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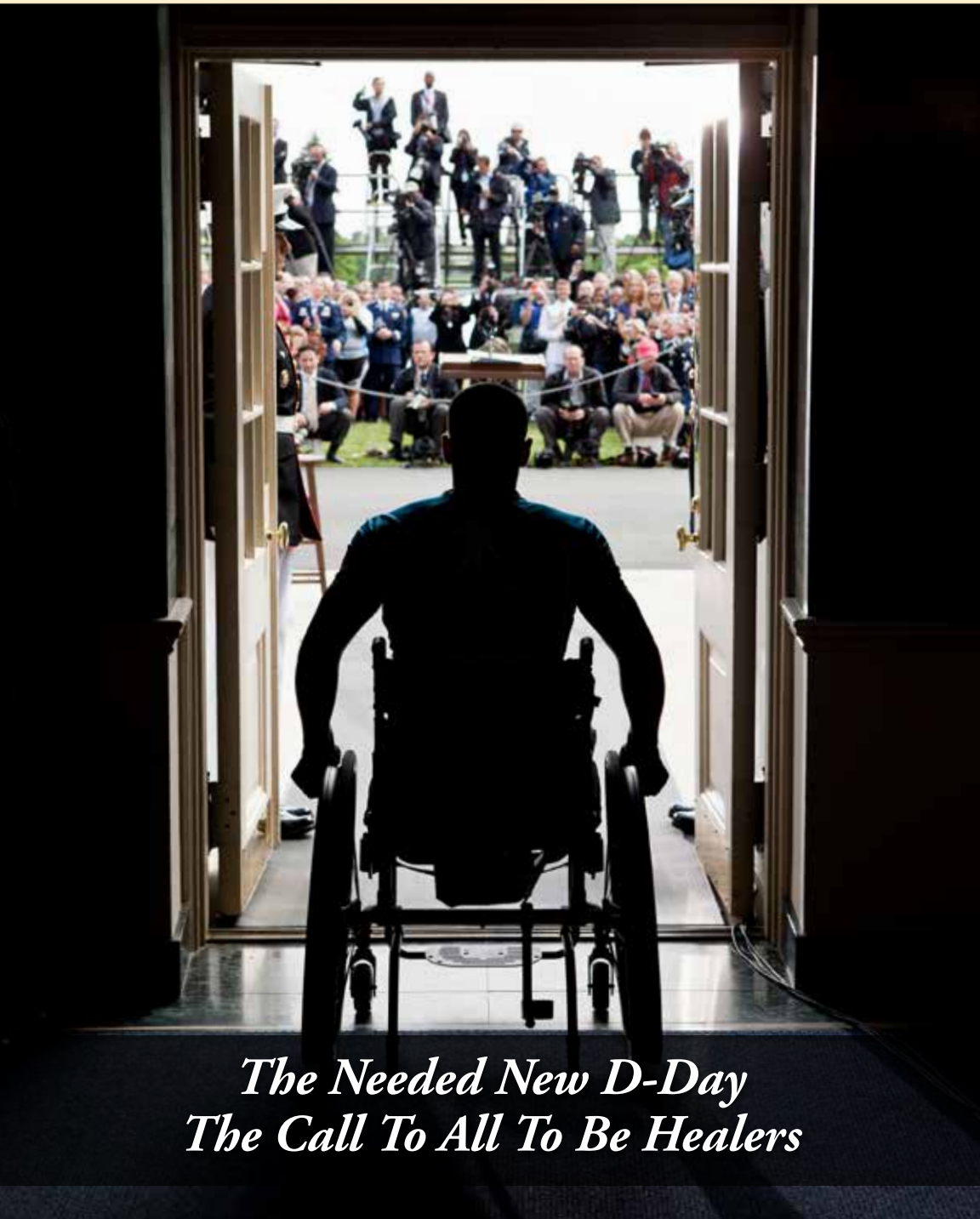

The Needed New D-Day
The Call To All To Be Healers

Remembering President John F. Kennedy
For the 60th anniversary in 2023 of his loss to us all
November 22, 1963

Journal of Health and Human Experience

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The Journal is an interdisciplinary, academic, peer reviewed international publication. Its mission is to explore the full expanse of holistic and integrated health within the nature and meaning of human experience. Its scholarly and professional explorations richly convene all possible areas within the arts/humanities and the sciences, cultural and social concerns, diverse technologies, ethics, law, civil rights, social justice, and human rights. The Journal invites the reader into the fullness of our human nature, our history, and the expanding futures before us.

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The Critic's Choice

Under City Lights

The Semper Vi Foundation

"From Victim to Survivor to Victor"

Mission: The Semper Vi Foundation is a 501(c)(3) tax exempt public charity dedicated to the design, development, implementation, and promotion of social justice and human rights resources, programs, and diverse opportunities in education, publishing, research, and services that help the suffering find healing and meaning in their lives. Of particular interest for the Foundation's mission is Wounded Warrior Care and, equally, the care of all those who suffer in our wounded world.

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Values: Those who become involved with Semper Vi programs practice the Foundation's three core values: *Learning*, *Healing*, and *Serving*. Foundation participants seek to show those who have suffered that healing can be theirs especially when their stories and experiences become sources of comfort and care for others

Programs: Semper Vi Foundation activities are organized into four programs.

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Research: The Foundation serves as a sponsored projects college for investigators looking to promote a wide variety of academic and professional domains of inquiry. The Foundation promotes such programs in collaboration with various global universities, centers and institutes.

Social Justice Services: The Foundation serves as a gathering point for individuals and communities who design and promote diverse social justice services and resources supporting human and civil rights. The Foundation supports already existing approaches and promotes the invention and launching of new services to meet emerging social justice needs across the globe.

Reflection: Tales of heroes abound throughout world literature. Our attention is always captured by the stories of those who accomplish great deeds that benefit others and the world. Yet what is it that we mean by the term, "hero?" When is something "heroic?" A hero is one who, despite danger and weakness, musters the courage to sacrifice herself or himself for the needs of others. Sometimes this comes at the price of the hero's life. However, in all instances, the hero vanquishes the danger and rises above it as victor. Yet there is another nuance. The work of the hero often goes deeper. In many tales, the hero not only fights the oppressor, but also suffers grievous wounds in doing so. The hero embodies the suffering and takes it into her or him self. The hero endures and survives. Yet even more amazingly, in these stories the suffering and pain are transformed from curse to blessing. The hero matures from victim to survivor to victor! The hero becomes *"semper victorius!"* Always the victor!

Invitation: Join us as we build Communities of Victors, for today and tomorrow!

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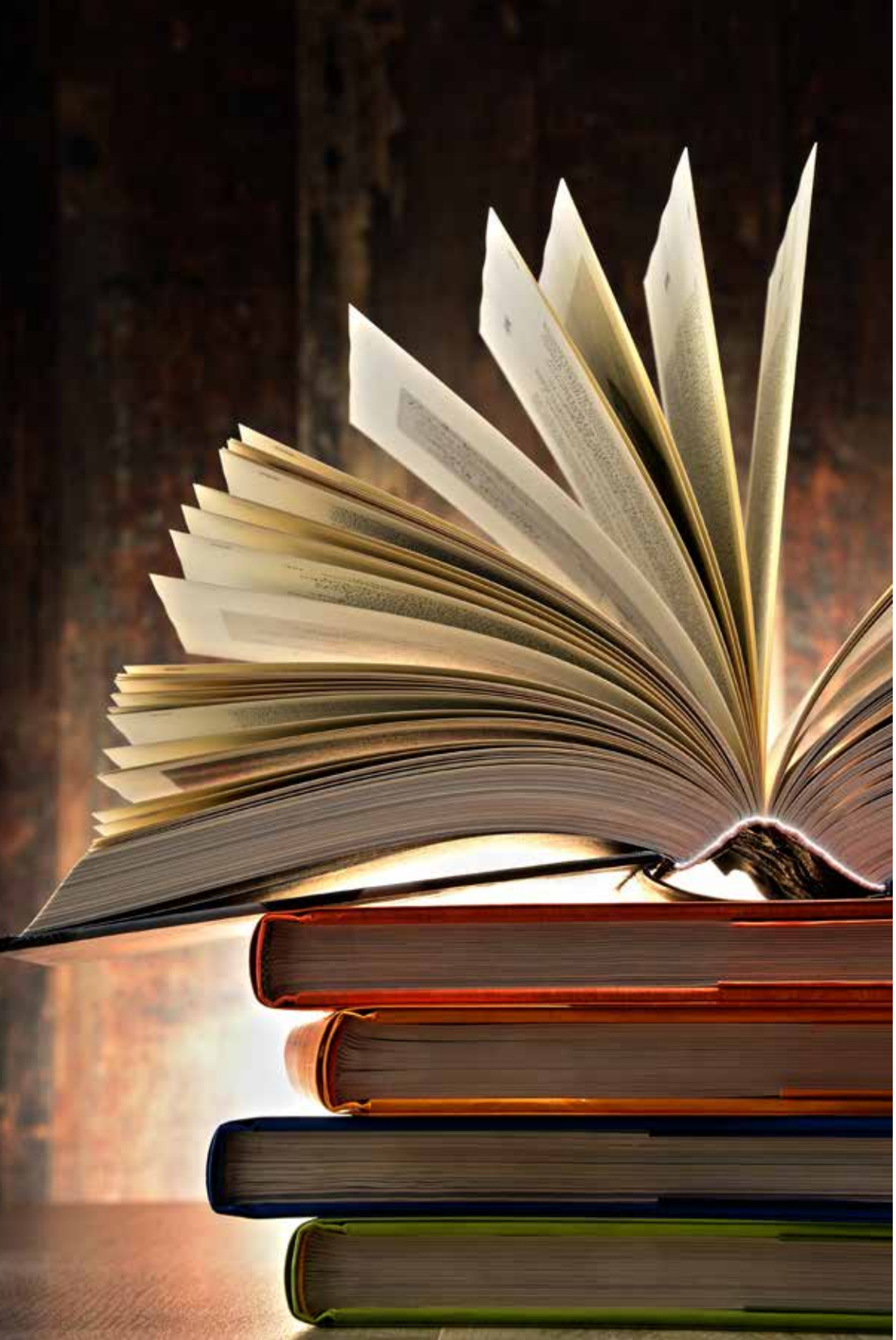

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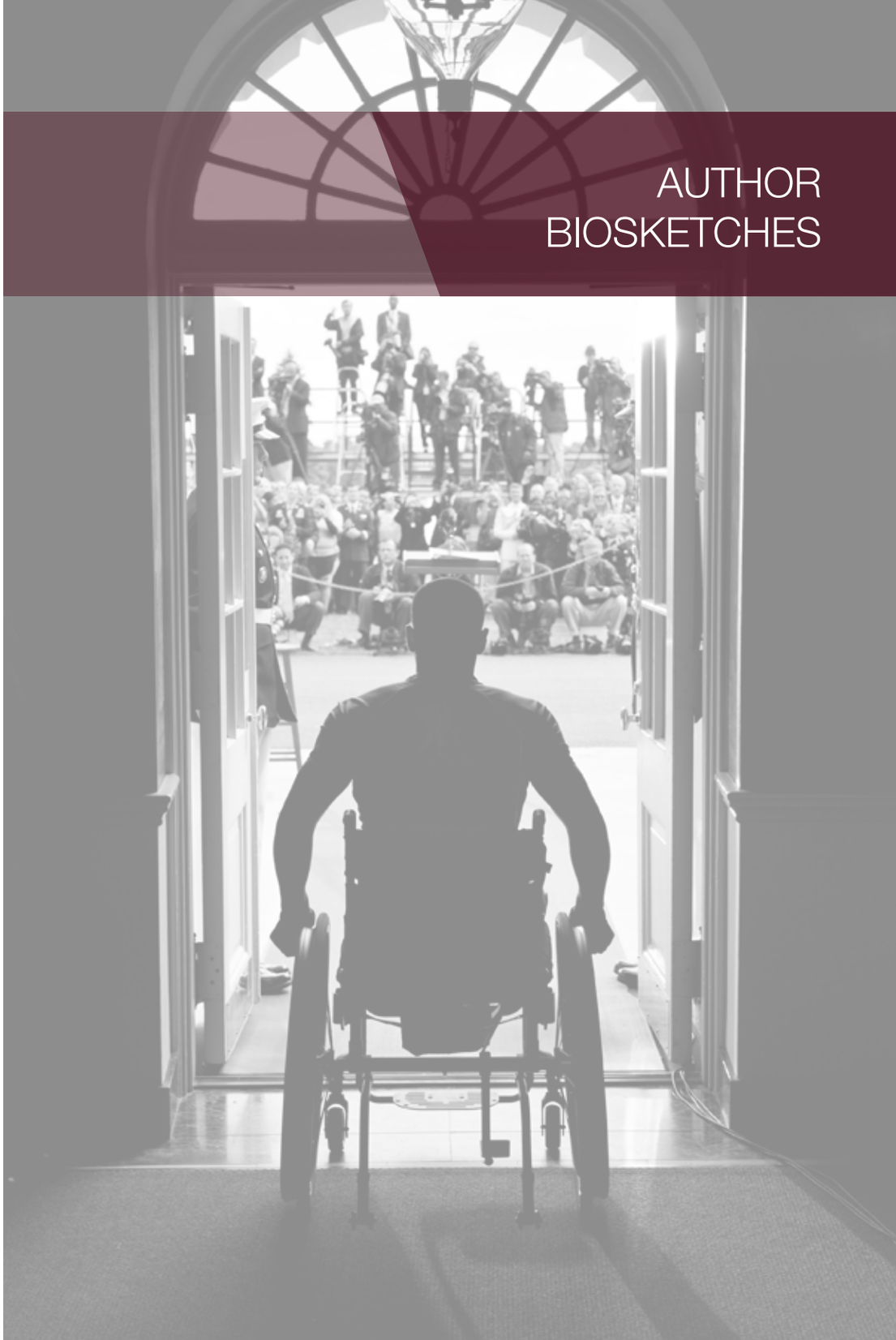

