The American Institute of Stress

COMBAT STRESS

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

Volume 11 Number 3 **Fall 2023**

Conserving the Fighting Strength: Sex Modifying Medications and Psychiatric Standards of Fitness in the U.S. Military

Inside: **To Conserve the Fighting Strength. Sex Modifying Medications and Psychiatric Standards of Fitness in the U.S. Military: A Repeat of McNamara's 100,000,** By C. Alan Hopewell and Robert Klein • **Coming Home Alone,** By Robert R. Rail • **A Different Type of Mission Creep,** By Janet L. Rail • **Boom Fall Down: Dark Humor as Stress Relief,** By Tom McMurtry • **Veterans Treatment Court - A New Way to Address Veterans Involved in the Criminal Justice System Currently at the State Level - And Why it is Needed at the Federal Level,** By DJ Reyes • **Summary of the Veterans Consortium,** By Colleen E. Miller • **Closing the Chapter: Stepping Away from Policing and Into a New Mission,** By Caleb Payne

The mission of the nonprofit American Institute of Stress is to improve the health of our community and the world by setting the standard of excellence of stress management in education, research, clinical care and the workplace. Diverse and inclusive, AIS educates healthcare practitioners, scientists, and the public. AIS is the only Institute in America solely dedicated to providing information, training and techniques to prevent and reverse human disorders related to stress, and to improve the quality of life and increase longevity through building resilience to stress. Credentialed AIS members provide leadership to the world on stress related topics.

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

COMBAT STRESS

We value opinions of our readers.
Please feel free to contact us with any comments, suggestions or inquiries. Email: editor@stress.org

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

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From January 26, 2021, onwards, there have been no restrictions on military service by gender dysphoric individuals, and this cohort has now been increasingly and actively recruited by the Armed Forces. However, contrary to the requirement in Directive-Type Memo 16-005 (DTM 16-005) that 2. … "Transgender (sic) Soldiers will be subject to the same standards as any other Soldier of the same gender, (sic)" but this has not proven to be the case. Many, if not most of these Soldiers, are currently exempted from basic military requirements such as physical fitness standards and deployment requirements as a result of a number of issues pertaining to their medical status. This seminal article reviews medication as well as psychological issues among this cohort which may well impact their ability to serve effectively and does so from the experience of actual combat Veterans who have direct experience with these issues who have served in garrison, in combat deployments, and on sexual surgery teams. Parallels are drawn with the failed "Project 100,000" program during the Vietnam War which sacrificed sound scientific knowledge bases for ideological purposes, with the end result neither helping those who were the recipients of the project nor the Armed Forces and eventually resulting in harm to both.

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The steps we take and the path we walk back home are not the same as the path and steps that we have endured inthe war zone conflicts that have forever touched or scared our minds and bodies. Once "there" we can never truly be completely home again. When we walk through the door of understanding and healing like we did as being deployed on a mission, some walk with us, some take our hand, and some we just grab by the shirt and pull along with us. But the door is always open and so is hope for one and all in a future of understanding and healing.

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Have you ever been embarrassed by finding yourself laughing at a joke that should not have been funny. I have. As a retired soldier and a police officer I have spent decades around men and women who do unfunny work under unfunny circumstances. They/we have found ways to poke fun at unfunny things in a way that often makes others cringe and question our mental health. This article is about dark humor, which like spicy food, is an acquired taste and needs to be consumed carefully.

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By Colonel DJ Reyes, US Army (RET))

The "cost of war" over two decades of US combat has indeed been costly in terms of our military's mental health posture. Although most servicemembers have proven their resiliency and successful reintegration back with families and local communities after deployments or transitioning from the military, a disturbing percentage of those who struggle with service or combat connected conditions resort to bad behavior that often spirals down to illicit or criminal behavior. The Veterans Treatment Court (VTC) which is found in most US states is the "Court of last resort" that helps these criminal justice involved Veterans get back on track. An initiative advocated by retired US Army Colonel DJ Reyes and others are also pursuing the VTC expansion to the US Federal District Court level.

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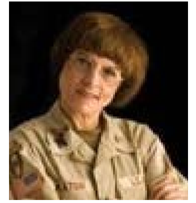
Colleen E. Miller serves as Deputy Director of Volunteer Outreach, Education, and Placement for The Veterans Consortium Pro Bono Program's CAVC Practice. The Veteran's Consortium is a leading non-profit organization that provides pro bono legal representation in federal venues to Veterans, their families, caregivers, and survivors. Since 1992, The Veterans Consortium has helped more than 75,400 individuals, handled over 7,702 cases, and trained more than 6,402 pro bono attorneys and associated professionals for its TVC National Volunteer Corps. To learn more about The Veterans Consortium and Ms. Miller's work

58 **Closing the Chapter: Stepping Away from Policing and Into a New Mission**

By SGT (RET) Caleb Payne

Too few are willing to chronicle the extraordinary difficulties in having no choice but to make the decision to leave the noble law enforcement profession. This is fraught with anguish on every level. What I have learned is that it is absolutely okay to be okay with this and to allow myself to work through the grief process in order to get to the other

Editor's Message



Our issues and our authors continue to be unsurpassed. It is high time to toot the horns of all those who are willing to write for *Combat Stress* many times over. That such gifted writers continue to seek us out or to respond to our requests to pen their incredible pieces of their written word is very clearly a blessing that keeps on giving. Thanks are most likely insufficient here.

That our Armed Forces have become quintessential in their quest for social experimentation, more so than combat lethality, has everything to do with rapidly declining recruitment and dangers that continue to multiple geometrically to the safety and security of this great nation. What is occurring in Israel as this issue readies for publication have placed the entire planet at its greatest risk since 9/11. The threat has evolved to an explosive point, as both domestic and international terrorism have humanity hovering at the brink of unimaginable disaster.

What is occurring in Israel as this issue readies for publication have placed the entire planet at its greatest risk since 9/11.

In this endeavor, **MAJ (RET) Alan Hopewell** and **Dr. Robert Klein,** nationally renowned psychologists for their celebrated work with traumatic brain injuries in the wartime theater and their recent distinguished work regarding gender-modifying medications as this applies to psychological fitness for duty, will leave the reader as riveted as the editorial staff. We are treading on very dangerous territory here as this applies to military readiness. There is every good reason to closely attend to their research, which necessarily takes the lead in our fall issue as the featured article and cover story.

Dr. Robert Rail and **Janet L. Rail** are new to our conglomerate of remarkable authors and hopefully, will become long-term contributors. Dr. Rail has chronicled the impact of returning from war like none other in his riveting piece, Coming Home Alone. This has wide applicability to generations of warriors and the tormented souls that must bear the terrible burdens and deep scars of the wartime theater. Janet Rail has also graced us with her tremendously insightful expose' that tells of the means by which war repeats itself throughout the life cycle, invading our dreams as we work through all that has been left behind in the deepest recesses of the psyche.

Officer (RET) Tom McMurtry has never failed to delight our readers with his most unique perspective on everything that nobody else ever thinks about. All things cringeworthy is the subject of Boom Fall Down. His uncanny ability to call forth dark humor as a human survival skill will undoubtedly result in chuckles and groans, as he takes our readers by his latest surprise. We sincerely hope that a book deal is on the front burner as he compiles and delivers the ultimate forms of stress relief to the masses.

COL (RET) DJ Reyes, now on the national stage for his undying efforts to federalize the Veterans Treatment Court mission, has focused his post-military career on the most noble of enterprises found in community service – as a volunteer within the State of Florida VTC system and now as an advocate for a proposed federal level VTC system. This full-time endeavor has given him entrée to where no Soldier has gone before; to save the souls and the very lives of countless returning Veterans who have found themselves on the wrong side of the law on a national scale, from the time they enter the criminal justice system until they become fully functioning members of society at large, with a return on their investment to once again, feel pride for having served by performing the most noble of deeds. COL Reyes represents an enormous number of Veteran advocates found throughout our nation today; those who have shed the uniform, but not the need to pay if forward daily in order to ensure that we "leave no Veteran behind."

A call to service has led attorney **Colleen Miller t**o serve as Deputy Director of Volunteer Outreach, Education, and Placement for the Veterans Consortium Pro Bono Program, once again demonstrating that one does not require a uniform to serve one of this country's most precious resources. As her article details, this exceptional forum exists in order to train attorneys to represent Veterans in desperate need of services for appeals of denials, reduction, or termination of disability compensation benefits from the Department of Veterans Affairs, all on a pro bono basis. These issues continue to be an enormous problem for countless Veterans who went to war, served this nation, but who have been terribly failed by a system fraught with incompetence and wrongdoing.

The exceedingly poignant piece by **SGT (RET) Caleb Payne** makes for the most fitting ending for any issue, as it narrates the heart-searing nature of one's decision to depart the law enforcement profession, one not of personal choice. The raw courage required to make this decision and the struggle to come to terms with this necessary exit strategy will leave the reader stunned with its agonizing truthfulness, as much as its optimism and the ability to adapt and overcome. This resignation letter embodies bona fide moral fiber and resilience on an entirely new level.

As always, profuse thanks to our authors and our exceptional editorial staff for a job magnificently done and to our readers who add immeasurable value to what it is that comprises our efforts to put forth this publication by the simple act of reading it.

Your Editor,
Kathy Platoni, PsyD, DAAPM, FAIS
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The more we learn, the more vital our mission becomes.

The American Institute of Stress is the only organization in the world solely created and dedicated to study the science of stress and the advancement of innovative and scientifically based stress management techniques. AIS provides the latest evidence-based knowledge, research and management techniques for stress and stress-related disorders.

Groundbreaking insights and approaches. World-changing mission.

Hans Selye, MD, PhD (1907-1982), is known as the father of stress research. In the 1920s, Selye coined the term "stress" in the context of explaining his pioneering research into

the signs and symptoms of disease curiously common in the majority of people who were ill, regardless of the diagnoses. Selye's concept of stress was revolutionary then, and it has only grown in significance in the century since he began his work. Founded in 1978 at Dr. Selye's request, the American Institute of Stress (AIS) continues his legacy of advancing the understanding of stress and its enormous impacts on health and well-being worldwide, both on an individual and societal level.

A forthcoming AIS initiative – called **Engage. Empower. Educate.** – will leverage the latest research, tools and best practices for managing stress to make a difference in a world increasingly impacted by the effects of stress out of control. We hope you will consider supporting this critical outreach campaign.

Click to view The American Institute of Stress Case Statement

A campaign to Engage. Empower. Educate.

The AIS campaign will support three key initiatives:

Engage *communities through public outreach*

Improve the health and well-being of our communities and the world by serving as a nonprofit clearinghouse for information on all stress-related subjects.

The American Institute of Stress produces and disseminates a significant amount of evidence-based information, but there is a need to share this material with a wider audience in the U.S. and around the world.

Support for this initiative will provide funding to expand the organization's public outreach for its website and social media, documentary films, magazines, podcasts, blogs and courses.

Empower *professionals through best practices*

Establish credentials, best practices, and standards of excellence for stress management and fostering intellectual discovery among scientists, healthcare professionals, medical practitioners and others in related fields.

AIS provides DAIS (Diplomate, AIS) and FAIS (Fellow, AIS) credentials for qualified healthcare professionals.

The AIS seal means a practitioner has training and experience in stress management and access to the latest stress research and techniques. It designates their practices as advanced treatment centers for stress-related illnesses.

Support for this initiative will provide funding to continually update best practices in the field.

Educate *all through the development and dissemination of evidence-based information*

Develop and provide information, training and techniques for use in education, research, clinical care and the workplace. Some of the research-based information AIS develops and disseminates includes:

- Productions – Mismatched: Your Brain Under Stress, a six-part documentary featuring some of the world's leading experts on stress. Released in March 2021.
  - Publications – *Contentment* magazine and *Combat Stress* magazine for service members, veterans and first responders.
- Podcasts, webinars and website resources – The free podcast series Finding Contentment

The American Institute of Stress

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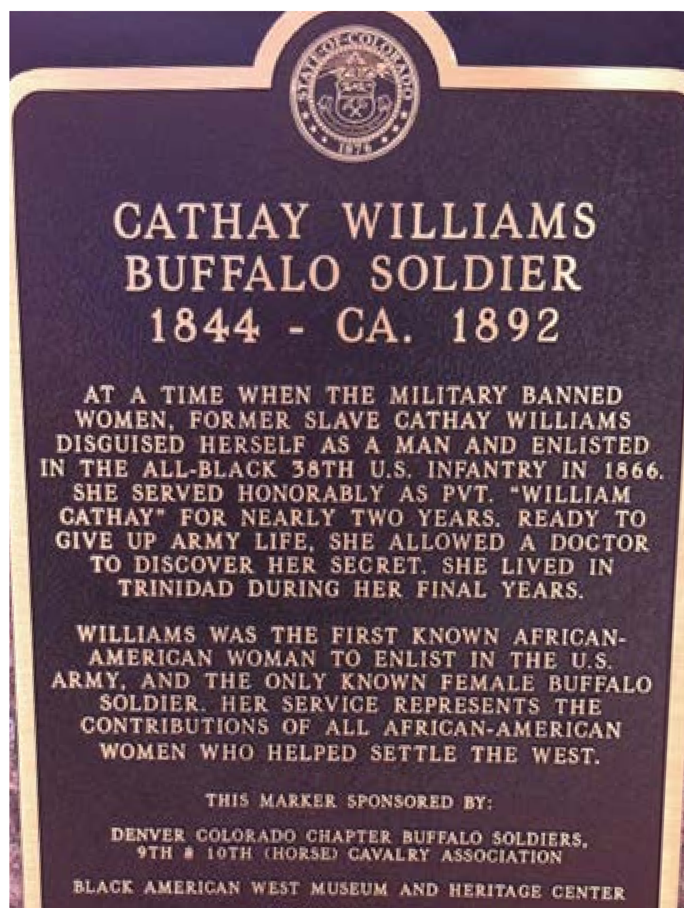
To Conserve the Fighting Strength. Sex Modifying Medications and Psychiatric Standards of Fitness in the U.S. Military: A Repeat of McNamara's 100,000

By MAJ (RET) C. Alan Hopewell, PhD, MP, ABPP, BSM and CPT Robert Klein, PhD, US Army

The History of Cross Sex Military Service

The United States military has a long history of female service personnel masquerading as males, dating back at least to the War Between the States. Initially, all such Service Members were women who disguised themselves as men in order to serve in military roles, presumably for various personal advantageous reasons. Two such famous women were Jennie Irene Hodgers, who impersonated a male Soldier in the War Between the States, and Cathay Williams, a female and former slave who disguised herself in order to serve as a Buffalo Soldier during Western service in the Indian Wars. PVT Williams even has a plaque honoring her service in Trinidad, Colorado. Obviously, no males are known to have masqueraded as females in order to serve in the military, and none of the women who disguised themselves as men really believed that they were the opposite sex. However, in more recent years, an increasing number of both males and females with what is now diagnosed as "gender dysphoria"[16] have served or have sought to serve in the military.



