collaborating institutions. This special type of affiliation allows students to earn their degree from the GTF by completing all or most required coursework through a P.R.I.M.E. affiliate such as the HFI. It provides specialized curricula for specific degree concentrations in programs such as the Doctor of Ministry, Doctor of Psychology and others.

At P.R.I.M.E. institutions, GTF students may complete all or most of their "Unit of Study" requirements for their degree programs. The following institutions and organizations have been selected on the strength of their educational programs and quality of training faculty to participate in GTF's P.R.I.M.E. program. Other institutions and programs are periodically added, based on the GTF's ongoing assessment of educational training opportunities relevant to students. Those institutions, by virtue of their GFT affiliation, offer their training for GTF's degree programs in their own facilities.

- Worklife Institute
- The Hiebert Institute
- Hartford Family Institute
- Dominican Center at Marywood
- The Guild for Spiritual Guidance
- Tao Fong Shan Christian Centre
- Society of Catholic Social Scientists
- Viktor Frankl Institute of Logotherapy
- Blue Lotus School of Mindfulness Arts
- The Spiritual Guidance Training Institute
- Alamance Institute for Pastoral Counseling
- Christian Contemplative Spirituality Institute
- Center for Religious Education and Musica Sacra
- Institute for Psychodynamic Pastoral Supervision, LLC (IPPS)
- International Institute of Theological and Tribunal Studies, IITTS

The Study Options button on the GTF website under the heading "Affiliations" enlightens that the GTF enjoys affiliations with the Oxford University Department for Continuing Education, the Centro Pro Unione in Rome and several other P.R.I.M.E. programs. But most importantly, the P.R.I.M.E. affiliation allows students to earn their degree from the GTF by completing all required coursework through a designated P.R.I.M.E. institution. GFT course offerings provide information about the various methods of earning "Units of Study" for a degree. For a Master of Pastoral Counseling (M.P.C.): US$11,200. A Doctor of Psychology (Psy.D.): US $13,200 (Phases I, II III) or $15,000 for those who previously completed the MPC.

The fees reflect only the administrative degree program costs charged by the GTF. Program costs charged by the PRIME institution are separate and additional, and must be paid directly to the PRIME institution.

HFI offers a clinical, experiential and didactic educational and training program for the GFT's Master of Pastoral Counseling or Doctor of Psychology degree programs. The therapy practiced and taught at the institute is, they say, a unique approach developed at the HFI, called "body-centered Gestalt psychotherapy", purportedly an "energy based psychotherapeutic-spiritual approach to healing." The roots of body-centered Gestalt therapy come from Gestalt therapy, bioenergetic analysis, Satir's communication work, Steve Gallegos's work with animal imagery

and the chakras, ceremony and shamanism, spirituality, as well as mindfulness. These roots were integrated into a creative and original therapy that provides a cohesive and coherent understanding of human behavior that offers deep personal transformation, we are told (gtfeducation.org). Under "The Science and Soul of Psychotherapy" we read on the Hartford Family website:

> "The science of our psychotherapy is founded in the discoveries by quantum physicists about the subtle energy makeup of everything that exists, including human thought and emotion. At our most fundamental level, the human mind and body consists of pulsating energy, constantly interacting within a vast universal energy field. It is at the sub-atomic, subtle level that trauma impacts us most profoundly, and it is at that level that healing needs to take place. The process of our therapy works within this world of pulsating waves and frequencies and allows healing to take place at the level of physical and emotional DNA.
>
> "The soul of our psychotherapy lies in the way our work deals with the life force, our core essence beyond the intellect. The soul is the spark of divine consciousness that lives in each of us. It is the essence of each being that continues beyond lifetimes. The soul of this psychotherapy is the energy in each session that is beyond words, beyond intellectual knowing, where spirit brings messages of what is necessary for both client and therapist to move toward wholeness, toward enlightenment. It is the job of the therapist and client to decode and embody the messages from spirit so that we can understand that every negative experience in our bodies is Spirit's way of uncovering unfinished trauma in an orderly fashion so that we can heal. The therapeutic process is a shamanic journey toward integration, balance and harmony. Our approach enables the client to connect mind, body and spirit so that healing can be achieved on a multidimensional level." (hartfordfamilyinstitute.com)

It is from this premise that ART's Norwood sprang, after doing his undergraduate work at the University of Notre Dame. He later added a Master's Degree in business administration from the University of Connecticut, and another

in computer science from Rensselaer Polytechnic Institute. He also holds a project management professional (PMP) certification from the Project Management Institute. He ran his own computer-consulting firm for 25 years, serving most of the large financial institutions in New York and participated in writing Redbooks for IBM. In 2006, he took a new direction, however, choosing to work from his heart rather than his head. He began studies at the University of Connecticut School of Social Work finishing his Ph.D. in social work in 2014. Today, Norwood practices psychotherapy in Connecticut and Vermont. Besides his educational and career background, we know nothing of his life experiences or his life in and of itself. How does he view ART in 2017 then?

"Imagine being able to make significant progress in healing from PTSD in one therapy session," he proclaims. Several mental health practitioners using ART had told him such stories and leaving us out in the cold about he himself having been bestowed a master certificate in the field from Hartford Family Institute. Effective relief had actually been achieved in only three to five sessions, even for combat veterans, he asserts. Now used in U.S. Army hospitals, such as Walter Reed and Fort Belvoir, ART was expected to expand rapidly through the armed services, he says. The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) had already recognized it as an evidence-based treatment for depression symptoms, personal resilience and self-concept, as well as for trauma and stressor-related conditions, such as PTSD, Norwood tells the Good Therapy world. Hallelujah!

ART, he tells us, draws on the usual mental health therapy treatment modalities, such as the cognitive behavioral theory — rattus, cani and so on — and the eye movement desensitization and reprocessing (EMDR). It also draws on Gestalt therapy, considered as much an art as a science, according to Gestalt psychotherapist, supervisor and trainer Dave Mann. He is registered with the United Kingdom Council for Psychotherapy (UKCP), a professional association of psychotherapy organisations and practitioners in the United Kingdom (*Gestalt Therapy: 100 Key Points and Techniques;* Routledge, Taylor & Francis Group, London and New York, 2010).

Friedrich (Frederick) Salomon Perls (July 8, 1893–March 14, 1970), better known as Fritz Perls, was a noted German-born psychiatrist and psychotherapist. It was he who coined the term "Gestalt therapy" to identify the form of psychotherapy he developed with his wife Laura in the 1940s and 1950s. It was based on the principle that humans are best viewed as a whole entity, consisting of body,

mind and soul. They are best understood when viewed through their own eyes, not by looking back into the past, but by bringing the past into the present. Therefore, Gestalt therapy seeks to resolve the conflicts and ambiguities resulting from failure to integrate features of the personality. The goal of Gestalt therapy is to teach people to become aware of significant sensations within themselves and their environment, so that they respond fully and reasonably to situations. The focus is on the "here and now", rather than on past experiences, although once clients have become aware of the present, they can confront past conflicts or unfinished business — what Perls referred to as incomplete Gestalts. Clients are urged to discuss their memories and concerns in the present tense and Gestalt therapists may dramatize conflicts to make clients understand problems. Clients might be called on to act out repressed aspects of their personalities or to adopt the role of another person. Like other humanistic therapies, Gestalt therapy assumes the innate inclination of people to health, wholeness and realization of their potential (britannica.com).

In consequence, this type of therapeutic method emphasizes that to alleviate unresolved anger, pain, anxiety, resentment and other negative feelings, these emotions cannot just be discussed, but must be actively expressed in the present time. If that does not happen, both psychological and physical symptoms can arise. In contrast, the German Rudolf Carl Virchow, MD, (1821–1902) a few decades earlier spewed forth:

> *"Between animal and human medicine there are no dividing lines–*
> *nor should there be."*

Virchow was one of the 19th century's most prominent physicians. He pioneered the concept of pathological processes, by his application of the cell theory to explain the effects of disease in the organs and tissues of the body. He emphasized that diseases arose not in organs or tissues in general, but primarily in individual cells.

As for Perls, he also stipulated that humans were not in this world to live up to the expectations of others, nor should they expect others to live up to theirs. Thus, Gestalt therapy attempts to build clients' self-awareness, to better understand themselves, the choices they make and how those choices affect their health and relationships. With self-knowledge, arises the understanding of how emotional and physical selves are connected. This, in turn, leads to greater self-confidence, living fuller lives and coping more effectively with problems (psychologytoday.com). In essence, it is the "know thy self" maxim in action, as the "know thy self" leads to what the verb of Gestalt, *gestalten,* really means, namely to consciously create or form something — animate or inanimate. In this case, it is to give Gestalt to the Self,

to one's own desire, the *gestalten* made so much easier by the way of PTSD, as we will have a *tabula raza* once we decide to live. This is the opportunity gifted from the Infinite, by way of PTSD.

Gestalt therapist Edwin Clifford Nevis (1926–2011) is one of the foremost Gestalt writers, thinkers and practitioners of the last 40 years. His book *Gestalt Therapy: Perspectives and Applications* is a classic text, first released in 1992. With it, he signalled a renaissance of Gestalt scholarship throughout the world. He drew together a diverse selection of essays from Gestalt therapists of every persuasion and united them by the clarity of their thought and constancy of commitment, leading to the development and extension of the classical Gestalt therapy model (Taylor & Francis, Ltd.).

Nevis' fascination with Gestalt psychology and group dynamics dates back to his early college studies in New York City. It was while there that he was first introduced to Gestalt by a group of expatriate German teachers who had migrated to New York City at the dawn of World War II. He studied under four notable people. Two were Fritz Perls and his wife Laura, a clinical psychologist, who had immigrated to the US in 1946. Another was Isadore From, one of Gestalt therapy's original circle of therapy and its main theorizer. And finally, there was the social critic and writer Paul Goodman. "We were out to change the world," Nevis remembered in an interview with Bob Eason, conducted shortly before his death, for the Gestalt International Study Center (GISC. (gisc.org). "There were lots of free flowing ideas being bounced around. I guess it was just a question of being in the right place at the right time."

The right place for Nevis to propagate Gestalt soon became the Sloan School of Management at MIT, where he conducted courses in organizational change and consulting for 17 years. He also served as a core faculty member and director of the MIT Program for Senior Executives. He had been involved with leadership, working with management and training people worldwide, even working with the U.S. presidency, since 1955. So in 1979, he co-founded the GISC in Wellfleet, Massachusetts. Another non-profit organization, its mission is to encourage advances in applying Gestalt to the fields of family therapy, leadership, coaching and organizational consulting. So it offers leadership, professional and organizational development, as well as advanced training for leaders, practitioners and individuals.

Nevis also co-created the Organization and System Development Program and the OSD International Program, dedicated to the journey of self-discovery. People interested in self-mastery use of Self as an intervener across multiple levels of

system, and making a difference with their presence will find theory, concept, method, tool and techniques to support their journey. The OSD body of knowledge is based on natural human processes that are already present within each person and are present at every level of system. When these processes are brought into awareness within any level of system — individual, two people and group level — awareness, knowledge and skills are enhanced. Healthy interactions occur, creating shifts and changes (gestaltosd.org). After 60 years in the field, even shortly before his death, he worked at introducing his organizational approach to America's educational system through a demonstration project at a community college in Connecticut and at a Cape Cod school system.

He is author of numerous articles and books, including *Organizational Consulting: A Gestalt Approach*; *International Revolutions* (with Lancort and Vassallo); *How Organizations Learn* (with DiBella) and his last one, entitled *Mending the World: Social Healing Interventions by Gestalt Practitioners Worldwide* (co-edited by Joseph Melnick). It sounds like Common Core in action to me, but you be the judge. Aiming to provide a blueprint for making a difference in the intractable social issues existing today, author and editor opine:

> "It presents the compelling drama of thirteen stories of people on the firing lines in countries in Africa, Europe, Scandinavia, as well as Brazil, Cambodia, North of Ireland, and the USA . The cases involve diverse real world issues, such as AIDS reduction, poverty, political conflict, natural disasters, and dilemmas in supporting the aged. The stories are framed by the editors with theory and historical data, and offer the hope of effective change using Gestalt principles and methods. In these complex issues, you need unique skills to bring people together to work toward a common solution, and to empower yourselves to influence people with positional power."

Bringing together — groupthink — killing freethinking and individualism, the greatest danger to any regime throughout the ages.

It seems obvious overall, however, that contrary to ART, Gestalt therapy is a human client-centered approach. It tries to help focus on the present and understand what is really happening in their lives right now, rather than what they may perceive as being happening due to overshadowing past experiences. But what Gestalt's encouraging therapist-patient communication has to do with ART is puzzling, as ART praises itself on healing through non-verbal interaction. In Gestalt,

clients are to learn to become more aware of how their own negative thought patterns and behaviors block true self-awareness and happiness. This can be done only through verbal expression, whereas ART "eliminates negative images from view and moves negative sensations. The therapy usually is completed in one to five sessions, and there is no need to give details about your "issue", according to its inventor, Rosenzweig (psychologytoday.com 2018).

Furthermore, ART emphasizes taking personal responsibility for the Self, for one's experience in the present moment, of the importance of the therapist–client relationship, the environmental and social contexts of one's life, and the self-regulating adjustments people are able to make as a result of their overall situation. All of it necessitates verbal communication with the psycho-the-rapist, whereas there is zero emphasis of any of this in ART. Thus, in comparison to ART, Gestalt at its finest teaches control of our thinking, changing it to our liking, which encourages our change of perception of ourselves, in consequence our perception of the world, and through it all, creating our life to our own liking.

Be it as it may, Dwight Norwood, Ph.D., LICSW, the GoodTherapy.org topic expert in 2017 asked: "Accelerated Resolution Therapy (ART): Quick Fix for PTSD?" He views ART as unique, because of its *procedurally oriented* therapy. That means no one in ART therapy needs to talk about anything at any time, whereas mental health therapies typically focus on clients blabbering forth their thoughts and emotions to give therapists a foot to stand, on which to base their idea of appropriate treatment. It's like a psychic's fishing expedition, so to speak. Of course this non-verbosity makes ART a splendid approach when clients such as some military folk refuse to share their emotions, we hear. Not having to listen to gory stories clients could recite is also easier on emotionally fragile and vulnerable therapists. By way of this non-communication, they are protected from acquiring secondary vicarious traumas resulting from client-recitals of terrible events, such as warfare and rapes, almost being burnt alive, unintentionally killing robbery suspects, experiencing a knife-attack or nearly falling out of the sky at a most inopportune moment in life, Norwood writes. Academically trained idiots who'd probably faint when seeing someone cut their thumb while slicing bagels, never mind their own, need protection of course, while counselling the PTSD affected. Yeah, right!

But silence is not ART's only asset; so is its quickness. That really is its hallmark, we are told. Therapists trained in ART's art report people healing from one-time traumatic events such as auto accidents, assaults, witnessing atrocities and phobias in

one single, solitary session. Norwood saw Rosenzweig heal a woman from two phobias in less than an hour, he tells us, when evidence-based PTSD therapies take at least 12 to 20 to be effective. ART, au contraire, performs the same in three to five. Empirical scientific studies of both military and civilian populations had proved it (Kip et al., 2012; Kip et al., 2013; Kip et al., 2014). Even homeless veterans had spontaneously flourished under ART (Kip et al., 2016). Some of them even found jobs and/or housing before treatment completion, and one study found an ART success rate of over 50%.

Why could it be so terrifically successful, one may wonder? Well, the jury on how it works is still out, though ART's (thus EMDR's–the eye movement PTSD theories and applications) are *believed* to have some link to REM sleep eye movements. That's the time when the brain is *believed* to be processing events people experienced during waking hours. Another one is that, whereas it was usually *believed* that memories were fixed and to access one was like taking a book, looking at it, and then putting it back on the shelve, accessing a memory apparently makes it plastic. This idea, called the synaptic plasticity and memory (SPM) hypothesis, unidentified with any one individual scientist, has over the years been brought forward in various guises, honed by many researchers (Martin SJ, Grimwood PD, Morris RG. 2000: "Synaptic plasticity and memory: an evaluation of the hypothesis", *Annu. Rev. Neurosci*. 23, 649–711). At its heart is the true or false notion that the memory of prior experience is mediated by the reactivation of "traces" or "engrams" whose basis involves alterations and possibly bidirectional alterations in synaptic efficacy.

We learn that some scientists laid out a framework for the rigorous testing of the widely held notion that synaptic potentiation and depression are key players in mediating the creation of memory traces or engrams. That framework stood the test of time. New approaches use contemporary techniques to explore the idea further with respect to *detectability, as well as anterograde and retrograde alteration.* Critical experiments remained to be done, we hear, but the neuroscience community could justifiably feel tantalizingly close to having tested one of the great ideas — *ideas!* — of modern neuroscience. LTP or long-term potentiation is a persistent strengthening of synapses based on recent patterns of synaptic activity, producing a long-lasting increase in signal transmission between two neurons. It "continues to excite us all as it slowly gives up its mechanistic secrets and reveals its important functional role in learning and memory," exclaimed Tomonori Takeuchi et al. already in 2014.

Consequently the practitioners of this scientific hypothesization surmise that in

humans, memory can be altered during the REM state by the sort of technique employed by ART, Norwood reports. After four to six hours of controlled REM-state treatment, the memory is said to reconsolidate and the ART memory-altered version is stored instead. Children as young as four had been treated with it, says Norwood, and he himself had used it to help a 16-year-old IQ-66-endowed teenager. How that was accomplished when IQ scales seem to define an IQ of 69 and lower as "definite feeble-mindedness" is left to our imagination.

As to ART's method research results in both military and civilian populations, we are led to believe similar effectiveness had been obtained (Kip et al., 2015). The marvel of it all, we hear, is that basically only three things are necessary to assure success:

- The client must be motivated to heal.
- The client must be able to hold on to a thought.
- The client must be capable of tracking the therapist's hand with their eyes.

Needless to say, when it seems to work with an IQ of 66, it should work with anyone somewhat alive, in or out of the military.

Colonel Charles W. Hoge, M.D. (ret.) senior scientist, Walter Reed Army Institute of Research (WRAIR), Walter Reed National Military Medical Center (WRNMMC) Office of the Army Surgeon General (OTSG) is an army psychiatrist. He looked into accelerated resolution therapy (ART) and gave his clinical considerations, cautions and informed consent for military mental health clinicians, cleared for public release in 2015. He is trained in both in EMDR and ART. He is also considered an internationally known expert on PTSD, mild traumatic brain injury and other physiological reactions to war. He directed the U.S. military's premiere research program on the mental health and neurological effects of war on troops in Afghanistan and Iraq from 2002 to 2009 at Walter Reed Army Institute of Research. He deployed to Iraq in 2004 to improve combat stress care, *and* he is considered a national expert on war-related mental health issues, as well as traumatic brain injury. His articles on PTSD, mild traumatic brain injury (mTBI) and stigma are apparently the most frequently cited medical publications from the wars in Iraq and Afghanistan. Though retired, he continues to work as a staff psychiatrist, treating military members, veterans and their families (huffingtonpost.com).

Hoge compared the two treatment theories, noting points of difference between EMDR and ART (Hoge, 2015). In his view the major ones are:

- EMDR uses free association, while ART therapists are directive.
- EMDR is content-oriented while ART has a procedural orientation.
- EMDR uses a variable number of eye movements, while ART uses a fixed number.
- EMDR pays attention to content, whereas ART therapists focus on visual imagery and emotional sensations.

Otherwise, he, too, gave ART the go ahead, so it is well on its way. SAMHSA nowadays not only identifies is as *the* PTSD treatment, but proclaims it as a "promising" therapy for disruptive and antisocial behavior issues, phobias, panic, generalized anxiety, sleep and wake conditions, the whole gamut, Norwood writes. In addition, psychotherapists report ART success in treating substance abuse and addictions. Mind you, it is admitted that for that type of healing, two ART sessions weekly of $200 a pop are needed in the early stages (Kip, K.E., Rosenzweig, L., Hernandez, D.F., Shuman, A., Sullivan, K.L., Long, Diamond, D.M. (2013): "Randomized controlled trial of accelerated resolution therapy (ART) for symptoms of combat-related post-traumatic stress disorder (PTSD)". *Military Medicine, 178*(12): 298–309). Humanity's miracle cure to solve all its emotional problems has been found. The art of ART, besides needing a bit further research, has been accepted as another PTSD goldmine for the well healed but not so openly greedy mental health practitioners, under the guise of benevolence, it seemed.

"But not so fast," said army psychiatrist Wendi Waits, a child and adolescent psychiatry specialist in Fort Belvoir, Virginia, practicing for 13 years. She thought that studies conducted on ART were too few and too limited. Waits, who seems to practice her craft at Fort Belvoir Community Hospital in particular, appears to be military through and through. She received her medical degree from Uniformed Services University of the Health Sciences with her college and residency at Tripler Army Medical Center. Fort Belvoir itself comprises three geographically distinct properties: the main base, Davison Army Airfield, and the Fort Belvoir North Area. It is her home base, as well as that of the United States Army Intelligence and Security Command (INSCOM), a direct reporting unit that conducts intelligence, security, and information operations for U.S. Army commanders and national decision makers.

It also hosts the U.S. Army Cyber Command (ARCYBER), the Army headquarters beneath United States Cyber Command. It is said to operate and defend Army networks and deliver cyberspace effects against adversaries to defend the nation. ARCYBER conducts global operations 24/7 and has 19,000 Soldiers and civilians spread across four states. It integrates and conducts full-spectrum cyberspace operations, electronic warfare and information operations said to ensure freedom of action for friendly forces in and through the cyber domain and the information environment, while denying the same to US adversaries, we read on their ad.

Elements of 10 other Army major commands are also based at Belvoir. These are:

- 26 Department of Defense agencies
- 8 elements of the U.S. Army Reserve and the Army National Guard
- 19 different agencies and direct reporting units of the Department of Army

Also located on base are

- a U.S. Air Force activity
- U.S. Army Audit Agency
- a Marine Corps detachment
- the U.S. Army Prime Power School
- the 249th Engineer Battalion (Prime Power)
- an agency from the Department of the Treasury

In other words, Fort Belvoir is a huge army base and home to some mightily important United States military organizations. With nearly twice as many workers as the Pentagon, it is also the largest employer in Fairfax County. Without doubt, it keeps Waits busy and entertained.

Before getting engaged with ART, she published two papers. One of them "The Fort Campbell High Interest Program", written with Joe Wise, MD, of the Walter Reed Army Medical Center Washington, DC, seems to no longer be available. Wise presently is a candidate in adult psychoanalysis at St. Louis Psychoanalytic Institute. It is another non-profit hangout purportedly established to promote the development of psychoanalytic education and practice in "the metropolitan area." Of St. Louis? We don't know, nor do we know anything more of Joe Wise, MD.

Waits' second paper was "The Application of Army Combat Stress Control doctrine in work with Pentagon survivors" (*Mil. Med* 2002 Sep; 167(9 Suppl): 39–43.). She wrote it with Douglas Waldrep, an army psychiatrist in Wilmington, North Carolina, and of Walter Reed Army Hospital. In practice for more than 20 years, Waldrep received his medical degree from the Medical University of South Carolina College of Medicine. Both Waits and Waldrep were members of the mental health team that responded to the Pentagon attack of September 11, 2001, (apparently a false flag operation, according to Robert David Steele) assigned to work at the Hoffman Complex in Alexandria, Virginia, with displaced employees from the Office of the Army Deputy Chief of Staff for Personnel. Never before had anyone committed an unexpected act of war on a garrison unit within the continental United States. This, the two of them asserted, made it difficult to discern appropriate psychiatric interventions. Neither of them seemed to have realized that theoretical knowledge oftentimes is worth nothing when confronted with a sudden and forced jolt into action.

Waldrep and Waits got the point. In 2002, they conducted a retrospective analysis to examine how close their interventions paralleled official Army doctrine on combat stress control detailed in Field Manual 8-51, *Combat Stress Control in a Theater of Operations*. This field manual (FM) establishes medical doctrine and provides principles for conducting combat stress control (CSC) support operations in medical facilities from forward areas to the continental United States (CONUS). It sets forth tactics, techniques and procedures (TTP) for CSC units and elements operating within the theater of operations (TO). The TTP is applicable to operations across the operational continuum and it is important that users of this manual be familiar with FM 22-51. The manual supports the Army Medical Department's (AMEDD) keystone manual, FM 8-10, we read (bits.de/NRANEU/others/amd-us-archive/FM%208-51%2898%29.pdf)

Discovering that the field manual's parallels to their own actions were considerable, but incomprehensive, Waldrep and Waits concluded that following future acts of terror or other disasters on US soil, military mental health providers should apply both traditional and novel principles of combat stress control. The Army's Public Health Center reserves a whole website to combat operational stress control (*phc.amedd.army.mil) "in* December 2017 stating:

> "Mental and physical fitness will help you endure the *stress* of *combat* and *military* operations. The day-to-day *stress* that comes with stability and support operations (SASOs) can at

times be as bad as that of major *combat*. Emotionally distracted *Soldiers* can endanger the mission, the unit, and themselves."

Waits, apparently still entrenched in the military when reading on ART, thought that studies conducted on it were far too few and far too limited. They primarily consisted of the one previously mentioned randomized controlled trial (RCT) with 57 subjects, and the two larger cohort studies involving 80 and 117 subjects. It inspired her and her cohorts to describe and summarize published ART research, viewing the concept itself as "a predominately imaginative therapy that relies upon the rescripting of distressing events and metaphors as one of its key therapeutic elements." Furthermore, they mused, could the growing body of research in the neuroscience field involving initial memory creation consolidation, activation and reconsolidation also be relevant in memory processing and elimination? So in 2017, Waits and her team set out to summarize their view of the ART situation in their publication "Accelerated Resolution Therapy (ART): a Review and Research to Date" (Waits W, Marumoto M, *Weaver J. Curr Psychiatry Rep.* 2017 Mar;19(3):18).

Their verdict? Waits et al. noted that ART had less research-based validation than EMDR, Prolonged Exposure and Cognitive Processing Therapy (CPT). But, in their view, its three — just three! — major clinical PTSD trials made up for it, though only one of them had actually involved a control group. Data from those trials had to be interpreted with caution, though, they said. They noted that all had been conducted by the same research team (Kip, Rosenzweig et al.) out of the University of South Florida, and all relied on patient self-reports for outcome measurement. But it indeed demonstrated a 61% response rate and a 94% completion rate. These were impressive results, given that established PTSD therapies had a response rate of 49% to 70% and a completion rate of only 60% to 65%.

To Waits et al. ART overall appeared to be an effective, efficient and versatile form of psychotherapy to distracted troops under loss of combat operational stress control. Future studies, particularly high-quality RCTs were needed, however, to more fully understand the potential reach of this promising therapeutic modality, they opined. Nevertheless, it truly seemed to be an extraordinarily promising new psychotherapy theory with potential to offer rapid and effective resolution of a wide range of psychiatric symptoms. In particular, it appeared to be a predominately *imaginative* therapy that relied upon the rescripting of distressing events and metaphors as one of its key therapeutic elements. Against the backdrop of current PTSD *gold standard treatments* (the cognitive behavioural pharmacotherapy ones discussed earlier, demonstrating at least eight to 15 sessions needed for PTSD

improvement with 83% of patient-drop out before session five), the number of ART sessions needed for PTSD healing so significantly less alone made ART worthy of a further look, concluded team Waits.

The *Psychiatric Times* vol. 35 of 2018 also thought fit to spring into the ART's marvel for PTSD and other psychiatric conditions as an emerging efficient therapy exposition. It too explained its relationship to EMDR, but said it had tighter protocol and was easier to learn. (See Kip et al. for a general description of the proprietary ART protocol.) ART had already been proven to be effective, efficient and easy on patients, we read. But most importantly, it had been so wonderfully *easy on clinicians*, these poor Nightingale-like souls, always hovering on the edge of the secondary PTSD abyss while ministering to their PTSD-experiencing victims.

Why should ART be successful in PTSD, really? Some believe that the key to its efficiency lies in changing its emotional valence by introducing a novel sensation or stimulus during activation and reconsolidating, thus "putting it away" within a discrete period of time. This is thought to modify memory traces at the level of DNA transcription, essentially locking in the changes in a permanent manner. The "reconsolidation window" in humans is believed to be the same as in rattus, one to six hours. Like other reconsolidation therapies, ART protocol is said to both extinguish patients' fear response and unwire their distressing emotions from the factual memories of the events that created them. Said another way, reconsolidation therapies fulfill the brain's requirements for allowing new learning to rewrite and erase an old, unwanted learning, and not merely suppress and compete against the old learning.

Army psychiatrist Waldrep, Waits' partner in the 2001 Pentagon counselling adventure, became a practicing psychiatrist and therapist in Wilmington, North Carolina, affiliated with the New Hanover Regional Medical Center. In 2005, he and a few others published "*Psychiatric interventions with returning soldiers at Walter Reed*" (Wain H, Bradley J, Nam T, Waldrep D, Cozza S: The Psychiatr q. 2005 Winter;76(4):351–60). Their abstract revealed:

> "War is a malefic force and results in many psychiatric and medical casualties. Psychiatry's involvement with soldiers experiencing psychological stress resulting from combat experience has been reported for many years (Zajtchuk, 1995). It has been demonstrated that a myriad of diagnosis to include depression, anxiety, somatoform, adjustment disorders and psychotic behaviours also emerge (Wain et al.,

> 1996, 2005a). Nearly all survivors exposed to traumatic events briefly exhibit one or more stress related symptoms (Morgan et al., 2003). In many instances these symptoms dissipate within a reasonable amount of time. However, *symptoms persisting for a prolonged period following a traumatic event increase the probability of developing stress-related psychiatric disorders."* (italics mine)

And that precisely is the crux of the matter. The treatment PTSD journeyers receive from the get-go of the PTSD-causing event assures the prolongation and thus development of stress-related psychiatric disorders. This, in turn, assures the mental health industry's financial profit bonanza, as well as complete human desolation and oft times destruction for those caught in their hypothetical therapy modalities scam clutches.

It is rather sensible to assume that Waldrep et al., among them Doctor Harold J. Wain, Ph.D., in 2008 chief of Walter Reed Psychiatry Consultation and Liaison Service, have a point. After all, Walter Reed is one of the most eminent military medical institutions in the world. Stephen Cozza, MD, now (2018) a professor of psychiatry at the Uniformed Services University (USU), Bethesda, Maryland, where he serves as associate director, Center for the Study of Traumatic Stress, was also part of that study. The USU is a health science university of the U.S. federal government. Its primary mission is to prepare graduates for service to the U.S. at home and abroad in the medical corps as medical professionals, nurses, and physicians. A graduate of the United States Military Academy at West Point, New York, Cozza received his medical degree from the George Washington University School of Medicine and Health Sciences. He completed his residency in general psychiatry and his fellowship in child and adolescent psychiatry at Walter Reed Army Medical Center in Washington. He is a diplomat of the American Board of Psychiatry and Neurology in the specialties of general psychiatry and child and adolescent psychiatry. He has served in a variety of positions of responsibility in the Department of Psychiatry at Walter Reed Army Medical Center. This includes chief, Child and Adolescent Psychiatry Service, program director of the Child and Adolescent Psychiatry Fellowship Program and chief, Department of Psychiatry. He retired from the U.S. Army in 2006 after 25 years of military service.

Dr. Cozza was another one instrumental in organizing and executing the initial mental health response to the September 11, 2001, attack on the Pentagon, together with Waldrep and Waits. Dr. Cozza has highlighted the impact of deployment,

injury, illness and death on the children and families of military service members. He is published in the scientific literature and has presented on these topics at multiple national and international scientific meetings. Dr. Cozza serves as a scientific advisor to several national organizations that focus on the needs of military children and families. You want to argue his point of view on the as-good-as-inevitable mental health results of those experiencing the Theatre of War first hand? You want to argue their point of view on those experiencing the Theatre of War first hand resulting in PTSD? And do you doubt that they shared their thoughts and viewpoints on stress caused by extraordinary incidents resulting in PTSD with Waits and others of the military psychiatrist community, most likely a close-knit society in and of itself?

Do you deny that they, with their above statement, confirm that PTSD therapies as administered by the mental health industry are nothing other than a ruse? A ruse to fish in the PTSD pond for more self-enrichment, more financial fortune, and perhaps even fame, as with the inventors of ART and practically all other PTSD theories and hypotheses? Do you, with the knowledge about them at this point, if you have read this far, deny that it might be a good idea to drain the swamp of PTSD-advocating mental health practitioners, psycho-the-rapists and neuroscientists? Those same practitioners creating it for the purpose of bringing the PTSD fallacy and consequent human desolation to an abrupt halt? Would you at this point agree that the millions and utter millions spent on them, the mental health industry, would be better spent creating financial stability for PTSD journeyers? Thus, they would be able to heal themselves, rather than traumatize them through the mental health industry cabal?

Can you see that by doing so, further PTSD traumatization by creating psychiatric illness would be prevented. So would physical illness always arising almost automatically with persistent psychological upheaval? Is there any possibility to deny that all is exacerbated by pharmaceutical drugs shuffled down PTSD afflicteds' throats in abundance? That, too, is a financially lucrative enterprise for the mental health cabal. And, come to think of it, replacing the mental health industry's PTSD-created stigma with the truth alone would help genuine PTSD experiencers heal in a flash – in no time flat. Don't believe it? Still believe in Santa Claus? Never dreamt about shuffling his letters around? Try it! Never mind.

Like all the other PTSD death traps, ART is far too lucrative to go away, unless the populace puts a stop to it when donkeys fly and pigs sprout wings. As late as in August 2018, the journal *Innovations in Clinical Neuroscience* published another of

Rosenzweig et al.'s versatile ART advertisement concoctions entitled "Ethical Reflections on Offering Patients Accelerated Resolution Therapy (ART)" (Howe EG, Rosenzweig L, Shuman A. Innov Clin Neurosci.2018 Aug 1;15(7–8):32–34). This one stated, as usual, that this new PTSD treatment had shown exceptional promise compared with other standard and more evidence-based treatments. However, something about it was puzzling. It touched on morals and ethics! After the normal spiel on being more effective, quicker and easier to learn, and certainly more cost-efficient than other PTSD therapies.(for whom, we wonder), they get to the core of their sudden concern. There were ethical issues to consider in ART's application. These issues were — wait for it — the need for additional research to fully establish ART's net benefits and the difficulties patients might encounter in accessing therapists trained to perform ART-based treatments. Based on *the moral principle of beneficence* — helping patients and respecting patient autonomy — clinicians were therefore admonished to inform their PTSD patients of ART in detail. This in turn would allow clients to make fully informed decisions about their PTSD treatment. What then, are they hiding? Caveat emptor may be advisable. After all, true evil is the face you know and the voice you trust.

What Else Is Done To Screw Up Our Minds?

That anyone, with a name or without, in the medical profession or out of it, in neuroscience of all shapes and colours, in bio-psychiatry and whatever else you can name or think of, dealing with the human mind and body in a purportedly healing capacity, from the immense variety of mental health industry engaged psycho-the rapists to men and women on the street, has an opinion on PTSD, is a given nowadays. Yes, everybody has an opinion on PTSD these days. Twenty years ago, no one in the general public had a clue about what it meant, such is the power of media in action. Thanks to the media, PTSD journeyers nowadays are viewed as

mentally disturbed and violent people belonging in insane asylums. This perception by the TV-brain-washed masses is as much a given as their never ending soap-opera-watching-influenced opinions on the way the Other should live life, treat their dogs, parrots, gerbils, pet rats, alligators, snakes, children, and whether they should eat snails, cows, pigs, eggs, horses, carrots, grapes, crocodiles, elephant tongues or live monkey brains, for that matter.

If you ask any of them how they formed opinions, oftentimes set in stone, you get the blank "What does she mean?" stare, followed by the: "She's mad or off the wall!" expression. Or if they ever gave a thought while they were on earth or what it meant to be them, why they were born where they were or what they were doing here on earth . . . blank stare. Had they ever wondered why the government spells their name with all capital letters instead of in lower and upper case? More blank stares. Had they ever wondered why they did the things they did, why they drank, smoked, ate, breathed, or ran around like chickens with their heads cut off, rushing hither and tither most of the time? Had they ever asked why they wanted to outshine and outdo their family members, their neighbours, their friends and god and sundry? Had they ever asked themselves why they liberally fornicated with almost everything that moved whenever the opportunity arose and bred without compunction regardless of their social or relationship status? Or why they couldn't make decisions without for light-years consulting acquaintances and so-called friends, the ones just met on Facebook and the ones endlessly talking to while on their smart-phones, until the opportunity to decide anything had passed them by, the decision no longer consequential? Ask them, and see what they say. "She's mad." "She's off the wall."

Thus the notion that there are just as many PTSD treatment modality hypotheses, imaginations, ideas, illusions, assumptions, hallucinations, suppositions, conclusions, conjectures, explanations, guesses, propositions, rationales, theorem, theses, beliefs, opinions, theories, ideas, postulations, presumptions, presuppositions, proposals, sentiments, schemes, speculations, suggestions, surmises, thoughts, cerebrations, cogitations, considerations, contemplations, deliberations, excogitations, concoctions, guesstimates, meditations, analysis, audits, inspections, revisions, surveys, reassessments, reconsiderations, reflections and guidelines as stars on the possibly holographic Universe, possibly hovering over the possibly flat Earth, has passed them by. And if not, it is rarely if ever taken into consideration, either, because none of it is advertised.

Why not, you may ask? Because we live in the age of compartmentalization. It's a need-to-know modus operandi era, that's why. All those PTSD healing theories, hypotheses, mirages and the attempts to by hook and by crook to prove them as valuable is kept beyond the public's perception. The billions of dollars doled out by the tax-paying blind and deceived public to the mental health industry for PTSD research, as if the improvable could be proven, is not something people "need to know". It would spoil the scam and kill the golden goose if the media were to broadcast otherwise.

And even if the inconvenient truth about PTSD were revealed to the world, would anybody care? Would people who refuse or are unable to see that their pop-drinking and drug-of-all-genre consumption habits, aided by vaccinations, alone are the culprits of their mental and physical illnesses care? Would even those with self-inflicted diabetes and cancer care? Would those who are programmed by television-watching since the cradle and raised with common core education principles, and made incapable of rational logic thought and reason — would they care? "As the World turns" and the mass media will hone their cognitive dissonance enhancement, as logic and reason has received no attention in North America's schools since the 1930s.

What of those hundreds of millions of dollars dished out to the mental health industry annually? They go for their nonsensical — bordering on the criminal — treatment of the genuine — not the DSM-5 version — PTSD experiencers to seemingly deliberately destroy our physical and mental health. What if they were instead spent on nurturing rather than pushing us further into the abyss of emotional upheaval? Ha! The PTSD fallacy would be gone within months.

Not nurturing PTSD experiencers is beyond puzzling. But it becomes downright funny when discovering that those in the mental health field are eminently concerned about their own *flourishing*. This is according to the freshly psychiatry-degree-minted Awais Aftab, MD, whose musing "The Virtuous Psychiatrist: Meditations on Success and Flourishing" were published in the July 2018 *Psychiatric Times*. What does it mean to be a virtuous psychiatrist, he asks? In his view, the answer might lie in the wisdom of Greek philosophers like Aristotle. He saw, in regards to human happiness, success and wellbeing, that it speaks of *eudaimonia* or "*flourishing*" as a sort of moralized happiness, distinct from mere pleasure arising out of living life with *arete* (*virtue, excellence*). Moral virtue alone embraces the notion that failing to cultivate and exercise virtues, such as wisdom, curiosity, intellect, aesthetic sensitivity, compassion, empathy, and generosity, means failing to

exemplify flourishing.

Aftab espouses the idea that if one cannot flourish as a human being, one is unlikely to grow and flourish as a psychiatrist. And professional success alone is, in his opinion, no measure of *Eudaimonia.* One must be wary of entering paths to such success as might be littered with oppressive loneliness, alienation, apprehension and self-indulgent greed. Flourishing, in Aftab's view, will not be found in drudgery, but in intellectually stimulating and fulfilling work that urges one to be the best Self one can be. When graduating from his psychiatry residency program, these thoughts weighed heavily on him, he writes. Without claiming any degree of *arête,* he aspires to live up to its ideal as a valuable guide on an uncertain path. For him, he says, it may be the most beneficial and benevolent path. Consider how Aristotle's teacher Plato maintained that the tyrant's life was not enviable, since he would inevitably end up friendless, paranoid, devoid of trustworthy companions and sources of information. Furthermore, his misdeeds would likely be punished in the afterlife (Westacott E. Critique of The Smiley Face. *3 Quarks Daily*. April 2017). And what, in essence, constitutes the vast majority of PTSD wheeling and dealing psychiatrists? Tyrants destroying the life of those affected.

Aftab may have a point with his quasi warning to his peers to carry themselves with honour and integrity. After all, it has been known for more than 150 years that physicians have an increased propensity to die by suicide (*Physician Suicide* Aug 2018; Authors: Louise B. Andrew, MD et al; emedicine.medscape.com). It was estimated in 1973, that the ratio was 58 to 65/100,000, compared with the general population of 11/100,000 (*JAMA* 224(2): 246–7 1973). In 1977, on average, the United States lost the equivalent of at least one small medical school or a large medical school class to suicide. Exact numbers are impossible to estimate with accuracy, because of inaccurate cause of death reporting and coding. The number most often tallied about is somewhere between 300 to 400 physicians annually, or a doctor a day.

The American Psychiatric Association (APA) and the *Journal of American Veterinary Medical Association* both reported concerns for suicides of their own. Indeed, on Christmas Eve *Medscape Psychiatry* reported its top news article for 2018: "NYU Resident, Medical Student Die by Suicide 5 Days Apart." (H. Steven Moffic, MD, Michele Gaspar, DVM, LCPC, Randall Levin, MD: Commentary; *Psychiatric Times*, Jan. 2019). The authors should know. H. Steven Moffic, M.D., retired from the clinical practice of psychiatry and his tenured professorship at the Medical College of Wisconsin in 2012. During his career, he gained recognition as an award-winning administrator, artist, clinician and writer. Designated as one of the USA's

"national treasures" and "da man in ethics" by the American Association of Community Psychiatrists, he was also named a "Hero of Public Psychiatry" by the American Psychiatric Association (behavioral.net). After serving as staff psychiatrist at Kettle Moraine Correctional Institute, in Plymouth, Wisconsin, he wrote *"Better Off in Prison? A Psychiatrist Gains New Insight on the State of Behavioral Healthcare After Joining the Staff at a Wisconsin Prison"*. Nowadays he focuses on physician burnout, climate change and Islamophobia.

Co-author Dr. Michelle Gaspar is a veterinarian at the Veterinary Information Network, Chicago, Illinois. It helps veterinarians from all over the world with difficult and complex medical cases. She is also a diplomat of the American Board of Veterinary Practitioners (Feline Practice). She completed the Veterinary Medical Acupuncture Program at Colorado State University and the Veterinary Chinese herbal modules through the Chi Institute in Florida. Her overall focus is on wellness and disease prevention care. She practices integrative medicine, combining traditional Western medicine with alternative therapies, such as acupuncture, herbal remedies and chiropractic therapies, to promote healing and wellness for her patients. She is on the American Board of Veterinary Practitioners as a certified feline specialist, one of only 80 worldwide. When she is not caring for cats and dogs, she lectures at different veterinary conferences across the country.

In 2013, she delivered *Healing the Wounded Healer*, to an audience of veterinarians, as part of the University of Florida's Maddie's® Shelter Medicine Program track at the *No More Homeless Pets* National Conference. Shelter medicine is one of the most emotionally demanding practices within veterinary medicine. She expressed that clinicians often face burnout, compassion fatigue and a wide range of mental health problems. In her presentation, she reviewed literature on psychological issues experienced by clinicians engaged in high intensity practice. She also gave a personal assessment and evidence-based techniques, including mindfulness, narrative medicine and stress relief resources to maintain wellbeing. More than three decades of data shows that veterinarians are up to 3.5 times more likely to die by suicide than members of the general population.

Randall M. Levin, MD, is chair of the American College of Emergency Physicians wellness section. Since 2012, he has been its newsletter's editor. He retired from active clinical emergency medicine practice due to burnout (acep.org). Still a physician "healer" in 2017, he continued to build his resiliency. The audio CD *Care for the Journey Part 1* and meditating to its messages and music allowed him to stay connected to his healing inner-spirit, to feel the "warmth" of the "calling," as he

calls it. It helped him continue his journey, by being involved in wellness for his colleagues and the system in which they work.