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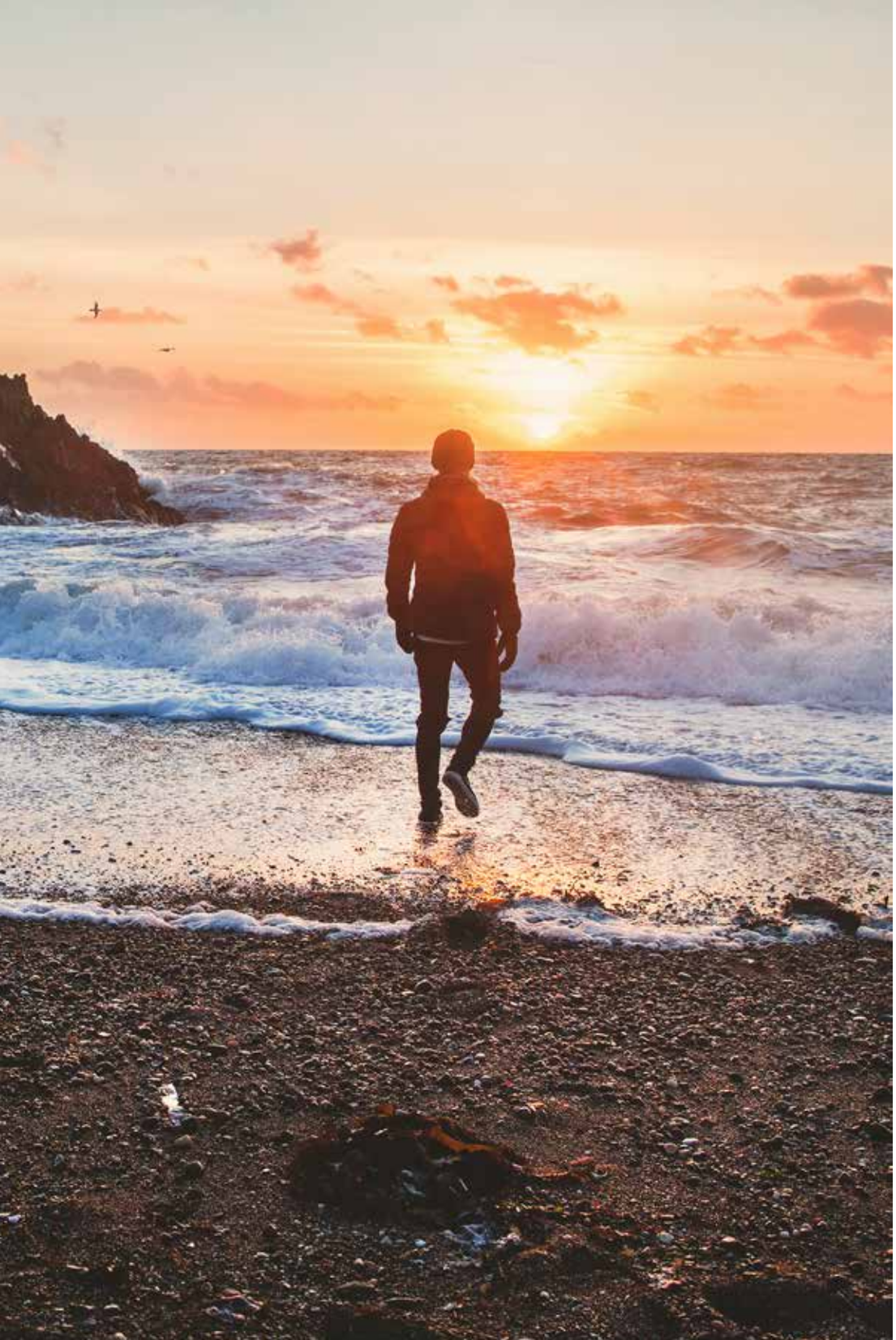

The Shores Before Us…..The Callings Continue

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This year marks the 80th anniversary of one of the most powerful moments in history for the United States and for the whole world.

D-Day

On June 6, 1944, the Western Allies, including the United States, landed on the beaches of Normandy in France to liberate Europe and defeat the horrors of Nazism and the dictatorship of Adolf Hitler. This battle would be the beginning of the final year of World War II. On this day thousands stood up to fight for life, liberty, and happiness, especially for those who for years had been suffering under the anti-human hate of Nazism. And among all the Western Allies, the price of this courageous landing would be staggering.

According to various sources, on D-Day itself more than 5,000 defenders would be wounded. And 4,414 would lose their lives, including 2,501 Americans. In the Battle of Normandy that followed, 153,000 were wounded and 73,000 were killed in action.

Indeed, this was a day that raised up the cost of giving one's life for one's country and for freedom for all. Indeed, D-Day is a moment in history that raises up for us the unfathomable dedication of those who accepted their calling, per the famous quote from the 1992 film *A Few Good Men:* "…to defend those who cannot defend themselves." It raises up the same for all of us today and always.

What a powerful anniversary and remembrance, including for all who journey on every possible pathway to bring wholeness and healing to anyone who suffers. Indeed, our women and men in uniform then and today remind us what it means to serve all those in need…and in a particular way those who suffer from hate and discrimination of any and every form.

Interestingly, leading up to this year's 80th anniversary of D-Day, the last months of 2023 also contained powerful anniversaries that provide deeply related reflections and calls to dedication and service. Last year was the 60th anniversary of the horrific assassination of President John F. Kennedy. It was also the 80th anniversary of Lieutenant, Junior Grade Kennedy and his shipmates becoming Wounded Warriors during the epic PT 109 incident in the Pacific. And of related significance in our own times, last year marked the 20th anniversary of the founding of the Wounded Warrior Project.

Powerful anniversaries indeed. And they surely raise up powerful reflections and calls to service so needed especially in our times.

With all these historic moments in mind, something very striking keeps surfacing. Is D-Day really a past event just to be remembered and then left aside when the date passes? Or is it something far deeper? I believe it is deeper than we can ever imagine. In fact, it is a living metaphor that opens up before us completely unforeseen portals of powerful meaning and possibility.

D-Day is always before us. Within all of our various professional positions and commitments there is ever a "new shore" that calls us to new and needed action. And these "new shores" are many. As we look at our world today, many needed callings are before us --- especially to stand up and fight against all the forms of hate and discrimination we are seeing and so many are experiencing. Indeed, we have a deep calling today to confront inequality and then promote the fulness of social justice and human rights. But there is another shore that also needs our landing with determination to change for the better.

That shore is the one inside each of us.

Each of us bears inside us, whether consciously or subconsciously, a variety of beaches that need our landing so as to change, develop, and deepen our own humanity in our very selves. We have a common calling to make the decision to launch onto the inner shores of who we are so as to grow and develop. This calling beckons us to go deeply inside our own selves and discern where we need to bring to our own internal beaches the needed defense to change where we perhaps subconsciously are not being true to humanness. We must find out what must be changed within ourselves for us and for our relationships both professional and personal. And while deeply within, we must also be open to the callings we are being given to promote and walk new pathways for positive growth and development for ourselves and for others.

In all of this, our D-Day defenders and heroes like President Kennedy and all of our Wounded Warriors stand before us inspiring us. Their presence calls each and all of us to know the experience of healing within our own personhoods. And, regardless of the price, their presence deeply moves us to hear and accept our own callings to become true healers ourselves for one another and for all those we meet in our own lives and in the world. The shores and beaches are before us. And the callings continue.

Indeed, D-Day is ever before us. Where are we being called to launch and land today?

Special Notation

The opening photograph is from the artistry of Joshua Earle. It depicts a man walking on a beach shoreline in Wales during sunset. It is listed as in the public domain on Wikimedia Commons at: https://commons.wikimedia.org/wiki/File:Exploring_Wales_(Unsplash).jpg

The concluding photograph is of US Army First Division troops disembarking on Omaha Beach on D-Day. A DoD photograph, it is in the public domain per Wikimedia Commons where its full information is found: https://commons.wikimedia.org/wiki/File:1944_NormandyLST.jpg

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Conflict, War, and Terrorism: Sensorimotor Psychotherapy with Civilian Victims of Trauma

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Special Editorial Introduction

The article that follows is a renewed version of the author's original article that was published in the Journal in 2015. The original article's information is found in the references (MacKinnon, 2015). With the author providing a wide variety of updates and revisions, this new version is deeply meaningful. Its message is very moving given the wide range of critically important social situations and life circumstances many are experiencing across the globe today.

Author Note

This article is a revised and updated version of an article written by the author (MacKinnon, 2015). The opinions expressed herein are those of the author alone and do not represent those of the institutions he serves. The author has no conflicts of interest.

Abstract

Civilians who have been victims of war, conflict, and terrorism and who are traumatized are likely to experience consequences that affect both the mind and body. An individual's narrative story is a product of their cognitions and affect but also contains the narrative of the body. Since body and mind are linked, the mind is connected to the experience of the body and the body is connected to the experience of the mind. The body becomes the focus of treatment as the therapist slowly begins to safely assist the patient to express what is contained in mind and body. In war, conflict, and terrorism the civilian trauma survivor is a victim of hate, prejudice, discrimination, and violence. Violence can occur as a result of hate and prejudice in war/conflict, racism, ethnic discrimination and attempts at racial/ethnic cleansing. The DSM-5 (2013) has a diagnosis of PTSD whereas the ICD-11 (2019) not only utilizes Post Traumatic Stress Disorder (PTSD) but has included Complex Post Traumatic Stress Disorder (CPTSD) and Prolonged Grief Disorder (PGD) which permits practitioners greater flexibility for applying tailored treatments and research. Sensorimotor Psychotherapy (Ogden, 2021) is a mode of treatment directed toward assisting patients to explore their internal experience

of trauma and combines that with the trauma to the body. The goal is to integrate the body with the cognitive experience of trauma to reduce the possibility of re-experiencing the body triggering off trauma symptoms.

Keywords: psychotherapy, hate, violence, DSM-5, ICD-11, civilian war, conflict and terrorism, trauma, sensorimotor psychotherapy

Introduction

A previous article by this author focused on Sensorimotor Psychotherapy as it is conceptualized, understood, and practiced in treating trauma with soldiers and veterans of war (MacKinnon, 2015). Sensorimotor Psychotherapy has been a psychotherapeutic approach for treating trauma by engaging the somatic experience where the body also becomes a container of the trauma experience. The body becomes the container of an external, physical insult, while the mind provides the meaning to the experienced physical insult. The psychological meaning given to a traumatic experience becomes a part the person's "story." Therefore, the human story includes experiences embedded in the physical body. The body ultimately responds to human experience where it is capable of performing heroic feats, on the one hand, and yet, on the other hand, can be betrayed by illness, disease, and trauma. The body remembers, creates, and transforms the meanings of "self" in its emotional capacity, psychological representations, and psychophysical constructions in the effort to cope and psychologically function. What happens to a person's body may be transformed by their capacity to reconfigure the cognitive meanings of what has occurred to their body but also to reconfigure the meanings of what has occurred within their psychological and physical body.

The physical body and the psychophysical meanings given to the body have emerged, in recent years, as an important element in the treatment of trauma and stress responses to environmental events. The premise behind body-mind psychotherapy and somatic psychology is the view that "the body reflects the mind and the mind reflects the body" (Aposhyan, 2004, p. 12). Although numerous investigations in the literature are concentrated on trauma work with soldiers and veterans of war suffering from both mental and physical injuries, civilians in war, conflict, and terrorism also suffer from the devastating effects of traumatic assaults to mind and body. The underlying causes of war, however complex, are overshadowed by civilians who witness their communities being destroyed, displaced from home, fragmented families, injured bodies, loss, grief, and death. The deeper roots of war, conflict, and terrorism ultimately stem from hate, prejudice, and discrimination leading to violence toward a particular group or groups of people.

The Psychology and Trauma of Hate and Violence

The effects of war on civilian populations have gained increased attention resulting from numerous conflicts and wars around the world. War, violent conflicts, and terrorism as waged in various countries bring us to acknowledge the stress and devastating, traumatic effects of war on civilian communities and individuals. War, conflict, and terrorism appear unavoidable, and their causes and maintenance are complex. Whatever the causes for war, violent conflict, and terrorism, Johnson and Thompson's (2008) review identified the effects of war on civilian populations leading to a range of severely traumatic experiences, including fears of being in danger, being witnesses of extreme violence, displacement from one's family and community, being detained in a concentration camp, and fears of being tortured. Vincenzes (2013) indicates that civilians' exposure to multiple traumas distinguishes their experience when compared to soldiers.

Trauma and stress are not limited to war, conflict, and terrorism. The role hate and prejudice play in discrimination and ultimately violence is well documented but limited in research in the social sciences (Sugarman, et. al., 2018). Trauma is a recognized consequence of racism and ethno-racial violence (Cenat, 2023; Williams, et. al., 2018) and has inclusion in the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5, 2013). "Post-traumatic stress disorder (PTSD) is a reaction to a traumatic experience that impacts various facets of human functioning, including cognitive, behavioral, and affective components. PTSD is a highly disabling condition that tends to elicit pervasive and maladaptive avoidance behaviors associated with the traumatic experience" (Williams, et al., 2018, p. 243).

Hate crimes are on the rise in the United States. The Department of Justice (2023), Federal Bureau of Investigation defines a hate crime as a committed "criminal offense which is motivated, in whole or in part, by the offender's bias(es) against a race/ethnicity/ancestry, religion, sexual orientation, disability, gender, or gender identity. The report identifies that 65% of victims were targeted as a result of race/ethnicity, 15.9% were targeted for their sexual orientation, and 14.1 % targeted because of their religion" (p. 5). Hate-based violence is recognized as a trauma-inducing experience which "can lead to serious and potentially chronic traumatic stress reactions (including but not limited to posttraumatic stress disorder [PTSD] and complex forms of traumatic stress symptoms) can provide a framework for reducing the stigma experienced by survivors and increasing their access to effective treatments" (Ghafoori and colleagues, 2019, p. 5).

Prejudice and discrimination are typically at the foundation of hate-based violence. This violence can take the form of verbal violence, which may include degradation, harassment, humiliation, and threats. Hate-based violence may also take the form of physical violence, such as bullying, sexual violence, and maiming, and can go as far as murder and genocide. Ghafoori and colleagues (2019), citing key points of the international perspectives on trauma indicate that hate-based violence "is a traumatic stressor designed to instill fear and anxiety, inflict psychological damage, diminish a sense of belonging, exclude a group identified as "other," and/or expunge a group from the community" (p. 6). The traumatic impact of hate-based violence may be wide-spread, and the social consequences are generally complex. The traumatic events associated with these behaviors can be aligned with DSM-5 (2013) PTSD and attending physical and psychosocial disruptions. This potentially undermines the survivor's trust and confidence in their own sense of self and a mistrust of social institutions. Hate-based violence has increased in recent years (Department of Justice, 2023).