Beginning on June 30, 2016, and through January 1, 2018, the cohort now known as "gender dysphoric individuals" became eligible to serve in the United States military "upon completing transition." From January 1, 2018, to April 11, 2019, gender dysphoric individuals could enlist in the United States military under the condition of being stable for 18 months in presenting themselves in public with behaviors normally associated with the opposite sex. On June 30, 2016, Secretary of Defense Ash Carter, never having served in the Armed Forces himself, made an official announcement and published Directive-Type Memo 16-005 (DTM 16-005)[8] on this issue. From January 26, 2021, onwards, there have been no restrictions on military service by gender dysphoric individuals. However, contrary to the requirement in Directive-Type Memo 16-005 (DTM 16-005) that

> *2. … "Transgender (sic) Soldiers will be subject to the same standards as any other Soldier of the same gender (sic)"*

such standards are already being routinely ignored, as these Soldiers are far from subject to the same physical training standards as are

regular Soldiers[61] and such Soldiers apparently also do not need to be concerned about deployment requirements which affect all other military personnel. The question is also raised if these Soldiers are also being held to the same mental and legal requirements of others in that the first Soldier processed under this directive, U.S. Army MAJ Jamie Lee Henry, has already been arrested for conspiracy and wrongful disclosure of individually identifiable health information,[45] raising the question of if sexual confusion can ever be divorced from questions of psychiatric dysfunction, especially in cases such as Henry and Bradley Manning. A previous well known case involved sexually confused Soldier Bradley Manning, arrested and convicted of in July 2013 of violations of the Espionage Act and other offenses.[39]

Advocates of sexually confused individuals serving actively in the Armed Forces argue that there should be no concerns about such service and that such Soldiers, Sailors, or Airmen present no problems or burdens to service, being as "fit" as others for military service (Caputo;[57] Elders and Satcher,[18] and Klimas[37]). However, none of these individuals ever served in combat, never worked with Soldiers in Basic or Advanced Individual Training (AIT) as well as both in deployed theaters and in garrison (as have both authors,) and never served on a sexual surgery team at a major U. S. medical school as did the senior author. None of them ever managed the medication treatment of Soldiers in the most hostile combat environments imaginable, as did the senior author. Significant problems also occur on submarines or on naval surface ships, especially with those without a fully qualified Medical Officer on board, and can also occur during strenuous exercises prior to actual deployment such as Joint Readiness Training Center/ National Training Center (JRTC/NTC) operations, as have been experienced by the authors. Even a cursory glance at the medical and psychiatric care required by "gender dysphoric" individuals provide compelling proof that an increased burden of medical and psychiatric care is engendered under such circumstances and that this may be particularly problematic in combat or in challenging deployment conditions. Many such individuals may be ineligible for initial induction under normal circumstances due to their co-morbid psychiatric disorders or may be particularly prone to later Chapter or Medical Board separations.

The "opinions" of bureaucrats, ideologs, or "experts" do not count, unless backed up by solid experience, as was shown in the devastating debacle that was known as Project 100,000 or "McNamara's 100,000."[29] This is especially true of "opinions" which are based upon "feelings" rather than empirical research, preferably that which would meet Daubert standards[14] as well as evidence-based research requirements. For example, during the Vietnam War Robert McNamara and Lyndon Johnson had great "feelings" and "compassion" for those with intellectual disabilities, but the military experience of seasoned officers and the eventual solid evidence-based research proved how terribly mistaken they were about Project 100,000. The correct "solution" to the "problems" identified by McNamara and Johnson would have been never to have inducted this cohort into the Armed Forces to begin with.[29]

The induction of large numbers of previously unfit individuals into the Armed Forces unfortunately has a catastrophic historic

precedent and occurred during the Vietnam War under a program known as "Project 100,000 or McNamara's 100,000."[29] Project 100,000 was initiated by Defense Secretary Robert McNamara in October of 1966 to meet the escalating manpower requirements of the American government's involvement in the Vietnam War (the "problem") and to provide a "compassionate" way to improve the sociological, mental, and financial plight of some of America's poor and uneducated (the "solution"). In one sense this was no different from a number of seemingly "progressive" ideas that people as well as plants can be improved by environmental engineering which will eventually overcome genetic and Mendelian parameters of biological functioning, the latter idea about plants being espoused by the Soviet agriculturist Trofim Denissovich Lysenko (Kean;[36] Oury[48]). Eventual research showed that inductees of Project 100,000 died at triple the rate of other Americans serving in Vietnam and that following their service, this cohort of inductees had lower incomes and higher rates of divorce than their non-Veteran counterparts.[29] The project was ended as a complete and abject failure on the part of both McNamara and Johnson in December of 1971, although the effects of this disaster dragged on for years, as the senior author was still dealing with some of the residuals of this program as late as 1978 at Fort Jackson, South Carolina.

Robert McNamara and the bureaucrats who supported "McNamara's 100,000" held such ideas for lofty but naïve reasons, and the program was never grounded in reality. The opinions of ideologues such as Caputo, Elders, Satcher, and Klimas similarly really count for nothing except childlike reflexive support of erroneous ideological ideas. Like Robert McNamara, who framed his program in terms of "compassion," and thought that the "technology" of the times would result in these men being fully functioning members of the Armed Forces, current apologists seem to believe that medications and surgery – today's most advanced "technology" – will have similar results for sexually confused Servicemen and women. Robert McNamara and Lyndon Johnson ignored repeated advice and concerns from real Soldiers who served in real conditions in the Armed Forces,[29] and today's advocates seem to be once again repeating the mistake of relying on ideology rather than realism. Such problems and patterns of poor decision making based on ideology rather than science and evidence-based practice unfortunately seems to occur in cycles.

> *The "opinions" of bureaucrats, ideologs, or "experts" do not count, unless backed up by solid experience, as was shown in the devastating debacle that was known as Project 100,000 or "McNamara's 100,000."[29]*

One such cycle was that of Trofim Denissovich Lysenko who was a fraud Soviet

"agricultural scientist." Like current clinicians who ignore the genetic basis of sex and sexuality, Lysenko claimed that Mendelian genetic science and the chromosomal basis of biological development were all irrelevant to the development of putative resilient plant species. Since Soviet ideology asserts that environmental factors are paramount in human development and that differences between people or plants are simply "social constructs," organisms can "develop" into different physical and metabolic forms based upon environmental exposure, introduced chemical agents, and forced physical alterations of the biological system (in Lysenko's case plants). Based on Lysenko's theories in the late 1920s and early 1930s, Joseph Stalin undertook a "modernization of Soviet agriculture" by forcing these theories onto Soviet science and agricultural practice. This simply resulted in widespread famines that killed more than seven million people. It should be noted that the Soviet Union's allies also adopted Lysenko's methods with even worse results. China's population suffered even more as the number of victims is estimated at more than 30 million Kean;[36] Oury[48]). Similar to medical personnel who are now lionized as "innovators" in sexual surgery, Lysenko became a real hero in the Soviet Union and the inventor of "miraculous techniques" to transform biological organisms even while people were starving to death. In 1938, the Council of People's Commissars of the USSR fast tracked him to the head of the Lenin Academy of Agricultural Sciences. It should be noted in passing that as Lysenko ascended the ranks of power, he attacked scientists who defended genetic theories and destroyed their careers in similar ways to those currently being attacked for questioning the basics of "affirming care" for sexually confused individuals, and in many of the same ways in which line Officers during the Vietnam era were attacked and their careers put in jeopardy for questioning the all too predictable outcomes of "McNamara's 100,000" (Kean;[36] Oury[48]).

"Transexualism" as a Pseudo Disorder

Settled science has documented that a person's sex is comprised of chromosomal composition, with approximately 37 trillion of these cells being the "blueprint instructions" for each and every cell in the human body.[6] It is not possible to change these or to change even a single cell in ANY human body from "male to female" or from "female to male." Ideologues often like to quote extremely rare occurrences of intersex births or disorders such as Klinefelter's syndrome (YXX) which, of course, have nothing to do with the issue at hand. In addition, even these conditions cannot be "changed" genetically.[49] Therefore, it is not possible for any human to "change their sex" or become "transexual" or "transgender," ("gender" being a literary rather than a scientific sexual term,) but they are only able to modify physical function and cosmetic appearance by means of pharmacology, clothing, cosmetics, surgery, and / or learned behavior. Therefore, the very terms "transexual" as well as "transgender" are inaccurate, misleading, and nonscientific, and will not be used in this paper due to the inaccuracy and impossibility of these terms.

Also, one occasionally hears the statement that "so and so was born a male in a female

body," or with a "male brain in a female body," or vice versa, but again, this is not possible. The Chairman of the Diagnostic and Statistical Manual (DSM) committee which included the term "gender dysphoria" is Kenneth Zucker. Zucker has stated that this is a diagnosis with absolutely no objective markers and one which anyone, at any time, under any circumstances, can simply claim. He also points out two advantages of making up a diagnosis of "gender dysphoria." The first advantage in constructing such a diagnosis is that a finding of Delusional Disorder could therefore be avoided, and sexually confused individuals would not be classified as psychotic or delusional. The second advantage is that insurance benefits, much like the medical benefits now offered by the Armed Force and the Veterans Administration, could also be provided.[73] However, the advocates of including a diagnosis of a gender disorder in the DSM possibly failed to anticipate the irony that anyone claiming this disorder would now be officially meeting the criteria for a formal mental illness, whether the illness is called a "disorder" or a "dysphoria."

Such issues also raise the question that at least some "gender disordered" individuals may attempt to be recruited into military service not from a sense of any national duty or commitment, but because they see the military as a large "insurance/ health care agency" which can provide them with this type of care. This, once again, mimics the problems found with the "McNamara's 100,000" project, in that one half of the reasoning for inducting substandard Soldiers was to take care of them in terms of a sociological agenda. Research conducted on retention factors for military personnel and health care issues have long and firmly established that such motivations are strong predictors that such Soldiers will fail to be retained in the military and that they are poor induction prospects (Gregory;[29] Hopewell and Ozburn[32]).

Dr. Paul R. McHugh, the former psychiatrist-in-chief for Johns Hopkins Hospital, where John Money's failed sex treatment clinic was closed for malpractice after the suicides of some of his patients, concurs with the DSM that gender dysphoria is a "mental disorder" that merits psychiatric treatment, that sex change is "biologically impossible," and that people who promote sexual reassignment surgery are collaborating with and promoting a mental disorder. Dr. McHugh, one of the foremost sex experts in the entire world, has indicated that "sex change" is biologically impossible and that there is no scientific evidence that any person is "born into the wrong sexual body." The evidence does demonstrate, however, that people who undergo sex-reassignment surgery do not change from men to women or vice versa. Rather, they merely become feminized men or masculinized women.[41] The main difference is that instead of simply wearing transvestite clothing and adopting behaviors of the opposite sex, they additionally often undergo drug induced and surgical changes.

Co-Morbidity of Mental Disorders Among This Population

All sexually confused individuals are therefore mentally ill by their own definition, and as many as 80 percent display a large number of co-morbid disorders, making correct diagnoses and psychotherapy essential.[43] The most frequent of such co-morbid disorders include those of substance abuse, schizophrenia, bipolar disorder,

depression, anxiety disorders, personality disorders, autism, attention deficit disorders, self-harming behaviors, and those susceptible to hysterical epidemics (borderline personalities and young teenage girls, especially with autism, etc.[25] Since many such disorders will mandate either limited military service or chapter/ medical separation from service, the recruitment of such inductees is anticipated to create an increasing burden upon military health care as well as upon administrative separations.[2]

Some of these incapacitating conditions or disorders requiring separation include:

- Current or history of disorders with psychotic features such as schizophrenia, paranoid disorder, and other unspecified psychoses, such as delusions of being the other sex.
- Current mood disorders including, but not limited to, major depression, bipolar, affective psychoses, and depressive not otherwise specified.
- History of mood disorders requiring outpatient care for longer than 6 months by a physician or other mental health professional, or inpatient treatment in a hospital or residential facility.
- History of symptoms consistent with a mood disorder of a repeated nature that impairs school, social, or work efficiency.
- Current or history of adjustment disorders within the previous 3 months.
- Current or history of misconduct or behavior disorders.
- Recurrent encounters with law enforcement agencies, antisocial attitudes or behaviors that are tangible evidence of impaired capacity to adapt to military service (demonstrated by some "gender nonconforming" individuals).
- Current or history of personality disorders.
- History (demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other social groups), interview, or psychological testing revealing that the degree of immaturity, instability, personality inadequacy, impulsiveness, or dependency will likely interfere with adjustment in the Armed Forces is disqualifying (almost a sine qua non of many sexually confused individuals).
- Current or history of other behavior disorders including, but not limited to conditions such as a history of suicidal behavior or history of self-mutilation.
- Current or history of anxiety disorders (anxiety or panic), agoraphobia, social phobia, simple phobias, obsessive-compulsive, other acute reactions to stress, and posttraumatic stress disorder.
- Current or history of dissociative disorders, including, but not limited to hysteria, depersonalization, and others (related disorders).

> *All sexually confused individuals are therefore mentally ill by their own definition, and as many as 80 percent display a large number of co-morbid disorders, making correct diagnoses and psychotherapy essential.*[43]

- Current or history of somatoform disorders ("gender dysphoria,"?) including, but not limited to hypochondriasis or chronic pain disorder.
- Current or history of psychosexual conditions, including, but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.
- Current or history of alcohol dependence, drug dependence, alcohol abuse, or other drug abuse.
- Current or history of other mental disorders that in the opinion of the civilian or military provider will interfere with or prevent satisfactory performance of military duty.