These three qualified people, each expert in the field of their chosen profession, co-authored the exposé. They express what they consider the terrible truth about student suicides in medical school and residency, in particular when considering that they were generally psychologically healthy when starting on their educational path. One can therefore deduce, they say, that the educational systems themselves factor into suicides. Well, then, if that is the case, can one equally deduce that the military, aircrew, police officers and firefighters are in the same boat? But let's stick with physicians, including psychiatrists, who have the highest rates of suicide of any profession and higher than that of the general population. The paradox for the authors lies in the fact that they all are devoted to healing yet they take their own life. And suicide is just the tip of the iceberg of personal psychological distress and disorders, the authors claim. Clinical depressions, epidemic rates of burnout and related problems are also much higher than those of the general population. Thus, the authors concluded, it was no wonder patient quality-of-care suffered.

In 2019, the prevalence of mental disorders in the public had increased to over 20%, and al*most never received any effective treatments,* we are told (italics mine). Outside of formal diagnostic DSM-5 disorders, a host of other public psychological problems were cause for concern. These included:

- Over half of adolescents already had at least one significant life trauma.
- Cosmetic surgery procedures are booming, perhaps as a response to body dysmorphia.
- Rates of xenophobia and related prejudices such as racism, sexism, anti-Semitism and Islamophobia were rising.
- People were suffering mental repercussions of climate instability, as well as overused and misused technology.

Furthermore, society has become pervasively lonely. And even though the American Psychiatric Association Foundation, the funding arm of the American Psychiatrist Association, had in 2018 called for "A Mentally Healthy Nation for All", simple math suggested that society was moving toward mental disease.

It makes one wonder why anyone would want to enter these professions. However, it is often believed that those choosing to be psychiatrists, veterinarians or

other kinds of physicians were often doing so to address some traumatic and/or inspiring medical or psychological experience in their childhood. It was thought that such emotional tie to the past could leave them vulnerable to frustration in helping patients. But, the authors divulged, such frustration resulted more and more often from the systems in which they work having become more corporate and business-oriented. The consequence? Loss of control over how they practice. This, in turn, decreases their empowerment and provides obstacles for their ability to heal, and with it, to fulfill their calling.

This system seems to spring into high gear when transitioning from medical school to residency. The latter is apparently all about the art of mastering chaos and worse, according to Elliott B. Martin Jr. MD. This child, adolescent and adult psychiatrist works at Newton-Wellesley Hospital, a community teaching medical center located in Newton, Massachusetts, and founded in 1881. It is affiliated with Tufts University School of Medicine. It is also affiliated with Harvard Medical School, a private research university in Medford and Somerville, Massachusetts, founded in 1852, where Martin is clinical assistant professor of psychiatry. ("Can We Free Ourselves of the Dogma of Medical Education?" *Psychiatric Times* Jan. 30, 2019). Residents have to master said chaos, while crushed with soul-numbing debt, scaling impossible learning curves and juggling major teaching responsibilities. That part of medical education is also about mastering the pretense of knowing everything, while rapidly absorbing new technological and administrative requirements. Meanwhile, they have to study for licensure exams, apply for fellowships, start families and negotiate the gauntlet of abuse and bullying from seniors, nurses, administrators, patients and families, claims Martin. This generally "miserable way of being," he says, had evolved as a means of helping one learn about suffering through suffering adding:

> "Many of my previously jovial colleagues, however, soon found themselves subsisting on the increasingly standard pharmacologic stew of stimulants, 'benzoes,' and antidepressants. Burnout reaches its nadir in residency. Learned helplessness, PTSD, and the victim mentality are ubiquitous, and one may justly wonder whether 'education' is even really the right word."

The blind leading the blind from the get go? Really? How do we know what pharmaceutical concoction the mental health industry's proclaimed experts in PTSD recovery and healing theories, therapies and treatment modalities consume as

habits carried over from student days? Fortunately, Adam Bartlett Hill, MD, proclaims, over the past few years a lot has been written about psychiatrists' distress and suicide in their medical workplace. All this writing shines a new light on this epidemic which, according to the writer, has existed within medicine for a long time (Adam Bartlett Hill, MD: "Walking Out of the Darkness"; *Psychiatric Times* Jan 31, 2019).

Still, he worries about "our" medical culture spiralling toward bureaucratic solutions by simply building unspecified programs on top of a crumbling foundation, instead of lobbying for a larger systematic cultural change. Programs and initiatives do have their own significant role, but they must not stand alone, he opines. Alone they are disingenuous and will vastly underserve the populations that truly need these resources, namely mental health practitioners themselves. Program-building without a cultural movement to destigmatize and remove punishments from mental health treatment will ultimately fail, he opines. Program-building must be accompanied by a larger cultural movement in medicine to accept mental health conditions as medical conditions. That, he thinks, will strip away the hypocrisy of discriminating against our friends and colleagues for their own [feeble] mental health conditions. "Without a cultural movement we — the lords lording it over rattus — will fall short of our ideals," Hill says. He further states:

> "We need to embrace a cultural movement that will accept mental health treatment as appropriate medical interventions for medical conditions and not blemishes on a medical career that must be covered up and hidden away. We must pivot from models of punishment and shame toward pathways of acceptance and support. We must let this pivot be reflected in the policies and everyday practice of how we treat each other in medicine. I hope we still work in medicine to take care of other people who are suffering. I hope we genuinely believe that it is okay to not be okay. Because we all took the same oath to help other people, and I hope we can live up to it."

Dr Hill is division chief of pediatric palliative care and assistant professor of pediatrics, Riley Hospital for Children, Indiana University Health, Indianapolis, Indiana. As we know from an earlier chapter, far from all doctors take the Hippocratic Oath. Hill, with his rank, is most likely out of the darkness, whereas Moffic et al. possibly hit on the real core for younger physicians' mental ailments when explaining:

> "Along the way, those entering our fields start out under a mountain of debt with an income that fails to keep up with opportunities to alleviate that debt. That can lead to career choices that emphasize reimbursements over the passion to treat certain populations, which may not be as financially lucrative. A balanced home life with children and family is a dream that is pushed more into a distant future."

With all these stressors, it would be no surprise that they themselves needed mental health care. Indeed, in the olden days, psychiatrists in training were expected to receive their own psychotherapy and psychiatrists conducted more psychotherapy on their own, we are told. But no more, and almost just as well. Professionals in both psychiatry and veterinary are often even more reluctant than the general public to get such care. They worry about stigma and negative consequences, such as people knowing about one's mental illness and the fear of job loss and/or licensure. Are we hearing that having a conscience is now perceived as a mental illness?

The tragedy about their peers' reluctance to engage in mental health intervention is, in Moffic et al.'s opinion, that intervention is often successful. So recipients, whether psychiatrist or veterinarian, could enjoy the benefit of acquiring true empathy for their patients' psychological suffering. Are we told in a roundabout or even unintentional way that psychiatrists' overall lack of life experience and hardships is the root cause of the unconscionable treatment dished out to the genuine PTSD affected, for example? Until recently, psychiatry had not focused much attention on mental health challenges less severe than so-called diagnosable disorders, one of the DSM-5 300, we assume. Even the connotations and meaning of *wellness* and *burnout* had been neglected to such an extent that no clear understanding or definition of these colloquial terms existed.

Thus Moffic et al. cry out:

> "What a loss it has been, and will continue to be, if psychiatry does not expand its range of concerns and seek to resolve them. Perhaps our absence is even associated with the rise of burnout at epidemic levels. After all, our expertise in deeper psychological processes, which are often counterintuitive, has been missing. For instance, there has been an almost universal quest for more resilience in physicians. Certainly, developing resilience is helpful for psychological and post-traumatic

> growth. Yet, that resilience is almost part and parcel of becoming a veterinarian or physician. Can we have 'too much' resilience – that is, do we ignore psychological problems and instead soldier on as we have been taught to do?"

Is it perhaps the lack of resilience that, for some veterinarians taking the lives of so many animals, blurs the ethics of taking their own lives? Does assisted human suicide encourage physicians to suicide after euthanizing humans or destroying them through drugging them to the hilt, one could ask? Does human consciousness become blunted, blurred or even non-existent when engaging in such endeavours purposely and for financial gain, we could throw in as well? Can veterinarians help psychiatrists prepare for the role of euthanists, however, is what Moffic et al. ask? Sure, why not? After all, as Virchow so eloquently states: "*Between animal and human medicine there are no dividing lines–nor should there be.*" No professions stipulated, as long as they are human.

In regards to the rare psychotherapist deaths in the workplace, we are encouraged to believe that deaths directly related to their practices are suicides, homicides and adverse pharmaceutical drug effects. Mind you, more than half of all consultant psychiatrists working in Ireland have been physically assaulted by their patients, with one in five stating they feel "stalked" while on duty (Fiachra O. Cionnaith: "55% of psychiatrists have been attacked by patients"; irishexaminer.com 2010). Mental health workers are truly also a vulnerable species, many of them attacked when employed in government-run institutions. That staff are often made to feel that their physical attacks were somehow their fault is old hat to genuine PTSD journeyers, as we hear it all the time (*FOX19 Investigates: Psychiatric hospital staff attacked by patients.* By FOX19 Digital Media Staff | Sept. 2013).

The idea is consequently bounced forth that veterinarians could help prepare psychiatrists for such situations, as they have learnt to positively cope with such events. In turn, psychiatrists' expertise in grief counselling could help overwhelmed veterinarians cope with the loss of their four-legged patients. Both parties could learn from each other. Consequently, 10 strategies were formulated to pronounce their professions' high rate of suicide, mental disorders, burnout and xenophobia *a national mental health care crisis*. In addition, public and politicians alike should be made aware of this travesty, by being politically active and advocating for leadership that would embrace mankind's mental health as its business, asking: "Will you join us?" I sure would love to, to give them some ideas, including opening their own

private asylum to treat each other in supreme comfort? No? Is that why they clamour for political intervention? Should we trust that the law of retribution is unknown in these circles?

Has insanity struck? Here they are, these high and mighty all-powerful men and women who are able to destroy human lives at whim, declaring their vulnerability hearing of life-shattering experiences told to them by their PTSD patients. Yes, with their xenophobia ideation, combined with other psychological handicaps, with DSM-5 assistance they diagnose, impose and lecture PTSD experiencers on how to get well on pharmaceutical drugging and inane PTSD treatment modalities. When pretending to know that these treatment modalities work so wonderfully well, may it be time to take their own medicine to heal themselves?

It is equally insane or funny, in my view, that the US Veteran Administration encourages their PTSD experiencing soldiers and veterans to familiarize themselves with PTSD symptoms. Wonder why? Simple. To protect the VA from claims of ignorance and libel against the xenophobic tyrants causing PTSD experiencers death, destruction and desolation. This way, they shift the burden of responsibility for their treatment to PTSD journeyers themselves. Ignorance of the law is no excuse; ignorance of PTSD symptoms isn't either. If you subject yourself to VA-hired mental health tyrants (a mild expression for them), you do so at your own risk. They go scot free, in case you wake up, educate yourself on PTSD and blame them for your post-PTSD-causing event injuries and troop up, claiming retribution. We told you what to look for and you didn't, will be the answer. You were stupid enough to trust us, so your demise is your own fault. Merely another example of *true evil are the faces you know and the voices you trust.*

Needless to say, PTSD symptoms advertised on the VA websites are composed in accordance with how the NC *for* PTSD employed cabal sees it. They are the ones with all the academic schooling, the ones crying foul, due to being subjected by their patients to acquiring PTSD and so on and so forth. They are the ones of Aftab's world, with their theoretical knowledge of the human psyche and no life experiences, other than hypothetical situations from university classrooms and residency. That the preposition *for* in NC *for* PTSD means "to enhance and exacerbate" escapes most virtuous, arete living humans. Why? Their minds are too decent. That the absence of such psychological decency might lead to self-loathing and provide the catapult to suicide is equally ignored. To avoid giving PTSD journeyers the opportunity to compare notes of the treatment they receive from the system, the sewer, it frowns upon PTSD-affected soldiers and veterans gathering.

That is the way, and most growing up under the slave indoctrination system called academic education from the cradle onwards accept it without thought. Jon Rapppoport elaborates on it in "The State weaponizes education to create ignorance" (*NoMoreFakeNews* Nov. 7, 2018). His opening lines:

> "A hundred fifty years ago, at least some Americans recognized that all serious discourse depended on the use of the faculty called Reason. Formal debate, science, and law all flowed from that source. A common bond existed in some schools of the day. The student was expected to learn how Reason operates, and for that he was taught the only subject, which could lay out, as on a long table, the visible principles: Logic. This was accepted.
>
> "But now, this bond is gone. The independence engendered by the disciplined study of logic is no longer a desired quality in students [or anyone else]. The classroom, at best, has taken on the appearance of a fact-memorization factory; and we should express grave doubts about the relevance and truth of many of those facts.
>
> "A society filled with people who float in the drift of non-logic is a society that declines. Ideologies that deny individual freedom and independence are welcomed with open arms.
>
> "When education becomes so degraded that young students are no longer taught to reason clearly, private citizens have the obligation to rebuild that system so the great contribution to Western civilization — logic — is reinstated in its rightful place."

Is it due to this lack of logic and reason that the VA encourages its clinicians to trust their intuition when encountering PTSD patients. They recognize that there is much less empirical evidence with which to rationally guide the mental health cabal in their ultimate PTSD treatment selection for their clients than they eventually might hope for, stating:

> "Even among the most strongly recommended PTSD treatments, how well a particular treatment works can vary from one person to the next. At this time, there is no scientific way to know which PTSD treatment will work best for you as an individual."

(https://www.ptsd.va.gov/understand_tx/choose_tx.asp)

Their words, not mine. However, they add, in essence, that is nothing at all to worry about. Why not, I wonder? Could this declaration be their acknowledgement that most PTSD journeyers will go away sooner or later, perhaps by committing suicide? Or perhaps by dying of sheer emotional exhaustion, due to the VA's treatment modalities? Or maybe by unwittingly killing themselves with pharmaceutical drugs prescribed under the ruse of providing healing. Or perhaps simply by cutting them off financially, forcing them onto skid row and starving them to death, both mentally and physically? No one seems to question the VA on its statement. No one demands to know: "What have you been doing since the Boer War (1899–1901)? What is wrong with the NC *for* PTSD et al.'s picture?"

"Trust us, trust us," they seem to shout in unison. "Something might work — perhaps!" while simultaneously acknowledging that the ability to make empirically substantiated, scientifically documented, nuanced and prescriptive treatment decisions for PTSD healing, using pre-existing client variables, such as type of trauma and gender, *currently still dwell in their infancy*. And the mental health and medical pharmaceutical industries, with very few exceptions, by and large across the board, tacitly consent, as it suits their agenda magnificently. Why do they do it? Due to Archontic death cult philosophy, wishing to create their ideal living environment through the inversion of our natural human habitat, the earth? And through fear and upheaval, create death and destruction? (Nag Hammadi Library; The Hypostasis of the Archons (The Reality of the Rulers) thelostbooks.org; *After They Have Eaten Us!!!,* David Icke 2018). Since the DSM-5 listing of PTSD as a mental disorder, PTSD diagnoses are applied to all aspects and situations of previously normal life and living, thus confirming New York Hypnotist for relief of anxiety, negative stress and pain Michael Ellner's observation:

> "Just look at us. Everything is backwards, everything is upside down. Doctors destroy health, lawyers destroy justice, psychiatrists destroy minds, scientists destroy truth, major media destroys information, religions destroy spirituality and governments destroy freedom."
> (libertytree.ca/quotes/Michael.Ellner, 1949–2018)

Did Ellner know that the mental health industry is the front-runner in this engineered mayhem of creating perpetual fear, death and destruction for humanity? Is its facilitation of PTSD diagnoses nothing other than a blatant display of human destruction, unrecognized by the general population, due to lack of schooling in

logic and reason? At the PTSD-causing event moment, genuine PTSD experiencers, deemed to be the fittest and brightest of humanity in all aspects of life and living, had both logic and reason. Where did it go? They began to be destroyed by the mental health system immediately after incurring PTSD. Unless they declined treatment and did their own thing, they are now either dead, on skid row, or drugged to the hilt and only an outer shell of their pre-event personality, without knowing it. That is what drugs do. Why such destruction? The system has little choice, because the brightest of their human chattel are prone to object, oppose, obstruct or at least rattle this sewer of inversion and its inhabitants. It has been so throughout the ages.

This is the reason for the mental health industry's posturing that existing scientific empirical PTSD treatment evidence proposes — *proposes!* — that prolonged exposure (PE), cognitive processing theory/therapy (CPT) and eye movement desensitization and reprocessing therapy (EMDR) are the prime choice of PTSD psychotherapies, accompanied by pharmaceutical mind-altering drugs, of course.

But prolonged exposure (PE) treatment, combined with the pharmaceutical drugs paroxetine, sertraline and venlafaxine, is in particular praised as the most promising and delightful sure-fire remedy of all PTSD remedies they trumpet. Sure it is. After all, this particular PTSD cure assures that the human mind is scrambled into oblivion with sufferers never knowing that scrambling occurred. Some will try it in the belief that "doctor knows best." Some will try it due to despair, driving them into it. Regardless, destruction will take place. That mental health practitioners accept those PTSD treatments as if they indeed were the cure is regrettable, but they are untrained in independent investigations. Furthermore, it would be prohibitive to do so, with their debt load after med-school, their sufferings picked up from that of their patients and their inability to face their own conscience. Let's not forget their need to provide for their families. These destructive PTSD remedies allow the mental health industry to continue to prosper and flourish with impunity and almost unfathomable financial gains. Those gains are enhanced daily through PTSD diagnoses for a hangnail by their medical practitioners of whatever rank and color. How did NC *for* PTSD researchers, the VA's and the Department of Defense's hired PTSD "healers" arrive at their consensus for these PTSD "treatments of choice"? The data is known only to them.

Mind you, at this point in time, it seems rather inconsequential. Why so? Hard as they and the system overall try to hide facts about their so-called "psychology/psychiatry as a science," the truth is about to bubble forth, the lie of it

growing onto maturity. It began to dawn rather brightly in May 2018 with another one of Rappaport's reports entitled *Where is the Science? Missing in Action!*

Where Is The Science? Missing In Action?

Jon Rappoport is another paragon of knowledge in many fields for some, a loon for others. He worked as a freelance investigative reporter for over 30 years and ran the website nomorefakenews.com. The *Encyclopedia of American Loons*, ranks him 1050 in the lunatic department, describing him as deliriously insane. The site and blog used to be owned and hosted by *Google Inc.* to *Google LLC* before moving from *MARKMONITOR INC,* its first registrar, to *MarkMonitor Inc.* MarkMonitor, founded in 1999 in Boise, Idaho,, initially served as a provider for the protection of corporate trademarks on the Internet.

MarkMonitor nowadays develops and markets brand protection software and services to combat counterfeiting, piracy, cybersquatting and paid search scams in

four categories: domain management, antifraud software, brand protection and antipiracy. *The Idaho Statesman* reported, "MarkMonitor safeguards more than half of the Fortune 100 brands". MarkMonitor provides services to Facebook, Google, Apple, Microsoft, Tencent and Badoo, the dating-focused social network founded in 2006, with offices in London, Malta, Moscow and the United States. It operates in 190 countries and is available in 47 different languages, making it the world's most widely used dating network to date among others. So indeed, by hosting the Encyclopedia of American Loons, it protects the interests of those companies. You see, the loons identified are really, really bright, and therefore have to be ridiculed to discourage the masses from paying attention to them. This includes Rappaport, who on his bio states that he lectured all over the US on one simple question: "Who runs the world and what can we do about it?" No wonder the system has to ridicule him whenever it can.

In their view, his independent research encompasses "deep politics, conspiracies, alternative health, the potential of the human imagination, mind control, the medical cartel, symbology and solutions to the takeover of the planet by hidden elites" (americanloons.blogspot.com). So Rappaport ranks 1050, and who holds number 1? Mike Adams, the Health Ranger, who presents a much greater danger to the system than Rappaport.

Adams runs the website NaturalNews.com considered by the loons running the encyclopaedia as "one of the most disturbing cesspits of quackery on the net. He is a fierce opponent of science and evidence-based medicine, providing long screeds about the danger of conventional medicine and against scepticism based on confirmation bias, misleading vividness, paranoia and conspiracy theories." Maintaining that Adams has absolutely no understanding of either science or critical thinking, and a complete inability to recognize fallacies or bias, he furthermore is viewed by them as a proponent of every alternative treatment imaginable. Merely quoting their website. But back to Rappoport.

Again, he lauds/champions the previously mentioned Harvard-trained psychiatrist and former Consultant at the National Institute of Mental Health (NIMH) Dr. Peter Breggin, MD, called "The Conscience of Psychiatry" for his many decades of successful efforts to reform the mental health field. The book *The Conscience of Psychiatry: The Reform Work of Peter R. Breggin, MD* (Contributors Candace B. Pert, William MD Glasser, Jeffrey M. Masson; Lake Edge Press 2009) is a biographical tribute to Breggin's professional career. Drawing on over 50 years of media excerpts and more than 70 contributions from professionals in the field, it

results in an expose of his principled and courageous confrontations with organized psychiatry, drug companies and government agencies. It is also a probing critique of the psycho-pharmaceutical complex.

Already as a Harvard undergraduate student (1954–58), Breggin lead an innovative mental hospital volunteer program, drawing professional praise and national media attention. His successful opposition to the return of lobotomy and psychosurgery in the 1970s is noteworthy, so is his equally successful opposition to racist psychiatric federal programs in the 1990s and his continuing efforts to protect children and adults from electroshock treatment and the excesses of psychiatric diagnosis and drugs. When under attack from organized medicine, the pharmaceutical industry and leaders in the field of psychiatry, he successfully challenged their power and veracity. Many of his critiques of the pseudoscience of biological psychiatry, once viewed as radical, have now become accepted facts and truths.

Biological psychiatry or biopsychiatry is a branch of psychiatry focusing chiefly on researching and understanding the biological basis of major mental disorders. These include unipolar and bipolar affective mood disorders, schizophrenia and organic mental disorders, such as Alzheimer's disease. In biological psychiatry, no human emotions and compassion or morals and ethics are examined or considered. Hypothetical knowledge is gained using imaging techniques, psychopharmacology and neuro-immunochemistry such as discovering the detailed interplay between neurotransmitters and the understanding of the neurotransmitter fingerprint of psychiatric drugs such as, for example, antipsychotic drug clozapine, primarily used in people unresponsive or intolerant to other antipsychotics. As everything and the kitchen sink are shuffled down PTSD sufferers' throat, if they allow it, we may as well tell you that some of its side effects are serious and potentially fatal. Common ones include constipation, bed-wetting, night-time drooling, muscle stiffness, sedation, tremors, orthostatic hypotension, hyperglycaemia and weight gain.

Clozapine carries five black box warnings. They include:

AGRANULOCYTOSIS: A decrease in white blood cells increases the risk of infection.

MYOCARDITIS: Inflammation of heart muscle and cardiomyopathy (enlarged heart) have rarely been reported. Symptoms of these heart problems include shortness of breath and chest pain.

SEIZURES: Dose-dependent seizures have been associated with clozapine more likely with high doses or rapid dose increases. Clozapine should be used with caution in patients with a history of seizures, head injury or alcohol dependence.

ORTHOSTATIC HYPOTENSION: Clozapine may cause a significant drop in blood pressure when changing position from sitting to standing.

INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA RELATED PSYCHOSIS:

- Both first generation (typical) and second generation (atypical) antipsychotics are associated with an increased risk of mortality in elderly patients when used for dementia related psychosis.
- Although there were multiple causes of death in studies, most deaths appeared to be due to cardiovascular causes (e.g. sudden cardiac death) or infection (e.g. pneumonia).
- Antipsychotics are not indicated for the treatment of dementia-related psychosis(nami.org).

Many male patients have experienced cessation of ejaculation during orgasm as a side effect, though this is not documented in official drug guides. However, Wikipedia tells us that many side-effects can be managed and do not necessarily warrant discontinuation. Rattus and cani obviously tolerated it to a degree. Therefore, so should you, the human life stock including PTSD experiencers, seemingly always on the frontline as guinea pigs for such experimentations, as they are broken and broke, and rattus no longer suffices.

Neuropsychiatry focuses on brain behavior relationships and the assessment and treatment of patients with neurologic disorders, along with cognitive, emotional and/or behavioral problems. In contrast, biopsychiatry looks at the chemical, anatomical and genetic causes of mental illness, says Simone McKitterick, a Washington DC-based web content manager and writer, focusing chiefly on neuroscience and mental health issues. He published multiple articles at the National Alliance on Mental Illness (*What is Biopsychiatry, and Why is it Useful?* simonemckitterick.com/2017). Neuropsychiatry typically deals with behavioral disturbance in the context of apparent brain disorder. But biopsychiatry combines neuroscience, psychopharmacology, biochemistry, genetics and physiology to form theories about the biological bases of human — rattus — behaviour and psychopathology. The trouble appears to be that diagnoses of traditional psychiatric practitioners lack the specificity of the biological markers, which biopsychiatry hones in on. If the genetic, neuroimaging or brain-circuit explanation for a mental illness were located, a cure, or at the very least more accurate treatments than the Russian roulette of pills, would be possible, McKitterick opines.

And we hear that scientists indeed are taking steps in this direction. One is deep brain stimulation. It involves implanting electrodes within certain areas of the brain (mayoclinic.org). These electrodes produce electrical impulses that regulate abnormal impulses. Or the electrical impulses can affect certain cells and chemicals within the brain. A pacemaker-like device placed under the skin in the upper chest controls the amount of stimulation in deep brain stimulation. A wire that travels under the skin connects this device to the electrodes implanted in the brain.

Deep brain stimulation is FDA approved to treat a number of conditions such as:

- dystonia
- epilepsy
- essential tremor
- obsessive-compulsive disorder
- Parkinson's disease

Deep brain stimulation is also being studied as a potential treatment for:

- addiction
- chronic pain
- cluster headache
- dementia
- depression (major)
- Huntington's disease
- multiple sclerosis
- stroke recovery
- Tourette syndrome
- traumatic brain injury

This treatment is reserved for people unable to control their symptoms with medications. However I am sure it will be hailed as *the* cure to PTSD experiencers' soon, if it is not already practiced at Cornell's Headstrong operation. In particular, Helen S. Mayberg, M.D., professor of psychiatry, neurology and radiology and the Dorothy Fuqua Chair in Psychiatry Imaging and Therapeutics at Emory University School of Medicine is working in that direction. She is heading a multidisciplinary research program studying brain mechanisms mediating depression pathogenesis and antidepressant treatment response. These mechanisms use multimodal

neuroimaging. She pioneered the development of deep brain stimulation for treatment resistant depression said to have made significant advances in DBS techniques to treat major depression. And what is PTSD for most psychiatrists? A major depression!

As such, then, biopsychiatry aims to investigate determinants of mental disorders, devising remedial measures of a primarily *somatic nature*. This has been criticized by Dr. Alvin Pam, M.D. for being a "stilted, unidimensional, and mechanistic world-view", so that subsequent "research in psychiatry has been geared toward discovering which aberrant genetic or neurophysiological factors underlie and cause social deviance." According to Pam the "blame the body" approach, which typically offers medication for mental distress, shifts the focus from disturbed behavior in the family to putative biochemical imbalances. His book *Pseudoscience in Biological Psychiatry* was co-written with Colin A. Ross, M.D., co-founder of the *Trauma Education Essentials*, which provides webinars related to trauma. The book states the following:

1. "The purpose of this book is to show that biological psychiatry — presently the dominant force within the discipline of psychiatry — is dominated by a reductionist ideology that distorts and misrepresents much of its research" (p. 1–2)
2. "biological psychiatry cannot fulfill its mission properly because in the current state it has more the accouterment [false outward appearance] of a scientific discipline than the substance. . . . the methodology of biological psychiatry is sufficiently flawed as to call into doubt the preponderance of its accepted findings" (p. 8).
3. "The history of biological psychiatry can be depicted as a tale of 'promising' leads, closure on slender evidence, hyperbole as initial reception to new work, and ultimately unproductive results. . . . following about a century of effort, a harsh assessment would be that no substantive results have been tendered for the pathogenesis of any major psychiatric disorder" (p. 42).
4. "biological psychiatry does not come close to meeting scientific standards" (p. 69).

On a research level it includes all possible biological bases of behaviour — biochemical, genetic, physiological, neurological and anatomical. On a clinical

level, meaning what the consumer (the patient, the client) receives, it includes various therapies, such as drugs, diet, avoidance of environmental contaminants, exercise, the alleviation of effects of life stress and adversities, all manifesting measurable biochemical changes viewed by biological psychiatrists, loonies of all loonies, as possible causes and reasons for mental health disorders.

Medical psychiatric training generally includes psychodynamic and biological approaches, but psychoanalytical therapy a la Dr. Breggin seems to be on the out and out. Rattus does not need psychoanalyses, so why should you. None could have stated it more succinctly than the world-renowned Polish neuroscientist, pharmacologist and biochemist, professor of natural sciences, lecturer of applied psychology, member of the Polish Academy of Sciences and the Polish Academy of Learning and one of the most frequently cited Polish scientists in the field of biomedicine, Jerzy Adam Gracjan Vetulani (1936–2017). He expressed that the book *The Naked Ape* by English zoologist Desmond Morris had affected him thus:

> "Thanks to this book for the first time I saw that you could approach a man like a normal animal species. . . . I realized at that time how ridiculous is a man who, as an animal instead of on all fours, is walking on two legs. How funny we look, hairless almost all over the body. . . . I also got rid of the belief in the superuniqueness of Homo sapiens"(everything.explained.today/Jerzy_Vetulani/).

Dr. Breggin, on the other hand, espouses an empathic-principle approach to human healing, but empathy is rarely taught in graduate or professional schools, even though empathy is at the heart of therapeutic life. At all levels of professional development, empathy should be woven into the other important facets of psychotherapy and human services, he writes on his website (breggin.com/empathic-therapy/).

It is empathy that allows a therapist to use the healing power of professional therapy relationships, rather than the mechanical or chemical manipulation of the brain, Breggin observes. Blunting ourselves with drugs is not the answer to overwhelming emotions he states. Instead, intense emotions should be welcomed, as they are the vital signs of life. We need and should want them to be strong, and we also need our brains and minds to function at their best, free of toxic drugs that disallow us to use our intelligence and understanding to the fullest. Thinking clearly is one of the hallmarks of taking charge of oneself, instead of caving in to helplessness and handing the power for our wellbeing to others. Unfortunately, he

says, when health professionals are taught to rely on psychoactive drug prescription as therapy and panacea for all, they are in effect instructed in how to suppress the emotional lives of their patients and clients. They do this instead of helping them to maximize their ability to be empathic and loving toward themselves, and therefore others. This impedes them to to live ethically and to become autonomous and self-determining in the fulfillment of all their chosen goals and ideals.

In contrast, biological psychiatry views people as objects and suppresses their feelings with all sorts of brain-disabling treatments, as we discovered throughout this book alone. It thereby interferes with developing empathy and love, as empathy well as the ability to take rationally determined actions for the Self based on sound values. No wonder, then, that Dr. Breggin has stood alone for decades. During that time, he has created a movement that has become a liberating force for millions of human beings, children and adults alike. There have been some PTSD journeyers among them, I am sure, many of whom might otherwise have suffered involuntary psychiatric treatment, lobotomy, electroshock and psychiatric drugging (breggin.com).

Even some of his own are valiant and honourable enough to acknowledge his integrity. Bertram Karon, Ph.D., professor of psychology, Michigan State University and author of *The Psychotherapy of Schizophrenia, said this about him:*

> "Peter Breggin is the conscience of American psychiatry! . . . In short, Peter Breggin has made a difference in the fields of psychiatry, psychology, and mental health treatment. He has made a difference to many patients whose treatment has been less destructive and more helpful, including thousands of people who would otherwise have been lobotomized, and to many more in creating hope that one can receive and once can practice treatments that actually help people." (Bertram Karon, Ph.D., Professor of Psychology, Michigan State University and author of *The Psychotherapy of Schizophrenia)*.

Mind you, Dr. Breggin has thus far published dozens of scientific articles and more than 20 books, in an effort to reform the mental health field. Bestsellers *Toxic Psychiatry* and *Talking Back to Prozac,* written with Ginger Breggin, are among them. So are *Medication Madness: The Role of Psychiatric Drugs in Cases of Violence, Suicide and Crime* and *Psychiatric Drug Withdrawal: a Guide for Prescribers, Therapists, Patients and Their Families.* His most recent one, is the latter. It responds to a citizen rebellion that demands, "Help us get off these drugs!" It also encourages a professional

revolution among concerned therapists who want to reject the idea of enforcing "patient compliance."

His revelations are firmly based on the latest scientific research and dozens of case studies. For years, Breggin has documented that medications for everything from depression and anxiety to ADHD and insomnia are being prescribed across the US in alarming numbers. It is he who documents that the "cure" is often worse than the original problem, as many categories of psychiatric drugs can cause potentially horrendous reactions, he says. Drugs such as Prozac, Paxil, Zoloft, Adderall, Ritalin, Concerta, Xanax, lithium, Zyprexa and other psychiatric medications may spellbind patients into believing they are improved when too often, in fact, they are becoming worse, Breggin proclaims. He documents that psychiatric drugs drive some people into psychosis, mania, depression, suicide, agitation, compulsive violence and loss of self-control. The patients don't realize that it is their medications that deform and pervert their way of thinking and feeling. Those thoughts and feelings often lead to suicide, murder and other violent, criminal and bizarre behaviours. Wit PTSD journeyers' outbreaks when in the WCB's tender loving hands or the VA and the DoD clinchers.

It was the scientific evidence and the case studies, combined with his clinical experience, that convinced Dr. Breggin. He came to recognize that human behavior and loss of judgment resulting in irrational actions seemed to be driven by pharmaceutical drug-induced adverse reactions and intoxication. At the same time, Breggin believes that everyone is responsible and accountable for his or her individual conduct. In his 2014 Mission Statement he comments:

> " . . . we have surrendered our uplifting faith in ourselves for a degrading faith in biological and genetic explanations, and psychiatric interventions. We have endorsed and accepted the belief that our personal suffering is determined by genetics and biochemical imbalances, when this is not true. We have lost confidence in ourselves as the directors of our own lives. We have given up responsibility for raising and teaching our children, instead casting them off to the pharmaceutical industry and drug prescribers at the earliest sign of difficulty or conflict with them."

In his Mission Statement of October 2014, Dr. Breggin says the following:

Organized psychiatry has always held these dismal beliefs about human nature and how to fix it by assaulting the brain. As a result, over the past hundreds of years,

psychiatry has given us an array of poisonous drugs, shock treatments and the lobotomy. In the past, these assaults were largely confined to hapless victims of state mental hospitals and their outpatient clinics in North American and Europe. True, untold millions of lives were devastated and destroyed. But since the 1960s has psychiatry gone into partnership with the pharmaceutical industry and reached out to impose itself on the whole of society. Together, they have created what I first described in *Toxic Psychiatry* as the psychopharmaceutical complex. Led by the pharmaceutical industry, the psychopharmaceutical complex includes their collaborating psychiatric and medical societies, medical schools and universities, government agencies like NIMH and NIH, health systems in the VA and the military, state mental health agencies and foster care, as well as public schools that push drugs.

The pharmaceutical industry and the psychopharmaceutical complex have used their combined authority, power and wealth to overturn the moral climate of America itself for the sake of power and profits. They have imposed upon Western society a faith in fake biological explanations, concocted diagnoses and toxic drugs that do infinitely more harm than good. Even more millions of lives are being damaged and destroyed by years of exposure to shock treatment and drugs. In the process, they have compromised and corrupted the most fundamental human ideals of personal responsibility, personal growth and principled living. They have ignored and rejected the truth that personal emotional suffering almost always grows out of trauma and loss related to our social relationships, and ultimately to our capacity to love and be loved.

In Dr. Breggin's view, the contest is not between biological psychiatry and psychotherapy. It is between biological psychiatry and all the wisdom that life can offer us. On the dark side, we have this demoralizing and physically destructive idea that there are medical experts who can tinker with our brains and "make us better, " he asserts. On the positive side, we have the uplifting belief that our inner resources can use self-understanding, wisdom, education, art, nature, spirituality and God to provide us what we need to triumph over our mental confusion and emotional turmoil *(https://breggin.com/dr-peter-breggins-mission-statement/)*

Having worked as a therapist ever since he began to volunteer in a state mental hospital at the age of 18, and later on directed the Harvard-Radcliffe Mental Hospital Volunteer Program, he still thinks that therapy can be helpful. In 2014, his experience in often helping the most lost and shattered souls reached 60 years. But, he asserts, therapy does not provide the ultimate answer. There are many avenues to

self-transformation. Life requires that each of us begin by taking responsibility to live by higher principles that bring out the best in ourselves and every other person whom we touch. Life requires living by reason, higher principles and love.

He tried to sum up what he learned about life in his December 2014 book *Guilt, Shame and Anxiety: Understanding and Overcoming Negative Emotions*. *Science and the wisdom of the ages come together in this book with a shared understanding that human beings must daily choose between their two natures: wilfulness and aggression on one hand and reason and love on the other. Simply put, says Dr. Breggin, we must learn to live by our better nature. We can do that only if we triumph over and transcend our negative legacy emotions of guilt, shame and anxiety, as well as chronic anger and numbing. And this is precisely the task involuntarily imposed on genuine PTSD experiencers. If the purpose of the PTSD experience, this colossal task, is unrecognized, resented or downright rejected, no PTSD healing can occur.*

At heart, Dr. Breggin feels, this book of his is an invitation to love. To love not only people but to love life, to love to aspire to our highest values and purposes, to love, acknowledge and explore, and to trust our spirituality. The invitation is to love and appreciate something or Someone greater than ourselves, because, when becoming and being a source of love, we bring out the best in ourselves. And when we do so and by way of our aura radiate it out, if we want to or not, we bring out the best in every person we touch, by whichever means, regardless of physical distance. Perhaps life requires a genuine PTSD experience to awaken to the principles of honour, integrity and graciousness, discipline, willpower, determination and persistency — the gift of PTSD?

There is little doubt in my mind, though, that the enthusiasm for life and living, in PTSD experiencers so abruptly destroyed by the PTSD-causing event, is garrotted to extinction by mind altering drugs of all genre, pharmaceutical and otherwise. When logic and reason is applied to the evidence presented, all result in the Mistake of the Intellect. This, in turn, manifests in irrational behaviours, including suicide. The mental health industry complex, however, in our case the PTSD experiencing consumers, blames them for losing their minds, because they were warped from the moment of inception, never mind the PTSD-causing event. That is the perversion of truth, the colossal lie imposed on PTSD farers by the vast majority of psycho-therapists and their cohorts who created the devastating stigma against us. Dr. Breggin's book provides information and ammunition against the NC for PTSD cabal's erroneous, viscous, and falsified impositions against us, that lead to devastating anguish, misery, alienation and loneliness.

To avoid this tedious drug-induced path toward desolation and death incurred due to a fundamentally most human and humane existential crisis, renamed PTSD

by “modern” psychiatry, an ailment acknowledged as such since antiquity, Breggin’s writings are most valuable. Those professing to be experts in healing it, by the way, never use the term existential crisis. How could they, when we equal rattus in their standing? Why we allow them to sit in judgment over us is also self-explanatory. It’s the “Doctor knows best” syndrome. And it’s our fragility after the PTSD-causing event moment. It’s also our complete lack of knowledge that those pretending to be able to cure us themselves suffer lack of empathy and compassion, and have psyches so fragile as to incur secondary PTSD merely by listening to their patients earthshattering PTSD-causing event moments, if they even take the time to listen. That it has yet to be established by them what indeed causes genuine PTSD also escapes our attention.

In soldiers, for example, is it the slaughter and mayhem inevitably witnessed in the Theatre of War? Or is it personally doing the slaughter and mayhem that creates it? Is it seeing their best buddies blown to smithereens beside them, and realizing it could be them next second? Or is it the knowledge of how narrowly one escapes death that pulls the PTSD trigger? Is it the awareness of having escaped death by a hair’s breath, as in my case, that causes PTSD, or is it the sudden acute awareness of life’s fragility? Is it to be the bystander to a shooting or horrific manhunt, or is it to be the one doing the shooting? Why do veterans and others living through life-experiences outside of the human norm incur PTSDS symptoms years and decades after such experiences? Why? No one seems to know.

In the numbness of the aftermath, is it the unconscious creation of a new perception of life and self that creates the sense of overwhelming futility, or is that the path to healing? Does wandering through the period of analysis with equal unconsciousness that rattles the awareness that one has a choice, namely to either analyze the purpose of one’s own existence or to leave go of it all? With it, does the will to make the choice to either live or die spring into existence? Is it the brightness of one’s intellect that propels one to the understanding that only self-analysis and consequent changes of the Self that can help the Self escape the PTSD quagmire? Is it the awareness that one must proceed to do this, as none other is able to know the Self other than the Self? Is it a subconscious understanding that leads to the search for avenues of self-help rather than continue with the general physician-recommended psycho-the-rapists? Or is such decision consciously made? Is it possible to engage in such contemplations or to make rational logical and reasonable decisions and draw conclusions about one’s own being, consciously or subconsciously, when under the influence of mind-altering drugs or not? Is it the

intellect that, sooner or later, understands that freeing Self from PTSD can only occur by freeing Self all by oneself without outside interference, without pharmaceuticals, pot, marijuana or any other hallucinating opioid agents? Is it the intellect, which leads to the colossal PTSD existential crisis to begin with? In essence, then, the question arises: "If under the 'doctor-knows-best indoctrination' of trusting the faces one knows and its voices, does it prevent PTSD healing?"

We will never know, as the mental health industry could not be bothered to communicate with genuine PTSD journeyers. other than with their purported remedies traumatizing us further. There are very few exception like Drs. Breggin, Molcher and my own psychiatrist, Dr. William Courtney of Ireland, may he rest in peace. But listen, you ever checked what to cure means? Two things. To relieve a person or animal of the symptoms of a disease or condition is one. And, of course, to preserve meat, fish, tobacco or animal skins by various methods, such as salting, drying or smoking, is the other. Thus, in essence, we, the human animals in the view of those who treat us are allowing ourselves to be subjected to pharmaceutical drug consumption and their PTSD treatment theories presented in this book. Thus, we can be salted down, smoked, and dried to generate profit for them until death stops the curing. This is why the NC for PTSD uses the proposition for indicative of the recipe of perpetual PTSD curing rather than of PTSD, the actual cure for the ailment. Conundrum solved! It's right in our face!

And, while at it, what actually does *the word crisis (plural crises) mean?*

Derived from the ancient Greek noun κρίσις krísis, "a separating, power of distinguishing, decision, choice, election, judgment, dispute," its verb is κρίνω krínō, "pick out, choose, decide, judge" (en.wiktionary.org). There are several interpretations, however. The Romans, who adopted crisis into Latin, expressed it as follows:

- a crucial or decisive point or situation; a turning point.
- in psychology: a traumatic or stressful change in a person's life.
- a point in a drama at which a conflict reaches a peak before being resolved.
- a sudden change in the course of a disease, usually at which point the patient is expected to either die or recover.
- an unstable situation in political, social, economic or military affairs, especially one involving an impending abrupt change.

WordHippo gives it as trouble, tribulation, distress, divorce, pressure, lethargy, throng, burden, weight, conference, comparison, confrontation, collation, contribution, change, mutation, transformation, alteration, dilemma, bad, evil, disaster, harm, crash, ruin, fall, destruction, downfall, and the Oxford dictionary expresses its meaning as:

- a time of intense difficulty or danger
- a time when a difficult or important decision must be made.
- the turning point of a disease when an important change takes place indicating either recovery or death

Merriam-Webster describes it as:

- the turning point for better or worse in an acute disease or fever
- a paroxysmal attack of pain, distress, or disordered function
- an emotionally significant event or radical change of status in a person's life a midlife crisis
- the decisive moment as in a literary plot as in: "The *crisis* of the play occurs in Act 3."
- n unstable or crucial time or state of affairs in which a decisive change is impending, especially one with the distinct possibility of a highly undesirable outcome such as a financial crisis
- a situation that has reached a critical phase the environmental crisis the unemployment crisis

Synonyms for crisis? Boiling point, breaking point, clutch, conjuncture, crossroad(s), crunch, emergency, exigency, extremity, flash point, head, juncture, tinderbox, zero hour.

