Guerrilla War's – Terrorism's – Pathogenesis and Cure

Assuming the practical application to Combat Trauma of

Addendum:

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

Jesse W. Collins II

The Etiotropic Trauma Management™ Series

Book IV

So some of you academes finally want to cure combat trauma?

Because we've been doing it (curing psychological trauma) for a third of a century; and for the purpose of saving western civilization (WC) and probably the rest of the world a bunch of lives, as well a few mega-trillion dollars, and about a half century of futile research and development, not to mention WC's freedom from the prospects of extinction, here is a five step summary of how to get started.

Five Required Steps to *Just Begin* Curing Combat-Caused Trauma or PTS

Step One: ***De***-stigmatize combat psychological trauma for military personnel and veterans; ***– Don't*** approach it from the DSM's perspective as a mental disorder or illness. Explain what combat psych-trauma is (think molecular etiology) instead of what it is behaviorally characterized by.

Step Two: Never, never, never rely, depend upon (meaning to turn command's final responsibilities for combatant welfare), nor expect to be saved from combat-created psychological trauma by the psychiatric and clinical psychological *professions*. There are individual professional clinical management practioners who can be very helpful; but that fact is an individual human phenomenon, not a function of the professions' trainings and clinical modalities and the organizations which support them. They have become, as a whole, the great burden to doing what's right to solve the problem of combat related psychological trauma. Curing combat psych-trauma on the scale currently presenting in WC's progression is an intrapsychic, interactional and systemic – meaning organizational, national and civilizational – management issue, not just an individual clinical one.

Step Three: Cease application of the pharmacological approach to the management of stress caused by combat-related psychological trauma unless the combat affected are comorbidly influenced by schizophrenia, bi-polar or the like illnesses.

Step Four: Distinguish between hepatic enzyme- and stress-caused pathological drug (alcohol) use by trauma affected combatants; regardless of the source or cause of the application, remove it and any attendant recreational use during the trauma's address. Mandate managing for the most difficult case, not the wishful thinking one.

Step Five: For the easiest way to cure combat related psych-trauma, plan to switch from the Nosotropic to Etiotropic trauma management paradigm. Then, contact me for permission to use it.

Those five (in steps) admonitions are just for starters. If you don't already understand and believe in them, then read this book and its companion *The Great Evidenced-Based, Cognitive Behavioral Therapy, Self Help and Government Merger: Monopolistic Cultural Infusion of Behavioral Whack-a-Mole* or *Psychological Trauma Cope or Cure?!* by the same author – Jesse W. Collins II

Guerrilla war and terrorism, the latter not always being the same as the former ─ but which depending on the epistemologies of the users often are joined in their applications ─ are primarily psychological trauma management issues first and foremost, and only military combat ones as the second priority. Hence, successful counter guerrilla or terrorism warfare relies upon the commander's capacity to manage combat psychological trauma expertly, or less so.

Author's Message

Author's Thesis and Goals as they underpin all ETM Publications

Having done this work for the past three decades-plus, I'm leaving the next generation of dedicated ETM TRT professionals with this missive. Naming it the "Author's Message,"

> *it is the most important thing I have to say about ETM TRT, showing its meaning for and importance to humanity and concluding with clarification of the model's goals that I've set for it to achieve by the end of the century.*

Restating for emphasis, ETM TRT has endurably, completely and Etiotropically resolved the psychological trauma affecting every case to which it was administered in accordance with its application criteria. As ETM TRT's author celebrating this 30th (plus) anniversary of its initial development (1979-1981), I am stating what I have learned starting with the years just following its inception and continuing thereafter to be true: "Resolution" as I've employed it here means that

ETM TRT has cured, stills cures, and will continue to cure immemorially

people affected by psychological trauma and its more recognizable outcome Post-Traumatic Stress Disorder (PTSD). Moreover and in case you have not understood the full meaning of this statement, no other secular-based body of psychological research and study has ever provided the world since the beginning of humankind's existence a view or experience of this phenomenon's equal. Imagine the final removal of the deepest, darkest vacuum of devastation that heretofore has hollowed our hearts and minds of their ontological essence, vacating ordinary existence, joy and pleasure from our lives as they have been taken inexorably over the millennia to their endings, never having known without abuse their life's wonderments. Albeit not intended as an ideological creation for a utopian person, society or world civilization, due to ETM TRT's applications so far to some members of our generations, for them there'll be no more sequestered haunting trauma attended by seemingly perdurable loss-causing shock, horror, unyielding anxiety, hurt, shame, sadness, disillusion and everlasting depression.

Psychological trauma has two other functions different from just being the intrapsychic source of individual, family and community life long misery. These variables make psychological trauma the Gordian knot to be untied if anyone other than me, and I know already that there are a few, intends to end pain and suffering that has been

reinventing itself as if an infinite part of man for (at least) the last three to five thousand years.

First, psychological trauma provides an inexhaustible fuel supply for that inveterate relic of the once dark ages of mental health, the "cycle of violence." Traumatized people sometimes traumatize others, including even their loved ones. In that same vein, traumatized people have also been found to be hindered by the same trauma from defending themselves and their loved ones against recurring like events. Second, psychopaths use trauma, for example, created through the killing of innocent citizens as a time responsive intrapsychically implanted manipulation device that systemically controls their political oppositions' defensive management activities. That is called "terrorism."

Strategic ETM employs its oft referenced to be daedal structural features in conjunction with TRT's ability to cure trauma affected individuals and systems in order to expunge and then dispose of that system management debilitating fuel that repeatedly re launches the "cycle." Removing the fuel interrupts the cycle and then ends it.

Thereafter, what also can we expect to succumb to our cause, determinations, and Strategic ETM strengthened capacities? It will be those perpetrators of perpetual calamity and hysteria. That is, strategic uses of ETM will end not just their hegemonic methods, but also the very existences of those people who would commit the heinous and vile deeds the methods require to traumatize their prey. The days where terrorists so adroitly exploit peace and innocence to advance minority interests are coming to an end. Without any equivocation, ETM TRT is the sword that will cut the Gordian knot of otherwise believed to be human nature-inspired thus ever continuing criminal, as in terrorism, violence.

Imagine, then, even more profoundly if you dare, what our world could be like without that cycle of violence and the ability of psycho-socio-pathic offenders to use trauma to control others; although ending that cycle is not suggested or intended to produce a utopian civilization, it is the intent to create one that operates itself without perpetual heinousness constantly attempting to predominate decision making: that is, how we conduct and otherwise manage ourselves. But at least if our thirty years past, current and near future preparations work, that is, establishing global understanding that trauma as a horrific and sometimes self-perpetuating force can be removed from our planet's populations' lives, then our next generation of determined ETM TRT professionals can more easily and readily spend their time just finishing the job of

actual implementation: extricating the rest of our civilizations out from under trauma's now obscenely unnecessary multidimensional burden. After achieving the goals of ridding our citizenry of trauma's effects and then preventing it from being used by criminality and the insane, who knows what else a world without psychological trauma can do?

I intend to train and certify as ETM TRT competent and with my authority to administer the model, only those professionals who can and will ascribe to the referenced goals. And please know and remember: Even if you are not the administrator of ETM's strategic functions, it is the clinical TRT incremental work done at the individual cure level that can and will make the more grandeur view become reality.

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Book IV

Published by ETM TRT Publications LLC.

Printed in Houston, Texas

ISBN: **0-9768934-2-8**

Library of Congress Catalogue number

This book is taken with permission from several original essays and The ETM Tutorial and other training and ETM certification texts written, published and copyrighted electronically (online) by Jesse W. Collins II between 1979 and 2012.

Errors Due to Technical Translation

This version of this book, originally written in 1990-1992, and then revised in 2003 and 2007, has been translated by OCR technology to an online presentation model so that it may be made available for free viewing. As of February 17, 2012, this version still contains technical transition-based errors. They are being addressed at this time. Sorry for the inconvenience. We'll let you know when the transition is completed. We are publishing it now because it at least gives a fairly good overview of the subject and meaning we append to it despite the referenced shortfalls.

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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.

Introduction

According to professional testimonials and patient feedback having affiliation with Etiotropic Trauma Management (ETM)™ and Trauma Resolution Therapy (TRT)™ (referenced as ETM TRT), the theoretical and action elements of this book, ETM TRT is sensitive, incrementally precise, ethical above reproach and the most profound psychological trauma etiology reversal clinical instrument ever created. Some say ETM TRT is the best trauma clinical and management model available anywhere (see online professional testimonials). I say it is a cure for psychological trauma and PTSD. But what most don't know is that ETM TRT has an even more important role than clinical treatment. When used strategically against contrived violence, its structured existentially oriented clinical attributes also provide very powerful high velocity battle weapons. Their targets are the philosophies, concepts and methodologies that guide perpetrators of violence. Targets include the perpetrators' capacities to deliver their eventually to become unconscious implants: shock, contradictions to the existential composition (values, beliefs, images and realities) of personal identity. In the instance of guerrilla war, ETM TRT is to terrorists and guerrillas what Strategic Defense Initiative (SDI) is intended to be to nuclear attack and to all combat strategies that come with its prospects. ETM and TRT can intercept and neutralize the trauma explosion of pain brought about by a single or multiple guerrilla contrived shocking event and prevent its becoming embedded into the minds of millions of people. Where those implants have in the past adversely influenced decision making by the many, ETM and TRT can make it not so. Hence, the purpose of this book is to present the trauma battle tools, strategic ETM and TRT, showing how to preclude the destruction by terrorists and guerrillas of the decision making capacities of a nation.

This book delineates guerrilla warfare's pathogenesis and cure. The presentation of the disease's origin and development includes a description of virulent neuropsychological causes, systemic progressions and complete symptom manifestation. Regarding the pathology's cure, the book shows how Etiotropic Trauma Management combines disease paradigm with combat to formulate a highly focused solution, all applied within the aegis of the battle plan. Clarifying the use of 'disease' with a well known correlate, medical treatments for cancer kill cells; this disease solution strengthens our capacity to kill guerrillas. Particularly where death of innocents is the guerrilla's aspiration, Etiotropic Trauma Management's™ model is

intended to eradicate this malevolent and egregious form of war and those who wage it.

The title references a "cure." It is a theory and plan that defines and eradicates trauma etiology caused by guerrilla actions. The idea is to address the etiology before it fosters symptoms, or if where they have already been initiated, bring their influences to an end. Two of the symptoms are controversial in that they include antiwar protests and the weakening of the will with which to fight the guerrillas. The plan when implemented will undermine those symptoms' effects. There'll be more about "will" later in this introduction.

Interpretive Analogies

Most have heard the systems analogy regarding psychological trauma: throw a rock into a pond and the impact results in a splash and ripples. They represent the trauma's influence on, not just the immediate victims, but the surrounding system. Many, though, have not heard the ripple metaphor's extension, as this is its first presentation. A high diver scores all ones. That dive results in more than ripples, but in great splashes thrown out of the pool, high waves that crash against the pool's sides, and considerable turbulence on the water's surface. Another diver springs from the same board and receives all tens. The dive has imploded into the water's surface. There were no splashes, waves or ripples emanating from the entry.

The first example is intended to demonstrate guerrilla warfare without an appropriate defensive trauma management system. The second example uses a high quality defensive model. In the non trauma management model, the consequence is continuous and extraordinary harm, arguably considered to be irreparable. In the trauma management model, it has blocked the trauma's aftereffects before they can become the disastrous never ending pathology. Chapters one – three detail the pathogenesis as it exists in combat, specifically guerrilla warfare, scenarios. Chapters four – eight explain how trauma's effects are intervened upon by Etiotropic Trauma Management at the origination of the pathogen and thus before it can be developed.

Immutable Will

This book shows that, exclusive of Etiotropic Trauma Management (from now on 'ETM'), today's anti-guerrilla warfare combat models are represented metaphorically by low rated dives, splashes upon the walkways, against the sides and surface's clashing of waves. For example, because of the attending trauma, a gun battle can

have catastrophic consequences, not just upon the combatants, but on the entire management system operating virtually around the world. Will, needed by the affected system to achieve the original mission for which the battle was fought, is undermined by those dramatic consequences. In the alternative, this book will also show that the second analogy is epitomized by ETM. In this illustration, will, embodied in the commitment to complete the mission, is immutable.

How Guerrilla Warfare Works and Its Antithesis

Terrorists and guerrillas use small groups to oppose organizations of much greater size and force. The former succeed in their pursuits by applying violence (combat) caused psychological trauma to the latter, and then managing for the terrorists' - guerrillas' advantages the trauma's deleterious professional, personal and systemic influences. That management includes continuous attacks by the smaller force in geographical areas thought to be controlled by the larger one. Regardless of preparedness, frequent and surprise attacks traumatize the larger battle force and the chain of authority connecting it to its top management, which in democracies include the population. Although the battle force is well schooled in how to professionally objectify, thus control, the events' influences, increasing attacks, dead and wounded nevertheless degrade not so well prepared personal experiences of the trauma. Pleas from elected leadership to the population to stay the course don't work as well as they once did. Continuing traumas' influences reduce a large portion of the population's will to fight, belief in the mission and any meaning that originally underpinned the war. The combatants, increasingly affected by battle trauma, and thus in dramatic need of their leaders' and populations' supports, are instead losing support. The now divided population, and similarly dividing leadership weaken the combatants by removing underlying beliefs in their mission, and degrading the meaning underpinning the wounding and deaths of their comrades. Fought in this manner, the war is lost.

The war does not have to go that way. Strategically impose Etiotropic Trauma Management upon the guerrillas' – terrorists' tactical uses of the trauma. That is, within time allowed, remove the battle trauma from the combatant resulting from the combat with guerrillas and terrorists. While the battle trauma is being removed, the combatant becomes strengthened, not just against future combat trauma, but against the traumatized and divided home front population. The defenses against combat and home front projected trauma instill the necessary controls with which to finish the job. With that kind of strength added to the combat force, the population will also

lose its vulnerability to the guerrilla. The larger force and its leadership can now, with certainty, win the war.

This solution proposal begins with a description of guerrilla combat trauma's psychological and neurobiological impacts on the individual combatant (U.S. service men and women). The focus shifts to related systems. They include combat teams, next hierarchal managements, media, protests groups, CIA, NSA and The White House. The description continues by positing how traumatic symptoms whirl throughout, between and to encompass all decision making by the referenced groups, the object being to strengthen some (opposition to the particular war), and then incapacitate others (in support of the war) until they capitulate to the guerrilla - terrorist. This paper shows how, beginning with the individual combatant and then progressing to the various systems, removal of the guerrilla's tactics (and their outcomes) can and should be as much a mechanical application within the guerrilla war as is calling for air support against an enemy's automatic weapons positions. Nebulous interpretations and address of trauma's impact on combatants are not permitted. Just hard work is applied, definitively, directly and sharply focused upon and at removing those elements of the trauma causing the retreat of what otherwise should be the enormously overpowering force.

Nomenclatures

For purposes of providing for me some objectivity in describing the work of heinous individuals and their groups, this article refers to 'terrorists' and 'guerrillas' as offensive trauma managers (or OTMs). 'Psychological trauma' is reduced to trauma. 'Etiotropic Trauma Management' is referenced by its acronym ETM. It's clinical component is Trauma Resolution Therapy™ (TRT). It is called a "structured psychodynamic approach to the treatment of psychological trauma and PTSD." The models in most ETM literature are represented together as a singular model, the acronym being ETM TRT.

'Etiotropic' (Tabor, 2001) is best understood when seen in conjunction with its opposite, the Nosotropic approach, a treatment – problem solving modality that focuses on identification and the remedy of symptoms. 'Etiotropic' solves problems by focusing upon those symptoms' causes, otherwise known as 'etiologies.' 'He' stands for both men and women. 'Deleterious individual, professional and systemic influences' are described below. Traumatic event is written as 'event.' 'Strategic' refers to that part of ETM that is administered to win war, as opposed to the component that treats for individual clinical needs.

Although this book is intended to focus primarily upon the strategic use of ETM TRT, I've included in this first part definitions for ETM's theory of trauma and applications in standard clinical environments. They show a basis for the strategic model's functioning. Because one of trauma's bases is psychodynamic sequela following trauma's occurrence, understanding of the Etiotropic concept of trauma usually requires repetition of event samples' to demonstrate the initiation, influences on and disposition of the sequela as it would be addressed in combat. This paper offers four such samples. They depict the full onslaught of the sequela's effects beginning with the events at the combat site, following the affected combatant back to the more secured area, treatment planning, and address of the sequela with ETM and its application, if necessary, all the way home.

Chapter One

Trauma Implants: Trauma Etiology and Sequela

From the fire team on the battlefield, to the personnel managing the war from Command Headquarters, for example, in the United States the Whitehouse, trauma implants are the single most important concept to understand and address when in engaged in guerrilla or terrorism based armed conflict. The group with the best theory, definitions, and implementation plan for managing those implants will succeed over its competitor. As you begin reading this chapter, OTMs' (Offensive Trauma Managers') highest level strategists hold the lead. By the end of this book, you will.

OTMs create trauma implants in the minds of their adversaries by causing a rapidly reality-changing (housed in memory) and depreciating event. In the age of terrorism or in a guerrilla war, the event comes in the form of an apparently heinous act, often an explosion that kills many civilians in an otherwise peaceful location. Decapitating an individual on video or blowing a vehicle trailing in a convoy into the sky provide additional examples. You can think of many more, I'm sure.

Implants derive their conceptualization from the fact that the referenced changes in reality are undergone in the physiology or substrate of memory. Where that will be discussed later in more specific terms, for now the implant is nothing more than the introduction by a third party of the process of formal extinction of the synaptic long-term potentiation of the synapse that houses the retention of that pre event reality in memory. When the extinction has run its full course, the so called implant dissolves or is no longer existent. Until that happens, implants have thought and behavioral ramifications which frequently and unconsciously and often unbeknownst to pertinent managers play a big part in how any human organism and the organizations in which they work and reside function.

Once located in memory, implants extend their functioning capacities to include an ever expanding influence that eventually interferes with decision making. I'll show that influence later in these initial chapters and highlight it the chapter regarding systemic symptoms of trauma. Before doing so, however, let me demonstrate now the implant's psycho neurobiological composition. That is necessary for the purpose of showing later how implants may be both individually and systemically removed while in theater in temporarily secured zones. Remove implants and

remove their deleterious effects on combat management decision making.

Trauma Etiology and Sequela

So-called in this thesis, " trauma implants" are comprised of trauma etiology as it presents in sequela.

Generally, 'etiology' refers to the source of a problem or disease. Specifically as it pertains to trauma, etiology is formed in this definition as extinction of identity. Making things a little tricky conceptually speaking ─ due to limitations that attend the use of words to describe experience ─ molecular extinction is a natural, that is, phylogenetic brain integrative process; but when it is interfered with it becomes truncated or "bottled up" while otherwise being stored in memory. Because the hypothalamus-adrenal-pituitary-axis (HAPA), which is also called the "stress" response, keys off of that integration activity, stifled or not, non-progressing (again meaning "interfered with") extinction then manifest as untoward sometimes even likely erratic or non sequitur behavior. In those instances, the "natural extinction" ongoing during the brain integrative activity looks unnatural, depending on the degree of the experience and one's views and training backgrounds. Hence, in this description, whereas neuromolecular extinction connotes normalcy, the term etiology (inferring that something is wrong) also fits because something indeed is going wrong at some level.

"Identity" refers to existential elements of being such as values, beliefs, images other realities. 'Extinction' of identity means that when a traumatic event occurs, it contradicts the values, beliefs, images and other realities to the extent that the opposite elements of the identity now exist. For example, a fragmented arm consequent of a grenade explosion immediately alters the long held identity image and value of the arm's undiminished presence and use, respectively. The new reality that the arm doesn't work as it did and that it is marked with scars where torn by the explosion is the opposite. The contradiction and opposite combine when stored in memory to form trauma etiology.

'Sequela' means 'aftereffect of disease or injury' or 'secondary result' (Webster). Its use here refers to a downward stair step of continuing cause and next related effects from trauma's initial influence. In this instance the sequela begins with the event's occurrence (step one) and continues to step two, the contradiction to and replacement of opposites of personal identity's values, beliefs, images and other realities. Step two of the sequela is the location in identity of the trauma etiology.

The psychological aspects of trauma don't always satisfy those who disavow psych theory in any form. Regardless of that view, however, trauma etiology and symptomatology are neurobiological facts. Following is a short review of the subject with references for a complete study.

Trauma etiology's neurobiological substrate is derived from an event's reduction of long term potentiation (LTP) of the synapse, suspected by many investigators of neurobiology to be located in the amygdala, a part of the limbic system of the brain, and initially retained in the mossy fibers of the Hippocampus. Its role has been posited to be a transfer location, holding near term memories in the beginning. They then were thought historically to move to long term memory storage in various and other segments of the brain. That notion has recently been altered somewhat for some memory storage to only be the growth of additional synapses on the same neurons. The new synapses appear to be constructed to house the same but now long-term memory or learning storage, and not necessarily in completely different areas of the brain.

'LTP' has been determined for almost two decades to be the locus of neurological (molecular substrate) learning and retention of it. Hence, if LTP comprises a particular potentiated value, and that value is contradicted by an event, LTP is affected negatively. That is, both the LTP and the rest of the synapse's structure are altered (downward or less than) until they become long term 'depression,' not to be confused with the psychiatric condition of 'depression.' The referenced 'opposite' resulting from the contradiction of identity components pertains to new synaptic growth of LTP representing the facts that the originals no longer exist.

Another, but less detailed, neurobiological theory of brain etiology is provided by Kolb (1987). The event overloads the neuronal cortical barrier, resulting in neurological cellular change. Kolb locates the cellular damage in the temporal - amygdaloid complex. In his ten year study, Bremner posits in his central thesis, and then goes on to show that 'stress induced brain damage underlies and is responsible for the development of a spectrum of trauma-related psychiatric disorders' (Pg. 4, 2002).

Physical changes in synaptic functionings are facilitated by Noradrenergic (adrenergic) and Opioid (for protective survival denial) operations. The Noradrenergic and Opioid interactions from there initiate additional substrate for behavioral symptoms (see 'Symptoms' below). Significantly, the Noradrenergic response is thought to assist in the morphology of synaptic development to include

strengthening of physical cell plasticity. These elements play a role in extinction of the LTP maintaining the old reality and to include growing the new synapses for housing the new one. One of the primary benefits of the Opioid interactions is the support of denial that the change is ongoing. The modulation between the Noradrenergic and Opioid systems manifest behaviorally as grief. For more information, which is offered in considerable detail, read *Neurobiology of Psychological Trauma Etiology and Its Reversal* (same as "Cure") *with Etiotropic Trauma Management* (Collins, 1992 - 2009).

In combat organizations, combatants enter a trauma causing event with two identities, personal and professional. The latter is formed by inculcated pre combat training and management protocols consisting of strong beliefs in discipline, repetition, stoicism, and mantras such as: 'I'm a Marine - soldier doing my job during war; I'm a leader for my men; they and those above me must depend on me.' 'I must accomplish my mission and take care of my men.' Other stringent controls support practiced and much needed attitude adjustments, and the ability to quickly select behavioral alternatives as responses to an event. Professional identity prepares combatants for consequences of occurrences such as explosions, small arms fire, wounding, near death and death of team members, enemy deaths, maiming and death of civilians, to include women and children.

Although the professionally formed identity and attendant methods work fairly well (considering the challenge to the combatant), personal identity, and often unbeknownst to the professional, is being pummeled and often without the conscious's knowledge or for that matter permission. Its values, beliefs, images and other realities consist of the value of life, belief that people should not be harmed, images of the team's wounded and dead who should not be that way, the belief in the continuity of life for innocents, are all being contradicted by the occurrence of their trauma created opposites.

Losses attend the contradicted components of personal identity. Those losses, comprising step three in the downward stair step of the sequela, often mirror the contradictions. Examples can include loss of: a best friend, a team mate, the belief in the continuity of lives of friends, your friend in particular. There are losses of security, power, trust (in the capacity to do your job), control over your life, like self determination, that is, being able to do what you choose, make your way through the rest of your life unimpeded by most anything. As an aside, the losses to this personal identity are not unlike those experienced by other non-combat identities: disease, disaster, accident.

Accompanying each loss is an individual emotional continuum. It, which is step four of the sequela, includes readily known grief level emotions like shock, denial, the driving most powerful elements of the grief chain, fear, horror, terror, anger, rage, and then the most existentially encumbering of all, sadness and an incomprehensible void. The identifying phrases reflecting the void: 'There is no answer to this.' 'It doesn't mean anything.' 'Get over it.' 'I don't want to talk about it.' 'Take it to the chaplain.' Such is the point where personal identity is shaping into a core of trauma etiology for the warrior, albeit, it's unseen by the professional, and often his constituents, too.

Summarizing the formation of the sequela's four steps,
it is:

1. Event's occurrence
2. Etiology is established - the event contradicts personal identity's values, beliefs, images and other realities and replaces the contradictions with their opposites
3. Losses result from the contradictions and replacements
4. Emotional (grief) continuum extends from every loss

Each new event impacts personal identity further. For example, being blown spinning through the air unexpectedly, separated from one's weapon, and then surviving physically unscathed can give the professional identity the appearance of being maintained. That is, the combatant can press forward continuing to do his duty, defending himself and his associates, saying 'This is my job.' 'If I don't do it, we'll all be dead.' 'I've got to crawl to my rifle wherever it is.' 'I've got my rifle, now, but have to keep my head down, and at the same time raise it enough to shoot.' And that shooting helps a lot, affording a sense of and actual power with which to support those necessary professional expressions of control.