A preliminary study by Shevlin, Hyland, and Karatzias (2022) highlights the massive mental health affects to the civilian population in Ukraine as resulting from Russia's invasion and genocide in 2022, and previously in 2014. The study indicates that people "exceeded clinically accepted thresholds for PTSD (21%), depression (22%), anxiety (18%), somatization (55%), and hazardous alcohol use (14.3% of men and 1.7% of women)" (p. 105). Ukrainians are likely to experience mental health problems that fit the criteria for complex trauma and prolonged grief as a direct result of the war.

The emotions and attitudes behind hate are at the root of behavioral acts of prejudice, discrimination and/or violence. The extremes of this thinking and feeling is the desire to eliminate a person or group who symbolizes what is despised within the violent group. Violent groups promote violent behavior among their members by removing psychological obstacles to violence (i.e., by making violence less aversive) and by increasing members' motivations to engage in violence, particularly through group identification (Littman and Levy Paluck, 2015, p. 79).

Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress is a response following the experience, the witnessing of, and exposure to an overwhelming or life-threatening event. Trauma is an experience that can overwhelm the psyche and physical body in such a way that the ego is weakened, becomes fragile, and potentially becomes fragmented. The resultant reactions interfere with the person's daily functioning and relationships. The devastating effect on an individual's thoughts and emotions become exaggerated:

> When faced with danger, the body and mind will temporarily react to alarm by freezing, numbing, detaching, and forgetting. When the defense mechanisms have been overwhelmed, and there is a failure to restore homeostasis, the memory of that event also becomes encoded in a way that impairs cognitive consolidation (Williams, 2006, p. 322-323).

The operational diagnosis of PTSD originated as a distinct entity in the DSM-III (APA, 1980) and defined as the experiencing of an event that is outside the range of usual human experience and that would be considered distressing to almost anyone. The diagnosis was expanded in the DSM-IV (APA, 1994) as having experienced, witnessed or confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of self or others and, in addition the person's response involved intense fear, helplessness, or horror. It was considered an anxiety disorder. In DSM-IV-TR (APA, 2000) the person has been exposed to a traumatic event in which both of the following were present: (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and (2) The person's response involved intense fear, helplessness, or horror. Additionally, it included three cluster symptoms: reexperiencing of the trauma in the form of intrusions of thought, avoidance of stimuli associated with the trauma, and increased arousal.

Diagnostically, Post Traumatic Stress Disorder (PTSD) included emotional numbing as one of its major affective symptom clusters according to the DSM-IV (APA, 2000). In the revised DSM-V (APA, 2013) emotional numbing is subsumed under Criterion D (negative alterations in cognition and mood) in a new category titled Trauma and Stressor-Related Disorders. Concerns have mounted regarding the unintended consequences of these changes in the criteria from DSM-IV (APA, 2000) to DSM-V relative to the PTSD diagnosis.

Hoge, et. al., (2014) found that when using the Post Traumatic Checklist (PCL) for the DSM-IV (APA, 2000) in comparison to the Post-Traumatic Checklist (PCL5) for the DSM-V that 30% of combat veterans did not meet the criteria in DSM-V (APA, 2013) and 45% of those who did meet criteria had a discordant classification when the two sets of criteria were compared. This may present clinicians with some confusion regarding the emotional sequelae seen in combat veterans.

PTSD, in the DSM-V (APA, 2013) was no longer considered an anxiety disorder and given a new classification of Trauma and Stressor-Related Disorders. The hallmark symptoms in DSM-V (APA, 2013) include several cluster criterion including: A. the person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, B. the traumatic event is persistently re-experienced, C. the traumatic event is persistently avoided, and D. Negative thoughts or feelings that began or worsened after the trauma, and E. trauma-related arousal and reactivity that began or worsened after the trauma.

The inclusion of PTSD in the International Classification of Diseases (ICD-11) (WHO, 2019) is defined by 1) re-experiencing the traumatic event in the present in the form of nightmares, flashbacks, or vivid intrusive memories typically accompanied by strong emotions like fear or horror, 2) avoidance of reminders of the traumatic events, and 3) persistent perceptions of heightened current threat as indicated by, e.g. hypervigilance. The ICD-11 now includes a category of Complex Post Traumatic Stress Disorder (CPTSD) as a diagnosis and is organized around symptoms related to PTSD and symptoms related to disturbances in self-organization (affect regulation, negative self-concept, and disturbances in relationships) (Moller, Sogaard, Elklit, and Simonsen, 2021). In a study by Shevlin, et. al. (2018) whereby they studied DSM-5 (APA, 2013) and ICD-11 (WHO, 2019) diagnoses of PTSD, they concluded that the ICD-11 (WHO, 2019) diagnosis can be considered optimal in humanitarian contexts because clinical resources are limited. Because this may lead to fewer diagnostic cases of PTSD, they recommend screening for other psychiatric disorders post-trauma.

Conceptually, complex trauma (CPTSD) has a long-standing recognition as a disorder, however it has not been included in the DSM-5-TR (APA, 2022). However, it was included in the International Classification of Diseases-11th edition (ICD-11, 2019) providing practitioners a diagnostic classification of PTSD and CPTSD, which is particularly useful for civilians caught up in the conflict of war/conflict, and terrorism. In addition, the inclusion of Prolonged Grief Disorder (PGD) addresses the intense longing for a person who had died or preoccupation with thoughts of that person (DSM-5-TR, APA, 2022). Whereas PTSD denotes a time-limited duration of trauma experiences (e.g., car accidents, natural disasters, etc.) the addition of complex trauma (CPTSD) describes a chronic experience that continues or is repeated over months or even years (e.g., sexual abuse, war trauma, etc.). Nestgaard and Schmidt (2021) comment that the inclusion of CPTSD represents an important addition in diagnosing trauma. Although further research is needed, it increases access to more tailored treatments and stimulates further research.

Sensorimotor Psychotherapy with Civilian Populations

Beyond what has been generally known about trauma induced by war for soldiers, a recent report presented by the United Nations suggests up to 90% of the victims of war trauma are civilians (Rajasingham, Mardini, Milibrand, and Boketa (2022). Although there are many obstacles to assessing civilian victims in conflicts of war, community populations are subject to trauma related experiences which include but are not limited to: blast injuries and gunshot wounds which are predominant in the civilian populations. Extremity injuries were frequent with head and neck injuries and superficial/soft tissue wounds. Thoracic and abdominopelvic injuries were less frequent (Wild, Stewart, LeBoa, Stave, and Wren, 2020). Civilians can have wounded and damaged bodies that tell a narrative story just as those of soldiers wounded in war.

Civilians may be considered more vulnerable and fragile than soldiers and many casualties stem from war-induced poverty, hunger, and medical shortages, both supplies and facilities.

Victims of trauma report intense emotional responses without words and with no apparent connection to any precipitant or past experience. Even after the events have ended, traumatized individuals can continue to experience flashbacks and nightmares, fears, shame and rage, numbing of their feelings and bodily sensations, a loss of initiative and energy, where the body is experiencing a cumulative impact of chronic stress and life events, and subsequently develop Post Traumatic Stress Disorder (PTSD) (Fisher, 2019). Treatment of traumatic stress responses in recent years has acknowledged the increased use of somatic principles that incorporate treatment strategies and interventions that are focused on the physical and physiological symptoms of the trauma experience. Traditional "talking" psychotherapy forms the foundation where body-mind techniques are employed in the service of targeting the trauma more directly within the body. Body-mind strategies have been well known for many years. Their applications to traumatic experiences have allowed traditional talking therapy to become more robust with the inclusion of what the body is telling us about trauma.

Sensorimotor Psychotherapy (Ogden and Minton, 2000; Ogden & Fisher, 2015; Ogden, 2021) is a therapeutic approach that integrates traditional talk therapy with body-centered techniques to address the impact of trauma and stress on both the mind and body. It recognizes the intricate connection between psychological and physiological processes and seeks to help individuals process and integrate traumatic experiences through mindfulness, body awareness, and movement. They describe this dimension of psychotherapy as,

> ...a comprehensive method that utilizes the body as a primary entry point in trauma treatment, but one which integrates cognitive and emotional processing as well and emphasizes sensorimotor processing which entails mindfully tracking the sequential physical movements and sensations associated with unassimilated sensorimotor reactions, such as motor impulses, muscular tension, trembling and various other micromovements, and changes in posture, breathing, and heart rate (Ogden & Minton, 2000, p. 150).

Traditional psychotherapy for traumatic experiences has been primarily focused on conventional modes of talking therapy. As the therapist listens intently to the words and internal representations of the patient, the corresponding affect can be explored and understood. Listening to the conflicts presented by the patient can lead to new understandings of their experience and the meanings they give to it. Although conventional psychotherapy is helpful to many individuals, including those who have been traumatized, Sensorimotor Psychotherapy additionally targets the body for therapeutic intervention. Ogden and Fisher (2015, p.13) note that therapists are "mostly dependent on a client's verbal narrative. Yet the story told by the "somatic narrative"--gesture, posture, prosody, facial expressions, eye gaze, and movement--is arguably more significant than the story told by words.

The mind and body as a subject of inquiry have been an important dimension in the advancement of the treatment of traumatic experience and loss. The impact of psychological trauma on the body has only received attention in the literature (Ogden and Fisher, 2015, Ogden, 2021; Ogden, Minton, and Pain, 2006). Classen, et. al. (2020) reported on a randomized controlled trial examining the benefits of a 20-session sensorimotor psychotherapy group for women with histories of chronic interpersonal childhood trauma. Their main

hypotheses, that treatment would lead to greater awareness of their bodies and less bodily dissociation was reported to be successful. The intervention increased awareness of somatic experience but did not reduce dissociation. Langmuir, Kirsh, and Classen (2012, p. 219), in a pilot study using sensorimotor psychotherapy in group treatment of 10 traumatized women, found that there was significant improvement among members in increasing awareness of their bodies, dissociation and receptivity to being soothed. Mindfulness provided a therapeutic construct to teach skills that enhanced body awareness. Although this study demonstrated some limitations relative to a small sample size and a lack of a control condition, it provides some preliminary evidence of the efficacy of a "somatically informed group intervention."

In a systematic review and meta-analysis of body- and movement-oriented interventions for PTSD, Van de Kamp, et. al. (2019) found that the meta-analysis of 15 studies showed a significant decrease in PTSD symptoms. These included veterans and individuals who experienced trauma from exposure to early childhood abuse, natural disasters, and traumatizing events in occupational settings. They suggest further research is needed with body and movement-oriented therapies and that these complementary therapies use an integrative approach, often attractive to patients because they alleviate PTSD symptoms and enhance physical health.

It is the body's awareness that brings patients to an attentional focus centered around guiding them toward an awareness of their internal body sensations. Mehling, et. al. (2011) describes that body awareness therapies have demonstrated some effectiveness with a variety of medical conditions including chronic low back pain, pelvic pain, fibromyalgia, chronic pain, eating disorders and obesity, coronary artery disease and congestive heart failure, anxiety, and depression. A number of mind-body therapies may include, but are not limited to yoga, Tai Chi, body-oriented psychotherapy, mindfulness-based therapies and meditation are utilized for a variety of health conditions. Practitioners concentrated their theoretical positions on the integration of self where mind and body are not viewed as separate entities and the innate human capacity for embodiment. Overall, body awareness therapies seek for the "integration of mind, body and life context" (Mehling, et. al., 2011, p. 10).

Fisher's (2011) overview of Sensorimotor Psychotherapy characteristics describes it as a somatic approach backed by neuroscience research. Utilizing principles in psychodynamic psychotherapy, gestalt therapy, cognitive-behavioral therapy, and body psychotherapy the focus is on the patient's cognitive and emotional symptoms but also includes bodily and autonomic effects of trauma. The mind has a narrative to be understood as well as the body's narrative in the traumatic memory of the patient (the story includes the meaning of what is embodied). The focus in treatment is on the hallmark symptoms of trauma that include intrusion, numbing and avoidance. Additionally, the physical autonomic reactions of the body's narrative and affective dysregulation assist the patient in becoming more aware of their thoughts and feelings rather than interpreting or analyzing them.

> As the patient relates a traumatic experience, the therapist listens attentively, paying equal attention to the narrative and to the body responses until signs of unresolved emotional, muscular, visceral or autonomic activity are observed. Therapeutic interruption of the trauma-related reactions and refocusing the patient's attention to the somatic responses facilitate their being witnessed simply as sensations and emotions rather than experienced as signals of danger (Fisher, 2011, p. 176).

When signals are typically interpreted as dangerous, the body reacts accordingly with anxiety, however, through self-observation, patients can learn to notice the physical signs that are the indicators of dysregulated arousal. Ogden and Fisher (2015) describe this as the "wisdom of the body" (p. 77). Patients learn skills in becoming more aware of their bodies and the signals their bodies project through physical movement and sensations from their wounds.

> Those who feel betrayed by, fearful of, disappointed in, or angry with their bodies will find explanations for why they might have developed these attitudes, learn to understand their adaptive functions, and through this understanding, begin to cultivate more salubrious attitudes. Clients for whom disconnection from the body has been pervasive and resulted in unforeseen consequences, such as self-harm or accidents, might begin to understand that reconnection with the body and its wisdom can help them heal from the past (Ogden and Fisher, 2015, p. 77-78).

Ogden, Minton, and Pain (2006) identify a comprehensive psychotherapeutic treatment regimen that integrates the body in the overall experience of traumatic sequelae. When the body is subjected to a traumatic experience, the organism's established coping responses are activated. The psychological and physical response may not be adequate to compensate for what has been experienced. When the body is included in processing trauma, therapists can work more directly with physical sensations and movement and how they are connected to arousal and affect symptoms. The goal is to promote changes in cognitions, emotions, belief systems, and the ability to relate to others.

Traumatic events are encoded and processed at a subcortical level where past, present, and future are confused with one's present reality. The necessity of helping the patient sort through and understand past, present, and future thoughts and emotions along with the corresponding bodily sensations can move the patient in the direction of learning more effective ways of coping and relating to the world.