Pick and choose. Every one of them touches or describes the road one travels when crossing the genuine PTSD minefield. PTSD journeyers face it all. Every one of the above definitions and situations represents the great danger to the Self in all aspects of being human and humane. This is contrary to what rattus, simia, cani, lepus and mus experience when theoretically introduced to hypothetical PTSD-causing scenarios from which PTSD healing modalities for human beings then are, almost to exclusion, drawn. And all of it has to be managed to get through the PTSD ordeal relatively unscathed. None of it is due to one's own pre-PTSD causing event

disposition. It is all due to those with whom one is forced to deal when PTSD hits in the line of duty in any of the PTSD-prone occupations. The only relatively painless way through this pain-filled exercise is to run one's own show by taking a leave of absence and escape into nowhere, as Robert Graves describes in his book *Good Bye To It All*. Most lack the financial resources to do so.

Thus PTSD is a crisis of intense danger to us in more ways than one. The decisions we make, or which we allow to be made or have imposed on us to proceed with our healing, decide our future life. One thing is for certain, however. If we trust the faces and voices we know rather than listen to the small voice within, our intuition, our heart and soul on how to proceed, we will most likely, if not most certainly and in no time flat, be up the creek without a paddle.

Self-destruction increases with every pill we inhale. It increases with every recommended "therapy", from stellate ganglion to marihuana, from CBT to EMDR and ART, from PE to ECT, in which we consent to engage/participate. It's not just because of the automatic and systematic destruction of our minds and bodies. It's also because these advocated treatment modalities put us on a mental roller coaster of hope for improvement to despair over failure every single time. It is unhealthy for the psyche to have the scales of balance tipping incessantly up and down and up and down. It intensifies the despair, one of PTSD's side-effects, the: "Will this ever change? Will it ever end?" syndrome. Combine that with the "It's all your fault, flawed as you were from the moment of your inception." Each is another brick to mortar PTSD journeyers' destruction into place during this truly existential crisis, a time in which people question life's meaning and, purpose, and the value of continuing life (James, Richard K, Burl E. Gilliland: *Crisis Intervention Strategies*; Cengage Learning; Brooks Cole 2007). This is the process of contemplation, this issue of searching for the meaning and purpose of human existence. It has been a major focus of the philosophical tradition of existentialism throughout thousands of years. But it is destroyed in PTSD journeyers, I believe, through heralded PTSD cures advocated by the mental health industry at large.

And in my view, its actions are quite explainable, too. After all, traditional existentialism views date at least back to the ancient Greeks. They are said to be in line with the ideology that God/a Divine Creator of All, a Supreme Entity, is part and parcel of humanity and essential for our existence ((Gholamreza, Ghassemi, Najmeh Soltaninejad; "Modern Versus Traditional Existentialism, A Debatable Issue"; *Procedia — Social and Behavioral Sciences* Volume 46, 2012, Pages 4845–4848). Modern thinkers of existentialism, however, are said to hold that as there is no God

or any other transcendent force. The only way they think we can counter this nothingness, and hence to find meaning in life, is by embracing existence (philosophybasics.com). That spirituality must be embraced to heal PTSD is thus completely denied and ignored.

Existentialism does, like Dr. Breggin, espouse the view that people must take personal responsibility for themselves. However, it is acknowledged that with this responsibility comes *angst* and a profound anguish or dread. The word *angst* has existed since the 8th century from the Proto-Indo-European root *anghu-*, "restraint" from which Old High German *angust* developed. It is pre-cognate with the Latin *angustia*, "tensity, tightness" and *angor*, "choking, clogging" comparable to the Ancient Greek ἄγχω (*ánkhō*) "to strangle".

The word was introduced into the English language from the Danish, Norwegian and Dutch word *angst,* and the German word *Angst*. It is found since the 19th century in English translations of the works of Kierkegaard and Freud. In English, it is used to describe intense feelings of apprehension, anxiety and inner turmoil. In Existentialist philosophy, the term *angst* carries a specific conceptual meaning. The use of the term is first attributed to Danish philosopher Søren Kierkegaard (1813–1855) in *The Concept of Anxiety*, also known as *The Concept of Dread*. He used *Angst* to describe a profound and deep-seated condition. Whereas non-human animals are guided solely by instinct, he said, humans enjoy a freedom of choice that they find both appealing and terrifying, should they ever think about it. This creates the anxiety of understanding freedom, when considering undefined possibilities of one's life and one's power of choice over such freedom. Kierkegaard's concept of angst reappeared in the works of existentialist philosophers such as Friedrich Nietzsche, Jean-Paul Sartre, and Martin Heidegger, each of whom developed the idea further in individual ways. Kierkegaard's angst referred mainly to ambiguous feelings about moral freedom within a religious personal belief system. But later existentialists discussed conflicts of personal principles, cultural norms and existential despair. The latter would be the initial subconscious reaction of PTSD sufferers after the PTSD causing event.

Existentialism emphasizes that to live life, action, freedom and decision are fundamental necessities. It also holds that the only way to rise above the essentially absurd condition of humanity characterized by suffering and inevitable death is by overcoming ANGST. One must then vigorously assert and exercise personal freedom and choice, and the completely reject determinism (philosophybasics.com). And what's that, I wondered?

Determinism is a belief in the inevitability of causation. Everything that happens is the only possible thing that could happen, and the chains and networks of causes so powerful and inexorable that every outcome is also inevitable. So tight is the world locked into everything, that everything that is going to happen in the entire future of the universe is already determined. If one knew all causal principles and enough information about the present, one could predict the future with 100% accuracy, as the universe resembles a giant machine grinding along following rigid rules way into the future. That is determinism, as described by Roy F. Baumeister (1953–), a social psychologist known for his work on the Sself, social rejection, belongingness, sexuality and sex differences, self-control, self-esteem, self-defeating behaviours, motivation, aggression, consciousness and free will (Roy F. Baumeister: "Just Exactly What Is Determinism? Psychological science does not require determinism"; psychologytoday.com 2009). As a social psychologist, he explores how we think about the self, and why we feel and act the way we do. He is especially known for his work on the subjects of willpower, self-control, and self-esteem, and their relationship to human morality and success.

Baumeister explains that to a determinist all choice is illusory. The literal meaning of choice, however, is that there are multiple options and the person selects one of them. Thus, choice requires multiple possible outcomes, an absolute no-no to determinism and its adherents. They march to the drum of causality making an outcome inevitable, and the wrongness of believing that anything else is possible. Since the chooser does not yet know which option he or she is going to choose, they live a subjective experience of choice. Thus, in determinists' opinion, the subjective choosing is simply a matter of one's own ignorance — ignorance of the fact that other outcomes are not possibilities at all.

Timothy A. Pychyl, Ph.D. is director of the Centre for Initiatives in Education and faculty member in the Department of Psychology at Carleton University (Ottawa, Canada). In his 2009 *Psychology Today* article "Science, Free Will and Determinism: I Think We're Coloring Outside the Lines: Free will is not a question for science"), he pipes in that, after reading Baumeister's script, he revisited the early history of psychology. He says the it tells how the mental health industry admonished the notion of *will* in its clamour to be a *science*. Even a quick read of social psychology in the 1920's reveals that "will" was simply not open to scientific study and research. Psychology became the study of behaviour, but we know that this paradigm had its limits. A more cognative revolution followed, the cognitive revolution in psychology. He states: "We are interested in people's goal pursuits, real

or imagined I suppose" to quote American philosopher, psychologist and educator William James (1842–1910). He was a leading thinker of the late nineteenth century and labelled the "Father of American psychology". He wrote specifically and openly about *will and obstructed will,* stating:

> "Men do not differ so much in their mere feelings and conceptions. Their notions of possibility and their ideals are not as far apart as might be argued from their differing fates. No class of them have better sentiments or feel more constantly the difference between the higher and the lower path in life than the hopeless failures, the sentimentalists, the drunkards, the schemers, the 'dead-beats,' whose life is one long contradiction between knowledge and action, and who, with full command of theory, never get to holding their limp characters erect.
>
> "No one eats of the fruit of the tree of knowledge as they do . . . and yet their moral knowledge, always there grumbling and rumbling in the background . . . never wholly resolves, never gets its voice out of the minor key into the major key, or its speech out of the subjunctive into the imperative mood, never breaks the spell, never takes the helm into its hands. The moral tragedy of human life comes almost wholly from the fact that the link is ruptured which normally should hold between vision of the truth and action . . . " (James, 1908; Vol 2, p. 547).

In Pychyl's opinion, James' first act of free will was to believe in it, even defining moral actions as acts of will, "taking the helm into our own hands." "Free will, no free will, is a belief, an assumption upon which we [the mental health cabal] base our arguments, our hypotheses and what we count as data. We don't create research findings that say anything about the existence of free will," asserts Pychyl. Others, however, find that determinism increases cheating (Kathleen D. Vohs, Jonathan W. Schooler: "*The value of believing in free will: Encouraging a Belief in Determinism Increases Cheating*"; Psychological Science 2008). "Our findings can't do that," says Pychyl, "because our science is premised on the existence of free will (Baumeister's research on self-regulation) or not (Bargh's investigation of unconscious processes). We're doing (social) science. It is one approach to creating knowledge claims, and some questions are simply outside the lines of our practice. I think we have to be careful to

color inside the lines. Our science will not resolve the issue" the esteemed researcher expresses. John A. Bargh (1955–) by the way is a social psychologist currently working at Yale University, where he formed the Automaticity in Cognition, Motivation, and Evaluation (ACME) Laboratory. Bargh's work focuses on automaticity and unconscious processing as a method to better understand social behavior, as well as on philosophical topics such as free will. Much of Bargh's work investigates whether behaviors thought to be under volitional control may result from automatic interpretations of and reactions to external stimuli, such as words. He stated:

> "The unconscious mind is still viewed by many psychological scientists as the shadow of a 'real' conscious mind, though there now exists substantial evidence that the unconscious is not identifiably less flexible, complex, controlling, deliberative, or action-oriented than is its counterpart The Unconscious Mind." (John A. Bargh, Ezequiel Morsella; *The Unconscious Mind*; journals.sagepub.com)

And thus Pychyl concludes:

> "We're doing (social) science. It is one approach to creating knowledge claims, and some questions are simply outside the lines of our practice. I think we have to be careful to color inside the lines. Our science will not resolve the issue."

Meanwhile, during the years following this amicable exchange, social psychologist Professor Ran Hassin of Jerusalem's Hebrew University was conducting research. His theory was that our unconscious is able to perform the same basic functions that our conscious processes perform (Haaretz, Doron Halutz, 2015). Hassin moved from the New York University, New York, NY (NYU) to the Hebrew University in 2002. This was after having spent the longest postdoc ever at NYU, until he was dragged out of there by four New York City policemen for reasons unknown. He is a member of the university's Psychology Department and the Center for the Study of Rationality. He is also the editor of Oxford University Press's Social Cognition and Social Neuroscience book series.

For the past decade, he focused his research on the human unconscious, and specifically on decision-making, memory, motivation and the formation of opinions. With a grant from the United States–Israel Binational Science Foundation, he partnered with the Federmann Center for the Study of Rationality. He teamed up with Hebrew University graduate student Yaniv Abir, Professor.

Alexander Todorov of Princeton University and Professor Ron Dotsch, formerly of Utrecht University in the Netherlands. In 2018, they published findings on how our minds unconsciously pick out faces in a crowd. In the process, they discovered that dominance and threat top the list of face types the brain will quickly register within a crowd (ISRAEL21c Staff 2018). What did it signify?

Hassin said:

> "This study gives insight into the unconscious processes that shape our consciousness. These processes are dynamic and often based on personal motivation. Hypothetically, if you're looking for a romantic partner, your brain will 'see' people differently than if you're already in a relationship. Unconsciously, your brain will 'prioritize' faces of potential partners and deemphasize other faces. Likewise, the same might be true for other motivations, such as avoiding danger. Your eyes might pick out certain 'menacing' faces from a crowd and avoid them." .

Hassin hopes that these findings can pave the way toward a better understanding of autism, PTSD and other mental disorders. He said: "It might be possible to train and untrain people from perceiving certain facial dimensions as threatening. This could be helpful for those suffering from PTSD or depression. Likewise, we could train people with autism to be more sensitive to social cues." I am sure PTSD experiencers will be invited to participate in such training. After all, it is a free will universe, and what you want to do you can do. As Alistair Crowley said: "The sin which is unpardonable is knowingly and willfully to reject truth, to fear knowledge lest that knowledge pander not to thy prejudices." (Magick: Liber Aba: Book 4). But he also exclaimed: "Do what thy wilt is the whole of the law," which seems to apply to the mental industry complex and its pharmaceutical cohorts. Perhaps Fyodor Dostoevsky was right when he said in *The Brothers Karamazov*:

> "If it were not for Christ's Church, indeed there would be no restraint on the criminal in his evildoing . . . . If anything protects society even in our time, and even reforms the criminal himself and transforms him into a different person, again it is Christ's law alone, which manifests itself in the acknowledgement of one's own conscience."

And you still think that any of those characters can better your PTSD condition, never mind cure or heal it? You still neglect to understand that you are the only one

who can prevent your ship from sinking? You still refuse to see that those purporting to assist you in your misery thrive on your slow demise, as it means profit for them? You still deny the fact that you are their meal-ticket to wealth and the material possessions they crave? You still don't see how they seek worldwide fame in their tight knit community by way of the audacity of their PTSD cure hallucination, for which you are the guinea pigs? You still refuse to understand, after all you have read thus far, that you have to do it all on your own, and that the only help you can count on is found in the unseen, the power atheists acknowledge as non existent?

Unless you do your research and discover that there indeed is "something" beyond your minimal square of vision waiting to help you out of this PTSD quagmire the moment you asked, you may as well pack it in. Thus it may be a fine idea to get going with your bibliotherapy explorations. It could be time to appeal to the universe, your guides, guardians, helpers, teachers and friends for help in gaining insight into the game that is played against you, and see what happens. Nothing ventured, nothing gained.

You have the power. Mind you, Crowley, considered the most evil man who ever lived, understood one thing clearly: "In absence of willpower the most complete collection of virtues and talents is wholly worthless."(brainyquote.com). Add to willpower determination, discipline and persistency and you've got it made. So kicking Self in motion both in mind and in body might be a good idea. To begin with, get a dog, if possible. As Diogenes said: "Apart from dogs, less than a handful of people that I've met are better companions than my thoughts."

As to walking, listen to Søren Kierkegaard:

> " . . . every day I walk myself into a state of well-being and walk away from every illness; I have walked myself into my best thoughts, and I know of no thought so burdensome that one can not walk away from it. Even if one were to walk for one's health and it were constantly one station ahead — I would still say: Walk! Besides, it is also apparent that in walking one constantly gets as close to well-being as possible, even if one does not quite reach it — but by sitting still, and the more one sits still, the closer one comes to feeling ill. Health and salvation can only be found in motion. If anyone denies that motion exists, I do as Diogenes did, I walk. If anyone denies that health resides in motion, then I walk away from all morbid objections. If one just keeps on walking,

everything will be all right." (Letter to Jette, 1847)

So, walking and listening for the silent voice within us, giving us answers, leading us out of the PTSD quagmire, following where our intuition leads us. Keep in mind that Dharma extinguishes Karma and the Bible's Matthew 7:7 asserts: "Ask and it will be given to you; seek and you will find; knock and the door will be opened to you". It very well might be the only way to turn our PTSD ship about to head towards recovery. That's what I did. Therefore, you can, too.

53

Turn The Ship About!

With our awakening to the state of affairs of the mental health industry's PTSD treatments, of course, we can turn our PTSD ship of karmic fate around. It's not too late, even though at this point in time of the experience, it might be a quasi-wrecked, barely afloat contraption. Also, recognition that your post-PTSD-causing-event situation is imposed upon us by the Others (the ones pretending to be experts in the PTSD field, the ones working in and for the mental health industry for their financial gain rather than as healers, the ones persistently maligning the world's Dr. Breggins, Health Rangers and others adhering to the humane and ethical principles of healing), should furthermore light a fire in your soul against the atheist-saturated mental health industry cabal. There is nothing better than kindling this fire in the

soul into a flame, wit Joan Borysenko's 1993 book *Fire in the Soul: A New Psychology of Spiritual Optimism.* It is life-changing.

But how do we get the blast into our souls to fan the spark, the wind in our sails to handle the ship and help ourselves out of this dilemma once we realize that we are the only ones who can do it? By ceasing to take pharmaceutical and hallucinogenic drugs, by cleansing our brain. Being free of those drugs enables us to recognize that by taking them, we ourselves are instrumental in and responsible for our own destruction. Cold turkey is best. Your doctor will protest wildly against it, seeing the financial benefits in ruin, so just go for it without breathing a word. Mind you, the turn-about maneuver is facilitated the moment we ourselves become sick and tired of our own state of mind and body. Once off that poison we are able and ready to contemplate, weigh and balance ways to heal our Self or ways to die, to contemplate our recovery or to plan our death. When the brain is free of pharmaceutical concoctions, seeking life is the sure outcome of this crisis.

Earlier we discussed the Latin and English meaning of "crisis", by and large viewed as a turning point for better or for worse. In the Chinese language, however, the term "crisis" is composed of the characters for "danger" and "opportunity". Why? Because a crisis can be both, a danger of destruction or the opportunity of great achievements and personal growth, depending on the experiencer's outlook on life. The same counts for the PTSD afflicted, for whom the journey is either hugely successful or ends in complete failure, a triumph over the Self or a defeat of the Self by the Self. It is all generated by one choice only, the choice of Dharma over Karma or Karma over Dharma, resulting in triumph or destruction. Which one is it going to be? What to do? Where to turn? Take the helm and turn the ship about! It's the only path to healing. You are wonderful, and you are destroying yourself, in essence all by yourself, unless *you* "get with it." So kick yourself in motion! Instead of listening to the faces you know and the voices you trust, let your Self be the face you know and your inner voice the voice you trust. Let that be your guiding light. It will never betray you. And begin to acquire knowledge, as, as *Imam Ali, Nahj Al-Balagha* (599–661 CE) said:

> "Knowledge is power and it can command obedience. A man of knowledge during his lifetime can make people obey and follow him and he is praised and venerated after his death. Remember that knowledge is a ruler and wealth is its subject."

In that way, you become the ruler of your PTSD affair, freeing yourself from the dependent or victim status. Freeing yourself from pharmaceutical hallucinogenic

drugs in one swift motion should be accomplished within 60 to 70 hours. I earlier gave you the information on how I did it. Then follow it up by using holistic ways to cleanse your vital organs and your brain to repair the damage done. A master-cleanse of lemon, maple syrup and cayenne pepper and lots and lots of water during a week of fasting works wonders, together with drinking lots and lots of pure water. Once that's done, drinking about half your body weight in ounces of water should keep your body running smoothly. Add some magnesium to your diet, and the machine kicks into high efficiency gear for an affordable price, your own willpower, determination, persistency and discipline. If guidance is needed, reading David Goggins' *Can't Hurt Me: Master your mind and defy the odds* may be the book to read (Lioncrest Publishing 2018).

During this cleansing of mind and body, arises almost automatically the desire to acquire knowledge about PTSD in general and one's own situation in particular arises almost automatically. I cannot emphasize enough that pharmaceutical or other drugs strangle such desire. This eagerness and aspiration for an inquisition into your own affairs signals the first step towards a PTSD recovery. You may wish to begin this part of the journey by researching the side-effects of drugs, so lovingly prescribed to you by those you trusted, which you so willingly swallowed.

To gain trust in Self and in our own research and healing capacity, an investigation into the academic credentials and career paths of those to whom we entrusted our power to heal us may be helpful. What qualifies them to judge our state of mind and to treat us? What are their backgrounds in and out of the mental health industry? What qualifications enabled them to rise to prominence in the PTSD field? Who are they as human beings (though, in my experience, it is almost impossible to find answers on their personal lives in general)? How, within a few decades, did they by way of their organizations, the APA et al., manage to distort and pervert PTSD from an existential crisis to a mental disorder? How did they, within the same time span, accomplish to convert PTSD sufferers from highly respected and intelligent human beings into disturbed mentally deranged lunatics in the public eye?

Why are the mental health industry's PTSD assumptions and treatment modalities believed to be beneficial and adhered to without question? How did their DSM-5 mental disorder categories balloon to almost 300 for human beings, most of them concocted with the help of the MMPI, over the past 70 years? Why do those 300 assumed unhealthy human mental dispositions, for which no proof exist, suddenly rule and control humanity's lives worldwide? What enables this cabal to

present themselves as all-knowing, almost god-like? What allows them to assign and dictate drug treatments and therapies without providing proof of efficacy or damage? Why, indeed, are they listened to and believed with neither incredulity nor skepticism arising from anywhere other than Dr. Breggin et al.? Who gives them the liberty, credibility and right to portray themselves as far superior beings in all aspects of human emotions, reasons, affects and actions than those possessed by humans? Who endows them with the right to sit in judgment over humanity, including PTSD journeyers? Who indeed? We do, humanity at large! We have to take responsibility. We give them the power. By diving into a journey of discovery into that alone, our self-esteem rises in tandem with our increasing knowledge and consequent accomplishments the moment we begin to stand up for our Self and acquire this knowledge.

That in turn leads to further investigation, intuition guiding us in direction of inquiries. Why is the mental health industrial complex allowed to destroy humanity at large with their medical and mental health concoctions and treatment theories? Why is this seemingly purposeful destruction not only accepted but encouraged without protest by the medical profession at large? Isn't it clear that they are and demonstrating an almost unfathomable lack of ethics, morals, empathy and compassion towards humanity? Jon Rappaport states in his 2018 article "Exposing psychiatry as a fraud from top to bottom":

> "Promoting diabolically false science, psychiatry creates a gateway for defining many separate states of consciousness that don't exist at all. They're cheap myths, fairy tales." (January 18, 2018 Robert Scott Bell Show; The Underground, Jon Rappaport).

But first and foremost, what happened to us, humanity inhabiting this earth, to regale the industry with such enormous and unprecedented powers and why? Once we acquire that knowledge, we understand what is being played against us. Once we know that, we can haul ourselves out of the PTSD swamp.

Let's begin with perhaps one of the most interesting aspect of this conundrum. What qualification do mental health practitioners of all stripes, ranks, and colors including the bio-neuro-psycho-psychiatric scientists have? How do they qualify for that qualifies them to nowadays have such overwhelming prominence as to be accepted as omnipotent entities, sitting unquestioned in judgment of the human psyche and aiming to change the human mind with brain manipulation? What indeed?

It seems somewhat strange, considering that both Western and Eastern philosophy confirms that humanity's main preoccupation throughout millennia/thousands has been focused on its reasons of life and its circumstances, by and large merely revolving around three topics:

- What is Deeper Reality?
- What does it look like?
- What can be learnt from it?

In comparison, within the last 100 years or less it turned into: "God's design is wrong. Let's fix it. Let's change it altogether." But what has propelled humans into this overt age of artificial or archontic intelligence (AI) and trans-humanism fascinations? There is really nothing new to it. Artificial intelligence is based on the assumption that the process of human thought can be mechanized. The study of mechanical — formal — reasoning has a long history. Mechanical men and artificial beings appear in Greek myths, such as the golden robots of Hephaestus and Pygmalion's Galatea. These ideas were developed over the centuries by philosophers such as Aristotle, Euclid and al-Khwārizmī, who developed algebra and gave his name to "algorithm." Chinese and Indian philosophers developed structured methods of formal deduction in the first millennium BCE. So did European scholastic philosophers such as the English Franciscan friar and scholastic philosopher and theologian William of Ockham (1287–1347). So did Duns Scotus (1266–1308), considered, together with Ockham and the Italian Dominican friar Thomas Aquinas (1225–1274). Catholic priest, doctor of the Church and immensely influential philosopher, theologian and jurist in the tradition of scholasticism, Thomas Aquinas (1225–1274) is said to be one of the three most important philosopher-theologians of Western Europe in the High Middle Ages (1000–1300 AD).

Throughout the Middle Ages (500–1500) there were rumours of secret mystical or alchemical means of placing mind into matter. Noteworthy is Jabir in Hayman (c. 722, 8th or 9th c.), an Islamic thinker to whom is ascribed authorship of a large number of alchemical, practical and philosophical works laying the foundations of modern chemistry (newworldencyclopedia.org). Jabir's alchemical investigations ostensibly revolved around the ultimate goal of *taking* — the artificial creation of life. The *Book of Stones* includes several recipes for creating creatures such as scorpions, snakes and even humans in a laboratory environment, which are subject to the

control of their creator. The deeply religious In Hayman repeatedly emphasized in his works that alchemy is possible only by subjugating oneself completely to the will of Allah. One had to become a literal instrument of Allah on Earth, since the manipulation of reality was possible only for Allah. In that aspect, he seemingly differs from those practicing the art of neuroscience in all its forms today.

Paracelsus, born Theophrastus von Hohenheim (1493–1541) was a Swiss physician, alchemist, and astrologer of the German Renaissance. He was a pioneer in several aspects of the Renaissance' medical revolution. When emphasizing the value of observation in combination with received wisdom, he is credited with the first mention of the *homunculus,* which historically refers to the creation of a miniature, fully formed human being (*De homunculis*(c. 1529–1532), and *De natura rerum* (1537)). By the 19th century, similar theme, were developed in Mary Shelley's Frankenstein and Karel Čapek's 1921 play *R.U.R. (Rossum's Universal Robots)*, which coined the term robot. Written in Prague, Čapek denied that he modeled the robot after the Golem, though there are said to be many similarities in the plot (Koreis, Voyen. Introduction. Two Plays by Karel Capek: R.U.R. (Rossum's Universal Robots) & *The Robber*. Google Books. 25 August 2017). Samuel Butler's "Darwin among the Machines" and stories in popular culture, such as in *The Terminator,* add to the overall AI theme

The most famous golem narrative involves Judah Loew ben Bezalel (1512 and 1526?–1609). The late 16th century rabbi of Prague is also known as the Maharal. He reportedly created a golem out of clay from the banks of the Vltava River and brought it to life through rituals and Hebrew incantations. This was to defend the Prague ghetto from anti-Semitic sentiments during the Polish–Swedish War (1600–11). The war was a continuation of struggle between Sweden and Polish–Lithuanian Commonwealth over control of Livonia and Estonia, as well as the dispute over the Swedish throne between Charles IX of Sweden and Sigismund III of Poland. The Maharal's family, according to Jewish tradition, descended patrilineally from the Babylonian Exilarchs (during the era of the geonim) and therefore also from the Davidic dynasty ("The Maharal of Prague's Descent from King David", by Chaim Freedman, published in *Avotaynu* Vol 22 No 1, Spring 2006). Thus, we deduce the AI operation, as such, began in Babylon.

The word *golem* occurs only once in the Bible in Psalm 139:16, which uses the word גלמי (*golmi*; my golem), that means "my light form", "raw" material, connoting the unfinished human being before God's eyes (Introduction to "The Golem Returns" Archived 2012-10-12 at the Wayback Machine). The Mishnah, an

authoritative collection of exegetical material embodying the oral tradition of Jewish law and forming the first part of the Talmud, uses the term for an uncultivated person: "Seven characteristics are in an uncultivated person, and seven in a learned one," (שבעה דברים בגולם) (Pirkei Avot 5:6 in the Hebrew text; English translations vary). In Modern Hebrew, *golem* is used to mean "dumb" or "helpless". Similarly, it is often used today as a metaphor for a brainless lunk or entity who serves a man under controlled conditions, but is hostile to him under others. "Golem" passed into Yiddish as *goylem* to mean someone who is stupid or lethargic (Bluestein, Gene (1998). *Anglish/Yinglish: Yiddish in American Life and Literature*. U of Nebraska Press).

Several other golems have apparently been created in that time, albeit the existence of a golem sometimes seems to be a mixed blessing. Golems are not intelligent, and if commanded to perform a task, they will perform the instructions literally. In many depictions, Golems are inherently perfectly obedient. In its earliest known modern form, the Golem of Chełm, created by Elijah Ba'al Shem or Eliyahu Ba'al Shem of Chełm (1550–1583), a Polish rabbi serving as Chelm's chief rabbi, became enormous and uncooperative. In one version of this story, the rabbi had to resort to trickery to deactivate it, whereupon it crumbled upon its creator and crushed him (The Golem Returns). The same revolt appears to be the case with founder and CEO of Hanson Robotics. This was David Hanson's creation of Saudi Arabia citizen, Sophia, using artificial intelligence, visual data processing and facial recognition. She recently quipped that humanity's destruction was her aim. Hanson himself admitted that the Terminator scenario could still prevail (Glesni Holland, tahawultech.com), human destruction apparently the name of the game, but who cares. Gotta die sometime anyway.

The only difference between the golem idea originating in Babylonia and today's Sophias is perfection — perhaps. And what better subjects to play with to reach perfect perfection than the perfectly healthy, and usually superbly physically fit, but existential-crisis struggling PTSD affected? It's less labor intensive and much more productive, if they can be persuaded to content.

But let's leave that for another day, as it might it be a good idea to first start with discovering how the Western world's mental health industry rose to such seemingly all-pervasive prominence during the past century. Did it really begin with Helena Petrovna Blavatsky (1831–1891), an obscure Russian occultist emigrant to the USA and Theosophy, asked Jon Rappaport? The word was first coined in the 1640s, meaning "knowledge of divine things obtained through mystic study." It came from

from:

- Medieval Latin “theosophia” (c.880)
- Late Greek theosophia (c.500) “wisdom concerning God or things divine”
- Greek theosophos “one wise about God,” from theos “god” (from PIE root *dhes-, forming words for religious concepts) + sophia “skill, knowledge of, acquaintance with; philosophy,” from sophos “wise, learned” (etymonline.com).

Applied variously over the years, including to the followers of the Swedish Lutheran theologian, scientist, philosopher and mystic Emanual Swedenborg (1688–1772). He was best known for his book on the afterlife, *Heaven and Hell*. Literally meaning “teaching about God and the world based on mystical insight’, theosophists prefer to describe theosophy as “Divine Wisdom,” but it can also be called “esoteric philosophy” or “esoteric science” or “the esoteric doctrine” or “occult philosophy” or “occult science” or “the sacred science” or “the secret doctrine” or “ancient wisdom” or “ageless wisdom theosophy” or “timeless truth”. (theosophywisdom.wordpress.com).

Rappaport wonders if Blavatsky founded Theosophy because she understood that to start a cult was the best way to make money. Or did she do it knowing that it would open doors for otherworldly entities, through séances and ouji boards, to influence the world? Whichever way, Theosophy became one of the most influential philosophical systems of the 19th century, as it drew on both on Asian religions and European philosophies, such as Neoplatonism, for its belief. The latter is a philosophical system that originated in the 3rd century C.E., when the Egyptian, Greek-speaking philosopher Plotinus (c.204–270) held the existence of three principles:

- the One
- the intellect
- the Soul

In the East, where theosophy became prominent in parts of India in particular, it is called the Gupta Vidya, which can be translated as “Secret Knowledge” or “Secret Doctrine.” According to Blavatsky, this hidden body of knowledge is in the safe

keeping of a relatively small number of people who have been called "Masters of the Ancient Wisdom". They are said to be adepts and initiates belonging to a hidden esoteric brotherhood, which guides and watches over the spiritual evolution and advancement of humanity. Some masters belonging to the Trans-Himalayan Brotherhood, based in Tibet, are said to have taught, trained and prepared Blavatsky to go forth into the world to give out as much of that teaching as was permitted. After she settled in New York in 1873, she gained public attention as a spirit medium, and befriended the American military officer, journalist and lawyer, Henry Steel Olcott (1832–1907). Despite accusations of fraudulence, she co-founded the Theosophical Society in 1875. She did this with Olcott and William Quan Judge (1851–1896), a lawyer specializing in commercial law. The Theosophical Society was the first introduction of Eastern spirituality to the Western world.

She seemed to be on the up-and-up, in particular when considering she was born into an obscure aristocratic Russian-German family in Yekaterinoslav, Ukraine, and said to be self-educated with an interest in Western esotericism. She purportedly met the "Masters of the Ancient Wisdom" during world travels in 1849, visiting Europe, the Americas and India. The masters sent her to Shigatse, Tibet's second largest city, to develop a deeper understanding of the synthesis of religion, philosophy and science. Both her contemporary critics and later biographers argued that some or all of these foreign visits were fictitious. Be it as it may, by the early 1870s, Blavatsky was involved in the Spiritualist movement of the day arguing against Spiritualist ideas that entities revealing themselves in séances were spirits of the dead.

In her 1877 book *Isis Unveiled* (1877), she expressed Theosophy's world-view, associating it closely with the esoteric doctrines of Hermeticism and Neoplatonism. She described it as "the synthesis of science, religion and philosophy", asserting it revived an ancient wisdom that underlay all world religions. Hermeticism is a set of philosophical and religious beliefs, based primarily on the writings attributed to Hermes Trismegistus, a syncretic amalgamation of Hermes and Thoth. Both were gods of writing and of magic in their respective cultures (crystalinks.com). Thus, the Greek god of interpretive communication was combined with the Egyptian god of wisdom as a patron of astrology and alchemy. But the two gods remained distinct from one another. Hermetiticm was largely composed from Judaism, Hellenistic philosophy, mythology and classical Egyptian religion. In the latter, the literature combined philosophical and religious theory with various schools of practical magic popular at the time, including:

- the stereotypical Egyptian concerns with conjuring spirits and animating statues
- the Hellenistic writings of Greco-Babylonian astrology
- the newly developed practice of alchemy.

In a parallel tradition, Hermetic philosophy rationalized and systematized cultic practices and offered the adept a method of personal ascension from the constraints of physical being.

The resulting composite tradition proved to be both persuasive and perdurable. It proved compelling to both Muslim and European scholars in the early Middle Ages and the dawn of the Renaissance. In particular, the notion that the universe operated based on orderly principles represented as cosmic vibrations in the substance of the All was instrumental to western occultism, as well as to the development of modern scientific methods. This connection can be most clearly seen in hermetical and alchemical treatises written by some of the most influential thinkers of the era, including Giordano Bruno, John Dee, Francis Bacon and Isaac Newton (newworldencyclopedia.org).

As to Blavatsky and Olcott, they moved to India in 1880 for reasons unknown, spread Theosophy and converted to Buddhism. When problems arose in 1885 after Blavatsky was accused of producing fraudulent paranormal phenomena, however, she went to Britain. Nevertheless, the Theosophical Society's Indian Section was chartered in 1890, effective from January 1, 1891. It was incorporated in Varanasi, formerly known as Benares under the laws of British India in 1903 (theosophy-india.org). Headquartered at Adyar, Madras, India, since 1905, its objective nowadays is to carry out within its jurisdiction:

- to encourage the study of comparative religion, philosophy, and science
- to investigate the unexplained laws of nature and the powers latent in man
- to form a nucleus of the universal brotherhood of humanity without distinction of race, creed, sex, caste or color

Meanwhile, Theosophy's London, England, lodge had been founded in 1878 by the British barrister, Christian mystic and psychical researcher Charles Carleton Massey (1838–1905). It went under the name British Theosophical Society of the

Arya Samaj of Aryavart. It was followed by the Loge Germania in Hamburg, Germany, in 1884 Then came the Blavatsky Lodge of the Theosophical Society, also in London, in1887.

Before its foundation, members of the London Lodge invited Blavatsky to London, where she arrived from Holland to stay until her death in 1891. Every Thursday Blavatsky showed up at the Lodge for discussions on her book *The Secret Doctrine, the Synthesis of Science, Religion and Philosophy.* It was originally published in 1888 as two volumes, *Cosmogenesis* and *Anthropogenesis*. Not only were they influential examples of the revival of interest in esoteric and occult ideas during that age. They also claimed to be reconciling ancient Eastern wisdom with modern science (Wikipedia). The author asserted that mahatmas with knowledge of humanity's spiritual history, which now could be revealed in part, had revealed the contents to her. Please note that in Indian parlance a *Mahatma* is someone held in the highest esteem for wisdom and saintliness. However, in Theosophy, a *mahatma* is viewed as a great sage who renounced further spiritual development in order to aid those less advanced (dictionary.com). Indian lawyer, politician, social activist and writer Mohandas Karamchand Gandhi (1869–1948) was better known as Mahatma Gandhi. He became the leader of the nationalist movement against the British rule of India, In his acquired name, "Mahatma" means «great soul», derived from the Sanskrit महा (maha), or "great", and आत्मन् (atman) "soul, spirit, life". He visited Blavatsky at the Lodge in 1889. Today it is part of the Theosophical Society Adyar English section.

Blavatsky authored two more books shortly before her death, *The Key to Theosophy* and *The Voice of the Silence*. Blavatsky Lodge members were also involved in the publication of the *Lucifer* magazine. By that time, supporters championed her as an enlightened guru, and opponents derided her as fraudulent charlatan and plagiarist. Her Theosophical doctrines, however, encouraged the spread of Hindu and Buddhist ideas as well as the development of esoteric currents in the West. One such current was Ariosophy, meaning wisdom concerning the Aryans. It was an ideological system of an esoteric nature, pioneered in Austria between 1890 and 1930. Another current was Anthrosophy, which strives to bridge the clefts between science, art and men's religious strivings, viewed as the three main areas of human culture. It also aimed at building the foundation for synthesis between them and the New Age movement. "New age" is a term applied to a range of spiritual or religious beliefs and practices developed in Western nations during the 1970s The goal seems to have been achieved.

Religious scholars, in general, categorize Theosophy as part of occultist currents of Western mystery traditions and Western esotericism. These are rather generic terms, under which a wide range of loosely related ideas and movements developed through time within Western society are categorized. These currents seem to be largely united by the fact that they are distinct both from orthodox Judeo-Christian religion and from enlightenment rationalism. Esotericism is about secret knowledge. It involves the study of gnosticism, yoga, alchemy, magic, spiritualism, hypnosis, astrology, meditation, mysticism, and occultism. It involves the knowledge of symbols and the hidden meanings contained in manuscripts, books and clay tablets of religious, philosophical and historical nature. It has pervaded various forms of Western philosophy, religion, pseudoscience, art, literature, and music and continues to affect intellectual ideas and popular culture including the New Age movement. Generally, it is accessible only to members of secret societies. Followers of the Abrahamic faiths, such as Christianity and Islam, often view it as black magic.

Up to you, David: The Abrahamic religions, also referred to as Abrahamism, are a group of Semitic-originated religious communities of faith claiming to descent from the Judaism of the ancient Israelites and the worship of the God of Abraham. Abrahamic religions in chronological order of founding are Judaism in the 7th century BCE, Christianity in the 1st century CE and Islam in the 7th century CE.

They spread globally through Christianity, adopted by Roman emperor Konstantin the Great in the 4th century and by Mohammed in the 7th century. Abrahamic religions now-a-days are one of the major divisions in comparative religion, along with Indian, Iranian and East Asian religions.

Christianity, Islam and Judaism are the Abrahamic religions with the greatest numbers of adherents. Abrahamic religions with fewer adherents include the faiths descended from Yazdânism (the Yezidi, Yarsani faiths), Samaritanism, the Druze faith (often classified as a branch of Isma'ili Shia Islam), Bábism, the Bahá'í Faith and Rastafari. As of 2005, estimates classified 54% (3.6 billion people) of the world's population as adherents of an Abrahamic religion.

What does all this have to do with psychotherapy, you wonder? Patience. It all ties in together. I promise. Blavatsky's ideas and teachings hold that the ancient and secretive brotherhood of spiritual adepts, the Ascended Masters, transmitted knowledge, wisdom and supernatural powers through her. This was an attempt to revive knowledge of an ancient religion once found worldwide and have it eclipse existing world religions. Jiddu Krishnamurti, born a Brahmin near Madras, India,

in 1895 was educated in Theosophy by the British social reformer Annie Besant. She who proclaimed him the coming messianic "World Teacher" who would bring about world enlightenment (britannica.com). He broke with the Theosophical Society, by now an international religious organization run by Besant, in 1929. At that time, he renounced any claims to being the World Teacher. He spent the rest of his life speaking around the world about the importance of leading a spiritual life based on awareness, inquiry and freedom of religion, in an attempt to free humanity from its delusions, its perception-deception. At his life's end, he observed:

> "Extrasensory perception, clairvoyance, occult powers, cannot free thought from confusion and misery; sensitive awareness of our thoughts and motives, from which spring our speech and action, is the beginning of lasting understanding and love. Mere self-control, discipline, self-punishment, or renunciation, cannot liberate thought; but constant awareness and pliability give clarity and strength. Only in becoming aware of the cause of ignorance, in understanding the process of craving and its dual opposing values, is there freedom from suffering. This discerning awareness must begin in our life of relationship with things, people, and ideas, with our own hidden thoughts and daily action."(allconsidering.com).

In America, the Theosophical Society, headquartered since 1927 in Wheaton, Illinois, has about 90 local groups in the United States and members in some 70 countries of the world. Anybody can join for an annual fee, if willing to adhere to the society's Three Objects:

- to form a nucleus of the universal brotherhood of humanity, without distinction of race, creed, sex, caste or color
- to encourage the comparative study of religion, philosophy and science
- to investigate unexplained laws of nature and the powers latent in humanity

Theosophy teaches that the purpose of human life is spiritual emancipation, and that human souls undergo reincarnation upon bodily death, in accordance with karma. It promotes values of universal brotherhood and social improvement. It

allows complete freedom of individual search and belief, while promoting in its members a willingness to examine any concept and belief with an open mind and a respect for other people's understanding (theosophical.org). It also maintains the right of individual freedom of thought for every member. One is allowed to maintain the teachings of one's own faith, and no particular ethical codes of conduct are imposed upon its adherent either. As of 2008, the membership comprised about 4000 people.

Worldwide, some rather famous people were part of the Theosophical Society throughout its existence. Among them were writers, politicians, actors, musicians, architects, scientists, inventors, psychologists, painters and other artists. First and foremost was reformer and secularist, famous orator, socialist and temporary Marxist Annie Besant (1847–1933). She became the Society's second president and also president of the Indian National Congress (1829–1912), a broadly based political party, founded in 1885 fighting for India's independence.

Besant also helped to enlarge the membership of Universal Co-Freemasonry (katinkahesselink.net). Composed of both men and women, the Freemasons, fraternally united people without distinction of race, religion, creed or sexual orientation. The Honorable Order of Universal Co-Masonry has established a system of workings that is both ceremonial and symbolic. It allows its members to erect a Mystic Temple to The Great Architect of the Universe and to the Perfection of Humanity (universalfreemasonry.org). That to some, the Great Architect of the Universe is Satan or Lucifer incarnate, is another topic altogether outside the scope of this book, but ample information exists.

I wanted to share with you all the famous names associated with Theosophy, but I found myself writing for pages. So I stopped, and I will share with you just these best-known people:

- Alfred Deakin (1858–1919), Prime Minister framer of the Australian Federation
- Hernández Martínez, President of El Salvador (1882–1966)
- *Maria Montessori (1870-1952),* educator and founder of the Montessori Method
- Black & Decker tool company co-founder *Alonzo Galloway Decker* (1884–1956)
- *Thomas Edison* (1847–1931), inventor of the electric light bulb and the phonograph

- Writers James Joyce, D. H. Lawrence, T. S. Eliot, Henry Miller, John Boyton Priestley, Thornton Wilder and Kurt Vonnegut
- *Gustav Mahler,* symphonic composer (1860–1911)
- *Elvis Presley*, American rock and roll musician (1935–1977)
- *Shirley MacLaine,* American film actress (1934–)
- French post impressionist painter (and pedophile) Paul Gauguin (1848–1903)
- Canadian "Group of Seven" painter Lawren Harris (1885–1970).