On the underside, personal identity continues to take a beating. The behavioral experience of flying through the air is of absolute shock and numbness, followed by paralytic terror so encompassing that it's impossible to move arms and legs, shoulders, torso and head, upon hitting the ground. Becoming detached and unstable, to say the least, accompanying life or death self analysis ensues (am I dismembered, dying or even dead?). Personal identity elements of control, safety, security and continuity of life, the beliefs that one should not be threatened by near death or dismemberment are the ability to control attacks upon him, and assurance in the continuity of life. As in the first event, the emotional chains extend from these losses, becoming combined with those from that initial traumatic

experience (event). Those chains connect shock, denial, numbness, fear, horror, terror, anger, rage, despair and abject nothingness.

These behavioral experiences all manifest as components of the molecular extinction of the pre trauma substrate. That means that they are fundamental to the process of both storing and integrating radical change to the concept of pre trauma psychological reality.

Another and practically identical sequela then follows the first, allowing for codification of this second trauma induced internal experience. Summarizing this sequela's four steps, They are:

1. event's occurrence – blown through the air hitting the ground in apparent paralysis
2. etiology is established - control, safety, security and continuity of life, the beliefs that one should not be threatened by near death or dismemberment are contradicted; their opposites become manifest
3. etiology produces losses of self-esteem, worth, trust in the ability to control attacks upon the combatant, assurance in the continuity of life
4. Emotional (grief) continuum extends from every loss – in this sequela, the chains connect shock, denial, numbness, fear, horror, terror, anger, rage, despair and nothingness.

The two sequel**a** merge their individual components to become the plural sequel**ae**, layering etiology, loss and emotion from two separate events upon each other. Thereafter, the sequelae will serve as the attractor for all future sequela related to combat. The following examples add more sequela to the now forming sequelae.

For the third example, when OTMs' kill U.S. combatants (and many innocent civilians), the events are followed by disposition of the dead. The mission provides a both sad and morose example of the professional functioning and increasingly non functioning personal identity. Taking care of our own killed in action professionally, again, draws upon the necessary slogans: 'She died for her country.' 'This is our duty to fight, risk our lives, and if necessary lose an associate or friend to death.' Management of their bodies, placing them into a bag or poncho, carrying them without the covering, viewing the carnage, for example, looking down into any team member's brain, opened like a furrow dug out from his forehead through grey pink matter, continues the need for reliance upon business-like expressions. Again: 'This is my job.' 'I'm in war.' 'I'll get used to our men who are killed.' 'I'm a soldier - Marine. I can do this. I have to show others that I'm capable of doing it. I have to be tough. I am tough.'

When carrying men and women combatants' bodies to helicopters, jeeps, trucks or other vehicles for transfer back to those places that process the dead, helpful slogans are also replaced by quiet stoicism. Words do not suffice.

The killing of team members pounds personal identity into the ground. That identity, shattered by the previous events and this one, is both projected onto and transferred from the bodies of the dead, losing the combatant's ability to separate himself from the deceased, no matter professional identity's pre war training to do so. The combatant thinks of himself as the same as the dead. The enemy will be doing the same to him next. He sees his brain like that one in the man he carried. For people who've had spiritual beliefs (which represents approximately eighty-five percent of the American population), the combatant says to himself 'How do people believe in God when everything with which they believe is torn from their bodies.'

While the professional crisis manager, in these references a combatant, removes (or covers) those thoughts from his mind with necessary slogans, other personal values and beliefs in the process of life are undermined. Former images of those bodies previously being intact, now are changed. They are not intact. Where God was real before the event, after carrying the dead combatant God for some survivors apparently has no further basis within that previous reality.

The sequela steps for this event, as in the others, continues with losses to self of esteem and worth, dignity, trust, security, the belief in one's mental stability, the combatant's friend, his belief in God. Emotional elements including shock, numbness, denial, confusion, fear, terror, horror, anger, rage, sadness and hurt metaphorically, but with the feeling of physicality and realness penetrate, divide and asunder the being. It's as if someone reaches into the chest and squeezes with their hand his heart, pulling it out with unbearable pain. In battle, the emotions are suppressed in conjunction with the losses and contradictions to identity. But some of the emotional continuum collapses, becoming more exaggerated conscious rage, catastrophic loss and weeping expressions of hurt and sadness.

The previous sequelae, formed by the merger of the two events and each sequela, attracts and combines into itself this third sequela, its identifiable event being the killing and management of the bodies of associates. Following the outline provided by the first and second sequela, a summary of the third sequela's four steps include:

1. event's occurrence – managing the bodies of dead and wounded

team members

2. etiology is established - personal values and beliefs in the process of life are undermined; former images of previously intact bodies now are reflected as opposites
3. etiology produces losses to self of esteem and worth, dignity, trust, security, the belief in one's mental stability, the combatant's friend, his belief in God
4. emotional elements of shock, numbness, denial, confusion, fear, terror, horror, anger, rage,

In the fourth example of a sequela's formation, management of the enemy's dead is much easier, professionally speaking, than one's own. Although the image is likely sanitized through the bodies' systematic alignment (beside each other), in a row(s) as long as the count, viewing the bodies' carnages and working with team members to move the corpses requires some adaptation akin to those KIAs discussed earlier.

For example, "This is the enemy. They've killed my team members. Or "They killed innocent civilians. These guerrillas (terrorists) don't fight fair. They deserve to be dead. Kill them again." Or the soldier thinks nothing. That's the way it is for the professional standing over, carrying or stacking mutilated enemy corpses: in control, following - dispersing orders, possibly using dark humor with which to disparage the corpses. The professional is beginning to exists in an infrequently trodden arena. Most of the world's population, except in places where genocidal methodologies reign, do not go there; maybe and sometimes they do so in a matter of seconds on TV.

While the professional is maintaining his composure, and no matter that the dead were the enemy, personal identity still suffers repeated assaults. Values that people are supposed to be alive, images that bodies are supposed to be intact, and that people are not to be dismembered and massacred, are all contradicted by the truth of the supplanting realities. The conditions brought about on the battlefield filled with corpses, unexpended ordinance, and depending on the time following the battle the stench of burned people and surroundings, and death, all contradict, and bombard, beliefs in and realities of personal safety, security, and the notion that life is a continuing thing. There is a further reduction of any belief in God; too much horror. Getting sick-nauseas, throwing up, all the while existing in a state of surrealism, as if walking off the ground, leads the combatant into an abyss of confounded existence. It is derived from consolidation of each loss attending each contradicted element of identity. The emotions, mostly unexpressed, are the same as those felt in previous events. Getting near the bottom, "This is my lowest time on earth and will be from this day on." the combatant believes.

Following the outlines provided by the first, second and third sequela, a summary of the fourth's four steps include:

1. event's occurrence – managing the enemy's dead
2. etiology is personal values and beliefs of life are undermined; death in mass operates outside the norms of everyday living; even the worse need proper processing for one's own humane needs; there's no God where before there was
3. etiology produces losses to self of esteem, worth, dignity, the belief in one's sanity
4. emotional elements of shock, numbness, denial, confusion, fear, horror, anger

As described earlier, two sequela make a sequelae. In ETM's thesis, additional events of the same kind, in this instance combat related, can be added to the sequelae indefinitely, depending on the combatant's exposure to the war and his capacity to withstand trauma etiology. For example, if a combatant, as influenced by these four sequela, were to become affected by twelve more events, then the sequelae would have a total of sixteen apparently fused events with virtually identical components comprising etiology, loss and emotion.

For combatants in guerrilla war, all the events and attending sequelae are cloaked within an environment of perpetual guard, rightful paranoia. They may be attacked while doing their duty at all times, even after a battle is seemingly over. The need for survival supersedes everything else, adding great power to the process by which the sequelae is repressed. This forced cover up of personal identity's erosion creates a dangerous - unseen dichotomy for the combatant and those surrounding him. He thinks he's ok, but from the silent personal identity perspective is assuredly not. His team, of whom he may be in charge, and those to whom he answers, are basing their appraisals of him and belief in their dependence for survival on his professional conduct - leadership. It may look good, but its counterpart, decimated personal identity, eventually threatens professional attitude and performance. The weakening is not disguised, however, for the OTM. It is the point for which he has waited since causing the sequelae's formation. It is manifestation of the underpinned etiology's primary symptom, failure of the combatant to function properly.

Important to this thesis, the referenced sequelae provides the so called and noticed here as implants to the psych of the combat trauma affected personnel. Much of it

exists in the unconscious, and necessarily so; nobody can walk around doing other tasks attending survival which includes doing one's job without the capacity to place the extinction safely, it seems, away in the recesses of the forgotten. Nevertheless, it still resides while ongoing in the brain. And that's all the Offensive Trauma Manager wants at this stage of his or her offensive.

Once located in memory, implants extend their functioning capacities to include an ever expanding influence that eventually interferes with decision making. I'll show that influence later in these initial chapters and highlight it the chapter regarding systemic symptoms of trauma. Before doing so, however, let me demonstrate now the implant's psycho neurobiological composition. That is necessary for the purpose of showing later how implants may be both individually and systemically removed while in theater in temporarily secured zones. Remove implants and remove their deleterious effects on combat management decision making.

The "trauma implant" gets that designation in this management construction because the entire process of the sequelae's development through the experience of multiple combat events resides in a logical and ordered system within the substrate of combatant psychology. In this theory, and in my observations in fact, the implants exist as the brain's integrative effort to unlearn at the personal identity level those values, beliefs, images and other realities and then relearn the new realities attending that combat experience. That integration facilitates extinction are reduction in the efficacies of the long-term potentiation of the synapses maintaining the pre combat reality, sending all those cells into long-term depression of their synaptic processes. It is going to be ongoing now until completed for each individual comprising those exposed to the combat, in this instance referring to guerrilla or terrorism created events. They are, in turn created by Offensive Trauma Managers for that purpose because when they do not complete, hell is to pay.

That means personal and professional behavior change to function differently from the training manuals. And those differences cause another sequela (sequelae) manifested by neurological extinction of both personal and now professional identities. Job performance, which of course includes decision making at pretty much all stratifications within and along the management continuum, fails.

Chapter Two

Systemic Etiology

Personal identity's etiology combines with other individuals' etiologies to form systemic etiology. 'Systemic etiology' refers to a group of shared and derogated components like values, beliefs, images and other realities. Those parts merge, usually unbeknownst to all, with others creating the systemic effect.

Each squad, platoon, company, battalion, command headquarter group, CIA, NSA and to include the Whitehouse not only has its own system, but they each are part of a greater organization, operating under one united (intended to be so) set of beliefs, commitments, goals, command leadership and political voice (a belief in democracy). Moreover, and as the system definition goes, the whole of this system is greater than the sum of its referenced parts. That is, the system takes on a cogent life of its own, a synergism.

As each personal identity has sequela starting with the event and ending with emotions, so also do the various systems. They share an event's contradiction of group values, beliefs, images and realities, attending losses, and contiguous emotional chains. With today's media being what it is, virtually everybody and every system will rapidly follow and share the same path caused by a single traumatic event in a far away place.

When government leadership attempts to apply countervailing force to OTM tactics, such as more stringent commitments, cognitive adaptations, additional armed capacity and new planning, a systemic negative synergism derived out of the myriad sequelae fends off the additional control support efforts. The connections between the systems' etiologies grow, eventually encompassing the total system. Then, when an OTM caused event strikes at one point, the pain, suffering and accompanying damages streak through the fused etiologies. Each individual within his near system, and it within the overall group, incurs similar, if not the same, contradictions, losses, and emotional pain, as if the compendium of systems were those of the most closely affected. All trauma etiology from the battlefield to the Whitehouse becomes one.

Chapter Three

Individual and Systemic Symptoms

Individual personal and systemic etiologies produce both individual and systemic symptoms. As in etiology discussed previously, symptoms have a neurological basis.

'In Bessel van der Kolk's (van der Kolk, 1987) presentation, Central Nervous System change results from the externally generated trauma-causing event. Included in this change are reductions in the capacity to produce various neurochemicals ─ norepinephrine, serotonin, and dopamine. Reductions or depletions of these and other neurochemical stores and processes underpin the formation of defenses, symptoms of the trauma. Such symptoms include hyperarousal, hysteria, startle response, repeated reliving of the event, increased drug (psychoactive) use, depression, and aggression. Endorphin activity stimulated by attempts to address the trauma result in increases in the various neurochemical activities making the address difficult for both patient and practitioner (see ETM Tutorial: About / Comparison – Contrast / **Biology**). "Difficult" means that wide emotional swings, hyperarousal and hysterical reactions to the attempted remedy, block the direct address.' This quote (indented paragraph) is authored by Jesse Collins and is found in Web publishing at Etiotropic.org / Tutorial / Professional / Academic / Comparison-Contrast / In contents click 'Psychology' Subject: Psychology and Neurobiology of Trauma Etiology and Symptomatology, 1992). The information may also best be found in the updated *Neurobiology of Psychological Trauma Etiology and Its Reversal* (meaning'Cure') *with Etiotropic Trauma Management*.

According to Kosten and Krystal (1987, 1988), individual behavioral symptoms pertaining primarily to alarm, and then "restlessness, irritability, sleep disturbance, exaggerated startle response, and general autonomic arousal," are facilitated neurologically by periodic depletions, with large swings to over production of Noradrenergic (adrenergic) capacities and Opioid operations.

Generally speaking, mostly systemic symptoms are important to strategic ETM's application to guerrilla – terrorism warfare. The systemic symptom perspective begins with a directly assaulted group, such as a combat squad or support personnel, and ripples, a common metaphor being 'as water does following a stone's being

thrown into a pond,' to the next management level, and so on. The intermingling symptoms continue until top executive management is affected. Like merged etiologies, the resulting symptoms occur at all levels of management, to eventually encompass the Presidency, as well as the system as a whole. Symptoms resulting from devastated personal, professional and organizational (systemic) identities include, but are not limited to:

1. media hysteria
2. chaos, panic
3. surrealism
4. massive denial of the etiology from past events minimizes the increasing need to take appropriate action, that is, to take direct military action against the perpetrators - war
5. grief continuums: emotions attending grief include shock, confusion, terror, horror, anger, profound sadness, the experience of loss
6. staunch rebuke (hiding from) of the internal emotional elements attending the events
7. eidetic (movie like) memory recall
8. startle, withdrawal, irritability, connection (relationship) impediments, hyper arousal (all are symptoms for individuals and systems)
9. paranoia
10. dissociation
11. overwhelming confusion
12. preaching 'we have to be tough' when it's too late
13. obsessive media reference to and pronounced fears of 'quagmires'
14. extraordinary and pathological divisiveness (intra-system conflict alters opposition focus)
15. fusion between team members
16. low morale
17. troop expressions of low morale: 'I want to go home'
18. Stockholm syndrome effect (where system members support the opposition)
19. leadership deception
20. leadership blame by competing parties, weakening security: the blame supports OTM will
21. possible over constraint of civil liberty
22. home front attacks on military personages
23. rationalizing mission goals
24. third party exploitation of the disintegrating personal and professional identities

25. third party exploitation, as in surfing the ripples caused by the stone's contact with the pond, of individual and system symptom manifestation
26. perfidy
27. expressions of will a sundered
28. no regard for mission meaning
29. abandonment of the mission
30. repeated castigation of individual, unit and national selves
31. ever questioning, without answers, the meaning and purpose of the war and themselves within it
32. inability to adjudicate traitors

Etiology and its symptoms obfuscate solutions. As long as etiology and symptoms exist, problem solvers, including expert anti guerrilla warfare combatants and their leaders, cannot function at levels required to fight OTMs as effectively as those experts otherwise could. Views remain the same: futile, with periodic and slight positive attitude changes following victories. Decision making elements impaired by system etiology and symptoms include:

1. analysis
2. learning
3. option delineation
4. choice

There are three special systemic circumstances where trauma's influences, including symptoms, are used for pecuniary or political advantage. They include the activities of perpetrators, protesters and the media.

Perpetrators' of civil violence, albeit not foreign OTMs in war, influence their systems as do other terrorists (in war). I'm including an aside and short focus on perpetrators in this paper because their behavior and control of victims provided a learning bank for ETM's application to attacked systems. Perpetrators, guerrillas and terrorists have similar goals, objectives and methodologies. In that regard, perpetrator demolished personal identity and discombobulating symptoms control the attacked system to meet perpetrator ends. They include control of spouses, friends, neighborhoods and other victims of violence for monetary gain.

Anti war protesters, especially those that side with OTMs, target the morale and will of the combatants. The target weapons, that is, where the protesters' side with those

who are killing combatants, reach deeper into the survivor's psychology than symptoms, fragmenting personal identity. It's as if the parents of the society are trying to kill the combatants. That is, protestors from home support the people that are trying to end the combatant's life, and who are killing his associates. The trauma affected combatant's pain and confusion are overwhelming as the interior identity is rendered virtually non-existent by the protests.

Media exploit the degenerative processes attending combat trauma etiology by emphasizing the event, contradictions, losses and shock, anger, fear, as a morass of outcome denoting profound failure. Both combatants and customers experience the morass, also within the generalized perspective the media offers. The media mimics the guerrilla's control methods, but they are directed at those at home. For example, a series of events run contrary to home member values, etc. Positive outcomes support identity. When media over emphasizes the negative, that is, group shared contradictions, loss and emotion, with no positive offset, then collective etiology's symptoms become manifest, traumatizing the polity further. At that time, those causing the additional trauma take control of the crowd, as do OTMs.' Hence, application of a one sided presentation maintains and increases viewer, listener and reader market share. Moreover, identity erodes faster than it would if just being impacted by the events without the extra speed. The more rapidly etiology forms, and then accelerates symptom presentation within the system, the more quickly confounded combatants,' government's and the public's etiologies and symptoms bring to an end the ability for all to continue fighting, of if not quite that, yet, thinking rationally.

Chapter Four

Historic Anti-Guerrilla Trauma Management Responses

Having read, or only perused the basic clinically oriented definitional sections in chapters one through three, you should have an idea of guerrilla and terrorist warfare's pathogenesis as proposed in ETM thesis. You can identify the pathology's applications to U.S. administrations and the turmoil then created by the lack of combat initiated anti-guerrilla trauma management programs. Those recently affected governments in our history without effective trauma management programs include the administrations of presidents:

1. Kennedy
2. Johnson
3. Nixon
4. Ford
5. Carter
6. Reagan
7. Clinton
8. Bush

Exclusive of ETM, there have been several hopeful remedies, but that have not produced well against OTMs' guerrilla warfare combat models. The remedies include elements of behavioral, cognitive behavioral, emotional debriefing, and psychoanalytic theory and implementation.

The first is comprised of strict behavioral methods. They consist of time tested and rigorous discipline in the ranks fostered by drill, respectful language, salutes, dress codes, repetitive training, vigorous application of combat nomenclature and principles, automatic response to battle events, and absolute order.

The second, cognitive behavioral, consists of helpful third party (platoon leader, chaplain – counselor) interpretations of the process undergone by the individual during and following the event. Those methods also support positive thinking and action underpinning professional identity. The warrior is taught how to identify symptoms, how to keep functioning, how to be a responsible human being when the

war's over, and not to let the symptoms get in the way of relationships, etc. Except symptomatic thoughts and behaviors, as they've been explained in this article, are not interpreted in combat as they are here.

The third includes methods that rely upon abreaction, purgation, or often referenced emotional debriefing. The applications begin at the scene shortly following an event. The process is akin to directed Client Centered Therapy, where emotions, for example, those described above pertaining to grief continuums, are shared with other members of the team.

The fourth is comprised of psychotherapy and its derivates. They are the primary historic post war clinical mediators of trauma. They are intended to assist the warrior, post war and only when showing symptoms of Post Traumatic Stress Disorder (PTSD). Although the model digs into the personal identity, it does so with the focus of the effort on the pre war relationships of the combatant with his parents. As a rule, the psychoanalytic theory says that the reason PTSD symptoms are manifesting is that the relationships were pathological, causing the post war problems. The therapist would then spend the time allocated to the remedy to analyze historic parental to child relationships.

Considering what may be wrong with the 4 methods, none of them address all elements of the sequelae. Some address a few of the elements, but without consideration for the order inherent in the sequelae. And all of the methods treat combat derogated personal identity as if it is either not there, an ingrained mass of psychopathology resulting from influences of other than the event, generalized grief over the loss of associates, or there is no division in the first place between professional and personal identities.

1. In the first (behavioral) approach, attendant discipline is great, a must. But the method doesn't consider underlying and crumbling personal identity's capacities to continue its downward progression no matter the rigor. There is always a strength test ongoing between the press for disintegration and the hoped for remedy of courage. In protracted guerrilla (they are all protracted) war, the OTM wins the struggle. When it does, our will becomes vulnerable to manipulation by the OTMs.
2. In the second example, cognitive behavioral methods also switch the subject from the trauma's locus (etiology) to later components of the sequela. They are trauma induced symptoms and changing behaviors. Although this debriefing like

exchange has value to the combatant, depreciated personal identity still remains to continue the presentation of more symptoms than those being interpreted.

3. Unbeknownst to the professionals applying at or near the scene the emotional person centered short term grief processing therapy (number 3), failure to approach the emotions absent reconciliation of trauma etiology can give impressions of full address in some. But the address is far from complete. Worse, at that close range to the event, the individual combatant is in shock, which requires that a reasonable period must pass before considering the state clinically.

4. The most devastating of the four modalities is the psychoanalytic theory and method.

It most certainly cannot be relied upon to address personal identity while it is undergoing bombardment in the battlefield. (The method doesn't even work long after the battlefield.) Generally sweeping and even the opposite pedantic approaches to personal identity would place the warrior's combat identity into disarray, a sink hole sucking into it a house and street. Moreover, asking the soldier - Marine to address loss - grief chains, and then mistakenly tracking them to historic parental – childhood issues, which is what psychotherapy tends to do, undermines the strengths established (by professional identity) to remain combat ready, proficient and reliant. The remedy has to be postponed, applying it at a much later time. There can be no help for the trauma affected combatant during the war, and there can be for sure no use of the therapy as a counter to OTM work. Hence, the method becomes moot as a strategic response in combat against guerrilla – terrorism war.

Chapter Five

Toughness and Time

Unless Henry V (Shakespeare) is the speaker, the most assured way of bringing guerrillas salivating to the attack, and more and more attacks, is the use of 'toughness' in defensive rhetoric. Terrorists are waiting for the etiology underpinned toughness exclamations to come forth from the opposition's leadership. 'We're going to defeat the guerrilla.' 'Terrorists are cowards.' 'We'll overwhelm their will and abilities to fight.' 'We condemn the evil actions.' 'Leaving the combat area is not an option.' 'We're not leaving.' 'We need more troops.' And so on. The expressions exhilarate the OTM to further acts of horror. They see victory on the horizon. Time is running out for their prey. And it is. Just create more events. Plant a few more etiologies. Murder more soldiers / Marines / civilians under our protection. Time is up. And the toughness turns to rationalizations of goals, search for exit strategies, political blame, and more signals of surrender. Support in the polls drop. The sooner and more often the 'get tough' language is used to strengthen support here, and to show stalwartness to guerrillas there, the less time remaining for waging, or more to the point winning, the war.

When the words of retreat are spoken, they are symptoms of systemic trauma etiology. Absent ETM, there is no way out of this psychodynamic. There's only ignominious defeat, again, it would appear. The guerillas have won, they and political adversaries think. And they may well do so, unless trauma etiology is undone. Make it so from the battlefield to the Whitehouse, and tough rhetoric will not be necessary. Time, in guerrilla warfare, will no longer be of the essence.

Chapter Six

Sunder Offensive Trauma Managers (OTMs)

The OTM methods that take advantage of our trauma management remedial and defense deficits can be, without any doubt, sundered. We do not have to lose a guerrilla – terrorist war because we haven't known how to manage trauma as well as do terrorists and guerrillas.

Etiotropic Trauma Management (ETM) offers the means to reconcile the OTMs' traumatic event caused personal and professional identity etiologies by reversing personal identity etiology in the post combat arenas, but without threatening or otherwise undermining the quality of defense the professional identity affords the combatant. Generally speaking, 'reversing personal identity etiology' means that the etiology is expunged. It has been or is being removed. More specifically, reversal occurs when the degenerative and suppressed sequelae of contradicted personal identities, consequent losses, attendant emotional (grief) chains and undermined professional identities are exposed within a logical framework of incremental cognitive and briefly experiential addresses. 'Logical framework' refers to the process of conscious accounting for all elements of trauma etiology and its attending loss - emotional counterparts.

The accounting method is ETM's remedial locus. Its principal element is a matrix that overlays trauma in all its presentations. The Matrix is a clinical management accounting structure that allows facilitators and combatants to stay the course toward the goal, etiology reversal, under very stressful circumstances. As described later, the Matrix was born out of the need for individuals exposed to heinous circumstances, in some instances extant, to address the traumatic sequelae referenced earlier.