> The fact that reminders of the past automatically activate certain neurobiological responses explains why trauma survivors are vulnerable to react with irrational- subcortically initiated responses that are irrelevant, and even harmful, in the present. Traumatized individuals may blow up in response to minor provocations; freeze when frustrated, or become helpless in the face of trivial challenges. Without a historical context to understand the somatic and behavioral residues from the past, their emotions appear out of place and their actions bizarre (van Der Kolk, 2006, p. 277-278).

The convergence in treatment of psychological and neurobiological systems is necessary to enhance the organism's capacity to integrate psychophysiological arousal and symbolic representations of the traumatic experience. Saporta (2003) presents a theoretical proposal for synthesizing a psychoanalytic and neurobiological approach for understanding how trauma impacts an individual in their capacity for representation and self-regulation of "biological safety and alarm mechanisms" (p. 104). He argues that the overwhelming experience of trauma presents both biological and psychological reasons for why neither can be encoded just as verbal symbols. Words and linguistic categories are not adequate to articulate the trauma and the biological consequences of trauma interfere with the organism's capacity to symbolize what has happened.

In developing a three-phase model for integrating somatic experience in psychotherapy, Ogden, Minton, and Pain (2006) describe "sensorimotor psychotherapy" as a blend of "cognitive and psychodynamic therapies (such as attention to cognitive schemata and putting language to felt experience) with somatically based interventions (such as learning to track bodily sensations and working with movement)" (p. 188). In the present experience of the patient's body, how they begin to understand and track their body reactions, changes, and movements (both subtle and gross motor movements) become a part of the therapeutic process. More traditional therapists are skilled in listening and understanding affect, thoughts, and emotions in the patient's narrative. The therapist's role becomes that of an observer (body-reader) to the patient's physical presentation, movements, beliefs about their bodily experience and their capacity for regulatory processing of physical experience.

The initial phase of treatment, known as safety and stabilization (Phase I Treatment; Ogden, Minton, and Pain, 2006; Ogden and Fisher, 2015; Ogden, 2021) in the sensorimotor psychotherapy model provides opportunities for the patient to become aware of their inner experience (such as memories, images, emotions, thoughts, and bodily patterns) in a safe environment. This allows the patient the needed space to explore their own triggers with trauma and monitor internal resources. The patient is guided in developing internal psychological resources designed to increase self-regulation for both mind and body.

Patients are encouraged and guided to access a state of consciousness called "mindfulness." Mindfulness is a self-reflective state, cultivated by gently focusing one's attention inward. Patients are taught to be observant and more curious rather than fearful "about their emerging thoughts, emotions, sense perceptions, and their internal body sensations and movements" (Fisher, 2011, p. 174). The therapist guides the patient in identifying survival resources, the patient has used in the past. When bodily sensations arise, the therapist teaches patients ways of distancing themselves from trauma-related sensations. Mindful observation requires a mixture of psychoeducation and practice as the patient is making the shift from fear to curiosity and self-regulation.

Ogden (2021) notes, when addressing the use of Embedded Relational Mindfulness in Sensorimotor Psychotherapy that, "Trauma of all kinds (interpersonal trauma, the trauma of oppression, racism, and historical trauma) as well as relational stress (in significant relationships and in society at large) strongly influences unconscious processes that underlie explicit content in the therapy hour" (p.127). In the case of unresolved trauma an individual often feels powerless to dysregulated emotions, unsettling physical sensations, intrusive images, pain, smells, emotional and physical constriction, and numbing. These physical experiences, in turn, compromise one's cognitive sense of self, to cognitive distortions such as, "I am damaged," "I am a bad person," or "I cannot protect myself."

Mindfulness as an approach, is particularly useful as the somatic is addressed in therapy. The introduction and application of Embedded Relational Mindfulness is described in Ogden and Goldstein (2017) in working with children and adolescents. Mindfulness is not practiced as a separate task, instead it is incorporated in the moment-to-moment experience between therapist and patient. In the present moment, the patient is encouraged to observe their own internal experience as it becomes evident in the present moment. As the experience in the

present moment is disclosed, the patient is then encouraged to verbalize the experience as it is occurring. The therapist gives close and thoughtful attention to five "building blocks" of present moment internal experience-emotions, thoughts, perceptions of the five senses, movements, and body sensations (Ogden, 2015).

A group therapy process utilizing Sensorimotor Psychotherapy, Phase I stabilization of complex PTSD, was studied by Gene-Cos, Fisher, Ogden, and Cantrell (2016). The population included 20 subjects who met the criteria for PTSD. The treatment effect across four assessment measures indicated there was overall improvement, a reduction in PTSD scores, a reduction in depression scores, and improvement in daily life activities and close relationships. All but one subject moved on to Phase II. The goals achieved in the group included learning to regulate autonomic arousal and imitate others' willingness to learn new responses. Experiences that served as triggers within the session itself were reframed as learning opportunities. The therapist encourages the patients to use newly learned strategies to regulate arousal when triggered. As the patient increases their ability to effectively cope, it assists in stabilizing the patient during more difficult times.

Practical interventions specific to Phase I (Ogden and Fisher, 2015) include the exploration of bodily sensations and the ability to label them. Bodily sensations are integrated with emotions and used to explain dysregulated arousal patterns. This provides the patient with an understanding of how sensations, beliefs, and arousal patterns are associated with the trauma. Patients are instructed in recognizing triggers and regulating low or hypoarousal and the high or hyperarousal states which previously were not understood nor regulated well. Assisting patients in appreciating their strengths and the creative resources they have utilized in surviving is transformed by replacing the survival resources with more of their personal creative resources.

Phase II (Processing Traumatic Memory and Restoring Acts of Triumph; Ogden, Minton, and Pain, 2006; Ogden and Fisher, 2015) focuses on the integration of the traumatic events and merges it with the patient's narrative story rather than it being "split off from conscious awareness and stored as sensory perceptions, obsessive thoughts, and behavioral reenactments" (p. 234). As the patient is able to identify signs and effects of implicit memories (such as sensations, sensory intrusions, emotions, movements, and thoughts) they can develop new resources which assist the patient in making integrations into the painful events of the past.

Following the experience of trauma, the patient reacts defensively, almost as if time is suspended while the body continues to reenact the sequence of the traumatic event. "When the threat is perceived, mobilizing defenses are stimulated, then suddenly halted, followed by persistent dysregulated arousal and immobilizing defenses of freezing, collapse, and numbing" (Ogden, Minton, and Pain, 2006, p. 248). The therapist assists the patient by staying focused in the present moment and uses prompts, encouraging the use of resources. This helps the patient from becoming over dysregulated emotionally during memory work. As they feel a sense of empowerment that couldn't be used in the past, it addresses the emotional dysregulation that needed to be defended against.

The approach the therapist utilizes is to assist the patient in developing a sense of mastery and "triumph" by addressing incomplete defensive responses in memory. Acts of triumph refer to the resources of the individual prior to the traumatic event. Specifically, before trauma,

the patient would engage in actions that would help them overcome a sense of helplessness. Assisting the patient in recapturing the memories of pre-trauma "triumphs" begins to generate "skills and competencies, mental and physical actions, images, things, relationships, and memories that give people a sense of mastery and internal cohesion" (Ogden, Minton, and Pain, 2006, P. 244).

The therapist, in Phase II, carefully brings to awareness the non-verbal memory fragments of the remembered event. As the memory of the event is activated the therapist assists the patient to connect such memories with the somatic and autonomic experience in such a way as to help the patient regulate their arousal systems at a pace that is tolerable. The ability to regulate somatic resources and integrate them with the traumatic memories provides a level of mastery which expands the sense of tolerance needed to function more fully. The focus of sensorimotor processing of traumatic memories can allow the possibility of not activating somatosensory and physical stimulations that are disruptive to the individual's present functioning. Successful integration is realized when the patient is able to recognize that the trauma happened to them and when they experience bodily sensations associated with the traumatic event, they no longer are overwhelmed by it but instead can be more tolerant of it.

Ogden and Fisher (2015) have designed intervention worksheets that are practical and highlight memory, not only as it relates to real experiences in trauma, but also includes the subjective meaning of the individual's personal perspective. "Reconstructing a memory" (p. 469) focuses on positive experiences that occurred or resources used following the painful event. The focus in this phase is ultimately to restore a sense of empowerment by helping patients understand their "immobilizing defensive responses" and attempting to replace them with more adequate "mobilizing defenses" (p. 533).

Phase III (Integration and Success in Normal Life; (Ogden, Minton, and Pain, 2006; Ogden and Fisher, 2015) emphasizes moving clients forward in feeling empowered and to conceptualize and practically develop a life after trauma. Trauma can have a shattering and disintegrating affect in how the individual processes beliefs about themselves, others, and the world where the cognitive distortions attached to the traumatic memories may persist long after the actual symptoms subside (Janoff-Bulman, 1992). As the patient is now more equipped in reducing traumatic symptoms and resolving traumatic memories and has sufficient emotional regulatory control, the therapeutic experience moves forward to a re-engagement in life. The opportunity to adapt arousal systems, learn new skills and abilities creates opportunities for engaging more fully in social and attachment experience, displays more regulation of the energy needed for self-care, play, and sexuality.

As the meanings of self, others, the world, and the body are altered by the traumatic experience, this phase begins to address cognitive distortions directly related to the trauma and those not directly related. Ogden, Minton, and Pain (2006) identify that the goals associated with Phase III treatment include, "1) identify reflexive beliefs, 2) explore how they interface with physical tendencies, 3) endure the associated affects, 4) consider the inaccuracies of the beliefs, and 5) further develop their integrative capacity to challenge and restructure these beliefs and their somatic counterparts" (p. 271).

"Sensorimotor processing alone is insufficient; the integration of all three levels of processing--sensorimotor, emotional, and cognitive--is essential for trauma recovery" (Ogden,

Minton, and Pain, 2006, p. 300). As the patient is empowered by new thinking and the development of new skills, over time, have increasing abilities and tolerance for experiencing pleasure without activating fear and anxiety that defend against somatic reactions. Early in treatment, experiencing a positive affect may trigger feelings of anxiety and the goal is for a new experience of self without having affect activated by physical sensations associated with traumatic *sequelae*.

The ultimate hope and goal of sensorimotor psychotherapy is to empower traumatic survivors with a belief that they have achieved some sense of control over their experience and are strengthened by their experience; not hopeless nor powerless. "Teaching patients to find pleasure in bodily sensation and actions during therapy sessions paves the way for their finding pleasure, on their own, in other activities such as eating, touch, warm baths, and other sensual pursuits" (Ogden, Minton, and Pain, 2006, p. 297).

Practical interventions (Ogden and Fisher, 2015) at the third phase of treatment are cognitive in nature focusing on re-engaging attachments and re-configuring one's core beliefs as they relate to emotions. The use of mindfulness is critical in re-establishing one's understanding of and movement through the world post-trauma. Near the end of treatment, connecting in relationships and learning how to engage in "pleasure, play, and positive emotions" (p. 735).

It should be noted that, although this treatment regime is presented in a more linear fashion, therapy operates out of a mindset of flexibility. While some symptoms may re-emerge, it is appropriate for the therapist to engage the patient in managing somatosensory and memory responses as they are activated during the course of therapy.

Discussion

The body and mind have a story to tell in the experience of trauma. The exposure to war and conflict are inevitably embedded in the body. The mind cannot tell the story without the experience of the body and the body cannot tell the story without the mind. This is true for veterans and civilian experiences in war torn countries. Civilians face a prolonged period of recovery following traumatic experiences from war, conflict, and terrorism. Traditional psychotherapy has focused on verbal and cognitive presentations of the trauma experience. However, the incorporation of the body in the treatment regimen potentially offers a more complete treatment process.

Hate, prejudice, and discrimination are at the root of war, conflict, and terrorism which culminate in violence. Violence generally involves the civilian population in war and results in traumatic experiences for both mind and body. Johnson and Thompson (2008) identified the effects of war with civilians which include, fears of being in danger, being witnesses of extreme violence, displacement from one's family and community, being detained in a concentration camp, and fears of being tortured. Hate-based violence may also take the form of physical violence, such as bullying, sexual violence, and maiming, and can go as far as murder and genocide. Violent groups promote violent behavior. They are able to accomplish this by removing the psychological obstacles to violence (i.e., by making violence less aversive) and increasing members' motivations to carry out violent acts, a result of group identification (Littman and Levy Paluck, 2015, p. 79).

The diagnostic criteria of the DSM-5 PTSD category has evolved since its' inclusion in the 1980 DSM. The constant revisions to the present diagnostic nomenclature have occurred as the psychiatric community has tried to refine the diagnosis of PTSD due to it being a complicated and longstanding experience for trauma survivors. The ICD-11(2022) has gone forward with a CPTSD disorder in their system which has given practitioners diagnostic considerations for more complex manifestations of trauma. Although CPTSD has the criteria utilized for PTSD, it additionally includes a focus on self-organization (affect regulation, negative self-concept, and disturbances in relationships) (Moller, Sogaard, Elklit, and Simonsen, 2021).

Sensorimotor psychotherapy (Ogden, Minton, and Pain, 2006; Fisher, 2011; Ogden and Fisher, 2015) has been developed and conceptualized as a method of integrating the somatic, cognitive, and arousal functions of the person, which are activated as part of the traumatic experience. In civilian populations, the goal of Sensorimotor Psychotherapy is to integrate cognitive and affective disruptions with bodily insults to minimize long-standing traumatic symptoms and reenactments. Modulating arousal and affect can increase an individual's sense of control over the self. The ultimate goal of psychotherapy is to promote new ways of thinking about the self, relationships, one's experience in the world, and relating to these in new, positive, and productive ways. This includes relating to one's body as a primary mode of experience and interrelatedness with cognitive and arousal systems.

The three-phase model offered by Ogden, Minton, and Pain (2006) and Ogden (2021) and subsequently the volume of interventions (Ogden and Fisher, 2015) provide clinicians an additional mode of working with traumatized survivors to promote a more complete sense of self and one's ability to optimize functioning. Phase I (safety and stabilization) is designed for the patient to start by exploring their internal thoughts and feelings in a safe environment. Phase II (Processing Traumatic Memory and Restoring Acts of Triumph) focuses on the integration of the traumatic events and merges it with the patient's narrative story. Phase III (Integration and Success in Normal Life) emphasizes moving clients forward in feeling empowered and to conceptualize and practically develop a life after trauma.