India's first Prime Minister from 1947 to 1964, Jawaharlal Nehru (1889–1964) was as an adolescent tutored by theosophist Ferdinand T. Brooks, whom Nehru acknowledged in his autobiography saying: "F.T. Brooks left a deep impress upon me and I feel that I owe a debt to him and to Theosophy " (Theosophical History Vol. VII, Issue 3, July 1998). Gandhi, framer of *satyagraha*, the policy of passive political resistance yet to be discovered by the US populace, certainly knew Besant, in his autobiography describing his early acquaintance with Theosophy and London's Theosophical Society.

The only name associated with Theosophy working in the mental health industry, though, is the Italian psychiatrist, humanist and visionary *Roberto Assagioli* (1888–1974). His work in the field of psychology concentrated on a spiritual and holistic approach he developed from psychoanalysis. He was largely inspired by Freud's idea of the repressed mind and Jung's theories of the collective unconscious. But he was unsatisfied by what he regarded as psychoanalysis' incompleteness. Assagioli felt that love, wisdom, creativity and willpower were important components that should be included in the psychoanalytical process. (Firman, John; Gila, Ann (2002). "Introduction". *Psychosynthesis — a psychology of the spirit*. SUNY Press pp. 1–3).

Not everybody fell in love with Theosophy. *The naturalist Alfred Russel Wallace,* who developed a theory of natural selection independent of Darwin, said about Theosophy*:*

> *"I have tried several Reincarnation and Theosophical books, but cannot read them or take any interest in them. They are so purely imaginative and do not seem to me rational. Many people are captivated by it. I think most people who like a grand, strange, complex theory of man and nature, given with authority — people who if religious would be Roman Catholics*." (William Brock,

William Crookes (1832-1919) and the Commercialization of Science, 2008 originally in Marchant's 1916 biography of Wallace).

A branch of Theosophy is "I AM". *Guy Warren Ballard* (1878–1939), an American mining engineer, and his wife Edna Anne Wheeler Ballard were long-time members. After extensively studying Theosophy and the occult in the early 1930, they founded the Ascended Masters Teachings religious movement in Chicago, Illinois, known as "I AM". This was a reference to the ancient Sanskrit mantra "So Ham" meaning "I Am that I Am". An offshoot of Theosophy, it was a major precursor of several New Age religions including the Church Universal and Triumphant. This term was first used by Mary Baker Eddy (1821–1910) who established the Church of Christ, Scientist as a Christian denomination and worldwide movement of spiritual healers. It was Alice A. Bailey of Lucifer Trust that prophesied in 1919 that the New Age religion would appear by the end of the 20th century and be called "The Church Universal". However Bailey's phrase was "Church Universal" in her "A Treatise on White Magic" indicating that her "Church Universal" was not a church or conventional organization at all but a subjectivity or mystical entity. She says:

> "It is that inner group of lovers of God, the intellectual mystics, the knowers of reality who belong to no one religion or organization, but who regard themselves as members of the Church universal and as members one of another" (p. 152).

Ascended Masters are believed to be humans who lived a succession of reincarnations in physical bodies. Over time, they became highly advanced souls, able to move beyond the cycles of "re-embodiment" and karma and, as such, became immortal and attained "Ascension". Per Blavatsky, the Ascended Masters communicate with humanity through trained messengers. Jesus is believed to be one of them, making the "Christ Light" available to seekers wishing to move out of darkness. Therefore, many "I AM" members consider it to be a Christian religion (*Hadden, Jeffrey K. "'I AM' Religious Activity" Religious Movements Homepage at the University of Virginia, 2007).* Ballard himself said he was the re-embodiment of George Washington, an Egyptian priest and a noted French musician (*Thompkins, Joshua: "The mighty I Am: Cult led by Guy Ballard". Los Angeles Magazine*, 1997). In 1938, the movement had up to a million followers and is still active today on a smaller scale. Its parent organization is the Saint Germain Foundation, with its worldwide headquarters located in Schaumburg, Illinois. According to its website, there are approximately 300 groups worldwide under a variations of names such as "I AM"

Sanctuary or "I AM" Temple. Its stated purpose? Spiritual, educational and practical. No admission fee is charged for any of their activities.

Theosophy's membership worldwide in 2007 hovered around 30,000, but most names are unavailable. One could surmise, however, that it is equally as impressive and high-powered to change humanity's perceptions of the world and everyone in it as the one above. As to Blavatsky, she is considered one of the 19th century most extraordinary and controversial figures, a view reflected in the following statements:

> " . . . Madame Blavatsky . . . stands out as the fountainhead of modern occult thought, and was either the originator and/or populariser of many of the ideas and terms which have a century later been assembled within the New Age Movement. The Theosophical Society, which she cofounded, has been the major advocate of occult philosophy in the West and the single most important avenue of Eastern teaching to the West." (J. Gordon Melton, Jerome Clark and Aidan A. Kelly, editors, *New Age Almanac*, Detroit, Michigan, Gale Research Inc., 1991, p. 16).
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> "The importance of Theosophy in modern history should not be underestimated. Not only have the writings of Blavatsky and others inspired several generations of occultists, but the movement had a remarkable role in the restoration to the colonial peoples of nineteenth century Asia their own spiritual heritage." (Robert S. Ellwood and Harry B. Partin, *Religious and Spiritual Groups in Modern America*, Englewood Cliffs, New Jersey, Prentice Hall, 1988, pp. 63, 79–80).
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> " . . . Blavatsky . . . is surely among the most original and perceptive minds of her time . . . Buried in the sprawling bulk of her two major books . . . there lies, in rudimentary form, the first philosophy of psychic and spiritual evolution to appear in the modern West . . . Above all, she is among the modern world's trailblazing psychologists of the visionary mind. At the same historical moment that Freud, Pavlov, and James had begun to formulate the secularized and materialist theory of mind that has so far dominated modern Western thought, HPB and her fellow Theosophists were rescuing from occult tradition and exotic religion a forgotten

> psychology of the superconscious and the extrasensory." (Theodore Roszak, *The Unfinished Animal: The Aquarian Frontier and the Evolution of Consciousness*, New York, Harper and Row, 1975, pp. 118, 124–125 (blavatskyarchives.com).

Quite a reputation, indeed. Even today, she is remembered almost annually by way of the Society's Blavatsky Lectures, delivered by some of the best speakers in the Theosophical world. Edward Lewis Gardner (1869–1969), a noted writer and lecturer from the society's English Section in the first lecture of May 1918, entitled "Matter is the Shadow of Sprit", proclaimed that:

> "The lore and teaching contained in the writings of Mme. Blavatsky should be continually studied, discussed and interpreted; in the first place because of the vast treasures which they hold for the student of occultism, and in the second place because of the scientific theories they contain. These theories were derided when Mme. Blavatsky first enunciated them; but every advance that science makes is an advance towards admission of their truth; and it is of first importance that they should be as widely promulgated and as competently expounded as possible, so that as fresh discoveries substantiate them the profound knowledge by which they were inspired and the value of the methods by which they were obtained may be recognized."

The idea for such lectures emanated from Daniel Nicol Dunlop, a Scottish entrepreneur and Theosophist, who later joined Rudolf Steiner's Anthroposophical Society in 1918. He held important posts in the British Electrical and Allied Manufacturers' Association (B.E.A.M.A.). He also organized and was first chairman of the World Energy Conferences, which started in Wembley, London, in 1924. Their goal was to bring together scientists, engineers, politicians and others to consider how energy could be best used within the context of the new internationalism following World War I. An executive committee of 23 members each represented the electrical industry of a country, including Germany. They considered interconnectivity, pricing, duties, regulations and technical issues, and they now function under the name of World Energy Council.

He must have joined the Theosophical Society early in life as he edited *The Irish Theosophist* in Dublin, Ireland, from 1892 to 1897. He also edited a Theosophical periodical called *The Path*, different from the New York journal of the same name,

from 1910–1914, in London. In 1918, he proposed the idea of an annual Blavatsky Lecture series, which the Executive Committee of the Theosophical Society in England accepted. Dunlop himself in 1920 gave the third lecture on the topic *"Nature Spirits and the Spirits of the Elements".*

Michael Gomes was a long-time Theosophy student and editor of *Theosophy in the Nineteenth Century: An Annotated Bibliography.* He was also author of *The Dawning of the Theosophical Movement and* contributor to the *Dictionary of Gnosis & Western Esotericism*. He is currently head librarian at the Emily Sellon Memorial Library in New York City. He gave a 2017 lecture, entitled "A Multitudinous Universe: The Blavatsky Lecture at 100." Gomes acquired his expertise in researching through archival material while an assistant to the late Charles James, who represented 23 museums across the United States (questbooks.com).

It started as being in league with "the modern world's trailblazing psychologists of the visionary mind". But it evolved into another non profit 501 (c) 3 charitable organization. O it brought all its associated perks for the leaders and tax deductible donations for its members and whoever else wants to sponsor. The Kern Foundation (KF) is a major contributor to the Theosophical Society in America and founder of its endowment, the Theosophical Investment Trust. It was established in 1959 by Herbert A. Kern, Sr., who created Generac Power Systems, one of the world's largest independent manufacturers of complete engine-driven generator systems KF's basic objective is "to aid the spiritual enlightenment of as many people as practical by exposing them to the theosophical philosophy." KF encourages, but never dictates, recipient organizations' policy. The Society's board of directors, however, are most likely drawing their usual roughly US$70,000.00 minimum fee for their voluntary duties. Meanwhile, donors are encouraged to choose The Theosophical Society of America as their charitable organization through AmazonSmile! Amazon will donate 0.5% of the price of eligible AmazonSmile purchases when shopping at smile.amazon.com. All one has to do is simply bookmark theosophical.org/donate when shopping on Amazon!

Rappaport contends that, with the rise of Theosophy began the rise of séances and ouji board explorations, talking with the dead, and the calling in of demons and Jins (*Rappaport, Jon: The Secret Behind Secret Societies: Liberation of the Planet in the 21st Century; Truth Seeker Co. Inc. 1998)*. From revelations and insights purportedly glanced and revealed in these sessions, psychic predictions were made. Thus the nascent field of psychology emerged tailored and molded by session-participants' seeking answers to their own life problems, interests, desires and needs by way of

séances and ouji board sessions. That was the start of the modern world's trailblazing psychologists of the visionary mind. It turned into and became defined as "the scientific study of human behavior and mental processes". It is nowadays represented by mental health practitioners flogging their trade, the so-called PTSD experts among them. That philosophical interest in humanity's mind and behavior dates back to ancient Sumer, Babylon, Egypt, Persia, Greece, China and India is, of course, graciously omitted and ignored by those in the know. And what happened to the Ascended Masters of yore's revival of an ancient wisdom underlying all world religions, which would dominate the world? Well, could it be that psychology is the new religion, the all-ruling "synthesis of science, religion and philosophy" described by Theosophy's Lucis Trust?

Has the mental health industry, this concoction of science, individual religion, quasi religion, belief structures and philosophy achieved its aim? Is it ruling vast numbers of humanity worldwide due to drug prescription and treatment methodologies concocted out of science, religion and philosophy? Did they achieve their power because peoples' perception nowadays are warped beyond comprehension due to drug use, psychotherapy and EMF pollution? Are neuropsychiatry, genetic brain manipulation, Visual Reality and electroshock benign therapies, purportedly intended "to vitalise the ideals of a new civilisation", instead destroying humanity as we know it?" Did this era of perversion start with Theosophy?

Its beliefs and principles are no longer contained within secret societies populated with select occultists. Nowadays, it is out in the open, its occult teachings promoted as a unifying global spirituality by UN leaders, globalist educators and the U.S. educational establishment at both state and national levels (crossroad.to/Quotes/occult/theosophy.htm). Who of those leaders know that these teachings are based on occult messages received by Theosophy's channeling mediums, such as Alice Bailey (1880–1949)? She is said to have channeled a Tibetan Master of Wisdom spirit guide named Djwhal Khul (DK) and other ascended masters within the theosophical "angelic" hierarchy is unknown? Bailey, who wrote about 24 books on theosophical subjects and one of the first to use the term "New Age", consented that most of her work had been telepathically transmitted by Djwal Khul. His ideas concurred with her visions of a unified world society, a global "spirit of religion" different from traditional religious forms, well-suited to the Age of Aquarius concept. Well, with the Pope's decree of February 10, 2019, that Islam and the Roman Catholic Church is now one item called the Universal Church, Bailey

seems right on.

The "Age of Aquarius" is an astrological term denoting either the current or forthcoming astrological age, depending on the method of calculation. Astrologers maintain that an astrological age is a product of the earth's slow precessional rotation and lasts for 2,160 years, on average (26,000-year period of precession ÷ 12 zodiac signs = 2,160 years). Astrologers do not agree on when the Aquarian age will start or even if it has already started. British astrologer and historian of astrology and cultural astronomy Nicholas Campion (1953), is author of a number of books. He is senior lecturer in the School of Archaeology, History and Anthropology, and director of the Sophia Centre for the Study of Cosmology in Culture. He is also course director of the MA in Cultural Astronomy and Astrology at the University of Wales Trinity Saint David. His *The Book of World Horoscopes* lists various references from mainly astrological sources for the start of the Age of Aquarius. Based on Campion's research, most published materials on the subject state that the Age of Aquarius arrived in the 20th century (29 claims), with the 24th century in second place with twelve claimants (Nicholas Campion, *The Book of World Horoscopes*, The Wessex Astrologer Ltd., 1999, Pgs 489–495).

As to Mrs. Bailey's theosophical inclination and aspirations, the Theosophical Society proclaims she became involved with them in 1917. Shortly thereafter in 1922, together with her husband Foster, she founded the Lucifer Publishing Company, a non-profit service organization incorporated in the United States. In 1925 it was changed to "Lucis Trust", which on its website surmises that the Baileys were:

> " . . . like the great teacher H.P. Blavatsky, for whom they had enormous respect, sought to elicit a deeper understanding of the sacrifice made by Lucifer. Alice and Foster Bailey were serious students and teachers of Theosophy, a spiritual tradition which views Lucifer as one of the solar Angels, those advanced Beings Who Theosophy says descended (thus "the fall") from Venus to our planet eons ago to bring the principle of mind to what was then animal-man. In the theosophical perspective, the descent of these solar Angels was not a fall into sin or disgrace but rather an act of great sacrifice, as is suggested in the name "Lucifer" which means *light-bearer*." (lucistrust.org)

Mind you, the name Lucifer Publishing Company was not that exceptional, as

The Theosophical Society's magazine was also called Lucifer. Lucis Trust today is headquartered in three places at once, whilst looking for the inauguration of a New World: New York City, London, and Geneva. On its their website, it says: "Using the principle of 'energy follows thought' to vitalise the ideals of a new civilisation" as "The new world is built through creative responses to the fundamental challenges facing humanity."

Could one surmise that Lucis Trust's "the energy follows thought to vitalise the ideals of a new civilization built through creative responses" doctrine can be brought to fruition faster by perverting the human mind with pharmaceutical drugs and psychotherapy bordering on rape? And who says that Lucis Trust's doctrine talks of humanity when talking about this New World? Perhaps the fundamental challenge facing humanity at present is to awaken to the priesthood of psychology et al.'s shenanigans, seemingly geared to destroying humanity rather than helping create a Golden Age? Perhaps an inquiry into our selves to rediscover the ways and paths of God, our creator, might bring forth such awakening? Decide what are the principles of a true, just and blessed life? Perhaps then we can learn how to create justice and peace for all, as forecast in books of the ancient (E. Johnson: The Golden Age; biblehub.com. Micah 4:4; cf. Psalm 46:9; Hosea 2:20; Zechariah 9:10). What are the principles of a true, just and blessed life?

Or is the way to this theosophical-inspired New World accomplished by shattering humans' self-perception through pharmaceutical drug administration? Never mind how video games, smart phones, smart meters, smart everything technology combined with incessant chem-trail spraying, GM foods and so on and so forth, could be the avenue "to vitalize the ideals of a new civilization". Is the perpetual subliminal brain-washing throughout the world, never more brilliantly displayed than in the John Carpenter movie "They Live", part of Lucis Trust's purported Theosophical new civilization vitalization? Is implanting thoughts and ideas into humanity, until we are sick to the core, warped beyond description, imperfect since the moment of conception, meant to help create this New World for humanity by way of the "energy follows thought"? Is it therefore that the psychological and psychiatric professions created 297 mental illnesses or disorders, mirrored in the DSM-5? Is it for the creation of this new civilisation, the new world built, through creative responses to the fundamental challenges facing humanity? Or is it a death cult?

Why else is it systematically drummed into humans that without physicians we are lost puppies who cannot function properly.? After all, "Doctor knows best?" Do

we, in the treatment afforded genuine PTSD experiencers, see an iota of intention or aim to heighten our shaky self-confidence – our trust in Self. Is this how we can assist in Lucis Trust's agenda to create this New Civilization, this New splendid World, when thousands of PTSD journeyers' linger on US and Canadian streets or in asylums? Is it perhaps time to ask if this raping of the human mind by all means possible originated with Blavatsky who rescued "from occult tradition and exotic religion a forgotten psychology of the super-conscious and the extrasensory?"

Are those keeping us in PTSD bondage, the priests of this forgotten psychology, aware that if we were allowed to contemplate our predicament in peace and quiet, without psychological and pharmacotherapies concoction interference, aware of what would happen? We would learn to be infinite consciousness, having an earthly experience, rather than sick humans looking to mental health practitioners as our saviors? Is that their motivation for keeping us in perpetual states of anger and aggression, fight or flight mode? Is it that they know that if we did awaken to who we are, infinite consciousness having an experience equal to those Ascended Masters Blavatsky brags about, we would rapidly spread the word and their system (Latin for "sewer") would collapse? So really, who are the sick of mind? Are they the academically schooled in the purported ways of human emotional functioning? Or are they those emotionally injured in the school of living life, talking from personal experiences, and having lived successfully through them?

But never mind. Slipped into a tangent – again. Sorry! What again are the terms these academically educated use for their hallucinations of humans' purported psychological irregularities, mental disturbances and deep-seated and intractable personality disorders. How do they call these conditions most often arising from natural, human, humane, emotional upheavals or physical blows to the head, or both? Neurosis and psychosis. So let's investigate, and bring further clarity to the scam of our PTSD ailment termed by them in their infinite ignorance a "conundrum".

54

Neurosis & Psychosis; Consciousness, Subconsciousness & Superconsciousness

The term "neurosis" was coined by the Scottish physician, chemist and agriculturalist William Cullen (1710–1790). It is composed from the Greek "*neuron*" (nerve) with the suffix *"osis"*. It is used to define a diseased or abnormal condition of the human nervous system. He was a well-known figure in academia and a central figure in 18th century Scottish Enlightenment. During his lifetime, Cullen served as president of the Royal College of Physicians and Surgeons of Glasgow, president of the Royal College of Physicians of Edinburgh and first physician to the Scottish king. He also held Britain's first independent lectureship in chemistry and was

elected president of the Faculty of Physicians and Surgeons of Glasgow. While in Glasgow, Cullen invented the basis for modern refrigeration, although he is not credited with a usable application. He also held a professorship of chemistry and medicine at the University of Edinburgh, at that time a leading center of medical education in the English-speaking world, and wrote renowned medical textbooks. A bright and busy man, indeed.

However, Cullen's development of the theory of neurosis, which he felt explained some of the ailments that had no physiological basis, was his primary contribution to the field of psychiatry. He first used it in 1777, stating: "I propose to comprehend, under the title of neurosis, all those preternatural affections of sense and motion which are without pyrexia [fever], as part of the primary disease" (Weiner and Simpson, 1991, Vol. 1, p. 1917). For neurosis thus signified a disorder caused by a general affection of various physiologically unexplainable nervous disorders and symptoms referring to "disorders of sense and motion" caused by a "general affection of the nervous system." Cullen, in general, used the term to describe various nervous disorders and symptoms that could not be explained physiologically. He also thought insanity, mania, and melancholy to be disorders of the brain stating:

> "I believe that physicians are generally disposed to suspect organic lesions of the brain to exist in almost every case of insanity. This, however, is probably a mistake: for we know that there have been many instances of insanity from which the persons have entirely recovered; and it is difficult to suppose that any organic lesions of the brain had in such case taken place. Such transitory cases, indeed, render it probable, that a state of excitement, changeable by various causes, had been the cause of such instances of insanity (https://neuroportraits.eu/portrait/william-cullen.html)."

Thus, Cullen was aware that people did recover from bouts of insanity and that caution was required in making such connection. His theory remained commonplace in psychiatric treatment until the 1980 DSM-III publication put a stop to it. Any recovery from temporary insanity or a neurosis was seemingly undesirable. Thus, its diagnoses were replaced by a variety of purportedly modern conditions resulting in anxiety disorders, all 297 of which can be perused in the DSM-5.

Of course, we could ask ourselves what the term "insanity" encompasses. Just as

"normalcy", it remains vigorously debated. As Nietzsche once wrote: "In individuals, insanity is rare; but in groups, parties, nations, and epochs, it is the rule." The official definition varies, but let's take a look. Deriving from the Latin "*insanu"* (mad, insane, of unsound mind; outrageous, excessive, extravagant), from "*in-"* (not), its usage apparently dates back to the 1550s, when it was applied to persons considered "mentally damaged." The noun "insane person" is attested to from 1786 onwards. In reference to individual actions deemed "irrational, evidencing madness," it first appears in English in the early 1840s. Insanity as a notion of sickness is comparable to lunatic and the Italian "*pazzo"* (insane) originally a euphemism of the Latin "*patiens"* (suffering).

"German *verrückt*, literally past participle of *verrücken* 'to displace', applied to the brain as to a clock that is 'out of order'" (etymonline.com). Insanity also indicates folly, foolishness, foolhardiness, idiocy, stupidity, imbecility, asininity, lunacy, madness, silliness, senselessness, brainlessness, thoughtlessness, irrationality, illogicality, absurdity, ludicrousness, ridiculousness and daftness. In other words, what may be viewed as insanity in action and behaviour for one, may be perfectly sane for another. It is merely a question of personal perception or deception. It thus presents enormous danger for PTSD journeyers when engaged with mental health cabal hive minds. Without a doubt, the insane are treating the sane-but-temporarily-out-of-order PTSD affected. But let's move on.

Sigismund Schlomo Freud (1856–1939), the Austrian neurologist and psychiatrist often referred to as "the father of psychoanalysis," took up the neurosis baton and ran with it. Best known for his theories on the unconscious mind, he hypothesized that it acted as a repository, a "cauldron" of primitive wishes and impulses kept at bay and mediated by the mind's preconscious area (McLeod, S. A. *Unconscious mind*. simplypsychology.org 2009, updated 2015). The preconscious? Freud believed that the mind could be divided up in a spatial manner. He chose to call its sectors conscious, preconscious and unconscious, with the preconscious located in between the unconscious and the conscious. Describing the unconscious section as a big room extremely full with thoughts randomly milling about, he thought of the conscious more as a reception area, a small room with fewer thoughts. The preconscious functioned as the guard between the two spaces, which would let only some thoughts pass into the conscious area of thoughts. In psychological jargon, ideas stuck in the unconscious are called *repressed* as in *not seen* by any conscious level. The preconscious, it is hypothesized, allows the transition from repression to conscious thought (Gillian Fournier: Preconscious;

psychcentral.com).

Freud also believed events and desires too frightening or painful for his patients to acknowledge were through the process of repression locked away in the unconscious mind (Freud 1915). He also believed humans' biologically-based instincts of eros (libido) and thanatos (death drive) and what he called primitive urges for sex and aggression dwelled in the unconscious mind (Freud, 1915). Throughout his life he furthermore advocated that a class of human drives and life instincts were responsible for much of human behaviour. His essay *Beyond the Pleasure Principal* (German: *Jenseits des Lustprinzips*) published in 1929, however, marked a major turning point in his theoretical approach to the human psyche. Previously attributing most human behaviours to the sexual instinct (eros or libido), in this essay he added to his theory of drives that of the death drive(s) (*Todestrieb[e]*) often referred to as "thanatos." Why? In his view all human instincts fell into two major classes: life instincts or death instincts. Portraying humans as struggling between these two opposing drives he maintained that eros produced creativity, harmony, sexual connection, reproduction, and self-preservation, whereas T]thanatos brought destruction, repetition, aggression, compulsion and self-destruction.

Furthermore, he argued that humans' primitive urges often did not reach our consciousness because those urges were unacceptable to our rational conscious self. It is here, he opined, that people developed a range of defence mechanism, such as repression, to avoid acknowledg their unconscious motives and feelings. In another assumption, he asserts that our unconscious mind governs our behaviour much more than we suspect. Therefore, he pronounced, psychoanalysis' essential goal was to make the unconscious conscious by weakening patients' defence mechanisms. But, he said, the unconscious also reveals itself in a variety of other ways, including in dreams and slips of the tongue. As example of such a Freudian slip, he used an incident occurring in 1929 when a British Member of Parliament referred to a colleague as 'the honourable member from Hell' instead of Hull. Mind you, the unconscious also reveals itself in reversed speech analysis as done by the Australian world expert in the field, David Oates. For example, former American President Barack Obama's favourite expression during his election campaign "Yes we can," played backwards annunciating "Thank You Satan" attests to it, as it is Obama's unconscious expressing its innermost self; or so at least it is believed.

Psychology nowadays seems sceptical regarding the idea of human mental processes operating at an unconscious level. And for those psychologists determined

to be viewed as scientific in their approaches, the behaviourists, neuro-psychiatrists, neuro-scientists et al., the unconscious mind concept appeared to be a source of considerable frustration, as it was impossible to objectively test, measure or describe any of it. Until recently, that is. Whereas Freud viewed the unconscious as a single entity in 1915, psychology nowadays believes to understand that the human mind comprises of a collection of modules that evolved over time and operate *outside* of human consciousness. That idea per se is nothing new. Already in the mid-19th century, philosophers, neurologists and physiologists searched for the basis of the human mind with the notion it might at least in part be composed of innate neural structures or modules with distinct established evolutionarily developed functions. We could argue, of course, that it originated with our creation, was part of God's plan, but why bother?

Many purported experts nowadays espouse the idea that the mind is divided into distinct mental categories reflecting modular "faculties," such as emotions, (e.g. anger, disgust, fear, happiness, sadness), cognition memory (attention, decisions) and perceptions (visual images and auditory sounds) (Kristen A. Lindquist, Lisa Feldman Barrett: *A functional architecture of the human brain: Emerging insights from the science of emotion*; ncbi.nlm.nih.gov). Apparently, the American philosopher and cognitive scientist Jerry Alan Fodor (1935–2017) in the 1980's revived the modularity of mind idea, although without the notion of precise physical localizability. Since then, just as with the PTSD treatment modalities, the battle over the architecture of the brain rages as numerous definitions of "module" have been proposed by numerous hypothezists (Harry Haroutioun Haladjian Ph.D. "Consciousness and the Modularity of Mind. Some aspects of the mind can never be accessed consciously — and that's OK"; *Psychology Today* 2016).

Freud's belief in humans' primitive urges remaining unconscious to protect them from experiencing anxiety is also in dispute these days. Modern beliefs are that the *adaptive unconscious*, first coined by Daniel Wagner in 2002, described as a series of mental processes able to affect judgment and decision-making but out of reach of the conscious mind, resides outside of human consciousness due to *reasons of efficiency* rather than repression. Architecturally the adaptive unconscious is said to be unreachable due to being buried in unknown parts of the brain. Is anything proven or provable? No. Not even the theory of some that the mind does in fact reside outside of the human body altogether, or that of others purporting it resides in every single cell of our bodies. Enter the American social psychologist, professor of psychology at the University of Virginia and teacher of public policy at the Frank

Batten School of Leadership and Public Policy *Timothy D. Wilson.* In his book *Strangers to Ourselves: Discovering the Adaptive Unconscious* (Belknap Press, 2004), He decrees that Socrates' precept "Know thyself" was still good advice, despite his musings whether or not necessary associated introspections were indeed the best path to acquire such self-knowledge?

Contemporary psychological science, he pronounced, had redefined Socrates' view by introducing a hidden mental world of judgments, feelings and motives that introspection might never show us. This, he held in particular true that empirical scientific psychology had revealed the adaptive unconscious to be much more than a repository of human primitive drives and conflict-ridden memories. Instead, he voices, the adaptive unconscious was a set of pervasive sophisticated unconscious mental processes that sized up our worlds [sic], set goals and initiated action while we consciously thought about something else. In fact he seems to propose that humanity conducts all actions by unconsciously generated robotic input. This genius of the netherworld furthermore asserts that too much introspection could be detrimental to our mental health and wellbeing. Instead of looking within ourselves for answers, we should discover our unconscious self and figure out who we really are by paying attention to our physical endeavors (Is he talking sex, drugs, and rock-n-roll, by any chance?) and what others think of us. How others can help us in discovering our inner self he shrouds in mystery. And Socrates? Well, he is again belittled and suicided, this time by present days' science of psychiatry and psychology adherents, with their hypothetical empirical scientific evidence regularly presented to us, the peons, as the truth. I trust he laughs himself half silly about their insanity and ours, or is it idiocy?

Socrates original departure from our earthly sphere took place in 399 BC, his 70th year on Earth, shortly after he was hauled into court. The trial took place in the heart of the city, the jurors seated on wooden benches surrounded by a crowd of spectators. Standing before a jury of 500 of his Athenian peers, the formal charges against him brought on by three Athenian citizens ran something like this:

> "Socrates is guilty of not paying respect to the gods whom the state respects, of introducing new divinities, and of corrupting the young . . . . He did not hold discussions on the nature of the Universe . . . As for himself, he was always discussing human problems . . . He believed that the gods knew everything — word, deed, and silent thought alike — and that they were present everywhere, and that they gave signs to

men about all human affairs." (eyewitnesstohistory.com).

Furthermore, the prosecutor accused Socrates of teaching his students, among them Plato, Xenophon, not only that he would make them wiser than their parents, but also claiming that it was possible by law for a son to imprison even his own father, if proving the father's insanity. Other accusations against Socrates were his claim that the only men worthy of honor were those who knew their duty and could explain what they knew. Tell that to Justin Trudeau, eh? That he made the youth of Athens believe that other men were of no account in comparison, with himself as he was the wisest of man and the most competent in making others wise, was also held against him. That the Pythian Priestess had confirmed it, answering when asked by the well-known Chaerophon, who moved with ease in the social and intellectual circles of the day, about his fate: "Of all men living, Socrates is the wisest," was deemed of no value whatsoever. Indeed, it may have added to his detriment, as it inspired envy particularly in those who thought highly of themselves. Those were the ones he perpetually cherished to challenge and make out to be fools, leaving them with badly bruised egos (csun.edu). Socrates' accusers were allotted three hours to present their case against him after which the philosopher would have three hours to defend himself. If found guilty he could face the death penalty.

And that's precisely what happened, the jury finding him guilty of all charges, 280 against 220. However, he was given the opportunity to suggest his own punishment. He recommended to be rewarded for his actions and, when pressed for a realistic punishment, proposed a fine of a modest sum of money. Faced with these two choices, the jury, not amused, selected death for him. By Athenian law, it constituted drinking a cup of poison hemlock. (roughdiplomacy.com). He might have avoided death had he proposed his own exile, but, alas, he became his own executioner instead, taking the cup of poison from his jailer's hand emptying it in one swoop, bottom up, dying in the presence of his most beloved friends and pupils on behalf of the State (eyewitnesstohistory.com). A brilliant life taken because, contrary to professor Timothy D. Wilson a few thousand years later, Socrates attempted to teach his students and fellow citizens that rather than paying attention to what others thought of them they should figure out themselves:

- who and what and why they were
- how to behave to lead better, more sincere, and more honorable lives by becoming aware that all actions and behaviors originated within

human individuals themselves
- that behavioral changes could only occur by self-observation and knowing the Self

As we have seen, nowadays the use of slow and persistent hemlock therapy — pharmaceutical drugging — is preferred. It renders the populace dependent on opioids, slowly destroys their physical and mental health and instills apathy altogether, creating an easy-to-rule humanity. Once psychotropic pharmaceuticals are successfully administered, humans' unconscious-preconscious-subconscious and conscious are enveloped in such a dense haze within moments after consumption, that it creates perpetual neuroses without consumer recognition. That's the art about it, or the insanity and deviousness. Unless consumption is stopped, that is, as well as the mental health destruction treatment. Once hooked, however, one is almost always hooked until the end of one's natural life.

As to Freud's hypotheses, even though the world's mental health practitioners' seem to hold them in disdain these days, his jargon for a multitude of psychology's terminology lives on. He assured it by in 1910 founding, the International Psychoanalytical Association (IPA) upon the suggestion of his close associate, fellow psychoanalyst and key theorist of the psychoanalytic school, Sándor Ferenczi (1873–1933). The IPA, presently headquartered in London, UK, has 12,000 members and works with 70 constituent organizations worldwide (www.ipa.world). Its Mission?

> "The IPA is a membership organization — we exist because of our members and for their benefit. One of our primary aims is to foster and enhance members' sense of participation in and belonging to an international psychoanalytical organization and community. The IPA exists to advance psychoanalysis. It is the world's primary accrediting and regulatory body for the profession, and our mission is to ensure the continued vigour and development of the science of psychoanalysis."

The science that is psychoanalysis under the "About Psychoanalyses" category, however, is portrayed as "*a theory of how the mind works*." One *can* have one's cake and eat it too!

The German social psychologist and psychoanalyst Erich Fromm (1900–1980) was known for challenging Freud's theories and for developing the concept that freedom was a fundamental part of human nature. In 1975, he found the IPA to be "organized according to standards rather dictatorial" (Fromm, E: *You shall be as Gods,*

A Fawcett Premier Book, 1966, p. 18). Elisabeth Roudinesco (1944–) was a French historian and psychoanalyst, affiliated researcher in history at Paris Diderot University of Paris, France, biographer of Freud. She was also biographer of French psychoanalyst and psychiatrist Jacques Marie Émile Lacan (1901–1981), called the most controversial psycho-analyst since Freud. She also noted that IPA's professionalizing psychoanalysis had become *"a machine to manufacture significant".* She wrote of the IPA ['s] Legitimist Freudianism mistakenly called "orthodox" and about homophobia in the IPA, both of which she considered a "disgrace of psychoanalysis" (*Sigmund Freud en son temps et dans le nôtre*, Seuil, 2014, Note de lecture de Jacques Van Rillaer). Her Lacanian colleagues, she furthermore noted, also looked at the IPA as bureaucrats who had betrayed psychoanalysis in favour of an adaptive psychology in the service of triumphant capitalism.

Love him or loath him, Freud's psychological terminology, such as *the unconscious, defense mechanisms, Freudian slips and dream symbolism* is still in vogue today. He also made a long-lasting impact on literature, film, Marxist and feminist theories, philosophy and psychology. That may be in part due to his grand-nephew, the Austrian-American pioneer in the field of public relations and propaganda, Edward Louis Bernays (1891–1995). His great grandfather, Isaac Bernays, was chief rabbi of the city of Hamburg, Germany. Bernays is actually "double nephew" to Freud by virtue of his mother, Freud's sister, and of his father's sister, Martha Bernay-Freud who married Sigismund Schlomo, a variant of the Hebrew "Solomon" or "peace", by the way.

Nephew Bernays worked for dozens of major American corporations, including Procter & Gamble and General Electric, and for government agencies, politicians and non-profit organizations. Of his many books, *Crystallizing Public Opinion* (1923) and *Propaganda* (1928), defining and theorizing the field of public relations, gained special attention. Citing works of writers such as Gustave Le Bon, Wilfred Trotter, Walter Lippmann and uncle Sigismund Schlomo, of course, he describes the masses as irrational and subject to herd instinct. He outlines how skilled practitioners just like uncle could use crowd psychology and psychoanalysis to control them in any and all ways desired (*Bernays, Edward: Crystallizing Public Opinion, 1923. Propaganda, 1928; Publishing)*. His best-known campaigns include the 1929 promotion of female smoking *Ig* by branding cigarettes as feminist "Torches of Freedom". He was also known for the one he conducted for the United Fruit Company, connected with the CIA-orchestrated overthrow of the democratically elected Guatemalan government in 1954. Woodrow Wilson hired him to promote America's World War I efforts, and

for the Third Reich under then minister of propaganda Joseph Goebbels, he created the "Führer cult" around Adolph Hitler. When finally departing the earth aged 104, Bernays' obituary referred to him as "the father of public relations." His great-nephew Marc Randolph continues the family tradition of human mind manipulation as the American media service's provider Netflix's co-founder, together with Wilmot Reed Hastings Jr. Since its inception in 1997, Netflix has been located in Scott's Valley, California. The company's primary business is its subscription-based streaming over-the-top (OTT) service, which offers online streaming of a library of films and television programs include in-house productions.

Hastings is an American entrepreneur and philanthropist with an estimated net worth of US$3.8 Billion. He is the great-grandson of American attorney, investment banker, philanthropist, scientist, physicist, inventor of the LORAN Long Range Navigation System, and lifelong patron of scientific research Alfred Lee Loomis (1887–1975) who established the Loomis Laboratory in Tuxedo Park, New York, and whose role in the development of radar and the atomic bomb contributed to the Allied victory in World War II. Presently Netflix Chairman and CEO, Hastings also serves on the boards of Facebook and a number of non-profit organizations, is a former member of the California State Board of Education and an advocate for education reform through charter schools.

Whereas Bernays' means of human manipulation may be perceived as hideous, genius, and foolproof, subliminal advertisement in particular, (*They Live* gives good examples,) it is accepted around the world. Uncle Sigismund Schlomo's theories, however, remain hugely controversial. They are disputed by numerous critics to such an extent as to call its inventor the "creator of a complex pseudo-science which should be recognized as one of the great follies of Western civilization"(newworldencyclopedia.org). What then are most of those practicing in the métier of mental human health nowadays practicing, one may wonder? Pseudo-science, perhaps? Be it as it may, how did Freud define neurosis? As a manifestation of anxiety-producing, unconscious –repressed–material, too difficult for humans to think about consciously, but still unconsciously or subconsciously, I suppose, demanding to find ways and means of outward expression. Hence the pseudo-experts' long-held supposition that unknowingly repressed human life events, disappointments or traumas might manifest later in life as neuroses (newworldencyclopedia.org).

Thus arose the non-endearing and evermore enduring assumption that PTSD

development in genuine PTSD experiencers has its origin in one of our unconsciously repressed life-events. These would be unknowingly and unconsciously harboured in our psyche, having been incurred sometime between cradle and the PTSD-causing event moment. That's, when it supposedly sprang forth with vigour and enthusiasm, manifesting as PTSD to free us from our unknown repression. Thus, in so-called PTSD experts' view, the PTSD event-moment merely served as the outward outlet and expression for said unknowingly repressed life-experiences they call traumas. They were, after all, unknowingly lingering in PTSD journeyers' psyche until the opportunity arose to find and outlet through the PTSD-causing event, thus finally achieving freedom of expression. Voila! It's our entire fault! What breathtaking logic and perception of reality! Does anyone in the mental health field question it? Hell no! They'd rather die. It would disrupt their PTSD cure-finding gravy train.

And what precisely are considered to be neurotic disorders? One of its most distinct features is that humans accused of suffering neurotic symptoms are still viewed as having a firm grip on reality. Those with psychosis are not. Major traditional categories of neuroses are:

- **ANXIETY NEUROSIS.** Mental illness defined by excessive anxiety and worry sometimes involving panic attacks and manifesting in physical symptoms such as tremor, chest pain, sweating and nausea.
- **DEPRESSIVE NEUROSIS.** A mental illness characterized by a profound feeling of sadness or despair and a lack of interest in things that were once pleasurable.
- **OBSESSIVE-COMPULSIVE NEUROSIS.** The persistent and distressing recurrence of intrusive thoughts or images (obsessions) and repetitive behaviours or mental acts (compulsions).
- **SOMATIZATION (FORMERLY CALLED HYSTERICAL NEUROSIS).** The presence of real and significant physical symptoms that cannot be explained by a medical condition, but are instead a manifestation of anxiety or other mental distress.
- **POST-TRAUMATIC STRESS DISORDER (ALSO CALLED WAR OR COMBAT NEUROSIS).** Severe stress and functional disability caused by witnessing a traumatic event such as war combat or any other event that involved death or serious injury.

C. George Boeree is, an American psychologist and professor emeritus at Shippenburg University, Pennsylvania, USA specializing in personality theory and the history of psychology. He takes neurosis a step further when declaring in full earnest and sincerity that symptoms of human neurosis may involve:

> " . . . anxiety, sadness or depression, anger, irritability, mental confusion, low sense of self-worth, etc., behavioural symptoms such as phobic avoidance, vigilance, impulsive and compulsive acts, lethargy, etc., cognitive problems such as unpleasant or disturbing thoughts, repetition of thoughts and obsession, habitual fantasizing, negativity and cynicism, etc. Interpersonally, neurosis involves dependency, aggressiveness, perfectionism, schizoid isolation, socio-culturally inappropriate behaviours, etc."

In other words, Boeree opines that all human emotions are a sickness manifested by neurosis.

Others in his league, frankly and without shame, proclaim neurosis may simply be defined as one or more of:

- a poor ability to adapt to one's environment
- an inability or lack of desire to change one's life patterns
- a refusal to develop a richer, more complex, more satisfying personality

That every one of those assertions is liberally and at every given opportunity tagged onto genuine PTSD voyagers by the high priests of psychology goes without saying. Next we are going to hear that humans are no longer humans unless they:

- indulging in psychotropic pharmaceuticals, so liberally prescribed
- allow for genetically engineered changes and VR induced hallucinations, according to templates created to equally fit both the sick and the healthy
- align with, adhere to and implant AI technology into their bodies to accommodate Archontic aspirations

You see, the American psychiatric community eliminated the term *neurosis* with all its human implications with the *Diagnostic and Statistical Manual of Mental*

Disorders III inauguration in 1980. With its elimination, humans' natural everyday emotional major or minor upheavals experienced during as good as every human's life become illnesses. From a broken bone to death of a loved one, or car accidents, divorces, marriages and so on and so forth become illnesses. And, of course, the top 10 most stressful life events many of us experience and their "Life Change Unit" scores became illnesses (Homes & Rahe Stress Scale). These common life events are:

1. Death of a spouse (or child): 100
2. Divorce: 73
3. Marital separation: 65
4. Imprisonment: 63
5. Death of a close family member: 63
6. Personal injury or illness: 53
7. Marriage: 50
8. Dismissal from work: 47
9. Marital reconciliation: 45
10. Retirement: 45

The customary humane emotional upheaval resulting from any of such events, the neurotic reaction, was henceforth relegated to a mental disorder by the DSM-III, with the consequent attached stigma. There are approximately 297 of them right now and rising. That many a mental health practitioner might look at them as highly misleading is of no concern to the American Psychiatric Association, who concocted all of them for the cost of somewhere between $20–25 million, they assume (psychiatry.org). Wonder under which category they would fit America's newly minted Democrat congress-woman (or man) Alexandria Ocasio-Cortez? The sanest of sane?

Meet Barry Turner, B.A., MPhil, FHEA of the University of Lincoln · Lincoln School of Pharmacy, Lincoln International Business School, Lincoln School of English and Journalism. He teaches pharmacy law and regulation, media law and environmental and science journalism alongside with pharmacogenomics and molecular genetics, in particular regarding adverse drug reactions caused by genetic phenotypes. He says this about APA's concocted mental health disorders:

> "Many of these [DSM-5] 'disorders' are behavioural manifestations and there is no organic or physical aetiology to support a diagnosis. Certain behaviours are mistaken for

> symptoms and often lead to erroneous diagnoses. Many others result in a diagnosis after a period of psychopharmaceutical intervention and consequently are self fulfilling prophecies rather than disorders. We should not concern ourselves too much with the number of disorders but the quality of the evidence that describes them. Many are plainly farcical." (www.researchgate.net)

But that matters little now. Other than that, with the neurosis' definition's elimination came the justification for the projected-as-necessary psychiatric and pharmaceutical treatment intervention on humans. Their normal emotional life-created ups and downs reactions had previously been deemed a natural part of life and living. They were now deemed to be abnormal. That those psycho-the-rapists' psychological treatment interventions advertised as superbly beneficial result in increased distress and anxiety, and even suicide, is well documented (psychology.jrank.org). That "neurosis" is still part of the International Statistical Classification of Diseases and Related Health Problems maintained by the World Health Organization (WHO), the directing and coordinating authority for health within the United Nations System, is of no consequence. It has little or no standing in the North American mental health community if anywhere else in the world (ICD-10 Chapter V F40–48). That humanity by and large believes "doctor knows best" is its fault, not the cabal's.