Think, then, of the Matrix as an internal chart or table. Its dynamics hold the information, that is, event, etiology, loss and emotion, together that is placed categorically into the Matrix, keeping everything from more combat on the battlefield to protestors back home from shaking the structured and codified information loose and back into a mix of convolution, chaos, confusion and hysteria. While retained in the Matrix under those stress inducing circumstances, the sequelae remains available

and ready for address. The Matrix is ETM's component that makes trauma influenced individuals and systems capable of standing up to the onslaught of guerrilla – terrorism warfare.

The Matrix is applied to every participant within that traumatized system. For the individual, the Matrix helps to identify each event by placing it, or a part of it, into the first column of a 3 column form (Figure 1; 'Sequela Number' is not a formal column in this example). The post trauma depreciated existential elements of identity, the nucleus of etiology, makeup the second column. Their losses account for the third. Depending on necessity and appropriateness of application, the Matrix may be used with or without writing. Reading across the 3 columns, and starting from the accounting for the first event, the Matrix's first row is created. Additional events' contradictions and losses are placed one row after another. Figure 1 provides an example of multiple sequela (each row) and one sequelae (the entire Matrix).

Figure 1

ETM Matrix for Combatant
Name: PFC

Sequela Number	Column 1: Event/Incident	Column 2: Trauma Etiology	Column3: Losses
1	I was wounded by shrapnel in my arm	image of a damaged body; something is now wrong with me; value of arm's functionality; I should be working with my arm	Esteem; worth; belief in my capacity to function
2	Blown spinning through the air	Belief in control; values of safety, security, continuity of life; I should not be threatened by near death or dismemberment	self esteem; worth; trust in my ability to control attacks upon me; assurance in the continuity of life

3	Manage bodies of killed in action	I put myself on them; began believing of myself as dead. I was not; believing that they were doing the same to me next; my brain should be whole, not like that one in the man I carried. I stopped believing in God because of brain decimation; my life was undermined; my team members' bodies should be intact; they were not	I lost self esteem, worth, dignity, trust, security, my belief in my mental stability; my friend, my belief in God
4	Manage bodies of enemy dead	My values and beliefs of life were undermined; death in mass operated outside my norms of everyday living; I believed that even the worse people need proper processing if not for any reason than my own humane needs; there's no God where before there was; lowest day on earth; surrealism is not right	I lost self esteem, worth, my belief in everyday life; I lost my belief in respect for the dead; I lost reality; I lost God

Very likely, a single event will be divided into multiple incidents with attendant columns affixed to each incident. For example, an ambush could result in several incidents: incoming explosions, firefight, calling close air support and getting it very close, rescue under fire, helping wounded, bringing the dead to a helicopter or truck. Such a Matrix for handling this event would be 3 columns across and 6 rows down, with each of the sample incidents listed in the first column, with their respective components filling the rows.

The emotional address is a function of the skills of the ETM counselor, who facilitates the combatant at identifying, expressing and experiencing the particular feelings while proceeding along each row, across the 3 columns of the Matrix. For example, as the combatant reads across a row where the incident of 'incoming explosions,' is identified, the emotional elements of (the continuum) shock, denial, fear, horror, and terror will be experienced. In the next column 2, the contradicted values, beliefs, images and other realities will also be identified and accounted for.

The ETM clinician would facilitate recognition and expression of attending shame, anger and muted rage (exaggerated emotional or re traumatizing states are muted by the stability inherent in the Matrix and its facilitation). 'Shame' accompanies practically every instance of trauma etiology and loss, no matter that it is undeserved in another's view. In column 3, still on the row initiated with 'explosions,' the combatant accounts for the losses, simultaneously addressing the final emotions of hurt, guilt and sadness. Thereafter, the other 5 incidents comprising the 1 event are considered in order of their importance to the individual. Their rows contain the information pertinent to this person's experience, but as always in the formation of the Matrix. Importantly, and as different from other clinical remedies, these other incidents' and the rows' processing's would occur, once initiated with a practice row's address, with high desire by the combatant to complete the work, that is, accounting for the information comprising the sequelae resulting from this event.

Once a Matrix is initiated, for example, for a squad member whose team had been overrun, the form (meaning to place on current technology communications – 'palm computers' etc.) begins the file(s) on the affected combatant. The file, to include the Matrix's startup, can be made available during non combat periods, allowing for flexibility within available time (during the job). For example, an event could occur on one day. The onsite ETM trauma team would map the combatant's position within the event. Two weeks later, a short 20 minute introduction meeting between the ETM team member and the combatant would explain the process, completing a sample from one of the less impacting events or incidents. There is no facilitation of (or search for), or certainly not to push for, catharsis. After combatant confidence with the Matrix and facilitation process is established, an assignment is eventually given whereby the combatant accounts for the entire set of incidents into the Matrix. Thereafter, the discussions between the combatant and ETM team member will continue in brief sessions until the information contained in the Matrix has been fully discussed and accounted for. The application for a full (20 sequela sequelae) Matrix, consisting of exposure to 3 to 4 events, would likely take less than 90 days, over 3 to 5 sessions, to complete for each affected person. Note that computerized record keeping allows for continuation of the address in multiple locations, all the way home. If the combatant does not begin reversal within 90 days, then another Matrix adjusted for symptoms is added. Resolution becomes a longer term affair best suited in secure home base environments where the likelihood of a return to combat events is diminished, at least for this period.

Nothing from the sequelae gets by the Matrix. Apply 1 row into the form, and all others will be drawn in by the combatant automatically. The Matrix becomes the

accounting format for codifying the total scene, the total individual and team damage, to include what before has always been thought to be psychological dynamics incapable of resolution in ordinary clinical environments, much less just coming off the battlefield.

No matter the combat environment, ETM is applied within the ethics of clinical counseling, placing human caring next only to completion of the primary mission. In that regard, ETM's application is notably a first function of enhancing the combat team's and country's abilities to withstand guerrilla – terrorist battle. ETM is akin to wearing an extra impenetrable suit, as used in chemical and biological warfare, except that it's not so hot. ETM professional training and the ETM Online Tutorial demonstrate the full counseling application of ETM and its ethical code.

This paper has emphasized the concept of strategic as opposed to standard ETM application. Trauma etiology, the force implanted by the OTMs for the purpose of debilitating combat capacity and will, is said here that it can be overcome almost as soon as it has been struck into the psychologies of the combatants. Reverse trauma etiology, end deleterious symptoms, and reestablish pre trauma personal identity, system integration, cohesiveness, clarity, mission meaning and the unfettered capacities to delineate solutions and achieve goals. OTM methods will no longer work. They will be obsolete and have to be abandoned. The larger force's power will be returned.

In application of the ETM Matrix's long form (more columns denoting symptoms and their effects), which is a different ETM approach used when the time from the event has exceeded 3 to 4 months, a singular phase taken from that long form and applied to the near term events, allows the facilitator to report back how he or she views the combatant, after having shared the combatant's Matrix. For combatants, it is extremely important for the facilitator to reflect her vision of the combatant's heroism, dedication and sacrifice for us all. Speaking for the nation, the ETM team member says in the most comfortable, but still meaningful, ways possible, 'We thank you for your service to our country.' Never let a combatant exit the process of accounting for trauma etiology without hearing these most important words for the invaluable service.

Presidency, Protestors, Media, Civilian Perpetrators of Violence, Public

Regarding the Presidency, past examples of OTMs' influences on decision making are legion. But 2 examples stand out: President Carter's being controlled by student – terrorists – kidnappers in Tehran; President Reagan's state of control by Mideast terrorists through their capture and murder of his friend, CIA Station chief William Buckley. The former resulted in the US government's being stalled for 1 ½ years. The latter consequence was Iran – Contra. Mrs. Reagan addressed this neglected area of management near the end of her husband's presidency. According to her, the president had no one, as did everyone else, with whom to discuss the severe emotional and stress producing elements of the murders, and the effects on the President, but her. Responses to her criticisms were typical: 'The President just needs to be strong.' Just like the PFC being blown through the air, the Executive should have etiology reversal made available at all times. Do that, and affected managers down the chain will be assisted as well to address their trauma caused and mostly unknown impediments.

ETM confronts the perpetrator assault - control model. Reverse victim etiology; regain pre attacked strengths and controls. Victims, that is, family, friends, employers, or neighborhood harmed individuals can become immune to the perpetrator's control model.

ETM's application defends the combat and support personnel from back door (home front) protests and media operations targeting. Once etiology is reversed and identity reestablished, protests and exploitation have the same effect as, the often used analogy states, 'water off a duck's back.' There would be no more combatant trauma etiology left for traitors to manipulate, suck the remaining but weak life out of, turn a knife in, and crush further. A couple of eggs thrown at combatant personal identity etiology can make it last a lifetime. With strategically applied ETM, there would be no more OTM caused, protests – media exploitation facilitated national disasters like Vietnam. The psychological burden of war will no longer have to be placed on service men and women.

Reversal of individual and systemic etiologies, when applied incrementally to 1 unit, for example a squad, will have the opposite effect and eventually in the same proportions that attended the OTMs' systemic influences on fused etiology. Reverse

etiologies for a squad. The systemic fusion will begin to be reversed throughout the continuum within the system as a whole, to include that at the Whitehouse. Never let one increment of etiology go without being reversed; systemic etiology and its symptoms will not manifest at all, much less grow to even partial levels of encumbrance.

When ETM is applied to combatants, its open accounting based reversal method doesn't just reverse combatant etiology, but the method also demonstrates for the public its own. In the process, hysteria and other public symptoms are precluded from interfering with a clear appraisal and analysis of the circumstances surrounding the war. That clarification consequence conveys the explicit price the public and the combatants pay for the value intended to be gained by the war. A correlate: the greater the clarity made available through delineation and reversal of combatant and public etiologies, the greater the depth of understanding afforded in defining the rationale for which the war is being fought.

Chapter Eight

Prejudices, Axiom, Teams, Costs, Motto

ETM applied strategically to guerrilla war and terrorism supports the goals of the ETM program's administrators and users over their opposition's. For example, if the group in power applies ETM, the etiology reversal for systems will absolutely strengthen the likelihood of achievement of that group's goals, and at the same time reduce the probabilities that the opposing polity can interfere with that achievement.

ETM is prejudiced to the address of trauma etiology that influences combat or other support personnel. Moreover, although strategic ETM is war mission centric, it will only work strategically if individual etiology for combatants is reversed first.

Axiom

Once a basis for trauma etiology reversal has been formulated and established within the system, reverse systemic etiology in small places and it will be reversed in all places. This reversal will occur rapidly.

Teams and Costs

To reference prospective costs in war, practical implementation today would require in the beginning an approximate amount of anti guerrilla warfare 3 man teams equal to the number of journalists embedded in the ranks of coalition forces attacking Iraq during the, 2003, Iraqi war. If starting late (the guerrilla war has already started), apply a team for every 1 (substantial) event per every other day. Each team should consists of 3 ETM trained specialists. A team member should have an additional expertise as either a corpsman – medic, clinician - counselor or chaplain – counselor, culminating in all 3 professions being represented in a team.

The teams' job functions should be 2 fold. One, find trauma etiology and two, reverse it (initiate the TRT process for its reversal).

Motto

Here is ETM's combat motto. It is delivered by the team, but from us all. Referring to the combatants' personal needs following the battle:

‘They did for us. We do for them.’

Addendum

The rest of this book is reprinted from the ETM Tutorial and textbooks. It accords the reader some of the instruction regarding ETM and TRT facilitation of near and long term trauma. This writing is not intended to supplant the textbook or Etiotropic Trauma Management (ETM) Trauma Resolution Therapy (TRT) Online Training Certification School. Any professional electing to apply ETM and TRT in combat and following circumstances should be trained in and certified as proficient by that school.

Chapter Nine

Implementation Guidelines

An opposition's attack strategy (using "Guerilla" tactics) involves implanting (causing) trauma etiology at five strategic levels. They are:

1. National executive management
2. Intermediary Management
3. Direct Combatants
4. Combatant's family, associates, friends
5. Public

This chapter shows how to prepare for, defend against, and then reverse trauma etiology implanted by the attack.

Assumptions

The ETM strategic applications recommended in this chapter are intended to be applied to combat trauma experienced during guerilla warfare. Battles and subsequent traumatic events are occurring periodically for various combat units. They are not engaged in direct battle and continuously for long periods.

An assumption in this description is that following an event, military force is applied and security, emergency medical, and crisis communications needs are met in parallel paradigms. They are not subjects of this management focus.

Sections of this chapter address reversal of trauma etiology for non organizational (non government employees) people like family members, friends and interested members of the public. Although acceptance of ETM or any therapy by such people cannot be assumed, the pertinent part of the ETM plan is presented within the notion that all people will eventually study, evaluate, and through other means decide on the course of trauma response that is individually and collectively appropriate. In that regard, ETM is adequately competitive to instill confidence in any group who would apply themselves so rigorously to understand, reconcile, resolve and reverse trauma's deleterious individual and systemic effects.

Prepare with ETM Standard (Trauma) Operations

Before attacks occur, establish ETM's Standard (Trauma) Operations (see Strategic/ **Standard Trauma Operations**) as a defensive structure for the referenced targeted groups. Be prepared to respond Etiotropically.

Purpose/Goals

Apply ETM to the affected (and below referenced) system.

ETM's humanitarian purposes are to find and reverse individual and systemic trauma etiology.

ETM's strategic purposes are to

1. Preempt/remove the collective and deleterious symptoms of psychological trauma caused by the event. They include (not limited to)
    - extraordinary and pathological divisiveness - intra-system conflict alters focus from the opposition
    - fusion between team members that detracts from objective performance
    - low moral
    - hysteria
    - Stockholm syndrome effect (where team members support the opposition)
    - leadership deception
    - over constraint of civil liberty
    - home front attacks on military personnel personages
    - rationalizing mission goals
    - abandonment of the mission
2. Strengthen system collective decision making; prevent trauma's symptoms from impairing
    - analysis
    - learning
    - option delineation
    - choice

To achieve these objectives, ***ETM's strategic goals*** are to:

1. identify (beginning with the greatest and progressing outward to the lesser affected) all individual and system etiology.
2. reverse individual and system trauma etiology.

Obstacles

Realize that the ETM response is likely to not be as specific for people existing outside of the management apparatus. For example, it would be impossible to apply ETM to family members who don't want to participate in a clinical process. ETM also cannot be applied in mass - to the public.

But systemic benefits (later) of ETM's individual applications to the first three categories (National executive management, intermediary management, direct combatants) *can* be expected to have a positive effect on the last two groups' (family - friends and the public) addresses of psychological trauma etiology. Moreover, preparedness information supplied to families and the public can assist both to understand the trauma response protocols being administered. And the more skilled the ETM administrators are at reversing trauma etiology within the clinical setting, the more successful they will be at indirectly assisting those who are not part of that setting.

Following the ETM Standard (Trauma) Operations protocols, pre-combat training regarding combat trauma and its reversal can objectify the etiology reversal process. Explain ETM's reversal process and its purpose -- relationship to the combatant's ability to continue to do his or her job.

ETM Command

Establish an ETM command unit (individual or group). It should be equipped with intranet communications capacities that accord ETM command the ability to maintain instant communications with ETM teams dispatched to any near combat site. ETM command administers the following guidelines for identifying individual and system trauma etiology.

ETM Combat Response

Follow the recommendations below. Prioritize ETM's applications to the five groups in the order in which they are discussed in this section.

Combatants

After an engagement where trauma occurs:

1. Secure (remove from exposure to attack) the affected unit(s) within 90 days -- it should not have to provide primary protections for itself or others.
2. No social drug (alcohol) use (until ETM Fast Help Immediate and Intermediate Protocols have been administered.)
3. Once the affected combat unit is secured, deploy (to the unit) ETM teams one and two.
4. Using ETM Fast Help Immediate Trauma Response Protocols (Etiology Identification and Grading form -- Protocol #6), the ETM teams collect etiology identification information. Interview:
    - Corpsmen, medics, chaplains
    - Unit officers and non commissioned officers
    - Combat unit members
    - the wounded; no matter where they were sent, have a team member find them and collect the etiology identification information
5. Send ETM team 3 to administer ETM Fast Help Intermediate Trauma Response Protocols. Using etiology identification information collected by teams 1 and 2,
    - Schedule etiology reversal
    - Reverse etiology in accordance with the schedule
6. Depending on the degree of the trauma affecting the event (acquire ETM team and command recommendations), hold combatants from combat duty for a reasonable period following etiology reversal. "Reasonable" could be 7 to 30 days.
7. Absent wounded, return the entire team to regular combat duty.
8. At the end of the tour, or following removal of the affected combat unit to its home, return wounded to the original team, or ensure in some fashion that the group is able to see each other as they were constituted during the combat episode(s).
9. Upon return home, team 3 members facilitate reintegration (regarding the event) with family. See "Family, Friends, and Associates" later.

National Executive Management

1. Identify on whom the attack has had the greatest impact. It should be upon:
    - those who supported the mission (leading to the battle) most vigorously
    - the final decision maker(s) (highest authority).
    - any close associates of the combatants who directly experience the battle or who are killed in the event.
2. Apply ETM Fast Help Immediate Trauma Response Protocols for scheduling etiology reversal.
3. Apply ETM Fast Help Intermediate Trauma Response Protocols for reversing identified trauma etiology.

Combatant's Family, Associates, Friends

Beginning with family of the dead and wounded, and then progressing to their associates and friends, then proceeding to the same relationships to the surviving non wounded combatants,

1. Apply ETM Fast Help Immediate Trauma Response Protocols
2. Apply ETM Fast Help Intermediate Trauma Response Protocols for reversing identified trauma etiology.

Intermediary Management

Identify most committed support and management personnel (managers).

1. Apply ETM Fast Help Immediate Trauma Response Protocols
2. Apply ETM Fast Help Intermediate Trauma Response Protocols for reversing all identified trauma etiology.

Chapter Ten

ETM Crisis Management Theory

Crisis Management

This chapter describes ETM theory for psychological trauma's effects on:

1. crisis managers
2. organizations that manage traumatic events and their outcomes

Terms used in this chapter to discuss ETM Crisis Management theory depend on explanations provided in About/ Theory/ **Psychological Etiology** and **Etiology Reversal.**

Introduction

Psychological trauma affects crisis managers and their organizations somewhat differently, respectively, from lay men / women and their families (see ETM Tutorial: About / Theory / **Families**).

Unlike the layman, the crisis manager carries two existential identities into the traumatic event. One is personal and the other is the system of values, beliefs, images and realities inculcated by training as preparation for the event.

When the manager experiences the traumatic event, there is, because of the assiduous professional preparation, little or no damage to professional existential identity. A primary goal of the professionally inculcated identity is to provide the manager with a system of psychological protections to personal identity operational functioning so that the difficult tasks confronting the manager can be accomplished.

Unlike laymen, the crisis manager must, usually in order to care for others, overcome the trauma-causing situations and restore safety and security. Despite the professional identity's protections, however, contradictions to personal identity still occur. Moreover, in the process of providing the protections, the damage to the manager's personal identity may, and usually does, go undetected.

An additional problem for the manager can ensue: where the damage to existential identity for the layman is retained in memory via ordinary defenses, the damage to

the professional is retained in memory through the application of extraordinary defenses. These extraordinary defenses can and often do include the professional protections themselves: crisis management training and organizational policy and procedures that direct performance during and following the high stress activities.

If the protections do not include reversal of the etiology affecting the personal identities of its managers, the organizational protections can, like families' protections, become controlled by the individual etiologies that eventually combine to produce a collective and often destructive effect on the protective trainings, policies, and procedures. As occurs for individual and family management controls affected by trauma, the crisis management organization's protective measures can, themselves, also become an extension of the trauma's controls -- the organization is managed by the problem, which because of the trauma's influences then appears to be unmanageable.

This chapter explains these processes, trauma's effects on individual and organizational management, and describes how to establish controls that reverse etiology early on and in the process prevent the organizational controls from becoming the new problem.

Individual Crisis Managers

Unresolved trauma that affects the crisis manager's personal existential identity will foster development of the first and second psychological trauma patterns: respectively, the contradiction of personal values, beliefs, images, and realities and the retention in memory of loss resulting from the contradictions. The following paragraph provides a few examples of how on-the-job traumatic events can contradict personal values, but not contradict professional ones.

During combat, death of an associate or the requirement to kill another person are events and activities that are professionally accepted -- a part of the professional values, beliefs, images, and realities. Where military and law enforcement personnel expect such events as a prospective function of the job, personal beliefs that people should not kill each other and that there should be continuity of life exist in personal indentity as the opposite of the death of associates or the requirement to take life.

Similarly, deaths resulting from homicide and accident are also expected by professionals who have to address the deaths and provide society's administrative responses to the resulting problems. But again, personal identity expects life and continuity of it.

The losses experienced because of the contradictions to personal identity are the same as those that would be experienced by a layman. They include self-esteem, self-worth, trust in and respect for people, role model images of how people, populations, civilizations, families, parents, spouses, children, and social leaders are supposed to act.

The manager's emotional cycles felt in conjunction with the loss are also the same as those experienced by laymen. The emotions presented in the grief cycles are shock, disbelief, fear, anger, embarrassment, shame, rage, hurt, guilt, sadness, and mourning.

The retention in memory of patterns one and two will eventually produce survival responses that are manifested first as additional contradictions to personal identity, and then later as contradictions to professional existential identity. These survival responses and their contradictions to both identities produce the third psychological trauma pattern.

Examples of survival responses that contradict personal identity include; withdrawal from spouses, children, parents, other family and friends; projections, through explosive behaviors and other interactions, of the emotion comprising the patterns onto spouses, children, parents, other family and friends; the refusal of caring / love and the inability to give either; incomplete control of thought processes related to personal interactions; increasing paranoia; the application of selective truth-telling; lying as a matter of routine.

Examples of contradictions to personal identity resulting from the survival responses can include the following. Family members are supposed to be involved with each other, to care for one another, to control one's thoughts and emotions, to treat loved ones fairly, to have courage against inner fear so that it does not control all perception, and to be honest - not lie to loved ones.

Examples of survival responses that eventually contradict professional identity can include: confused thought and erratic behavior, wide emotional swings, inflexible and inaccurate interpretation of rules, fusion with victims, burnout, alignment with perpetrators, impaired judgment, illegal or unethical use of power, social self-destruction, suicide. Confused thought and erratic behavior, inaccurate interpretations

and appraisals and poor judgment contradict professional values and beliefs that the affected crisis manager is supposed to think clearly, behave responsibly, plan intelligently, and use good judgment. The professional image contradicted is one of high standards in the delivery of quality work. Wide emotional swings undercut professional beliefs in the value and importance of emotional control. Fusion with victims or alignment with perpetrators contradict values, respectively, of professional separateness/distinction and proper conduct -- the maintenance of objectivity. Illegal or unethical use of power contradicts professional values, belief, image and reality that relate to professional oaths and allegiances to the profession and the public that is being served.

The third pattern, that is, the contradictions to both identities will result in the experience and likely repression of additional loss and accompanying emotional cycles in the professional identity -- the formation of the fourth psychological trauma pattern. The patterns are defended in the subconscious through the same paradoxical system of control that defends laymen, except that the cognitive strengths underpinning the part of the paradox that is trying to prevent the trauma's resolution is reinforced by the crisis manager's use of cognitive-behavioral controls provided during training to help the person to do the job while the traumatic event is occurring. That is, the controls adopted from the training and that are needed to help the person to do a good job, paradoxically reinforce the survival dynamics that prevent the trauma's resolution.

Crisis Management Organizations

Trauma's etiology is not only retained incrementally in the individual subconscious of the system's members, but the etiology is also retained in the collective subconscious of those members. That is, the system's professionals share the same trauma-causing experiences and if not the same specific experiences, at least like experiences. The individuals comprising the system share the retention of the same 4 psychological trauma patterns -- almost identical contradicted values, beliefs, images and realities, similar losses and the same emotional cycles.

The collective retention of the trauma produces systemic survival responses similar to the ways families are affected. Management controls become politically polarized in the leadership, and polarized between the leadership and the public; fusion in relationships is offset by intense interactional conflict; turf battles are common-place; boundaries between individuals and professional roles are eroded. Projection and

counter projections occur to the extent that bureaucracies become even more rigid and paranoid. Low morale occurs with the focus of the cause of the low morale being the clients, the public, the organization is intended to serve. A surreptitious conflict, us against them, between the managers and the public evolves.

These contradictions produce organizational liabilities. Some are: the prospective destruction of property, the harm or death of associates or other innocent people, the increased propensity for violation of civil rights, alignment with perpetrators through corruption, the loss of order within the society, and the tendency to give up the goals of the organization or program on the basis that they are unattainable - the experience of futility and the development of fatalistic attitudes.

Synergism

Aside from the effects described in the previous two subsections, there is another dynamic affecting crisis managers and crisis management organizations that requires some interpretation. While managing treatment team operations, we observed that there was a direct relationship between the treatment of families with high numbers of sources of trauma affecting the family and the manifestation of increasing degrees of treatment team survival response. In other words, the more sources of trauma affecting a family, for example, the more people in the family affected by chemical dependency, and the inclusion of other sources of trauma like incest, battering, homicide, suicide or combat, the greater the survival response required or manifested by the treatment team: meaning the greater the probability of pairing, fusion between therapist and family member(s), counter transference, team member incapacitation, and altering of the treatment plan (giving up or allowing diversions from the goals of the therapy).