Such conditions are even more problematic during conditions of deployment, especially in hostile combat environments in which medical care may be limited.[62] United States European Command Instruction regulations require, for example, that:

- Personnel who require medication(s) will travel with up to a 180-day supply of their maintenance medications (see paragraph 1.h.(2) below for controlled medication requirements).
- Controlled Medications. All FDA controlled substances (Schedule CII-CV) are limited to a maximum of a 90-day supply in-theater, with only 30 days' supply allowed on the person. All controlled substances need to be secured (i.e., to prevent diversion). Controlled substances must be monitored using a validated quality assurance program.
- Prior to deploying, individuals need to arrange to obtain a sufficient supply to cover the remainder of the deployment.

Individuals also need to be aware that certain countries (i.e., Germany) prohibit the mailing of prescription medications. Note also that many Soldiers and military personnel who are deployed to other areas may need first to transit through Germany on their way to other deployments or may, by necessity, need to be deployed back or evacuated to/through Germany such as those evacuated to the Traumatic Brain Injury Clinic founded by the senior author at Landstuhl Army Medical Center, so these or similar regulations may well apply regardless of the Soldier's deployment status.[31] Other conditions noted by USEUCOM include issues of:

- Border Clearance. Medical conditions must meet border clearance criteria of the countries in which the individual will be deployed (note that some countries may refuse admission to certain sexual conditions and/ or medications).
- Ability to Function During Flare-Up. Medical condition must not reach severity which completely incapacitates the individual.
- Alert and Oriented. The individual must be alert and able to perform sensitive tasks with appropriate judgement when required (i.e. medications causing drowsiness must clear the body quickly).
- Functional in Austerity. Individuals must be of sufficient fitness to successfully function and conduct the mission in the extremes of environmental conditions while wearing appropriate protective gear.
- Low Risk to Command. The medical condition must not place coworkers at safety risk or at risk for mission failure.
- **Severity of medical condition. Conditions must be of sufficient simplicity to be managed by a general medical officer in facilities with limited equipment** (emphasis added - a direct violation of the guidelines of the World Professional Organization for Transgender Health (WPATH) which argues exactly the **opposite**.[24]

Endocrine-Related Disorders		
Any of the following conditions that require medications that have special hazardous materials (HAZMAT) require a Commander's Endorsement letter from the first O-5/O-6 in the individual's chain of command for a waiver to be considered (see Enclosure (E), Appendix B for example letters).		
Sequence #	**Condition**	**Description (Waiver Required for Any of the Following, Unless Stated Otherwise)**
E1	Diabetes Mellitus	**1.** Insulin **2.** Oral or injectable medications with a risk of hypoglycemia or severe complications **3.** Poor glycemic control (hemoglobin A1C > 7) **4.** Less than 90 days since last adjustment in medication regimen **5.** Diabetes mellitus complications (i.e. micro or macro neuro-vascular changes, history of hypo- or hyper-glycemic urgency) in the prior 6 months **NOTE:** Item 4 requires Glucagon Emergency Kit prescriptions if waiver approved
E2	Hypo/Hyperthyroid	**1.** New onset (within past 6 months) of either hypo- or hyper-thyroid function **2.** Changes in thyroid-related symptoms during previous 3 months **3.** Changes to medication or dose in preceding 3 months **4.** An episode of acute thyrotoxicosis in the preceding 6 months **5.** Requirements for physician follow-up within a 3 month period
E3	Replacement/adjustment therapy considerations	Condition must be stable, require no laboratory monitoring or specialty consultation, and require only routine follow-up which must be available in the deployed location or by specific arrangement.
E4	Hormonal preparation requirements	Must be administered by oral or transdermal routes, be within clinically appropriate dose parameters, have no special storage requirements, and not produce side effects which interfere with the normal performance of duties or require additional medications to manage.
E5	Injectable contraception	No waiver required

Table B-5. Endocrine-Related Disorder DLCs

The use of psychoactive medications also poses additional risk in the deployment environment, such as risk for heat injury, serotonin syndrome, lapses in judgment and alertness, etc. These medications are commonly used to treat depression, insomnia, drowsiness, concentration and alertness problems, mood disorders, anxiety, chronic pain, migraine headaches, seizures, etc., many of the exact co- morbid disorders from which many sexually confused people suffer. The following concerns will be scrutinized closely when considering waivers for psychoactive medications:

- Behavioral effects. Psychoactive medications affect alertness, sleep cycle, and judgment; all effects can be magnified when multiple medications are combined.
- Suicide risk. Psychoactive medications pose additional risk for suicide based on the physiologic effects of the medications, and in their normal use by patients at higher risk for suicide.
- Polypharmacy concerns. Medications prescribed to counter-act the side effects of other medications are problematic, due to compounding of side effects (i.e., treating awakeness (sic) and alertness, while also addressing insomnia) and contribution to polypharmacy.

Some of the conditions related to endocrine circumstances are summarized in Table B-5, and indicate the difficulty of managing some of these conditions under circumstances of deployment by a general medical officer in facilities with limited equipment, or in many circumstances by a nurse or a Physician's Assistant (PA) who may be supervised by a Medical Officer who is not even in the same facility, as experienced directly by the authors during combat conditions, or as is frequently the case in some Naval convoys. As Cone and Oliverson have testified,[11] the long-term management of these agents is extremely problematic and even gender dysphoric individuals enrolled in specialized gender clinics

frequently have trouble receiving adequate care as so few specialists exist or are willing to assume the liability for such treatment. This *cannot* be considered adequate treatment, such as the management of hypothyroidism where an endocrinologist "gets the dose of Synthroid correct" and then pushes the management down to a Family Practitioner or a master's degree clinician who can simply dispense the medication endlessly.

The psychiatric disorders list is extensive, and will not be repeated here, but almost any of these disorders could be manifested by sexually confused individuals with these co-morbid disorders. These sexual disorders are also mentioned in Table B-18, with the risks of suicide, psychiatric disorders, and psychiatric burdens clearly identified:

Note that "the gaining unit [must possess] personnel who know the normal baseline of the transitioned person, and can recognize high risk variations," and that "leadership determination of risk, especially for high-risk positions" is required. Would anyone really think that such resources are readily available in most deployed commands? Perhaps only naïve individuals who never even served in the Armed Forces, such as Carter, Elders, Klimas, and Satcher, or those not involved in warfare operations such as Caputo.[57] To further "pound in" how completely unfit even the Army considers these recruits to be, they are now exempted from any type of Physical Fitness testing as well.[61]

A5.5 Approved Exemptions

A5.5.1 The unit commander, or equivalent, will sign a memo authorizing the exemption.

Transgender

All gender transitioning or transitioned individuals require a waiver. All waiver requests must address the following:

1. History of suicidal behavior and dates of episodes
2. Past and current medications, therapies, and surgeries.
3. Documented gender stability for minimum of 12 months (24 months preferred)
4. Commander's Endorsement letter signed by the first O-5/O-6 in the individual's chain of command addressing the following:
  a. Gaining unit possesses personnel who know the normal baseline of behavior of the transitioned person, and can recognize high risk variations.
  b. The individual has demonstrated a successful trial of duty in the stable gender.
  c. Leadership determination of risk, especially for high risk/sensitive positions.
5. Documentation from BH professional of how the individual defines successful gender transition end point.
6. The following monitoring requirements must be addressed:
  a. Laboratory follow-ups (F/U)
  b. Behavioral F/U
  c. Specialist F/U

Note1: injectable medications are normally disqualifying.

Sequence #	Condition	Description (Waiver Required for Any of the Following, Unless Stated Otherwis
Q1	Gender dysphoria	**NOTE:** Personnel with history of gender dysphoria present a significantly higher risk of suicide, life dissatisfaction, and interpersonal relationship dysfunction pre-, during, and post-transition. Such disturbances can pose a safety risk due to interpersonal stress. This is especially concerning when performing high risk jobs, such as long-haul transp aviation, heavy equipment operation, personnel reliability program missions (i.e. nuclea surety), etc. Waiver requests must address stability of the above concerns.
Q2	Gender transitioning	**NOTE1:** USEUCOM requires that deloying individuals are therapeutically stable. **NOTE2:** USEUCOM generally disapproves of deploying individuals who are actively undergoing therapeutic adjustments; thus, individuals actively in transition are generall considered nondeployable. **NOTE3:** Several countries supported by Operation Atlantic Resolve (OAR) have polici which only support traditional classifications of gender.

Table B-18. Transgender-Related DLCs

A5.5.2. Unit Fitness Program Managers (UFPM) will document the exemption in myFitness, using the commander's composite exemption.[61]

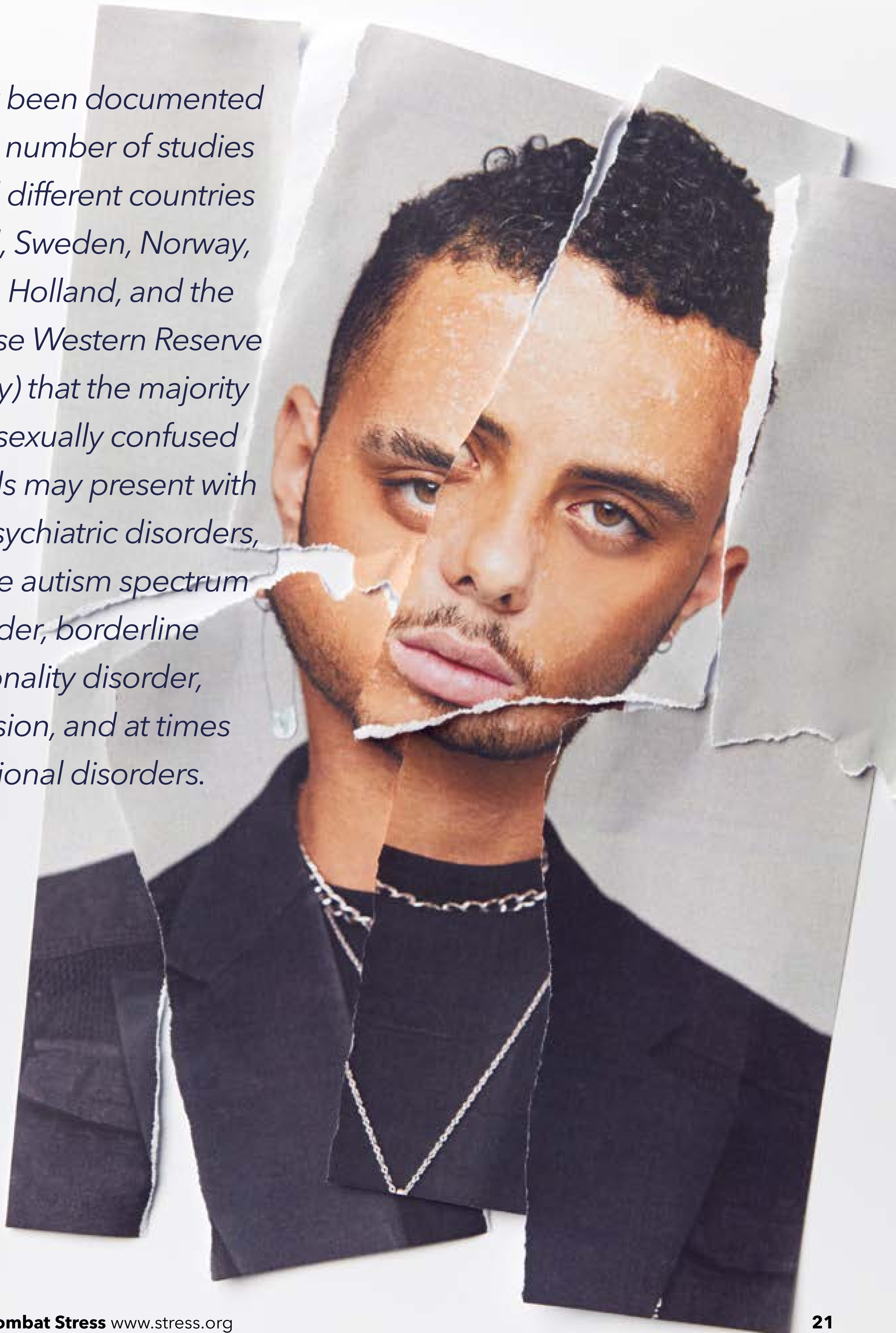
Who would think, therefore, that a Service Member who is unfit to deploy and unfit even to meet basic physical training standard while sitting behind a desk in a Continental United States (CONUS) garrison will be of much use to the Armed Forces, any more than the vast majority of McNamara's 100,000 inductees were? Note also that every geographic Combatant Command (COCOM) has rules for medical fitness which might vary; Bahrain's being very strict, and some geographic areas do not permit entry to persons with what are classified in those cultures as sexual disorders.

Suicidality and Co-Morbid Mental Disorders

It has now been documented in a large number of studies in several different countries (England, Sweden, Norway, Finland, Holland, and the U.S, at Case Western Reserve University) that the majority of such sexually confused individuals may present with serious psychiatric disorders, to include autism spectrum disorder, borderline personality disorder, depression, and at times delusional disorders. For example, autistics necessitating mental health treatment for their autism spectrum disorders are now seven times more likely to identify as sexually confused than the general population (Vrangalova[68] and Warrier[70]). A study by Meybodi[43] has found the rate of co-morbid personality disorders among sexually confused individuals to be as high as 81.4 percent. Therefore, even a cursory glance at the medical and psychiatric care required by gender dysphoric individuals provides compelling proof that an increased burden of medical and psychiatric care is engendered under such circumstances, and that this may be particularly problematic in combat or challenging deployment conditions.

