The "Preface" (below) reprinted from the following titled book –

Guerrilla, Terrorism, Asymmetric Warfare's Pathogenesis and Cure

Assuming the practical application to Combat Trauma of ETM TRT SHOM

Addendum:

Etiotropic Trauma Management™ (ETM) and Trauma Resolution Therapy™ (TRT) applied to Combat and Crisis Management Personnel and Organizations

by

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– serves as due diligence support for application of ETM TRT SHOM to crisis management, including military organizations.

Preface

Department of Defense PTSD Experts Examine ETM TRT

In June, 1990, and following a U.S. Department of Defense (DoD) study group's evaluation of Etiotropic Trauma Management's™ (ETM) clinical and industry system management programs, I, through the ETM Master Trainer Craig Carson, was requested by leaders of the Army's Chaplain Corps, a component of a Department of Defense psychological trauma and PTSD study group, to write a plan taken from our applications of ETM TRT and training and certifications schools taught at the University of Houston with which to test and employ ETM as a response to combat. I did write the plan, and doing something not expected, emphasized ETM's strategic application in guerrilla warfare conditions as an addendum to the clinical care training and information the group had already received in the primary certification school.

The strategic ETM TRT consultation, theory and application referenced in the previous paragraph (presented in 1990) is based on Vietnam combat and my experience in ground combat and helicopter operations where I was directly engaged in the processing of the wounded and those killed in action. A summary of that experience is described in the ETM Tutorial's development section. I did not write the consultation strategic focused document with the idea of telling my personal traumatic experiences of that duty, for example, as if telling a combat story showing that as a combatant I knew a lot about trauma, although that is true. Instead, I wrote as a combatant in a unique role that gave me tremendous, that is for a trauma manager, researcher and author, insights into the traumatization of combatants, first respondents, and supervising managers. Of course, I did not think of trauma management at the time, but did so later when learning about trauma through development of ETM TRT for individuals (affected by all kinds of trauma) and systems as families controlled by a trauma perpetrator – one of the members of the family usually a Chemically Dependent Person, and systems as organizations having crisis management duties affected by trauma.

I was also the body guard in all combined helicopter and infantry operations for the Commanding Officer, Colonel William Gentry Johnson, later to be Major General Johnson. Being that he was the TACA (onsite - over and on the battlefield integration of helicopter and fixed wing combat with infantry activities) of every operation,

approximately 1 per week (for me 9 months) lasting from 3 to 21 days, I saw the war and the various infantry - air (helicopter and fixed wing) and ground support (trucks and jeeps) activities, and then how they were evaluated and appraised by the Colonel when sending the "Lesson's Learned", a term coined by Robert McNamara, directly back to him as the Cabinet member in charge of the Department of Defense (DOD). From that duty I became an operations representative, often the only such person performing in that capacity for forward integration with helicopters positioned in the field closer to the infantry's ground operations. I made every operation in I Corps Vietnam between January and August of 1966 supporting MAG 36's combat role with such infantry groups as 2nd Battalion, 7th Marine Regiments (2 – 7), 3 – 7, 2 - 4 and other heroic Marine units of that time. Those "grunts" and our helicopter pilots, crew chiefs and corpsmen were awe-inspiring men and from whom I tried to pattern my military contribution and the rest of my life as a man. My group was awarded 2 Presidential Unit Citations.

I also made those missions such as troop, reconnaissance insertion - extraction, emergency medevac, resupply and strike activities from the perspective of the helicopter combatant role, and often and importantly, being left in zones to accommodate helicopters too full with wounded. That fact is important because not only had I been in my own battles, but I was able to see firsthand what a responding trauma manager (as I have designed and created a combat support position) would see and experience entering a battle just following it or during it, and without having direct duties with the ground infantry (grunt / units). That freed me to observe the process. Later again after completing my service with the Marine Corps and then becoming a student, clinical treatment provider and author of trauma, I integrated those combat observations with these additional experiences in order to structure the underpinning of the strategic and humane application recommendations I incorporated into the ETM TRT onsite trauma managers' duties.