Also, multiple families presenting with multiple sources of trauma had an even more destructive influence on treatment team operations. These relationships between greater numbers of sources of trauma and treatment team systemic and individual survival responses were codifiable by mathematical formula, which I eventually found could be utilized to predict treatment team behavior following exposure to certain numbers of presenting instances of trauma.

This formula, which historically was presented in our schools, but which presentation has been discontinued for lack of time, is also not presented here. Although the specifics of the math demonstrate the predictability of the relationship between multiple client traumas and treatment team behavior, the formula is not necessary

(and the mathematical presentation requires considerable space) to make the general point. It is:

> *larger amounts and more intensely experienced traumas will predictably affect treatment team operations adversely.*

We hope that it will suffice to emphasize 4 principles about this relationship.

1. Any individual, family, or group of people influenced by psychological trauma will carry with them a negative synergism that paradoxically both protects and hinders the individual, family or group by helping them to resolve the traumas and at the same time prevent the trauma's resolution.
2. The power of this synergism is great and becomes proportionately greater with the amount and intensity of the trauma: the number of sources of trauma.
3. The synergism functions as its own psychological entity and it will confront, and can even demolish, efforts to help that do not take its force into consideration.
4. The converse is also true; when the treatment team does recognize the negative synergism's influences and also does adopt *appropriate strategies* for the team to countervail that influence, then the negative synergism can be reversed and the opposite will occur: the synergism will act to accelerate the resolution process.

"Appropriate strategies" refers to the crisis management team's thinking, planning and acting *in concert toward the goal of resolving all of the trauma the management system encounters, including both the trauma that affected the people the team is supposed to manage and the effects of that trauma on the team.*

ETM, including its use of TRT, is designed to provide crisis mangers and the organizations for whom they work the appropriate strategies to reverse the negative synergism effect.

Traumatized System Dilemma

If trauma etiology is allowed to become long-term, individual and survival responses will present as contradictions to standards for system conduct/behavior. System

management has to use behavioral control methods to constrain the contradictions: maintain order.

Subsequently, any focus upon etiology can be interpreted as an excuse for aberrant behavior and illegal conduct. The excuse can't be tolerated if the behavioral method for maintaining system order is to be successful.

Thereafter, the system is required to ignore trauma etiology least its reversal prove the behavioral, including the responsibility and accountability, methods to be inherently flawed management responses to trauma.

The dilemma: Ignore trauma etiology and ensure continuing presentation of system survival responses, which require more behavioral constraint applications and ever greater ignorance. The system and its members are precluded, and without even knowing it, from learning their way out of the dilemma. It is self sustaining.

System Dilemma Solution

There appears to be no answer to this dilemma. But it can be easily solved by

1. reversing near-trauma etiology immediately; stop the addition of future presenting individual and systemic survival responses.
2. reversing long-term trauma for humanitarian reasons: the trauma etiology is a liability of the organization -- anybody can understand that idea.
3. declaring survival responses to long-term trauma etiology to be only likely theory; *as a rule*, continue to hold employees responsible for their behaviors while reversing the etiology in a parallel management continuum ("As a rule" means that while an employee is participating in an ETM clinical etiology reversal activity, some temporary adaptation -- tolerance for profound grief experienced during the clinical procedure -- is required by system management. But that temporary tolerance would not be much of an adaptation when compared to the pathological adaptation the system would otherwise have to make in response to individual and systemic survival responses).

If your organization applies itself to finding and reversing all trauma etiology resulting from employment, then the referenced dilemma will no longer exist. There won't be any more survival responses to unresolved trauma.

And trauma-affected employees cannot use PTS as an excuse for aberrant behavior where the etiology has been reversed. No etiology -- no symptomatic survival responses. Etiology reversal has the paradoxical effect of appearing to weaken the behavioral method, but in the end actually strengthening it and the authority of those who would employ it.

See ETM Tutorial: Professional / ETM **Strategic** for a discussion of how to implement ETM theory for reversing near- and long-term trauma etiology, and restoration of operational functioning of crisis managers and their organizations.

ETM Ethics

Use ETM ethics when applying TRT to crisis managers (or anyone).

Generally, ETM requires, among other things, the disclosure (before the therapy is applied) of the therapy's goals and the methods used for achieving them. This disclosure is made to the end user of the therapy, the trauma-affected crisis manager.

Importantly, although the early etiology reversal method will have positive organizational effects, for example, system hysteria and chaos resulting from traumatic events will be ended, the application of TRT must be accorded to individuals existentially: because the trauma has occurred and the etiology needs to be reversed because it exists.

In that regard, never tell a trauma victim (or make via policy the primary reasons for the applications of TRT) that the therapy is being applied to make the trauma victim a better police officer, counselor, therapist, or manager supervisor, or to make the institution operate more efficiently (save money). If such instructions prevail, either the individual therapy applications or the motivations for installing ETM, the referenced paradoxical systems of control defending the individual etiology will be supported. The etiology will not be reversed. And if it is not reversed, neither will be the system etiology. Trauma induced systemic behavior will predominate the organization's management efforts.

The basis of ETM is caring for people who have been hurt. If this tenet is emphasized as primary and followed accordingly, managers can enjoy operating a system that is not disrupted by trauma.

Chapter Eleven

Strategic ETM (Addendum Version)

Introduction

There are two kinds of ETM Strategic Trauma Responses. They are "Extraordinary" and "Standard."

ETM Extraordinary Trauma Operations

Some traumatic events are planned, caused and their emotional consequences used for strategic purposes. They can be to advance a political or pecuniary interest. When trauma is exploited in this manner, the strategic trauma methodology is referred to (in ETM terms) as an "offensive trauma management tactic."

Examples of offensive trauma management tactics include the uses of:

1. certain kinds of violent crime intended to intimidate a polity or community's authority.
2. terrorist acts to alter a government's policy.
3. guerilla warfare to immobilize military combatants and their leadership.

Offensive trauma management tactics target:

1. unsuspecting civilians or even ready (and non ready) military combatants
2. their organizational management structures

Offensive trauma management tactics implant individual and systemic trauma etiologies because when they are not addressed, they can be relied upon to produce individual and systemic symptomatologies. They, then, discombobulate the targeted management apparatus. Specific examples of trauma-induced organizational management impairment are provided in About/ Theory/ **Crisis Management**.

The primary offensive trauma management target is the highest management position in the opposing system. The position includes its advisors and support personnel. Individual and systemic symptomatologies are easily manipulated to achieve the offensive trauma manager's objectives.

While the targeted management is disabled by the etiology (implants) and symptoms, the offensive trauma managers, they are the perpetrators of the trauma, then get or take what they want.

Strategic ETM Extraordinary Trauma Response is intended to counter offensive trauma management tactics. It interprets those tactics and counters by reversing the implanted etiologies that are being established at the targeted levels.

Hierarchical (highest) management etiology reversal must occur first. It is emphasized in this strategy because strengthening that level of management against the onslaught of individual and collective symptoms can immediately restore a strategic counter to the offensive management strategic application. This counter is needed rapidly so that it may provide the leadership required to remove the trauma's effects from the remaining elements of the targeted system and individuals.

Restore - defend strategic leadership quickly and expect to:

1. intercede the traumatic sequelae that will otherwise adversely affect the rest of the system
2. preempt individual and collective survival response, including management's deleterious and sometimes re victimizing survival responses
3. strengthen democratic - collective management force; make it cohesive
4. use it to make the offensive trauma management methodology obsolete

The sections entitled ETM Tutorial: Strategic / Criminal Violence/ Civilian Terrorism / Guerilla Warfare explain how to accomplish these tasks within the respective topical headings.

Standard Trauma Operations

ETM strategic theory for ETM Standard Trauma Operations is different from Extraordinary Trauma Operations. They are ETM strategic counters to heinous events contrived to disable the protecting management apparatus. To be strategically successful, those ETM counters require immediate identification and reversal of trauma etiology at the highest management level. Standard Trauma Operations, on the other hand, are addressing individual and systemic traumatic events that are not contrived. Hence, the urgency to reverse higher level management etiology is not as great.

Examples of traumatic events addressed by strategic ETM Standard Trauma Operations include (but are not limited to:)

1. Accidents
2. Natural catastrophe - disaster (floods, hurricanes, tornadoes, earthquake)
3. Fire
4. Criminal violence (but where the primary target is not the community's management authority)
5. Disease

Even though these events are not (as a rule) contrived for purposes of disabling a community's management authority, the events still create individual and systemic traumatic etiology and symptomatologies that encompass not just the obvious victims, but the responding management apparatus as well. Consequently, strategic ETM Standard Trauma Operations also require address of trauma etiology at victim and management levels.

Furthermore, the same general strategy for identifying and reversing individual and systemic trauma etiology applies. Address management etiology first. Strengthen management's capacity to then identify and address lay person trauma etiology.

Specific theoretical aspects of individual and systemic trauma etiology and symptomatology are discussed in About / Theory/ Crisis Management. Specific application steps for countering individual and systemic trauma etiology and symptomatology are provided in Strategic / Standard Trauma Operations.

Chapter Twelve

Standard Trauma Operations

Introduction (from Chapter 12**,** ETM TRT Online Training Certification School Textbook)

ETM's strategic application for Standard Trauma Operations addresses traumatic events that are not contrived. For example, accident, disease, and natural catastrophe cause traumatic events that are addressed as Standard Trauma Operations.

Perhaps Standard Trauma Operations can be made clearer by comparing it to ETM's strategic approach to Extraordinary Trauma Operations. They are applied to traumatic events that are contrived for the purposes of advancing a particular interest, usually pecuniary or political. Acts of terror and criminal violence provide examples of events addressed by Extraordinary Trauma Operations. They are addressed in the ETM Strategic sections regarding criminal violence, terrorism, and counter insurgency (guerilla) warfare.

This chapter considers ETM:

1. Organizational policy formation
2. Implementation Guidelines
3. Use of Fast Help
4. Etiology Identification and Grading
5. Team functions and management
6. Ethics
7. Schools
8. Application of TRT to crisis managers

Policy and Program Descriptions

Establish ETM organizationally with a program description and policy statement that together set forth the goal(s) and expected benefits, tasks, personnel requirements/responsibilities and implementation procedures. This section offers suggestions for formulating the policy and description.

Goal

Your program policy's stated goal should be commensurate with ETM's. Identify and reverse all trauma-induced etiology affecting the individual members of the system. Depending on scope, an organization may restrict ETM's address of trauma-induced etiology to that which results from organizational activities.

Purpose - Expected Benefit

Timely and ethical reversal of trauma etiology is intended to:

1. Reconstitute individual identity
2. Intercede individual survival responses
3. Prevent additional instances of trauma that would have resulted from survival responses to etiology, had it not been reversed.
4. prevent discombobulation of operational, including management activities responding to the event
5. restore operational activities to their primary focus

Plan

A written plan should describe the organization's course of action as a response to prospective trauma-causing events. The plan should provide consideration of the degrees and nature of the events. For example, the plan should note the steps to be taken as responses to, say, a natural disaster that affects everyone at once and virtually catastrophically, or as a response to, say, a single incident where an individual has been injured in a violent episode or accident. These notations should also delineate tasks and the interrelatedness of the job functions created by the event.

Elements of the plan related to coordination of emergency medical, security, and other safety and physical health-based services should be devised (by district management) depending on district resources, trainings, and professional considerations. In addition to ETM training, emergency response personnel should have completed basic life saving (CPR) courses.

The plan should include provisions that interface ETM's application with additional trauma resources required during disaster emergency response. For example, when Red Cross emergency disaster relief trauma management personnel respond to an event scene caused by a natural catastrophe like a tornado, hurricane, or flood, the plan should describe methods for interface with such agencies.

ETM General Implementation Guidelines

Here are organizational guidelines for implementing ETM.

1. ETM should be separated from the accountability/ responsibility management system.

   ETM is about caring for profoundly injured people. The caring occurs best in a non competitive environment, which the responsibility and accountability models are. Drop performance standards during the etiology reversal period and longer where clinical issues require such adaptation.

2. Reverse etiology for the individual's sake first, the organization's second.

   Should organizational interests compete with a trauma affected individual's, keep the focus of care on the individual.

3. Trauma resolution is a contingent liability of the organization because the trauma's occurrence is a job related experience.

   The employer pays for the reversal; it is not a personal therapy matter.

4. When a traumatic event occurs, following application of emergency response protocols (see the next section "Fast Help"), make the necessary referrals automatically

   Don't wait for self- referrals.

5. Facilitate the use of the system through training, education and recommendation.

   Don't demand compliance unless a prospective employee is apprised (before employment) of the likely hood of exposure to trauma and the needs of the organization to have employees be free from PTS. Both the trauma's damage and its reversal are understood to be job-related experiences.

6. The TRT short form can be provided onsite by the organization's agent.
7. The complete TRT process (all 5 phases), including the address of personal issues unrelated to the trauma experienced on the job, should be provided in

TRT facilities (Certified ETM/TRT Counselor) outside of the crisis management system.

8. If survival responses are allowed to develop (management does not reverse etiology in a timely manner), they must be treated by the program as likely theory.

   The organization has to demand performance, despite the sequelae's development. The answer to this predicament (having to demand performance that is unlikely achievable), is to not be remiss in identifying and reversing near-term trauma etiology. If long-term etiology does develop, give the employee an opportunity to reverse it, allowing a period for adaptation commensurate with the degree of injury.

9. Directly following the event, restrict social drug use like drinking alcoholic beverage, etc.

   Don't drink before administering the TRT short form. Social use following the reversal is irrelevant to it.

10. Integrate ETM with other crisis management models with an understanding that the languages and methodologies are different, and language translations are necessary.

    ETM teams require ETM leadership to facilitate integration between differently trained resources.

Use of Fast Help

Fast Help protocols provide detailed direction for immediate (emergency) and intermediate trauma management responses.

Etiology Identification and Grading

Categories of Event Effects

When the traumatic events occur, they have 1st direct, 2nd direct, and indirect traumatic effects.

First Direct

"First direct effects" refers to people who are the most directly influenced, physically and psychologically, by an event. Examples of 1st directly affected people include those who survive shootings or stabbings, accidents, or catastrophe. A very close friend or family member of a person who has committed suicide provides another example of a 1st directly affected trauma victim.

Second Direct

A "2nd directly affected" person refers to an individual who either witnesses an event, or is part of a closely related group where one or more of the members have suffered direct trauma.

Indirect

The "indirectly affected" category refers to those people who are part of the overall system and who have heard about the event. They are also professionals who are engaged in providing remedial services to the 1st and 2nd directly affected individuals. There are myriad examples of indirectly affected individuals. A few include school counselors, nurses, administrators, principals, teachers, industry supervisors where accidents have occurred and supporting personnel like police, emergency medical technicians and firemen. Depending on the event and their roles in relation to it, any of these examples can also be and often are first direct and second directly affected people.

The differences between 1st directly and 2nd directly affected and then 2nd and indirectly affected people are not always clear, nor should they be. All the groups are affected seriously enough by the trauma to warrant addressing it and the categories only serve to provide assistance in determining priorities for the application of the remedy.

Additional explanation is provided later.

ETM Teams

A fully organized ETM program engages several activities that are administered by trauma teams. With the emphasis on the etiology reversal component of the response to the trauma, the several activities are described here.

Team 1

Upon notification that a traumatic event has occurred, team 1, which may be comprised of one or several people, responds by going directly to the scene. That team coordinates (with community resources) security, safety, and health response activities.

Communications equipment should support team one activities. A written plan should delineate this team's responsibilities and duties (see Fast Help protocols).

Where the first priority of this primary trauma response team is to provide support for the assurance of the physical security and health needs of the trauma victims, the people comprising this team also identify and make note of the psychologically or prospectively psychologically affected (1st, 2nd and indirectly affected) individuals. Although the obvious psychological effects of trauma (behavioral symptoms of psychological trauma) may be noteworthy, such effects do not have to present as a requirement for identification of a prospectively affected individual.

For example, a person may be functioning quite well behaviorally during and immediately following the crisis. The person shows no symptoms of psychological trauma. Nonetheless, such people qualify for identification as 1st, 2nd or indirectly (prospectively) affected individuals.

Where time allows, the notes reflecting prospective and real psychological trauma-induced effects should reflect the person's relationship to the event. Later, these notes will help TRT counselors to assist the trauma victims to identify the specific contradictions, making it easier to reverse the etiologies (assuming more than one victim is affected) formed in response to the event. See ETM Fast Help.

Team 2

A second team

1. has primary responsibility for coordination of the disposition of trauma victims' from the scene to a stable environment.
2. responds to the scene as support for the previously described team's duties.

3. coordinates continuing safety, security, and health management activities, but with an emphasis toward facilitating the trauma victims out of the crisis scene and to either the health and security institutions, and to families where pertinent.
4. coordinates integration between trauma victims and people coming to the scene.

The organization's plan will no doubt provide for the clear disposition of (accounting) all involved. While providing for this disposition, identification of 1st, 2nd and indirectly affected people continues.

Use the same criteria described under the heading "Team 1" for identification of prospective and obvious psychological trauma effects. When listing the 1st, 2nd and indirectly affected categories, be sure to show the relationship of the person to the event. Noting this relationship, provides the appropriate counselor who is administering (at a later time) the TRT short form to the victim timely insights into the prospective contradictions to existential identity resulting from the trauma-causing event.

Team 3

A third team has primary responsibility for etiology reversal of 1st, 2nd and indirectly affected members of the system.

Team 3 retrieves the notes taken by teams 1 and 2 during the crisis and analyzes the prospective etiology developed in response to the event. This analysis portrays the full scope of the trauma's etiological effects. The analysis should show prospective incremental (formed in individuals) and collective (shared) etiologies. Apply the TRT short form in a timely and orderly manner and under the standards governing any therapy's application and specifically under ETM standards for such application.

Apply the TRT long form (all 5 phases) where appropriate.

Etiology Reversal Scheduling and Timing

The categories (1st, 2nd and indirect) representing the manner in which the various individuals have been affected by the event, influence the timing of the application of TRT.

First directly affected individuals may have to recover from physical injury to a level of cognitive and emotional functioning that allows the therapy to be applied. In some

cases, the psychological trauma to 1st direct affected people requires considerable introductory therapy that must be used for gaining trust, a normal transition to therapeutic process. Pain medications necessary for physical injury will likely postpone TRT's application.

For such severely affected people, it is appropriate to extend the timing of the application of the TRT short form to several months, even further if necessary. If this extension becomes necessary, the team 3 member may always rely on the application of TRT's long and written forms to address any etiology.

Second direct affected people should receive the TRT short form application within 1-3 weeks following the event. Extensions of this time or long introductions to therapeutic process are usually not required for such people.

Indirectly affected people who serve as crisis managers (trauma team members) can use the therapy at between 1 to 4 weeks following the period when they provided assistance to the 1st and 2nd directly affected trauma victims. Other indirectly affected people may receive the therapy at between 2 to 4 weeks following the episode.

Generally, extensions on all of these times may be accorded, but the farther time progresses from the episode, the greater the probability that the full TRT method will become the most appropriate application.

Team 3 members may elect to use other modalities such as critical incident stress debriefing where, within 24 hours of the event, the group of managers/helpers share through client centered group techniques their experiences, emotional and otherwise, related to the event. This application, however, should never be considered as an alternative to the direct etiology reversal method provided by TRT.

Team 3 members should not apply any form of TRT to any group immediately following a traumatic event. Wait at least several days, and usually a week before applying TRT.

Team Management

Trauma team management coordinates the activities of teams 1, 2, and 3. Achievement of the goal of reversing all etiologies formed as a result of the event is the responsibility of this management.

General Activities

Following an event, organizational leadership should apply appropriate communications techniques to everyone involved. Especially in school environments, traditional group discussion methods used for processing feelings and thoughts about the event are used as matter of routine.

These methods can include non intense discussions or the application of grief resolution techniques at the time of the incident. But these methods do not supplant the need for or requirement of etiology reversal via TRT.

The leadership may also be trained in the alternative Nosotropic (symptom focused) methods and because of this training know how to observe for symptoms of post-traumatic stress. The leadership then responds accordingly by making a proper referral.

The leadership will find, however, that as the Etiotropic method described in this section is routinely applied, reliance on symptom identification will be reduced. The leadership will not have to remain vigilent against symptom presentation because the etiology is likely to have already been reversed. There can be no symptoms if the etiology is reversed.

Ethics

Generally speaking, use the principles of the ETM ethics (demonstrated in Training/ **Cases; Examples**) when applying TRT to anyone.

ETM requires, among other things, the disclosure (before the therapy is applied) of the therapy's goals and the methods used for achieving them. This disclosure is made to the end user of the therapy, the trauma victim, and to any interested party having rights with regard to clinical applications.

Importantly, although the early etiology reversal method will have positive organizational effects; for example, system hysteria and chaos resulting from traumatic events will be ended, the application of TRT must be accorded to

individuals existentially: the trauma has occurred and the etiology needs to be reversed because it exists.

Never tell a trauma victim (or make via policy the *primary* reasons for the applications of TRT) that the therapy is being applied to make the trauma victim a better student, teacher, etc., or to make the institution operate more efficiently. If such instructions are allowed to predominate either the individual therapy applications or the motivations for installing ETM, the Survivor-based individual and systemic controls defending individual and systemic (organizational) etiologies will be supported. The etiologies will not be reversed.

The basis of the ETM program is caring for people who have been hurt. If this tenet is emphasized as the primary one and accordingly adhered to, managers can enjoy operating a system that is not disrupted by trauma.

Schools

School districts have, historically, not been viewed as crisis management institutions. Within the past 40 years, however, schools have increasingly become focal points of traumatic events.

The management of the effects of those events is the responsibility of the districts' managers. In fact, our experience of the very recent past (5 years) has shown that school districts are becoming leaders in providing one of the principal organizational responses to trauma affecting communities: trauma affecting the school district affects the community.

Events that Cause Trauma in Schools

There are myriad examples of traumatic events that affect schools. Some (examples) include death, injury, or property damage resulting from bus, automobile, and other accidents. Additional examples include injury and death from flood, hurricane, tornado, fire, shooting, stabbing, earthquake, bombing, drug overdose, rape, other physical assault, robbery, disease, suicide, and homicide.

ETM Application of TRT to Crisis Managers

The application of ETM to crisis management organizations does the same for them and their employees that TRT does for individual trauma victims and families -- ETM provides for the direct reversal of trauma-induced etiologies affecting the system. At the same time, ETM restores management control.

Generally, ETM application to such groups and individuals is comprised of two parts. First, etiology reversal activities must be focused on the people that the crisis managers and the organization are attempting to help. For this group, use TRT long and short forms to reverse trauma-induced etiology affecting all clients the organization serves. Second, use the TRT long and short forms to reverse etiology formed within the helper's psychology when that person is observing and experiencing client trauma and when the manager, while trying to help, directly experiences traumatic events. Directions follow.

TRT Short Form Application to Crisis Managers

The TRT short form reverses the etiology established (found in patterns 1 and 2) as the initial response to the trauma. An assumption implicit in the short form's application is that the 2nd etiology that develops as a response to contradicting survivor behaviors has not been formed.

Pre-therapy Education

If possible, provide ETM education to the system prior to the actual applications to crisis managers. In-services showing the purpose and theory of the model objectify the eventual therapy applications. ETM and TRT educational programs include presentations for crisis managers and their organizations.

Beginning

Following an event, the supervisor of the trauma-affected crisis manager should refer that person to the TRT counselor.

When beginning the session, remind the person of the therapy's goal. It is to reverse etiology formed as consequence of this specific event.

The TRT short form is usually provided orally (as opposed to being written), but can utilize a comparable written format (if homework is required) for more difficult to describe incidents.

The process can be provided in an individual session or in a closed or open ended group process, depending on the circumstances.

Application Steps

See "Fast Help Intermediate Trauma Response Protocols/ Etiology Reversal for a description of TRT's short form application to near term trauma.

Applying TRT's 5 Phases To Crisis Managers

Crisis managers are accorded all 5 phases of TRT when such application is shown to be appropriate: the assessment indicates the person would benefit from the application. Usually, such people have been exposed to substantial psychological trauma and for over long periods. If at any time during the assessment or application phase other sources of trauma are identified, then all of the 5 phase TRT process is applied to the various sources of trauma based upon the guidelines for addressing multiple sources of trauma.

Chapter Thirteen

Strategic ETM Civilian Targeted Terrorism

Apply ETM

When terrorists kill civilians, apply:

1. TRT's short form (see ETM Fast Help Protocols) to the governing group's executive and intermediate level managers.
2. ETM's Strategic / Standard (Trauma) Operation response, including ETM's Fast Help Immediate (Emergency) and Intermediate Trauma Response Protocols to survivors, family and crisis management personnel.

Preparation

Plan for heinous acts by implementing the preparedness elements of the Strategic/ Standard (Trauma) Operations. Add into the policy and program description TRT's short form application to executive and intermediate management following terrorist initiated traumatic events.