The prevalence of autism or mild autistic traits, for example, has been shown to be very common among people with gender dysphoria relative to the general population. Even less frequent diagnoses, such as bipolar or personality disorders, are relatively common among people with gender dysphoria.[25] Regarding self-harming behaviors, including attempts at suicide, the incidence is also documented to be increased among people with gender dysphoria, especially among young people ages 18 to 24 (a prime age for potential military induction). Among this cohort, depressive and anxiety disorders are also commonplace and again, exactly within the age range which would be "prime induction ages" for most military recruits; Swedish studies determined that 18.2 percent to 25 percent of those patients identifying as gender dysphoric suffered from major depression, 20.9 percent to 28.5 percent from anxiety disorders, 3.6 percent to 4 percent from personality disorders, 14.7 percent to 16.3 percent from autism spectrum disorders, 13.5 percent to 18.4 percent from ADHD etc., and 4.9 percent to 13.7 percent from self-harm.[25] All of these disorders, in addition, may result in either increased burdens for medical care during military service, limited duty requirements, and/or necessitate outright separation from service on psychiatric grounds.[2]

It has now been documented in a large number of studies in several different countries (England, Sweden, Norway, Finland, Holland, and the U.S, at Case Western Reserve University) that the majority of such sexually confused individuals may present with serious psychiatric disorders, to include autism spectrum disorder, borderline personality disorder, depression, and at times delusional disorders.



In addition, settled science has shown that sexually confused individuals demonstrate a significant increase in suicides over the general population.[25] This report documented a 4.9 and 13.7 times increase in the risk of suicide, respectively, as compared to the general population. Research by agencies supportive of gender confusion issues have themselves found that data indicate that 82 percent of transgender individuals have considered killing themselves and 40 percent have attempted suicide, with suicidality highest among transgender youth, the age range of many potential recruits.[3] A 1984 study of transgender individuals requesting sex-reassignment surgery showed even higher suicide attempt rates between 19 percent and 25 percent.[22] Finally, a large sample of 40,000 primarily U.S. volunteers completing an internet survey in 2000 found transgender persons to report higher rates of suicide attempts than any group except lesbians.[41] This is all confirmed by the most recent comprehensive study to date, a study undertaken in Denmark.

A report from the American Foundation for Suicide Prevention and the Williams Institute,30 a think tank for LGBT issues at the UCLA School of Law, summarized findings about suicide attempts among sexually confused adults from a large national sample of more than 6,000 individuals. This constitutes the largest study of such adults to date.

Summarizing the major findings of this study, the authors write:

> *"The prevalence of suicide attempts among respondents to the National Transgender Discrimination Survey (NTDS), conducted by the National Gay and Lesbian Task Force and National Center for Transgender Equality, is 41 percent, which vastly exceeds the 4.6 percent of the overall U.S. population who report a lifetime of suicide attempts, and is also higher than the 10 to 20 percent of lesbian, gay and bisexual adults who report ever attempting suicide."*

At the same time, people with gender dysphoria who committed suicide also had very high rates of serious psychiatric diagnoses, such as harmful use or addiction to various substances, schizophrenia or personality disorders (such as borderline personality disorder). As a result, what is clearly known is that suicide risk among people with gender dysphoria and other co-occurring psychiatric diagnoses is much more pronounced than within the general population. With the concern of the military for increased suicides over the past decade or so, this is certainly a very prominent concern.[12] The Armed Forces have a high enough suicide rate; why make attempts to *recruit* a cohort where the rate is catastrophic? Additional concerns are presented when such individuals must be seen by mental health personnel and at times subsequently be medically evacuated out of the wartime theater, at times from combat or hostile service areas. The 785th Combat Stress Control (CSC) Company, based out of Fort Snelling, Minnesota, for example, during its second tour of Iraq, had the most mental health contacts of any CSC in Operation Iraqi Freedom (OIF) – well over 40,000 contacts. Although being successful at retaining more than 98 percent of all CSC patients in theater, the remaining 2 percent who had to be medically evacuated to CONUS comprised a considerable number and created substantial psychiatric demands on medical staff. In addition, at Fort Hood alone, these evacuations accounted for approximately

2 to 4 returning Solders *every day*, resulting in increased psychiatric burdens on the receiving units and hospitals.[12] At the time, Carl Darnall Army Medical Center, although an Echelon IV Army Medical Center, could not meet all of the psychiatric needs of these returning Soldiers, and was forced to transfer Soldiers needing ongoing care to civilian facilities as far away as Dallas and San Antonio. They were also reduced to relying on psychological screening "tests" that were downloaded from the internet, as mental health services could not meet the pressing needs.[58] Combine this with the even greater naval burdens of evacuating suicidal Sailors from a naval ship or submarine and the ongoing care of such personnel under even normal circumstances. This became astoundingly burdensome. *None* of such mental health treatment programs could be reasonably expected to provide the higher echelon care needed by gender dysphoric individuals on dangerous medication regimens, or even the complicated psychiatric symptoms constellations presented by such patients.

The second reason for increased burdens includes the nature and effects of many of the drugs taken for gender dysphoria, as well as the possible long-term effects on a Soldier's mental as well as physical wellbeing. This latter issue has, to the best of the knowledge of the authors, never really been addressed in the literature and will therefore be the focus of this paper.

Settled science has shown that sexually confused individuals demonstrate a significant increase in suicides over the general population.

Puberty Blockers and Cross Sex Hormones

Medications taken by gender dysphoric individuals in an attempt to "become" the opposite sex generally include two different classes: the so called "puberty blockers" and cross sex hormones. The medications most commonly used to suppress puberty are known as gonadotropin-releasing hormone (GnRH) analogues. "Puberty blockers," also known as gonadotropin-releasing hormone (GnRH) analogues, were introduced for medical use in the 1980s[63] and were originally developed to supersede other therapies in the treatment of prostate cancer. While it is uncertain how many military recruits would enter service on such medications, a large number may have taken them in the past and may well still be experiencing the lingering effects of such agents, since the effects are not reversible, as claimed by some ideologues.

GnRH is a naturally occurring hormone in humans responsible for the release of follicle-stimulating hormone (FSH) and luteinizing hormone (LH) from the pituitary gland. Through this mechanism, the body produces its gonadal estrogen and testosterone. GnRH agonists bind to the GnRH receptor and activate it, causing it to be continuously stimulated. This causes an initial increase of LH and FSH. Then over the course of several weeks this causes the pituitary gland

to become desensitized, pausing the natural sex hormone production. Although proponents of using these agents claim that the effects are "reversible," this has been shown NOT to be the case and in fact long term use can cause permanent suppression of the hypothalamic/ pituitary/ gonadal axis.[47] In addition, many of these circuits overlap, such as with the hypothalamic/ pituitary/ adrenal axis, which is known to be disrupted in cases of post-traumatic stress disorder.[47] The gonads and the adrenal glands are involved in two separate, but interrelated pathways (or "axes") of hormone signaling: the hypothalamic-pituitary-gonadal (HPG) axis and the hypothalamic-pituitary-adrenal (HPA) axis. Therefore, the use of such drugs prior to military service may actually increase the vulnerability of such individuals to later dysfunction in brain circuits, especially if they are exposed later to severe stress or develop PTSD.

Short-term side effects of puberty blockers include headaches, fatigue, insomnia, muscle aches and changes in breast tissue, mood, and weight. After exhaustive study, these medications have been banned in England due to the serious side effects experienced by children given these agents (Barnes;[5] Transgender Trend[65]). Long term effects may be even more serious, and more than 10,000 adverse event reports filed with the FDA reflect the experiences of women who have taken Lupron. Lupron (Leuprolide) is one of the gonadotropin-releasing hormone (GnRH)

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analogues which was originally developed as an anti-neoplastic agent to combat prostate cancer and is one of the most dangerous drugs on the market due to its low therapeutic index.[29] Like other gonadotropin-releasing hormones, the drug interacts with DNA or its precursors, inhibiting the synthesis of new genetic material or by causing irreversible damage to the DNA itself. By disrupting cell cycles and preventing the body from producing normal sex hormones, the expected development of puberty is blocked, and both the brain and physical characteristics of the body known as the secondary sex characteristics are disrupted. Reports of adverse effects describe everything from brittle bones to faulty joints and include depression, anxiety, suicidal urges, and seizures – all of these potentially service-disqualifying. Drugs used to halt puberty in children are also known to cause lasting health problems in adults.34 Among men who take Lupron, its label warns of increased risk of heart attacks, strokes and sudden death. Adverse effects on bone mineralization, loss of bone density, osteopenia, chronic pain, and compromised fertility are also now well-known adverse effects of pubertal suppression secondary to GnRH agonists.[71]

Research on the long-term effects on brain development, cognitive function, fertility, and sexual function is limited, but researchers suspect that a number of long-term problems may eventually be better documented (Terhune, Respaut, and Conlin[63] and Rosenthal[55]). Consistent with this, a study conducted by Chen and other researchers[9] suggested that "pubertal suppression may prevent key aspects of development during a sensitive period of brain organization," adding that "we need high-quality research to understand the impacts of this treatment – impacts which may be positive in some ways and potentially negative in others." In 2016, the FDA even ordered drugmakers to add warning labels to puberty blocker drugs stating: "Psychiatric events have been reported in patients," including symptoms "such as crying, irritability, impatience, anger and aggression." In 2022, the FDA also reported an increased number of cases of idiopathic intracranial hypertension and pseudotumor cerebri in patients taking puberty blockers.[53]

Hormones responsible for sexual differentiation are generally thought to exert on the developing fetus either organizational effects — which produce permanent changes in the wiring and sensitivity of the brain, and thus are considered largely irreversible — or activating effects which occur later in an individual's life (at puberty and into adulthood). Organizational hormones may prime the fetal systems (including the brain) structurally and set the stage for sensitivity to hormones presenting at puberty and beyond. The hormone will then "activate" systems which were "organized" prenatally. It must be noted that the primary goal of puberty blockers is to disrupt the normal development of the brain and the resulting instructions to the body for psychosexual development. However, considerable evidence exists that there are specific "windows" for critical brain development in children, and if this development does not take place at the appropriate time, permanent and irreversible damage or lack of proper development may occur, such as in the case of feral children and poverty of language development (Birdsong,[7] Curtiss,[13] Mihai[44]).

Similar issues may also occur in youngsters given chronic gonadotropin-releasing

hormone agonist (GnRHa) agents in that there is now documented evidence of disruption of long-term memory in sheep who have had their brain function disrupted in this manner.[33] Hougha et al. note that these adverse results suggests that the time at which puberty normally occurs may represent a critical period of hippocampal plasticity, and that perturbing normal hippocampal formation in this peripubertal period may also have long lasting effects on other brain areas and aspects of cognitive function. The effects do NOT appear to be reversible and would be of even increasing concern in a male who had taken puberty blockers prior to enlistment, who had subtle effects on memory function, and then had possibly increased cognitive decline as they continued to deliberately manipulate their hormone levels as an adult.

Goodman and Gilman's authoritative text on therapeutics notes that "few categories in medicine in common use have a narrower therapeutic index and a greater potential for causing harmful side effects than do the antineoplastic drugs – the puberty blockers"[28] (emphasis added pg. 1381.) Agents in this category typically used with sexually confused patients include the adrenocortical steroids, progestins, estrogens, antiestrogen, androgens, and gonadotropin-releasing hormone analogs. Note that although Soldiers might have been prescribed some agents only during puberty, such as the gonadotropin-releasing hormone

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analogs, the effects of these agents are now known to last over the lifespan. Recent testimony from a 45 year old individual who is well within military active or retirement age range illustrates these problems.[11] During legislative testimony, Cone[11] testified that he had trouble receiving adequate medical care as he aged and had increasing difficulty with the side effects of drugs on his body and his abnormal hormonal levels. Being on hormones for three decades, he is no longer able to produce his own hormones and must rely solely on hormone replacement therapy. He is now increasingly concerned, since low testosterone levels have been linked to dementia in males, but he can find no neurologist or endocrinologist outside of a "gender clinic" to treat him. Even though he was a civilian residing in CONUS with presumed access to full medical care, he explained that most physicians would refuse to attempt to treat him at this stage of his numerous medical problems and would uniformly try to refer him to "gender clinics." When attempting to access care at such clinics, however, Cone found that such "clinics" are over-burdened and do not follow the standard of care promulgated by the World Professional Association for Transgender Health (WPATH) by almost uniformly having no specialists, such as endocrinologists, on staff. In addition, although Cone is a professional with advanced IT experience and employed in that position, even he has been unable to find a "gender clinic" which has a neurologist or endocrinologist on staff to treat him properly in his state of residence. Cone also asserts that no adequate research exists at all for people at this stage of hormone therapy and that no clinicians exist who are experts in coping with these complications. He also asserts that patients such as this will often resort to obtaining drugs and hormones illegally and without proper prescription. Entire communities exist which produce "bathtub estrogen" for use by these patients (essentially home-produced drugs). This begs the question: if a knowledgeable and medially sophisticated patient such as this, treated with the best medical care available for three decades, with adequate medical insurance, residing within CONUS and with access to all preferred medical care cannot receive adequate care at this stage in life, how can we expect to provide an adequate level of care to Soldiers who may often be deployed as well as expected to function under conditions and in locations where such care would be impossible? Note that current deployment guidelines require that medical care and medications be dispensed by "a general practitioner," meaning that it would be against regulations to deploy Soldiers needing such specialist care to areas in which it is not available. This would also be in violation of WPATH guidelines which state that "The (doctor) is not merely a technician hired to perform a procedure; the (doctor) is part of the team of clinicians participating in a long-term treatment

Being on hormones for three decades, he is no longer able to produce his own hormones and must rely solely on hormone replacement therapy.

process."[24] This is exactly what most military treatment facilities, especially outside of CONUS, do not have and cannot offer: a "team of clinicians participating in a long-term treatment process" for a specialty as complicated as sexually confused individuals with extremely high co-morbid psychiatric disorder rates and rates of potential suicide, and taking drugs off label with long-term and unknown effects. This is hardly the case of "these patients are simply taking the equivalents of birth control pills" so casually stated and cynically dismissed by Caputo,[57] a Coast Guard Officer with no combat experience.