In a recent meta-analysis review by Hoppen and Morina (2019) of individuals worldwide who have been impacted by war, they estimate that about 1.45 billion individuals experienced war between 1989 and 2015 (and about 1 billion were still alive in 2015). The estimate from this study was that about 354 million adult war survivors suffer from PTSD and/or Major Depression (MD) with about 117 million who suffered from comorbid PTSD and MD. Since most war survivors live in low-to-middle income countries with limited means to manage the vast mental health burden. Although physicians and surgeons care for and reconstruct the effects of physical trauma, psychologists and mental health practitioners work with cognitions, affect and the body.

The experience of trauma can present major and life-altering consequences for civilian members of a community. Experiences of trauma represent a challenge to the medical, psychiatric, and psychological sectors of the community seeking healing for survivors. The need is for continued long-term research and continued advances in psychological and somatic treatment. The ultimate goal is assisting survivors in the challenges of restoring their bodies, minds, and spirit to an optimal sense of functioning. "Our hope for all our patients is that they too can take up their lives as people who survived terrible experiences but were ultimately strengthened, not destroyed, by them" (Ogden, Minton, & Pain, 2006, p. 301).

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The Relationship Between Leadership Style and Staff Burnout in Healthcare

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Abstract

Occupational stressors, both internal and external, contribute to the critical challenge of burnout in the healthcare workplace. Leadership is one unique and powerful aspect of shaping the determinants of organizational culture and resulting presence of healthcare burnout among clinical and non-clinical staff personnel. With both known and unknown impacts of healthcare burnout, ranging from rising costs to variable outcomes in quality of care, establishing the relationship between leadership and burnout is paramount. Reflecting upon published literature on various leadership styles and resulting healthcare burnout prevalence helps illuminate key aspects of this relationship and offers a window of opportunity for improvements.

Keywords: burnout, leadership, healthcare, COVID-19, meta-analysis

Introduction

People are truly the most valuable component of any organization, particularly in the primary industry charged with the maintenance and optimization of individual wellness, namely, healthcare and hospitals. Existing and future healthcare leaders confront a unique and challenging landscape, particularly in recent years with the volatile evolution of a global pandemic and iterative aftershocks. While employees in every sector experienced dynamic obstacles and an acute increase in stress, healthcare workers: doctors, nurses, ancillary staff, and executives, alike, endured an exponential rise in exhaustion that compounded the known problem of burnout (De Hert, 2020). Indeed, all who work in healthcare are, arguably, essential employees with real exposure to the occupational hazard of burnout.

Burnout is a term first coined nearly 50 years ago by psychologist Herbert Freudenberger, who described a constellation of symptoms seen in New York City public health clinic staff who presented with emotional exhaustion, cynicism, and reduced effectiveness (Reith, 2018). Nearly a decade later, American psychology professor, Dr. Christina Maslach, further defined the phenomenon to include depersonalization and a diminished sense of personal accomplishment (Maslach & Jackson, 1981). The myriad chronic occupational stressors endemic in healthcare workers' daily experience contribute to alarmingly high rates of burnout among physicians and nurses, with more than half of doctors and one third of nurses meeting the defining criteria even before the novel coronavirus pandemic ravaged the globe in 2020 (Reith, 2018). However, this condition is not restricted to front line nursing or provider roles, as it affects all personnel working across the challenging spectrum of health care delivery in various ways. From pharmacy staff and social workers to numerous clinical aides and technologists, the impact radius of burnout is far-reaching and noteworthy.

It is critical to understand the drivers of burnout and identify all preventable root causes, particularly in the error prone context of healthcare and hospital systems. As asserted by Kohn et al. (2000) in the landmark Institute of Medicine report, *To Err is Human*, nearly 100,000 people die each year due to medical errors. Today's healthcare providers engage with vulnerable populations and patients who often seek care in dire circumstance and require sensitive and empathetic caregivers who strive to meet holistic needs to achieve optimal wellness goals and health outcomes. Such challenging ambitions are quickly undermined by cynical or disengaged healthcare providers, burned-out nurses, and disengaged support staff. The general work-life balance and staff satisfaction of the caregiver directly impacts quality, patient safety, and turnover trends among these key stakeholders in the healthcare delivery system (Shanafelt & Noseworthy, 2017).

The functional design and executive management of complex systems and processes in hospitals are contributing factors to both burnout among healthcare workers and, specifically, the multitude of medical errors that continue to adversely impact patients and health outcomes (Kohn et al., 2000). The fiscal and regulatory realities emerging from the 2010 Affordable Care Act, complicated reimbursement arrangements, and expanding staffing shortages that confront leadership teams encapsulate the multidimensional stressors that test even the most seasoned and successful chief executive officer (CEO) (Shanafelt & Noseworthy, 2017). Notably, the median tenure among acute care hospitals' CEOs is just four years, with that frequency of turnover negatively affecting community and provider relations, as well as the morale and general climate of the healthcare workforce (Hearld et al., 2019).

Clearly, administrators are not immune to the drivers of burnout and the cost of this widespread burden jeopardizes the health and safety of both patients and staff. Healthcare expenditures in the United States are already exorbitant and exceed that of every other nation, yet primary care physician turnover attributable to burnout, alone, accounts for an additional excess of $260 million (Sinsky et al., 2022). Nurse managers and leadership, too, experience burnout rates as high as 25% with compassion fatigue, lack of work-life balance, emotional strain, and loss of meaning in work (Kelly et al., 2019). The broad expanse of burnout and its

downstream effects in nearly all healthcare occupations exposes the very real fragility of the industry and an urgency in arresting the problem and reigning in both human and monetary costs. While healthcare worker burnout has yet to be remedied, there is no greater issue in which to channel existing and new resources, strategies, and innovation.

The extensive problem of burnout among healthcare occupations represents a clear and present danger to patient safety, quality of care, mental health, and the stability and sustainability of the U.S. healthcare system (De Hert, 2020). The ramifications of unchecked staff burnout contribute to known provider and nurse shortages which were sharply magnified over the course of the slow to recede COVID-19 pandemic (Moss, 2021). The associated hospital personnel and resource gaps led to a reduction in available services, lower numbers of staffed inpatient beds, increased workload for remaining staff, and far too often, hospital closure. All these dynamics serve to further strain, stress, and burn out personnel. To be sure, people filling the diverse vocations of healthcare work are invaluable and not easily replaced, with excessive fiscal and opportunity costs related to the monetary impact and calendar months that are consumed by expensive advertising, laborious recruitment efforts, and staffing related service disruptions. The "wicked problem" of burnout does not originate from within the individual employee, but instead stems from the systems and organizations that fail to adequately cultivate a culture resistant to the toxicity of internal and external threats (Rozario, 2019, p. 7).

This academic commentary was conducted via synthesis of published literature regarding the problem of burnout to identify leadership behaviors or styles that defend against or ameliorate a prevalent burden. To appropriately mitigate the damage and secondary consequences of burnout in the healthcare workforce, it is imperative to first evaluate the best practices and strategies that are utilized by hospitals or healthcare systems, starting at the top – the leadership (Shanafelt & Noseworthy, 2017). For individual hospitals and the larger healthcare system to survive and thrive, the trend and intensity of burnout must be aggressively targeted like a slow growing, but malignant cancer. Identifying and implementing key strategic initiatives driven by the most effective system's healthcare leaders may have the potential to transform, renew, and heal a broken workforce (McPherson et al., 2022).

Leadership in complex, high risk, human-centered organizations like healthcare must succeed to avoid preventable harm. The background and training of today's healthcare leaders varies extensively and includes diverse physicians, nurses, credentialed administrators, accountants, and business professionals, to name a few. However, identification of the most effective leadership style to meet the problem of burnout has the potential to markedly improve the landscape of staff satisfaction, meaning, and engagement in the workplace (Popli & Rizvi, 2016). Leadership development and training can become a force multiplier across the industry and breed a new and transformed culture of healthcare work. By carefully zeroing in on leadership styles and burnout metrics it is possible to significantly contribute to the existing body of knowledge with novel findings and, potentially, an antidote to burnout (Popli & Rizvi, 2016).

One specific assumption in this analysis is the majority stake or impact that leadership holds as an independent variable contributing to burnout prevalence and the rate of increase or

decrease in healthcare workers. While this may be more correlational than causal and subject to confounding variables, it is the premise from which an investigation begins. Certainly, there are many non-modifiable contributors to occupational stress and the work-life balance of employees, particularly in the healthcare sector. Some specific jobs or tasks carry an increased level of risk that face concrete boundaries on mitigation, requiring disclosure, patient consent, and liability protections. Workplace leaders, from the unit level to the executive suite, generally set the tone and tenor for the organization through their specific style and approach. There is a basic framework of traditionally defined leadership styles: transactional, autocratic, transformational, laissez-faire, task-oriented, and relationship-oriented (Sfantou et al., 2017). However, this is far from all-encompassing and might minimize the combination of approaches that may be context specific to an event or workplace condition.

While the operational definitions of burnout and leadership style may vary to a certain degree across international boundaries, the principle that healthcare workers experience broadly similar conditions and responses according to respective leadership is assumed. Similarly, the variable measurement tools and instruments to document and record the presence of burnout and its constellation of subjective symptoms are assumed to be equally reliable for the purpose of this inquiry. Some leadership styles are objectively better than others and lead to a host of better outcomes, at least within anecdotal or retrospective contexts. While there are several distinct leadership styles, some may be more likely to consistently contribute to a reduction of staff burnout in the healthcare workplace.

As specified in assumptions above, there may be limited generalizability of variable research studies originating from different countries that have dissimilar healthcare system attributes and workforce drivers. Studies conducted by survey alone, with or without validated instruments of measurement, will reflect variable response rates among voluntary participants. The levels of satisfaction or disaffection of the employee may elicit a less representative sample and limit the ability to interpret significance or to make wider generalizations. Qualitative aspects of published literature in the existing body of knowledge regarding burnout are subject to effects of participant, researcher, and confirmation biases. Furthermore, the possibility of currently unknown or unclear confounding variables may obscure any conclusions drawn from the relationships between leadership style and burnout among healthcare industry or hospital employees.

Effective healthcare delivery requires countless people directly involved in the compassionate and empathetic care of other people with whom they interact in a variety of routine, urgent, or emergent settings. The sustainment of this dynamic requires continual nourishment from high performing leaders who directly and indirectly cultivate the climate and workforce culture, satisfaction, and sense of purpose for all those they employ. While there exist leaders from many different occupational backgrounds and training pipelines for chief executives and C-suite personnel, specific leadership styles emerge and prove variably successful. Evolving chronic and acute stressors on the healthcare workforce become key contributing drivers of burnout. However, some leaders emerge more successful in mitigating the damage, impact, or local prevalence of burnout in their organization due to their approach and distinctly influential styles. Identification of the most effective leadership style to constrain or diminish

healthcare worker burnout can shed light on stopgap measures and mechanisms to reduce and, perhaps, eradicate the systemic burden and cumulative holistic cost of burned-out hospital staff.

Analysis

In pursuit of meta-analysis and synthesis, an initial academic search engine query returned 238 results, many of which were out of context or were not peer-reviewed. Only English language journal articles were included, although not unnecessarily limited to the United States or American researchers or authors. Titles and abstracts quickly exposed the most relevant publications, with unrelated content intentionally excluded. Among the analyzed literature, a total of 12 qualitative research articles, 1 book publication, and 4 literature review and synthesis articles were further dissected. Collated publications were grouped based on primary object of narrative or descriptive analysis, essentially compartmentalizing results into either healthcare burnout studies ($n = 11$) or investigation of healthcare leadership and styles ($n = 11$), with several articles describing outcomes at the overlapping intersection ($n = 5$).

By reviewing the frequency that the selected authors' work was cited by others helped to zero in on the most dominant voices and names on this subject area. Authors Shanafelt, Maslach, and De Hert were just three prominent authors that are readily cited by the work of others investigating this general topic domain. One article by Maslach, for instance, has been cited over 19,000 times and represents a center of gravity on this subject (Maslach & Jackson, 1981). In reviewing the literature, these basic methods quickly distilled many burnout factors and influences with clear style implications for organizational leadership.

Most of the burnout related literature required survey-based measures to capture epidemiological data. The most reliable and valid survey instrument used is the Maslach Burnout Inventory (MBI), developed over 40 years ago by renowned professor Maslach of the University of California – Berkeley. Maslach (1981) showed the reliability and validity scores for this tool to be remarkably significant, ranging from 0.05 to 0.001 levels. Importantly, this tool established discriminant validity, differentiating burnout from such things as generalized job dissatisfaction (Maslach & Jackson, 1981). Five various versions of the MBI have been introduced and applied either generally, to students, educators, or human services, such as medical personnel (De Hert, 2020).

Healthcare Burnout

As burnout is not unique to a single occupation, alone, Professor Maslach contributed a great deal to our understanding of this phenomenon, to include descriptive research, as well as introduction of validated tools for measurement (Maslach & Jackson, 1981). Since Dr. Maslach's early works, a multitude of subsequent research efforts zeroed in on several high prevalence occupations. The healthcare sector is represented across a number of various professions and specialties.

Belgian anesthesiologist, Stefan De Hert (2020), provided a recent narrative review of the current, pre-pandemic, climate of burnout in the healthcare workforce. Identifying the

condition and symptoms, the significant prevalence, and impact, the author goes on to describe mitigation strategies for prevention and improving the health and well-being of the clinical occupations affected most. The review provided graphical depiction of the 5-staged phases of worsening physical, emotional, and mental exhaustion that begins with an enthusiastic "honeymoon" stage, followed by stagnation in "stress onset", leading to pervasive frustration in the "chronic stress" stage, giving way to an early apathetic "burnout" stage, and finally the fifth stage of "habitual burnout" that requires intervention or risks secondary harms through impairment of effectiveness, safety, quality, or resulting employee attrition (De Hert, 2020, p. 174). While he discusses interventional concepts such as establishing balance between work and home life, self-care and wellness, stress relief and recuperation, the onus is placed on the individual physician, rather than the leadership and the organization's contributing modifiable factors (De Hert, 2020).