I also saw trauma's impact and management from the grunt's (infantryman) perspective for the first 4-5 months of my tour. My duties included participation in squad size patrols, two man night reconnaissance missions, working in CAP (Combined Assistance Program) which involved living with fire teams (four men) in villages for extended periods, building the security infrastructure for the Helicopter Base (Ky Ha) at Chu Lai at its infancy (August, 1965), squad rifleman and machine gunner, and machine gunner for the Emergency Reaction Team for rapid insertion into difficult situations, for example, securing a downed crew and helicopter in an unsecured combat zone, and other duties.

I did have two traumatic brain injuries causing concussions and loss of consciousness from one. For each, I was nominated for a purple heart. I declined them because my body was still intact, unlike other men's. Although I now know that I was profoundly affected, but went on to continue my duties, at the time I did not think that I deserved the medals because I was not in the category of those men maimed and otherwise so badly affected. Moreover, the attitude underpinning those decisions was taken from having been trained by members of the "old" US Marine Corps from WWII and Korea. Whatever the case, I still suffered PTSD and neurological damage from those injuries, eventually becoming disabled from them. Of course, that experience has also influenced my perspectives of trauma occurring during combat. For example, I know what it is to be blown through the air by a grenade and to walk a battlefield after it is silenced, and as if my feet were six inches off the ground, and while my mind existed in a state of beginning dissociation. As a Platoon Sergeant from 1966 – 1968, I specialized as a trainer in anti-guerrilla warfare for the United States Marine Corps, 5th Marine Division.

Merging that personal combat, injury, observation information and anti-guerrilla warfare trainer with my professional clinical and management work, and coupled with my academic education at the University of Texas at Austin and pre therapist training while working in corporate management, the experiences from those pre ETM TRT years would weigh heavily in the development of the final anti guerrilla warfare plan that was presented to the DOD study group and which now comprises this book. There was much more information gleaned from our decade's work from 1979 to 1990 within the community supporting multiple crisis management organizations such as law enforcement, Children Protective Services, Family Service Centers, women's shelters, schools (another full story of this model's application to organizations being affected by trauma) and many other agencies and community assistance agencies.

Just as Craig Carson presented the plan to the study group's leadership, the Gulf War began. It was August, 1990. Although agreeing on its merits, the parts of the plan that would require inserting trauma management teams into the newly secured battle Zones, then mapping a combat event's personal and systemic influences would require presentation and incorporation by senior operational (combat) leaders. That would require considerable training that was integrated with infantry and helicopter units. The parts of the plan intended for implementation in the rear areas could be applied only by chaplains and other ETM TRT specialists. Due to the ensuing war, however, final acceptance and implementation of the plan were postponed. Participating officers (in the training and plan's discussions) received transfer orders related to the War, removing from the ETM TRT training implementation process.

Following its end, many permanent reductions throughout the military in personnel, including senior officers who were members of the study group, brought the plan's near-term implementation to a close. Here is one of several reference letters provided by the DOD PTSD study group's senior officer leadership.

ETM TRT Reference Letter and Report from the 1990 Senior Officer Leadership of the Department of Defense Study Group for Military Based PTSD Professionals

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For both personnel and organizations, Etiotropic Trauma Management™ (ETM) with its clinical component Trauma Resolution Therapy™ is the most effective and comprehensive crisis and trauma treatment program in the country.

My interest in crisis debriefing and trauma treatment dates back to working with soldiers on the battle field in Vietnam, returning prisoners of war, and medical personnel in hospital trauma settings. Since the Vietnam War, I have continuously worked with victims of trauma and their families. My studies in crisis and trauma resolution include: Harvard University, the International Society for Traumatic Studies, the programs of Dr. Jeff Mitchell (author of Critical Incident Stress Debriefing), National Organization for Victim Assistance (NOVA) and others.