Problems with the Anabolic-androgenic Steroids

Once a potential military recruit has ceased taking puberty blockers, however, they must continue to take "cross sex hormones" if they wish to maintain the fiction of "being the opposite sex." These normally constitute the androgens, which are various ratios of testosterone and estrogen – the very agents that are usually banned in sports competitions and are well known to place individuals at risk for a number of health issues, to include "roid rage." The use of testosterone agents even seems to have contributed to the very well-publicized death of a recent Navy SEAL candidate Kyle Mullen.[17]

Natural testosterone is a steroid — an anabolic-androgenic steroid. "Anabolic" refers to muscle building, and "androgenic" refers to increased male sex characteristics. However, when one hears the term "*anabolic steroids*," they are generally referring to synthetic (made in a lab) variations of testosterone that are injected into the body. Healthcare providers use synthetic testosterone to treat and manage various medical conditions and these agents are generally safe when used medically appropriately. Synthetic testosterone is the main drug of masculinizing hormone therapy, which is a treatment used to produce the male secondary sex characteristics. Although most studies have been done with males taking testosterone, similar adverse effects may occur with females who are on these agents for long periods of time. Prolonged use of high doses of androgens (principally the 17-α alkyl-androgens) has been associated with development of hepatic adenomas, hepatocellular carcinoma, and peliosis hepatis — all potentially life-threatening complications. There have been post-marketing reports of venous thromboembolic events, including deep vein thrombosis (DVT) and pulmonary embolism (PE), in patients using testosterone products.

Testosterone, as testified by Cone[47] is frequently subject to abuse by sexually disordered patients, typically at doses higher than recommended for the approved indication and in combination with other anabolic androgenic steroids. Anabolic androgenic steroid abuse can lead to serious cardiovascular and psychiatric adverse reactions. In diabetic patients, the metabolic effects of androgens may decrease blood glucose and, therefore, insulin requirements. There are also reports of hepatocellular carcinoma in patients receiving long-term therapy with androgens in high doses. Withdrawal of the drugs did not lead to regression of the tumors in all cases.

Known effects of testosterone use include, but are not limited to: increased blood pressure, increased risk of myocardial infarction, bleeding from the gums or nose, bloating or swelling of the face, arms, hands, lower legs, or feet, blurred vision, bone or muscle pain, discouragement, dizziness, eye pain, feeling sad or empty,

headache, irritability, lack of appetite, loss of interest or pleasure, nervousness, painful or difficult urination, pounding in the ears, ringing in the ears, slow or fast heartbeat, stomach pain, tingling of the hands or feet, trouble concentrating, trouble sleeping, unusual tiredness or weakness, unusual weight gain or loss, changes in behavior, thoughts of killing oneself, seizures, hyperparathyroidism, prolactin increased, polycythemia, increased hematocrit, thrombocytopenia, anemia, diabetes mellitus, fluid retention, hyperlipidemia, hypertriglyceridemia, increased blood glucose, Korsakoff's psychosis nonalcoholic, male orgasmic disorder, restlessness, sleep disorders, cerebrovascular insufficiency, reversible ischemic neurological deficiency, transient ischemic attacks, and amnesia. Marked affective and psychotic symptoms have also long been documented, symptoms which would often disqualify Service Members from military service.[51]

> *Testosterone, as testified by Cone[47] is frequently subject to abuse by sexually disordered patients, typically at doses higher than recommended for the approved indication and in combination with other anabolic androgenic steroids.*

Military Psychiatric Retention and Potential Medical Evacuation Concerns

It is of interest here to note that one of the most frequent debilitating disorders in terms of medical evacuation, especially in hostile deployment theaters such as the Middle East, involve cardiac events – the very same events which can be precipitated or exacerbated by testosterone use. One of the major contributors to health care burden in the U.S. Armed Forces during *Operation Iraqi Freedom* was that of cardiovascular diseases,[60] accounting in 2005 alone for a total of 1,369,581 person years of disability at an annual rate of 5.8 percent. CENTCOM medical air evacuation data from 2001 to 2005 show a stunning number of evacuations for both cardiovascular diseases, as well as depressive disorders, both of which may be associated with testosterone use.

Recent reports have indicated even higher levels of risk, with the danger levels for males taking cross sex hormones increasing by as much as 93%. According to a Danish study published in August in the European Journal of Endocrinology[1] both sexually confused men and women developed a "significantly increased risk" of developing high blood pressure and high cholesterol and were more likely to have heart attacks and strokes. Males on opposite sex hormones were 93% more likely to develop a heart issue than men not taking hormones and 73% more likely than biological women. Biological women taking testosterone were found to be 63% more likely to have heart disease than women not taking hormone treatments and have over twice

the risk of developing a heart condition as were biological men.

With data such as these, the risks of androgen use on active military service, especially in areas with less-than-optimal Echelon IV and V Level care, cannot be avoided. Echelon IV care includes full medical and surgical care, along with further definitive therapy for those patients in recovery phases. Echelon V provides full convalescent, restorative, and rehabilitative care, treatment often needed by cardiac patients; neither Echelon IV nor V care can be provided in deployed areas.

Concerns with Estrogen Abuse

Estradiol is the most potent and ubiquitous member of a class of steroid hormones called estrogens. Fetuses and newborns are exposed to estradiol derived from their mother, their own gonads, and synthesized locally in their brains. Receptors for estradiol are nuclear transcription factors that regulate gene expression, but also have actions at the membrane, including activation of signal transduction pathways. The developing brain expresses high levels of receptors for estradiol. The actions of estradiol on developing brain are generally permanent and range from establishment of sex differences to pervasive trophic and neuroprotective effects. The specific mechanisms of estradiol action permanently impacting the brain are regionally specific and often involve neuronal/ glial crosstalk. The introduction of endocrine disrupting compounds into the environment that mimic or alter the actions of estradiol has generated considerable concern, and the developing brain is a particularly sensitive target.[42]

Animal models indicate that experimentally induced alterations in the levels of steroid hormones, particularly estradiol, in the brain cause significant behavioral changes observable within minutes, leading some researchers to conclude that steroid hormones actually have the capacity to function directly as neurotransmitters in the central nervous system. In the nervous system, estradiol plays an important role in a wide range of neurological functions. To this end, estradiol is involved in fine motor control, learning, memory, sensitivity to pain, motor coordination, and protecting the brain against stroke damage and Alzheimer's disease. Verbal memory, spatial ability, and fine motor skills are all influenced by estrogens. Estrogens are also

Top 20 Primary Diagnosis Codes, CENTCOM Medical Air Evacuation Data Oct 2001-Dec 2005

Rank	Diagnosis Code	Diagnosis Name	Frequency (n)	Percent (%)
1	E991.9	Other & Unspecified Fragments	662	2.1
2	786.5	Chest Pain	618	2.0
3	550.9	Inguinal Hernia w/o obstruction or gangrene	463	1.5
4	724.5	Backache (unspecified)	438	1.4
5	829	Fracture of unspecified bones	382	1.2
6	E991.2	Other Bullets	366	1.2
7	836	Dislocation of Knee	336	1.0
8	724.2	Lumbago (low back pain)	273	0.9
9	592	Calculus of Kidney & Ureter	266	0.8
10	E993	Injury due to War Operations by Other Explosion	263	0.8
11	E991.3	Antipersonnel bomb (fragments)	260	0.8
12	311-M	Depressive disorder, NOS	236	0.7
13	836.2	Other tear of cartilage or meniscus of knee	219	0.7
14	780.39	Other convulsions	214	0.7
15	824.8	Ankle NOS (unspecified closed)	211	0.7
16	724.9	Other unspecified back disorders	207	0.6
17	831	Dislocation of Shoulder	207	0.6
18	413.9	Other & Unspecified Angina Pectoris	206	0.7
19	784	Symptoms involving head and neck	202	0.6
20	780.2	Syncope and Collapse	195	0.6
		Total	6224	19.6

Total (N = 32,319) Total Missing (n=817, 2.5%)

TRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES); includes 1st CENTCOM TO EUCOM EVACUATION

Stamps et al. (2006)

involved in the strategies used to solve spatial or navigational puzzles which, as a result of their differences in estrogen levels, differ between males and females.[53] Declines in estrogen have been associated with a number of changes in the brain, including cognitive changes, and effects on both sleep and moods. Furthermore, estrogen interactions have been indicated in a number of neuropsychiatric disorders, including Alzheimer's disease, schizophrenia, and depression.[56]

Note also that toxic substances, such as male hormones introduced into a female body, will therefore inevitably be at biological "war" with the biologically authentic commands of the appropriate cells and chromosomes, resulting in eventual damage and dysfunction to the body that has been mistreated. This is also **settled science** and cannot be argued or disputed. One of the easiest ways for laymen to understand this fully is to look at some of the abnormalities produced in East Germany before the fall of the GDR (the German Democratic Republic) with their sex hormone experiments. Androgen abuse originated in the 1950's, a product of the Cold War, whereby communist Eastern European countries could develop national programs to achieve short-term propaganda victories over the West in Olympic and international sports.26 The senior author was recently able to review some of these files personally while on a research trip to East Germany in March of 2019. The destruction of lives stemming from those taking these drugs, many of which are the same as are given to patients who want "to change their sex," was so egregious, that they were even included in a movie about East Germany and shown widely throughout Germany as well as English speaking countries – *The Weissensee Saga*.[72]

Deployment Concerns

In order to be an effective Soldier, Sailer, or Airman, the Service Member must be available and fit for deployment throughout the world, whenever and wherever needed. Indeed, such military readiness is a prerequisite to military service.[2] Therefore, deployment limitations demonstrated by sexually confused individuals may present a mission-jeopardizing problem for Commands.

Since ALL sexually confused individuals are mentally ill by their own definition, and as many as 80 percent display a large number of co-morbid disorders, deployment Commands must anticipate higher risks of psychiatric emergencies, disorders, and medical burdens upon medical treatment facility (MTF) staff with this group of Soldiers. The risk factor must also logically lead to increased risk factors for wartime theater evacuation due to these issues, as well as potential medication complications. Many of these guidelines were previously reviewed in the directives issued from United States European Command (USEUCOM).[19]

The use of psychoactive medications poses additional risks in the deployment environment, such as risk for heat injury, serotonin syndrome, lapses in judgment and alertness, etc. These medications are commonly used to treat depression, insomnia, drowsiness, concentration and alertness problems, mood disorders, anxiety, chronic pain, migraine headaches, seizures, etc.

Some of the conditions related to endocrine disorders have previously been summarized in Table B-5 and demonstrate the difficulty in managing some of these circumstances under conditions of deployment. The psychiatric disorders list is extensive and will not be repeated here, but almost any of these disorders could be

manifested by sexually confused individuals with these co-morbid disorders. These sexual disorders are mentioned in Table B-18 and the risks of suicide, psychiatric disorders, and psychiatric burden are clearly identified. (See Table B-18 on page 19.)

Eventual Anticipated Military Burdens

It is therefore abundantly clear that despite the naïve statements or even willful rejection of scientific evidence by influential but naïve figures such as Jocelyn Elders, David Satcher, Ashton Carter and others that sexually confused individuals may be "perfectly fit" for military service, the opposite is quite true, and substantial military burdens are expected from the attempted integration of such individuals into the Armed Forces. Unfortunately, this mirrors very closely the previous disaster with the "McNamara's 100,000" project in that repeated warnings from mental health professionals and experienced military personnel who well understood the issues of both strenuous military service and mental handicaps, these being so callously and cavalierly dismissed for political gain. At least 80 percent of sexually disturbed individuals will demonstrate co-morbid mental disorders and as many as 40 percent may demonstrate suicidal ideation or attempts, greatly increasing the demands upon military health care providers. Among the psychiatric disorders manifested, the very fact that such individuals reject reality in terms of rejecting basic biology, are excessively narcissistic and may also frequently defy authority as well as display marked difficulties with social mores that are manifested by most of society will inevitably create problems in many military units. This will also negatively impact military members at large and in addition, can be expected to increase friction within the service and probably among the ranks, with more "Bradley Manning" and "Jamie Henry" types of incidents are likely to occur. Furthermore, the tendency of this group of individuals to demonstrate narcissism, to reject the social mores of "normals" and to blame everyone else for "bias," etc., rather than facing issues stemming from their own adjustment struggles, will not be helpful in this regard. The substantial medical and neurophysiological burden increased by the use of "cross sex" drugs will also tend to substantially increase medical needs and care factors for this cohort and may eventually result in many of them being unfit for service or deployment. The combined factors of pre-existing co-morbid psychiatric disorders, as well as medications use, will also undoubtedly result in many such individuals being increasingly vulnerable to stress-related disorders encountered in the military, such as PTSD, and other disorders of depression and psychiatric debility. Once separated from active duty due to their disabilities, most of this cohort will presumably qualify for ongoing care and benefits from the Veteran's Administration, also increasing the medical and financial burdens of those services.[69] In accordance with the medical benefits package, VA provides care and treatment to Veterans that is compatible with generally accepted standards of medical practice and determined by appropriate health care professionals to promote, preserve, or restore the health of the individual[69] (AUTHORITY: 38 U.S.C. § 7301(b); 38 C.F.R. § 17.38). Of course, such policies will inevitably increase the burden of care on the VHA and may even be postulated to encourage some of this cohort to join the service with the anticipation and goal of eventually

receiving lifelong care, ensuring that the VHA is now their permanent "insurance policy," consistent with the statements of Kenneth Zucker.[73] In addition, hundreds of "detransitioners" are now coming forward[35] and it is guaranteed that a number of sexually confused individuals will eventually decide to "detransition," either while in active service or after transferring upon service separation to the VA. Jorgenson,[35] in particular, outlines the long-term iatrogenic damages to such patients, the burden of care also inevitably falling to either the Armed Forces or the VA, much as the long term care for McNamara's 100,000 eventually cost the United State millions of dollars.[29]

All of this must also be considered in terms of the ability of the military to provide such care; treatment being typically limited at best, even in Echelon IV and V areas of care, and certainly not in the majority of Command or deployed theaters. Because of the virtually certain increased substantial strains upon the military health care system as well as increased separation and morbidity rates, the risks of service must be very carefully considered and may eventually have significant implications for our conservation of the fighting forces. Let's not repeat the "McNamara's 100,000" catastrophe, especially when we have been so strongly advised in advance.

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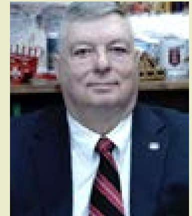

Dr. Alan Hopewell holds four degrees and four foreign language certifications, to include his BS, MS and PhD in Clinical Psychology and a second Master of Science Degree in Clinical Psychopharmacology.

He received his formal Clinical Neuropsychological training during his residency at the University of Texas Medical Branch in Galveston in the Division of Neurosurgery where he was the very first student of Harvey Levin, PhD, ABPP.