ETM Counselors - Managers at Risk

Advise ETM clinicians and managers that no matter their ethical application of ETM (victims first; organization second), that the strategic organizational benefit (see About/ Theory/ Strategic/ Terrorism) of their activities will nullify what otherwise might be viewed by the opposition as a strictly humanitarian response. Subsequently, ETM professionals would likely be at risk. And disaster emergency response groups like the Red Cross could lose their perception of neutrality even when their mission is only humanitarian.

Chapter Fourteen

Faster Response Help

Introduction: Immediate and Intermediate Protocols

ETM Fast Help consists of 11 protocols that provide immediate (emergency) and intermediate (first 90 day) management and clinical responses to a traumatic event. One through six address the immediate emergency response to the event; those protocols are administered during the first day. Protocols 7 - 11 assist the INTERMEDIATE response; it usually is administered from day 2 and continuing for approximately 90 days after the event. You are currently in the "Intermediate" Fast Help section. Return to the Fast Help main menu (by clicking on the green ball in the upper right corner of the heading) to access the immediate (emergency) ETMN Fast Help protocols.

In addition to the immediate and intermediate ETM Fast Help applications, this section (from the Fast Help main menu) also provides links to corresponding ETM Patient Education sections (they support Fast Help's address of nearer-term trauma) and ETM Strategic (it supports organizational development and management process intended to remove the effects of psychological trauma on systemic functioning). Find these supportive sections by clicking on the green ball in the upper right corner (in the heading).

Etiology Reversal Scheduling

1. Immediately following the event (within 2 - 5 days), plan and schedule etiology reversal appointments for:
    - 1st directly affected (event participants)
    - 2nd directly affected
    - Indirectly affected
2. When making the appointments
    - remind the participant of the appointment purpose - follow-up to the traumatic event
    - schedule adequate time for pre-session patient/client education (see below, Etiology reversal Ethics: Client Education")

3. For scheduling reversal sessions, use the following guidelines

Scheduling Etiology Reversal: Guidelines

With the exception of people involved in convalescence from physical trauma (see below), etiology reversal processes should, as a rule, *begin no earlier than one week (earliest = 3 days for indirectly affected) following the event; beginnings periods should not exceed 90 days post-event.* Reminding the ETM professional (and referring to the reversal protocol "10b"), once initiated, reversal proceeds at a pace determined by the client. Consequently, the period to reversal completion may exceed 90 days, depending on individual needs.

Directly Affected (1st Direct)

Schedule etiology reversal to begin no earlier than 3 days, and usually no earlier than one week following the event. Significantly, do not begin etiology reversal within 1-3 days of the event. Otherwise, the reversal process will actually function as counseling for shock, the first stage of grief counseling. Even at 3 days to 1 week delay, most of such a session will continue to be engaged in providing the first stage of grief resolution. Where needed, provide that grief/shock counseling response as often as necessary immediately following the event, but do remember to distinguish the clinical functions: etiology reversal from grief counseling. When an individual is also affected by physical trauma, provide interim discussion-based, feelings-sharing clinical processes between the event and the time etiology reversal is initiated. But only initiate that reversal when the physical convalescence is completed. Then schedule etiology reversal for the physical intrusion and any difficult medical treatments/consequences; follow with a schedule for etiology reversal for the psychological effects of the event. If the waiting periods for the etiologies' reversals exceed 90 days, apply the written Trauma Resolution Therapy (TRT) form for the address of long-term trauma. And as indicated earlier, that written form is very helpful when reversing etiology resulting from heinous events/experience.

Second Directly Affected (2nd direct)

Subject to the appropriateness for the client, schedule etiology reversal to begin at between 1 - 3 weeks. Provide interim (between the event and the etiology reversal period) discussion-based and feelings-sharing counseling for grief resolution where believed to be valuable.

Indirectly Affected (Indirect)

Schedule etiology reversal to occur optimally at between 2 to 4 weeks. Grief/shock counseling may not be as valuable to this group as to the first two.

Pre-Etiology Reversal

Ethics

Before reversing the etiology, explain the clinical procedure, its purpose, and intended benefit (see "Education" below); ensure that the client is accorded the opportunity of making an informed choice about any clinical process

Where etiology reversal can have both individual humanitarian / medical / psychological) and systemic (strategic organizational management) benefits (see etiology reversal theory), always reverse etiology for the benefit of the individual first, the system second; should dual interests compete, subordinate the system's interests to the individual's medical / psychological interests /needs

Elicit proper parental or other authorization for the application of any clinical procedure.

Maintain respectful regard for different helping processes; integrate any ETM assistance with other modalities, including both secular and non secular ones; see Parallel ETM Facilitation Guidelines under (10b) Etiology Reversal

Follow the ethical code of conduct governing the ETM professional's licensing or other governing body/agency

Confidentiality

1. Maintain confidentiality of privileged information acquired during clinical settings
2. Break confidentiality upon threat of violence: when life is threatened or personal damage is probable/possible
3. Follow confidentiality requirements of the ETM professional's licensing authority

Patient Assessment and Education

1. Explain that trauma resolution (clinically referenced in this document as etiology reversal):

- is intended to end some of the incapacitating effects of the psychological trauma resulting from the event
- may assist in loss/grief resolution
- may strengthen the individual to proceed less encumbered by the trauma's effects

2. Where the client/patient is interested, overview ETM theory of trauma etiology and its reversal
3. Where possible, make ETM client/patient education materials available so that the client is properly informed of the goals and methods of the procedure
4. Use the ETM near-term trauma assessment form to screen for appropriateness of application of the etiology reversal procedure
    - identify additional sources of trauma; explain that etiology reversal of near-term trauma may evoke recollections of past traumas, but the procedure is not intended to resolve or reconcile those experiences, albeit, through client choice, they may be reversed through referral to additional ETM clinical processes
    - identify the client's usages of any competing methodologies; provide non competitive (non persuasive) interpretation of etiology reversal's prospective conflicts with the competing paradigms
    - when the assessment demonstrates etiology reversal is likely to conflict with the client's otherwise established methods/philosophies for coping with the event, withdraw recommendation of the ETM near-term etiology reversal procedure and either apply the compatible modality or make an appropriate referral (to a professional who subscribes to and otherwise practices with that method)

Drug and Alcohol Use

In follow-up conversations with event participants, ask them to refrain from social or other alcohol consumption *until the interim etiology reversal procedure has been completed; emphasizing neurobiological trauma issues, explain why* (see)

Pharmacological Psychological Trauma Treatment Methods

1. Generally, do not attempt etiology reversal with and while a client is using psychoactive substances
2. And, because application of pharmacological psychological trauma treatment methods by non ETM trained professionals will likely interfere with etiology reversal procedures, study the issues under ETM Theory and attempt to

reconcile professional differences so that attending conflicts are not imposed on the already traumatized client

Pre-reversal Clinical Functions

1. Follow professional clinical standards
2. Ensure that
    - the clinical relationship has been properly initiated and established:
        - know what happened to this person (see the etiology identification form)
        - know the relationship of the client to the event (see the etiology identification form)
        - care about the person
        - acquire and honor client trust
        - accord client control by assuring that goals, purposes and parameters of the clinical processes are understood (see previous "9 Ethics, Confidentiality, Education")
    - additional issues reflected in the assessment are discussed (reviewed and disposition considered)
    - the client and you have the capacity to discuss the event (more)
    - you've timed/planned the address of convoluted traumatic sequelae that are consequences of:
        - physical trauma
        - loss of life (usually a close relationship)
3. Proceed to (11) Identification and Reversal of Trauma Etiology

***Planning* Etiology Reversal for Convoluted Sequelae Resulting from Physical Trauma**

1. When a client has been physically traumatized, direct the etiology reversal process to unravel the otherwise combining of two sequelae, the etiology related to physical trauma and the etiology resulting from the occurrence of the event
2. Usually, reverse the physical trauma psychological etiology first, and then in a separate (following) session(s), reverse the etiology related to the event's occurrence
3. Example: a teacher is wounded during a gang-related shooting

- First: identify and reverse the psychological etiology that results from the physical intrusion to the body and subsequent medical care
- In the following session, or after adequate processing of the first etiology reversal process is completed (possibly two sessions or when the client is ready - see parallel guidelines), identify and reverse the etiology stemming from the event's occurrence: that someone would attack the teacher, threaten and attempt to, and then harm that person, especially in an environment otherwise intended to be secure and focused on providing education, etc.

Planning **etiology reversal for Convoluted Sequelae Resulting from Loss of Life (someone who formed an element of a close relationship)**

1. When a client has been affected by a traumatic event that also results in the loss of life of a loved one (or other close relationship), direct the etiology reversal process to unravel the otherwise combining of two sequelae, the etiology related to the event, itself, and the etiology resulting from the loss of the life
2. Opposite from the physical trauma address referenced in the preceding protocol, reverse (usually) the event etiology first, and then in a separate (following) session(s) reverse the etiology related to the loss of life
3. Note: the (loss of life) etiology will necessarily present during address of the event-related etiology reversal process; use patience and traditional (existentially-based) clinical skills combined with ETM skills (use of structure simultaneous with existential modality applications) acquired from ETM training (and overviewed under "Parallel Guidelines") to facilitate both processes, but with the goal to eventually reverse the event-related etiology

   Example:
   A student witnesses the loss of her best friend's life during an accident; it is an extraordinary event in and of itself; before this etiology has been identified and reversed, you should be prepared for the student to enter the etiology reversal process related to the loss of her best friend's life; the preparation should accord you and the student the opportunity of completing reversal of the etiology stemming primarily from the accident.

In the following session, or after adequate processing of the first etiology reversal process is completed (possibly two sessions or when the client is ready - see parallel guidelines), begin identification and reversal of the etiology stemming from the loss of the friend's life; this process may take multiple sessions that last over weeks-

months, and following the etiology reversal session, the extended process should follow traditional psychodynamic forms of grief counseling, but without the confusion attending unresolved trauma: the etiology has been reversed.

Capacity to Discuss the Event

Generally, the client's capacity to discuss or even initiate discussion of the event is reliant, not just upon client intrapsychic capability to identify and reconcile the event's influences on existential identify, but also, and in no small part, upon the modality used by the helper to facilitate discussion of the event and experience, as well as upon the clinician's confidence/skill to address profoundly affecting traumatic events and to work therapeutically/experientially at intensely painful thresholds of human existence and interaction. If you are ETM trained, then you will know how to use the ETM structure to facilitate discussion and then reversal of the etiology for virtually any event and with practically any client.

If not ETM trained, then your decision to proceed with severely affected trauma victims is based on other (usually Nosotropic, including non structured psychodynamic-based) clinical experiences, professional trainings, and studies of the literature.

If lacking confidence, experience, training, study, etc. to assist such (severely) trauma affected people, get professional supervision before and during provision of the assistance, or get ETM trained if time allows, or refer the client to someone who can provide the necessary care.

Identify and Reverse Trauma Etiology

In addition to selecting and then following specific procedures "A" through "F" below, see and use Parallel ETM Facilitation Guidelines: Etiology Reversal of Near-term Trauma

1. Step A. Facilitate event description
2. Step B. Facilitate "first" emotional processing (feelings identification, experience, expression)
3. Step C. Facilitate identification and expression of event-contradicting values, beliefs, images, and realities (from now on called "existential identity")

to existential identity
5. Step E. Facilitate "second" emotional processing (feelings identification, experience, expression)
6. Step F. Reflect your (or group's) perception of client value

Conclude Etiology Reversal

1. Schedule and conduct follow-up sessions as appropriate
2. Also where appropriate, make proper referral (to address additional traumatic sequelae or other issues)
3. Prepare clinical discharge summary

Etiology Reversal: Step A. Facilitate Event Description

1. Discuss the circumstances leading up to the event
2. Facilitate the client's overviewing the event; if necessary (the client doesn't overview the event easily), use the information from the etiology identification/grading form to assist the review

   (note: while assisting in the review, use the information from the form to generally orient the conversation; do not use it to fill in trauma-causing facts as their recollections and descriptions by the client are fundamental elements of the etiology reversal process)

   In planning to address the specifics of the event and at your discretion, apply the oral-only or combination written/oral form for describing the event; use the following and general guidelines for making this decision:

   - the more heinous or catastrophic the event, the greater the tendency to use the written form
   - the more fragile the client appears in response to the event, the greater the need of the written method

3. Returning to the discussion of the event, facilitate the client's description of his or her experience of the specifics of the traumatic elements of the event; the client describes:
   - date, day of the week, and time (if not already established in the review)
   - place

4. Step D. Facilitate identification of specific losses resulting from contradictions
    - what happened
    - specifics (details) of the most traumatic aspects of the event
    - note: referring to your training and the parallel guidelines,
        - use your clinical (existentially-based) skills to share any emotional pain (crying) expressed during these descriptions; "sharing" infers listening and otherwise letting the client know that he or she is not alone (see Parallel Facilitation Guidelines)
        - remember that the next step in the etiology reversal process assists the client to focus upon (that is, identify specific emotions and then to experience and express them as they present) this emotional experience
        - if possible, that is, unless your clinical expertise and ETM training directs otherwise, do not accelerate the clinical process to identification of feelings until the facts of the event have been related; once the emotion is shared, then return to the description until it is completed; then, proceed to the etiology reversal process' next step "B." Facilitate "first" emotional processing (feelings identification, experience, expression)

Etiology Reversal: Step B. Facilitate "First" Emotional Processing (feelings identification, experience, expression)

1. Review for the client (and for yourself see parallel guidelines) ETM language for (definition of) feelings
2. Facilitate existentially the client's identification, experience, and expression of feelings
    - if the client education program has not already provided an overview of this procedure, preview (or review where necessary) for the client the existential method; very briefly, relate the vase analogy (provided with graphics in your ETM training program)
        1. a vase full of liquid also contains large air pockets that move in circular motion from the vase's bottom-to-top and then cyclically back to the bottom-to-top of the vase
            - as each feeling nears the top, it can be more readily identified, experienced, and shared
            - usually, the feelings will come in patterns, that is, their presentations follow an order, and even when they are identified, experienced and the experience shared with

re-identification, -experience and -expression, and often in the same or similar order
- within the overall cycle, the feelings usually present twice, but more or less depending on the individual
- concentrate on identifying, experiencing and expressing (sharing the identification and experience with the facilitator) one feeling at a time

2. begin the procedure
   - follow the general facilitation procedures under parallel guidelines
   - follow closely each feelings identification, experience and expression
   - the feelings or feeling states usually present accordingly
     - shock
     - fear
     - fill in later
   - they will likely present a second time and in the same order, and/or until no further identification, experience and expression are required
3. Proceed to step C, identification of existential identity (values, beliefs, images and other realities) contradicted by the event

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Etiology Reversal: Step C. Facilitate Identification and Expression of Event-contradiction of Existential Identity

1. Ask the question, "How did the event contradict your values, beliefs, images, or other realities?"; note: in lieu of "event," state what actually happened; for example, ask how the "accident," "shooting," "attack," or "death" contradicted (or otherwise function the opposite from) what the client valued, believed, viewed, or any other moral expectation held at the time of the event
2. If the client has difficulty answering this question, reframe it into a series of more simplified questions; for example, and pertaining to the time just prior to the event, ask
   - "What did you value just before the "accident," "shooting," "attack," or "death"?

the facilitator, the feelings tend to return to the cycle for
    - "What did you believe in that was disrupted by the "accident," "shooting," "attack," or "death"?
    - "What view of the (event) situation, related people, or image of yourself did you hold just before the event occurred?
    - or, "What other reality was contradicted by the event?"
3. The client will likely respond with equally simple (but no less profound) answers; if a shooting of a friend provided the basis of the contradictions, sample answers for the first or all of the questions in (1), (2) a, b, c, or d might include:
    - "I valued safety, my friend's life, security, our friendship
    - "I believed people should care about others; not threaten, or harm them, much less shooting them, and taking my friends life from me (us)"
    - "I thought we were going to be friends forever"; "I imagined our life going on together; (note: usually presenting images of specific planned involvements like sports, music, drama, dating, etc.)
4. Note: if the client cannot answer any of these questions, then ask him or her to take them home and work on them in writing; give the client a Phase Two form from Trauma Resolution Therapy's five phase address of long-term trauma (see your educational materials or go to for quick review); ask the client to fill in only the first 4 columns, leaving column 5 blank; when returning to the next session, ask the client to read the first 3 columns
5. After contradictions to existential identity have been identified and described (shared), proceed to the next step D.

Etiology Reversal: Step D. Identification of Losses Resulting from Contradictions to Existential Identity

1. Ask "what did you lose as a consequence of these contradictions/changes that you've just described?"
2. Facilitate identifications of loss resulting from noted descriptions of specific contradictions to identity
    - you might assist the client in reviewing each contradiction identified earlier;
    - following each contradiction review, ask for the correlate loss(es)
3. When losses resulting from reviewed contradictions are identified, the exercise is not complex, but ordinarily simple as the losses are often just a

restatement (cognitive identification) that the value, etc. was intruded upon, altered, taken from the person, or in some other way interfered with

4. Expect redundancy: losses repeat for various contradictions
5. ! Correlating specific losses to specific contradictions is the most important element of the entire etiology reversal exercise; the losses identified by themselves will have little benefit for the etiology reversal process: it will not occur if the contradiction-to-loss linkages are not cognitively established
6. Continuing the example used under "C", a girl loses her friend during a shooting, contradicted:
    - values of
        1. safety and security consequently result in losses of the sense and actuality of living safe and secure
        2. the friendship impose relationship losses of companionship, trust, continuity, the relationship, itself
        3. the fiend's life usually results in additional relationship losses of love, caring, sharing; also in intrapsychic losses of self-esteem, worth, and because of the natural tendency to project aspects of one's self onto another during close relationships, a loss of the girl, herself (usually the last loss to be identified), and usually identified as a loss of a part of "me."
    - beliefs that
        1. people should care about others results in losses of trust in and respect for people in general
        2. someone should not threaten or otherwise harm them foster losses of safety, security, continuity of both the friend's and one's (the surviving girl's) own life, much less shooting them, and taking my friends life from me (us)"
    - images (concepts and other realities) that
        1. the friendship would go on forever imposes losses of future, continuity, self worth self esteem, trust in relationships, the ability to care, love
        2. the two would live life together results in losses of not only the friend, but the projections of the survivor onto the lost friend - again, the loss of the projections are manifested as a diminishment of the self, that is, losses of self-esteem, self-worth, and as indicated earlier frequently reflected as a loss of "me"

7. If the client used the TRT Phase Two form (normally applied to resolution of long-term trauma sequelae) in step C, the client will likely continue the form's use in this step D
8. Proceed to the next step "E"

Etiology Reversal: Step E. Facilitate "Second" Emotional Processing

1. Using the same approach (the vase analogy) used in step "B," and remembering to utilize the general facilitation principles recommended under Parallel Guidelines, facilitate feelings identification, experience, expression
2. Where the feelings addressed in step B are usually discovered during the beginnings and middle of grief resolution, those addressed follow identification of contradictions to identity and subsequent loss usually comprise the latter or final phase of grief
3. Like the first emotional address occurring in Step B, these feelings too will probably present twice, but also again, more or less depending on the individual
4. Concentrate on identifying, experiencing and expressing (sharing the identification and experience with the facilitator) one feeling at a time
5. This emotional processing should be one of mourning, felt less or more profoundly depending on the degree of etiology established as a consequence of the event
6. Proceed to the next step "F"

Etiology Reversal: Step F. Reflect Your (or group's) Perception of Client Value

1. Reflect your, or where group process is used, facilitate the group's perceptions of this persons value; that is, tell the individual what it is about them that you think is valuable as you have come to know this person throughout this clinical process
2. When the client is also a trauma manager, for example, an emergency medical technician, police officer, nurse, counselor, principal, or other ETM professional, in addition to reflecting your perceptions of client value, also affirm the value of the role: the value of the service provided to the community by this helping role
3. Remember! This reflection is not to be confused with the very thorough process of reflection provided under the treatment completion step (5b) for reversing long-term trauma etiology (described in the 3rd and 4th training

days of the ETM School); in comparison, this reflection (for near-term etiology reversal) is spontaneous, occurring immediately following the final emotional processing of the traumatic event's effects on existential identity; you will recall that in contrast the reflection used at the completion of etiology reversal for long-term trauma requires fairly extensive planning and possibly to occur over multiple sessions

For additional facilitation assistance on TRT facilitation, look to the next chapter fifteen.

Processing Carnage Involving Combat Team Members
(Added from an online essay written in 2007)

An especially difficult process of reconciling trauma involving carnage of combat team members requires emphasis. When an explosion separates a team member's body parts, either killing or wounding him or her, the not wounded participant sees in reappearing glimpses (as part of the process) his own body elements removed the same. Here is a simple, that is brief, explanation of how this process works, and TRT's role in ending it.

Fusion has hallmarked the team's development. And it is underpinned by projection of one team member on to the others, and vice versa. As different in the traumatic instance when death is an outcome (as opposed to carnage in wounding) the loss is more obvious (than projection and transference attends carnage by itself). As explained in the ETM professional training course's address of Trauma Resolution Therapy (TRT) theory of combat trauma, loss of the life of a team member is, in the final understanding, equivalent to the loss of one's own life. A team member dies and the surviving team member eventually realizes that he is grieving at the deepest level of him/herself the death of the partner who has done the projecting onto the deceased. Therein, that surviving person grieves two people's deaths: the associate's and his - her own.

Carnage's effects are much the same, except that they are rarely noticeable and often only present from the unconscious or otherwise become available for processing in TRT, which never fails to address this issue. That issue will be confusion of the viewer's body parts that are still intact with the team member's that are not. For example, when a combat partner has been decapitated instantly by explosion or other means, the living associate not only goes into shock due to the beginning of the processing of loss of the head of the partner, but through the projection phenomenon onto that partner the head of himself.

The experience can be represented by apparent confused and indication of destablelizing thoughts which frequently manifest by asking of oneself: “Why is my head still on my body while his is over there in the grass?”; or asked another way, she may say to herself “Why isn’t my head lying over there in the grass?” Here, combat training helps combat functionality with rote and helpfully overlaying thoughts - defenses against slaughter such as “This is war." "This is my job." "People’s heads are supposed to be," or at least "It is natural - normal for an associate's head to be separated from his / her body after an explosion."

Of special note and what you will learn in TRT, the carnage should be addressed first before the loss of the associate's life and the transferring of the death onto the viewer.

When the surviving combatant returns to a secure zone, ETM TRT will (or should) be applied via its near-term method. It, like the longer-term TRT application (when the event occurred from 90 to an infinite number of days out), will apply its laser like incremental efforts to expunge that particular trauma’s etiology. The address by TRT will reverse (remove) that etiology and end the delusional thoughts attending patterns of same constructs (more flash thoughts that transfer the carnage onto the viewer). ETM TRT's reversal of the carnage induced trauma etiology ends the transfer of the carnage onto one’s self.

Chapter Fifteen

TRT Facilitation and Feedback Guidelines

Introduction

ETM Facilitation Guidelines for reversal of near-term trauma etiology are similar to those used for reversing long-term trauma via the structured psycho dynamic model "Trauma Resolution Therapy." Incorporate these guidelines into the process through which you facilitate steps A-F.

! Noting the use and importance of this structured approach, unlike unstructured psycho dynamic models such as grief resolution and Client Centered Therapies, the ETM etiology reversal process invites a trauma affected individual to lessen the use of thought paradigms that defend the etiology. Because of this invitation, which comes in the form of steps A-F, the interactive responses by facilitators or group members are necessarily guided through a similar lessening of the use of defenses against their experiences of the trauma-imposed etiology. If these guidelines were not used, then it is most likely that the defended group member or facilitator responses will not lessen at the same pace as that enjoyed by the person proceeding through steps A-F, and such an imbalance would prevent the etiology's reversal and likely hurt the trauma victim further.

! If facilitating etiology reversal with group process, use patient educational materials to explain the purpose of the structured psycho dynamic approach; its use, that is, following the facilitation / response guidelines provided below (and reframed for lay understandings in the patient education materials), is a condition of participation in the clinical process. If the materials are not available, then summarize these methods and controls for group members before they enter the process, eliciting their agreement to comply with the procedures for the purpose of expediting the reversal process for all participating trauma-affected individuals.

Parallel ETM Facilitation Guidelines

(1) Caring and the use of the ETM structure

The most important element of the ETM (etiology reversal) procedure is caring; the ETM structure is the second most important element. A balance between these variables results in the use the structure to assist you, the client, and any group participants to focus otherwise natural caring capacities upon the crux of the trauma's damage to identity; do not allow this balance to be altered so that implementation of the structure supersedes the application of caring for the client progressing through the etiology reversal process. (more refers additional information provided in the glossary at the end of this chapter)

(2) Empathize first; identify second

Use empathy, as opposed to identification, during application of steps A-F. Do not respond with identification until after the steps have been completed. (more)

(3) When reflecting (or eliciting) feelings, ensure that they do not become opinions

Feelings are often difficult to identify because they are covered over or otherwise diverted from identification by opinion; it tends to mask as feeling through expressions such as "feel like" and "feel that." Drop the "like" and "that" and reflect what remains in simple language: Feelings are usually identified, experienced and expressed as "shock," "fear" (terror), "horror," "anger," "sadness," etc.