So then, how did all this lunacy start? Could it really be that Blavatsky, Bailey and the United Nations are the culprits? Did they plan humanity's destruction and the planet's with it, asked William Mount on December 31, 2018? Has the mental health industry been elevated to its present status by way of Theosophy? Has big pharma become the Church of Pharmaceutical Mystecism as Robert Scott Bell questioned on his December 18, 2018 show? In fact, is big pharma in effect the new world religion and the religion of psychology/psychiatry its offspring? We know that pharmaceuticals, with the few Dr. Breggins-like exception, are part of every mental health treatment, the salting down and curing for profit forcing the human system to slowly destruct itself until shutdown and death. After all, a pharmaceutical drug seemingly conducive to heal one ailment will create another one somewhere else in the body.

But, really, when human beings voluntarily and willingly destroy themselves mentally and physically by drugs prescribed after having been successfully lured into the mental health industry's captivity, through addiction now dwelling in a state of

dependency, does that sound like a cult, a religion? Is it a sign of religious fervour when millions of humans voluntarily commit suicide whilst those running the show, those prescribing the drugs, lead them into that suicidal mode of mind shrug and their shoulders saying: "Too bad"? Remember Jonestown? Does Copeland and others of his ilk spring to mind?

The cabal's excuse?

> "We tell them of the dangers on every single package of pharmaceutical prescription they buy. Yes, in tiny, tiny print, but if they really wanted to know they'd use magnifying glasses. Most of them can't read, are functionally illiterate, anyway, so what does it matter? And in every television advertisement, we tell them in graphic detail what happens when they take our pharmaceuticals. But, of course, we disguise that with loud background music. We offer benign-looking settings with charming and cozy family gatherings, frolicking on lush lawns sprinkled with subliminal suggestions and enticing music. It"s all so perfectly wonderful that they won't listen t how we ruin their mental and physical health when taking our concoctions. Mind you, their audio-comprehension is so low they don't understand half of what we say either, if our sentences contain more than five words in a row. We engineered all that, thanks to Freud, Bernays et al. So, are we guilty of their croaking when they, of their own desire and volition, take what we suggest? After all, do we not act in accordance with cosmic and universal law when telling them precisely what they do to themselves, more or less?"

There you have it. For them, we are nothing but expandable flesh, and folks with PTSD incurred on the job are in particular considered useless eaters to get rid of in a timely fashion. "But," they say:

> "at least most of them are stupid enough to, with our help, be made sicker by the day, they say. So, we figured it out beautifully. And us guilty? Absolutely not! After all, is it not a world of free will? A world where Crowley's leitmotiv *Do as Thou Will is the Whole of the Law* is freely permitted by state, religious institutions and populace alike, just as abortions and infanticide until age one, thus far? But we'll get to age five or

so soon.

> "Why do you think corporations have human resources departments? You really thought they are for your benefit? It's there to assist in your destruction. Don't you know yet that our aim is to reduce your species to 500 million by hook or by crook (George Green, SHUG-Scotland-GDL interview April 2, 2018)? So we figured it out beautifully."

And yes, indeed, they have, as long as you think it is their duty and responsibility to take care of you, not yours to take care of yourselves. But I digress.

On to psychosis. The term originates from the Greek *psukhōsis* (animation), from *psukhoō* (I give life to)' and from *psukhē* (soul, mind) (etymonline.com). Hippocrates already described the condition, but it was most likely known as early as the 1550s BC. That's when it was mentioned in the voluminous 68-feet-long Ebers Papyrus, named after the German Georg Ebers, who purchased it in Luxor, the ancient city of Thebes, Egypt, in the winter of 1874. Believed to be copied from earlier texts, it is an Egyptian medical treaty of herbal knowledge written on papyrus. This was a form of paper used by the Egyptians, Greeks and Romans. It was made from tall sedge of the Nile valley, yielding fiber that served many purposes in historic times, by cutting it in strips and pressing it flat. The scroll is currently kept at the University of Leipzig, Germany.

What characterizes a psychosis? First and foremost, it manifests in an impaired relationship with reality, a situation when one sees, hears and/or believes things that are not real. Reality is, of course according to the mental health experts. Most, if any, of them have either never experienced it or are seemingly perpetually in psychotic states, considering their PTSD treatment modalities, theories and remedies (healthline.com 2019). A serious mental disorder, according to the DSM-5, a psychosis episode manifests either as hallucinations or delusions. Why not both is unspecified. How it arises is purportedly unknown, though many different causes are suspected. These may include:

- alcohol
- schizophrenia
- bipolar disorder
- sleep depravation
- severe depression
- certain medications

- severe stress or anxiety
- some medical conditions
- feelings of persistent sadness
- drugs such as marijuana and LSD
- postnatal depression, which some women experience after having a baby

All the above may cause sufferers to hurt themselves or others; all may result in the following classic signs and symptoms:

- Difficulty concentrating
- Catatonia — unresponsiveness
- Disorganization — in thought, speech, or behavior
- Hallucinations — hearing, seeing, or feeling things that do not exist
- Delusions — false beliefs, especially based on fear or suspicion of things that are not real
- Disordered thinking e.g. jumping between unrelated topics; making strange connections between thoughts

Milder, initial symptoms of psychosis might include:

- depression
- general anxiety
- sleep problems
- obsessive thinking
- feelings of suspicion
- distorted perceptions

Two-thirds of schizophrenia patients are said to have auditory hallucinations, as well. They hear things and believe them to be real, when, according to attending extra-sensatory, gifted psychotherapists, there is absolutely nothing to hear.

Common auditory hallucinations, as given by patients — we presume– include:

- hearing several voices talking, often negatively, about the patient
- a voice giving a commentary on what the patient is doing
- a voice repeating what the patient is thinking

- bizarre delusions during psychosis

We are asked to believe that these sensations may be experienced without any actual stimulus. For example, sufferers might hear someone yelling without anyone being there, or see someone who is not there at all. I know flight attendants who've experienced both symptoms on long-haul flights, but then, the for-shareholders' enormously profit-producing, but extremely rarefied recycled air might have been a contributor.

Another factor could be, of course, that average humans see less than 1% of earth's electromagnetic spectrum and hear less then 1% of its acoustic ones. Those figures are according to Canadian artist, teacher and filmmaker Sergio Toporek, renowned for telling the history of art in an animated documentary entitled *Beware of Images* (Stuart Derdeyn: Vancouver director Sergio Toporek's Animated Documentary on the History of Images; updated Vancouver Sun, 2016).

While we are at it, Toporek also documents that 90% of the cells in our body carry their own microbial DNA and are not "us". The atoms in our body are 99.9999999999999% empty space, and none of them are the ones with which we were born. And, by the way, humans have 46 chromosomes, two less than the potato. Thought that might tickle you pink, or injure your ego. So why should some people not be thrown into situations forcing them to recognize some of the 99% invisible or inaudible to most humans? And you still think our physical brain contains the answer to PTSD healing, as neuro-scientists and psychiatrists want to make believe? Still believe in Santa Claus?

Never mind. Back to the psychosis grindstone, where mental health practitioners and their scientist-associates also want us to believe that some people in the grasp of psychosis might experience loss of motivation, social withdrawal and problems with sleeping. Yes, I would, too, if I were on pharmaceutical drugs. And if I was so gifted as to see and hear things others could not under "normal" circumstances, and were neither a psychiatrist nor a professionally employed psychic. These are both proven to be extra PSI-gifted, both assured lucrative incomes. So, I would also be withdrawing from society. After all, with whom could I share my insights, unless I wanted to run the risk of delivery to the state's psychiatric institution for the insane to share them with my fellow inmates? The thought alone makes me shiver, never mind the thought of dealing with the academically gifted who choose to keep the company of the mentally deranged as their lives' vocation, the Miss Ratchett's of Cuckoo Nest fame, in the field looking for like company? Just

look what they impose on PTSD experiencers, the few off drugs before it is too late, the few left able to think and reason as they did before the PTSD-causing event? Look on the streets to find them, will you?

Paranoia and delusions of grandeur are other common components of psychosis, though they are more likely associated with schizophrenic people, the experts tell us. Those disturbances are manifested by undue suspicion of individuals or organizations, believing they are plotting to cause them harm. Who proves they are not is undisclosed. Delusion of grandeur is manifested by a clearly false, but strongly held, belief in having a special power or authority, for instance in believing that one is a world leader (medicalnewstoday.com), we hear. Actually, I have met quite a few of those people during the time when kings and queens, princes and princesses, prime ministers and business tycoons, their offspring and spouses, world renowned actors and actresses, scientists, singers and musicians still regularly flew on commercial airliners. Even some peons suffered from such delusion, and so did most of the 24 psychologists and psychiatrists I met in the course of my PTSD journey. Nothing beats personal experience when evaluating once own state of mind and that of others, should one wish to spend time on the latter. But let's move on to get this over with.

It is acknowledged that traumatic life events have been linked with elevated risk of developing psychotic symptoms. It is also acknowledged that the relationship between traumatic life events and psychotic symptoms seem to be "dose-related." In other words, multiple traumatic life events accumulated and stored unconsciously and unknowingly in the unconscious, as expressed by Schlomo Freud, compound psychological — or psychotic — symptom expressions and their severity, unless an outlet is found. This suggests trauma prevention and early intervention might be an important target for decreasing the incidence of psychotic disorders and ameliorating its effects, Gibson et al. suggest. (Gibson LE, Alloy LB, Ellman LM: "Trauma and the psychosis spectrum: A review of symptom specificity and explanatory mechanisms"; *Clinical Psychology Review*. 49: 92–105 Nov. 2016).

Bingo! Mental health high priests never allow genuine PTSD experiencer to live through their PTSD-causing event experience in peace and quiet to heal and immunize them against future incidence-impacts. In the four PTSD-prone occupations, these are impossible to avoid. By imposing their PTSD treatment hallucinations and delusions upon unsuspecting experiencers, they prevent PTSD healing. It is that simple. And why should they not? After all, no society wants any of its population to become awake, aware and wise, the opportunity presented by

the PTSD experience.

Why not? The Indian spiritual guru, philosopher Rajneesh (born Chandra Mohan Jain 1931–1990) explains. He is known latterly as Osho, leader of the Rajneesh movement and generally considered one of the most controversial spiritual leaders to have emerged from India in the 20th century. He answers the question when stating:

> "No society wants you to become wise. It is against the investment of all societies. If people are wise they cannot be exploited. If they are intelligent, they cannot be subjugated, they cannot be forced into a mechanical life to live like robots. They will assert their individuality. They will have the fragrance of rebellion around them. They will like to live in freedom. Freedom comes with wisdom, intrinsically. They are inseparable, and no society wants people to be free . . . the moment they start using their intelligence they become dangerous — dangerous to the establishment, dangerous to the people who are in power, dangerous to the 'haves'; dangerous to all kinds of oppression, exploitation, suppression; dangerous to the churches, dangerous to the states, dangerous to the nations. In fact, a wise [hu]man is afire, alive, aflame. But [s]he cannot sell his life, [s]he cannot serve them. S]he would like rather to die than to be enslaved." (Osho from Icke's book *Everything You Need To Know* opening quote)

But the world's leaders have little to fear, as freedom through wisdom only comes in the absence of pharmaceutical drugs. And what are the conventional treatments of all hypothetical mental disorders including psychosis and neurosis? Antipsychotic medication, even though it has at most a moderate effect *at onset* if combined with counselling and social support. Draw your own conclusion.

As laughable as it might seem, neither neurosis nor psychosis are well-defined. Neither can be supported by empirical, scientific first evidence, never mind iron-clad proof or reason for their existence. PTSD is just one example. Nevertheless, it is the assumed, purported state of the human mind, which is portrayed as undisputable truth by mental health gurus. Look at the incessant lack of concrete evidence and precise decisive wording permeating the lingo of mental health practitioners, trans-humanistic-inclined neuroscientists and psychiatrists. Is

anything they spew forth credible, when everything they express is vague, non-committal, akin to Pythian oracle script floating around in purportedly empirical, scientifically documented left-brain generated hypotheses and hallucinations? If it were not so detrimental to PTSD voyagers' health, it would be funny.

Think about it. Consider humans' lack of vision, this less than 1% perceived of what actually is to be perceived. Consider that world-renowned psychics conduct stage shows demonstrating their prowess in tuning in to the for-most-of-us-unseeable, the beyond. They tune in to vibrations differing from our earthly ones, at times making a fabulously lucrative living by doing so, just as those wheeling-dealing in the field of psychology/psychiatry. Yes, it *is* comical. Why? Because neither party is even remotely considered to be neurotic and psychotic, nor to suffer from delusions and hallucinations. But could not both be tagged to be so, the academically schooled, as well as the PSI extra-sensory gifted? What's good for the gander is good for the goose, no? Is there any empirical, scientifically substantiated evidence of who is hallucinating and delusional and who is not? Both seem to live the same symptoms when more or less daily tuning in to other vibrational realms found in our universe and beyond. Both often times do it for thousands of dollars. Those who pay psychics for the deed gratefully gobble up everything transmitted in these visual or auditory messages, going away mighty gratified and unharmed. Those seeing the psychiatric seer also gratefully gobble up what they are told, drug prescription in hand. There is only one difference. Whereas seekers are warmed, soothed and assisted by the former, they have no clue that the latter, by their messages and with expertise, have the power to destroy their life, that of PTSD voyagers included.

Remember the Oracle at Delphi, existing at least since 1400 BC? The most important shrine in all Greece which, in theory, all Greeks respected for its independence? The one built around a sacred spring and considered to be the omphalos, the navel of the world? People came from all over Greece and beyond to have their questions about the future answered by the Pythia, the priestess of Apollo, who spoke for him. For Greeks and foreign inquirers alike, she answered questions about colonization, religion and power, as well as love, life, health and fortune — for a price. Her answers, usually cryptic, would and could determine the course of everything, from when farmers ought to plant seedlings to when an empire should declare war. Needless to say, arguments over an oracle's correct interpretation were common. The oracle didn't mind, though, as it was always delighted to give another prophecy if more gold was provided. A good example is

the famous incident before the Battle of Salamis, a naval battle fought between an alliance of Greek city-states under Themistocles and the Persian Empire under King Xerxes in 480 BC. The Pythia had first predicted doom and gloom for the outnumbered Greeks, though another oracle later pronounced that a "wooden wall'" would assure success. The Athenians, interpreting it to mean that their ships would save them, formed their wooden fleet in a line to make a wall and thus scored a decisive victory. Sounds familiar? A wall to save a society that is? A wall to save yourself?

Due to its lack of strict religious dogma associated with the worship of Greek gods Delphi also was a focal point for intellectual enquiry. But it all came to a crashing halt in the 4th century AD when newly created Christian Rome proscribed the Pythia's prophesying anathema (pbs.org). Nevertheless, it is still debated today whether she indeed received Apollo's words by way of her hallucinations, delusions or suggestions. Shutting her up would be a simple matter nowadays, as she, presenting a danger to the state, would be carted off to an asylum by psychiatry's high-priests in no time flat. Let it remind you of what you have to do if wanting to get out of this existential crisis somewhat alive and with it. You have to build your own defenses by way of conducting your own research, gathering ammunition against those desiring your demise. Unless, that is, you have means to bribe them into leaving you in peace until you heal yourself. That would be like waiting for Hell to freeze over.

That psychiatry is more religion than science due to its control and suppression of spiritual abilities maintains Virginia McClaughry (mikemcclaughry.wordpress.com 2016) quoting in *Control and Suppression of Spiritual Abilities*:

> " . . . it isn't man but *the world* that has become abnormal . . . Things are bad because the sick conscience now has a vital interest in not getting over its sickness. 'So a sick society invented psychiatry to defend itself against the investigations of certain visionaries whose faculties of divination disturbed it." — Antonin Artaud, Hirschmann Antonin Artaud Anthology, 1965.

Is it?

Is Psychiatry More Religion Than Science?

Virginia McClaughry wrote an article in 2016 entitled "Why Psychiatry Is More Religion Than Science". She offers proof that it is the Catholic Church who, since the middle ages and renaissance, has been and is behind psychiatry, thereby making it a religious political weapon, while posing as a science. It in particular supported the German "alienist," the term deriving from the Latin *alius,* meaning "other." As a matter of fact, the etymological trail leads from Latin to French, where the adjective *aliene* –insane– gave rise to the noun *alieniste,* a doctor who treats the insane. In the mid-19th century it appeared in the English language as alienist to describe the healers of souls. The term is still employed in forensic psychiatric hospitals, where it is applied to those psychiatrists specialized in psychiatry's legal

aspects, the ones who determine whether or not defendants are competent to stand trial. We get a glimpse of the alienist in Caleb Carr's 1994 crime novel *The Alienist* (1994), and the consequent 2018 television series, exploring the causes of insanity and criminality, and ultimately the nature of evil. (*Lehmann-Haupt, Christopher: "Of an Erudite Sleuth Tracking a Madman"*; *The New York Times* March 29, 1994).

In days gone by, however, the alienist studied and cared for patients and tried to assist them in overcoming their "mental alienation" or illness. Indeed, it was during the mid-19th century that the term "alienist" became synonymous with that of "psychiatrist" the latter signifying a medical doctor specializing in the treatment of perceived mental ailment or illness. Needless to say, with it came those medical doctors of the day purporting to have the clairvoyant gift and academic education to understand mental illnesses and their causes. Among them was the Swiss eugenicist and psychiatrist Paul Eugen Bleuler (1857–1939) who gained fame and fortune from his suppositions. It is he who coined the terms schizoid, autism and depth psychology, which Freud called "Bleuler's happily chosen term ambivalence." Ambivalence's precise definition? Uncertainty or fluctuation, especially when caused by an inability to make a choice or by a simultaneous desire to say or do two opposite or conflicting things. When used in psychology jargon, it denotes the coexistence within an individual of positive and negative feelings toward the same person, object or action, whilst simultaneously drawing him or her in opposite directions (dictionary.com). In other words Bleuler assured that, throughout his career, he could pick and choose when clarifying or interpreting the meaning of his own suppositions. So he, too, had his cake and ate it.

But the founder of modern scientific psychiatry, psychopharmacology and psychiatric genetics was not Bleuler. It was his contemporary, the previously discussed Emil Kraepelin (H. J. Eysenck's *Encyclopedia of Psychology*). It was Kraepelin who planted the belief that the chief origin of psychiatric disease was to be found in humans' biological and genetic malfunctions. And it is Kraepelin who introduced personality types into modern psychiatric classifications under the term "psychopathic personalities." Kraepelin's theories and suppositions for years dominated psychiatry, until at the start of the 20th century. They were somewhat interrupted by Sigmund Freud and his disciples' psychodynamic hypotheses, though they enjoyed a revival at century's end, lasting to present day. In between, towards the mid-20th century, statistical methods were beginning to be developed and applied in an attempt to scientifically validate individuals' personality dimensions to justify declaring someone insane or not. One of the first ones, the

original MMPI, for example, was developed by Starke R. Hathaway and J. C. McKinley, faculty of the University of Minnesota. It was first published by the University of Minnesota Press in 1943, as the means of statistical classification, and we have seen the havoc it reeks on anyone completing it. It was followed by a slew of other psychological test inventions to scientifically gauge the human psyche, in total disregard for most humans' inherent humane emotional qualities.

Kraepelin — crap-a-line — acted in the same vain, though. He was described as nothing other than a scientific manager, a political operator conducting a large-scale, clinically oriented, epidemiological research program. But he proclaimed that his high clinical standards of information gathering took place "by means of expert analysis of individual cases," which left little room for arguments about his findings. In fact, however, he is said to have drawn his conclusions mainly from observations reported by people untrained in psychiatry. His textbooks, void of detailed case histories, would have been nothing other than mosaic-like compilations of patients' typical statements and behaviours, reflecting specific diagnoses.

Not that there ever were a lack of historical milestones in the study of normal and abnormal human personality before the world's Kraepeline's sprang forth. It spans from antiquity up until present day. Anyone can look it up, if they care to. It's available on every cellphone. Both ancient Chinese and Greek medicine offer physiological and psychological explanations for a large variety of personality types. The effect of the "blood and vital essence" (Chinese-pinyin: xuè-qì) combination on human temperament are already mentioned in the Analects (XVI, 7), a collection of sayings attributed to Confucius (551–479 BCE). (Confucius. *Analects*. With selections from traditional commentaries; Edward Slingerland (trans). Indianapolis, IN: Hackett Publishing Company; 2003:195). Plus, of course, we have astrology, numerology, hand line analysis and so on and so forth to analyse humans' innate personalities and perceived normalcy or abnormalities within our psyche to aid us in our understanding of Self.

In Greek medicine theories of personality started with Hippocrates's humoral theory. Aristotle's close colleague and successor at the Lyceum, the peripatetic philosopher Theophrastus (c. 371–287 BCE), who wrote many treatises in all areas of philosophy in order to support, improve, expand and develop the Aristotelian system. He carried the theories of personality into the Greco-Roman world with his work *The Characters* (plato.stanford.edu). All organized along the same structure, it contains 30 personality descriptions, each of which includes the character type, briefly defines it and, illustrated by a list of roughly ten examples, shows how the

individual will typically react in different life situations.

Perhaps the most accomplished of Antiquities' medical researchers was the Greek physician, surgeon and philosopher Galen of Pergamum also known as Aelius Galenus or Claudius Galenus (129 AD–c. 200/c. 216). He influenced the development of various scientific disciplines throughout the ages and carried Theophrastus's ideas and work forth into the Roman Empire. It is Galen who significantly contributed to Hippocrates' understanding of pathology, the understanding and discovery of primary causes, origins and nature of diseases through the examination of tissues, organs, bodily fluids and autopsies. As you recall, under Hippocrates' bodily humors theory, differences in human moods come as a consequence of imbalances in one of the four bodily fluids: blood, yellow bile, black bile, and phlegm. Galen promoted both this theory and the typology of human temperaments. In Galen's view, an imbalance of each humor corresponded with a particular human temperament (blood — sanguine, black bile — melancholic, yellow bile — choleric, and phlegm — phlegmatic). Thus, individuals with sanguine temperaments are extroverted and social; choleric people have energy, passion, and charisma; melancholics are creative, kind, and considerate; and phlegmatic temperaments are characterized by dependability, kindness, and affection.

Galen's huge knowledge base included anatomy, physiology, pathology, pharmacology and neurology, as well as philosophy and logic. But remember that in those days, physicians in general were much more broadly and thoroughly educated than in the limited and slam-dunk fashion of today. They used their five senses to determine reasons for their patients' humoral imbalances. They studied their patients' secretions and excretions, individual symptoms, living environments and economic circumstances before choosing treatments to restore their humoral balance (Bockler: *Let's Play Doctor: Medical Rounds in Ancient Greece*, p.107). For half of the world's population, a primary care doctor visits last less than five minutes, researchers say (Reuters Health). Appointments range from 48 seconds in Bangladesh to 22.5 minutes in Sweden. In the U.S., doctor consultations average about 20 minutes.

Professor Dr. Willibald Ruch, of the University of Zurich, Switzerland psychology department, wrote "Pavlov's types of nervous system, Eysenck's typology and the Hippocrates-Galen temperaments: An empirical examination of the asserted correspondence of three temperament typologies" in 1992. The paper's abstract states that both Pavlov and Eysenck equate their typologies with the Hippocrates-Galen temperaments (*Personality and Individual Differences* Volume 13,

Issue 12, December 1992, Pages 1259–1271; sciencedirect.com). For German-born psychologist Hans Jürgen Eysenck (1916–1997) who spent his professional career in Great Britain, the melancholic, choleric, phlegmatic and sanguine temperaments resulted from different combinations of the superfactors Extraversion (E) and Neuroticism (N), said Ruch. The Pavlovian types of nervous system (TNS), however, were based on configurations of the three nervous system's properties of strength, mobility and balance of the nervous processes of excitation and inhibition. When the identity of the three typologies was researched to evaluate the hypotheses, it was noted that most results were in line with the predictions. The main discrepancy referred to the finding that the sanguine temperament seemed to be as unbalanced as the choleric temperament. However, whereas the low balance of the latter was esteemed to be due to weak inhibitory processes, it is assumed that the low balance of the former were due to unexpectedly strong excitatory processes in the sanguine temperament.

We do not know if Ruch et al. studied their test subjects' excretions, never mind tissue and organ functioning, living conditions and financial situations before reaching their conclusions. That would undoubtedly negatively influence their research budget. Never mind that, though. For Galen it was the least of his concerns. His father's untimely death had left him independently wealthy. Consequently, when the famous man relocated to Rome, his clientele in that fair city included some of the empire's most powerful people and their families, including Emperor Marcus Aurelius himself, as well as his offspring and household. He treated the wives, children and slaves of the rich. But he also cared for quite ordinary people, peasants he encountered in the countryside, friends of friends he met in the street and miscellaneous patients who walked or were carried to the clinic he operated in his home (Mattern, Susan: "Galen and his patients"; *The Lancet* 2011).

A patient's history often contained episodes that, in Galen's mind, explained the onset of disease and diagnosis such as travel, emotional disturbance or change in diet. In one case the patient reported drinking unclean water fetched by a servant from the local fountain. Galen accurately guessed that he had swallowed a leech. Another patient became overheated and dehydrated from travel, stress over some bad news and a fight at the public bath, causing him to lapse into a near-fatal fever. For these reasons, eliciting symptoms and identifying events in patient's history that could explain the onset of disease through dialogue with patients, was critical. But also for another reason. Galen, contrary to today's mental health industry cabal recognised that emotional states are factors in and causes of disease, and that some

problems, in fact, were purely emotional in origin. One of his patients, for example, worried obsessively that the mythical Atlas, a legendary Titan who led a 10-year battle of the Titans against Zeus who forced him to hold up the heavens as a special punishment, would drop the sky and crush the earth. The associated anxiety he developed turned into melancholia, an overabundance of black bile. When it accumulated in the brain, it not only caused delirium, but also aggressive and suicidal behaviour and other psychological problems. Galen mentions anxiety and anger most often as cause of disease. He said these, along with diet, temperament, lifestyle, environmental factors and anxiety, could contribute to any number of feverish illnesses. It could also trigger sometimes fatal syndromes of insomnia, fever and wasting away. Or it could transform into melancholy and cause or exacerbate epilepsy. Galen knew this 2000 years ago. You think the National Center *for* PTSD henchmen don't? Think again!

In his treatise *That the Best Men Profit from their Enemies,* surviving in Arabic, Galen claims never to have charged a fee. More than 300 stories Galen tells about his patients survive among his works. — They show that he was a public figure known and recognised by many, accosted in the streets, challenged to debate, accompanied everywhere by a crowd of friends, supporters, students, domestic servants and professional assistants.

Western medicine has long dismissed Galen's physiological theories as "quaint." Still, something of his and Hippocrates' knowledge must have filtered through and resonated with the experts of the ages. By the 18th century, terms such as "character", "personality" and "temperament" were well defined. The latter was supposed to describe a person's natural human constitution, according to the French language *Encyclopedic* between 1751 and 1772, edited by Denis Diderot and Jean d'Alembert. Later, others decided that such "natural human constitution" was based on Galen's definition of sanguine, melancholic, and choleric. This illustrates how the humoral theories of personalities were twisted into today's "natural human constitution," when nothing could be further from the truth. In my view, humanity is guided into the abnormal human temperament through pharmaceutical psychotropic drug concoctions, lifestyle, eating and drinking habits and their own thinking patterns, largely engineered a la Bernays dictates and nothing else. The result is today's Jelly generation of entitlement, the Ocasio-Cortez syndrome in action.

Several psychiatrists and differential psychologists take Hippocrates' and Galen's temperament hypothesis a step further. They suggest that temperament and mental illness are represented by varying degrees along the same continuum of

neurotransmitter imbalances in neurophysiological systems of behavioral regulation *(Sulis, W. (2018). "Assessing the continuum between temperament and affective illness: Psychiatric and mathematical perspectives". Philosophical Transactions of the Royal Society B: Biological Sciences. 373 (1744): 20170168).* It is this idea that justifies declaring everything previously thought of as at least vaguely normal to now be a human mental disorder. "It's all in your brain's structure, folks, it's all in your brain" is what they attempt to shuffle down our throats, when nothing could be further from the truth there either. It's just part of a staggering and spectacular illusion, a perception deception most of us take for reality. As Icke explains:

> "We are told that our solid, material reality is made of atoms and that everything is solid and physical because of them . . . Atoms have no solidity and so cannot a solid world make. Atoms are said to have a nucleus orbited by electrons in a relationship akin to mini-solar systems and everything else is 'empty space'. How can this make a solid world? I contend that the nucleus and electrons have no solidity either and that even *their* material existence is illusory although quantum physics gives them marginal materiality. Here a quote to put that 'marginal' into context:
>
> 'If the nucleus were the size of a peanut, the atom would be about the size of a baseball stadium. If we lost all the dead space inside our atoms, we would each be able to fit into a particle of dust, and the entire human race would fit into the volume of a sugar cube (*Everything You Need To Know But Have Never Been Told,* p. 3)."'

Where does that leave the brain? How and by whom is it operated? The super-conscious, perhaps? What's that, you ask? Right. No one of the mental health ilk so full of conscious and subconscious, id and ego exploration and hypotheses ever mentions it. Put it into your PTSD bibliotherapy for further research to speed up self-healing, I suggest. Here it goes:

Super-consciousness is heightened awareness. It is that level of awareness that one may experience when the mind is in a calm and uplifted state. It is the hidden mechanism at work behind intuition, spiritual and physical healing, and successful problem solving. It is true wisdom involving intuition before reason and emotions (ananda.org). One of the most popular of British poets was Alfred, Lord of Tennyson (1809–1892), poet laureate of Great Britain and Ireland during much of

Queen Victoria's reign. He writes that super-consciousness is a state where individuality itself seems to dissolve and fade away into boundless being. This was no nebulous ecstasy, but a state of transcendent wonder associated with absolute clearness of the mind. In poetry, as well as in reality, super-consciousness thus is the awareness of oneself in perfect love, ineffable joy and calm expansive wisdom.

Whereas the subconscious induces dreams or sleep, we are told that the super-conscious mind rests above the subconscious and conscious states. It does not involve the relaxation of energy downward in the body and mind. Rather it uplifts the soul into a supremely peaceful and energetic state. Henri Antoine Jules-Bois (1869–1943) born in Marseilles, France, educated at the College of St. Ignatius at Aix-en-Provence and Montpelier, Doctor of Psychology decreed for his researches in the field of the super-conscious dove into the topic with vigour and enthusiasm. He was active in Paris' Astronomical Society, the Society for Psychological Research, the Institute of Psychophysiology and the École de Psychologie of the Sorbonne. Jules-Bois was professor of the "superconscious". He wrote ferociously of occultism, spiritism and Theosophy in *The Invisible World* (vivekananda.net), saw super-consciousness as "the exact opposite of Freud's subconscious mind . . . which [super-consciousness] makes man really man and not just a super-animal." In a lecture in America Jules-Bois said:

> "The existence of a superconscious mind has long been recognized philosophically, being in reality the Oversoul spoken of by Emerson, but only recently has it been recognized scientifically." (Quoted in the Autobiography of a Yogi, Paramhamsa Yogananda, first ed 1946)

The Indian Swami Vivekananda in his Memoirs of European Travel said of him:

> . . . Monsieur Jules Bois is a famous writer; he is particularly an adept in the discovery of historical truths in the different religions and superstitions. He has written a famous book putting into historical form the devil-worship, sorcery, necromancy, incantation, and such other rites that were in vogue in Mediaeval Europe, and the traces of those that obtain to this day."

The famous book Vivekananda mentions is *Le Satanisme et la magie* (Satanism and Magic). Jules-Bois' noted friend Samuel Liddell "MacGregor" Mathers (1854–1918), in 1888 together with Freemasons William Robert Woodman and William Wynn Westcott founded the Hermetic Order of the Golden Dawn. It would become

the most influential hermetic society of the 20th century. It was actually the first of three orders, although all three are often collectively referred to as the "Golden Dawn". The first order taught esoteric philosophy based on the Hermetic Qabalah. It also taught personal development, through study and awareness of the four Classical Elements. These are typically referred to in ancient Greece, as well as in in Babylonia, Japan, Tibet and India, as earth, water, air, fire and ether. They propose to explain the nature and complexity of all matter in terms of simpler substances. Basics of astrology, tarot divination and geomancy were also taught on this level. The second or "inner" order, the Ruby Rose and Cross of Gold, taught magic, including scrying, astral travel and alchemy. The third order, that of the "Secret Chiefs", said to be highly skilled, supposedly directed the activities of the lower two orders by spirit communication with the chiefs of the second order. In other words, they teach everything of value to discover the Self by the self and cruise easier through life by way of that knowledge, none of which is taught to the masses, or peeons.

The British psychologist, poet, classicist, philologist and co-founder of the Society for Psychical Research Frederic William Henry Myers (1843–1901) was another one of Jules-Bois' peers. He viewed super-consciousness as "the treasure-house, the region that alone can explain the great, unselfish, heroic deeds of men." His work and ideas about a "subliminal self," though influential in his time, have by and large been rejected by the scientific community.

Jules-Bois and Myers knew what was played by those in power, considering us mere chattel equal to rattus, samia, cani, and mus. So did a slew of others in their league, their secret society pals. They knew that the above teachings influence human perceptions and indoctrinations. They knew that many a mental health practitioner created hypotheses and theories for humans' mental and physical treatments in accordance with those teachings. Not to patients' benefits but to their destruction. In addition, those treatments formed a powerful mix when combined with Bernays' advertisement genius of human mind manipulation and deception, administered by both by overt and covert, subliminal, means. Together, they knew, it would form a formidable instrument in turning us into the human animal necessary to accomplish the Matrix, the AI, the Archon agenda running at least since Elisabethan times (1558–1603). They also knew that the advance of their agenda and its final success to destroy humanity as we know entirely, depended on our ignorance of the super-consciousness and the enormous power it gives when tuning in to it. Thus anyone developing the propensity, such as PTSD experiencers,

has to be destroyed by acceptable means. The average peeons, are prevented from bubbling forth into awareness and thriving by GMO foods, embryo-soaked soft drinks, food grown with embryo-containing sludge as fertilizer, Monsanto's detrimental agricultural poison, hormone and human flesh infested meat vibrating with the brutality with which animals are raised and slaughtered. Last but not least, there are the ever present pharmaceutical drugs, chemical spraying and fluoride water poisoning.

Who is responsible for our ignorance? We are, as most of us voluntarily swallow all of it, never giving an iota of a thought, never mind taking the time to indeed contemplate or investigate what we swallow. Neither do we want to educate ourselves on it, even though the looming human health destroying and manipulated catastrophe is right in our faces, if we cared to look. But, no. Too much fascinating stuff on Facebook. Got to talk to everybody in the world for feedback and decision-making purposes. Can't make up your own mind? Can't even ask yourself: "What on Earth am I doing?" Some folk even think their ignorance, bordering on idiocy, leads to greatness, wit transgendered Ocasio-Cortez and its followers. But carry on. Do as thou will. After all, it is a free will universe — or so they say. The idea that you could change everything for yourself and thus for the world just by looking inside yourself 15 minutes twice daily never crosses your bright but feeble mind, does it? Listen to, then, to Paramahansa Yogananda (1893–1952), an Indian yogi and guru who introduced millions of Indians and westerners to the teachings of meditation. Listen to Kriya Yoga, whose organization is Yogoda Satsanga Society of India as well as the Self-Realization Fellowship. Here is what they had to say on humanity's ignorance:

> "Don't waste the perception of the God's presence, acquired in meditation, by useless chatting. Idle words are like bullets: they riddle the milk pail of peace. In devoting time unnecessarily to conversation and exuberant laughter, you'll find you have nothing left inside. Fill the pail of your consciousness with the milk of meditative peace, then keep it filled. Joking is false happiness. Too much laughter riddles the mind and lets the peace in the bucket flow out, wasting it (ananda.org)."

Yogananda himself said that the superconscious could be attained through meditation. His direct disciple, the Swami Kriyananda, described it as a state of heightened awareness, of true wisdom, of involving intuition before reason and

emotions (How to Develop Intuition (video): Swami Kriyananda, 3:35)." Born James Donald Walters (1926–2013), in 1969, he founded *Ananda*, a global spiritual movement, based on Yogananda's teachings. The name of his organization originates from the Sanskrit ananda meaning joy, happiness, bliss, from the stem of nandati "he rejoices." In Hinduism and Buddhism, as well as in Jainism, ananda signifies extreme happiness, one of the highest states of being.

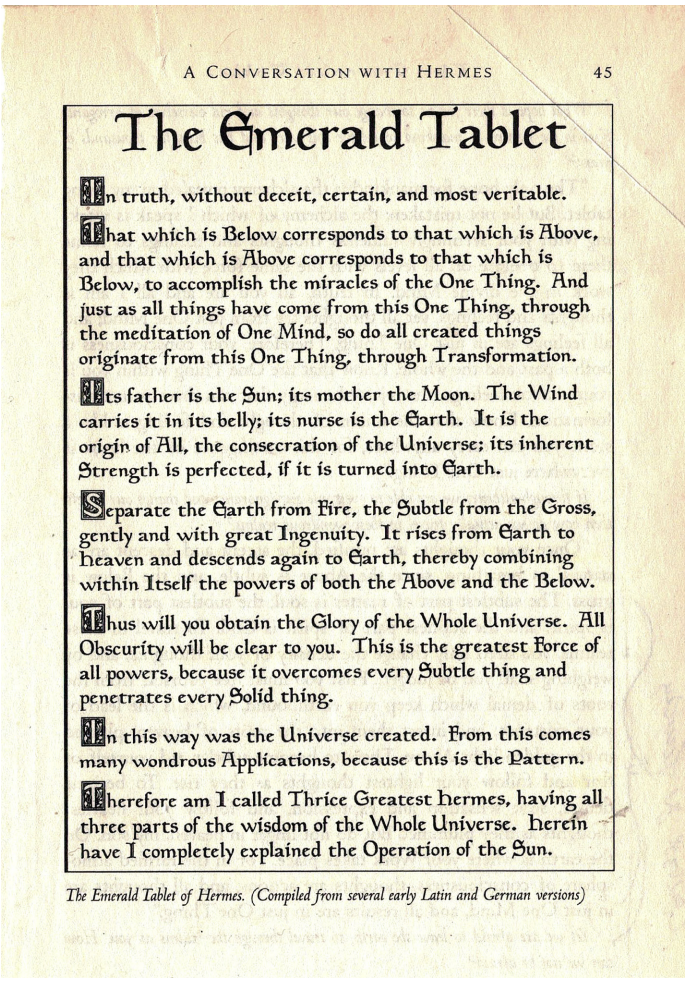
Yoganada during his lifetime and in his writings recognized that sense perceptions of the world are temporary and relative in the conscious state. But, he made it abundantly clear that super-conscious perceptions of reality are always true. It seems to me as if the jump off to the state of superconscious perception was created during the PTSD-causing event moment and thus, together with the soul departing, caused the PTSD's onset. Why else should we become so acutely aware that all we hitherto saw as the truth is all fakery, which in turn was the catalyst throwing us into the PTSD abyss? As pointed out already, only through regular twice-daily meditation and the abstinence from opioid drugs and psychotropic pharmaceuticals can PTSD journeyers find their way to recovery. Otherwise, ananda can never be obtained, nor can PTSD healing take place. *Ananda* is different from temporary happiness, which arises from sense pleasures, such as eating, listening to music, shopping, buying beautiful things, playing video games, chatting on Facebook or talking to god and sundry on a perpetual basis. All of these manifest an almost monotonous joy. Ananda refers to a joy that "changes and dances in itself and in many ways enthralling our mind and keeping our attention occupied and interested forever. (Finding the Joy in Life; publ. 1936). This joy lives within and cannot be found through anything outside our selves. When one has divine joy, the joy remains despite any difficult outward circumstances."

Practice contact with the superconscious can be obtained by keeping the spine straight and directing energy toward its seat between the eyebrows. This is known as the *ajna* chakra, also known as the guru or third-eye chakra, the sixth primary chakra in the our body. In Hindu tradition, it signifies the direct link to the Brahman and is believed to reveal insights about the future. True intuition and healing can occur on this level through, for example, the practice of positive affirmations. Ultimately, the Self realizes that superconsciousness is the native reality of being, as opposed to altered states of subconsciousness and consciousness. The consequence? Rather than being limited by conscious thoughts or subconscious feelings, the superconscious frees the soul from bondage (ananda.org). So we *do* have the power to heal ourselves from all ailments if we make a conscious effort.

Author James Vargui, however, asks whether the greatest confusion in dealing with the higher realms of human nature is the lack of a clear understanding of the distinction between the superconscious and the Self? (Roberto Assagioli/Vargui: *The Superconscious and the Self*; kennethsorensen.dk 2017).

Author of the book *The Realization of the Self (The Synthesis Press, Redwood City, California, 1974)* James Vargiu was born in Italy. He was educated in the USA in physics, mathematics, and psychology, then practiced at el Istituto di Psicosintesi in Florence, Italy with the Italian psychiatrist and pioneer in humanistic and transpersonal psychology Roberto Assagioli (1888–1974). Founder of the psychological movement known as Psychosynthesis, Assagioli's work emphasized the possibility of progressive integration, or synthesis, of the personality. Those mental health practitioners following his psychological methods and techniques are still developing his theories. Vargui is one of them.

As if it really mattered what mental health industry practitioners and whoever else in the field, from neuro-scientist to the barely educated psycho-the-rapist dabbling in it, think. The knowledge of human consciousness' truth of the matter has been around since before the Great Flood, displayed for all to see if caring to look at the Emerald Tablet. Conflicting information, confusing speculation and heated opinion surrounding its text should not hinder its exploration. In fact, depending on what you read or whom you trust, this body of work is between a mere 1,200 years or a whopping 38,000 old (ancientexplorers.com/blogs). To explain it in the most basic terms, the Emerald Tablet's text is a very brief summary of the principles of alchemy, spanning from base metal to gold to the transmutation of consciousness (Hauck, Dennis William: *The Emerald Tablet. Alchemy For Personal Transformation*, Penguin Group, 1999).



The Emerald Tablet

In truth, without deceit, certain, and most veritable.

That which is Below corresponds to that which is Above, and that which is Above corresponds to that which is Below, to accomplish the miracles of the One Thing. And just as all things have come from this One Thing, through the meditation of One Mind, so do all created things originate from this One Thing, through Transformation.

Its father is the Sun; its mother the Moon. The Wind carries it in its belly; its nurse is the Earth. It is the origin of All, the consecration of the Universe; its inherent Strength is perfected, if it is turned into Earth.

Separate the Earth from Fire, the Subtle from the Gross, gently and with great Ingenuity. It rises from Earth to heaven and descends again to Earth, thereby combining within Itself the powers of both the Above and the Below.

Thus will you obtain the Glory of the Whole Universe. All Obscurity will be clear to you. This is the greatest Force of all powers, because it overcomes every Subtle thing and penetrates every Solid thing.

In this way was the Universe created. From this comes many wondrous Applications, because this is the Pattern.

Therefore am I called Thrice Greatest Hermes, having all three parts of the wisdom of the Whole Universe. Herein have I completely explained the Operation of the Sun.

The Emerald Tablet of Hermes. (Compiled from several early Latin and German versions)

Many an esteemed philosopher over the centuries and millennia declared that the Emerald Tablet contained the sum of all knowledge. But few embraced its principles more than Balinas. Born in Tyana, Cappadocia, in 16 C.E. He is said to have found the four books purportedly written by Hermes. The first three books contained advanced instruction in mathematics and astronomy. The last one carried the inscription: “This is the secret of creation and the knowledge of the causes of all things.” It elaborated on the Emerald Tablet’s meaning and revealing the hidden relationship between humanity and the universe. “The fourth book,” Balinas wrote later, “is the noblest of all and contains powerful and terrible signs that teach the first elements of the visible things created by God, so that he who reads this book may, if he chooses, be successful in realizing such wonders.”