Dr. Hopewell was commissioned upon his graduation from the Texas A&M Corps of Cadets. He has served as Chief of Psychology Service at Landstuhl Army Regional Medical Center, where he founded the initial Traumatic Brain Injury Laboratory and at Brooke Army Medical Center, among others. He was the first Army Officer Prescribing Psychologist to serve and to practice in a Combat Theater, where he was awarded the Bronze Star Medal for meritorious service during Operation Iraqi Freedom. He was subsequently awarded a Meritorious Service Medal as he was a primary target during the Ft. Hood Jihadist Terrorist attack by his colleague, Nidal Hasan.

A former President of the Texas Psychological Association, he was also Awarded the Texas Psychological Association Award as the Outstanding Clinical Neuropsychologist in Texas.

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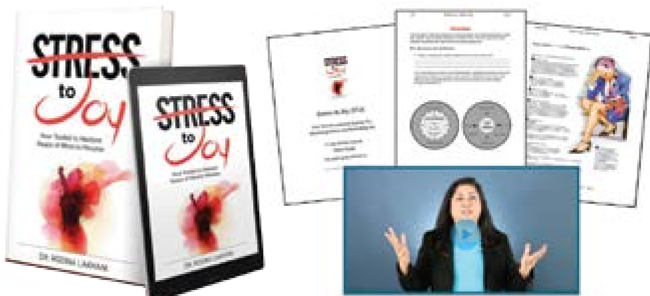

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"Coming Home Alone"

By Dr. Robert R. Rail

They feel alone as they return home from serving in the war zone, to where that "other person" they used to be, once lived. They are asked, "is everything all right," and "thank you for your service," or "great being back huh." But they feel like the words are being asked of some other person that's lost deep inside of them. Their families don't understand their constant excessive apprehension for their safety and overly protective, guarding nature. They want to tell their family members so much of all the things that are on their mind, but they know friends and family cannot understand where they have never been and the world they have just come from.

They think now and then about those who will not be coming home and those who have been so badly scared. After a deep sigh of relief that they returned home safely, there are still the unrelenting thoughts of the loss that others have suffered and it feels like it is all part of them. Time does exist for them, but very differently. It is measured by counting their sleeping and waking moments, and the numbness in between that is frustratingly

difficult to remember or even care about. It is a welcome escape to seek out a dark room of seclusion and isolation, or a vacant open field, or talk to an old pet – or a too familiar weapon. They cared for the weapon and the weapon cared for them. As time goes on it becomes less a weapon that others see it to be and more the one friend that will never let them down. It is that something, somewhere, or someone to listen to them, that will understand them during one of their overwhelming moods that explodes out of nowhere from the most insignificant of things said, seen, or done. They can wash away any and all moods or feelings of frustration, anger, and confusion, with an instant of destructiveness, wildness, or a last option.

They search for anything they can do or consume to provide them with that past adrenaline rush, and the welcome relief it brings masking the hollow pain of emptiness they feel. All that happened while they were in the war zone was worked out. No matter what it was, it was just handled in some way, and it was done, finished, because they were not alone. Here, they are alone in a crowd. Here, they cannot even hear the music others hear. Here, the humor that others understand, they don't care about. Here, what others touch they cannot feel. Here, the affection that others show, they reject. They know that something is gone that was once part of them, but now they can only touch the emptiness and loss that has taken the place of what was back there. Here, at their own home, they sense they do not belong.

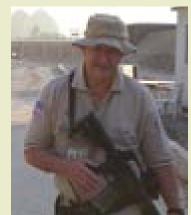
There are two paths they see ahead of them as they return. A path that has been born of conflict that is ever narrowing that leads them to only a quick resolution. Or a path of understanding that widens with time. The sooner they realize they are not alone and that their actions and feelings are not unique to only them, the sooner they will realize "they belong home."

Only seeing through their eyes, will allow us to understand what they see…
Robert Rail, "Surviving the International War Zone"

Reference

https://www.crcpress.com/Surviving-the-International-War-Zone-Security-Lessons-Learned-and-Stories/Rail/p/book/9781138374348

ABOUT THE AUTHOR



Dr. Robert R. Rail, a retired American Police Officer, and University Instructor, is recognized internationally as one of the foremost experts on terrorism recognition. As a war zone trainer to the International Police Task Force IPTF in Bosnia, Kosovo, and the DOJ in Iraq, Dr. Rail was responsible for designing curriculum and instructing elite police officers from 63 nations who have been deployed to various war zones of the world. He was also named as a physical confrontation advisor and resource training provider to select personnel of NATO and OSCE. Dr. Rail was a resident instructor at the Specialized Advanced Training Unit, of the High Institute, of the Baghdad Police College in Iraq.

A Different Type of Mission Creep

By Janet L. Rail

When I was a little girl, I remember watching my father take a nap and in the middle of it he started twitching and moving around in his sleep. I was going to wake him up because I thought something was wrong, but my mother stopped me. She said, "Let him sleep. Sometimes it's better not to remember a dream." This happened more than once, and the answer was always the same. Mom would always calmly lead me away so my dad could finish his nap undisturbed. When I was older, I finally asked my mom what she meant and what was it that my father was dreaming about that could be so bad. The simple answer – "The War." Dad served in the US Army during World War II. He was part of the 1st Division (the Big Red 1), and even though he is very proud of his service and what he did he never spoke to me about any of it. I was a child – and a girl – and back then, you just didn't talk about things like that. I knew he drove an ammo truck and spent a lot of time in Germany but while we were children the details were very sketchy. I'm sure my dad was involved in a lot of things that would give anyone nightmares, but he never said anything to us. It wasn't until my older brother entered the military that my father talked to us about his time overseas, and even then, most of what I learned was good memories and things that would not be upsetting to anyone. The "nightmares" of the war remained unspoken.

When Bob came home from his first mission in Bosnia there was more than one time he started twitching and moving around in his sleep. Laying there next to him I started to instinctively reach out to him to wake him up, but then I heard my mother's voice, calmly say, "Let him sleep. Sometimes it's better not to remember a dream." I would lie there, not moving because I didn't want anything to wake him up and I would wait until he would stop moving around. I would gently reassure him that he was home, and everything was okay. Sometimes he would wake up and sometimes he would sleep through the whispers, but I always noticed his body starting to relax. Most of the time, he would be able to go back to sleeping peacefully. Even after you are thousands of miles away from the fighting, the war can sneak up on you.

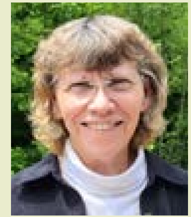
After Bob had been home awhile, the nights of rough dreams became fewer and farther apart, but when he returned home from Kosovo and Iraq once again the nightmare of the war came home with him. Talking about things during the day helped make the nights much better. The military may call it debriefing but just "listening" can be very helpful for both the returning soldier and the family that is waiting for them. Most of the time, the thoughts being recalled are random – good things and bad things, all mixed together. Stress will mess with your memories and there aren't many more stressful situations than being in a war zone. Sometimes it would be the same story he told me the week before and sometimes it would be all new information. What was important for me to remember was that Bob was not trying to hide information from me. He honestly had forgotten about some incident until that moment. There were things that happened in Bosnia that he remembered after he came home from Iraq.

Watching the news reports just before going to bed definitely did not help! And it didn't have to be news about the war. It could be something that seems totally innocent about an event that happened in a small town near home but there could be something that reminds him of "something that happened over there," and the floodgates of his memories were opened.

Time is truly the great healer. As the days turn into years the number of nights the war sneaks back into Bob's dreams is less and less and this is good. Sometimes I wonder if my dad still has nights when the war sneaks back into his bedroom.

Footnote *– When I first started talking about this topic in 2010 my dad had still not shared very much with any of the family. It was after he read some of our printed work that he finally started talking to us about some of the less pleasant things he was involved in with the war. Just before he passed away in 2018, he told us about his part in the Normandy invasion. His ship had been hit and was taking on water. All soldiers were on deck, wearing a life vest and having to decide if they wanted to attempt to swim to shore or hope the engineers could pump the water out fast enough to keep the ship from sinking, taking all the soldiers and equipment down with the ship. They were close enough to the shore to see the men being shot as they swam in, so he decided to take his chances and wait. Over half the men on his ship lost their lives that day. He carried that memory in his heart, all by himself, for over 60 years. We will never know what other nightmares he took with him to his grave.*

ABOUT THE AUTHOR



Janet Rail is a creative force, balancing the demanding responsibilities of multiple careers. She has developed the wisdom, patience, and fortitude necessary to maintain a positive yet realistic attitude in dealing with the challenges of today's ever-changing workplace.

As owner and high-ranking instructor of a martial arts school, Janet recognized that there was a need for specialized techniques in self defense that could be adapted to fit the individual physical and psychological nature of her students. Through years of refinement, Janet was able to create a style of very effective, yet easily learned, self defense techniques that do not rely on a student's size or strength.

For over four decades, Janet taught tactical self defense, arrest and control tactics, restraint of the violent mentally ill, tactical handcuffing, and understanding body language to such diverse groups as both private and federal medical professionals, Fortune 500 companies, private security firms, state and local police departments, federal law enforcement agencies, and special military units, both domestic and international.

Janet is also a Master Scuba Diver and has assisted in training individuals in learning how to dive. Because of her connection to the law enforcement community, it was only natural that she be involved in training officers in underwater evidence and body recovery at a university level.

Janet has proudly witnessed her training assist people of various backgrounds and professions achieve improved self-confidence and greater personal safety through the realization of their inherent potential.

The four courses below are available through a partnership with MUIH Professional and Continuing Education (PCE) and are certified by The American Institute of Stress. PCE provides advanced, superior quality, skills-based offerings leading to relevant credentials and real-world application. As a PCE learner, you can quickly expand your knowledge and distinguish yourself as a leader in your field. Additionally, various professional organizations and boards may accept these courses for continuing education requirements. **CLICK TO LEARN MORE.**

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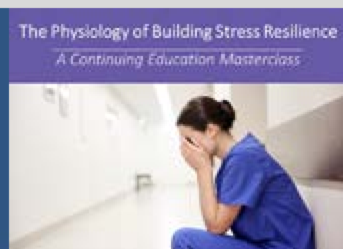

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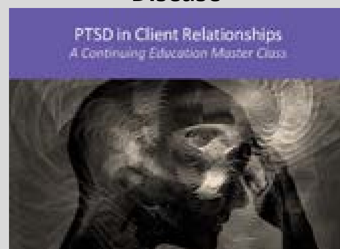

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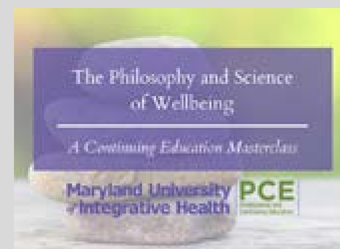

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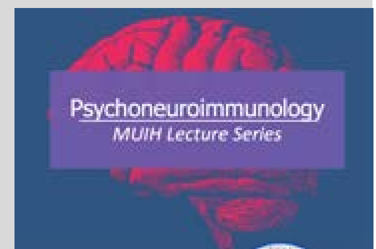

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Boom Fall Down
Dark Humor as Stress Relief

By Tom McMurtry, DAIS, Police Officer (RET)
CPT, US Army, Special Forces (RET)

My wife and I recently had the opportunity to babysit for two of our grandchildren, a boy aged 8 and a girl aged 3, while their parents were gone for a long weekend. It was a wonderful time for the generations to reconnect. As a watched my vivacious and energetic granddaughter fill the family room with dancing and laughter, I was reminded that my maternal grandmother's earliest childhood memory was when she was about the same age.

The Parlor Trick

To understand the story of this memory, I need to provide some background and describe the setting. Henrietta Wahlenmaier was the daughter of a successful businessman in Columbus, Ohio. At the time, there was no radio, no television, and no internet. News came from newspapers or messages that arrived at the door by telegram. Business and social connections were established and maintained through face-to-face contacts and physical gatherings. Many of these social gatherings happened in people's homes. Many homes of that era had a front room designed for this called the parlor. On the appointed day and time, those arriving would be greeted by the hosts and once everyone was there, the hosts would often offer a small entertainment to their guests to break the ice and set the mood for the evening. These were known as parlor tricks and in a way, still survive today in a form of entertainment known as close magic. My grandmother's memory was of her being the focus of such a small public entertainment, which her father called 'boom fall down.'

Henrietta would be allowed to stay up late, wear a party dress, and have her hair done. At the appointed time, her father would ask for everyone's attention and call for his daughter to come and stand in the middle of the parlor rug. He would then ask, "Henrietta, what happened to President McKinley?" My grandmother would make a face, hit herself in the chest, say "BOOM," fall on her back and play dead, while the adults exploded with laughter. Three-year-old Henrietta was called upon to do this several times until the tragic event of September 6, 1901, when President McKinley was assassinated.

I have wondered why what my grandmother did was so funny to the adults. I thought it might have been the juxtaposition of a young girl pretending to be an old man. Or was it the surprise and shock at her words and actions? Now I believe it was humor as a release from the collective social stress of the murder of a fellow Ohioan and the third American President to be assassinated in thirty-six years.

Dark Humor

Dark or gallows humor has probably always been around in some form or another. I have heard a lot of it over my years as a combat Veteran and police officer. In these professions, there were times when my companions and I would be tired, frustrated, angry, or bored, while also often being in varying levels of physical danger and having little or no ability to improve the situation in which we found ourselves. If these 'funny' jokes and stories were told under different circumstances or to people unaffected by the current conditions, they could almost certainly be seen as morbid, inappropriate, or just not funny.

What must they think of us?

While serving as a fulltime police officer, I volunteered to receive additional training as an evidence technician. On one occasion, I was called to the scene of a double homicide to try to identify the bodies of two teenage boys. I used a mobile fingerprint scanner and was able to identify the first victim, who was lying on the ground. The body of the second was wedged between the front of a car and a wall, so I would have had to move the body to gain access to his hands. Someone from the Coroner's Office needed to arrive before the body could be repositioned. So, I was part of a small group of law enforcement officials including homicide detectives and patrol officers just standing around. As time passed, we fell into conversation, which drifted from the case we were working on to more casual topics. The senior detective started telling stories of past cases, including some amusing anecdotes. After one that got everyone laughing, I looked around and saw a group of grim-faced people standing on the far side of the yellow crime scene tape watching us. I felt sure some were family members of the two young men who had died less than an hour ago. I suddenly felt terrible laughing. What must they be thinking of us?