(4) Once initiated (steps A-F), preclude etiology reversal interruption by Nosotropic-based coping (symptom focused) modalities and philosophies; they usually include:

- stoicism (more)
- cognitive-behavioral, including positive thinking and other Rational Emotive Therapies (RET), styled methods (more)
- psychotherapy (more)
- projection; (in this example) presumptions that guesses and theories are reality (more)
- advice-giving (including that necessary for self-protection) (more)
- any application that switches the reversal focus to the memory of another (historic) traumatic event (more)

Pre-etiology reversal client education that explains the etiology reversal goal and ETM method for achieving it is the best means of preventing interruptions; a well trained (in ETM language) facilitator is the second best defense against interruptions. (For those readers having completed ETM training, you might recall the first 3 days of that professional education experience.)

(5) Follow a pace for etiology reversal that meets the client's needs

Use the integration procedures (next in #6) to facilitate especially difficult to describe episodes (more)

(6) Integrate the client (with yourself and the group) before, and if necessary, during, and then after the reversal process.

Apply the following ETM client integration procedures more or less assiduously depending on the delineation of the etiology as, respectively, a consequence of "directly" ("first direct"), second direct, or indirectly affected by the event.

Moreover, the heinousness and physical trauma associated with an event will also determine the need for application of the following client ETM integration procedures a - e.

- share/reflect feeling (more)
- give perceptual feedback (more)
- direct client acknowledgement of group or facilitator response (more)
- during responses, ensure that eye contact is made between client and responders (more)
- touch the client on the arm or shoulder at extraordinarily painful (cathartic) times, but with noted restrictions (more)

ETM Glossary: ETM Language/Meanings (and some ETM Theory/Philosophy)

Caring

In this (ETM) usage, caring means to lend One's Self to, including the temporary conscious merging/sharing of your identity with, the trauma victim during his or her identification and reconciliation of the traumatic event's effects upon the assaulted identity.

Structure

ETM "structure" is comprised of all of the etiology reversal protocols for both short and long term trauma, to include the Parallel ETM Facilitation Guidelines. The protocols and guidelines provide the crux of the mechanism that facilitates identity merger (and subsequent separation) to the degree required to reverse the trauma etiology.

If the structure is properly administered, it will automatically facilitate all identities to

work together to complete reversal of the trauma etiology and then to return to normal (non clinical) functionings; that is, the identities will automatically separate after the procedure is completed.

Caution! When the facilitator's attempts to follow the structure are administered to the degree that the focus on structure is emphasized to the extent that caring is minimized, the etiology reversal process will become bureaucratic, and in the process lose its value; the etiology will not be reversed. The first 3 days of "local" ETM training provide the professional experience/skills with which to use the structure to focus caring where it is most needed, and without concern for the prospective bureaucratic effect.

Empathy

Empathy is the process through which one feels, shares, or otherwise understands another's experience. When empathizing during etiology reversal, the responder reflects those feelings and other experiences to the person providing the original description; the focus of the sharing/feeling remains upon the first person's passage through reconciliation of his or her experience of the traumatic event causing the damage being addressed.

Identification

Identification is the method through which the sharing of one event initiates recollections of the listener's past traumatic experiences; they, then, are recounted as the primary response to the description of that original traumatic event.

Identification has value in that it lets a trauma victim know that he or she is not the only person to have been affected by trauma, and that because of the listener's (identifier's) past experiences, then that person may have some special capacity with which to understand the originally affected person's trauma and its effects.

Empathy or Identification; a matter of timing

Applying empathy to the wound (trauma etiology) during the reversal process facilitates it: identification of contradictions to existential identity, identification, experience and expression of related emotions, and reconciliation of loss resulting from the contradictions. The focus remains on the person reversing the etiology. Empathy works akin to a sponge absorbing the deepest elements of damage as it is identified, experienced and expressed. Although identification can have positive results, say, either before or following the administration of steps A-F, the application of the identification

method during the etiology reversal process will shift the focus of the clinical experience to the listener's trauma and away from the first person's reversal efforts, and at precisely the wrong time: while the person needs empathy from those listening to, sharing, and otherwise participating in the reversal effort.

Do not use the identification method during application of steps A-F of the etiology reversal process!
Prevent etiology reversal interruption by Nosotropic-based thought / methodological paradigms
Nosotropic

Meaning symptom (and in the case of psychological trauma to infer thought/behavioral), as opposed to etiology (that is, causal), focused.

Stoicism

Stoicism provides a primary survival psychological and sometimes believed to be instinctive response to trauma. It is necessary to be very strong at various times while responding to a traumatic event. And that being strong can include suppression and eventually even repression of emotional responses to the trauma; they can incapacitate an individual who is otherwise required to take protective action.

During the etiology reversal process, different strengths are required, and they are augmented with others. That is, identifying the specifics of an event's damage requires some fortitude. Contradictions to identity almost always evoke the experience of incapacitation - the condition of which the conscious Stoic is most afraid: if it surrenders to the emotional processing that accompanies etiology reversal, there may be no defenses remaining with which to protect one's Self.

The caring and structure used by ETM facilitate a gradual lowering of the requirement of the be-strong thought paradigm, stoicism, but only while the person is participating in the safe (ETM clinical) environment. The use of stoicism outside of that environment may still be necessary. Moreover, once the etiology is reversed, the client will usually find that capacity for strength with which to face the realities of the life consequences of the event has been substantially increased.

Consequently, through pre-etiology reversal client education, facilitate the disuse of that application of stoicism that precludes the direct address of emotions, but only

while steps A-F are being administered. Thereafter, clients will retain a different, and considerably broader, definition of strength, and become more facile and otherwise adept at employing most effectively (outside the clinical environment) stoicism philosophy and methodology.
Cognitive-behavioral, including positive thinking and other Rational Emotive Therapy (RET) oriented/styled methods

> Meaning methods that provide cognitive interpretation of trauma's thought/behavioral responses to their etiology, and then, in the uses of positive thinking or RET, teach the affected person how to rethink or adopt other views that frame the traumatic event and its consequences into a more favorable perspective.

For example, the death of a student's friend during an automobile accident which involved the surviving student might be reframed with positive thought to focus that student's perceptions primarily on the more favorable concept and fact that the student did not die as did his or her friend. Additional philosophies, sometimes couched in the forms of sayings or slogans, then support the more favorable view; a few examples might include "Life is for the living"; "We have to go on"; "there is a reason for the tragedy" (the other's death and not the survivor's), etc.

When the positive adaptations become established as primary thought/defensive paradigm, they present a serious obstacle to etiology reversal if they are used during the application of steps A-F. That use must be set aside until the reversal application has been completed.

Because these trauma adaptations are very popular, that is, well ensconced within socio-cultural norms/mores, and the adaptations serve a constructive purpose of restoring an ongoing attitude about the process of life, they must be addressed equally with deference and straightforwardness. In that regard, acknowledge the positive thinking methods' value, usually before the etiology reversal process has begun, and explain through patient education that they will, however, interfere with etiology reversal if used during its administration. Certainly, never tell trauma victims how to think, positive or otherwise, especially while they are engaged in the etiology reversal process.

ETM theory: stop the use of the adaptations during the reversal application and the etiology's reversal will not only end the trauma's symptoms, but also the need for the

adaptations.

ETM philosophy: taking positive action, like assisting a trauma victim to reverse the trauma's etiology, is a more valuable response to trauma than telling trauma affected people how to think. Reverse the etiology, and they will do their own thinking, forming attitudes that are conducive to their identities.

Psychotherapy

> Having broad and many interpretations; but in this context, referring to the use of clinical interaction to discover the meaning of the trauma to client, and primarily for the purpose of reducing post traumatic symptoms.

Where psychotherapy's approach to the trauma's meaning can be generalized, complex and require extensive time, ETM's etiology reversal procedure is specific about the etiology's locus and its remedy; simplicity is the norm and time requirements are miniscule when compared to that demanded by psychotherapy. ETM is not psychotherapy.

Moreover, non structured psychodynamic-based psychotherapies are shown in the literature to become overwhelmed by information overload when attempting to ascertain the meaning of the trauma: discover the trauma's damage to the internal functionings of the psyche. Because of the "information overload" (Scrignar, 1988), trauma victims may be prevented from achieving the goals of the clinical process.

ETM's structure on the other hand, whether applied to near- or long-term trauma resolution (etiology reversal), is reported to assimilate the otherwise thought to be unmanageable amount of information related to intrapsychic damage, allowing the client to achieve the goal: etiology reversal.

The differences between the structured ETM and psychotherapy models and the need, purposes and value of distinguishment are thoroughly addressed in the ETM Training School and in the associated literature; the differences' address are assumed to present too great an issue for further discourse by this review.

Summarizing, psychotherapy's goals and methods are sufficiently different to, if used in conjunction with ETM steps A-F, alter the outcome expected from the ETM etiology reversal application. Save psychotherapy for another clinical setting. Do not mix it with steps A-F!

Projection

In this usage, meaning to see One's own Self, needs, or interests in another.

If the people surrounding a trauma victim project onto that person their needs, interests, or their own identities, the trauma-affected person will not be able to identify his or her own values, beliefs, images, and realities contradicted by the event. Etiology reversal will not occur.

Projections can occur through the uses of guesswork about and the application of theory of an individual's thoughts and feelings.

Although this modality has recently enjoyed much popularity, don't do it or allow it when applying ETM's etiology reversal procedures (steps A-F).

Advice-giving

Meaning to tell clients how to think or act in their best interests, what to do to protect themselves from further harm, or how to proceed through their experience of a tragedy.

Clearly, the referenced advice is not only at times necessary, but a responsibility of the clinician; he or she must inform the client of prospectively dangerous situations and high risk behaviors. During the etiology's reversal, however, such advice will alter the reversal process and prospectively end all together the client's opportunity to reconcile the event's contradictions to identity.

Moreover, some people who are proceeding with the client through the reversal experience may attempt to block that experience, especially when it becomes very painful, by telling the client what to think or do. And some people just do not know what else to do when called upon to help, other than to give advice.

Only give needed advice, protective or otherwise, before or after application of steps A-F.

Models that switch (or allow the changing of) the reversal focus to the memory of another (historic) traumatic event

In his treatment of war veterans affected by trauma, Freud hypothesized that the trauma's failed reconciliation in adult life occurred because of childhood or earlier and still unresolved traumatic experiences. He used an analytical modality to reconcile the two trauma's; resolution of the first would lead to

eventual resolution of the second. Subsequently, considerable debate over the relationship of multiple life traumas and their effects on the psyche followed in the 1950's and, in fact, continues today.

ETM literature and the professional training School address this debate and provide specific protocols for the reversal of multiple traumatic etiologies. They are different from Freud's in that both the short- and long-term applications of the ETM structure to the trauma provide for the address and reconciliation of the trauma's separately, and in an order that considers first the trauma requiring the greatest attention, usually the later occurring trauma. You can find ETM's theory and formula for the address of more than one trauma under the title's "Multiple Sources of Trauma."

Reviewing your training, you may recall that when reversing etiology from near-term trauma, that the emotional pain and memory of the historic trauma will likely present. Following the ETM protocols referenced under "Multiple Sources of Trauma," listen to the presenting experience with empathy, assure the person that this additional experience will be addressed as thoroughly as the current traumatic event is being addressed. Then, with the client's agreement, return to the position within steps A-F where the memory of the earlier trauma was evoked.

In a few circumstances, that return to the near-term trauma resolution effort will not be possible or advised; see "Multiple Sources of Trauma" in ETM literature and training for descriptions of how to respond to the various issues that can present when in an individual is affected by more than one extraordinary life (traumatic) event. (Eventually, ETM methods for addressing multiple sources of trauma will be placed on this information system.)

Follow a pace for etiology reversal that fits the client's needs

The client sets the pace for etiology reversal. You do, however, expedite it by removing intellectual obstacles (such as interference by Nosotropically-based applications), and by providing empathy and other methods of caring for that person. Generally, the less interference (provided by following these guidelines) and the more attention provided, the more readily the etiology will be addressed/reversed by the client.

Integrate the client (with yourself and the group) before, and if necessary, during, and then after the reversal process

! *Remember, this is a review and, as a rule, not intended to supplant professional training. The ETM trained professional will recall and non ETM*

trained professionals are advised that the ETM Training Program demonstrates, with over 100 traumatic examples, the practical and appropriate applications of the following guidelines. The demonstrations provide considerable (for 4 days) experience/practice for the application of the following procedures to both near- and long-term trauma, and with usages of both the written and oral (only) TRT (Trauma Resolution Therapy) forms. Some or all of the procedures may be applied per the ETM trained clinician's discretion (appraisal of client need).

1. share/reflect feeling
    - following guideline "3" (explaining the method for identifying and sharing feeling as opposed to opinion), reflect your and the group's feelings; depending on the client's need, use this method before, during, and following a description.
    - when groups are employed, have each group member reflect a single feeling to the client.
    - example; a client is about to describe an especially heinous event, and the client was physically traumatized in the event. The client returns to (or enters) the state of psychological shock; it is manifested by his or her experiences of numbness, disbelief, and possibly the inability to express him or her self further. Preempt or stop the description for a moment and reflect your (and the group's) feelings to that person before he or she proceeds with the description. Follow feelings reflection with "c" and "d" from below. Use the same approach if during the description the client presents similarly (shock, horror, or another potentially incapacitating experience).
2. give perceptual feedback
    - before, during or after a reading, tell the client how he or she appears (appeared) to you
    - when using groups, go around the group and facilitate each member to provide his or her view of the client
    - at no time can reflections of perceptual feedback be confrontational (intended to criticize or change behavior) and should never include guesses about the client's internal thought processes
    - but the perceptual feedback can include a combination of a description of the behavior, a reflection of what the client "seemed" to be experiencing emotionally, and the feedbacking person's feelings
    - example: the client, a student, just used the written description method to recount a rape; she remained blunted in affect; you and the group

members, usually after having completed "a," tell her how she looked to each of you while providing the description. Providing with much care and sensitivity:

"You held your arms while reading; you rocked back and forth as you talked; you seemed to be hurting very much. At least, I know that I felt a lot of hurt (or felt "horror," "rage," etc.) for you while you described what happened to you. I still feel it"

direct client acknowledgement of group or facilitator response

- following your (or the group's) reflection of feeling or perceptual feedback to a client, ensure that the client acknowledges each reflection
- a simple "thank you" will make the connection

while responses are being given to the client, ask the client to look at the person making the comments (facilitate eye contact during the interactions);

- clients will often look downward or away from responder(s) after having described the event during responses
- eye contact facilitates the connection necessary to merge identities during reconstitution of the client's damaged one

touch the client on the arm or shoulder at extraordinarily painful (cathartic) times, but with noted restrictions

- use touch on the shoulder or arm when during or following a description a client is crying to the extent that he or she cannot see the others' (your) responses; eye contact will not suffice as an integrator because the catharsis precludes the connection (temporarily interrupts vision)
- the light touch lets the client know, as did the eye contact and verbal responses, that he or she is not alone while in this pain
- do not use hugs during the catharsis; stop people from running over to the person who is crying and hugging him or her; such attempts to help can interfere with the client's capability to experience the pain fully, which experience will lead to the etiology's reversal
- save hugs until after steps A-F, the etiology reversal process has been completed (at the end of the group session); they do, then, have considerable value and no interruptive effects

Chapter Sixteen

TRT's 5 Phases Applied to Long Term Combat Trauma

This chapter does not explain how to do Trauma Resolution Therapy. The Etiotropic series have many books that accomplish that process. But this chapter does provide a print out of combat long term trauma as it manifest itself within the structure of TRT.

The third phase of TRT for this veteran references changing attitudes toward people his age and his country. The source of those attitudes are not depicted in the earlier phases of TRT. Those sources are presented in the role plays of trauma victims, including this combatant, participating in the Etiotropic Trauma Management (ETM) Trauma Resolution Therapy (TRT) Training Certification School. The reasons for the source of trauma were protestors and past friends who met the individual on return and blamed him for criminal acts of war (in Vietnam). These reflected changes in thought are consequences of the protest movement.

Example (B1): Combat Trauma -- Five descriptions taken from TRT Phase One (to be applied to TRT Phase Two in the next section)

The following 5 descriptions are taken from the role plays used in the ETM Professional Training School. We draw your attention to example 4. It is actually several episodes couched as one. Incident 4 demonstrates how one continuous exposure to trauma occurring over several days can be recorded into the Phase One format. We have included this otherwise lengthy description because it shows how such experiences are accorded special handling when applied to Phase Two (demonstrated in in the next section).

(1) We were down south on an operation. I think the month was January; but it was hot. I was on a mission that brought a reconnaissance team in that had been out for five days. I was talking to a fellow from the team who I had not seen since boot camp. We were making a peanut butter and jelly sandwich when the sergeant across from me ejected the magazine from a captured Luger. He pointed the gun down and squeezed the trigger. The gun was not clear and he shot another man, who was standing next to me, in the groin. The wounded man began screaming and fell into a cactus plant; he was yelling and cursing. A corpsman was there before I could move. He tried to stop the bleeding. I helped to hold the wounded man down and keep him from rolling in the thorns and sand. When we got his pants down, someone was

yelling that his penis had been partially severed. Blood covered his groin and was pouring onto the sand. The corpsman was saying something about a femur artery. It would not stop bleeding. The corpsman tied his belt around the bleeding man's upper thigh in an attempt to make a tourniquet; someone was yelling to stop the blood flow. The tourniquet was not very effective. In a few minutes the wounded man stopped yelling, then talking or crying; he just lay there.

The sergeant was yelling at everyone and slamming the gun to the ground again and again. He seemed to have gone insane. I think the man who was shot died. I don't know for sure because they carried him to a helicopter which then took him to the *Repose*. The pilot told me later that he thought the man was dead when they got him to the hospital ship. I looked down. Blood was on my shirt, belt, and trousers. I ate the sandwich that I had made. All that I remember is that I felt numb. Everything seemed unreal.

(2) I was on an operation. I think it was early in the year. I remember it wasn't raining constantly anymore and it was getting hotter. We were in a place with a lot of sand. Machinegun fire was coming over the hill and through our position. Everyone ran and jumped into holes, or got behind whatever cover was available. One fellow about thirty feet away sat up on his knees and was yelling about how the fire was coming at us without any visibility from the enemy gunner. He was shouting that the gunner must be about 800 yards away given the trajectory. The fellow was hit in the chest and head. The way he was hit, he must have been dead instantly. Another man was shot in the chest while sitting on top of an Amtrac. He was dead. We carried them to helicopters. I tried not to look at the man shot in the head. The bullet entered where his eye used to be. I also couldn't keep from seeing that the back of his head was gone. One minute he was alive and carrying on. Then he was dead. I felt numb. It seemed unreal.

(3) I went with an officer who was the head of our group to a staff meeting in the same operation that I read about last week. On our way back it was just getting dark and automatic weapon fire was coming over the hill again. The man kept walking through it. I walked up higher on the hill and parallel to him so that he would be shielded and not killed. I could hear the incoming as it went past us. The whole time I was walking in the open I kept expecting the next bullet to hit me in the right side of my head and then I wouldn't have a left side anymore. I also kept seeing the fellow who had been shot in the eye. I had to force myself to keep walking. I wanted to lay down and hide. I felt fear. I was scared.

(4) In March, the NVA (North Vietnamese Army personnel) shot down a helicopter that was extracting a recon team. We carried a company (of Marines) into the area. About 20 helicopters carried the first part of the company. We circled the enemy unit. I heard the pilot say over the intercom that four helicopters were down. We landed and picked up one of the crews. I felt fear and vulnerable. We were exposed and I thought we were very open; while we were in the air, we were easy to shoot. I was shaking so badly that I couldn't talk to tell others where the fire (NVA automatic weapons firing) was coming from. I was embarrassed. Shooting the 60 (M60 machinegun) gave me courage. Until then, I wasn't sure that I could function; I kept telling myself that I could do my job when it got bad. The North Vietnamese were there in battalion strength. We loaded and landed a battalion to match theirs. The flights took us most of the day. We carried people and ammunition to several zones in the area. During a strike in the morning, and then again in the afternoon, I always thought the jets that were coming down over us were going to hit us. I remember that they were going so fast and diving so low, and sometimes even beneath us, that I wondered how they missed smashing into the ground. They were shooting. We were shooting. Everyone on the ground was shooting too. Once the battalion was completely in, the Vietnamese showed a division. When we went back in, they came out of caves and tunnels. They were shooting at us with automatic and antiaircraft weapons. We kept flying up and down the hills, then turning back around and going back through the zone. I shot at flashes of fire. We were going up and down so fast and so low to the ground that I became airsick. I started throwing up. I tried to shoot NVA, but they kept coming up behind and sometimes inside of our perimeters and positions. I was scared that I would shoot the wrong people. I also felt embarrassed and ashamed that I had thrown up.

On the second day of the operation I flew port gunner on three missions. On the first mission, we stayed aloft and overhead while another helicopter went in and picked up four wounded Marines. When they lifted off, we went in and picked up seven more. Three of the men were wounded in either the chest, arms, neck, or head. When they got on board, I felt detached; I just looked at them, and then looked away when I could. The other four men were carried on board by their buddies. Two Marines had fragmentation wounds in the chest. A third had lost the lower part of his leg. The fourth man had been shot in the leg twice. The bone was broken and sticking out of the bandage. The man was screaming. Then he stopped. Most of the wounded lay on the floor, except for one guy who sat against the side of the helicopter. I was afraid we were carrying too many people and that we couldn't get up, off the ground. We started taking fire and we left. No one was hit. We flew back to the base. On the way the tourniquet came off the man's partial leg and it started bleeding again; I tied the

tourniquet back on. The corpsman was on the other 34 (helicopter) and I didn't know what I was doing. Neither could I believe that I was looking at the end of where this man's leg was supposed to be. I kept telling myself to do the job that was expected of me. I stopped the bleeding. My biggest fear was that I wasn't trained well enough to help this person properly. Everybody was in shock including me.

On the next flight, we went in and the other helicopter stayed up. This time, the corpsman rode with us. We took four people; all of them were wounded in the upper portion of their body. The corpsman told me how to keep pressure on wounds to stop the flow of blood. I never worked in the medical field before this and I couldn't remember what boot camp had taught me about wounds. My fear for myself, though, was not as great any more; I began to be more concerned for the other people than just myself and my inabilities. I felt desperate to be better at what I was doing.

On the third mission we dropped ammunition at another spot first and then went into a landing zone to pick up wounded. We had yellow smoke and the zone was supposed to be secured. The clearing was very small. A hill with heavy foliage went straight up from the clearing's perimeter. As we were loading three Marines, we began taking fire from about 3/4 the way up the hill. NVA were shooting down on us and through the floor. The plane was damaged and wouldn't get up, so we unloaded the wounded back to their defensive positions. Two of the wounded men were hit again; one in the hip and the other in the wrist. The man shot in the hip was knocked down hard. The other man's hand dangled and the blood pumped out. Someone grabbed him and then laid down next to him and held the wrist to stop the blood. The crew chief fired up the hill the whole time. Our copilot was hit in the neck and chest. The crew chief took him down and was trying to stop the bleeding. I felt terrified. I fired on the position up the hill with the chief's gun until the chase bird landed. There were explosions on the hill, I think from rockets fired from a jet; maybe they came from artillery. This time I saw the jet and it hit the hill again. The jet was so close I thought the rockets were going to hit us. The incoming stopped. We loaded the wounded lieutenant, pilot, crew chief, and the three wounded men. I didn't think we could get off the ground. The pilot and crew chief fought to save the lieutenant's life. He was alive at C Med. I was exhausted and can remember no feelings except that after the rockets had hit the position, I was afraid that I was going to cry. They told me the lieutenant was sent to Da Nang.

The North Vietnamese disappeared the next morning. I was told that in the two days they killed 206 of us, mostly grunts, and that we had killed over 2000 of them. I was glad that I was alive. I was glad the others were alive too. I also remember being

grateful to the person who was flying that plane; I never met him. I cannot describe my feelings for the dead Marines. I just felt sad for them; my feelings are beyond description. I felt stunned and numb. I think this numbness lasted for several days. I remember that when I walked or got around other people, I felt detached and sometimes as if I were operating in slow motion. I began to feel separate from everything. I don't know for sure, but when I went back to the base, I think that those people looked at me differently too. Even though I was with other people for these days, I began to feel different and alone.