American internal medicine physician and medical school professor, Dr. Thomas Reith, similarly provided a narrative review of the epidemic of burnout in healthcare that existed at the time of publication. In contrast to De Hert, Reith (2018) emphasizes the role of leadership in combatting this detrimental problem, citing an old phrase of anonymous origin, "the fish begins to stink at the head," alluding to the fact that many problems originate at the level of an organization's executive leadership (p. 3). Indeed, such leaders play a central role in establishing healthy incentives for work productivity, balancing workload and schedules for staff, prioritizing mental health and peer support, as well as implementing sound administrative systems that constrain clerical burdens, such as sound and end-user friendly electronic health record systems (Reith, 2018).

Canadian physician Dr. Duncan Rozario published a narrative descriptive article that reinforced the prevalence of physician burnout, specifically, in much the same way that the previous American and Belgian counterparts, but he deemphasized concepts of personal resilience or initiative, instead describing a shared responsibility between institutional and leadership factors for urgently needed course correction. Rozario (2019) then references the Mayo Clinic's instructive article that introduces nine organizational strategies to reduce the "wicked problem" of burnout, beginning with effective leadership. Regardless of the type of health care delivery system or the nation in which it is provided, the prevalence of burnout is of international reach and demonstrates similar impact and generalized harms that are contrary to the professions of healing.

Shanafelt and Noseworthy (2017) published the powerful descriptive, mixed-methods Mayo Clinic article, aptly titled "Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout." This recent guide for best practices demonstrated anecdotal success at the Mayo Clinic where post-implementation data showed a 7% reduction in physician burnout, despite an 11% rise in absolute burnout rates observed nationally. Notably, Shanafelt and Noseworthy (2017) concluded that the key to progress in this domain lies in sustained attention from the highest levels of executive leadership.

In addition to the authors mentioned above who described the physician burnout climate across the globe, additional staff affected by this problem include nurses, nurse leaders, and

even chief executive officers themselves. Kelly et al., (2019) used mixed-methods research to document the problem of burnout as it affects nurse leaders, at low, middle, and executive management levels. Interestingly, the risk was shared across the hierarchy and authors conclude that strategies for individual and organizational resiliency are a necessity (p. 404). While nursing directors showed a significantly reduced level of burnout or "compassion fatigue" when compared to front line nurses, they were not immune and experienced worse work-life balance (Kelly et al., 2019, p. 406).

Between the year 2006 and 2015, Hearld et al. (2019) published the troubling trend and high turnover rate among hospital chief executives, where nearly 25% of hospital CEOs leave the position in just three to four years. Certainly, the abbreviated tenure of strategic leadership may have an adverse correlation with physician, nurse, and mid-level manager engagement or employee burnout. Furthermore, the results that were pooled from annual surveys conducted by the American Hospital Association illustrated a worsening and even more worrisome turnover amongst rural or frontier CEOs (Hearld et al., 2019). However, the urban area chief executives produce far greater reach and impact, both positive and negative, due to the size of the workforce and the variable size of the beneficiary population served.

Leadership Style

The Institute of Medicine produced eye-opening revelations in their reporting on medical errors and the attribution of preventable harms, to include nearly 100,000 deaths that result each year (Kohn et al., 2000). The book published groundbreaking details of the factors that contribute to these costly mistakes, but pointed largely towards system problems, rather than laying the blame solely on the clinicians involved. Of the three dozen references to leadership as a pivotal factor in reducing the burden of errors in medicine, the authors present a framework for building visibly strong and professional healthcare leaders: safety-minded executives, organizational, and clinical leaders (Kohn et al., 2000).

In their article, Delmatoff and Lazarus (2014) introduce leadership characteristics that are fundamental to the "most effective leadership style" during the inception of the Affordable Care Act landscape (p. 245). The expansive tectonic shifts that this massive legislation pronounced required deft command at the higher levels of executive leadership and administration. The authors describe workforce anxiety, insecurity, and heightened resistance to change that yields dysfunction and demoralized staff. The impact of these terms, reasonably synonymous with descriptors of burnout climate, may be mitigated by effective leadership. Leading with "emotional and behavioral intelligence" can ensure a more supported and empowered workforce, more resilient to challenge and change (Delmatoff & Lazarus, 2014, p. 246).

In the published work by Gabel (2013), the paradigm of transformational leadership is described as an empirically effective approach that warrants wider adoption which begins with education at all levels of training and positional authority. Gabel describes the essential tenets of this leadership style, to include "idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration" (p. 56). Indeed, the holistic application of these fundamentals in the healthcare setting has the potential to transform tasks and the workplace

into a wellspring of meaning, purpose, and accomplishment for staff and the organization, where workers go beyond and strive to realize ideals and exceed expectations (Gabel, 2013).

In a recent *Harvard Business Review* publication, Moss (2021) describes the role of empathetic leadership in preventing burnout. She discusses a modified "golden rule" wherein organizational leaders must "do unto others as they would have done unto themselves" (p. 3). This requires a thorough understanding of the workforce and their individualized needs and challenges. Authentic and visible efforts must be translated into processes and approaches to tailor leadership tasks and interactions to the diverse workforce functioning under considerable strain. Commitment to genuine relationships, interdependence, and selflessness were cited as assets that enabled healthcare workers to weather the immense challenge of the coronavirus pandemic (Moss, 2021).

McPherson et al. (2022), in their qualitative exploration of burnout in academic medical centers, by contrast, identify "authentic leadership" style, in lieu of transformational and focused on authentic leadership as key and essential to defeating burnout syndrome in healthcare workers. Emphasizing that such leadership traits can be learned, the authors conclude that job satisfaction and retention will be improved in the organization. The authors suggest that instructional approaches still need to be developed in order to teach emerging future leaders, promote relationship transparency, openness, and more effectively support the clinical workforce (McPherson et al., 2022).

Authors Sfantou et al. (2017), in their systematic review of leadership style, focused on quality of care as a dependent variable and highlighted the potency of effective leadership and variations in style and subsequent outcomes. They described six of the common styles and correlated specific leadership approaches with quality-of-care outcomes, such as mortality. Notably, transformational leadership was associated with lower patient mortality, increased patient satisfaction, and improved processes related to quality. The authors found that transformational leadership is a style that "conceptualize(s) management as a collaborative, multifaceted, and dynamic process," leading to improved outcomes and efficacy (Sfantou et al., 2017, p. 14).

Indian researchers Popli and Rizvi's (2016) article on the role of leadership style and drivers of "employee engagement", antonymous with burnout, mentions "transformational" a total of 50 times. The authors go on to cite the retired, but renowned CEO of General Electric, Jack Welch, who described employee engagement as the decisive measure of an organization's health (p. 965). The authors compared the top and bottom quartiles, in terms of employee engagement, finding that top performing organizations had as much as 65% less staff turnover 37% less absenteeism, and 22% higher profitability and productivity. Transformational leadership in the organization mirrored increases in employee engagement. Additionally, the authors cite elemental drivers of engagement, to include: "expansive communication, trust and integrity, rich and involving job, effective and supportive direct supervisors, career advancement opportunities, contribution to organizational success, pride in the organization and supportive colleagues/team members" (Popli & Rizvi, 2016, p. 967).

Sinsky et al. (2022) published a Mayo Clinic descriptive cross-sectional analysis on the costs of physician burnout and turnover. With an emphasis on constraining the exorbitant and rising healthcare expenditures in the United States, the authors highlight the preventable condition of occupational burnout in primary care physicians. Mitigating strategies discussed include improving leadership, organizational culture, and interpersonal connections to build teamwork and support (Sinsky et al, 2022).

British professors West and West (2015) reviewed the literature and published on the need for collective, cooperative, integrative leadership culture in healthcare organizations, specific to the National Health Service of the United Kingdom. This requires uniform direction, alignment, and commitment in the execution of the leadership task at every level, from nurse, to physician, to executive levels, as well as component team leadership. After examining the evidence, the authors found that cooperative and interdependent leadership across vertical and horizontal levels of hierarchy is critical to developing the shared culture of responsibility in delivering compassionate, high-quality healthcare, in what they define as "collective leadership" (West & West, 2015, p. 2).

Lastly, Van Dyke (2019) published a roadmap for battling physician burnout, citing an increasingly difficult practice environment for clinicians. One of the foundational strategies Van Dyke describes that will help address burnout is the training and development of transformational leaders who can aid in the clinicians' pursuit and realization of meaning in their work. The author discussed a pilot leadership training curriculum in place at Stanford Medicine where leaders are trained to engage employees in transforming workflows and schedules to eliminate inefficiencies and inflexibility that contributes to personnel frustrations and burnout. Intentional and systematic organizational approaches to eliminate drivers of burnout require adaptive and engaged leadership that constantly reassesses conditions of culture and evolving challenges in order to build resilient organizations from the bottom up (Van Dyke, 2019).

Discussion

Sorting through the published literature helps consolidate several key concepts and focus areas: epidemiology, primary drivers, and outcomes of burnout and employee engagement; recognized leadership styles and impacts; influence of leadership and management strategies; and the specific relationship between style and staff burnout characteristics. Beginning with relevant history about occupational burnout, collated details from an existing body of research illuminates the context of the phenomenon and sheds light on the association of these factors. The particularly disruptive condition of burnout exists broadly among healthcare sector employees and demonstrates a degree of correlation with healthcare leadership style (McPherson et al., 2022). The relationship between leadership style and staff burnout prevalence in the healthcare workplace is likely indirect, but strongly linked.

The nature of work, in its broadest human sense, stands in sharp contrast to leisure and implies an expenditure of energy to achieve goals or work products. The frequency and intensity of any such activity has an inherent tradeoff through stress effect and accumulation. In her study of occupational behaviors, University of California, Berkeley, Professor Christina Maslach (1981) described a syndrome of depleted, emotional exhaustion, and cynicism now known ubiquitously as burnout. She discussed the staff-client dynamic as rendering some relationships uniquely vulnerable to the syndrome (Maslach, 1981). While any profession may encounter the distress and disruption of burnout in the workplace, clinical healthcare workers exhibit a high prevalence with a constellation of adverse consequences for all stakeholders involved (De Hert, 2020). Indeed, the burnout term found its occupational descriptor origin among staff in a public health clinic in 1970s New York City, where chronic illness, substance abuse, and emergence of acquired immunodeficiency in many patients rapidly exhausted the long-suffering healthcare workers (Reith, 2018).

Due to some subjective variance in operationalizing the syndrome definition, prevalence of burnout in healthcare workers varies between 30-50% (Van Dyke, 2019). The secondary effects of burnout among healthcare workers may include increased absenteeism and personnel turnover, depression, substance abuse, isolation, impaired relationships, suicide, and medical errors (De Hert, 2020). The potent range of adverse impacts stemming from healthcare occupational burnout highlights the urgency in which all associated factors demand adequate inquiry to find mitigating strategies and courses of action to diminish detrimental harms. While there is unlikely to be a single approach that satisfies all root causes of burnout, building resiliency in individuals, teams, and organizations is a contemporary approach still in early phases of implementation across the sector (Van Dyke, 2019).

Some healthcare employee cohorts are more likely to exhibit the features of burnout, particularly clinical physicians and bedside nurses (Shanafelt et al., 2012). A Rand Corporation study described by Rozario (2019) showed that physician "inability to provide accessible, quality healthcare" was the principal stressor among this medical provider category (p. 6). In the United States, hospital-based nurses collectively experienced high burnout with overall prevalence rates between 33 and 43%, leading to higher rates of patient mortality and transmission of hospital acquired infections – both of which result in costly downstream effects (Reith, 2018). While most describe these healthcare occupations as meaningful vocations, satisfaction with work-life balance demonstrates a relative inverse correlation with burnout, where lower levels of satisfaction in this domain are more likely to correlate with characteristics of emotional exhaustion and depersonalization in employees (Shanafelt et al., 2012). Striking a sustainable balance of meaningful work with adequate recuperative respite is a daunting calculus for healthcare organizations and their personnel, especially with immovable fiscal constraints. The compounded problems of staffing shortages and increased workloads cause successive strain and lead to even more attrition, in a metastatic feedback-loop of contagion for remaining staff (De Hert, 2020).

Leadership Styles

Some of the most effective leaders in history inspired followership, selfless service, camaraderie, perseverance, and courage in the face of challenge. The United States military offers more examples than can be named here, but the general reference provides a backdrop in which to explore the various styles of leadership. Six of the more frequently encountered styles

seen in healthcare settings are: transformational, transactional, autocratic, laissez-faire, task-oriented, and relationship-oriented leadership (Sfantou et al., 2017). To be sure, there is not a one-size fits all approach that would work for every organization and succeed in each evolving challenge or crisis. However, there are some styles of leadership that are well-suited to engaging the workforce, positively shaping hospital culture, and achieving a more balanced and satisfied team of vocation-oriented laborers (Gabel, 2013).

Dr. Sfantou (2017) provided an overview of laissez-faire leadership style, originating in the French language and literally meaning "allow to do", it is characterized by non-interventional leaders that are the antithesis of micromanagers – instead, providing little decisive guidance or direction (p. 2). In a heavily regulated and risk-laden workplace like healthcare, the liability of this approach is self-evident. In autocratic leadership, the desires, will, or considerations of subordinates are stifled while the leader executes decisions, actions, or policy independent of their voice, vote, or consensus. In military combat settings, this may be more effective than in healing and wellness organizations like hospitals. Transactional leaders engage with their employees in a quid pro quo, where exchange of some sort of desirable good or reward is delivered to achieve buy-in for worker outcomes, productivity, or effort. In absence or dearth of such reward continuation, recidivism towards complacency status quo is predictable. Similarly, task-oriented leadership focuses solely on priority action items or events at hand, ushering personnel to completion through effective project management approaches (Sfantou et al., 2017). In caring for patients and families in healthcare settings, this can estrange the caregiver from the genuine, complex, human interaction that occurs, depersonalizing encounters. In contrast, relationship-oriented leaders put emphasis in the human interactions themselves and the dynamic relationships that result, investing in workers with support, recognition, and empathy. If too singularly focused on these granular sociological structures, important organizational business benchmarks and metrics may not be reached or realized. Lastly, transformational leadership style is marked by inspiration, shared vision, and authentic communication and actions that fosters confidence, loyalty, and purpose amongst subordinates or employees. This relation strengthening and cohesive approach nourishes and enhances a unity of effort throughout the organizational culture and appears well-suited, both for the hospitals' healthcare workforce and the clients that depend on their essential goods (Sfantou et al., 2017).