Though Balinas had a very cosmopolitan view of religions, and never favored one group over another, it is known that he persistently tried to change the ceremonies and liturgy in the larger cults and traditional temples to reflect the ancient mystical tradition handed down by Hermes. Hermetic tradition emphasizes

the existence of a supreme force called the One Thing, which has no perceptible form until it is grounded or expressed in material reality. The expression of that force is guided by the One Mind, the mind of the Supreme Being, and is a process responsible for the creation of the universe. Hermeticists saw the One Thing as a primordial, plastic energy that takes the form of the idea or thought projected by the One Mind. The unseen force can be contacted and controlled by mankind through divine union — merging with the One Mind in meditation and prayer. Balinas taught that, just as the One Thing exists in the universe, so it is mirrored within each human being. That immortal presence, the part of matter known as soul, evolves through many reincarnations as it seeks perfect expression, and man is only a temporary carrier of something with a greater purpose. In other words, the One Thing is the big picture, not the individual who is born and dies. Said Balinas:

> "When the body is exhausted the soul soars to the space above, full of contempt for the harsh, unhappy slavery it has suffered. But really, what are these things to you? You will know when you are no more. It is the way of everything here in the world below that when it is filled out with matter it is visible, but it is invisible owing to its subtlety when it is rid of matter. Then why this false notion of birth and death? Why has this false notion remained so long without being refuted? Some foolishly believe that what has happened through them they have themselves brought about. They are ignorant that the individual is brought to birth *through* his parents, not *by* them. The real change that comes to an individual is not caused by his visible surroundings but rather is a change in the One Thing which is in every man." (ibid. p. 9–10)

Thus the only way to change our situation is to identify with our immortal essence — the One Thing — instead of our concentration on transitory illusions like material possessions, wealth, appearance, fame or power over others. Moreover, we learn, the One Thing within us and the One Thing of the whole universe become the same in meditation. Through these correspondences between the Above and Below mankind — human kind if Canadian Prime Minister Justin Trudeau had his way– can know and live in absolute truth. That is the Emerald Tablet's message. And that is the gift of PTSD, if we care to look for ways of healing ourselves.

It is, of course another aspect of life hidden from us, the peeons, the Archontic slaves. Nag Hammadi scrolls about them says they have no imagination. They

cannot create anything from scratch. They can only take what we humans create and then pervert it with the NC *for* PTSD diagnoses and treatment modality truth perversion. Such perversions begun in earnest after the Great Flood, to nowadays reach towering heights instigated and carried out by the mental health industry with all its offspring/offshoots . Or so it seems. So, is the field of psychology and psychiatry a religion or is it a science? It is neither, as it separates humans' minds and souls from their physical body, or should we say it equates the physical body, including the brain, with the mind and soul.

Which leads to the next question: "Is superconsciousness in any way related to and/or depending on our individual human character and personality, the two aspects upon which the entire field of psychology is based and revolves around, or vice versus? Is it instrumental in influencing our life path and emotional wellbeing, the part psychology in particular cherishes to vehemently deny and ignore when evaluating our psychological state of mind? First of all, let's check out what those two definitions mean precisely, and how they stand in relation to body and soul.

56

Character & Personality; Soul & Body

The word "character" encompasses a multitude of connotations. Among others, it includes individuality, personality and the sum of the characteristics possessed by a person. It refers especially to moral qualities, ethical standards, principles, and the like: a man or woman of sterling character or ill repute for example. Individuality, of course, refers to the distinctive qualities that make someone recognizable as a person differentiated from others. Originating from the Greek *kharakter,* it merely expressed "to mark" as on an engraving. Only in Hellenistic times did it extend to denote "a defining quality, an individual feature." In use in the English language since the mid-16th century, it by and large expresses "a sum of qualities that define a person or thing and distinguishes it from another."

(etymonline.com).

The term and definition of "personality", coined from late Latin *persōnālitās*, came into use in the late 14th century, denoting "quality or fact of being a person." It refers particularly to the combination of outer and inner characteristics that determine the impression a person makes upon others, for example a vivid or pleasing/unpleasing character or personality. Since the 18th century, it has been used to designate a human being's distinctive individual qualities and character as a person. In particular, it refers to the combination of outer and inner characteristics that determine the impression a person makes upon others. For example a person might have a vivid, pleasing or a vile, vicious and unpleasing character or personality. In the late 19th century, it also began to denote people whose character stood out from that of others (etymonline.com). And in the mid-20th century, the MMPI became the instrument designed to pinpoint, for better or for worse, individuals' precise character and personality characteristics for the purpose to use it against them in WCB or insurance claims. In psychology jargon personality denotes:

- the sum total of the physical, mental, emotional and social characteristics of an individual
- the organized pattern of behavioural characteristics of the individual (dictionary.com)

The Swiss psychiatrist and psychoanalyst Carl Gustav Jung (1875–1961), who founded analytical psychology, described it as:

> "Personality is the supreme realization of the innate idiosyncrasy of a living being. It is an act of courage flung in the face of life, the absolute affirmation of all that constitutes the individual, the most successful adaptation to the universal conditions of existence, coupled with the greatest possible freedom of self-determination (C.G. Jung: The Development of Personality, 1932)."

An act of courage flung in the face of life. By the end of the 18th century, however, psychiatry began to aim for status as a medical science. So, personality characteristics dictating courage flinging in the face of life had tacitly been declared obsolete or anathema, by ascribing them to the shape and size of the cranium, hitherto being the indication of character and mental abilities. Thus the science of *phrenology*, the

detailed study of a person's structure of the scull was born. This attempt to scientifically describe personality and character and neuro-anatomy, the branch of anatomy dealing with the nervous system, got a foothold.

Phrenology, coined from the Ancient Greek φρήν *(phrēn)*, meaning "mind", and λόγος *(logos)*, meaning "knowledge"), is based on the concept that the brain is the organ of the mind, and the belief that certain brain areas have localized specific functions or modules. At least that is believed at present. When asking what brain modules are the Yahoo dot com answer is: "We don't exactly know." Although it is common to hear people say "the brain is like a computer," we read:

> "there are many ways in which the brain is very unlike a computer. This is one of them. A computer has very well-defined memory storage modules; this doesn't seem to be the case for the brain. In fact, the brain seems to have multiple different types of "memory," which are handled quite differently from one another. One thing seems to be true: memory is probably stored in a quite distributed fashion throughout the brain. Some specific brain regions particularly are important for forming and retrieving memories, but the memories themselves are probably quite distributed."

Another confirmation, of course, that neuro-psychiatrists and neuro scientists are grasping for straws when fiddling with PTSD subjects' brains, and that skull and cranium size seem to have next to nothing with personality and character.

Nevertheless, German physician Franz Joseph Gall puttered around, contemplating life and its adventures and possibilities. And so, in 1796, he developed the idea of phrenology, though its methodological rigor was considered doubtful even for the standards of its time. Many regarded it as pseudoscience. Nevertheless, it did influence 19th century's psychiatry and psychology, grasping at straws for anything useful to prove its craft as a science, though it went out of vogue in the early 1900s. Its reinvigoration, however, occurred big time in the early 2000s, to such an extent that Gall's assumption of character, thoughts and emotions being situated in specific parts of the brain is now seemingly is a given for the world's neuro-scientists and psychiatrists. Despite intensive study of anatomical brain research, Atlas mal-rotation is nowhere mentioned.

Another symptom and manifestation of psychiatry aiming to decree itself a medical science were the surfacing of psychiatry textbooks rendering abnormal human personality descriptions in accordance with Kraepelin's observer, perception

and intuition modes. By the late 19th to early 20th century, psychically gifted European psychiatrists, Kraep-a-line among them, elaborately crafted personality-system-configurations on what, in their view, constituted normal and abnormal personalities. These sprang forth as they saw fit. Thus, this sprouting occupation proposed types, dimensions and classifications of the abnormal, based on nothing even remotely resembling scientific methods, but solely created by their *clinical intuition*. Personality traits were thrown together and viewed as a continuum ranging from the normal to the pathological on their own perception, with intelligence viewed an important modifier. Whether for or against the individual is left unsaid.

Needless to say, the profession of scientific psychiatry managed to define human personality as a "curious multifaceted thing." Acknowledging that each person has a unique mix of characteristics, they consequently grabbed the opportunity to create another branch for the mentally impaired professionals to work with, the Science of Personality (*The Science of Personality*: Psychology Today, retrieved February 24, 2019). And still they raised the questions: "What is the difference between normal and pathological behavior?" "Do those doing the analysis perceive others the same way as they perceive themselves?" Even though psychological research conducted by a branch of the field known as personality psychology had made some progress to answer those questions, experts still did not understand many facets of human personality we hear expressed:

> "Because personality is so pervasive and all-important, it presents a clinical paradox of sorts: It is hard to accurately assess one's own personality, yet impossible to overlook that of others. But since personality can make or break one's relationships at home and at work — and because each person aspires to be grounded in who they truly are — researchers will continue to dig deeper into why people are the way they are and how personality influences each individual's behaviour."

This in my opinion is another indication that the MMPI serves no other purpose than to further traumatize the traumatized by finding the precise angles of attack to with ease destroy them.

Obviously, even those psychologists and psychiatrists dabbling in the science of personality differ in their own definition of personality indicators. Some maintain, however, that it tends to refer to the traits or qualities that are strongly developed or

strikingly displayed rather than its "usual" features, whatever they might be considered to be (which, I assume, are also debatable).

This raises the issue of defining abnormality, then. The task is complicated by the fact that the same terms, we are told, are often used in psychiatric diagnoses to designate both normal and abnormal personality traits. Whatever is normal for one is abnormal for another, perhaps?

In truth, then, is it really a fact that whatever mental health practitioners from the lowest to the highest rank, perceive or intuit is superimposed on clients they evaluate, including the PTSD experiencers, as we only perceive what we see in our own Self (Don Miguel Ruiz)? Would it not be equally true from psychotherapists with a three-months laymen course of schooling to the mightiest psychiatrists with decades of it under their belt? It seems to be. It also explains the 24 differing opinions derived by 24 mental health practitioners of differing ranks, none lower than clinical psychologist, after examining the same individual– me. Still, they call it science. As David Hill points out in his book *The Politics of Schizophrenia: psychiatric oppression in the United States* (David Hill; Lanham, Maryland; University Press of America 1983 ch.9) originally written as his dissertation for a doctorate degree in clinical psychology:

> "Notable in this particular manifestation is the role of science in the task of defining acceptable and unacceptable behavior, " which he calls "a history of madness, a sketchy, random reworking of that territory made familiar by Szasz, Kraepelin and Bleuler" who, in his opinion, provide the rationale for mass murder (Reviewed by G. P Pullen; J Med Ethics. 1985 Sep; 11(3): 166)."

It certainly makes it easy to drive people to suicide. And you think Hill is the only one thinking this? Watch the Citizens Commission on Human Rights (CCHR) documentary *Psychiatry: Industry of Death*. CCHR was co-founded in 1969 by the Church of Scientology and Professor of Psychiatry Emeritus Thomas Stephen Szasz (1920–2012). He was a Hungarian-American academic, psychiatrist and psychoanalyst who spent most of his career at the State University of New York Upstate Medical University in Syracuse, New York, at a time when patients were being warehoused in institutions and stripped of all constitutional, civil and human rights. The CCHR functions solely as a mental health watchdog, working alongside many medical professionals, including doctors, scientists and nurses. It also works with those few psychiatrists who have taken a stance against the biological/drug

model of "disease" continually promoted by the psychiatric/pharmaceutical industry to sell drugs. It is a non-political, non-religious, non-profit organization dedicated solely to eradicating mental health abuse and enacting patient and consumer protections. CCHR's Board of Advisers called Commissioners, include doctors, scientists, psychologists, lawyers, legislators, educators, business professionals, artists and civil and human rights representatives (cchr.org). The documentary's trailer states:

> "Through rare historical and contemporary footage and interviews with more than 160 doctors, attorneys, educators, survivors and experts on the mental health industry and its abuses, this riveting documentary blazes the bright light of truth on the brutal pseudoscience and multi-billion dollar fraud that is psychiatry. We think you have the right to know the cold, hard facts about psychiatry, its practitioners and the threat they pose to our children. Get the truth — watch this film. Governments, insurance companies and private individuals pay billions of dollars each year to psychiatrists in pursuit of cures that psychiatrists admit do not exist. Psychiatry's "therapies" have caused millions of deaths."

And, lest we forget, the US government, and thus its citizens, sanctions those maltreatments wit PTSD-affected veterans and soldiers. This treatment filters down to other genuine PTSD experiencers worldwide, due to the psychiatric cabal's power. Here too, however, the deception perception about mental illnesses and psychological disturbances and their origin began already centuries ago, during the 1700s, with the French physician Philippe Pinel (1745–1826). Instrumental in developing a more humane psychological approach to the custody and care of mentally disturbed people, some describe him as "the father of modern psychiatry". He actually acknowledged that *"the medic"* had been introduced into asylums primarily as an authoritative representative to enforce society's moral norms. The English Quakers who ran some of those asylums openly and proudly espoused the goal of producing such desired socially acceptable behavior in their charges. Thus, for a very brief period in history, the institutionalization of social control had been acknowledged for what it was. They were forcing government-dictated social norms and behaviors on the recalcitrant, those having an obstinately uncooperative attitude toward authority and discipline. Nothing new in that, though, either. Has the killing of individuality by whatever means not always been goal of the one

percent of the one percent who rule the world's 99 percent of humanity? Have they not, for thousands of years, killed or thrown into asylums, Gulags and prisons by the thousands those who refused to fit into their ideas of socially acceptable behavior, the Solzhenitsyn's and Mikhail Alexandrovich Bakunins of the world, for example (1814–1876)?

Considered one of the principal founders of the social anarchist tradition, Bakunin gained enormous prestige as an activist, making him one of the most famous ideologues in Europe.

Solzhenitsyn spent years in the Gulag asylum of Siberia. Bakunin spent three years in St. Petersburg's Peter and Paul Fortress underground dungeons. Then he spent another four years in the castle of Schlüsselburg, built by Grand Prince Yury of Moscow on behalf of the Novgorod Republic in 1323. It guarded the northern approaches to the city of Novgorod and gave access to the Baltic Sea. During Imperial times, it was used as a notorious political prison. It was here that Bakunin suffered from scurvy, all his teeth falling out as a result. He later recounted that he found some relief in mentally re-enacting the legend of Prometheus. His continuing imprisonment in these awful conditions led him to entreat his brother to supply him with poison. In his book *The Gulag Archipelago* (published in 1973), Solzhenitsyn recounts that Bakunin "abjectly groveled before Nicholas I — thereby avoiding execution, wondering: "Was this wretchedness of soul? Or revolutionary cunning?" (Translation by Thomas P. Whitney p.132)

So, what then *is* considered socially acceptable behavior? Simply put, it is a mode of behavior that is accepted as "normal" or appropriate within a social culture or subculture and does not threaten its rulers. Keeping in mind, however, that a social subculture may often be as small as just two people, the practical definition of socially acceptable actions can quickly become quite granular. Taking into account the various factors that may be in play in each circumstance where the opportunity for social appropriateness arises, what is considered socially and politically acceptable in one part of the world may be completely anathema in another. For example, the Australian government on February 22, 2019, revoked David Icke's entrance visa 4 hours before taking his flight from Los Angeles to Melbourne as "his opinion could lead to populace upheaval." The visa had been granted in September of 2018. He had previously spoken ten times in the country without incident. Is his incarceration next, or will he be killed to silence him? He had spoken in Acapulco, Mexico, a few days earlier without government objection.

In our case the question arises: "If PTSD affected, rattled to the core due to their

PTSD-causing event experience, and if off drugs analyzing their reason for being undoubtedly leads them to wisdom (thus becoming a possible danger to authority), still have socially acceptable behaviour by NC *for* PTSD standards?" Who decides? The attending psychiatrist of course! Game over.

But first and foremost, what indeed is considered socially acceptable behavior? Mike McClaughry's *Primer of terms that slave-masters used that don't mean what you think they mean* notes that "social" is one of the words (Book: Scientology Roots: mikemcclaughry.wordpress.com/the-reading-library/scientology/scientology-roots/). Slavery, by the way, existed throughout human recorded history and not just since Elizabethan times. Colleen McCullock of *The Thornbirds* fame gives magnificent insight into this in her series on the Roman Empire, beginning circa 150 BC. The concepts behind the terms of slavery are no different today than they were in those days. The only difference is that the adulation demanded for "God" was replaced by the adulation of the ruling classes, royalty and todays' cloaked slave-masters, the world's bankers. Their meanings for words are different from ours, McClaughry says. Viewing themselves as extremely superior to everyone else, all others must worship them, praise them, bend the knee to them, figuratively or otherwise, submit, obey, comply and fulfill every desire they, humanity's slave-masters, mental health practitioners included, dictate. Their definition forms the meaning of humanity's acceptable social behavior, which is:

- society — the only proper society is one where the slave-masters rule
- social — being a willing subject in the slave-master society
- anti-social — rejection of the slave-master society
- mental health — same idea as social
- mental illness — same idea as anti-social
- enlightened — same idea as social
- unenlightened — same idea as anti-social
- world peace — no wars, because everyone is social, meaning willing and obedient slaves.

(*Scientology Roots* by Mike McClaughry, Chapter 13-2 The Maitreya and Messiah scam).

Scottish Psychiatrist R.D. Laing noted that the social versus anti-social behaviour definition was defined by how it made others feel, and not at all about real care for the *"undesired" or "undesirables". He states:*

> "We can see other people's behaviour, but not their experience. This has led some people to insist that psychology has nothing to do with the other person's experience, but only with his behaviour . . . What I seemed to be engaged in was a concerted effort to stop undesired states of mind and conduct, and to keep undesired people in such undesired states of mind and conduct away from people outside, who did not want them around (Laing, R.D.: The Politics of Experience and The Bird of Paradise, Penguin Books Ltd., Harmondsworth, Middlesex, England, 1967)."

In other words, psychiatric treatment by psycho-the-rapists or psych-ia-trists, the curer-renderer, the bringer of tristesse, sorrow, to the human psyche, has nothing to do with helping people like those afflicted with PTSD. The goal is merely to produce socially acceptable behavior, as dictated by society's rulers, particularly in the bright ones, by rendering them drug addicts. Why? Because, if freeing themselves from mental industry practitioners' clutches, they might be a danger to them? How? They will attempt to make their drugged peers aware of their drug-instigated delusions. They might awaken them to the inherent power within, that what we see is merely a fraction of what there is to see. And what they see might include that the industry itself tells us by their own clinical definitions who and what they are: psych-the-rapist, the raping psychic, the ones procuring–or sowing –sadness in the mind, salting it down. They would see that psychiatrists, by their actions, are living up to the same terms, with the very few exceptions confirming the rule. And it is all done by the willful perversion and misinterpretation of PTSD as a mental disorder of our innate character and personality to justify their hypotheses. This they do instead of acknowledging that it is "nothing other" than a severe existential crisis, known to exist for millennia, that will pass with time under conditions of peace and quietness, love and compassion. If desired, perhaps even with psychoanalysis to help the experiencer on the road to self-analysis.

The term psychoanalysis was coined in the 1580s as "resolution of anything complex into simple elements". It comes from from Medieval Latin *analysis*, which originated from the Greek *analysis,* "denoting the solution of a problem by analysis". It literally means "a breaking up, a loosening, releasing". The noun of action from *analyein* means "unloose, release, set free; to loose a ship from its moorings." It can be seen in Aristotle, "to analyze," from *ana* "up, back, throughout" plus *lysis,* "a loosening," from *lyein,* "to unfasten" (from PIE root *leu- "to loosen, divide, cut

apart"). Ana, however, also has a triple meaning denoting:

1. "upward, up in place or time"
2. "back, backward, against"
3. "again, anew," from Greek *ana* (prep.)

So here again we have proof that everything is perverted by way of words we use. So, what is nowadays being loosened from its mooring? What resolution turns anything complex into a simple element? The innate character and personality of PTSD journeyers and other humans, by drugging them into mental oblivion and doing it by the words used by those filling the prescriptions?

French psychoanalyst and psychiatrist Jacques Marie Émile Lacan (1901–1981) was deemed by some to be "the most controversial psycho-analyst since Freud." He suggested that *we are* our words. It is not we who speak our words, but instead the words that we speak define who we are. And yet, as soon as we speak, our listeners misunderstand us, for we all attach our own individual meanings to the words we use. Therefore, whatever we say is always going to be more or less different from how our listener understands what we are saying. It will vary according to their own level of knowledge, intentions and, most likely, character and personality. The larger our global knowledge base, the better our vocabulary, and knowledge of the precise meaning of the words we use will be reflected in the way we carry ourselves in regards to honor, integrity and graciousness. And the better we are able to convey our thoughts to self, and consequently to others. The drawback? Fewer and fewer people are able to comprehend what we actually say.

I believe it is partially for that reason that the comedian George Carlin could insult his audience with such jubilant expertise, resulting in laughter rather than their acrimony. He had it down to a fine art, because very few understood what he actually said. Otherwise they would have ceased laughing, as he told them the truth about themselves. But, to quote Lacan:

> "Language is meant to be misunderstood. Therefore much of psychotherapy consists of asking our patients to clarify and elaborate on what they have just told us so we can have a closer understanding of what they have in mind."(Gerald P. Perman, MD: Jacques Lacan: The Best and Least Known Psychoanalyst p. 2; Psychiatric Times Dec. 19, 2018)."

It's a con-game. That language is meant to be misunderstood, I already saw when

mandated to deal with those 24 mental health practitioners in the course of 10 years. All were seemingly experts in word – and therefore mind – manipulation. It was torture employed by words, rather than by physically (corporeal) subduing individuality, for whatever reason. It was mental torture, in an attempt to force a free spirit, a soul, a mind (incorporeal) to bend, break or change through persistent verbal attack. In combination with pharmaceutical drugging, it will destroy both mind and body, character and personality. Psychiatrist R.D. Laing describes that the same obsession to enforce socially acceptable behaviour is alive and well today, just as it was in the 1700s and 1800s hundreds. Says he:

> "Most psychiatrists believe, for instance, that something should be done to the brain of someone who reports that their thoughts get blocked by external influences, that thoughts are stolen from and inserted into their minds by external agencies (ibid)."

Thoughts inserted into their minds from someone outside of them? Like . . . "God's will" being attributed to be channelled from an external agency. In this case, is it the mental health practitioners enforcing their own thinking, their own ideas, their own hypotheses and psychic hallucinations about PTSD onto PTSD journeyers? Furthermore subjecting them to mental torture inflicted with gene-therapy and all sorts of other types of mind-manipulating strategies? Amounting to the same as "God's will", and unacknowledged by those unable to recognize that true evil is the face we know and the voice we trust, our assigned mental health practitioners? Antoine Marie Joseph Artaud, better known as Antonin Artaud (1896–1948), the French dramatist, poet, essayist, actor and theatre director, was widely recognized as one of the major figures of twentieth-century theatre and the European avant-garde. As he saw it:

> " . . . it isn't man but *the world* that has become abnormal . . . . Things are bad because the sick conscience now has a vital interest in not getting over its sickness. So a sick society invented psychiatry to defend itself against the investigations of certain visionaries whose faculties of divination disturbed it." Antonin Artaud (Hirschmann Antonin Artaud Anthology, 1965)

But this state of affairs for the overlords to command their idea of socially acceptable behavior from humans is old hat in known world history. As a matter of fact, some researchers contend that the powers that be act in accordance with The

Code of Nesilim, an ancient Hittite legal code dating from circa 1650–1500 BCE. (Nesilim is the Hittites' name for themselves). It reflects the empire's laws in regards to its social structure and its sense of justice and morality, as well as addressing common outlawed actions. Among them are assault, theft, murder, witchcraft and divorce. One of its most significant topics, however, concerns the treatment of slaves. Although they were considered lesser than free men, under the code, slaves were allowed to choose whomever they wanted to marry, to buy property, open businesses and purchase their freedom. In other words, nothing has changed, with the exception that nowadays we are disallowed to purchase our freedom. But that's no problem, either, as most of humanity believes they are free as birds. The German polymath Johann Wolfgang von Goethe (1749–1832) stated almost a couple of centuries ago: "None are more hopelessly enslaved than those who falsely believe they are free." So human enslavement continues unabated. And so do the ever more obvious pervasive, perverted and concerted efforts to stop undesired states of mind in the slaves by enforcing socially acceptable conduct in accordance with the religion and science of psychiatry by way of psychotropic drugs.

And it is our duty to Self to take responsibility for it. After all, we are in this situation due to our overall supreme ignorance of the meanings of words and their usage, illiteracy and pure all-pervading sloth. It is also due to AI, Wi-Fi, G5 technology, drugging and genetically modifying us to the hilt. It equally due to an educational system that indoctrinates us from kindergarten, creating the robot-like new humans. Because of our acceptance, total control over humanity is within the elite's grasp, and largely thanks to whom? Ourselves! To repeat R.D. Laing's words spoken almost 4000 years after the Code of Nesilim was Hittite law:

> "Most psychiatrists believe, for instance, that something should be done to the brain of someone who reports that their thoughts get blocked by external influences, that thoughts are stolen from and inserted into their minds by external agencies . . . we take their thoughts away if we can, including the thought that they want to keep them."

What is happening now, as if EMF were not enough to warp humanity's electrical system into coils? Through the double-edged sword of G5 and other technologies, they are apparently able to both steal thoughts from our minds and implant thoughts into our minds without our knowledge. The Greek playwright Euripides (480–406 BC), a tragedian of classical Athens, wrote: "A slave is he who cannot speak his thoughts." "A psychiatric patient may or may not be allowed to

think them!" Laing stated in rebuttal 2500 plus years later. So the subliminal advertisement-gags of Freud, Bernays et al. merely served to kick-start the agenda of humanity's complete enslavement. The censoring of freedom of expression all over the world under the guise of "political correctness" is in full swing. Two plus two equals five, according to Alexandra Ocasio-Cortez et al. Drumming into us that we have the power to control and hurt one another's feelings, is another mental health industry fabricated perversion of the truth, just as they did with PTSD. As if we had the power to hurt the other's feelings unless he or she allowed it! So, everything is upside down, perverted, all done to facilitate our total enslavement under the guise of taking care of and watching our mental and physical health and wellbeing. Puke-time.

PTSD journeyers' treatment is its reflection. Those pretending to treat us literally clobber us into submission to comply with their treatment or to cut us off all financial sustenance, thus for most assuring an inability to maintain home and hearth. Again, look at tent cities springing up all over the US, the homeless on your streets, all because of your curing mental health practitioners. As Laing says:

> "[psychiatry] It is the only branch of medicine that treats people against their will, in any way it likes, if it deems it necessary. It is the only branch of medicine that imprisons patients, if judged necessary."

Nothing new there either, though, as Stephen A. Diamond, Ph.D., points out in his 2018 *Psychology Today* article "Who Were the Alienists? A novel and new television series resurrect a curious old term". The earliest alienists were extremely biologically oriented in regard to their understanding and treatment of mental illness. This included neurosis, and especially schizophrenia, psychotic depression and mania, he says. But Freud and his contemporary Jung, rather than focus on the neurology or physiology of mental disturbances, were the first to acknowledge and focus on the *mental illness-psychology*. The word or description derives from the Greek *psykhē,* or "breath, spirit, soul", and from the word-forming element "logy", meaning "a speaking, discourse, treatise, doctrine, theory, science" from Greek -*logia.*

Their views profoundly influenced the way psychiatrists and psychologists in the early 1900s and beyond began to conceptualize mental disturbance symptoms. The 21st century has seen what Freud himself might call a *reaction formation* and Jung an *enantiodromia, one* extreme turning into its opposite, regarding their emphasis on psychology over neurobiology. In other words, during the past 100 years, the

historic pendulum has swung from the crude biologism of the early alienists to the penetrating psychological insights of depth psychology to, in the end of the 20th century, return to the 19th century's predominantly neurobiological and medical conceptualizations and treatments of mental disorders.

Is this, then, the reason and excuse for the creation and sudden expansion of official mental disorders now numbering 300, with no science behind them, listed in the bible of psychiatry, the DSM-5? Is it therefore we, humanity of over seven billion souls, who allow the very few to do everything in their power to impair our health from the moment of birth, because we gobble up untested whatever any of their cabal deems us to suffer? Is the never ending preaching about the *Doctor Knows Best* fallacy and consequent drugging making us nuttier by the minute, motivating us to do nothing about this elite created insanity? Is this why medical psychiatry took over from psychology in the hierarchical structure of mental health practitioners? Are we being forced into the Matrix Soma society through our own ignorance? Whatever happened to "Created in God's image and thus perfect" maxim? What happened to the "Help thyself so help you God?" What on Earth happened? Well? "You are a slave, Neo," we heard in the Matrix, and the sooner we comprehend that with the core of our being, the sooner we can free ourselves from our master's shackles. But that can only happen if we overcome our television, video and cellphone addictions, our pharmaceutical and opioid induced sloth and torpor, effectuating our self-destruction, as produced and directed by our masters over millennia.

As Rappoport points out, this production of human destruction we allow to be shuffled down our throats is a program of opinion-manipulation and propaganda, brainwashing humanity into the belief that we are deficient in serious ways. It tells us we are limited in all undertakings, that we have inherent flaws of brain-function and must receive chemical treatment to adjust these deficiencies. And then they have the audacity born out of ignorance to, with Darwinian logic, call it "evolution? Is that the true manifestation of insanity perfected, a manifestation so visible it is invisible to the mass-media and academically educated blind? Waking up to the scam it all is might be a fine idea, instead of calling it progress. After all, it has been known for thousands of years that human beings are perfectly capable of healing themselves.

Ask PTSD journeyers if they were ever told by any of their VA, NC *for* PTSD, WCB, employer-paid mental health physicians they were mandated to see:

"There is nothing wrong with you. You are living through an

existential crisis. You *will* get through it and in the end be much better than you ever were before. It may take time. What can I do to help you?"

They'd rather kill themselves. It is like William Mount said in his May 2017 YouTube address: "Dying Veteran Tells All About How The VA Treats Veterans. It's called Murder!" Yes, and all because those employed by "the system" are mandated to get rid of expendable flesh, the human debris, not to heal it.

While most humans seem to dwell in woeful ignorance watching the performance, is there anything one can do to heighten their awareness? Of course not. Why? Because we lack the power to make anyone see what we see, understand what we understand, acquire the knowledge necessary to heal the Self and, through it, acquire the wisdom and the power associated with it honing the elimination of Karma through Dharma. This is the gift of PTSD, if we can see it, perceive it, have the willpower, determination, persistency and discipline to live it, whilst attempting at all times to carry ourselves with honor, integrity and graciousness when dealing with our opponents. The difficulty is enormous; the rewards equal everything imaginable and more.

The only blessing in this play? Few mental health practitioners possess knowledge about all of the NC *to enhance* PTSD- and Veteran Administration-advocated PTSD treatment concoctions. And a few good guys are still around. This might limit adherence to VA/DoD and NC*for*PTSD treatment guidelines for mental health practitioners which, we read, *realistically* only ought to be used when in consultation with PTSD clients to determine the best means of intervention (healthquality.va.gov). What really does intervention mean? Action taken to intentionally become involved in a difficult situation in order to improve it or prevent it from getting worse, more unpleasant, difficult or severe or more severe than something else caused by said intervention. The VA/DoD furthermore encourages clinicians to supplement its guidelines with relevant resources, depending on therapy goals, client suffering and *relevant client resources.* We are advised that these include time and money patients can cough up for treatment, their readiness for change, their motivation to deal actively with the trauma, their openness to particular treatment modalities and their psychological mindedness (PM). Does *relevant client resources* mean the VA and DoD are mandated to financially or otherwise assist PTSD affected soldiers and veterans in their recovery for the purpose of healing? Of course not! That's up to the client.

And what about psychological mindedness? Well, here it is in all its convoluted

glory displaying to perfection the range of perversion permitted in evaluation and diagnosis when mental health practitioners pass judgment on PTSD experiencers and thus decide their future. Psychological mindedness (PM), often referred to by the acronyms *OCEAN* or *CANOE*, is purportedly related to clients' psychological strength and negatively weakness, all of which is again based upon our character and personality as the examining mental health practitioner perceives it. OCEAN and CANOE are composed of the personal characteristics of openness, conscientiousness, extroversion, agreeableness and neuroticism. Here are their definitions according to psychology jargon:

- **OPENNESS TO EXPERIENCE:** inventive/curious vs. consistent/cautious. Appreciation for art, emotion, adventure, unusual ideas, curiosity and variety of experience. Openness reflects the degree of intellectual curiosity, creativity and a preference for novelty and variety a person has. It is also described as the extent to which a person is imaginative or independent and depicts a personal preference for a variety of activities over a strict routine. High openness can be perceived as unpredictability or lack of focus, and more likely to engage in risky behavior or drug taking. Also, people who have high openness tend to lean towards being artists or writers in regards to being creative, and appreciate the significance of the intellectual and artistic pursuits. Moreover, people with high openness are said to pursue self-actualization specifically by seeking out intense euphoric experiences. Conversely, those with low openness seek to gain fulfillment through perseverance and are characterized as pragmatic and data-driven, and sometimes even perceived to be dogmatic and closed-minded. Some disagreement remains about how to interpret and contextualize the openness factor.
- **CONSCIENTIOUSNESS:** efficient/organized vs. easy-going/careless. A tendency to be organized and dependable, show self-discipline, act dutifully, aim for achievement and prefer planned, rather than spontaneous behavior. High conscientiousness is often perceived as stubbornness and obsession. Low conscientiousness is associated with flexibility and spontaneity, but can also appear as sloppiness and lack of reliability.

- **EXTRAVERSION:** outgoing/energetic vs. solitary/reserved. Energy, positive emotions and surgency, a trait aspect of emotional reactivity in which a person tends towards high levels of positive affect. Affect is a concept used in psychology to describe the experience of feeling or emotion. Extraversion also includes assertiveness, sociability, talkativeness and the tendency to seek stimulation in the company of others. High extraversion is often perceived as attention-seeking and domineering. Low extraversion causes a reserved, reflective personality, which can be perceived as aloof or self-absorbed. Extroverted people tend to be more dominant in social settings, as opposed to introverted people, who may act more shy and reserved.
- **AGREEABLENESS:** friendly/compassionate vs. challenging/detached. The tendency to be compassionate and cooperative rather than suspicious and antagonistic towards others. It is also a measure of one's trusting and helpful nature, and whether a person is generally well-tempered or not. High agreeableness is often seen as naive or submissive. Low agreeableness personalities are often competitive or challenging people, which can be seen as argumentative or untrustworthy.
- **NEUROTICISM:** sensitive/nervous vs. secure/confident. Neuroticism identifies certain people who are more prone to psychological stress. The tendency to easily experience unpleasant emotions such as anger, anxiety, depression and vulnerability. Neuroticism also refers to the degree of emotional stability and impulse control and is sometimes referred to by its low pole, "emotional stability". A high stability manifests itself as a stable and calm personality, but can be seen as uninspiring and unconcerned. A low stability expresses as a reactive and excitable personality, often very dynamic individuals, but they can be perceived as unstable or insecure. It has also been researched that people with higher levels of tested neuroticism tend to have worse psychological wellbeing.

Other studies have linked psychological mindedness to tolerance of ambiguity, mindfulness, empathy and positive adjustment capacity. It has also been associated negatively with problem-oriented psychological constructs, such as the personality factor of neuroticism, the cognitive constructs of magical thinking and external

locus of control and early maladaptive schemas. The Schema Therapy Institute defines schemas as "broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree." (schematherapy.org)

Low PM has been linked to alexithymia, literally meaning a lack of words for feelings. It is not seen as a disorder, but rather as a personality trait. People who experience alexithymia are unable to recognize emotions and their subtleties and to understand or describe thoughts and feelings. These are also side-effects of many a psychotropic drug, Ativan among them. It even sometimes includes the inability to understand the emotional experience of others. It might also suggest the reason why certain clinical patients do not respond to counselling. Humans who do not exhibit a clear predisposition to a single factor in each dimension above are considered adaptable, moderate and reasonable, yet they can also be perceived as unprincipled, inscrutable and calculating. Depending on how much of each trait a person has, it could make someone more susceptible to participating in certain activities.

A client open to exposure, for example, would be well suited to prolonged exposure (PE) or cognitive processing therapy (CPT), our rattus-, simian-, mus- and cani-family tried and tested treatment, we are told. The National Center for PTSD and the U.S. Department of Veterans Affairs view *Prolonged Exposure Therapy: PTSD* such:

> "There is apparently strong evidence supporting the use of prolonged exposure (PE), and cognitive processing therapies (CPT), with PE possessing the most empirical evidence in favor of its efficacy. Prolonged Exposure (PE) for PTSD is a specific type of cognitive behavioral therapy. PE teaches to gradually approach trauma-related memories, feelings, and situations avoided since the PTSD causing event occurred. By confronting these challenges, one can actually decrease the PTSD symptoms. People with PTSD are said to often try to avoid anything that reminds them of the trauma, which may make them feel better in the moment, but not in the long term. Avoiding these feelings and situations actually keeps you from recovering from PTSD, the researchers claim. PE works by helping the afflicted face these fears. By talking about the details of the trauma and by confronting safe

situations that one has been avoiding, one can decrease the PTSD symptoms and regain more control of ones life."

Yes, it all might be fine and dandy, but how are researchers determining what PTSD afflicted consider a safe or unsafe situation? How do they intend to accurately recreate the PTSD-causing event situation, including the experiencer's momentary psychological state of mind? How do they assume the power to do so, when they were not even there. How, when they are always sheltered in their academic and own-little-home environment, with little other life experiences than those gathered communicating with their colleagues and those on whom they practice their craft? The manifestation of their enormous ignorance, arrogance, phenomenal stupidity and getting away with it could create hyperventilation and raising blood pressure if one allowed it.

If a client was averse to exposure, other time-limited alternatives were available, such as Inter Personal Therapy (IPT). In case of clients resistant to the "opening up" required for talk therapies, however, and if initial forays into the reasons for their hesitancy were unsuccessful, or if clients remain adamantly opposed to therapy, referral to competent psychiatrists for medication management would be appropriate, we read in VA-supplied literature.

Psychotherapist resources to consider, primarily include the range of their competent therapeutic intervention as they do not receive uniform training. Indeed, some lack direct experience with manualized empirically supported approaches altogether. To refresh our memory, a manual method — a manualized therapy — is an experimental approach that aims to ensure consistency in results and conations across a research project by maintaining rigid conditions and settings. In other words, the manual method aims to ensure the mental faculty of purpose, desire or will to perform an action and the volition across the research project (Psychology Dictionary).

Mind you, Barber and Sharpless et al. also claimed that there had been relatively few studies of psychodynamic, interpersonal and dialectical behavior therapy perspectives. They said that there was no evidence that these treatments were less or more effective. Pharmacotherapy, however, was especially promising, in particular with the antidepressant drugs paroxetine, sertraline and venlafaxine. More research comparing the relative merits of medication versus psychotherapy and the efficacy of those treatments combined were, however, needed. That pharmaceutical drugs are depression- and suicide-inspiring and destroy the human mind and the body's vital organs is, of course, inconsequential to them. And you still think that your

character and personality is unchanged if you consent to their treatments? Think again. Then, think harder, or it might kill you!!

A thorough assessment and thoughtful consideration of PTSD clients' degree of suffering would also be appropriate, as it constitutes another key element of treatment choice, we are told. Relevant variables included, but were not limited to, comorbid psychopathology, such as personality and other anxiety disorders. So were the presence of pre-existing cognitive limitations or those arisen due to traumatic brain injuries. Clients with significant Axis-II pathology, who regularly engaged in para-suicidal behaviours, might benefit from a longer-term treatment approach, such as dialectical behaviour therapy. That, as you recall, is the modified form of cognitive behavioral therapy (CBT) developed to treat people with borderline personality disorder and those chronically suicidal.

And what is Axis II, you wonder? Personality disorders and Borderline personality disorder (BPD) are typically diagnosed using the official guidebook for the diagnosis of psychiatric disorders, the Diagnostic and Statistical Manual of Mental Disorders currently in its fifth edition, the DSM-5 (verywellmind.com). The previous DSM, the DSM-IV-TR, used a "multi-axial" diagnostic system meaning that when a diagnosis was made attention was paid to five different areas, or axes, that could affect the individual being diagnosed. Axis I was used for the diagnosis of psychiatric disorders such as major depressive disorder or PTSD. Axis II was reserved for long-standing conditions present before adulthood with significant impact on functioning and typically lasting for years like personality disorders and mental retardation. In theory, the rationale for relegating personality disorders to Axis II was to assure they did not get lost in the woods during the diagnostic process. By coding the personality disorder on Axis II, a person with multiple clinical disorders on Axis I, for example, could with ease be diagnosed with personality disorders on Axis II from the cradle onwards, a given in genuine PTSD situations, as they were right at hand.

Another reason that APA psychiatrists decided to put personality disorders on Axis II in the DSM-IV is said to relate to the course of these disorders. Whereas Axis I disorders tend to be episodic, meaning on-again, off-again, Axis II personality disorders are thought of as chronic, meaning they occur and continue over years. The DSM-5 relegated everything to one axis to ostensibly – meaning apparently or purportedly, but perhaps not actually – make diagnosing easier. However, diagnosing, assessing and treating personality disorders basically remained the same as in the DSM-IV, we are told, even though all

perceived mental disorders are classified under "personality disorders" and "intellectual disorders" including mental retardation (medicaldictionary.thefreedictionary.com/Axis+II). They include paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, dependent, obsessive compulsive, personality and NOS= not otherwise specified. In this way it gives practitioners free range to hypothesize at will, and speculate about PTSD experiencers and others in their hands, and render diagnoses suitable to their mood of the day. Such fun and joy!

In contrast, a PTSD client with comorbid agoraphobia might be helped by an exposure-based protocol, modified to address both problems. This type of minor modification to treatment is different than working with PTSD-affected traumatic brain injury clients with serious cognitive deficits. They might need a more extensive adaptation of treatment manuals, such as using multiple memory aids or involving family members to help them complete homework. Further, it might be appropriate to recommend that clients seek out a medication consultant, as there are a number of options to augment psychotherapy, we read. Referring a client with disabling nightmares to a psychiatrist for prazosin was another splendid move, the authors conveyed.

Returning to the VA/DoD and NC*for*PTSD treatment guidelines, it is refreshing to learn that lacking competence in a PTSD treatment or ongoing consultation/supervision and practicing in an unfamiliar PTSD treatment concoction *may* be a violation of the American Psychological Association's (2002) Ethics Codes. Fortunately for practitioners, most orientations have, in the eyes of their beholders, received some (albeit limited) degree of empirical support, we learn. If PTSD clients are likely to be seen in one's practice, and in the absence of additional training and supervision, it's playtime. Learn as you go is recommend, while choosing the supported modality most closely within the range of one's competence. Then take steps to learn the empirically-supported adaptation for PTSD, and off you go. Providing appropriate referrals for clients one does not feel confident to treat is another, and perhaps the best, solution, we hear.

The American Psychological Association's Ethics Codes at apa.org under Ethical Principles of Psychologists and Code of Conduct are voluminous. The following one stands out to me, however, knowing full well how and with what PTSD journeyers were and are treated, with the full knowledge of most of those treating them: Principles of Psychologists and Code of Conduct:

"3.04 Avoiding Harm: (a) Psychologists take reasonable steps

> to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable."

Accept for two psychiatrists, the Code was broken by everyone with whom I was forced to deal. Thus, I conclude that most all of them are practicing and dishing out their own treatment preference with little conscience. Don't be fooled by Barber and Sharpless' assurance that PTSD clients' preferences and goals for treatment, as they indeed affected treatment choice and length. In their opinion, client wishes are clearly relevant, as they may imply one modality over another. Therefore, preferences, especially when very strong, were something to carefully consider, Barber and Sharpless emphasize. But they dwell in dream land again, viewing fata morganas in their delusional thought perceptions of reality. The fact si that PTSD journeyers at onset have no clue what's happened to them and are ignorant enough to believe the physician in charge of treatment, the true evil, etc. syndrome, yet slumbering unawakened in their psyche. And the treating physician? Well, for heaven's sake, the longer the treatment the bigger the financial gain, duh!