Proceed with Caution

Studies have shown that laughing has many other measurable health benefits, beyond being a great stress reliever.[1] I have seen dark humor used to great effect in lifting the mood of men whose spirits were sagging. If any of my brothers or sisters in the military or law enforcement communities use or might consider using it to achieve the intended positive effects, two factors should be kept in mind. First, the point of humor, the butt of the joke, should be carefully chosen and not directed at other members of the group. The jokes and stories told at such times can be sarcastic, ironic, or even grim, but should not be personal, bitter, or mean. Secondly, be careful of the target audience. If a joke is told to a group of people within an organization and half of the people laugh and half don't know what was so funny, then it is an inside joke, and half the people may feel like outsiders. Even if the group is in the same rough spot as the one telling the joke, be careful that the dark humor is specific to the group and the situation. Jokes about 9/11 or the holocaust may not be funny to people stuck in an airport overnight. Dark humor should not hurt people who are already hurting.

Studies have shown that laughing has many other measurable health benefits, beyond being a great stress reliever.[1]

As a young man, I remember late night comedian Johnny Carson making a joke about the death of Abraham Lincoln on Lincoln's birthday. I have forgotten the specific joke, but it was something like "Other than that, Mrs. Lincoln, how did you like the play?" The joke fell flat and drew "ooohs" from the live audience.

Johnny then made a comment to his sidekick, Ed McMahan, about the fact that after more than a hundred years, it was still "too soon" to tell that joke. That comment then got a big laugh. I found out later that this was a years' long running gag. Carson, who was a student of comedy and a master at his craft, used the joke to set up the quip. The fact that the dark humor wasn't funny, was funny.

For people under stress, I believe that almost any laugh is a good laugh. The comic Jeff Foxworth became famous by giving examples of "You might be a red neck if …." Staying with that theme, if you laugh at any of the following examples of dark humor from the internet, you might be an Iraq Veteran.

Reporter: *How can you tell the difference between a terrorist vehicle and a school bus?*
Service Member: *How the hell should I know I'm a drone pilot.*

Why aren't there any Walmarts in Iraq? Because there's a target on every corner.

A man calls the mental health hotline in Iraq.
Man: *I've been having suicidal thoughts.*
Operator: *Great! Can you drive a truck?*

Son in Iraq to father in the US:
Son: *Dad, I've killed five people over here.*
Dad: *I killed a lot more than that in the first Gulf War.*
Son: *I thought you were a helicopter mechanic.*
Dad: *I never said I was a good one.*

Be well, my brothers and sisters. Help each other and try to laugh every day.

References

1. https://www.va.gov/wholehealthlibrary/tools/healing-benefits-humor-laughter.asp

ABOUT THE AUTHOR

Tom McMurtry has spent most of his adult life serving others. He joined the U.S. Army at the age of nineteen, volunteered for and completed Infantry, Airborne, and Special Forces training. After three years serving on a Special Forces HALO Team Tom became a Reservist. He remained in the Special Operations Reserve for twenty more years. He was recalled to active duty for the invasion of Iraq as a Psychological Operations Specialist, during which he was awarded the Bronze Star Medal. After his combat tour Tom returned home and entered the police academy at age 49. He served as a patrol officer for 15 years and received the Distinguished Action Award for his response on the night of the Dayton mass shooting in the Oregon District. Tom retired at the age of 65 but was recalled to part time duty by his department at the height of the pandemic to help cover for fellow officers who were sick. All of that aside, Tom will tell you that he takes greatest pride in his 45-year marriage to his wife, Holly, along with their five children and ten grandchildren.

Veterans Treatment Court – *A New Way to Address Veterans Involved in the Criminal Justice System Currently at the State Level – And Why it is Needed at the Federal Level*

By Colonel DJ Reyes, US Army (RET), Senior Veteran Mentor Program Coordinator, 13th Judicial Circuit Veterans Treatment Court, Tampa FL

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

The Response: The Veterans Treatment Court, or VTC, is a hybrid court, blending aspects of the traditional Drug, Criminal, Mental Health, and Diversionary Court processes. Its primary focus is on the effective identification, treatment, and successful reintegration of every enrolled Veteran back into his or her local community. There are currently over 620 VTCs or Veteran dockets found throughout most of the United States. *In Tampa FL and the 13th Judicial Circuit's VTC, the program has received accolades and recognition from the local, state and national levels since its inception in late 2013. In 2019 Tampa's VTC swelled to over 225 defendants.*

The Tampa VTC Volunteer Veteran Mentor Program and the 501c3: *It is often said that the key ingredient that directly accounts for Tampa VTC's success (88 – 92% graduation rate) and local county tax cost savings lies within the ranks of its Volunteer Veteran Mentor Program.* Established and led by its Founder and Mentor Program Coordinator, Colonel DJ Reyes (US Army retired) since its inception in October 2013, the current VTC Volunteer Mentor Program, and its 501c3 – Mentors For Hillsborough County Veterans (MHVC) – are comprised of a Senior Mentor Council, and currently 50 active Veteran volunteers (in 2019 the Mentor Corps rose to over 100 active serving) who serve as peer mentors to their assigned VTC Veterans and ensure that the Veterans "stay on track" and comply with the VTC Judge's court mandates.

Experience wise, the Senior Mentor Council (retired senior grade and non-commissioned officers) alone enjoys over 250 years of combat, operational, and command leadership experiences ranging from the Vietnam War to the Global War on Terror in the Middle East and North Africa. In direct support to the VTC Judge, they oversee, direct and train fellow volunteer mentors that are assigned to 7 Task Force Teams – each mentor receives one or more Veteran defendants to individually mentor, encourage, and assist in navigating through the VTC requirements in a program that adheres to the national problem solving court model set forth by the National Association of

Drug Courts Professionals (NADCP). This is a 5 phased model (1st phase – 30 days; 2nd – 5th phases are 60 days each) where the judge works collaboratively with all VTC supporting organizations to focus treatment and wellness.

The Veteran Mentors also provide critical guidance and resources (thru the MHCV) to assist the VTC Veterans in the areas of alternative transportation, employment, educational assistance, food, housing and clothing support. To support this effort, the Senior Mentor Council relies on an extensive community resource network at the local through federal levels. In Hillsborough County, this includes local strategic partnerships with the following: educational institutions (Keiser University, National Louis University, Stetson and Western Michigan (Cooley) Law Schools); legal support organizations (Hillsborough County Bar Association's Military and Veterans Affairs Committee, Bay Area Legal Services); religious institutions (Idlewild Baptist Church, Christ the King Men's Ministry and The Society of St Joseph, Knights of Columbus); various law firms; businesses and chain stores (Walmart earlier supported the "Bikes for Vets" Program); and numerous local chapters representing Veteran Service Organizations (VSOs) that include the Vietnam Veterans of America (VVA), Veterans of Foreign War (VFW), The American Legion, and Team Red White and Blue (RWB). The Program also partnered its efforts with local 501c3 organizations that support local Veteran needs and programs. These include the Corporations to Develop the Communities of Tampa (CDC), Hillsborough County Veterans Helping Veterans, and the Diversity Action Coalition (DAC). Finally, the Mentors closely interact with James Haley Veterans Administration to ensure medical support requirements are provided in accordance with the VTC Judge directed orders.

Spreading the Gospel – Nationally and Internationally – Ongoing Initiatives.

In support of the awareness and education efforts, former VTC Judge HON. Gregory P. Holder and Colonel DJ Reyes travelled to Washington DC in October 2016 to brief both Chief Judge Robert Davis (US Court of Appeals for Veterans Claims) and (then) US Secretary of Veterans Affairs, HON Robert McDonald. Colonel Reyes also briefed the Program's successes to (then) FL Governor Rick Scott, Mayor Bob Buckhorn, and at the 2017 FL Bar Association and Conference in Boca Raton. In 2019, as part of (then) US Congressman Charlie Crist's (FL-13th) sponsorship of the VTC Coordination Act of 2019, DJ Reyes was invited to brief the Tampa VTC and Mentor Program in the White House, and before select Congressmen on Capitol Hill.

In 2022, by specific request of Federal Magistrate Judge Anthony Porcelli (US Middle District Court of Florida), Colonel Reyes agreed to voluntarily mentor a Veteran defendant currently on federal charges. Judge Porcelli's request recognized the current "gap" between the State and Federal level regarding the Veterans Treatment Court, and understood that Colonel Reyes could act as the interface between the Federal, State, Veterans Affairs medical center, and other local community support services to help the Veteran obtain the necessary medical, legal, housing, education, and employment resources required for rehabilitation, treatment, recovery, and

successful reintegration back into the local community.

Also in 2022, Colonel Reyes joined forces with the Veterans Court Coalition (VCC), led by retired Chief Justice, Kansas Supreme Court Hon. Lawton Nuss to address legal support to Native American combat Veterans currently living on the US reservations. As of this article, Reyes and Nuss have been coordinating with the US Tribal Commission, Navajo Nation (AZ/NM), and the Pottawatomie Tribe (KS) to determine how best to provide advisory and training support regarding the establishment of their VTC and Veteran Mentor programs.

Additionally, and on the international front, Colonel Reyes was requested in 2022 to join the training and advisory committee of Judges, National Judicial College (Reno NV) to assist the Ukrainian Ministry of Courts and Judges in their VTC program establishment. Reyes has been instrumental in providing assistance in the ZOOM training sessions thus far.

Two additional issues regarding national level Veteran support have grown from this VTC movement. The first is Colonel Reyes' direct involvement and advocacy in federal legislation addressing Veteran illnesses resulting from toxic exposures ("burn pits") during deployments in the Middle East. Known as the "Promise to Address Comprehensive Toxins" or PACT Act, Colonel Reyes worked with FL (US) Congressman Gus Bilirakis, Congresswoman Kathy Castor, and US Senators Marco Rubio and Rick Scott to push for the successful bill passage and subsequent POTUS signature. As a result of this action, Colonel Reyes was invited by US Congresswoman Castor to attend the February 2023 POTUS State of the Union.

The second issue involves Veteran homelessness, which is often noted with Veteran defendants entering the VTC program. In January 2023, Colonel Reyes was nominated and appointed by US Secretary of Veterans Affairs Hon. Denis McDonough to the US Secretary VA Advisory Committee on Homeless Veterans (ACHV). This Committee is responsible for reviewing all US VA policies and procedures regarding VA Veteran Homelessness and Housing programs and providing strategies to help mitigate and eradicate Veteran Homelessness across the USA.

In summary: The VTC's actions in getting Veterans the help they require and deserve are consistent with the military mantra of "leave no soldier behind on the battlefield." It is truly an "all hands-on deck effort" – local, state and federal agencies and non-profit organizations collaborating efforts to achieve the mission. It is the hope of many that this state level initiative will eventually be expanded to the US Federal Court level to service many more Veterans involved in the criminal justice system.

Thursday, November 2, 2023

2023 Tampa Bay Ethics Award – Honoring Colonel DJ Reyes

The son of a retired Korean War and Vietnam War Veteran, DJ Reyes is a retired US Army Colonel with over 33 years of faithful service to our great nation. Col. Reyes earned his bachelors, masters and juris doctor degrees from the University of Notre Dame, the US Naval War College and Temple University School of Law, and his leadership resume also includes key command and staff positions in special forces/special operations, military intelligence, infantry, airborne, and air assault. Combat and contingency deployments included tours in Iraq, Afghanistan, North Africa, Bosnia, Kosovo, Haiti and Korea.
In 2013, Col. Reyes established the volunteer Veteran Mentor Program that directly supports the nationally acclaimed Veterans Treatment Court (VTC) (Tampa FL). This court assists veterans in trouble with the law due to a disorder or condition incurred during military service. He is a national Veteran advocate who has briefed in the White House and on Capitol Hill and who lobbied for the successful passage of HR886 (VTC national funding) and HR3967/S3373 PACT Act (Toxic Exposures)/Burn Pits). Col. Reyes sits on various national, US Congressional, and State veteran advisory boards.

In 2023, the US Secretary of Veterans Affairs (VA) appointed Col. Reyes to the VA Advisory Committee on Homeless Veterans. In 2022, Col. Reyes received both the Military Officers Association of America (MOAA) Distinguished Service Award and Military Order of the World Wars (MOWW) National Citation for his community service. In 2021, Col. Reyes was selected by Florida Governor DeSantis and Cabinet for induction into the Florida Veterans Hall of Fame. In 2020, Col. Reyes received the Tampa Bay Lightning (NHL) Community Hero Award, the Bay Area Legal Services' Lieutenant General James Peake Award for Community Service to Veterans in the Judicial system and the University of Notre Dame's Reverend William Corby Award for Distinguished Military and Community Service. MOAA also selected Col. Reyes in the first "The ChangeMakers" edition for his impact on veterans in the criminal justice system. In 2018, WFLA (NBC) recognized Col. Reyes as Tampa's "GR8 Inspiration" for his life saving work in the VTC. In 2016, Col. Reyes was awarded the Hillsborough County Bar Association's "Liberty Bell Award" for his exemplary efforts in promoting, and advocating for, the legal judicial system and process as it supports the local veterans and special needs communities.

Col. Reyes supports efforts in combatting human trafficking in the Tampa Bay region. He is the current Vice-Chair on Tampa's Citizens Review Board, which oversees Tampa Police and community interaction and issues. Other boards include WFTS-ABC's Equity, Diversity and Inclusion Panel and the National Louis University's Advisory Board for Organizational Leadership. Finally, Col. Reyes supports his wife Julie's Diversity Action Coalition (501c3) that supports the military EFMP program and local community programs for the special needs and disabled.