Etiotropic Trauma Management™ is a program with integrity. It provides quality treatment and delivers on all of its claims. Other programs tend to decrease anxiety in the debriefing process and the crisis worker tends to feel better for a while. Later, issues arise, and trauma symptoms may go unrecognized and unattended. Only Etiotropic Trauma Management™ provides a method for dealing with the acute trauma manifestations. This trauma management system greatly reduces the chance of a crisis experience affecting their professional and personal functioning. My thoughts are that this system would minimize the worker's compensation claims from traumatic reactions (PTSD) and the acting out behaviors of traumatic stress symptomatology.

When conferring with several professional colleagues who are well versed in crisis debriefing and trauma treatment, all agreed that Etiotropic Trauma Management™ offers the only complete program for emergency medical service personnel. I am a career Army Officer and currently assigned to

Brooke Army Medical Center, San Antonio, Texas. ETM does not create victims; it resolves the impact of crisis and trauma. I urge EMS (Emergency Medical Services – crisis management styled) organizations to give their personnel the best program possible, Etiotropic Trauma Management™ (ETM) and Trauma Resolution Therapy™ (TRT).

Very truly yours,

Gerald W. Conner
CH (LTC) US Army

More ETM TRT Development

ETM was designed and developed, by my wife, Nancy Carson, and me, Jesse Collins. Craig Carson, not related to Nancy, has been a helpful editor of our books and articles, and the primary trainer of Certified ETM Counselors and Certified ETM Trainers for twenty-five years. ETM was first applied between 1979 and 1991 to people affected by virtually all manner of traumatic events. ETM's clinical component Trauma Resolution Therapy (TRT) was developed first within six and then eventually nine fully government credited and Joint Commission for the Accreditation of Hospitals (JCAH) facilities. That significance is that all patients' acute and following treatment applications were audited annually by those organizations for progress and compliance within all treatment facility clinical and case management standards. Additionally, each facility when treating a chemically dependent person required full family participation to include children to five years of age. The family program treated each family member as an identified patient for the individual, interactional and systemic effects of psychological trauma resulting from the Chemically Dependent Person's(s') behaviors with TRT applied in groups, and individual peer group therapy, marital therapy for the spouses, and family therapy within family therapy groups consisting of four families of usually four family members per group. The entire program lasted two years with TRT groups starting for the Chemically Dependent Person after sustaining approximately months sobriety.

These programs were administered by Nancy and me in the first years and then as clinical and executive directors for the final clinical and all authority in the six different facilities being operated nationwide. ETM TRT training developed out of the training processes learned and applied over seven years and then in an additional facility for another seven years. The training was provided to multi disciplined treatment teams consisting of Psychiatrists, MD Internists, Psychologists (PHd), Masters of Social Work (MSW's), Marriage and Family Therapists, Licensed

Professional Counselors, Licensed Alcoholism and Drug Abuse Counselors, Pastoral Counselors (Masters Level clinicians as well as chaplains or pastors), and volunteers.

On ETM's site (http://etiotropic.org), there are dissertations regarding ETM's development and standard and strategic applications found under Professional / Academic / Development. You'll also find many other books listed under the Etiotropic Series. One is entitled Neurobiology of Psychological Trauma Etiology and Its reversal with Etiotropic Trauma Management (ETM). It supports the work produced under this title: Guerrilla War – Terrorism's Pathogenesis and Cure. For professional training and patient educational purposes, I've written a total of thirty-two titles.

The ETM model was made available to constituents who used it as did we for treatment, social management, organizational (strategic) management (as in schools) and training in the arenas of battered spouse - family, chemical dependency, combat, post combat, crime, disaster, disease victims and most other trauma domains. ETM's strategic theory for professionals, like combatants, is taken also from and underpinned by a combination of work with many perpetrator caused trauma etiology reversals and then staffing with (teaching to) all manner of ETM trained professionals. They've included for over twenty-five years social workers, psychotherapists, School district counselors – teachers - principals, psychologists, marital and family therapists, alcoholism and drug abuse counselors, psychiatrists, children protective services counselors, law enforcement, other personnel, and etc.