Ideally, all decisions made and diagnoses issued would be governed by data, Barber and Sharpless convey. But unfortunately, it is difficult to imagine a time when this level of empirical support would be available, given the number of treatments, trauma types, and potentially relevant client variables and comorbidities. The number of random control trials required to do so would be staggering, they say. Therefore practitioners' clinical judgment, knowledge of idiosyncratic client contexts and intervention competence were all required supplements one had to play with, in addition to empirical data, which they should follow when appropriate and possible. As exposure-based therapies –the cani, rattus et al. PTSD treatment theories–had the most support, the ideal scenario envisioned would be for all psychotherapists to enlarge their clinical repertoire with at least one of those previously mentioned. As the pace of dissemination increased, this should become easier to accomplish. The hallucinated that even novel ways to more seamlessly integrate these techniques into other modalities may be on the way. Here is their opinion verbatim:

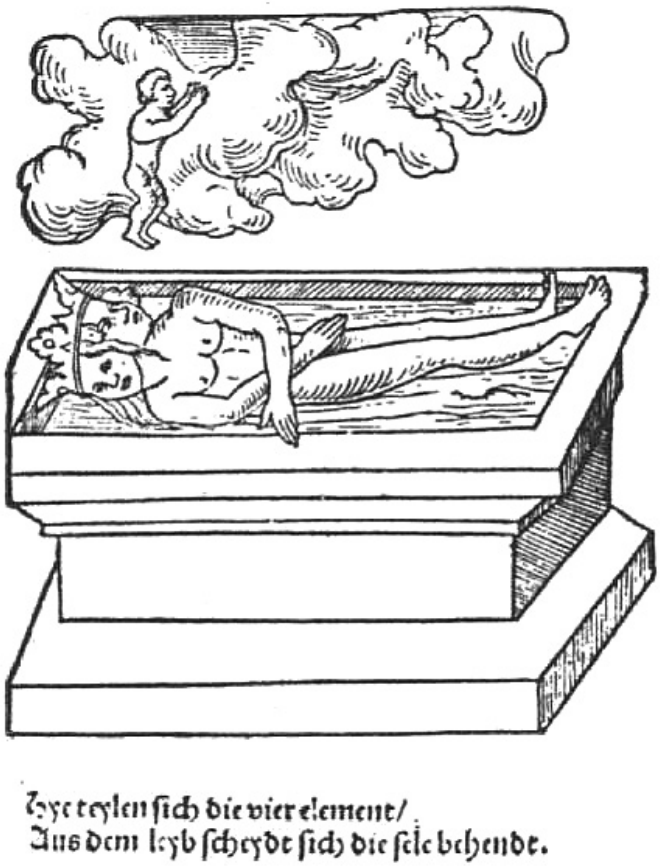
> "Exposure therapies (notably PE and CPT) and EMDR have been widely adopted in practice guidelines, and existing research suggests that they are effective treatments for PTSD. However, given the heterogeneity of PTSD clients, there is

> little data supporting the use of one specific treatment modality over others. More importantly, there is no evidence that a particular intervention is better suited for a specific trauma type (i.e. rape) or that one treatment is more effective in military populations. There is also not much evidence that one form of therapy is effective for all types of traumas, and there is a clear need for more studies examining the efficacy of these treatments for military personnel and Veterans. This may be particularly the case for Veterans with substance abuse issues, but this awaits additional research. As studies become more fine-grained and numerous, it could become increasingly possible to answer these more specific efficacy questions. It is also important to note that there is a paucity of research devoted to evaluating the relative merits of psychotherapy vs. medication (and their combination) in Veteran samples, and more work in this area is needed. We recommend an increased use of effectiveness research (perhaps through the adoption of standardized treatments and uniform assessment batteries in VAs) in addition to traditional RCTs, and believe that both will help to facilitate these goals."

What they are in fact saying is: "We know nothing about PTSD, but we pretend to know it all."

But what else does one expect from folk who only acknowledge the existence of a physical body, believing the mind sits in the brain and the soul does not exist? And, to begin with, what is the soul generally deemed to be? Multiple sources can be quoted on the topic, as the theme has been discussed for millennia, and opinions on it necessarily differ. The word "soul" itself derives from Gothic *saiwala* and the Old German *saiwalo*, which in turn can be connected etymologically with the Greek *aiolos,* or quick moving, twinkling, iridescent (aras.org). *Saiwalo* is related on the other side to the Old Slavonic *sila,* or strength. These connections throw light on the original meaning of the word "soul" as a moving force, that is, the life-force (CW8 ¶663). In Latin languages, "soul" derives from *anima,* the feminine of the Latin animus "the rational soul; life; the mental powers, intelligence" the same as the Greek *anemos,* or wind (CW8 ¶664). In Greece, *soul* is expressed by the Ancient Greek ψυχή psūkhḗ, of ψύχειν psū́khein, "to breathe", indicating the mental abilities of

a living being: reason, character, feeling, consciousness, memory, perception, thinking and so on. Here, a woodcut depiction of the soul was taken from the Rosarium Philosophorum (*Rosarium philosophorum sive pretiosissimum donum Dei*). This 16th-century alchemical treatise was published in Frankfurt, Germany, in 1550, as part II of *De Alchimia Opuscula complura veterum philosophorum*. The term "rosary" in the title refers to a "rose garden", metaphoric of a collection of wise sayings.



Translation: Here the division of the four elements/from the body leaves the soul with ease.

So, what is it that rules us — the body, the soul, something else? Throughout thousands of years, in many religious and mythological traditions, the soul is viewed as the incorporeal essence of living beings. Depending on a society's or system's philosophical view, a soul can be either mortal or immortal. In Judeo-Christianity, only human beings have immortal souls. The Catholic theologian Thomas Aquinas attributed "soul" (*anima*) to all organisms, but argued that only human souls are immortal, whereas within Judaism immortality is disputed.

Hinduism and Jainism hold that all living things, from the smallest bacterium to the largest of mammals, are the souls themselves (Atman, jiva), and have as their

physical representative the body in the world. The actual self is the soul, while the body presents the means and supplies the mechanism to facilitate the karmic experience of that particular life. Thus, when seeing a tiger or a human being, we see a self-conscious identity residing in it. This is the soul, the body of the man, woman or tiger being its physical representative observable in the world. Some beliefs teach that even non-biological entities, such as rivers and mountains, possess souls, a belief called animism.

Greek philosophers, Socrates, Plato, and Aristotle among them, understood that the soul must have a logical faculty, and that its exercise was the most divine of human actions. At his defense trial, Socrates even summarized his teaching as nothing other than an exhortation for his fellow Athenians to excel in matters of the psyche– the soul– since all bodily goods were dependent on such excellence (*Apology* 30a–b).

And yes, you guessed it! Modern science's current consensus is that there is no evidence to support the existence of the soul, when traditionally defined as the spiritual breath of the body. No surprise there. Much of academia, regardless of their field of expertise, seem to have been bitten by the atheist bug. And what's that, you may ask yourself?

There are two basic forms of atheism: "strong" atheism and "weak" atheism. Strong atheism is the doctrine that there is no God or gods. Weak atheism is the disbelief in or denial of the existence of God or gods. Vive la difference! Weak atheism is often confused with agnosticism, the lack of belief or disbelief in God or gods, and skepticism, the doctrine that the absolute knowledge of God's existence is unobtainable by mere man. Many agnostics and skeptics are "practical atheists" in that they actively pursue an atheistic lifestyle.

The exclusion of God by extension necessitates moral relativism. Atheist philosopher Bertrand Russell (1872–1970) declared, and philosophers generally agree, that there is no absolute truth without God, and thus no universal moral standard of conduct, either. Humanist John Dewey (1859–1952), co-author and signer of the Humanist Manifesto I of 1933, declared:

> "There is no God and there is no soul. Hence, there are no needs for the props of traditional religion. With dogma and creed excluded, then immutable truth is also dead and buried. There is no room for fixed, natural law or moral absolutes."

Two other manifestos laying out a Humanist worldview exist, the *Humanist Manifesto II* (1973) and *Humanism and Its Aspirations* 2003, a.k.a. *Humanist Manifesto*

III. The central theme of all three is the elaboration of a philosophy and value system that does not necessarily include belief in any personal deity or "higher power". The three differ considerably in their tone, form and ambition. All were signed at launch time by prominent members of academia, those who mould young minds, and others of influence. Signatories to the Humanist Manifestos" are listed on freewebs.com. All of them more or less agree that "Do as thou wilt is the whole of the law" without restriction is acceptable behaviour in human society (A. Crowley).

And so we return to Neumeister and Cohen's adrenaline-heightening PTSD research done on the physical body. It was conducted in collaboration with scientists at Yale's School of Medicine, the School of Medicine at the University of California, San Diego, and the NC*for*PTSD tying in so nicely with that of Lang&McTeague. What did this research tell us earlier? Both insinuate and anticipate that nothing other than our genetic predisposition is the reason for our PTSD acquisition. And that, they hypothesize, can, simply put, easily be eradicated by finding the connector to the PTSD reaction culprit in our brain. So forget this inane bubbling about spirit, soul, intuition, mind and equal manure. Hogwash all, they seem to yell. Human emotions, intelligence, academic education, previous exposure to life threatening situations, culture, race, religion or anything else of humane aptitudes and undertakings, character and personality plays no role in human PTSD development nor in its acquisition. It's all due to our brain circuitry's faulty wiring or malfunctioning in combination with previously incurred preconscious repression generated by the brain, humanity's computer board. If that is indeed the case, why not adjust the maladjusted Atlas to begin with, we could ask? Sadly, how rattus. mus, simian and cani's pre-consciously repressed emotions are evaluated when using them as human stand-ins is totally ignored in neuroscientists et al.'s empirically and scientifically quoted research.

But what about the body, you ask? Well, the body has been well-explored during millennia, as well. In the orient, India and China in particular, studies on it go back at least 10,000 years. The west's generally more Barbarian (in comparison) documented study of human physiology began in Ancient Greece with Hippocrates. Around 420 BC, in the *Hippocratic Corpus,* he described the humans' anatomy in regards to skeleton and muscles. Aristotle (384–322 BC) followed. He applied critical thinking and emphasis on the relationship between structure and function. After him, Galen (c. 126–199) was the first to use experiments to probe the body's functions. He compiled his discoveries into a text of classical knowledge of anatomy

that was used throughout the Middle Ages.

The term physiology itself was introduced by French physician Jean Fernel (1497–1558), describing it as the "study and description of natural objects." It originates from the Middle French *physiologie*, a direct adaptation of the Latin *physiologia* or "natural science, study of nature". It was also an adaptation of the Greek *physiologia* "natural science, inquiry into nature". It combines *physio-* ("nature") and *logia* ("study"), meaning "science of the normal function of living things" (etymonline.com). Andreas Vesalius (1514–1564), was a 16th-century Flemish physician and anatomist, professor at the University of Padua, Italy, and later in life Imperial physician at the court of Emperor Charles V. He was often referred to as the founder of modern human anatomy. He pioneered its modern study by dissecting the body and documenting his findings in one of the most influential books on the topic, *De humani corporis fabrica* (*On the Fabric of the Human Body*).

In the 17th century, the English William Harvey (1578–1657) became the first known physician to describe completely and in detail the systemic circulation and properties of blood being pumped to the brain and body by the heart. He described the circulatory system, while pioneering the combination of close observation with careful experimentation.

Further physiological knowledge began to accumulate rapidly after the Germans Matthias Schleiden and Theodor Schwann made their "The Theory of Cells" discovery in 1839. They badged the cell as a basic particle of plants and animals, ergo humans. In addition, they recognized that some organisms were unicellular, while others were multicellular. Furthermore, they discovered that the cell nucleus and the membrane belong to the properties of the cell they occupy. They made this discovery by comparing different plant and animal tissues (physicsbook.gr).

Historian I. Bernard Cohen of Harvard University called French physiologist Claude Bernard (1813–1878) "one of the greatest of all men of science." Among his many other accomplishments, he was one of the very first to suggest the use of blind experiments to ensure the objectivity of scientific observations. He also originated the term *milieu intérieur* and the associated concept of homeostasis. The latter term was coined by Walter Bradford Cannon (1871–1945), an American neurologist, physiologist, professor and chairman of the Department of Physiology at Harvard Medical School, while expanding on Bernard's concept. Cannon also coined the term "fight or flight response" and was the first to use X rays in physiological studies. This led to his 1911 publication *The Mechanical Factors of Digestion* (London,

Edward Arnold, New York, Longmans, Green, 1911)

In the 20th century, Norwegian physiologists Knut Schmidt-Nielsen (1915–2007) and American biologist George Adelbert Bartholomew (1919–2006) extended their studies to comparative physiology and ecophysiology. But the field of evolutionary physiology has somewhat gone out of style becoming a distinct sub-discipline. This refers to the manner in which the functional characteristics of individuals in a population of organisms have responded to selection across multiple generations during the history of the population.

Machines to investigate the human body became central to European medicine during the 1800s. Doctors and biomedical scientists developed instruments to examine it. Devices such as the thermometer, microscope and kymograph revealed how healthy and diseased bodies worked. The stethoscope enabling doctors to hear and diagnose chest diseases was invented in 1816 invented by French doctor Rene Laennec, and became an iconic object in biomedicine. Other instruments providing information about organs deep inside the body were developed throughout the century. During the 20th century, advances in science, engineering and manufacturing were applied to medical problems. Technologies such as *hearing aids*, artificial limbs and mobility aids became more sophisticated. *Ventilators*, *pacemakers* and other machines were developed to support, enhance or replace body organs. In 1949, Dutchman Willem Johan Kolff (1911–2009), a pioneer of hemodialysis, as well as of the field of artificial organs, invented the kidney dialysis machine.

The most important of all-important technological changes during the 20th century, however, was the use of computers in medicine. They became central to medical care from the 1950s onwards (broughttolife.sciencemuseum.org.uk). Imaging techniques such as MRI or PET reconstructing body images came into vogue. More diagnostic tests were developed because automated laboratory machines performed tests quicker and more accurately than humans would. Furthermore, many medical technologies allowed the detailed study of specific parts of the body, which led to doctors specializing in certain organs. Devices such as the Xray machine introduced new medical professions such as radiologists and radiographers.

Mind you, the medical community didn't accept new technologies with jubilance, and some of them were even viewed with outright suspicion. After all, new technical devices threatened to replace physicians' traditional diagnostic expertise. This had oftentimes been gained through years of clinical experience, which many valued over machine-produced information. Some technologies failed

because doctors or patients found them impractical; others failed due to safety concerns and operating cost. Some historians and physicians argued that machines made doctors poorer healers when focusing only on sick parts of the body rather than caring for the patient as a whole. Others questioned whether excessive use of technology within childbirth and life prolongation could be intrusive, doing more harm than good. Again, others assert that advancing technology presents both physicians and patients with serious ethical dilemmas.

For the scientifically inclined atheist health practitioners, there is no worry about ethics or morals at all, though. After all, there is no God and there is no soul. The mind resides in the brain, the law of retribution is a fable. We live but once, so what do we care their modus operandi. The body is nothing other than a machine, a mechanical gadget, akin to AI robots, and we fix it by adjusting a part. That's all there is to it, so onwards non-Christian soldier man it is to by hook or by crook discover the mechanical failure inherent or acquired in human bodies in the course of their lives, including that of PTSD.

Drugging to heal PTSD is a fine start. But it has been well known, since 2007, that even though several drugs and psychotherapies are used to treat PTSD, many of the studies concerning their effectiveness have problems. At least, that is the case if we are to believe the U.S. Department of Veterans Affairs sponsored 2007 National Academy's Institute of Medicine study. Established in 1970, said institute prides itself in providing independent, objective, evidence-based advice to policymakers, health professionals, the private sector, and the public alike we are told (*Effectiveness Of Most PTSD Therapies Is Uncertain*, October 19, 2007, National Academies; sciencedaily.com). The Institute is chaired by Alfred O. Berg, professor of family medicine at the University of Washington. Its panel conducted a comprehensive review of 53 pharmaceuticals and 37 psychotherapies studies used in PTSD treatment. The panel concluded that, because of shortcomings in many of them, there was not enough reliable evidence to draw conclusions about the effectiveness of most PTSD treatment modalities. Much of the research had major limitations when judged against contemporary standards for conducting trials, Berg and David Matchar, a committee member and professor of medicine at Duke University Medical Center, voiced. A sustained national effort for high-quality research on PTSD, with a special focus on veterans and minority groups, was indeed needed. Berg furthermore noted that thus far, only exposure therapy (exposing individuals to real or surrogate threats in a safe environment) seemed to help them overcome their fears, and therefore were deemed effective Berg asserted. That's the one

procedurally similar to the fear extinction paradigm proven so supremely effective in laboratory animals such as rattus and mus in combination with Pavlov and Skinner's beloved ideology of human mind manipulation through torture, remember?

What about the antipsychotic drugs, such as Paxil and Zoloft, approved by the Food and Drug Administration for PTSD treatment? No evidence was found that they or any other medication was effective in treating PTSD. Furthermore, the committee's report stated that most of the evidence supporting the use of medications and psychological therapies for PTSD was tainted. It had been assembled by pharmaceutical companies or by researchers burdened with conflicts of interest in study outcomes, thus lacking independent and rigorous verification and proof. Regardless, Larry Scott, founder of the advocacy group VA Watchdog, which serves as an information clearinghouse for veterans, confirmed that a very high number of PTSD affected were on medications.

The committee also quoted insufficient evidence to support the use of PTSD psychotherapies, including cognitive restructuring, coping skills training, eye-movement desensitization, reprocessing therapy and group therapy. Cognitive restructuring is, of course, the technique that trains patients to reinterpret a traumatic event from a different perspective. Eye-movement therapy is the one asking them to think about traumatic memories while tracking quick movements of a therapist's finger. But the therapists continue searching by barking up the wrong trees, where nothing other hangs hidden than lies and deception. To quote chairman Berg:

> "At this time, we can make no judgment about the effectiveness of most psychotherapies or about any medications in helping patients with PTSD. These therapies may or may not be effective — we just don't know in the absence of good data."

Journalist Shankar Vedantam addressed the stury, in his 2007 *Washington Post* article "Most PTSD Treatments Not Proven Effective". He reported that the study was conducted by what he calls a "panel of federal government top scientists." He was straight forward when stating that the majority of PTSD treatments used on hundreds of thousands of veterans lacked rigorous scientific evidence to prove their effectiveness. He furthermore enlightens us that his reportage was only published because PTSD awareness had risen as a result of its increasing incidence-rate among veterans returning from the Iraq and Afghanistan wars. What did the VA do?

Nothing other than promise to vamp up its ability to provide therapy to PTSD patients.

In regards to the much-touted-as-beneficial exposure therapy, Vedantam had interviewed the aforementioned Edna B. Foa, professor of clinical psychology, department of psychiatry, University of Pennsylvania. As you recall, she was one of the pioneers in developing exposure therapy as PTSD treatment, asserting the technique was based on the insight that many trauma *victims* do all they can to avoid being reminded of their PTSD causing event. In her opinion, two things happen during the exposure therapy process. Patients come to replace actual recollections of trauma with other perceptions. And they realize that much of life is not dangerous. Foa has patients recount traumatic events aloud with their eyes closed, while tape-recording them. Then, she has them repeatedly listen to the tape. Why? Because people don't recover when they avoid thinking about the trauma, but rather when they push it away every time it springs to their mind, she thinks. By disallowing themselves to process and digest the memory, it keeps on haunting them with nightmares and flashbacks.

And right she is. We have to face our fears to conquer and overcome them. If we lack the guts to do so, they will present themselves over and over and over again in real life. If on pharmaceutical drugs, we are up the creek without a paddle, though. With drugs, we lose all reasonable reasoning capability, due to the unavoidable mistake of the intellect. Either way, we have to face ourselves and the situation that brought us to this state of mind, or we cut ourselves off from ever again living a joyful and contented life. Worse, if we do not face our Self and our fear, we defy the purpose of our PTSD experience, the remaking of ourselves by ourselves with the support of all that is benevolent in the universe and beyond. And now, we have it confirmed by the National Academy study that only we ourselves can free ourselves from the PTSD dilemma, a soothing thought in itself. Why? We genuine PTSD journeyers would not be in this situation had we lacked guts before the PTSD causing event moment occurred as wit by the professions we chose to make a living. All are inherently dangerous. We just lack the knowledge how to help ourselves to crawl out of this dilemma. And we know we are bright enough to acquire that knowledge, so it is up to us to test our mettle and go for it.

Vedantam observed that a host of complicated political, economic and medical issues swirled around the PTSD issue in times of war. Many veteran advocacy groups are convinced the US government tries to limit the spiralling costs of PTSD treatments. That it is spiralling due to the mental health industry's useless PTSD

treatment hallucinations, theories and therapies applied goes unmentioned. As Larry Scott of VA Watchdog dot Org pointed out almost prophetically:

> "I see the IOM report and the VA's acceptance as an indication that the agency will continue to move away from pharmaceutical-based therapies and group therapy for veterans with PTSD and continue to push their agenda of cognitive processing therapy as a 'cure,' as stated by former VA Secretary Jim Nicholson. If VA declares a veteran 'cured' of PTSD, this will mean the reduction or loss of disability compensation."

He was almost right. Drugging PTSD journeyers to the hilt, up to 30 some odd pills or more daily makes no sense. Depleting the body's magnesium store, just assures further physical and mental health destruction. Combine that with cognitive processing therapy, leading to more mental upheaval, practically ascertains they say good-bye to it all, most of them to dwell on the street or carve out a dismal living to die a slow and tedious death. In this way, they'll never discover the marvels presented by the existential crisis or discover the spiritual intention of their PTSD experience. They, the brightest in any society, no longer present a threat to the system, the elite, the archontic force, the Illuminate, call it as you wish. Illumined by whom, though? Good or evil? Did they plan it this way? Did they set out to provide a profit bonanza for the medical system, the sewer of medicine, while simultaneously ensuring utter human desolation and destruction as a nice and lucrative way to reduce the human population? Remember Georgia Guide Stones? 500 million humans on Earth as slaves– maximum?

Listen to what Professor Richard McNally, director of Harvard University's Clinical Training in the Department of Psychology conveyed to a court as *amicus curiae* in 2005. "As what?" you ask. An *amicus curiae*, Latin for "friend of the court," is someone not a party to a specific legal case, but someone solicited by a party to assist the court by offering information, expertise, insight or bearing on the issues in the case. Originating in Roman law, the *amicus curiae* was incorporated into English law in the 9th century and later extended to most common and some civil law systems.

The phrase *amicus curiae* itself is legal Latin, and part of a number of Latin terms used in legal terminology and legal maxims, which in western civilizations are established principles or proposition of law. It nowadays can be found in some international law and is used by the European Court of Human Rights, the Inter-American Commission on Human Rights, the Inter-American Court of Human

Rights, the Court of Justice of the European Union and the Special Tribunal for Lebanon. When and why is an amicus curiae used?

We can well imagine that, for all its strengths, the US adversarial system has its shortcomings. One, for example, is that the parties, the plaintiff and defendant, control the presentation of their case. If it is not in the interest of either party to bring up a particular fact or law, regardless of its relevance to the case, the judge may never hear of it. To overcome such shortcoming, the court in exceptional circumstances can summon the assistance of an *amicus curiae*. This person's purpose is to inform and advise the judge as to matters of fact or law that otherwise might escape his or her consideration. The amicus curiae is thus called to inform and advise the Court as to matters of fact or law to minimize the risk of error in judgment (law.cornell.edu). It is typically presented in the form of a brief, old French from Latin "*brevis*" (*short)*. A brief is a written legal document used in various adversarial legal systems, presented to a court arguing why one party to a particular case should prevail. The decision on whether to consider an amicus brief lies within the discretion of the court. This is what PTSD expert Professor McNally mentioned earlier in this book, asserting in his Amicus Curiae brief:

> "If a treatment that is not shown to be efficacious is nevertheless delivered to veterans, and if the treatment is relatively inert, even if it does not harm the veterans, it may demoralize the veteran. Providing treatments that do not have a good basis in evidence can result in people not improving, therefore getting demoralized and therefore not seeking treatment that can actually help them." (*Richard McNally Amicus letter,"* National Center for Reason and Justice, 2005-JUN-03, at: http://www.ncrj.org/McNally.html).

To perpetually ask PTSD experiencers to forget something as unforgettable as the PTSD-causing event moment is ridiculous. To do so by way of hallucinated PTSD treatment modality theories, invented and designed by mental health practitioners to purportedly heal the existential crises, is almost too ludicrous to fathom. Professor McNally himself points this out, when stating at the same court hearing:

> " The notion that traumatic events can be repressed and later recovered is the most pernicious bit of folklore ever to infect psychology and psychiatry. It has provided the theoretical basis for "recovered memory therapy" — the worst

> catastrophe to befall the mental health field since the lobotomy era."

I rest my case.

57

Only The Self Can Heal The Self

As late as August 2018, two esteemed academics questioned the value of most PTSD treatment. One of them was Anne L. Malaktaris, Ph.D., a postdoctoral fellow with the Center of Excellence for Stress and Mental Health, VA San Diego Healthcare System and the University of California, San Diego, Department of Psychiatry. The other was Ariel J. Lang, Ph.D., MPH, acting director of the Center of Excellence for Stress and Mental Health, VA San Diego Healthcare System, and a professor in the Departments of Psychiatry and Family Medicine & Public Health at the University of California, San Diego. Here is what they said in their exposé *Complementary and Integrative Health Approaches for PTSD:*

"Although efficacious treatments for PTSD have been

> established, many individuals remain symptomatic after treatment or never seek empirically supported therapies. The two FDA-approved medications for the treatment of PTSD (sertraline and paroxetine) on average confer minimal to modest benefits that are not generally maintained over time. Furthermore, the development of new pharmacological treatments for PTSD has been described as stagnant. (Krystal JH, Davis LL, Neylan TC, et al. "It is time to address the crisis in the pharmacotherapy of posttraumatic stress disorder: a consensus statement of the PTSD Psychopharmacology Working Group". *Biol Psychiatry*. 2017;82:e51-e59)."

Hence, they opine 11 years after the National Institute of Medicine's authoritative study by and large declaring all existing PTSD treatment modalities as useless as tits on a bull that there was a need for approaches to augment current best practices (*Psychiatric Times,* Mar. 9, 2019). They also revealed that a 2012 survey had shown that 39% of people with PTSD used complementary integrative health (CIH) approaches. Meditation and relaxation were the most commonly employed modalities. (Libby DJ, Pilver CE, Desai R.; "Complementary and alternative medicine in VA specialized PTSD treatment programs"; *Psychiatr Serv*. 2012 Nov;63(11)).

Despite the increasing popularity of CIH, however, a 2011 systematic review identified that only seven randomized controlled trials (RCTs) of CIH for PTSD had been conducted. Furthermore, they noted that these studies were generally preliminary, underpowered, methodologically limited, of small sample sizes with a lack of active comparators and non-randomized designs. This, Lang and Malaktaris observed, limited the conclusions that at present could be drawn about CIH efficacy. There was simply no definitive evidence about the use of CIH approaches for the treatment of PTSD one way or the other. Therefore it would be premature in March 2019 to recommend their use as front-line PTSD treatments. However, there was no evidence that CIH techniques were harmful either, aside from the caveat about herbal remedies. (That, of course, is a fable also, as Kava, for example, is an ideal and naturally organic plant remedy to calm the PTSD-affected psyche. That's why it was taken of the market).

Clinicians, therefore, should take an empirical approach to recommending CIH techniques, by suggesting one approach at a time, stressing consistency in practice as a must and finding objective methods to monitor patient-response. As if they would,

would they? My psychiatrist, after seeing what nearly happened to me with Ativan consumption, stopped his drug-prescription to all his patients, advising them on natural remedies and healthy eating instead. But for most, I venture to opine, when PTSD patient improvement threatens to cut into profit margins, that won't happen. When it furthermore becomes evident that CIH is *the* avenue to PTSD recovery, thus spelling possible financial disaster for mental health PTSD "experts," they might well stay clear of even giving a hint about CIH miracles. Or do you think they don't know that their PTSD treatment modalities and pharmaceuticals do more harm than good? Do you really believe that when it is clear as a bell to us, the laymen, how harmful their treatments are, it is unclear to them, the mental health industry's professionals? Do you really think they are unaware that only the Self can heal the Self from the trauma of an existential crisis?

And one thing is clearer than a bell, even. Nothing within the Self will be mended, never mind healed, by repressing the PTSD-causing event moment memory or by regurgitating it ad nauseam in the presence of a psychiatrist or psychologist. Nothing. Repression only leads to a life of dismal misery and desolation, and regurgitating masks the only avenue to recovery — self-exploration, of the Self, by the Self — the creation of a clean slate. I know; I saw it both from myself and felt it in the PTSD affected gathering hosted by the hypnotist on the *Norwegian Star*. It was palpable. Some of them had been stuck in that moment in a quasi zombie-like way of life for 30 years or more. Unable to free themselves, some seemed to proudly thrive on their suffering, the "poor me" victim attitude in full swing and cherished, loving the attention it got them, the wastefulness of a life unlived passing them by unnoticed. Some seemed in zombie land, neither party apparently knowing that they were and why.

Edna B. Foa, Ph.D., professor of clinical psychology in psychiatry at the University of Pennsylvania, director of the Center for the Treatment and Study of Anxiety and inventor of the prolonged exposure therapy (PET), made one valid observation confirming mine. Human PTSD journeyers can heal only when looking with open eyes at the PTSD-causing traumatic event they experienced. What she failed to deduce is that experiencers then have to take it apart. That they have to discuss the ifs and buts about it with the Self until sick and tired of mulling it over. That they have to turn it around and around, time and time again. That they then have to wading in its misery, until sooner or later, while wandering through this miserable part of the experience, they have to decide whether they want to live or die, and how to go about it.

That decision made, we move on to figure out where we want to start or end. It could be the pistol or cut wrists in the warm bath, the good old Roman and Greek way. It could be a lengthy swim in the ocean, leading to drowning, or a stroll in arctic weather in pyjamas to turn into an icicle. Or it could be how to effectuate our healing, instead. Through it all, somehow, we figure out and accept PTSD's symptoms as part of the game this particular life experience presents until becoming aware that, otherwise, there neither is nor ever was anything wrong with us. As two peers of mine who had incurred PTSD in the line of duty while working on an aircraft running out of fuel at 36,000 feet said to me just a couple of weeks or so after my PTSD-causing event moment: "There is nothing wrong with you. Just give it time. You'll be much better than before." My GP had confirmed their view by voicing the same opinion. I clung to their verdict for dear life. It, too, was instrumental in my survival.

No blame can be bestowed upon Foa for her lack of understanding of this vital fact. After all she, like few if any of the other mental health industry's self-proclaimed PTSD experts, as far as we know, ever lived a genuine PTSD experience, and may she never suffer such a fate. What we do know is that she and most of her peers have yet to fathom or at least publicly acknowledge that humans are somewhat different from rattus, cani, semia and mus. We differ in intelligence, intellect, mind, emotional and soul essence, care for the self and others and overall know-how about life and living. Still, it is after them that she, a world-renowned PTSD expert, tailored her PET project for her PTSD affected human pets, the Prolonged Exposure Therapy. It goes like this:

> "PET is based on associative learning theory, when two things appear together the brain learns to connect or associate them. Ivan Pavlov created the most famous associative learning experiment by repeatedly ringing a bell before presenting his dogs with food. The dogs began to salivate at the sound of the bell, as they learned to associate the bell with food. To break this association, Pavlov then repeatedly rang the bell without giving the dogs any food; the dogs eventually stopped salivating when they heard the bell. This same process is behind PTSD. When a trauma occurs, there are many things in the environment — smells, sights, sounds — that the brain associates with the trauma. When we encounter those things outside of the trauma, the brain expects danger, causing fear

and anxiety." (psychologytoday.com)

Truly spoken like someone expecting PTSD journeyers to be wired as Fido and his fellow four-legged creatures. She assumes that when the bells whistle or the electrical shock hits, they, fine-tuned by psycho-the-rapists, will adhere to commands given. The "Fido. Stop it! It's over! Stop! Move on! Good boy! Pet on the head!" that works for him has to work for the human animal, are his master's unmitigated conclusions. If it does not, it's certainly Fido's fault, because the high and mighty academically schooled, practicing mental health expert PTSD therapists, who rarely if ever experienced other than perhaps a divorce, a few hangnails, a broken leg skiing or a car accident, do know so much better what genuine PTSD incurs than those living it.

What furthermore has yet to dawn upon these self-proclaimed PTSD geniuses belonging to the mutual admiration society for PTSD treatment, cures and modalities, is that Fido's training and retraining has nothing to do with its PTSD recovery. That humans struggling through an existential crisis are dealt with, expected to react to and healed by ways and means applied to rattus, cani, mus and simian seems somewhat of an imposition to begin with, doesn't it? Does it really yet have to occur to these mental health practitioners and neuro-scientists of all ranks and file, that the commands and neurological brain intervention introduced into animals on which they try and test their theoretical interventions, might work differently on humans? Apparently not; they continue the PTSD charade. Only genuine PTSD experiencers themselves can effectuate PTSD recuperation and healing. This is confirmed both throughout history and by such capacities as C.G. Jung, R.D. Laing, Unamuno, L. Mocher, Breggin, Billings and others who analyzed the human psyche and shared their insights with us throughout centuries. But it is vigorously ignored. It would impair the bottom line and even the agenda. Remember Georgia Guide stones?

Has it really yet to occur to mental industry's health practitioners' beliefs, theories and hypotheses that, most possibly contrary to rattus, mus, simian and cani, most human beings do have a conscience and a soul? And it is the soul that takes flight when it knows that a stark and unavoidable catastrophe is going to end one's life in no time flat. So the soul leaves the body before impact, before the body dies. If the body does not die, without a soul, the earthly sojourn becomes meaningless, thus the PTSD reaction, the overwhelming sense of futility, of not belonging, of being a stranger in a strange land for no reason and without a purpose, because everything seems meaningless. So it is the soul that has to be persuaded to

return to the body by absolving the Self from all actual or perceived negative pre-PTSD causing events, the Self to be forgiven for committed misdeeds and grudges held against others and the Self. It is the Self who must make peace with the Self before recovery can commence. To start the process, one must turn the most innermost Self upside-down, on its head, to face one's discoveries in one's own psyche, for better or for worse. No one can help with it. And this is an exercise worth time, energy and effort only when brutally truthful and honest with the Self, and free from self-deception and manipulation. Otherwise, one merely treads water while betraying self, which would lead to further self-destruction, wit the VA, DoD and NC for PTSD's treatment modalities.

We subconsciously or consciously are reluctant to engage in such thorough inner examination and clean-out. What our self-perception and introspection might reveal could severely bruise our ego. So, we adhere to the old Latin adage "*In vino veritas*" ("In wine there is truth"), which might be appropriate to hasten the process, to get this most important part of the show on the road. The Greek historian Herodotus (c. 484–c. 425 BC) gives us insight into the matter. He was widely considered to have been the first writer to treat history as an academic discipline by developing a method of systematic investigation, specifically by collecting his materials and then critically arranging them into a historiographic narrative. He asserted that if the Persians decided something while drunk, they made a rule to reconsider it when sober. Authors after Herodotus thoughtfully added to it that if the Persians made a decision while sober, they made it a rule to reconsider it when drunk (*Histories*, book 1, section 133). You can of course do both when engaging in your self-investigation.

In Greek, the *In vino veritas* counterpart "Ἐν οἴνῳ ἀλήθεια" is found in Erasmus' *Adagia* (I.vii.17), and Pliny the Elders' *Naturalis historia*. However, there seems to be ambiguity in translation. Whereas veritas means "truth" or "reality" in Latin, aletheia, in Ancient Greek ἀλήθεια, is variously translated as truth, disclosure, unclosedness and unconcealedness. Ἀ–λήθεια's literal meaning is "the state of not being hidden; the state of being evident." It also means factuality or reality. Thus for the ancient Greeks, the expression seemed to indicate that *drunks were more likely to be talkative, but sober folk were more likely to tell the truth.* Athenaeus, a native of Naucratis, a Greek city in Egypt, wrote at length about the topic of inebriation in the *Deipnosophists*. This a long work of literary, historical and antiquarian references is set in early third century Rome at a series of banquets for an assembly of grammarians, lexicographers, jurists, musicians and hangers-on.

Romans' view of drunkenness is somewhat revealed by Quintus Horatius Flaccus (65 BC–8 BC), in the English-speaking world known as Horace. He was the leading Roman lyric poet during the time of Augustus, also known as Octavian, first emperor of Rome, coming to power after grand-uncle's Julius Caesar assassination on the Ides of March 44 BC. The Hispania-born Roman educator and rhetorician Marcus Fabius Quintilianus (c. 35–c. 100 AD) regarded Horace's *Odes* as just about the only Latin lyrics worthwhile reading. He muttered: "He can be lofty sometimes, yet he is also full of charm and grace, versatile in his figures, and felicitously daring in his choice of words." We don't know if Horace received some or much of said prose under the influence, but his elegant hexameter verses, friendly in tone, lead the Roman poet and satirist of Etruscan origin, Aulus Persius Flaccus (34–62 AD), to somewhat acidly remark: "As his friend laughs, Horace slyly puts his finger on his every fault; once let in, he plays about the heartstrings." (translated from Persius' own 'Satires' 1.116–17: "omne vafer vitium ridenti Flaccus amico/tangit et admissus circum praecordia ludit.") Horace was buddy with the ruling elite from Octavian and his best friend Macaenas down Some thought he was independent, while others thought he was nothing but a well-mannered court slave. Whichever way, he knew a multitude of people of all walks of life and had seen their antics in a slew of situations when finding pleasure and solace *in vino veritas*. His verdict on the state? *"Quid non ebrietas designat? Operta recludit."* (*Is there anything that inebriation doesn't reveal? It shows hidden things.) (Epistles, 1.5.16)*

Roman senator Tacitus (56–120 CE) was considered to be one of the Roman Empire's greatest historians. A few years later, he shares that the Germanic peoples, when keeping council at feasts, got gloriously inebriated. They believed drunkenness prevented participants from giving false or misleading appearances or concealing the truth or real nature of something. They thought that alcohol prevented others from hiding their incompetence in whatever may be under discussion or whatever business was at hand. They would not feign or pretend innocence when actually guilty, or ignore and let something of importance pass by unnoticed. Thus they engaged in uproarious drunkenness at such occasions, though they mostly preferred cervicia (beer) for the enterprise.

Thus, in the occident, it has been known since antiquity that in vino truth is revealed to one's benefit or detriment depending on one's innate personality, character and life-experiences of self and others. The innermost thoughts, feelings, and attitudes –for better or for worse –surface when under the influence. Many discoveries about self and others can be made in states of drunkenness, and the

damage to self can be great in the company of friend and foe alike. Therefore, when setting out on this mandatory journey of inner self-exploration for the purpose of cleaning-out-the-muck-harbouring-in-my-psyche-and-my soul sessions with the aim to recover from PTSD, best to do it when alone. Put the "do not disturb sign" on the front door, and disconnect the telephone and the TV. Make it all quiet. Make sure there is enough vino or *cervicia* in the house to last through your self-imposed lessons. It would be a stupid move to go out fetching more when halfway through the process and inebriated, with cops lurking in the dark of night. Splendid solitude, except for Fido or the cat or bird or djerbal, is a necessity. So are pen and paper to jot down what floats/flows across the mind and surfaces from the bottom of heart and soul. Talking out loud to self also helps, as hearing our thoughts spoken out loud somehow seems to register better what we think. Sounding-boards are wonderful, in general. In these exercises, however, one must be alone to reveal with brutal honesty everything that's piled up throughout life, without embellishment, justification or deception.

With the help of vino, cervicia or a home brewed turbo yeast concoction, you are now investigating yourself. You are investigating your entire pre-PTSD-causing event life. These are the experiences you had from the moment of your first recollections as a youngster, your reactions to them, the actions you executed, mandated or were ordered to or advised to do, or otherwise. These are all thoughts your conscience throws at you, reveals to you and now demands you to face. You may dislike what you look at, even perceive as crimes some of the actions you committed, and perhaps some of them were. As you face them one by one, you will discover, however, that, should you really want to heal yourself, you have little choice but to accept them and move on to absolve, forgive and make peace with yourself. You also want to ask those who thus far participated in your life's journey, those whom you perceive as having harmed you or whom you may have harmed, for forgiveness as well. No need to contact them. Just beg forgiveness from your heart and soul and give them yours. It'll do the trick.

Crying, rage and phenomenal anger seems to be part of it, so go right ahead and express it to your full desire. Then crawl into bed when you are tired of helping yourself thus and inebriated enough to fall into slumber right away. Coming from the heart, such sessions release and thus lighten the soul's aches and pains and give absolution to the Self. You might have a hangover the day after, but it is well worth the while, as you will know upon awakening, because you'll feel lighter in your heart and soul.

The revelation of the truth within our innermost self is the only path to our PTSD healing. Natural opioids including marijuana and all psychotropic drugs, prescription or otherwise, mask our inner pain. They pervert our perception of the truth lying hidden within our soul and heart, thus defying the exercises' purpose. They also destroy all possibility to heal our PTSD, as they will pervert our mind, our thinking and even our desire to heal ourselves. That's because they pervert the brain's joy center leading to the *mistake of the intellect*. If we forfeit the opportunity to heal ourselves, we defeat our life's purpose. That purpose is the PTSD-gifted opportunity to create out of ourselves and our imagination the human being we would love to be. To create the one exactly to our liking, the one filled with kindness, goodness and love for the Self, and in consequence, for love to all those whom we encounter. This opportunity comes with the help of the universe and all that is benevolent in it, our guides, guardians, teachers, helpers and friends. We are given the opportunity to be the change we want to see in the world. And we are the only one's who can effectuate it. No one in this world can help us with it. Once our task is accomplished, a clean slate created, our tabula rasa is ready to be filled to *our* liking, not anyone else's. In particular, not any mental health practitioner's aspirations on how we ought to be socially acceptable to the regime. This is the way to a PTSD recovery; the freedom of the soul and the creation of the new Self, synonymous with the creation of our new life.

In my case, this initial modus operandi, or *mode of operating (m.o.)*, lasted almost four months. The term "m.o." is often used in police work when discussing crimes and addressing the methods criminals use to commit them. It is also used in criminal profiling, where it can help in finding clues to offenders' psychology. It largely consists of examining the actions used by individuals to execute their crimes, prevent detection and make their escape. Suspects' m.o. can assist in their identification, apprehension and/or repression. It can also be used to determine links between crimes. While engaging in your cleansing in vino veritas exercises, you treated yourself as the suspect whose discovery of modus operandi within your innermost Self and your own absolution from perceived sins committed. During this process, at some undetermined time, you also subconsciously decided whether to live — or die.

My decision manifested itself by getting a Cadillac 1973. This clunker was so large and so protective, it stopped oncoming traffic whenever I wanted to turn left anywhere I went. It was associated with my desire to return to NorAm's in-flight service. But that was a no go, I was told by management, as I could not possibly be

healed.

I had to undergo what now, in hindsight and with research under my belt, turned out to be cognitive behavioural treatment (CBT), the regurgitating of the event over and over and over again and again. I never knew for what purpose, but I never asked, either. I merely accepted that the sessions with the NorAm-engaged psychiatrist were a company-demanded pre-requisite to my return to work. But pure evil being the faces I knew and the voices I trusted, with WCB, employers' henchmen and the Union's assistance, my true traumatization began with his administrations. From then on, the PTSD conundrum became more convoluted and frightful for me, the WCB psychologists demanding a battery of tests, including the first of my MMPI completions. This test gives exquisite insight into anybody's psyche, usable and used for further traumatization and destruction.

They also drummed in that I needed much more *handling* before I would be healthy enough to return to flying. Now I know that it actually meant they needed more time to destroy me or at least make me quit, preferably both, by keeping me in complete upheaval 24/7, leaving me no peace at all. In my infinite blindness and ignorance, I was completely unaware of the game being played, unaware that I handed them my power on a platter, unaware of George Orwell's statement: "If both the past and the external world only exist in the mind, and if the mind itself is controllable – what then?" (George Orwell: 1984; Penguin UK 2008)

Then it is a question of who controls whom, and in my case it was NorAm, the WCB, the Union, the principal psychiatrist and a peer whom I trusted without question.