Ticket information
https://www.eventbrite.com/e/2023-tampa-bay-ethics-award-honoring-colonel-dj-reyes-tickets-720027259917

ABOUT THE AUTHOR

DJ Reyes is a retired U.S. Army Colonel with over 33 years of faithful service to our great Nation in special operations and military intelligence assignments that included multiple combat/contingency tours in Iraq, Afghanistan, North Africa, Bosnia, Kosovo, Haiti and Korea. Reyes also holds a bachelors, masters, and juris doctor degree from the University of Notre Dame, the US Naval War College, and Temple University School of Law, respectively. In 2013, DJ established the volunteer Veteran Mentor Program that directly supports the nationally acclaimed Veterans Treatment Court (VTC) (Tampa FL). This Court assists Veterans in trouble with the law due to a disorder or condition incurred during military service. He is a national Veteran advocate who sits on various national, US Congressional, and State Veteran advisory boards. He received numerous national and state awards for his advocacy in Veterans issues and in 2022 was inducted by Florida Governor DeSantis into the Florida Veterans Hall of Fame.

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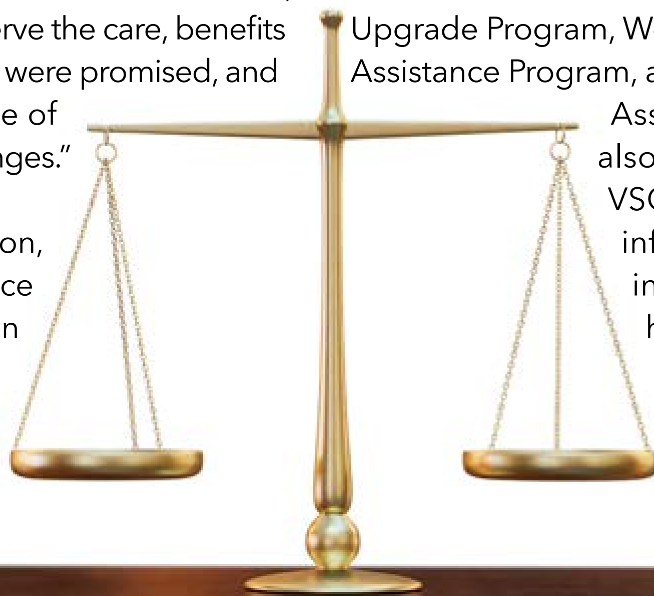
The Veterans Consortium Pro Bono Program: A Call to Service

By Colleen E. Miller, Esq.

My mother is an Air Force Veteran, and my grandfather fought in World War II in the Army Air Corp. He later transitioned into the Air Force, where he spent the remainder of his career. My mother had a long-term partner that was drafted and served in the Vietnam War. When I was a child, he told stories about parachuting into active combat zones and wading through the dense tropical foliage. He was also an alcoholic and, at times, cruel. I sometimes wonder if his life, and my childhood, would have been different if he had the support, services, and benefits that he earned. President George Washington said, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the Veterans of earlier wars are treated and appreciated by their nation."

No matter what path one takes to become a lawyer, it is a privilege. With that privilege comes a duty to serve those in need. I started as a volunteer with The Veterans Consortium Pro Bono Program (TVC) in 2018, and now serve as the Deputy Director of Volunteer Outreach Education and Placement. At TVC, "We believe that our Veterans, our nation's defenders, deserve the care, benefits and compensation that they were promised, and the best legal services, free of charge, to meet their challenges." More than thirty years ago, with congressional legislation, four national Veterans service organizations, The American Legion, Disabled American Veterans, National Veterans Legal Services Program, and Paralyzed Veterans of America, created TVC to enlist and train volunteer lawyers who, on a pro bono basis, would represent Veterans in appealing denials, reduction, or termination of disability compensation and other benefits from the Department of Veterans Affairs. The appeals, heard by the U.S. Court of Appeals for Veterans Claims, involve a wide range of issues: VA disability, educational assistance, survivor benefits, and pension benefit claims. The injuries suffered by these Veterans run the gamut from psychological to all manner of physical infirmities, including impaired vision, hearing loss, degenerative joint disorders, heart conditions and various types of cancers.

In recent years, TVC has expanded its legal services to address other legal needs for Veterans. These services include our Discharge Upgrade Program, Women Veterans Legal Assistance Program, and Veterans Naturalization Assistance Program. TVC also offers a Veteran and VSO helpline. Our contact information and helpline information can be found here: website, https://www.vetsprobono.org/, helpline no. and e-mail address, (855) 466-9678 or helpline@vetsprobono.



Pro Bono Opportunities:

TVC Federal Veterans Pro Bono Program (Nationwide)

This pro bono program provides representation for veterans and their families appealing the unjust denial of their VA benefits from the Board of Veterans Appeals (BVA) to the U.S. Court of Appeals for Veterans Claims (CAVC). TVC trains & mentors volunteers to represent them to regain eligibility for benefits.

Contact: volunteer@vetsprobono.org

TVC Discharge Upgrade Program (Nationwide)

This pro bono program serves veterans who have received a less than honorable Discharge due to conduct related to Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), Military Sexual Trauma (MST), anti-LGBTQ+ policies and/or other mitigating factors.

Contact: upgrades@vetsprobono.org

TVC Women Veterans Legal Assistance Program (Nationwide)

In addition to managing the Pro Bono Legal Clinic for Women Veterans (one of only 3 in the nation), WVLAP focuses on outreach and education to women veterans and informs them of their rights and the legal avenues available for their unique legal needs. This pro bono program provides representation for women veterans who are filing for VA disability compensation or appealing claims for conditions related to military sexual trauma (MST).

Contact: wvlap@vetsprobono.org

Veterans Naturalization Assistance Program (Nationwide)

VNAP assists veterans applying for naturalization through military service. TVC volunteers are trained to assist veterans with their naturalization applications which involve gathering evidence, writing defenses when needed, and ensuring applications are properly completed. Practicing Immigration attorneys serve as Mentors to volunteers when needed.

Contact: vnap@vetsprobono.org

TVC Client Services (Nationwide)

Our TVC Client Services team liaises with the Court, our veterans and VSOs to ensure appeals are filed in a timely manner. We operate a national helpline for pro se appellants at the U.S. Court of Appeals for Veterans Claims to help veterans understand the Court's processes. Client Services also provides forms and other documents for representation, as well as resources and referrals as needed.

Contact: mail@vetsprobono.org

*As of May 2023

TVC Legal Advice & Referral Clinics (DC, MD, VA Metro Area)

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10 AM - 2PM, every other Tuesday. Appointments are required. Call (202)-733-3329 to book an appointment.

Legal Advice & Referral Clinic

Pro Bono opportunities for all attorneys!
10 AM - 2PM, every other Friday. Appointments are required. Call (202)-733-3317 to book an appointment.

Clinics@vetsprobono.org **Contact Us!**

Chief Judge, Margaret Bartley, U.S. CAVC

"The Veterans Consortium Pro Bono Program is the gold standard; providing assistance to the veterans they serve and mentorship to the volunteer attorneys they train."

TVC National Volunteer Corps Member

"This is one of the best run programs out there. The training was top notch and the mentors are very knowledgeable and helpful."

For more information contact us at www.vetsprobono.org

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ABOUT THE AUTHOR

Colleen E. Miller currently serves as the Deputy Director of Volunteer Outreach, Education, and Placement for The Veterans Consortium's CAVC Practice. Prior to joining The Veterans Consortium, Colleen Miller served as sole legal counsel of operations for The Collier Companies, a multifamily housing management and real estate development company with over $2.0B assets under management and over $1.0B in development. She also served as a Career and Professional Development Advisor for the University of Florida Levin College of Law. Colleen Miller previously served as the co-managing partner for Quarles & Brady LLP's Tampa office. With over fifteen years of experience, she specialized in commercial loan disputes, title issues, creditor's claims, construction defect and insurance coverage disputes in both state and federal courts. While at Quarles & Brady, Colleen chaired Quarles Cares for the Tampa office and grew its community outreach programs and charitable contributions. She also developed and implemented Quarles's partnership with The Veterans Consortium across its ten offices. Through this partnership, attorneys represented Veterans in their appeals for disability benefits before the United States Court of Appeals for Veteran Claims.

Colleen graduated summa cum laude from Texas Christian University with a Bachelor of Arts in Biology and a Bachelor of Science in Criminal Justice. In 2007, Colleen graduated magna cum laude with a Juris Doctor from the University of Miami School of Law. She resides in Maryland with her husband, Joshua Miller, and their retired racing greyhound, Lara, and adopted cat, Mac.

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Closing the Chapter: Stepping Away from Policing and Into a New Mission

By SGT (RET) Caleb Payne

This is a very difficult and painful thing to write, so please bear with me.

I am medically retiring from law enforcement.

I grew up in a law enforcement family, so I suppose you could say it is in my blood. Having grown up around the profession, I knew it was something I wanted to pursue for myself. In many ways, I knew what I was getting myself into.

Then again, there were many realities I did not understand as I entered the academy in April of 2011.

Law enforcement is not an evil profession. It is a noble one. Society needs guardians who will stand up to the evils of this world and protect the innocent. I am proud to have done that exact thing for nearly twelve years.

Being a law enforcement officer changes every aspect of the way you see the world. It means never sitting with your back to the door and knowing all available exits. It means never feeling truly present in church because your head is on a swivel while scanning for threats. It means the "look" your wife immediately recognizes in public and tells her to take the kids to the car because someone you have arrested recognizes you. It means having a deep mistrust of most people.

Most people will never comprehend the amount of stress the law enforcement profession takes from those who boldly step into the unknown, shift after shift. The magnitude of liability, the authority to deprive people of their liberty, and the power to use brutal force when necessary is one that I never took lightly, but the weight of it is constant. Whether at home or at work, the weight is there, and the burden is so very heavy.

Add to that the weight of hugging and kissing your wife and children goodbye, while promising you will see them in the morning, knowing full well that it may be the last time you walk out the door. There are no words for this.

PTSD is a very real thing. In fact, it is no joking matter. It is so much more than anxiety. It is a mental injury that affects your entire existence and terrorizes your every moment. Anger. Despair. Feeling like a disappointment. Feeling unsafe, even at home. Feeling weak. Flashbacks. Irritability. Nightmares. Panic attacks. Sensory overload. Trying to sleep, but seeing their faces and hearing their pleas for help when you close your eyes. Unknown triggers that bring you to your knees, make you nauseous, and take your breath away. Wanting to die so your wife and kids will be better off.

First responders are repeatedly exposed to traumatic circumstances the average person could never grasp. I will not enumerate here the things I have seen, done, or been exposed to, but I can assure you that many of those heartbreaking situations are as real to me today as they were when they occurred.

I learned several months ago that it is okay to admit that you are not okay. Let me repeat that. IT IS OKAY TO ADMIT THAT YOU ARE NOT OKAY. Not only is it okay, but it is also noble. In fact, I have learned that it is the bravest thing you can do, not just for yourself, but for those you love and for those who love you.

Admitting to my command staff that I was struggling was the hardest thing I have ever done. In law enforcement, you learn to cope with things by stuffing them down or laughing them off. However, I have learned the hard way

POLICE
PAYNE

that unaddressed trauma builds and can quickly become unmanageable.

So here I am. After hours and hours of counseling and psychotherapy, and thousands of dollars spent out of pocket on my well-being, I am walking away.

Over the last several months, Kylie and our little ones have seen me struggle like never before. While I have reassured them that my struggles are not their fault, it has been tremendously difficult for us as a family. They have seen me at my deepest and darkest, but they have loved me unconditionally. They have been a source of joy and inspiration during my darkest days. I truly have no idea where I would be without them.

So, what is next for my family and me? I have applied for and been accepted into Xavier University's ABSN program in the hopes of becoming a pediatric nurse. After what my family has endured with two NICU hospitalizations, Kylie and I believe that I am being called into the nursing profession so that I can love on little ones and minister to parents who are in the same shoes we once wore.

I will always be grateful for my time as a cop. I made friends that became family. I learned so many things about myself. I accomplished more than I ever thought possible. I became a field training officer. I earned an extremely difficult certification as a Drug Recognition Expert. I was promoted to sergeant.

More importantly, I always did my best to serve honorably. I always tried to keep the parable of the sheep and the goats at the front of my

mind while recognizing that I was in a position to interact with "the least of these" on a daily basis.

There are so many things I will miss as I close this chapter. The brotherhood. The camaraderie. The adrenaline. The funny stories. The getting impaired drivers off the street. The phone calls to Momma on my way in every night and her diligent prayers of protection over my fellow officers and me.

Despite the things I will miss, I look forward to a bright future. One where my wife and children will not be afraid of losing me to the unknown as I walk out the door. One where I will feel safe and able to breathe again. At the end of the day, my career accolades and accomplishments mean nothing if my family cannot be together, healthy, and whole.

In the midst of this battle, God has been faithful and surrounded me with other people who, like me, battle PTSD. They have been a tremendous encouragement, as I hope I have been for them. My hope is that God is ultimately glorified in this season and that He uses my story to help others.

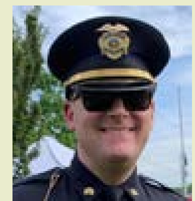
If you have read this far, thank you. Kylie and I would appreciate your prayers for our family as we move forward from all we have known in our marriage. We will certainly grieve the loss of this chapter of our lives, but we look forward to what is to come.

Again, it is okay to admit that you are not okay. It does not make you weak. It makes you strong. It is okay to have PTSD. It is not a blemish on your ability or character. It is a mental injury.

If you are struggling, reach out. You do not have to fight alone. If you know someone who is struggling, reach out. PTSD is not contagious, so check in. Be there. Empathize. Listen.

Love to you all who are doing just that for so many souls in need.

ABOUT THE AUTHOR



Caleb Payne is a medically retired police sergeant from Butler County, Ohio. He was raised in a law enforcement family, where he learned to revere and idolize law enforcement officers. He began his own career in law enforcement upon entering the police academy in April of 2011.

Over the course of his career, Caleb earned certifications as a Field Training Officer (FTO), Drug Recognition Expert (DRE), and Standardized Field Sobriety Test (SFST) Instructor. In June of 2019, he was the youngest officer ever promoted to Sergeant at his agency. His dream was to eventually become chief of his agency.

In February of 2022, Caleb was involved in a fatal shooting in the line of duty. After returning to duty after a short time off, he quickly began to understand the harsh reality of PTSD. Ultimately, he decided to walk away from the only life he had ever known and to choose his family and his mental health over his career. He now looks forward to serving in a different capacity.

Caleb lives in Butler County, Ohio with his wife, Kylie, and their three precious children. He is a lover of military aviation, the Chicago Bears, and the Cincinnati Reds.

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