Strategic ETM in School Districts and Regions
Application of the Same ETM Strategic Application to Combat

Starting in 1989 before the DOD plan was written in 1990, TRT was taught to School Counselors in various districts, most of which were operating within the Rio Grande Texas region. After its development and writing, the combat anti terrorism and guerrilla war model was adapted to those School districts being affected by gangs, drugs, community coercion, and violence including suicides and homicides. Hence, pertinent elements of the combat thesis theory and application principles began to be administered in School Districts in Texas.

In 1992 and at request of the Texas Education Agency (TEA), one particular large district training fifty counselors, medical personnel and principals from El Paso began a study of the various national psychological trauma management models used for responding to crisis and traumatic events. After two years of ETM TRT application of a nearly identical approach comprising the ETM TRT consultation plan provided the

DOD's trauma study group, the TEA governing approximately 1157 school districts asked that the results of the El Paso study be presented to the Agency's annual conference. Thus on September 4, 1994, the study's conclusions regarding the ETM organizational aspects of psychological trauma were presented to 6000 persons consisting of Superintendents, Principals, school district counselors, and medical and security personnel. The finding, which supported the DOD's conclusions referenced in the letter above, was that from a national perspective ETM TRT was the best trauma management program for educational based organizations and for individual trauma counseling for students and personnel. The recommendation was to train statewide all professionals from the referenced categories presented above (25,000 professionals). We began the work and before our illnesses (described later) trained pertinent personnel at 161 of Texas' 1157 school districts through 1995. Our illnesses and injuries ending our capacities to even function with modicums of competence precluded dissemination into school districts both nation and world-wide.

Cost Accounting's Expertise Created TRT

Aside from my career change made in 1978 into alcoholism and drug abuse treatment and clinical administration, my pre mental health work, education, and training were in the fields of accounting, statistics, finance, investment banking and organizational development. The accounting background's substantial influence is reviewed on the Internet. For now, let me just say that the intricate sorting analytical capacities of the tool of cost or managerial accounting provided me with the abilities to see the patterns of damage occurring within existential personal identity and to follow with the necessary detail the process of accounting for and then reconciling each category and then component of loss and its emotional (including grief) counterparts attending the identity elements sundered by various events, no matter the particular kind of event (battering, homicide, combat, disease, etc.). The accounting or loss reconciliation model could be successfully applied to what Scrignar (1987) later said was a conglomeration of intrapsychic and interactional damages that "overwhelmed the psychodynamic models" making them incapable of successfully treating trauma.

After substantial application of the developing TRT clinical identification component of the reconciliation activity, we discovered continuing use of the model between patient and therapist would lead eventually to resolution of the trauma and finally "complete resolution" of the entire disorder. By literature reviews I did between 1979 and 1994 in the arena of the psychology, systems analysis and the neurobiology of trauma with the help of Craig Carson (bibliography provided in the ETM School training texts and online in the tutorial) I proved without any doubt the logic of the Etiotropic approach to psychological trauma over the Nosotropic one. Professionals

even refer to ETM TRT as a “beautiful” theory, which as you know in physics is an indication of the essence of logic to such an extent that it serves as fact.

For reasons detailed in Etiotropic Trauma Management Series literature, after nearly thirty years (at times due to illness provided through Craig Carson’s analyses) of both application and observance of its replications by other therapists certified in ETM TRT, I decided to directly challenge the fields of medicine and psychology and begin to refer to ETM TRT as it truly is: an unequivocal “cure” for psychological trauma and PTSD.

Health tragedies for Nancy and me ended the public and professional notification component of ETM TRT dissemination for fifteen years.