Intelligence goes far beyond academic and clinical domains, with behavioral and emotional intelligence emerging as prerequisite building blocks of effective leadership, particularly in healthcare (Delmatoff & Lazarus, 2014). Indeed, a keen sense of self-awareness and understanding of the varied motivations, drivers, and challenges faced by individuals, both in and out of the workplace, sharply differentiate excellence from mediocrity in leadership. There is no room for the phony, as organizations comprised of intelligent and well-trained individuals quickly assess the sincerity, or lack thereof, in their unit, department, or C-suite leadership. These early appraisals and unspoken acknowledgements are pivotal in the establishment of trust and define the subsequent scale of engagement from the employee. Such authenticity in leadership proves influential in job satisfaction, empowering the workforce, and shapes work product and collective outcomes (West & West, 2015). As emphasized by Sfantou et al. (2017),

these outcomes, in healthcare, may result in significant differences in patient safety, quality, mortality trends, and perceptions of self-efficacy. These elements of authenticity, emotional intelligence, self-awareness, and workforce engagement are commonly correlated with the success of transformational healthcare leaders (Gabel, 2013).

The exploratory aim of this observational reflection is on the relationship between leadership style and healthcare burnout. Prospective academic research should be pursued to implement and evaluate specific training programs, organizational strategies, and any other mechanisms that might demonstrate superior efficacy of a particular leadership style in objectively reducing the prevalence of burnout. Upon identification of inappropriate or toxic leadership styles, it is reasonable that such characteristic leaders should be remediated or removed from positions to minimize burnout growth and collateral impacts.

Conclusions

The implications of the published literature reviewed for this commentary are now quite evident. Broadened awareness and intensive evidence-based curricula may aid and arrest the pace of burnout and its impacts throughout healthcare. The sum of literature reviewed in this meta-analysis illustrates a clear and consistent picture of healthcare workforce emergency of sweeping proportion, even before the once in a century viral pandemic brought on by a novel coronavirus. The literature reviewed and discussed provides a conclusive description of the widespread phenomenon with multiple mentions of leadership and specific behaviors or styles that may contribute to a healthier, more engaged, and effective healthcare workforce. Importantly, the collective weight of evidence underscoring effective leadership points consistently to empathetic, authentic, transformational styles and strategies that may be taught, developed, and implemented in healthcare organizations around the world to extinguish the rapid propagation of healthcare burnout.

Of the 11 articles reviewed pertaining to leadership style and effectiveness, five of them cited transformational leadership as fundamentally correlated to better physician engagement and/or staff satisfaction (Gabel, 2013; Popli & Rizvi, 2016; Sfantou et al., 2017; Van Dyke, 2019; West & West, 2015). Additional descriptors of leadership style that favor successful outcomes in engagement, quality, or burnout reduction were cited as "authentic leadership" and "empathetic leadership" by McPherson et al. (2022), and Moss (2021), respectively.

While operationalizing and defining some of these qualitative terms results in modest variation across the published body of literature, they are concrete enough to yield objective conclusions (De Hert, 2020). Various survey instruments have been introduced to document and collect data within distinct healthcare occupational populations. However, while the Maslach Burnout Inventory (MBI) is now a nearly universal tool for burnout measurement, there is not such a uniform mechanism for evaluating the variable of leadership style in the healthcare workplace, exposing some degree of limitation in interpretation or broader generalization, as described above (Gabel, 2013; Reith, 2018).

Notably, the current published articles depict a global problem that was not relegated by any border or to a single system of healthcare delivery, culture, or specific healthcare provider group (Popli & Rizvi, 2016; Van Dyke, 2019; West & West, 2015). The shared nature of this humanistic, relationship-oriented burnout issue highlights a significant and still growing dearth of meaning and purpose achieved in healthcare settings. Nevertheless, there are examples of organizations or clinical practice groups that demonstrate relatively improved statistics, as exhibited by Mayo Clinic data (Shanafelt & Noseworthy, 2017). While Shanafelt's organizational and leadership strategies, to include ongoing education in transformational leadership style and behaviors, demonstrate anecdotal successes, much more needs to be done (2017). Incorporating best practices of leading institutions may be an important initial step, but marginal internal improvements, alone, can be quickly outpaced and outnumbered by growing external contributing factors.

As large of an issue as healthcare occupational burnout is, there are many different directions that future study can take. In particular, development of transformational leadership educational curricula with prospective study, pre and post implementation, offers a host of research and entrepreneurial opportunity (Van Dyke, 2019). As systems and processes evolve in the rapid progression of the informational age, so too, do healthcare organizations and the personnel that staff them. Identifying objective mechanisms to enhance training pipelines and reinforce behaviors that are fundamental and characteristic of transformational leadership is a worthwhile research pursuit (McPherson et al., 2022). It is imperative to realize the best return on educational investments is in already costly training programs.

Change and transformation are continuous, requiring deft leadership to guide institutions successfully (McPherson et al., 2022). Researchers can investigate key drivers and barriers in adopting resiliency strategies, training, and processes. By reliably meeting the needs and desires of the workforce and implementing processes to eliminate undue burdens, satisfaction and work-life balance stands to improve considerably. Future study can define drivers, barriers, burdens, needs, and desires that directly impact healthcare burnout, as well as successful leadership actions and organizational approaches to help each employee optimize their engagement and maximize their potential (Van Dyke, 2019).

While many hospital organizations are now inserting chief transformation officers in their core leadership teams, future study should focus on comparing relative outcomes related to staff burnout, retention, and recruitment to assess the efficacy of this new role. Finally, by narrowing the focus of subsequent research into less heterogeneous organizations, such as similarly sized hospital systems in the northeastern United States, researchers may glean insights that are currently obscured. The scale and scope of the problem of healthcare burnout is so great that no stone should be left unturned, and every reasonable research effort must be appropriately funded and undertaken, for the current and future health and wellness of all.

Reflection

My own professional experience includes perspectives as an enlisted sailor, bedside nurse, naval officer, anesthesia provider, and military leader. I have endured and witnessed a variety of occupational stressors during peacetime and conflict, on hospital wards and warships, with distant transactional leaders, as well as the authentic and inspirational. Much has been written and published about *transformational* styles, individuals, organizations, and leaders. Unfortunately, I believe many people are now desensitized by what they reduce to yet another buzz word circulating far above them in administrative tower siloes – removed from the deck plate or point of care interaction where the bulk of laborers and clinicians truly nurse the ill and heal the wounded. To be sure, the healthcare landscape represents a particularly critical and vulnerable sector of the larger economy.

It is here that I recognize we are facing an inflection point deserving of mindful pause, novel approaches, and a deliberate and expeditious rehabilitation in the culture of leadership, oft mired in the status quo of executive task management. The uninspiring leadership by lip service and recitation of modern business lingo, without fervent action and authenticity, will breed a vacuous enterprise where even the brightest lights dim and talent departs, prematurely. The key to preempt a self-propagating critical mass of burnout disengagement in healthcare is passion. Harboring an insatiable hunger, a fire in the belly, a wholly invested and passionate communion of leaders who believe and embrace their mission and share the same vision will inoculate the organization against continued erosion. People will find purpose beyond a paycheck and meaning amidst the mundane when enveloped by an infectious cadre of committed and inspirational leaders. Throughout military history in the United States, it is these types of transformational leaders for whom countless soldiers, sailors, airmen and marines have solemnly laid down their lives in ultimate sacrifice. It is time for each of us to engage. It is time we embark on a voyage of reconstruction that may take a generation to bear ripened fruit. Importantly, there is no time to waste.

First, we must ensure a thorough assessment of the leaders in place across our healthcare organizations. It is imperative that this deliberate exercise captures an accurate composite appraisal of each level of leader, from middle management to top executives. Each leader's performance must be assessed specifically by the individuals they lead. A self-assessment must also be included with personally identified strengths and weaknesses, laying out a specific roadmap approach with objective measurable actions to correct deficiencies and fortify existing leadership acumen. The growth of our leaders must be continuous and match the expected continuity of process improvement activities occurring throughout the hospital environment. Effective leaders must exemplify self-awareness and embody emotional intelligence to succeed in trust and relationship building, both prerequisites to any subsequent burnout mitigation strategies. If any leaders are identified as persistently deficient or ill-suited to the tasks of this dynamic and vital role, they should be removed and appropriately replaced. In military contexts, generally outside of healthcare, this occurs with surprising frequency under the byline, "loss of confidence in the ability to command."

After objective analysis of existing leadership assets and human capital, a thorough evaluation of the existing mission, vision, and priorities must be addressed across the enterprise and rationally balanced against the current state of all available resources. A workforce that may have contracted 30% cannot reasonably meet previously laid out targets for productivity and performance. Seven primary care physicians cannot absorb the additional work from three vacant provider positions that may have been vacated or otherwise remain unfilled. Yet, extracting excessive workload production from remaining staff continues to be a first-line effort for administrators and key decision-makers when too far removed from the actual healthcare encounter in day-to-day operations. Optimism and administrative engineering solutions, alone, will fail any endurance test and result in overuse injury to the morale and manpower that is exploited. Innovation and emerging technology show promise, but remain out of reach, lacking in immediacy of its remedy. Leaders must recognize the real limits of their organization, incorporate accommodations and flexibility, and execute sound pragmatism that protects their most vital resource – people.

The final foundational necessities for strengthening and growing engagement and organizational resilience are honesty, transparency, and truthfulness that flows freely from the top. Leaders who avoid the temptations of spin, half-truths, and misinformation will inspire trust and followership. Veracity and character should be the hallmarks of a healthcare organization's executive team, as they lead with confidence, humility, and an outward mindset that focuses on service rather than self-aggrandizement. True power is that derived from passion and purpose which renews and transforms, turning the ordinary into extraordinary – a worthy pursuit.

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FLOTUS - A New Focus: How the Neurologic Health of the First Ladies of the United States Impacted U.S. History

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Abstract

It is well known that throughout history, the First Ladies of the United States (FLOTUS) have had a profound impact on politics and society as campaigners, advisors, and activists. What is less known, however, is how the health of these women impacted historical events and societal impressions of feminism and disability. An investigation into the neurologic health of the FLOTUS is crucial as it offers valuable insight into society's dynamic perception of neurologic disease in women throughout history. This will help clinicians gain a greater understanding of the impact of neurologic disease and thus can help improve care for women affected by such illnesses. Through an analysis of books and websites, this article describes neurologic diseases in 13 FLOTUS and delves deeper into the impact of these conditions on American politics and world history in several of these women. The results of this research revealed that nearly 25% of the FLOTUS had at least one neurologic condition. Of these, nine had chronic headaches, five had strokes, three suffered seizures, four had neurologic conditions of pregnancy, two experienced traumatic brain injury, two had peripheral neuropathy, one had

vertigo, one had tremor, and one had spinal cord compression. There are extensive differential diagnoses to explain these conditions including diseases such as temporal arteritis, hypertensive crisis, eclampsia, chronic traumatic encephalopathy, pernicious anemia, and many others. The neurologic diseases of the FLOTUS affected many areas of history with five significantly shaping the expectations of women, three significantly influencing the actions of the POTUS, and two impacting White House traditions.

Keywords: FLOTUS, feminism, disability, women's rights, suffragette, neurology, psychiatry, pregnancy

Introduction

President Abraham Lincoln was one of the most influential presidents in American history. During his eventful presidency, Lincoln made efforts to preserve the union, end chattel slavery and reunite a divided nation. Yet while he was leading the nation, his wife and trusted advisor, Mary Todd Lincoln, suffered from a complex neuropsychiatric condition that included a traumatic brain injury (TBI) and mania that often disrupted her husband's focus (Deppisch, 2015, chpt. 5, sec. 12). Without these disruptions, how might Lincoln have made different key decisions? Mary Lincoln is just one of many First Ladies whose neurologic disease may have significantly affected American events and world outcomes.

Since the birth of the nation, politics and society have continuously evolved. This includes the dynamic role of FLOTUS, which has included varying degrees of political, social, and symbolic responsibility. Many times, the FLOTUS has served as the president's advisor. One such example is Betty Ford, who reportedly had a significant influence on President Gerald Ford, including his decision to pardon Richard Nixon (Caroli, 2010, p. XVIII). Additionally, Mary Todd Lincoln, unlike her husband, came from a well-educated and wealthy family, and was suspected to have been an important advisor to the president in his early political career.

First Ladies have also influenced the country by focusing on their own causes. Some examples include Barbara Bush's fight against homelessness and Acquired Immune Deficiency Syndrome (AIDS), and Michelle Obama's campaigns for healthy eating in children (The White House [TWH], 2021, sec. 43, 46). We have also seen the FLOTUS covertly affect societal expectations of women throughout history. Women such as Lucy Hayes, the first college educated FLOTUS and a suffragette, represented a "New Era" of women who had their own independent aspirations (Geer, nd, sec. 4). More recently, Hillary Clinton and Michelle Obama, who had law degrees from Yale and Harvard University respectively, served as role models for young women eager to pursue their own careers independently of their partner's success.

Despite the impact of the FLOTUS on politics and society, their neurologic conditions remain elusive. Nonetheless, a literature review reveals a plethora of neurologic disease in the First Ladies. As shown in Figure 1, neurologic disease has affected First Ladies throughout history. The most common conditions include seizures, headaches, and strokes. Differential diagnoses to explain these conditions include temporal arteritis, traumatic brain injury (TBI),

psychogenic seizures, hypertensive crises, and many more. These conditions often affected the role of the FLOTUS in carrying out her duties, making public appearances, and working toward her aspirations. Some even had to vacate the FLOTUS role due to their neurologic conditions.

Although many medical diseases may significantly affect one's quality of life, neurologic conditions are unique for a number of reasons. Compared to other organs such as the heart or lungs, disorders of the brain have a history of being misunderstood as manifestations of purely psychiatric or even supernatural conditions. As a result, throughout history, many patients have attempted to hide their disease from others for fear of public judgement. Many neurologic conditions lend themselves to this concealment due to their sometimes intermittent and often overtly subtle nature. As a result, there is likely a discordance between the true prevalence of neurologic disease and the public's perception of their prevalence. For this reason, those who suffer from neurologic conditions may feel particularly misunderstood and isolated. Neurologic disability can make it difficult for patients to engage in their hobbies, continue their careers, or maintain their relationships. In addition to the multitude of physical ailments neurologic disease can cause, neurologic conditions often affect cognition and mood, often threatening the patient's perceived identity and sense of self.