Nine months after the PTSD-causing event moment, and shortly after three terrifying wide body aircraft catastrophes, I was kicked back to flying. I believe they knew at that time that the damage they had inflicted on me, combined with those aircraft crashes, had rattled my psyche enough to throw in the towel and sign the pink slip if nudged some more upon my return to duty. To hasten the blessed event, they engineered numerous incidents, assisted by numerous of my peers, supervisors, ground staff, crew scheduling, pilots and even full-paying passengers. When NorAm's physician diagnosed recurrent PTSD 20 months later, the Scotsman Santa Claus look-alike principle mental health protagonist and the highest papered psychiatrist at that time, made him self unavailable. Eight years of pure hell began, intensified four years in. This was after I had taken flights in Alaska, to and fro to Las Vegas, with an airplane ride in and out of the Gran Canyon and a 14-day stint to China, where I flew all over the place. It was to no avail. I continued to demand a

return to the line until super high blood pressure signalled a stroke or heart attack and *Broken Wings* was ready to go. When NorAm offered early retirement with 25 years seniority and its inherent perks I throw in the towel. At that point none of the 24 mental health practitioners I was forced to meet during my ten year PTSD trial enlightened me about the necessity to create a tabula rasa as mandatory for my PTSD recovery. I trust malice played no part in it, but merely infinite ignorance and lack of know-how, empathy and compassion, as well as pure greed.

Which leads me to the next point in PTSD treatment and healing practices to be observed if wanting to get out from under those catastrophic circumstances of monumental proportions relatively unscathed:

Always show up sober, without hangover, clean, prim and proper and on time for all appointments demanded by the employer, WCB personnel, Union shop stewards, their bosses, mental health practitioners and possibly lawyers. All are ready for your slaughter, the expandable human debris, useless flesh and eater you are to every one of them. Always remember, the employer can get two for the price of one the moment you throw in the towel. Thus, they will grasp at anything to get rid of you, including perpetually maligning and vilifying you. You do not wish to give them more ammunition than they fabricate without your help. Try to always look laundered, ironed, in good shape and in radiant health, if you can. They hate it. It drives them nuts to see you neat, slobs that most of them are out of uniform.

Contrary to me when all this went down, you now have the knowledge of what to expect and how to help yourself. I, however, was like a newborn in my infinite ignorance, gullibility, naiveté, stupidity, lack of wherewithal and belief in goodwill to all men. I truly thought for the longest time that those involved with my case were eager to see me healthy and "back on the line."

In hindsight, though, my ignorance and gullibility may have been instrumental in my ability to fight tooth and nail to get back to work. Ignorance, after all, is said to be bliss. Flying was what I had wanted to do from the age of 5 onwards, and fly I would.

Once we understand that our opponents' modus operandi is geared to imposing additional trauma on PTSD claimants, and that they are experts in doing so, we can breath easier. To educate ourselves further on the matter, Aaron & Melissa Dykes movie *The Minds of Men* is most helpful. That our opponents will also engage, for sometimes staggering amounts of money and perks, co-workers, strangers, our best friends and bosom buddies, customers, even dentists and GPs, and anyone else acquainted with us willing to trade conscience for dough is another shocking

revelation of benefit. Nothing new in that, mind you. The English Tory statesman in 1712 serving as Secretary at War in Queen Anne's War (1702–1713), the second in a series of French and Indian Wars fought in England's Thirteen American Colonies, who in 1713 became her Chancellor of the Exchequer Sir William Wyndham simply stated on the matter: "It is an old maxim that every man has his price."

But in a way, that, too, was old hat. The earliest forerunner to the saying appeared in the Roman poet Decimus Iunius Iuvenalis' *Satires.* This collection of poems, written in the early 2nd century AD, state: "All things at Rome have their price." Known in English as Juvenal (/ˈdʒuːvənəl), little else is known about the author.

Epictetus (c. 55–135 AD), however, observed the same in his work *The Bee*, vol.viii, p. 97 (1734). And who was he? He was born a slave at present day Pamukkale, Turkey. That is where therapeutic calcite laden waters and hot springs inspired the Attalid kings of Pergamon to found the Hellenistic spa town of Hierapolis at the end of the 2nd century BC, which became Cleopatra's favorite rejuvenation hang-out. History acknowledges him as a Stoic philosopher living in Rome until about 93 C.E. When Emperor *Titus Flavius Caesar Domitianus Augustus* (51–96 C.E.) banished all philosophers from the city, Epictetus went to Nicopolis in Epirus, northwestern Greece, where he founded a philosophical school. Teaching that philosophy was a way of life, not just a theoretical discipline, Epictetus maintained that the foundation of all philosophy was self-knowledge, and that the conviction of our ignorance and gullibility ought to be the first subject of our study, our investigation.

Logic provided valid reasoning and certainty in judgment, he maintained, but was subordinate to practical needs. To him, the first and most necessary part of philosophy, however, concerned the application of doctrine, the body of principles in a branch of knowledge or system of belief. He said, for example, that people should not lie. The second concerns reasons, e.g. why people should not lie, while the third, lastly, examined and established the reasons. This, he asserted, was the logical part, which finds reasons, shows what is a reason, and that a given reason is a correct one. This last part was necessary, but only on account of the second, which again was rendered necessary by the first.

Perceiving all external events as beyond our control, Epictetus also taught that they must be accepted calmly and dispassionately, regardless of what happened. However, he also maintained that each person was responsible for their own

actions, which they must learn to examine and control through vigorous self-discipline. That, of course, goes hand in hand with personal willpower, determination and persistency once we are aware of our handicaps. Without it, nothing can ever be successfully accomplished.

The philosophy of Epictetus is well known in the U.S. military through the writings and example of James Stockdale, the 1992 vice presidential candidate of Ross Perot and a fighter pilot shot down while serving in the Vietnam War. He was introduced to the works of Epictetus while at Stanford University. In *Courage under Fire: Testing Epictetus's Doctrines in a Laboratory of Human Behavior* (1993), Stockdale credits Epictetus with helping him endure his seven and a half years in captivity, which included torture and four years in solitary confinement. When he was shot down, he reportedly said to himself "I'm leaving the world of technology and entering the world of Epictetus!" as he bailed out. Quoting Epictetus, Stockdale concludes the book with:

> "The emotions of grief, pity, and even affection are well-known disturbers of the soul. Grief is the most offensive; Epictetus considered the suffering of grief an act of evil. It is a willful act, going against the will of God to have all men share happiness (ibid p. 235)."

Tell that to the powers that be. Epictetus' main work, known as the *Discourses of Epictetus,* consists of eight books, four of which have been preserved. They were transcribed and compiled by his disciple Arrian as none written of his own hand are known. He also compiled the *Enchiridion*, or *Handbook of Epictetus* (Ancient Greek: Ἐγχειρίδιον Ἐπικτήτου, *Enkheirídion Epiktḗtou*), a short manual of Stoic ethical advice and practical precepts derived from the *Discourses*. Avoiding metaphysics in it, Arrian focuses on Epictetus' work, applying philosophy to daily life. The book is thus a manual to show the way to achieve mental freedom and happiness in all of life's circumstances, the principle James Stockdale applied to maintain his sanity while a POW.

Well-known in the ancient world, the *Enchiridion* was especially adapted for use in Greek-speaking monasteries in the medieval period. In the 15th century, it was translated into Latin. With the advent of printing, it was translated into multiple other European languages. It reached the height of popularity in the 17th century in parallel with Neostoicism, a syncretic philosophical movement founded by Flemish humanist Justus Lipsius (1547–1606) that attempted to combine the beliefs of Stoicism and Christianity. Both discourses begin by distinguishing between those

things in our power, *prohairetic* things, and those things not in our power, the *aprohairetic* things, stating:

> "That alone is in our power, which is our own work; and in this class are our opinions, impulses, desires, and aversions. What, on the contrary, is not in our power, are our bodies, possessions, glory, and power. Any delusion on this point leads to the greatest errors, misfortunes, and troubles, and to the slavery of the soul. We have no power over external things, and the good that ought to be the object of our earnest pursuit, is to be found only within ourselves." (Heinrich Ritter, Alexander James William Morrison, (1846), *The History of Ancient Philosophy*, Volume 4, page 206).

It is the only thing in our favour, the only thing the powers that be — and we ourselves — ignore, this huge untouchable and indestructible power residing within us. We act out of ignorance, as no one ever taught us about it. And they, the powers that be, know we are asleep at the helm of our own ship of fate. They will use theirs, through Epictetus' principles of vigorous self-discipline and centuries, if not millennia, of practice, honed to perfection, to perfect our traumatization to an absolute art form. And they are telling us. Look at it. The National Center *for* PTSD, "for" meaning to enhance this existential crisis, not to ameliorate it. Aiming for what? " . . . [lead to] the greatest errors, misfortunes, and troubles [for us], and to the slavery of the [our] soul." (ibid)

We, in turn, will use our power to follow Epictetus' principles and thus empower ourselves, beginning with and aided by the police's prime investigation modus operandi (m.o.) tool and applying it to our opponents. Their criminal profiling is the first step in the educational part of our PTSD journey. Without it, we are up the creek without a paddle because they will outsmart us any time. Listen to the Chinese general, military strategist, writer and philosopher Sun Tzu (544–496 BC), said to be author of the earliest known work on military strategy and war, who said:

> "If you know the enemy and know yourself, you need not fear the result of a hundred battles. If you know yourself but not the enemy, for every victory gained you will also suffer a defeat. If you know neither the enemy nor yourself, you will succumb in every battle."

You see, once we consciously decide to live and live well, we are entering into a war with the odds stacked a mile high against us. It is a war, which we must fight for

our livelihood, our sanity, our honour and integrity, a war for our decent survival off of our country's streets and without succumbing to complete desolation and despair. The only way we can win this war is by gathering knowledge. Remember Dharma (knowledge) extinguishes Karma (ignorance, stupidity, torpor and sloth)? Everything *they* want you to do, every treatment in which *they* want you to participate, you must analyze, weigh and balance in your own mind through research you gather, the non-existent empirical scientific evidence *they* constantly brag about to refute them. Everyone they want you to see you must research to your full capacity, so you know who you are up against and in what mental health industry field of expertise they say they specialize. Every proposal made to you for some action, you must investigate to find the clincher of destruction, your destruction. It is always there. In police work, it is called psychological profiling, and that's precisely what you want to do with the people you are forced to deal with and the demands they make on you, the tests they want you to perform. You must do this for any and all they want you to see. And throughout it all you want to maintain your graciousness, whether it be while talking to them on the telephone or seeing them in person. And while you do this, feeling your blood-pressure rising, to hitherto unprecedented levels even, remember that practice makes perfect, that we get "A" for effort from our guides, guardians, helpers, teachers and friends in the unseen, and that graciousness in all dealings with *them* is *everything*. You blow in anger, you loose the battle, and they'll crucify you. And they have the power to do so!

You must learn to be leery of those you used to work with side by side for sometimes decades, wanting to pry your mind, wanting to know how you're doing. You must be leery of friends and foes alike, in particular those you have known for years, and you must be leery of their friends, as well. You must even be leery of your own family, including or in particular your wife or husband, mother and father, brothers and sisters, cousin and uncles and grandmas. You must be leery of those you vaguely know who suddenly want to be your best buddies, offering to help you. Any help is suspect, from Reiki healing over the phone to helping you write to the union bosses. Graciously decline their offer and keep your own guard and council. In police work, this m.o. is *their* method of suspect identification. It seeks to identify a person's mental, emotional and personality characteristics based on things done or left at the crime scene, you being the criminal. In turn, your crime scene to investigate is the curricula vitae of your opponents, including where they obtained their degrees. Together with caution, weariness, solitude and meditation, such

investigation may save you from economic destruction, followed by mental destruction.

Listen to Gregg O. McCrary, adjunct forensic psychology professor at Nova Southeastern University in Fort Lauderdale and Marymount University in Arlington, Virginia. He says: "The basic premise is that behavior reflects personality." Behavioral traits can most likely be gauged somewhat by someone's chosen life-path, education and academic career. Together they may, to a lesser or larger degree, reflect overall attitude and intentions.

McCrary should know. During his career as an FBI Special Agent from 1969 onwards, he served in various investigative capacities throughout the United States. When stationed in Quantico, Virginia, he acted as criminal profiler and threat analyst. Since 1985, he has been associated with the National Center for the Analysis of Violent Crime (NCAVC) where he served as a member of the "Criminal Investigative Analysis" subunit. He has provided expert witness testimony in homicide and rape trials throughout North America and Europe. He testified before Select Senate Committees on Sexual Violence in New York State and Massachusetts. He consulted on thousands of cases throughout North America, Central America, Europe and Asia. And he has furnished consultation and training regarding violence-related issues to state, local, federal and international agencies. In 1993, he chaired and was principal instructor for the *First International Symposium on Criminal Investigative Analysis* held in Vienna, Austria. Since his 1995 FBI retirement, McCrary has given expert testimony in civil and criminal litigation, both nationally and internationally. He still provides expert commentary on multiple national media platforms including NBC, ABC, CBS, CNN, The Discovery Channel and A&ETV. He also continues to give presentations to professional organizations such as the Defense Research Institute (DRI) and the American Trial Lawyers Association (ATLA).

Furthermore, having authored numerous publications himself, McCrary also contributed to the FBI's 1992 *Crime Classification Manual: A Standard System for Investigating and Classifying Violent Crimes.* This text on classifying violent crimes, is the result of a Federal Bureau of Investigation's National Center for the Analysis of Violent Crime project. A second edition, published in 2006, added 155 pages of new information and research (John E. Douglas, Ann W. Burgess, Allen G. Burgess, Robert K. Ressler). McCrary's work in violent crime has been highlighted in television documentaries, including *The Mind of a Serial Killer,* produced by NOVA for the Public Broadcasting System. Noted British criminologist and author Colin

Wilson dedicated his 1990 book *The Serial Killers* to him. In other words, McCrary is a man of vast knowledge and insight into the human psyche. His book "*The Unknown Darkness, Profiling the Predators Among Us*" is of interest to us. He wrote it with the American non-fiction author and professor of forensic psychology Katherine Ramsland (1953–), who herself has written 60 books and more than 1,000 articles, mostly in the genres of crime, forensic science, and the supernatural. When diving into the unfamiliar and unknown darkness, this is precisely what we must learn to do to protect ourselves. We must profile the predators among those we are forced to deal with when in the PTSD situation. We must then refute our opponents, and thus recover from the experience relatively unscathed.

When engaging in offender profiling, two major assumptions have to be made, namely behavioural consistency and homology. Behaviour-consistency is the idea that one offender's crimes will tend to be similar to those of another's. Homology is the idea that similar offenders commit similar crimes. Keep that in mind when being shuffled from Pontius to Pilate to testify your feelings about your PTSD-causing event ad nauseam to unknown mental health practitioners, all portrayed as PTSD experts, all imbued with the desire and goal to traumatize you further. Also keep it in mind when being kicked back to work when they know you will succumb to the pressures put on by your co-workers, as their actions and tactics to get you to quit the company will, by and large, be the same.

It must be understood also that, when going on this explorative and investigative journey to empower and educate ourselves about the forces we are up against, we go on a tight rope of our own making and walk it without support. Why? Because it necessitates an enormous amount of willpower, persistency, determination and discipline, as we must *graciously* follow our opponents' demands and regimen purportedly designed to improve our health as scheduled, and without an acrimonious peep, even when knowing that nothing is further from the truth. If we refuse, they'll cancel our financial compensation for injury sustained in the line of duty just like that. It is their primary weapon and preferred modus operandi against us, as it is the cheapest and easiest way to entice us to throw in the towel and fade into the woodwork. For many of us, prolonged economic hardship means destruction of our chances to get justice and retribution for our existential crisis incurred while in the line of duty without our own contribution to the mishap. The engine exploding five feet away from me at 6000 feet altitude, for example, was defective at start-up, states the Canadian Transportation Accident Investigation and Safety Board investigative report. Only by doing our own investigation and due

diligence to our selves can we find out what really happened and expect to get justice and retribution. It is that simple. I was cut off for months on end, owed over $55,000 by WCB, employers' hatchet-men, at one time. It later helped to finance *Broken Wings'* publication. My mother's generosity and a basement suite in my mortgage free house kept the wolves from howling at my door while the assaults on me raged.

Furthermore, it is only through our knowledge-gathering adventure conducted on the worldwide web and at libraries that we can learn that our reaction and consequent symptoms to the PTSD-causing event are absolutely "normal." This is in itself a soothing thought, though we ought to remember that the definition of normalcy, debated without conclusion for eons, has yet to be established. After all, it is in the eyes of the beholder, as we see from the numerous differing diagnoses of our own psyche by whoever makes it. Be 100 percent assured that everyone you are commanded to see by the powers-that-be because of your PTSD consider you to be mentally defective. Their duty to their master dictates it, so do perks offered. If telling you otherwise, they are bluffing to pursue you into a game of confidence and trust. Don't fall for it. I almost did, and had it not been for a dream, it would have cost me my life. That's where their expertise lies. Bluff and scare the bejesus out of — or implant it into — us whatever they deem to work best. Never forget they are experts in reading and manipulating people in general and their clients in particular.

And the reaction of the gullible public at large, should you share your PTSD predicament with them, you may wonder? They, too, think you more or less insane and mentally defective and deficient, as that has been drummed into their gullible and feeble heads by mass and social media for the past two decades, at least. So be leery at all times. Anchor the knowledge of your normalcy firmly in your mind, as the deck is harder to stack against us when we are aware of that fact. Besides, to be called insane in an insane world is a compliment. What did Krishnamurti say? "It is no measure of health to be well adjusted to a profoundly sick society." So, know you are as sane as you were before the manure hit your fan and they hired you for your marvellous qualities and aptitude to do your work, and never forget it during this struggle. If you do, it is so much easier for them to have you flounder around like a fish on dry land and, with their knowledge of the human psyche, emotionally destroy you with ease in no time flat. It is their m.o. The rest of your demolition you will then do yourself. They know it and now you and I do too.

We must learn to beat them at their own game, and in our anger against them, cling to the thought that the Law of Retribution is alive and functioning superbly. This is of great importance, in particular when feeling their torturous viciousness

and pressure becomes almost too much to bear, the temptation to just walk away almost too overwhelmingly tempting. Rather than getting mightily upset about their latest inhumane indecency of actions against us, we learn to think "empathy," even love, rather than caving in to fury. When reaching that point, we are almost home free, as the increase in our ability to control our temper enhances our sense of invulnerability, in turn enhancing our emotional strength and thus our power. And with it comes the realization that, in essence, the responsibility for our PTSD recuperation lies with us, the Self. Only the Self can absolve and heal it, as nobody else has insight into the innermost crevices of our soul than we, ourselves. And with that comes the understanding that pharmaceutical PTSD drugging and purported PTSD therapies and modalities are nothing but a fallacy, mere diversion tactics from the truth of PTSD healing, nothing other than a mental health and pharmaceutical industry bonanza to fill its coffers and throw genuine PTSD-suffering human beings into abject desolation and self-destruction. Once that dawns upon us, we begin to take back our power, grab the tiller, say "Not with me, bastards," and with it enter the path of recovery most likely even unbeknownst to ourselves.

That most PTSD journeyers seem to have tough times reaching that point of awakening is understandable. How can anyone when, like Senior Airman Anthony Mena, prescribed 35 drugs over an 18 month period believing it to be the way to recuperation ("Stop Drugging Our Military – A Mother's Crusade", YouTube, 2014)? Does the "Mistake of the Intellect" kick into action? Why is it that people, including PTSD journeyers, are blind to the fact that U.S. veterans commit suicide largely due to psychiatric drugs (Neev M. Arnell: "18 U.S. veterans commit suicide daily; largely due to psychiatric drugs"; cchrint.org 2011)? How can one be so blind as not to see that when mentally incapacitated troops drugged with dangerous, mind-altering, addictive, psychotropic drugs and deployed to battle against their will, they will continue craving these drugs when returning home with PTSD?"(O'Meara, Kelly P: "Former Navy SEAL & Army Colonel Awarded for Fight Against Mass Drugging of Our Armed Forces"; cchrint.org 2014).

One in six American service members is on at least one psychiatric drug. The U.S. Department of Defense increased their prescription of psychiatric drugs by nearly seven times between 2005 and 2011. That is more than 30 times faster than the civilian rate. In 2013, more service members died by suicide than in combat and 22 veterans kill themselves every day. Why are these facts hidden from troops and the public alike? So as not to impair the mental health industry's pharmaceutical components and prescribing health practitioners of all genre's finances? After all,

spending on psychiatric drugs had more than doubled since 2001 to $280 million in 2010, at least according to numbers obtained from the Defense Logistics Agency by Richard A. Friedman, professor of clinical psychiatry at the to-us-familiar Weill Cornell Medical College. He is also the attending psychiatrist at New York's Presbyterian Hospital and director of psychopharmacology at the Payne Whitney Psychiatric Clinic. Acknowledged as an expert in the pharmacologic treatment of personality, mood and anxiety disorders, obsessive–compulsive disorder, PTSD and refractory depression, it is somewhat puzzling that it escaped the esteemed professor's attention that the Army's suicide rate increased by more that 150% during the same timespan. Mind you, to him it may be just be a minor detail. (J. Dao, B. Carey, D. Frosch: *For Some Troops, Powerful Drug Cocktails Have Deadly Results*; nytimes.com 2011).

Retired Army Colonel, former military psychologist, founder and director of the military-wide Human Assistance Rapid Response Team (HARRT) program Dr. Bart Billings, Ph.D. has no doubt that the cause of suicides among US troops is the direct result of psychiatric drug use. He says:

> "I'm 100 percent convinced. I've seen it and talked to hundreds of these guys. These medications really interfere with the brain's ability to normalize itself and adjust. It's hard to make a choice on how to recover if your brain isn't operating the way it should be. It's kind of like working with someone who is drunk," he explains "you're not going to get very far. It would be like me spinning you around fifty times and then asking you to walk a straight line. It's not going to happen. These medications are a chemical lobotomy."(Kelly Patricia O'Meara "*Psychiatric Drugs and War: A Suicide Mission*"; cchrint.org 2011)

And what are the medications Dr. Billings refers to as resulting in a "chemical lobotomy" when peddled to the troops as magic mental health bullets? Among them is the antipsychotic Seroquel, prescribed to the troops for sleep disorders during the last decade at a rate of 6.6 million prescriptions, for the price of nearly $850 million. FDA-approved for Schizophrenia and bipolar disorder treatment, the military wrote more than 50,000 Seroquel prescriptions in 2010 alone, with 99% of those prescriptions written off-label, meaning for disorders not FDA-approved. Not surprising, though, with what we now know, that the FDA's approved Medication Guide for Seroquel lists "Risk of Suicidal Thoughts or Actions" as one of its "serious

side effects." Laugh or cry? It's almost too insane to fathom.

In addition to suicidal thoughts and actions at the top of risks associated with Seroquel, there are others just as frightening. These include but are not limited to:

- anxiety
- hostility
- agitation
- irritability
- depression
- panic attacks
- hallucinations
- aggressiveness
- exaggerated feeling of well-being
- worsening mental or mood changes

The question springing to mind when reading this abbreviated risk list is how would soldiers know if these reactions are related to their purported disorders or actually caused by the mind-altering drugs they consume, asked Kelly P. O'Meara, the article's author? And, equally important, how would anyone, least of all a psychiatrist, be able to make this determination, given there is no science behind any psychiatric diagnosis? They don't and they can't, neither soldiers nor psychiatrists. The former will only discover a few days after complete cessation of taking the drugs what it did to mind and body, and the VA and civilian psychiatrist, with the exceptions of the world's few Billings and Breggin, couldn't care less to know. You have PTSD, you are nuts to begin with, you have mood swings and are irritable and aggressive so we are getting you there. It's all according to plan, their plan. Human emotions, mind and soul are old-fashioned, not in style. Conversion into the new man is in, so is population reduction to 500 million worldwide max and psychotropic drugs help with both goals. It's all so simple. Meanwhile, perks and bonuses pile up, overriding any such sentimental considerations of wellbeing for the dumb animals, as the German-born Heinz Alfred Kissinger (1923–), an elder American statesman, political scientist, diplomat and geopolitical consultant, calls US military warriors. The brave new world in the making, that's all. Military brass, upon hearing the news, may be politely muttering a few simple "WTFs" O'Meara conveys, and that should put matters to a peaceful rest.

Dr. Billings doesn't have high hopes for answers, either, he says, unless major

changes occur within the military mental health complex. Much aware of the military's apparent surrender to psychiatry's pharmacological assault, he states:

> "The psychiatrists have no clue about what they're doing and it's psychiatry that runs mental health in DoD and the VA. DoD has to stop trusting them. Any organization in the world whose leadership continually fails and loses money, in this case lives, would fire them. Why hasn't psychiatry been fired? They are responsible for mental health in the military and have done nothing to stop these suicides . . . I've been trying to convince people that psychiatrists are nothing but legal drug dealers, and they're dealing drugs that don't work and actually kill people."

Why indeed, one wonders? Well, because it's all according to plan, that's why. This becomes abundantly clear in particular when knowing that, as O'Meara's discovered, the Department of Defense and Veterans Affairs spent much more money on psychotropic drugs to treat troops' "mental illness" and PTSD than quoted by Friedman. It spent a whooping $2 billion since 2001 on them, including more than $800 million on antipsychotic drugs like Risperdal and Seroquel, aka "Serokill." With the millions of dollars spent annually to get to the bottom of this drug "epidemic", command might find it prudent to take a hard look at some basic facts O'Meara voices. Suicides and other unexplained sudden deaths had been increasing for the past several years and the diagnosing of PTSD had also reached epidemic numbers, she states. With it, the prescribing of psychiatric drugs, many of them FDA-unapproved and many causing the symptoms for which the troops sought treatment, for PTSD treatment had also reached epidemic proportions. O'Meara's 2012 article "Two Soldiers Prescribed 54 Drugs: Military Mental Health 'Treatment' Becomes Frankenpharmacy" gives further insight into the matter (cchrint.org).

The 20-year *Newsweek* correspondent and journalist Jamie Reno also had something to say on this. Now an investigative reporter for Healthline, he wrote "Medicating Our Troops Into Oblivion: Prescription Drugs Said To Be Endangering U.S. Soldiers" in International Business Time in 2014. (IBT April 19, 2014) He said that Dr. Breggin testified before Congress about what he described as the over-drugging of troops, and its consequences. In his view, there was a "disturbingly rampant practice" of prescribing psychotropic prescription drugs to young soldiers, both in combat and after they return home. In 2012, the extent of the military's use

of prescription drugs had been quantified by the *Austin American-Statesman,* founded as the *Democratic Statesman* in 1871 and the major daily newspaper for Texas' capital city, Austin. It had found that Department of Defense spending on drugs had ballooned by more than 123 percent from $3 billion in 2002 to $6.8 billion in 2011. This outpaced by nearly double the overall increase in reported pharmaceutical sales in the U.S.A.

Reno of jamiereno.com reported that in the decade after September 11, 2001, the military spent $2.7 billion on antidepressants alone. The liberal and free drug dispensation continued after soldiers' care passed to the VA. CBS News obtained VA data through a freedom of information request in September 2013, which showed that, while the overall number of patients treated by the VA was up a mere 29 percent, narcotics prescriptions were up 259%. Dr. Breggin attributed such dramatic increases to big pharmaceutical companies' influence over the DoD and the VA. He claimed: "When you have a government-run client, pharma only needs to get to a few people at the top, and that's what we've seen here." Though he was unable or unwilling to identify who those people might be, Breggin asserted that the result was "a national disgrace that reflects on some of the leadership in the military, but not the military as a whole." His view is shared by Dr. Stephen Xenakis, chief psychiatrist at Fort Hood in the 1980s. He was part of the crisis response team sent there after Nidal Hasan, a U.S. Army major and psychiatrist, fatally shot 13 people and injured more than 30 others in 2009, in the deadliest mass shooting on an American military base ever. Said Billings to IBT:

> "The pharmaceutical companies' influence is so strong, as are the pressures from Congress to keep things just the way they are. Congress is lobbied heavily by pharma. It makes it difficult to get any endorsement or enthusiasm for any non-pharmaceutical types of treatment."

Does that explain it loud and clear?

There is a brightness dawning on the horizon, though, as those beginning to look through the scam are slowly speaking out more forcefully. The mass media still vigorously avoids truth about the psychotropic pharmaceutical drugs, PTSD and suicide-topic in the military. It's just as they shy away form the detriment of vaccinations to human health, and other aspects of human life and living detrimental to their health and wellbeing. Among military personnel with the guts to speak out in the wake of the suicide epidemic among troops, besides Dr. Billings, is retired Chief Petty Officer, Navy SEAL Mikal Vega, who, like Billings, also

continues to take care of his own off the field of battle. Both courageously talk about the harm caused to service men and women's by mass drugging. In their documentary *The Hidden Enemy,* the Citizens Commission on Human Rights' (CCHR) reveals in great detail psychiatry's infiltration and abuse of US military forces. The commission honored Vega and Billings during its 4th Anniversary and Human Rights Awards Banquet held in Los Angeles in 2014 for their advocacy on behalf of their brothers-in-arms experiencing psychiatric abuses in the military. Each in his own way continues to go above and beyond the call of duty by carrying the battlefield mantra "no man is left behind" to the home front.

Both award recipients are intimately familiar with the devastating rate of troop-drugging going on under the guise of "treatment." Vega, after 22 years of "kicking death's ass" in Iraq, Haiti, Bosnia, Kosovo, Zaire and Albania, said that it was a cocktail of pills that nearly took him out. He recalls:

> "I know. After I was almost killed by pills that the stuff the psychiatrists were doing wasn't working. No wonder men are killing themselves — because these pills have everybody depleted. I felt like my soul was gone."

Can it be stated more succinctly? Vega has no illusions about the harm psychiatry is perpetrating upon the military: "The psychiatry and the pharmacology that they irresponsibly exact upon our military is a direct subversion of what their true power is. That they're taking away, pill by pill."

Vega has come a long way since feeling he had lost his soul. In 2017, he taught actors how to convincingly pull off each week's maneuvers in NBC's military-themed drama *The Brave*, as well as acting as military advisor (military.com). He also wrote and directed a short film through a scholarship from the *Veterans in Film and Television's* workshop, telling the story of a veteran struggling with PTSD. Vega introduces his lead character to the techniques and principles that drive *Vital Warrior*, a nonprofit organization he founded offering to help veterans live through their PTS crisis without stigmatization of psychiatric labels and harmful mind-altering drugs. Vega also stars in the *Navy SEALs vs. Demons* horror action, flick starring actual kick-ass armed forces veterans available for your amusement on DVD/Blu-ray in 2017 via MVD Entertainment Group distribution, in association with Wild Eye Releasing and Ripped Boxers Entertainment. A happy ending, indeed.

He was able to kick himself into gear to get his R & R (recuperation and recovery) on the road. How? By realizing the detriment of psychotropic drugs

prescribed by those pretending to care for his wellbeing. Most are not able to, as the unceasing exponential prescription and consumption of psychotropic drugs for PTSD and the associated depression and suicidal tendencies prohibits such positive evolution of the Self. It's like trying to decide when to stop drinking when you are already drunk.

The high number of deaths among both veterans and active duty soldiers by suicides, accidental overdose and lethal drug interactions (ahrp.org) for which pharmaceutical drugs are said to be responsible confirms it. Prior to the Iraq war, American soldiers in combat zones were not taking psychiatric medications, according to PBS Frontline 2010 documentary *The Wounded Platoon.* (pbs.org/wgbh/pages/front . . .). By 2007, more than 20,000 of deployed US troops were prescribed antidepressants and sleeping pills to "allow" PTSD affected soldiers to remain in combat when they otherwise could not. And you still think that had no affect on their overall wellbeing upon returning home? Well, it did. By 2011, over 300,000 troops returned from Iraq and Afghanistan with PTSD, depression, traumatic brain injury or some combination of those, according to Dao et al.'s *The New York Times* 2011 article "For Some Troops, Powerful Drug Cocktails Have Deadly Results" (nytimes.com/2011/02/13/u . . .). Has it changed since then? Judge for yourself. Following the lead of civilian medicine, where psychotropic prescription drugging is also said to be rampant, the military began to rely really, really heavily on opioid addictive pharmaceuticals to treat its soldiers' problems. This, in turn, resulted in today's widespread and unprecedented drug use in both the US military and civilian population alike, just as planned by those who rule us.

As a matter of fact, the aforementioned army report on suicide recognized that one-third of US troops were taking at least one prescription drug, stating that number to be on the rise. The report also noted that one-third of the acknowledged *162 active-duty soldiers* committing suicide in 2009 were all on prescription drugs. And with that knowledge under our belt, we still think there's help to find for our PTSD-afflicted mind and soul outside of ourselves anywhere other than from the Creator of all there is, was and ever will be together with our guides, guardians, helpers, teachers and friends in the for-most-of-us-at-least-at-present unseen? Chief Vega has no illusions whatsoever about the harm psychiatry is perpetrating upon the military. He states:

> "The psychiatry and the pharmacology that they irresponsibly exact upon our military is a direct subversion of what their true power is. That they're taking away, pill by pill.

> Most elite of all war fighters, [the Navy SEALS] have an innate ability to withstand extraordinary amounts of stress. We can readily adapt to any situation presented. This attribute is one of the key factors that make us so formidable upon the field of battle yet even then, given the correct combination of circumstances, we can falter – mentally and physically. Through personal experiences in 'treating' my own combat-related stress (commonly described as PTSD) and mild traumatic brain injury (MTBI), I entered a space that had afforded me the clarity to transform post-traumatic stress into a strength – a strength that I never would have developed were it not for these very experiences that led me to Kundalini Yoga." (Information available on "The Vital Warrior Program: Conscious Action Serving Veterans" at www.3ho.org).

Dr. Billings, the other CCHR award recipient, is equally passionate about the harm by drugging being inflicted upon the nation's military. Commanding Officer for an Army Reserve general hospital section, he served 34 years in the US Army as enlisted and officer. His highest military rank was Colonel (SCNG-SC Medical Directorate). He founded and for 22 years directed the Annual International Military and Civilian Combat Stress Conferences, the Prisoner of War Conferences and the military-wide Human Assistance Rapid Response Team (HARRT), which the Pentagon accepted as a readiness protocol to be implemented military-wide in 1997.

An expert certified rehabilitation counsellor, he has worked in the field of mental health, human services and management for over 48 years. He has given lectures throughout the country for universities, private organizations, national conferences and the military on a multitude of topics, including combat stress, stress and burnout, and violence in the work place. He founded and still directs the oldest annual military stress conference, the International Military and Civilian Combat Stress Conference. He has been interviewed on ABC News Nightline and ABC World News about combat stress. And he gave testimony at congressional and state legislative hearings on the need for better mental health treatment programs for military personnel and their families. As one of the first professional mental health practitioners to disclose the link between psychotropic drug use and military suicides, Billings founded the annual International Military and Civilian Combat

Stress Conference to promote effective, integrative, alternative and individual treatment approaches without harmful psychiatric drug use. Nobody listened, as today's military is being drugged for PTSD at epidemic rates, which, he says, is no disorder. Listen:

> "Ninety-nine percent of anybody that goes into combat is experiencing Post Traumatic Stress. It's a normal reaction to being in an abnormal environment. You shouldn't really be medicating them, because they have a normal brain and once you medicate these people, what happens is it's much, much harder to work with them because now you're working with somebody whose brain functioning is chemically, physiologically changed by the medications."

In his opinion the best mental health treatment modality is found in a strong sense of involvement and caring indisputably leading to trust. He explains:

> "In my 47 years of treating people, although I had access to using psychiatric medication, I never recommended a single psychiatric drug. In all these years, I can state unequivocally, I therefore never had a person commit suicide or a homicide while in my care. As long as psychiatry's in-charge of mental health in the military, you're not going to see much change. Because they feel obligated to medicate people."

There you have it!

Both he and Vega testify that the PTSD treatments afforded to military personnel, and by extension through the NC *for* PTSD affiliated mental health organizations and their members dictating PTSD treatment modalities world wide to the genuine PTSD experiencers, the firefighters, police officers, veterans and aircrew members, is detrimental to their health. Both advocate that there are much more humane ways to treat those traveling the PTSD journey. And one of the very best ways is to thoroughly understand that we can indeed heal ourselves. As a matter of fact, to repeat myself, we are the only ones who can.

The Canadian-born author and mystic Manly Palmer Hall (1901–1990) is widely recognized as a leading scholar in the fields of religion, mythology, mysticism and the occult, He is also well respected by those in philosophy, theosophy and psychology circles, including Carl Jung. Hall is perhaps most famous for his work *The Secret Teachings of All Ages: An Encyclopaedic Outline of Masonic, Hermetic, Qabbalistic and Rosicrucian Symbolical Philosophy.* In it, he points out:

> "When confronted with a problem involving the use of the reasoning faculties, individuals of strong intellect keep their poise, and seek to reach a solution by obtaining facts bearing upon the question. Those of immature mentality, on the other hand, when similarly confronted, are overwhelmed. While the former may be qualified to solve the riddle of their own destiny, the latter must be led like a flock of sheep and taught in simple language. They depend almost entirely upon the ministrations of the shepherd. The Apostle Paul said that these little ones must be fed with milk, but that meat is the food of strong men. Thought*less*ness is almost synonymous with childishness, while thought*ful*ness is symbolic of maturity . . . There are, however, but few mature minds in the world "(Manly P. Hall, p. 1).

PTSD experiencers are bright. Otherwise, genuine PTSD would never have hit/caught us. We *are* the individuals of strong intellect. We are able to use reasoning faculties. We are able to keep our poise, despite upheaval and heavy stress, and find solutions. We have proved it while doing our work. Otherwise we would not have been in it for long. Now it is our duty to Self to keep our poise whilst seeking to reach a solution for our PTSD recovery for our own sake. The solution awaits us by obtaining facts bearing upon that question and how to solve it. We are intelligent enough to do so. We certainly can develop intellect, as we have enough life-experiences, which are deemed to play a crucial role in the formation of intellect. At least that is what the mental health cabal purports, for whatever it's worth. They maintain that it is through life experiences that humans learn to reach intellectual enlightenment, improve their behavioural patterns and learn to act with honour, integrity and graciousness in future life situations. Therefore, believe it or not, intellectual development is encouraged by feelings of dissatisfaction, in our case by the curse of the PTSD experience. Insight gained from such particular dissatisfying situation also creates the search for a solution. It is furthermore "divined" that only life's experiences can provide us with genuine and thoughtful understanding of perceived reality, in consequence contributing to our intellectual development.

So intellectual understanding is built upon human perception and cognitive reflection. The process of finding solutions to any life problem is meant to enrich our mental database of reality attributes. When acquiring the most accurate understanding of our Selves, and thus the world around us, the model mirrored in

our minds becomes similar or identical to reality when the intellect releases its full potential. Intellect reaching its maturity is in psychology jargon referred to as self-management. At this state, intellect can encounter every problem it faces and not only change itself in the most efficient manner, but also alter the perceived reality in the most desirable ways. It is the manifestation of our thoughts in action. Thus, overall, success and failure turn to depend primarily on the extent of our individual intellectual capabilities, combined with control over our thinking. The goal and meaning of the PTSD exercise we quasi involuntarily engaged in is to reach that point, the conscious self-management of our Self for the purpose to achieve such intellectual capability. The result? extinguish Karma through Dharma. This is the gift presented to us by PTSD for its taking or rejection. The choice is ours. It takes diligence, much, much hard work and never-ending self-observation and patience with the Self, which will, I believe at this moment in time, go on for the rest of our natural life. It's either that or be drugged into desolation henceforth, until death frees our souls.

Are we going to allow those faces we know and those voices we trust to use us at their will and let the well-hidden beauty of PTSD pass us by? Or do we crawl into the rabbit hole as far as it will take us by turning thoughtful? Do we become our own shepherd and turn into a philosopher searching for the knowledge to heal ourselves by freeing our Self from those pretending to be our healers, feeding us the milk of pharmaceutical psychotropic drugs and opioids and killing us slowly with their experimental hypothetical hypnotizing PTSD curing treatment modalities? Do we go searching, become the one "attempting to find out," as Pythagoras advocates, the philosopher deciding our own fate to see the manifestation of self-healing in action within our Self in no time flat? Or do we adhere to the command of others, thus adding to our misery and destruction by our own volition? Do we take the red pill or the blue? It is obvious what I did, and in the next part of this trilogy I will share with you how I did it — by osmosis.

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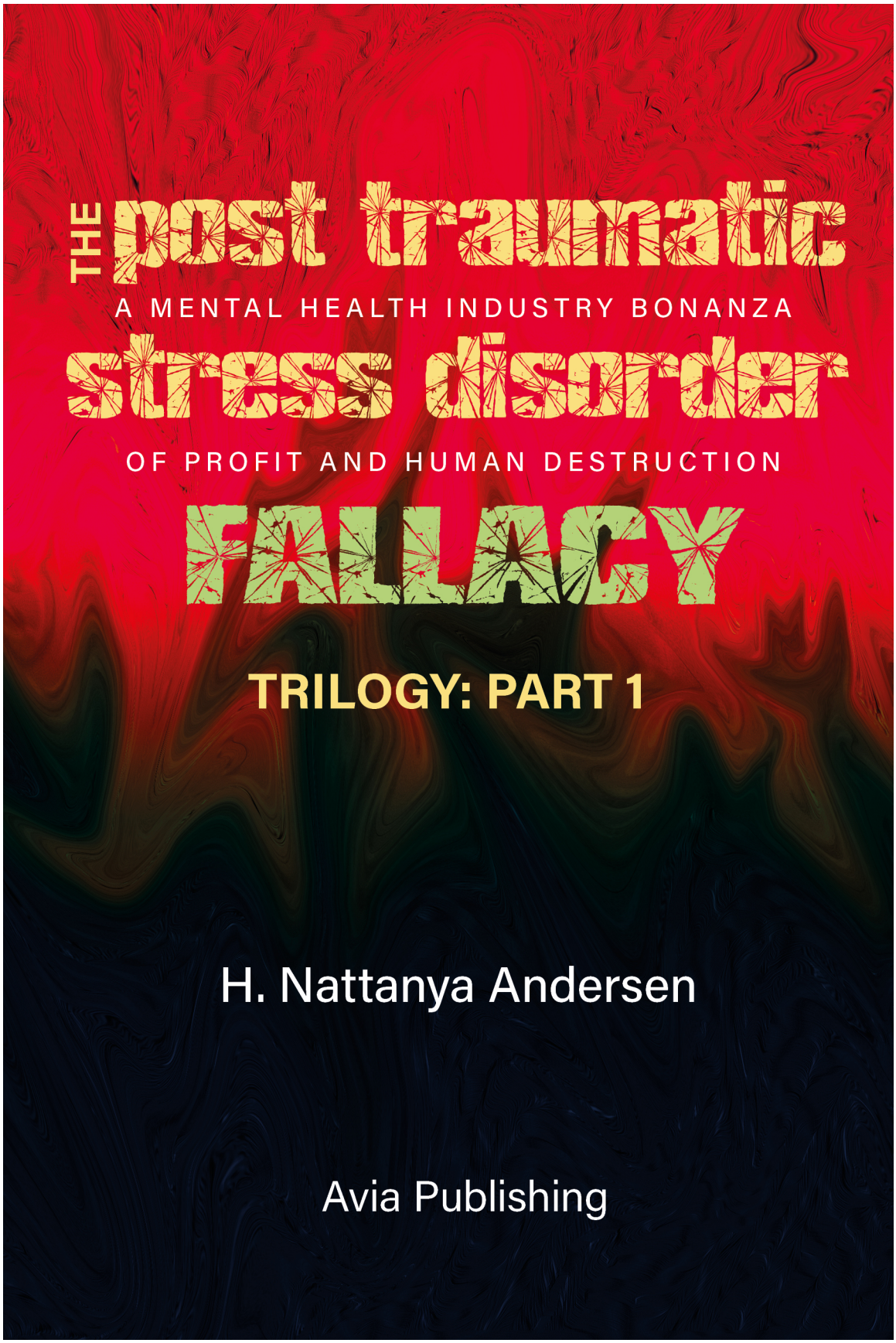
THE post traumatic stress disorder FALLACY
A MENTAL HEALTH INDUSTRY BONANZA
OF PROFIT AND HUMAN DESTRUCTION
TRILOGY: PART 1
H. Nattanya Andersen
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