In 1995, Nancy and my healths deteriorated to incapacitation for both of us, ensuring for much of the last decade that the military and crisis management plan would not be made available to the Department of Defense or to anyone else. The health issues were substantial and are described in the Tutorial and end of this book. Their importance to this work is that they stopped ETM’s presentations as a competing model to the Nosotropic based models (CBT) that have regrettably led the field of combat caused, Emergency Medical Services, and other crisis management employment caused trauma management and treatment until today. I state “regrettably” because as this book will show, and as ETM TRT’s application demonstrates, CBT doesn’t fail to do any good worth noting, but it dramatically harms patients as well.

Did you just throw this book across the room and then retrieve it out of curiosity to see why the field’s and possibly your own end all treatment model is malpractice. Well it gets worse. Apply ETM TRT for a couple of years to appropriate instances of trauma and you’ll become shocked, embarrassed, chagrined and angry at the stupidity of the field of psychology in general. It has failed trauma victims miserably.

Despite my disabilities, I published the work starting in 1994 as a free tutorial and one of the first distance learning programs on the Internet. In fact, it was recognized in a major $11,000,000 Federal grant proposal from Academia (Southern Florida University) in 1997 as a leading example of education via the Web. Even though Web technology has surpassed that used in 1994 – 1995, I’ve kept that presentation in tact because of its leadership in distance learning the times when nothing but coding was available.

Furthermore, the tutorial assured that all ETM TRT books and articles were published and available for researchers to study, placing the onus for the study of a superior PTSD treatment model on the VA and especially placing the burden for analysis by the VA Center for PTSD, a group representing itself as the apex of study of and consultation for PTSD administration after coming to life embarrassingly for them a full decade behind ETM TRT's development of a cure for the issue they were commissioned with many millions of public treasury dollars to study. We paid for our own research, study, and ten year application of the model under the highest credentials anywhere.

Conclusion

As guerrilla and terrorism combat principles have remained pretty much the same since that earlier time, and our government continues to be substantially weakened by that reality, and my health is improving, I've submitted (originally a second time in 2003) to those who would like to overcome guerrilla and terrorist-based warfare this book of the ETM thesis and implementation. I predicted the guerrilla war for Iraq and no matter my health, hurried at the time to post an Ebook of Strategic ETM as applied to terrorism. Because this book provides considerable strengthening over and above the online version, I am removing it now after six years of publication. As for that online book, you may view all supporting theoretical, development and practical implementation information pertaining to this stronger version of the theory and plan discussed in the Overview of the online ETM Tutorial and in the Development sections of the Academic component and finally the Strategic section of the same tutorial.

Get formally trained and certified in ETM TRT through the ETM TRT Counselor Training Certification School (both local over five days or online) and follow directions listed in this book and in the online ETM Tutorial and make US combat interests immune to terrorism and guerrilla warfare, not to mention begin returning the first generation of American fighting service men and women who do not have to live a post war lifetime of horror created by combat trauma.

Legal Notification of Prospective Patient Harm

ETM is a completely independent system. Moreover, its use is defended by Federally Registered Copyright, Trademark legal protections, and the ETM Certification Authority (the ETM TRT authors, Jesse Collins and Nancy Carson and Craig Carson). Do not attempt to apply the model without ETM TRT training and certification from the ETM Certifying Authority. Do not

use copyrighted ETM educational and training materials without permission of the authors. And in any circumstance, do not attempt to merge ETM TRT with any other model and ESPECIALLY Nosotropic based models like Behaviorism, Cognitive Behavioral Therapy (CBT), and virtually all non Etiotropically structured Psychodynamic approaches without consultation and permission from Jesse Collins! The purpose of this stringently rigid application control approach arises from the facts that TRT addresses trauma at a profound level and antithetical models used improperly and parallel to, or in conjunction with TRT can cause harm to the final users, patients and the organizations who apply ETM TRT for crisis management.