(5) This was the operation up north. I was sleeping on a cot in a tent set up for us to rest. The operation was over and we were supposed to go back to the base the next day. At 3:00 in the morning, an explosion went off and I was going, I think blown, through the air and across the tent, landing in the mud; we were in a partially drained rice paddy. A burst of light accompanied the explosion; but when I landed it was dark and I couldn't see anything. I thought I was dead or dying. I thought my body was gone; I couldn't feel anything. When I realized I was alive, my thought was that I couldn't find my rifle. I knew I would be dead if I didn't get it. At first I was too scared to move. I felt terror and horror; the feelings paralyzed me, making me immobile. I talked to myself silently and made my fingers dig into the mud so that I could pull myself through it. I had to find my rifle. There were many explosions and much shooting. Then they were shooting down on us. A flare went off and I saw another man next to me. He was a lieutenant. He was new. He had pushed his head down into the mud and water and was only 6 inches from my face. Then, with the aid of the light from a flare, I saw my rifle in the mud and crawled to where it lay. When I got it into my hands, I wasn't paralyzed any more. There were no holes that I could get into, so I crawled to the front of the tent so that I could kill anyone trying to run through it. There were lots of figures running very fast through the dark. I started to, but did not shoot; I could hear some yelling -- the people screaming were ours. One man was running along the top of the dike; I almost shot him, but then the light from the tracers and flashes and other explosions showed that he wore a flak jacket and helmet. He ran right into the middle of tracers, stood their for a second, and began yelling orders: <169>Kill them goddammit.-- This thing lasted about thirty minutes, before it became quiet. The men on the line, about 10 yards away, killed them all.

Apparently, a platoon had tried to run through our line, to overrun and take our position.

The dead bodies in the morning looked like manikins. I can't remember how many VC there were. They were shot many times. The impact of the bullets tore their bodies apart. We left them on the ground throughout the early morning hours until they were removed by a group of villagers. The villagers tied the dead mens' hands together at one end of a pole. Their feet were then tied to the other end. Two men hoisted each end of a pole onto their shoulders and then carried the bodies away, the dead Vietnameses' heads being partially blown away and dangling, hanging upside down like animals shot in a hunt.

I discovered that the Vietnamese had crawled to our perimeter, about 10 yards away, and had laid a grenade next to a Marine who was asleep. The grenade had gone off at the same time with the others. This one blew half the man's waist, shoulders, and a portion of his head from his body. Another man was shot, I was told, in the chest, stomach and side of his head -- I didn't see him. A third Marine was shot in the center and top of his head. Another man and I carried the corporal's body to the helicopter. On the way, part of his body fell out of the poncho. We stopped and didn't know what to do. Then I looked down into his brain and I couldn't talk. I sat on my knees and stared at him. I remember feeling fuzzy, as if my mind was swimming. I asked myself what happened to God when people lost the part of themselves that allowed them to think of such things.

When I returned from the helicopter, no one talked about what had happened. At least they weren't talking to me. The entire experience seemed unreal and I do not know what words could describe what it was like. I felt stunned and dazed. When I looked back at where I crawled during the attack, I saw unexploded NVA grenades laying in the mud around the area where I had been. It was unbelievable to me that the other

men were killed, that these grenades had not gone off, and that I, or that lieutenant, or anyone else, was alive. I felt numb and stunned by the attack, concussion, and the deaths.

We went to a memorial service for the dead Marines on Sunday.

Example (B2): Combat Trauma -- Applying the 5 Episodes taken from TRT Phase One to TRT Phase Two

There are three purposes underlying our use of the combat examples. They are explained here before showing the examples; but with the preface that (ETM Strategic / Crisis Management and Managers) addresses the same subject in detail.

First, combat personnel are crisis managers. Crisis managers are affected differently from all other trauma victims; crisis managers are comprised of two kinds of existential identity -- personal and professional. The trauma that they experience usually occurs as an interruption to personal identity, and even though there is no intrusion or contradiction to those values, beliefs, images and realities comprising professional identity.

For example, death and personal injury are expected aspects of the job function; thus, professional training provides a set of values, beliefs, images and realities that can accommodate those aspects of the job. When extraordinary events occur, the internal psychic damage is to the personal identity, and frequently unbeknownst to conscious psychology. Consequently, when applying into Phase Two trauma experienced by crisis managers, we ask that they record (emphasize in their deliberations) into column three contradictions to *personal* identity. Therefore, when you read this Matrix (example of a combat application), you may be saying to yourself, "This is combat; where is the person's professional self?" The answer is that it does exist, but it is not emphasized, at least in this phase of TRT.

Second, combat provides the means of describing how exposure to much carnage affects the reality system. In this example we emphasized those effects as they are a part of the professional address of some kinds of psychological trauma.

Third, in some instances an incident (4) is lengthy and complex -- there are many traumatic episodes occurring within the incident. This example shows how to apply such complex experiences to Phase Two.

The TRT Phase One combat incidents are applied to the TRT Phase Two "Matrix."

TRT Phase Two (The Matrix) Example: Combat Trauma

Summary of the Trauma-Causing Event	**Summary of Feelings/ Emotional States**	**Values, Beliefs, Images and Realities Contradicted by the Episode**	**Losses Resulting from the Contradictions to Values, Beliefs, Images and Realities**	**Thoughts and Behaviors Occurring as Survival Responses to the Event**
1 This was the accident where the man was shot in the groin	Numb and unreal. Shock, horror, anger, and sadness	My values were that people would not be hurt, much less mutilated or killed. I believed the sergeant should have been more careful and cleared the gun properly. Reality -- the man's blood was supposed to be in his body. Not on me and in the sand. His penis was not supposed to be injured	I lost a sense of safety and security. I lost my belief in how life should go on uninterrupted. I lost respect and trust in other people. I lost my belief in my partners -- despite the problems with the enemy, my own buddies might kill me by accident. I lost a member of the group	I continued eating my sandwich. I asked myself if there were anything wrong with me because I was eating with blood on my hands, arms, and clothes. I became paranoid and relied only on myself. I watched everyone so that they didn't accidently shoot me or anyone else. I constantly stayed

				on guard
2 One man was shot in the eye. Another in the chest. Incoming over the hill	Numb and unreal. Disbelief,, shock,, horror,, hurt,, and sadness	Even though this was war,, a part of me believed people shouldn't kill each other. Reality: The man should not have been killed. His eye should have been intact. The back of his head should have been together. The other man's chest and back should not have been torn apart. He should have been alive	I lost a sense of safety and security. I lost the belief in the continuity of life. I lost the belief in the meaning of life. I lost the belief that living or dying was anything but a random event. I began to lose my belief that there was a God	I dug deeper the holes that I used for cover and sleeping. I withdrew from others. I didn't talk about it with anyone; it was just part of my job -- combat and war. I blamed the men who were killed for not being careful enough.
3 Walking during incoming	Fear. Relief when it was over	I believed we should have taken cover	I lost safety and security., I kept doing my job	I also began to believe that I was going to be killed regardless of how hard I tried to do the job right. I began to wonder why I was alive and others were dead. I kept remembering the one man who was shot in the eye and I didn't want to be killed that way. I tried to put it out of my mind
4a This was the first day of a 2 day operation. I got airsick	Excitement, much fear, embarrass- ment and shame	I believed I wasn't supposed to throw up while I was needed. I should have been more dependable	I lost self-esteem, self-worth, and self-respect. I also lost safety, security and control.	My responses were that I did my job despite my fear and throwing up. I thought again that life or death was a random event; there was no meaning to life.

				There was no credibility to the concept of destiny
4b Same operation. We picked up wounded	Fear, shock and horror. Concern for the men and desperation to save them	I believed people shouldn't try to kill people who were wounded. Reality: the man's hand was supposed to be attached totally to his arm. His blood was not supposed to be pumping out of his body. People should not be disfigured or have their bodies mutilated	I lost understanding about life. I lost my belief in the continuity of body functions. I lost my belief in the continuity of life. I lost any sense of importance as an individual or sense of meaning to life	I did my job. I stopped the man's leg from bleeding. I began to think how glad I was that I had not lost my leg or hand. I began to wonder at times when I looked at my leg and hand why they were still there and others no longer had theirs.
4c The copilot was wounded	Terror. Intensely scared, concerned for him. Anger and rage. Relief and glad for the air support. Glad when the lieutenant lived	My beliefs were that people I knew should not be shot. I believed, even though I was trained differently, that people should not kill each other. I believed our helicopter could get us out of there.	I lost a sense of safety or control over whether I lived or died	I tried to stay alive and kill NVA. I helped with the wounded and the lieutenant. I told no one. I tried harder at being very good at my job. A part of me withdrew from others. I couldn't and didn't talk to anyone about the experience.
5a Up North. Several Marines and enemy were killed. I was almost	Stunned, dazed, and terrified. Rage at the enemy. Hurt from my near death from the explosion	I had believed that I was safer than I really was. I was supposed to be able to control whether I lived or died.	I lost self-esteem,, self-worth,, and me. I lost belief in the continuity of any life. I lost belief in the purpose of life. I lost belief	I walked around dazed. I tried to be tough and show that I could do my job and that I was unaffected. I tried to understand carnage. I decided

killed			in the prospect of my life going forward.	that dead is dead and life is life. I tried to not care as much about people in general.
5b Same incident. I observed carnage.	Unreal. I felt dazed,, sick, sad, nauseous, and separate. I felt sadness and loss for the man I carried because he was another human being and he was dead	Reality: People's bodies were supposed to be intact -- not torn apart,, mutilated, or disfigured. People deserved to be treated as humans when dead. I believed that anyone who had children, like the man who I carried, should not be killed. He should have gone home alive to his children.	I lost myself, safety, those men, the belief in the sanctity of life and belief that there was any meaning to life	I didn't talk to anyone about it, except the Chaplain. He said he did not understand it either. I wanted the dead man's children and wife to be OK. I could not understand why he was dead when so many needed him and no one needed me; and I was alive.

TRT Phase Three Application Example (B3): Combat Trauma

This section provides an example of TRT Phase Three's application to Trauma It is a continuation of the combat examples presented in TRT Phases One and Two.

Phase Three written instructions: Copy survival responses from Column 5 of the TRT Phase Two (Matrix) and apply to this page using the TRT Phase Three format. Remember to leave considerable space as margin on the right side of the page. You will use this space later in compiling the TRT Phase Four Worksheet.

TRT Phase Three: Combat

I became extremely paranoid and afraid of everyone.
I believed I might be killed even by accident.

I watched everyone so that they wouldn't shoot me.
I constantly stayed on guard. I dug deeper holes.
I withdrew from others.
I didn't talk about the deaths.
I believed intensely that it was just part of the job.
I blamed the men who were killed.
I kept doing my job even though I could have been killed.
I talked only with the chaplain. Then stopped talking with him.
I learned to be tough and act as if the damage was no big deal.
I began to believe I was above it all.
I quit caring about people.
I withdrew from everyone and didn't talk with anyone about what was really happening to me. I quit believing in God and decided life had no meaning.
I hated the NVN and wanted to kill them.

- I began to play like I was invincible and reflected to everyone that I was very strong and afraid of nothing.

I did my job in spite of throwing up and in spite of my fear.
I believed more intensely that life was a random event and that God did not exist.
I believed there was no reality to concepts of destiny or future.
I decided God was a fabrication to protect other people against the reality of what I was experiencing.
I did my job and decided life would only be a short term experience.
I tried my best to kill the NVA.
I helped the wounded as it was the only thing
I could do other than kill the NVA.
I became more intense at doing my job so that I could stay alive.
I began to believe that war and killing were natural.
I took pride in my ability to keep others alive.
I ignored the hurt.
I became obsessed with doing my job properly and hoped that would keep me alive.
I was amazed that my body still functioned and at times I could not believe that it was even still there.
I believed nothing mattered.
I wondered what my brain blown apart and laying on the ground would look like.

Chapter Sixteen: TRT's 5 Phases Applied to Long Term Combat Trauma

I thought I was going insane.
I began to show no courage and acted like a coward.
I wondered if my own stomach would be opened up and left in the dirt.
I began to hate my friends (at home).
I began to hate my Country that before I loved the
same as God and my family.
I withdrew from all people because I believed I was
not like any of them and that something was wrong with me.
I began to see myself as less than an animal.
I cried alone.
The way I changed was that:
At first, I remember being afraid to drive through an intersection
at home, -- I wondered where automatic weapons would
be placed for an ambush.
In my first relationship with a woman, although a part of me loved her,
I had to leave as I didn't know how to make a long-term commitment.
I no longer knew what long-term meant and had no concept of being
able to live an extended future.
I tried to avoid anything that resembled permanence.
Something always seemed to be missing for me and
I felt constantly different.
I started wondering what normal people looked like and
why I was such a crazy person as to have put myself into the conflict.
I started thinking, with the help of others that I had not
served because I cared about my Country, but because there was
something wrong with me and I loved violence.
I began to believe I must be a distorted and evil person inside.
I felt like a pin ball bouncing around between partial relationships
and different geographical places.
I had a yearning to go back to Vietnam and retake the area in
which I had fought and others had died.
My greatest regret was that Ho Chi Men died before I could kill him.
I withdrew from anyone who looked my age.
The only people with whom I felt the slightest identification were
the older generation that had fought through World War II.
I isolated myself further from the society and poured myself into
my job whatever it was.
Later, my ability to do my job began to fall apart as I
found myself being stuck.

Even though I sought help for relationship problems in my first marriage,
I could not do the things the other couples seemed to be doing.
Real caring and love were no longer in my vocabulary and
impossible to either give or receive.
I became a devout atheist -- all the while I felt that something was deeply wrong.
The most hurting thing that I did was decide that I would
never fight for my country again, even if it was dying.

Phase Four Worksheet and 2nd Matrix Examples
For Combat Trauma

TRT Phase Four Application Example (B4):
Combat Trauma

This section provides an example of TRT Phase Four's application to trauma This example continues the combat examples presented in TRT Phases One, Two and Three.

TRT Phase Four Worksheet Example: Combat Trauma --
Delineate Survival Responses from Phase Three by Category

Survival
Responses
Category Number

I became extremely paranoid and afraid of everyone. (1)
I believed I might be killed even by accident. (2)
I watched everyone so that they wouldn't shoot me. (1)
I constantly stayed on guard. (1)
I dug deeper holes. (1)
I withdrew from others. (3)
I didn't talk about the deaths. (4)
I believed intensely that it was just part of the job. (5)
I blamed the men who were killed. (6)
I kept doing my job even though I could have been killed.
(5)
I talked only with the chaplain. Then stopped talking with him.
(3)(4)

I learned to be tough and act as if the damage was no big deal.
(7)
I began to believe I was above it all. (7)
I quit caring about people. (8)
I withdrew from everyone and didn't talk with anyone
about what was really happening to me.
(3)(4)
I quit believing in God and decided life had no meaning
(9)
I hated the NVN and wanted to kill them.
(5)(7)
I began to play like I was invincible and reflected to
everyone that I was very strong and afraid of nothing
(7)
I did my job in spite of throwing up and in spite of my fear.
(5)
I believed more intensely that life was a random
event and that God did not exist. (9)
I believed there was no reality to concepts of destiny or future.
(9)
I decided God was a fabrication to protect other people
against the reality of what I was experiencing.
(9)
I did my job and decided life would only be a short term experience.
(5)
I tried my best to kill the NVA.
(5)(7)
I became more intense at doing my job so that I could stay alive.
(5)
I began to believe that war and killing were natural.
(5)
I helped the wounded as it was the only thing
I could do other than kill the NVA. (5)
I took pride in my ability to keep others alive.
(5)
I ignored the hurt. (7)
I became obsessed with doing my job properly and
hoped that would keep me alive.
(5)

I was amazed that my body still functioned and at times
I could not believe that it was even still there.
(10)
I believed nothing mattered.
(9)
I wondered what my brain blown apart and laying on the
ground would look like.
(10)
I thought I was going insane.
(10)
I began to show no courage and acted like a coward.
(11)
I wondered if my own stomach would be opened up and left in the dirt.
(10)
I began to hate my friends who were at home.
(12)(3)
I began to hate my Country that before I loved the
same as God and my family.
(12)(3)
I withdrew from all people because I believed I was
not like any of them and that something was wrong with
me. (3)(10)
I began to see myself as less than an animal.
(13)
I cried alone.
(3)
The way I changed was that:
At first, I remember being afraid to drive through an intersection
at home, -- I wondered where automatic weapons would
be placed for an ambush.
(1)
In my first relationship with a woman, although a part of me loved her,
I had to leave as I didn't know how to make a long-term
commitment. (3)
I no longer knew what long-term meant and had no concept of being
able to live an extended future.
(1)(2)
I tried to avoid anything that resembled

permanence. (3)
Something always seemed to be missing for me and
I felt constantly different.
(10)
I started wondering what normal people looked like and
why I was such a crazy person as to have put myself into the
conflict. (10)(14)
I started thinking, with the help of others that I had not
served because I cared about my Country, but because there was
something wrong with me and I loved violence.
(10)(14)
I began to believe I must be a distorted and evil person inside.
(10)(14)
I felt like a pin ball bouncing around between partial relationships
and different geographical
places. (3)
I had a yearning to go back to Vietnam and retake the area in
which I had fought and others had died.
(5)(7)
My greatest regret was that Ho Chi Men died before I could kill
him. (7)
I withdrew from anyone who looked my
age. (3)
The only people with whom I felt the slightest identification were the
older generation that had fought through World War
II. (8)
I isolated myself further from the society and poured myself
into my job whatever it was.
(3)(5)
Later, my ability to do my job began to fall apart
as I found myself being stuck.
(3)(5)
Even though I sought help for relationship problems in my first marriage,
I could not do the things the other couples seemed to be
doing. (3)
Real caring and love were no longer in my vocabulary
and impossible to either give or
receive. (8)
I became a devout atheist all the while I felt that something

was deeply wrong.
(9)(10)
The most hurting thing that I did was decide that I would never fight for my country again, even if it was dying. (12)

TRT Phase Four (The Second Matrix) Example (B4): Combat Trauma

Consolidated Description of Survival Responses	**Contradicted Values, Belief, Images and Realities**	**Losses Resulting from the Contradictions**
I became paranoid.	In my life prior to this experience, I was not afraid. I didn't believe that I should act so distrusting of everything and everyone around me.	My losses were of social involvement and openness. I also lost trust in my own perceptions of myself and others.
I believed I might be killed even by accident. I constantly stayed on guard.	I believed that people should not always be so defended or have to be so worried. I thought that in some place I should be safe.	I lost freedom to live. I also lost the experience of peace, quiet, and security in my life. I lost the belief that I could live without almost being killed.
I became isolated as I withdrew from others.	Before, I enjoyed relationships with my friends. I believed in being a part of others lives and they being a part of mine.	My losses were of esteem, self-worth, trust in myself, and a wider and more open view of life.
I didn't talk about what was really happening to me.	My values were that I liked to discuss whatever was important to me.	I lost companionship, the ability to express myself and confidence in me as a person.
I became obsessed with doing my job properly. This kept	My values were that I should complete my responsibilities well. But I also did not believe that I	I lost the ability to do other things such as socializing, reading, studying and enjoying the fun aspects of life. I lost my perspective of my own limits and an understanding of the reality

me alive at first.	should do my work to the exclusion of the rest of my life.	of my capacity to achieve certain kinds of goals. I lost myself through that obsessive attempt to accomplish things that were outside of me. I actually was always working to cover over what I did not know was inside.
I began to blame other people. I acted tough and as if I were invincible.	My values were that others shouldn't be hurt -- that I shouldn't hurt them. I was a regular and normal human being.	I lost a realistic image of myself and human qualities of humility and the ability to be humble.
I quit caring about people.	My values were that I should care for others.	I lost the ability to give and receive love.
I quit believing in God and decided life had no meaning.	My values and beliefs before this experience were that God cared about my life and others' lives.	I lost my love for one of the most important relationships in my life. I lost trust in any concept of spirituality.
I confused my physical body functions and components with those of others who were being mutilated.	I previously accepted those physical aspects of people as always functional and saw my own physical self as remaining intact.	I lost sanity; separateness from the carnage. I became over-run -whelmed with the prospects of my own destruction.
I gave up my country.	From the time I was a child three things made up the most important aspects of my life: my family, God and America. I believed that I should defend her with my life.	I lost my country.
I began to think of myself as lower than an animal.	At one time I believed I had value as a human being.	I lost self-esteem, self-worth, self-respect, the ability to relate, the ability to care, the ability to be a person, and the ability to be me.
I began to act like a coward.	I believed I should have courage.	I lost self-esteem, worth and respect. I lost me because I thought my courage was all that I had.
I blamed myself.	I shouldn't have been hurt	I lost self-respect and my reality.

	further.	

Introduction: TRT Phase Five

Phases 1 thru 4 resolve the trauma resulting from a particular source. Phase Five summarizes the resolution experience and provides for the therapeutic exit.

TRT Phase Five: Application

Two summaries, "A" and "B," comprise Phase Five. "A" summarizes the losses identified, experienced, and expressed in Phases Two and Four into 3 stratifications: different dimensions of being and interaction. These stratification delineations show how the trauma affected individual, relationship and multiple relationship (usually family) processes. Summary "B" overviews the learning aspects of the resolution process.

Application of TRT Phase Five (A)

Writing

The client uses the form provided by the combat example in this subsection. The purpose of the form is to summarize the patterns of psychological trauma, emphasizing the losses as they occurred over intrapsychic, interactional and systemic stratifications.

This process is fairly simple. Copy from Phases Two and Four the losses, without duplication, into their respective format.

Losses directly resulting from contradictions created by the initial trauma-causing event are placed in three columns at the top half of the form. Losses resulting from contradictions created by survival response are placed in the lower half of the page.

The only judgment, that is, evaluation process, involves the delineation of the losses into the 3 stratifications: intrapsychic (pertaining to individual experience only), interpsychic or interactional (pertaining to a particular relationship) and systemic

(pertaining to a combination of relationships, usually referring to a family). An example of how to complete the written component of TRT Phase Five (A) is provided below.

Example (B5a): Combat Trauma TRT Phase Five (A)

My combat experience contradicted my personal values and beliefs and resulted in:

Individual Losses of	**Relationship Losses of**	**Family Losses of**
Self-esteem	Trust of others	Love of my country
Self-worth	Respect of friends	The Nation
Self-respect	Belief in God	my country as a
A meaning to life	Trust in God	role model
Security	Love of God	Understanding of
Safety		my part within my
Continuity of life		country
Continuity of		My country
body functions -		Hope for the Nation.
Physical reality		
My own and separate		
identity from those		
who were killed		
Hope for myself		

Survival responses that contradicted my values and beliefs resulted in:

Individual Losses of	**Relationship Losses of**	**Family Losses of**
Trust in Myself	Openness	Socialization
Peace Quiet	Trust in my	A wider view of life
Security	perspective of	Confidence in my- self with others
Self-esteem	others	The ability to have
Self-worth	Freedom to live	fun with others
Myself	free from fear of	Relationship with
An understanding	being killed	my wife and the
of my limits and	Companionship	other family
	The ability to relate	members

capacity to achieve certain goals
A realistic image of myself
Humility
Sanity

The ability to express myself
The ability to love
Trust in any concept of spirituality
Separateness from the carnage
The abilities to relate, care and be

My relationship with my country

Reading and Facilitating TRT Phase Five (A)

When the written component is completed, the client notifies the TRT Counselor accordingly and a specific time is arranged to share the written exercise with group members. The reading process is completed in 20 to 30 minutes. Feedbacking guidelines remain the same; but few interruptions occur.

Application of TRT Phase Five (B)

Writing

TRT Phase Five (B) is an exercise in creative writing for the group participants, including the person completing Five (B). Each individual, including the exiting participant, is asked to prepare a written description of the person who is the focus of the exercise. At least 24 hours notice is required to provide for this creative endeavor. Most people are accorded 1 to 2 weeks notice before a Phase 5(B) is to occur.

The 5(B) writing has a special purpose; describe the individual who existed before the trauma occurred and who has been with the group throughout the experience. This writing becomes a representation of the writer's view of the ontology of the individual.

To provide this description, many people use poetry, selected prose from creative literature, or even song.

Reading and Facilitating TRT Phase Five (B)

No one (group member) misses a TRT Phase Five (B) reading. It is a fun, meaningful, joyous, and culminating event. The group member's decide who reads first. Then they

each share their descriptions with the individual. The letters never include confrontational interpretations of personality characteristics. Each person's writing is usually acknowledged by the participant with a hug. When the group members have completed sharing their perceptions of the person, the portrait is provided by that individual. Feedback processes are spontaneous and caring and love for the person lead the day. Everybody loves TRT Phase Five (B).

An example of Five (B) is provided in this section. This is the completion of the combat example. The reader will notice that the name "Ray" has been applied to the character. "Ray" is the name given to the example when it is used for role play purposes in the ETM School.

Example (B5b): Combat Trauma

Dear Ray,

I have shared with you much of your experience in Vietnam. I saw you living in hurt and not knowing that it was still happening to you. What I came to realize most about you was that the things you said that you decided that you hated, your country and your God, you truly loved all along. I also discovered that when you tried to stop other people from feeling their hurt by telling them how to protect themselves, you were not only trying to prevent your own pain from being discovered, but also caring about them. I also know that you have cared about me. So probably the most valuable trait that I have come to love about you is that you do care, not just about yourself, but about the things that you believe in and people with whom you become involved. I want you to know that because you are like you are, you've helped me to re-establish my faith in my own ability to care about others. I am glad that I have known you and I love you.

A group member

Dear Ray,

When you began TRT, you really made it rough on me. But even during that fairly difficult beginning, I felt from you something that made me like you. I liked your strength and your energy. I admired the way that you embraced the things that you believed in, even when your beliefs were interrupting what I and the others were trying to do. I liked the way you also tried to help the men who were hurt in Vietnam. It showed me that even though you were terrified you cared enough about others to risk your life. Another part of your caring was reflected in the way you risked becoming involved with all of us. That willingness of yours to reach out to others is

probably what I like most of all about you. I care about you and am extremely appreciative of having been able to know you.

A group member

Dear Ray,

I admire your courage most of all. I think the way you survived by being alone in your pain for so many years, when no one could hear or understand it, is an example of the same kind of strength you displayed in the war in which you fought. I know that you used that strength to fight the feelings of self pity that came from your grief. I realize that you had no choice but to rely upon that strength because no one knew how to share your pain with you. Even though that part of you who provided the ability to survive didn't always help you as you needed, I think the job that it did do was a job well done. I admire you for your strength in being able to resolve something that to me was terrifying and horrible. I also appreciate the caring that you gave to me and the rest of the people in this country.

I love you.

A group member

Dear Ray,

I love you. For me to write this to you is very difficult, because what keeps coming through my fingertips is what I would like to say to the other guys who were there too. I'm sorry you were hurt. I'm not really sad just because the experience of fighting was difficult for you. I'm sad because there was no way for you to have been cared for once you had returned. I'm sad too that you had to rely just upon yourself when you returned and that you had so little strength to draw from. But that brings up one of the strengths that I admire about you. I think that you have lots of courage. The way that you tried to help your buddies even when you thought you might die is one example of that courage. Another is the way that you fought and gave everything that you had to your job when you didn't think you had anymore. I'm also proud of you just because you went to Vietnam. I think the way you tried to survive when you returned was exactly what you needed to do at the time. It wasn't your place to give yourself your own appreciation and respect for what you did. And it wasn't your responsibility to have to defend what you were being asked and told to do. Through your own internal strengths you still did those things anyway.

Chapter Sixteen: TRT's 5 Phases Applied to Long Term Combat Trauma

I admire you because, not only did you have the courage to fight each battle, but you also stood alone and without support for years after you had returned. Most of all what I like about you, is the way that you cared about your country and those things that you thought were most valuable to your people.

I care about you and I love you. Thanks for letting me know you.

A group member and Vietnam veteran

To myself,

What I saw about myself was that before the trauma occurred, I believed in things. I believed that love was important. I thought there was meaning to life and that human beings were valuable. I believed in God, the concept of basic individual human rights, and what we as a group of people were doing.

When I fought I thought that we had said that what we were fighting was the antithesis of those beliefs. I thought as a group we had decided that these values were being severely threatened and that it was better to defend our way of existence while defense was still possible.

I also loved the children who lived in the village where I stayed. I liked those Vietnamese too who shared my interest in individual freedom. I cared about them because we were all saying that we wanted the same thing. They cared enough about it to risk dying for it and so did I.

Those are the things that I cared about. They were lost, not because of the trauma or its affects upon me, but because when I returned, no one cared. I started losing myself after that, but I kept fighting to see if I could get that me back from somewhere. I remember saying once that I would never again fight to defend this country, its values, or its ideals. I said that even if it meant its destruction and the death of its own citizens on its own soil, that I would never care about the people or this country again, and even if it meant the loss of my own freedom. I remember also that just after saying those things, that I felt as if I had been divided into two people. My saying those things hurt so badly that I immediately knew that I could not continue to live like that. I knew somewhere inside of me that I would care again and that I would do what my country needed me to do, or else I would break apart -- die.

I don't think I have a lot of courage. I mostly think I'm a person who feels strongly about what he believes in. And I like that about myself. I think the way I withdrew and protected myself and all the other things I did after the trauma were now pretty natural and probably what many people would do in the same situation. I appreciate this group and all that it has given to me. So I think maybe I've begun to learn how to love again. So I love all of you. I also think TRT is a miracle, and I appreciate you counselors, for thinking it up and then talking me into getting involved in it.

In that I'm at the end of TRT, I'm going to leave soon; however, I'm going to stay until next month so that I can help Sharon with her 5th Phase. I'm going to start my goodbyes to you now. Thank you again for listening to me and caring about me.

I love you all,

Ray

The descriptions of the TRT Combat examples depicting how to apply TRT Phases One through Five to combat episodes have been provided to the ETM School and to this book, now this web site, in memory of

Raymond C. Nora; USMC Private First Class
Killed in Action; Vietnam; May 18, 1968
and
William J. Goodsell; Major USMC
Killed in Action; Vietnam; June 16, 1966

Concluding TRT

At the end of TRT, clients will look back on the resolution process and report learning, that is, they will report that they know and understand:

1. Who they were before the traumas occurred.
2. Exactly what happened to them because of the events.
3. The difference between what they had to do to survive and who they were/are (as people).
4. Who they are now that the traumas have been resolved.

These learning experiences then provide the basic criteria for determining if resolution has occurred.

About ETM / Theory / **Measuring Trauma Resolution** (in the ETM Tutorial) presents specific guidelines for making this determination. The person exits TRT for this source of trauma. If another source of trauma exists, the patient will likely discontinue therapy for a while, months or even a year or two; the client will, as a rule, then elect to apply TRT to the other source of trauma.

Appendix A

The Iraq War Clinician Guide, 2nd Edition

By **National Center for Post-Traumatic Stress Disorder**, Department of Veterans Affairs

This planning by the VA rates an A+ for its desire, organizational goals of pre empting PTSD and thoroughness. Regrettably, the entire operation is Nosotropically based. Thus, not only can there be no real strategic benefits against guerrilla and terrorist applications, which is not a goal anyway, but they can't intercede on PTSD effectively as they would like. Furthermore, because Nosotropic models focus primarily on symptoms, depending on the denomination as in Behavioral, Cognitive Behavioral, or unstructured Psychodynamic, the trauma's etiology will not be addressed and live on to cause symptoms for the patient's life. Band-Aids will wear out as does the desire to keep replacing them. Eventually, the Nosotropic administrator, untrained in TRT's Etiotropically based model that extinguishes etiology first, thus ending symptoms, will conclude there must be something amiss during childhood or other pre existing trauma conditions.

The program places PTSD diagnostic tools at all of the mental health operations' segments. There are 5. Screens separate out prospective PTSD and its stages. The guide also delineates behaviors manifested as a result of combat or pre combat influences. When all is said and done, the evaluation intervention system refers into the huge VA PTSD treatment apparatus for all wars.

To be effective in both strategic and ordinary operations, the Iraq War Clinician Guide, should publish a 3rd Edition based on Etiotropic principles and guidelines found in this book, the Etiotropic Trauma Management (ETM) Trauma Resolution Therapy (TRT) Online Training Certification School and its textbook. The effect would be complete reversal of trauma etiology at early stages. That tactic would activate the powerful system etiology reversal methods that counter trauma implants and their effects administered by terrorists and guerrillas. The action would also have clinical benefits initiating etiology reversal before symptomatologies can be even formed. Remember, the ETM approach does not require the presentment of symptoms to activate the cure. It's application is based on the fact that the contradictions to existential identity did occur, thus forming the basis of trauma

Appendix A:

etiology and the locus of Trauma Resolution Therapy's (TRT's) beginning application.

There is no way to integrate Nosotropic methods with Etiotropic ones absent using the strategic application provided by ETM and only in certain situations. But it is relatively easy to retrain and refit the Nosotropic current organizational model adherents to incorporate the Etiotropic Trauma Management (ETM)™ organizational ordinary (standard) and strategic approaches in lieu of the Nosotropic models.

Appendix B

Authors' Backgrounds and ETM History of Development

My name is Jesse Collins. Nancy Carson is my wife. We began developing ETM in 1979. We are the authors of all ETM materials copyrighted from 1979, 1981 - 2009. I began translating ETM to the (Internet) information system in 1994 in the process developing the online ETM Tutorial (http://etiotropic.com/indextutorial.html).

For health reasons (described at the end of this chapter), Nancy and I are retired from basic ETM clinical and management dissemination activities. I have, however, provided system administration for the Web based technical elements of the **Etiotropic Trauma Management™ (ETM) Trauma Resolution Therapy™ (TRT) Online Training – Certification School**. It is different from this tutorial in that the tutorial is available for free study and reference, and the online program attaches a fee for a full and structured professional facilitated curriculum. It provides database storage and processing of the student's (professional therapist – counselor – other manager) course conferencing discussions, forum, study, testing functions and other indicators of progression.

Chemical Dependency Family Counseling, Vietnam Combat, and Cost Accounting

As described later (an in the preface of this book four), Nancy and I developed ETM and TRT while participating in the chemical dependency profession as counselors, and consultants to and administrators of inpatient and outpatient settings. We were fortunate to train at institutions internationally recognized for their excellences and extraordinary advances in treatment of and social response to virtually all addiction permutations. The advances were particularly noted to include a primary focus on the family. That focus would result in the initiation of both ETM and TRT. In depth descriptions of those initiations and follow throughs are provided in the Professional / Academic / Development sections of the online ETM Tutorial.

There were two more pre development factors. Both pertained to earlier skills and experiences taken from employments unrelated to counseling. In the first, I served a 4

year contract as an enlisted man with the United States Marine Corps. As a PFC, I worked in a combat role in Vietnam between 1965 and 1966. In one assignment, I was part of the first installation of Combined Action Programs. I, with two teams comprised of 4 men each, lived in villages and worked in conjunction with limited (2 man teams) South Vietnamese militia to defend villagers against communist assault, and to support corpsmen as they provided healthcare to those villagers. In a second duty, I participated in many of the jobs attending helicopter operations. Upon returning home, I served the last two years (1967 and 1968) at Camp Pendleton, CA. As pertaining to that job's influences on ETM, I worked as an anti guerrilla warfare training NCO for the 5th Marine Division.

In hindsight, those experiences gave me an affinity for, or capacity to assist, people affected by severe trauma. In addition, the experiences would also later in ETM's system application provide insight into the needs of organizations influenced by battle trauma. Part I of this book and attending crisis management programs were a direct consequence of my combat experiences. Where they relate to a counselor's training or patient's assistance, I'll make them available in limited translation. "Limited" in part means that you cannot learn to administer ETM TRT without completing the ETM Certification Training School / Course. Once completed, however, this book will provide every piece of information necessary to administer ETM TRT as it is applied strategically, in this book's emphasis, to combat, guerrilla warfare, and terrorism.

In the second employment, I worked in the investment banking field. I received academic credentials, a BBA in Accounting and Management, from the University of Texas at Austin. I also earned a Registered Representative (of the NYSE and other financial institutions) license required in stockbroker, financial research (considerably more precise and demanding than psychological research), accounting and corporate finance activities. Like the combat, the accounting specializing in intricate models of Cost and Managerial Accounting had a significant influence on TRT's development. My degree in Accounting and Management was earned from the one of the top 3 accounting schools in the nation, The University of Texas at Austin. These business experiences not only provided one of the academic underpinnings of ETM TRT, but it supported me in expanding our first private practice into a 6 facility Chemical Dependency and Psychological Trauma treatment and management business entities.

Extinction of identity, which is ETM TRT theory of psychological trauma etiology, is a host of traumatic event caused and appearing on the surface to be scrambled contradictions to values, beliefs, images, and other realities. Myriad losses attend the

contradictions, making the whole matter seem indecipherable. Scrignar (1987) stated that this damage was so overwhelming that it overloaded the psychodynamic helping model, making it impossible for clinician and patient to address the destruction. But were it not for the tools available to me and used in corporate finance to address complex cost accounting problems, there would have been no evaluative model from which to identify and clarify the consequences of traumatic events. When that identification – clarification was provided in conjunction with listening to and providing existential and cognitive based therapies through the accounting framework, the solution to Scrignar's 'overload' followed. It dissipated immediately. In listening to hundreds of battering descriptions by spouses of chemically dependent persons and people with other kinds of trauma, the developing trauma consequences accounting model provided a very thorough reconciliation view that facilitated the incremental codification of the etiology and its symptoms. That solution became the basis of resolution in Trauma 'Resolution' Therapy.

I attribute ETM's and TRT's developments primarily to the confluences of chemical dependency and family counseling training and state (Texas) certification, clinical work within the framework of our licensed and fully accredited facilities, accounting for incremental loss, business management and Vietnam combat histories.

From Alcoholism Counseling to Psychological Trauma Professional Leadership

Because alcoholism counselors are usually not looked to for clinical, professional, or academic leadership in the field of psychological trauma, 3 questions pertaining to our background - credentials, and thus ETM's TRT's credibility, merit answers.

How and why did such people, alcoholism and drug abuse counselors:

1. Become involved in the psychological trauma field?
2. Produce a clinical/prevention management model different from that which dominates the psychological trauma discipline?
3. Create an academic curriculum and certification program for the transfer of the ability and authority to use the models by professionals of all disciplines?

Detailed answers may be found at Professional / Academic / Development. The rest of this 'Authors: ETM History' overview summarizes them.

Development Environment - Responsibilities

Beginning in the late 1970's we started (in Texas), with consultation from the Johnson Institute of Minnesota, a family intervention chemical dependency and violence prevention program. It quickly became a clinical treatment process for spouses / family members of alcoholics, alcoholics and other drug addicted people, and eventually anyone afflicted by chemical dependency induced traumatic life experiences.

Having considerable success with these efforts, we opened and managed an additional 5 facilities. Importantly, all were government licensed (the first in the state) or JCAH accredited, which authorities mandated annual detailed audits. They required extensive explanation, definition and rigorous defense by us of theory and methodology as they pertained to client medical / psychological "problems," disorders or illnesses and as treatment progress or not affected by those issues. All phases of care, to include entry, treatment planning, acute and continuing care (the latter lasting no less than 2 years) were monitored for progress by the auditing and licensing processes. Making compliance considerably more complex than other (competing individually - intrapsychically focused) approaches, patient families participated and were charted fully over the entire 2 year period, with each member (to 5 years of age) having his or her own peer group, individual counseling and interactive family group therapy (3 to 4 families per group). For those of you understanding JCAH and government facility licensing requirements, each family member was treated and documented for the full two years as an identified patient. The importance of this fact is that family members and the system were focused upon in terms of the primary issue, which after some time with this complete approach was shown to be the address and need for resolution of psychological trauma resulting from Chemically Dependent Person aberrant drug using behaviors. Following those processes or often in tandem, communications as in marital and family therapy in conjunction with systems strategic therapy, plus such things as the application of psychodramas and art therapy for the smaller children strengthened the family members' capacities to rebuild the dynamics destroyed by the traumatic pathological alcohol using behaviors.

Other factors influenced our efforts. All facilities were multi- disciplined. Subsequently, they were staffed with Social workers, Alcoholism and Drug Abuse Counselors, Psychologists, Psychiatric nurses, Psychiatrists, pastoral counselors and other mental health and medical workers, all licensed in their respective professions. Moreover, these people routinely interacted through our facilities in intervention,

treatment and case management circumstances with the courts, probation departments, children protective services, police (including domestic violence units), family service centers, correction, and parole administration elements of our communities. And even though TRT functioned in some regard antithetically to the Twelve Step Program of and initiated by Alcoholics Anonymous, we still ensured that the chemically dependent person(s) in a family attended a consistent AA program throughout the full two years. Given that in the acute phase of treatment families participated in 4 nights of ETM application from 6:00PM to 9:30PM, that plus AA meetings of at least 3 per week added considerably more to the structure required for CDP's in outpatient (as opposed to residential) care.

The Academic and Treatment sections in the online ETM Tutorial provides detailed descriptions of all ETM facets including how ETM and TRT were integrated with the Twelve Steps. Most of our initial combat trauma cases (the psychological trauma management focus of this book) presented as comorbid with chemical dependency. Reviewing those two sections, which are quite lengthy, provides a supererogate coverage of the 12 years of ETM application under these treatment parameters, demonstrating without equivocation recorded, codified and annual compliance with auditing by credentialing authorities (Government and JCAH) the thorough, complete and unquestionably valid and validated experience in the development and application of ETM TRT to psychological trauma and PTSD. We owned and managed 6 of these facilities for 7 years and then provide more to a 7th operation for 5 additional years. We also opened, installed and provided long term care to psychiatric hospitals incorporating ETM as the primary treatment model.

As CEO, clinical directors, primary owners of the facilities and authors of ETM TRT, Nancy and I had several responsibilities that in meeting, strengthened ETM's early development. First, we were required to understand fully the various doctrines (theories and methodologies) accompanying the staff's many training backgrounds. Second, those understandings had to be interpreted so that the otherwise often competing modalities became integratable by newly hired staff professionals with our developing and then finalized ETM approach (next paragraph) into a homogeneous clinical model. Third and as referenced earlier, we ensured that it complied with the stringent facility licensing auditing processes, formalizing it into facility clinical and management protocols. Voluminous documentation attended ETM set up and application. Unlike circumstances where other academically credentialed professionals, for example, an MD Psychiatrist, might be in charge of a facility or individual case management, by virtue of the licensing - compliance processes, the

formalized protocols, and the knowledge of our own model, we bore and met all clinical, management and training duties and all attending responsibilities as the *final responsible parties*.

Producing a Different Clinical Psychological Trauma Theory and Methodology

The referenced 'developing model' (preceding paragraph) originated from use of the Johnson intervention approach (Johnson, 1980 Select 'References' #127). For the purpose of getting the drug dependent person into a treatment environment, the model required a focus by family members upon the chemically dependent person's drug use behaviors. Because they were very often traumatic, the model elicited considerable pain from family members as the events were recalled.

Making a major change (1979 - 1981) from the Johnson approach, we concluded that the first priority, as opposed to that of getting the chemically dependent person into treatment, should be upon the family members' pain, facilitating them to identify, understand and reconcile its intrapsychic, interactional and systemic origins. They were always the trauma-induced erosions to family member identity (values, beliefs, self - family images, and other realities) that were caused by the chemically dependent person's drug - using behaviors. We referred to this destruction as the trauma's etiology.

Having listened to many hundreds of these identification and reconciliation efforts, we found repeating presenting patterns in the process. Codifying them, we invented a series of written and patient - therapist interactive procedures that when utilized by the therapist and family members, strengthened their capacities to negotiate the patterns more effectively and efficiently, culminating in the straightforward address, and thus eventually what came to be our model's definition, of trauma etiology's 'reversal', or 'resolution.'

The procedures comprise ETM's referenced structured approach. It was and is named Trauma Resolution Therapy (TRT). ETM derives its base name, 'Etiotropic,' from that structure's focus upon, and resolution / reversal of, trauma etiology.

At the time (1979 - 1985), virtually everyone else (clinically speaking) used a symptom - behavioral (Nosotropic) approach. It identified untoward family member behaviors and attempted to correct, change, control them, defining their etiologies, in some Nosotropic ideological variations, as neurosis stemming from childhood developmental issues. Spouses of chemically dependent (and violent) people were

seen through the prism of the Nosotropic model, for example, as through the "Disturbed Personality Hypothesis, as attracting to the trauma. Other ideas interpreted aberrant systemic activity as dysfunctional, ascribing its etiology to unlearned communications skills. The learning failures had been passed down intergenerationally. Subsequently, the Nosotropic approach provided no definition of and treatment response to the etiology resulting from the drug use behavior caused trauma.

Eventually, TRT was found to provide the same treatment benefits to all trauma victims. Along with this application, it became our responsibility to define, convey and otherwise dispense ETM and TRT clinical theories and methodologies to interested professionals. Increasingly more often than not, those professionals did not practice, or interpret themselves as practicing, in the Chemical Dependency intervention - treatment environments.

System Management and Violence Prevention

From an organizational management perspective, ETM was first developed to implement TRT in treatment facility settings. Secondly, ETM provided a management theory and methodology for consultations to the referenced community social management resources. Thirdly, and most importantly, our work with treatment of trauma victims, intervention on perpetrators, and done in conjunction with referenced community social, educational, and legal service resources, produced our ETM theory and plans for preventing violence within our culture.

Transition: Focus on Education

During a very difficult financial time for all of Texas, the mid 1980's, we ended our direct service activities and created the academic and certification programs that now convey the skills and the authority required to administer the models to the public. The programs, which include the ETM Professional Training School and this ETM Tutorial, are a synthesized compendium of the body of actual and academic work produced over the past 30 years (now updated at year 2009).

In 1986 we were asked by the University of Houston's Chemical Dependency Counselor's Course to provide an advanced curriculum based on the ETM TRT model. We did and it was taught until 1990 when at that time we were contacted by

other academic systems to teach our school through them. We did. ETM TRT got additional history of teaching around the state of Texas, and next door in Louisiana. We built several curriculums. One taught clinical applications of ETM TRT to treatment programs, including private practices. Another had a background in combat and was designed for the military. A third emphasized crisis management in Schools, to include a focus on near term trauma addressed by ETM TRT. And a fourth demonstrated ETM TRT application on the EAP industry model. All models were taught through such academic and other programs like the University of Texas at its regional Schools in El Paso, (Rio Grande Valley) Permian, School of Public Health, Houston, University of Houston, clinical hospitals, Austin Independent, Fort Worth, Dallas and 150 plus other districts in Texas. The work with combat chaplains and other PTSD specialists for the Department of Defense (including US Army) the motivation for my producing this book. Professional needs being met and the system work done in schools, police departments, EAPs, children protective services, and etc. contributed to the development of the Strategic Application of ETM theory and implementation. That model was studied by one of our school districts (client) who beforehand studied competing models. After applying ours through to September, 1994, the program's leadership was invited by the management of the Texas Education Agency to present its findings to the Annual Symposium of Principals, Superintendents and Counselors. The 6000 participants heard that ETM TRT was the best of the programs studied and the recommendation that every principal and counselor in Texas should be ETM TRT trained and certified.

As you can see under the Health Addendum below the next heading, we were unable to follow through with statewide delivery for health reasons. In fact, excepting the work of trainers and certified clinicians, ETM TRT has been withdrawn from our contributions since that time in 1995, when the health problems began to intrude on academic activities, and until now, when some improvements in my treatments are allowing limited return to the ETM TRT training certification work in late 2004 and early 2005.

Deserving of its own emphasis, the academic effort included (by itself) a 2 year investigation of, and engendering of a theory for, psychological trauma etiology's substrate. I did this because no one else (all focusing on the Nosotropic substrate) had, and our clinical approach defined etiology as no one else had either (at the time; 1991 - 1994). It was the first dissertation on the subject. Twelve years later, it is still the primary consideration of the neurobiology of psychological trauma etiology and its reversal with ETM.

For you to appropriately use ETM and TRT, you will eventually have to evaluate for yourself whether or not this author's academic study and research supports their (ETM TRT) theories and methods. You may find that investigative and in some instances intended scholarly activity with all pertinent references and considerations in the Academic section of the ETM Tutorial. Also speaking for my wife, we wish you good luck and hope that all of the sections and the online ***ETM TRT Training Certification School*** are valuable to your pursuit of trauma's understanding and resolution for your patients, clients and associates.

Sincerely,

Jesse Collins
Etiotropic.org

Addendum regarding health influence on ETM TRT's dissemination: Top

In 1995 and 1996, at the height of our installation of trauma crisis management systems for school districts (161) in Texas (see the paragraphs above), Nancy and I each sustained major depreciations in health. They not only stopped the ETM work with schools, but have gone on to affect this life's work, apparently, we are told, forever.

For Nancy, she was found to have and treated for breast cancer. Compounding the difficulties of her situation, within the year a truck lost control on the other side of the highway and came into our lane, hitting us head-on. Nancy sustained brain injury, a malady that still adversely affects her. Ten years later, 2006, she was diagnosed with Lymphatic Leukemia. She continues treatment and care for that today. It has yet to enter remission.

At the beginning of 1996, while Nancy was in radiation treatment for the Breast Cancer, I was in a bizarre oral surgery accident where a suction apparatus was used and intended to retrieve a lost tooth root tip. The device when applied within the walls of the maxillary sinus and then outside became entangled in the major Trigeminal facial and cranial nerves, causing me irreparable damage, manifested by chronic pain – now atypical Trigeminal Neuralgia (TN). I'm told that this is a lifetime condition, as is Nancy's brain injury. The Trigeminal Neuralgia has neurological ramifications that retard my professional and social skills dramatically, enough to have placed our

trauma management activities on hold for about a decade plus a few years to this time, 2009. I'm formerly disabled by the injury 100%. We have an experimental brain surgery planned for me should treatment providers agree. I am also 100% disabled from combat while in Vietnam. I had two TBIs (Traumatic Brain Injuries) which have made the PTS fairly severe. Because of the medications attending the TN, I'm not a candidate for ETM TRT.

The work I do with ETM TRT is now done within the context and limitations of the referenced medical conditions. I have limited speaking capacities, reducing my communications on the phone and bringing an end altogether to educational presentations. While new medicines are allowing me to reconnect to limited work process through writing, I still rely on the ETM TRT Trainer Craig Carson to maintain most contact with clients. I'm grateful to Craig for his always steadfast efforts when filling in for me.

I am grateful most of all that my wife's breast cancer condition has been in remission now for 13 years (in 2009) following the surgeries and radiation treatments. The Lymphoma-Leukemia although a chronic illness, has been slowed at times. That is another matter for us both, again taking time from ETM TRT dissemination activities.

At home in the Moreno Valley, Northern New Mexico

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The Etiotropic Series

ISBN: 0-9768934-2-8