All these factors together create a unique situation in which patients are profoundly affected by their disease but may have less representation in society and lower levels of understanding from loved ones. This may make patients more reluctant to seek care, thereby having negative outcomes on their disease and quality of life. For this reason, it is important to raise awareness about neurologic disease within our history, especially in public figures who have held significant power. These efforts will help normalize neurologic conditions and educate the public about the prevalence of neurologic diseases and their importance within society.

It is the responsibility of the medical community to understand disease not just in a theoretical sense, but in a practical sense, which considers the affect such diseases have on the patient's life. In 2015, Dr. Nicholas Silvestri from the University of Buffalo gave a presentation on the neurologic conditions of American presidents. This research highlighted how presidents' health has affected decision-making, public impression, and ability to fulfill their official duties (Goldbaum, 2015). However, the neurologic health of the FLOTUS has not been similarly studied. Given the profound impact of neurologic disease on the individual and the importance of individual First Ladies on culture, society, and history; a proper examination of First Ladies' neurological health is critical for historians and practitioners alike.

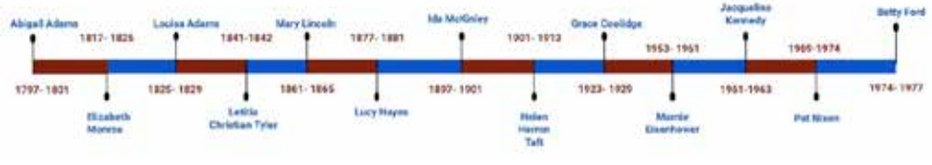

Figure 1: Timeline of FLOTUS in the White House with neurologic disease.

Methods

An analysis of historical literature was completed to determine what neurologic ailments gripped the First Ladies. First, a search was done on the White House website to identify the names of each First Lady from Mrs. Martha Washington to Dr. Jill Biden. Government websites were then used to identify which First Ladies suffered from neurologic conditions. Next, an analysis of the scientific literature was completed using the National Library of Medicine's PubMed database to describe reasonable diagnoses based on their reported symptomatology. This search also helped elucidate potential etiologies and pathologies behind their conditions. To gain a full picture of each FLOTUS' neurological health, narratives about their life were then reviewed in historical books. These were used to further analyze historical timelines and propose potential ways that the neurologic diseases of the First Ladies may have impacted world events. Finally, an internet search was completed using the google scholar search engine. The first ten hits were reviewed for any further description of neurologic disease in the FLOTUS. Of the FLOTUS who were found to have neurologic disease, particular attention was given to the conditions that appeared to have a clear impact on politics or history. This research is limited to what is available in printed literature and present on the internet. Due to these constraints, we had no limitations with respect to the FLOTUS we investigated; all FLOTUS living and deceased were included in our search. The results discussed in this manuscript draw conclusions based on available evidence. The differential diagnoses presented should be interpreted as plausible explanations and not definitive diagnoses.

Presidencies and Pregnancies

There are several FLOTUS whose neurologic diseases may have been related to pregnancy. The onset of neurologic symptoms in Ida McKinley, Lucy Hayes, Louisa Adams, and Letitia Tyler all appear temporally associated with their pregnancies. Pregnancy represents a state of increased risk for many neurologic conditions. Some factors that confer a greater risk include grand multiparity, which is defined as greater than five births (Al- Shaikh, 2017, p.2), and advanced maternal age of greater than 35 years (Mehari et al., 2020, p.2). Grand multiparity is associated with a greater risk of blood pressure dysregulation and cardiovascular disease (Dhawan, 2004, pp. 184-185) and advanced maternal age is associated with an increased risk of hypertension (Dietl & Farthmann, 2015, pp. 1627-28). Overall, women who are of advanced maternal age and grand multiparous are at greater risk of hypertension and the neurologic consequences of persistently elevated blood pressure. These consequences may result in headaches, seizures, or strokes. First Ladies Letitia Tyler and Lucy Hayes, depicted in Figure 2, both had eight children. FLOTUS Louisa Adams was pregnant 12 times. All of these grand multiparous women continued to give birth into their forties as well, putting them at high risk for neurologic complications of pregnancy.

Letitia Tyler

When President Harrison unexpectedly died just one month after taking office, John Tyler and his family were thrust into the role of First Family in 1841(TWH, 2021, sec. 10). This was particularly difficult for First Lady Letitia Tyler, who was hemiplegic from a stroke that occurred two years prior (Caroli, 2010, p.46). When Letitia began having children, she started to suffer from debilitating headaches and in 1839, suffered a paralytic stroke leaving her unable to walk or speak (Deppisch, 2015, chpt. 3). Three years later, Letitia Tyler made history as the first FLOTUS to die in the White House after another stroke (TWH, 2021, sec. 10). Letitia's migraines may have put her at a higher risk of stroke (Øie, et al., 2020, p. 593). However, Letitia's eight difficult pregnancies into age 40 may have also contributed to her risk of stroke by putting her at greater risk of hypertensive disorders and maintaining her in a nearly constant hypercoagulable state.

The effects of Letitia's poor health on John Tyler's Presidency are plenty. Sources suggest that his wife's declining health and impending death drove him to work harder and bury himself in his work. Letitia's role as FLOTUS were transferred to President Tyler's daughter-in-law, Priscilla Cooper Tyler (Deppisch, 2015, chpt. 3, paras. 14-15). Priscilla took great pride in this role and she was well-liked. Priscilla, a young actress, appealed to a country infatuated with youthful presidential hostesses. When Letitia died in the Fall of 1842, John Tyler remarried eighteen months later. It was President Tyler's second wife, Julia Gardiner Tyler who began the tradition of greeting the President with "Hail to the Chief" (Caroli, 2010, p.47). Julia Tyler's impact is felt even today as this song continues to be played at POTUS inauguration, POTUS public appearances and is also played during a former POTUS' state funeral as the casket is removed from the hearse.

Lucy Hayes

Lucy Hayes was the First Lady to 19th President Rutherford B. Hayes (1877-1881). Like Letitia Tyler, Hayes suffered from stroke and migraines which were temporally associated with her eight pregnancies that extended into her forties. In her final pregnancy at age 42, Hayes had convulsions that likely represented eclampsia. Eventually, Hayes was met with the same fate as Tyler - a fatal stroke in 1889 (Deppisch, 2015, chp. 6, sec. 6, para. 4). Despite the evidence that Hayes' symptoms were related to uncontrolled hypertension, a diagnosis of temporal arteritis might also be considered as an explanation of her chronic headaches. It is reported that Lucy Hayes suffered from chronic and persistent bodily pain described as "rheumatism" (Deppisch, 2015, chp. 6, sec. 6, para. 7). These pains mostly affected her shoulders, arms, and neck. This may have represented polymyalgia rheumatica which is associated with temporal arteritis in up to 50% of patients (Unwin, et al., 2006, p. 1547).

Regardless of her diagnosis, Lucy Hayes' neurologic disease changed history by affecting her ability to revolutionize the role of FLOTUS. As the first college educated FLOTUS, there were high hopes for Lucy Hayes to introduce the era of a "New Woman". In college, Lucy strongly advocated for women's rights. After her marriage to President Hayes in 1852, she became a central figure in the women's suffrage movement (Geer, n.d, sec. 13). Lucy's political activism made the public confident that she would be a pivotal character in history and transform the role of FLOTUS into one that holds significant political influence. Yet when she settled into the role of FLOTUS in the late 1870s, her focus seemed to shift from a very active role to a passive role (Caroli, 2010, pp. 89-90). Leaders in the women's suffrage movement who expected her to help in the fight for women's rights were disappointed at her lack of influence.

In 1878, a women's suffrage amendment proposed by Susan B. Anthony failed, largely due to the lack of support from President Hayes (Andrews, 2022, sec.6) and reportedly no clear help from Lucy Hayes (Geer, n.d, sec. 70).

Considering her neurologic history, it is not surprising that Lucy Hayes was not able to live up to public expectations as a pivotal FLOTUS. If Mrs. Hayes did not suffer from debilitating headaches and disability during her husband's Presidency, she may have focused more on advocacy work and the women's suffrage movement may have had the White House support necessary to advance the Women's right to vote. Additionally, this may have initiated an earlier transformation of the role of FLOTUS into a politically active position.

Figure 2: Two FLOTUS with neurologic complications of pregnancy. (A) is a portrait of Lucy Hayes in 1877, photographed by Charles Milton Bell. (B) is a portrait of Letitia Tyler by an unknown artist, date unknown. These portraits are used freely with permission as found in the original licensing on Wikimedia Commons.

Stroke and Success in the White House

Letitia Tyler, Lucy Hayes and Pat Nixon (Deppisch, 2015) are three FLOTUS who died from stroke. Despite modern medical advancements, stroke is still the fourth leading cause of death in the United States today (Ahmad & Anderson, 2021, p. 1830). Yet stroke not only has a significant influence on mortality, but on morbidity as well. Stroke is a leading cause of disability in the United States and is correlated to lower scores on mental and physical health assessments (Xie, et. al., 2006, pp. 2567–71). Two FLOTUS who survived their strokes but had lasting disabilities that impacted their performance in the White House are Ida McKinley and Helen Taft.

Helen Taft

Helen "Nellie" Herron Taft, as seen in Figure 3, was the wife of 27th President William Howard Taft (1909 – 1913) (TWH, 2021, sec. 28). Nellie was regarded as an intelligent and ambitious woman; her achievements include bringing music to White House dinners, planting trees in Washington, DC, publicly opposing prohibition, and supporting women's suffrage (National First Ladies' Library [NFLL], n.d, sec. Taft, Helen). However, in 1909, Nellie suffered a stroke resulting in aphasia and right hemiparesis. Despite the severity of her ailments, the President and his advisors attempted to conceal and minimize Taft's symptoms. A public statement by President Taft reported that the FLOTUS had fallen ill due to excessive heat and social pressures (Deppisch, 2015, chp. 9, sec. 6, para. 3-4). Historically, women's symptoms have been underestimated and sometimes falsely attributed to anxiety and stress, a practice that continues even today. Although Mrs. Taft made improvements over the following months, her speech and language function never fully recovered. In 1911, Helen Taft suffered a second stroke which again left her aphasic. Her doctor described this subsequent attack as "similar, but much less severe" than her first stroke (Deppisch, 2015, chp. 9, sec. 6, para. 1). Her condition improved within a few days. This reemergence of Nellie's symptoms may have been another stroke, or a recrudescence of her prior stroke. Post-stroke Recrudescence (PSR) usually presents as a transient worsening of post-stroke neurologic deficits that do not exceed the severity of the previous stroke (Topcuoglu, et al., 2017, p. 1053). As Taft was traveling at the time of her second event, it is possible that she developed an infection, or encountered other stressors that triggered a PSR. Nonetheless, Nellie's symptoms were again attributed to emotional stress.

Despite Nellie's passion for politics and determination to recover from her strokes, her neurologic ailments did affect her role as FLOTUS. After her stroke, Taft avoided social events and decreased her activism. Often, she delegated her responsibilities to her daughter and sisters. Taft did not often appear at public events and if she did, she did not speak for fear of revealing her speech and language impairment. Historians believe that Mrs. Taft would have revolutionized the role of FLOTUS if it were not for her struggles with her health (Deppisch, 2015, chp. 9, sec. 7, para. 1).

Figure 3: Portrait of Helen Herron Taft in 1909 by an unknown photographer. This image is used freely with permission as found in the original licensing on Wikimedia Commons.

Furthermore, in opposition to Mrs. Taft's support for the suffrage movement, her husband was a strong opponent and felt that women were "too emotional" (Mintz & McNeil, 2018, sec. 3206) to have voting rights. If it was not for her strokes, Mrs. Taft may have been more successful at gaining her husband's support for the suffrage movement. It is possible that Mrs. Taft's struggles with her health may have contributed to a further delay in the women's right to vote.

Epilepsy and Elections

Epilepsy affects approximately 70 million people worldwide (Singh & Trevick, 2016, p 837). For centuries, seizures were inaccurately assumed to be supernatural or psychological. It was not until the last century that seizures have been widely believed to have organic roots (Reynolds & Trimble, 2009, pp. 51- 52). This historical misunderstanding of epilepsy has perpetuated a stigma against those who suffer from seizure disorders. There are many different conditions that may cause seizures. As discussed previously, Lucy Hayes' seizures during pregnancy were likely due to uncontrolled hypertension. Other risk factors for seizures include a history of traumatic brain injury (TBI) and stroke, yet many seizures are considered idiopathic. In addition to Hayes, First Ladies Elizabeth Monroe and Ida McKinley, as seen in Figure 4, were also known to suffer from seizures.

Elizabeth Monroe

Elizabeth Monroe served as FLOTUS from 1817 to 1825 as the wife of President James Monroe. Elizabeth Monroe was not very popular as a FLOTUS, largely due to the influence of her predecessor Dolley Madison who was lovingly regarded as "First Lady of the People." In comparison to Madison, Monroe was significantly less involved with politics. Monroe did not appear interested in socializing and did not help to organize social teas, mixers, or dinners as her predecessors had. When her daughter Maria made history as the first daughter to be married in the White House, a decision was made to have the wedding as a private event. Not inviting the diplomats and high rank government officials was looked upon unfavorably by many (Caroli 2010, p. 18; TWH, 2021, sec. 5). However, it is possible that Monroe's detachment from the role of FLOTUS may have been a result of epilepsy. There are many reports of Elizabeth having convulsions and losing control of her body (Deppisch, 2015, chp.4, sec. 6, para. 2). When President Monroe's second term ended, Elizabeth was too ill to leave the White House. The First Family continued to reside there for three more weeks until she was strong enough to vacate. There are reports that soon after Elizabeth left the White House, she suffered a seizure near an open fireplace that left her with severe burns (Onion, et al. 2018, para. 6).

The debilitating nature of uncontrolled epilepsy makes it very likely that Elizabeth's illness influenced her decision to stay out of White House affairs. Nevertheless, Elizabeth's choice to give up her responsibilities to her daughter Eliza had an important impact. Eliza had studied at Maison d'éducation de la Légion d'honneur while her father was the foreign minister to France. Unlike her mother, Elizabeth "Eliza" Monroe Hay was considered to be outspoken and assumed a more dominant role, which was unusual for a FLOTUS in early America. Eliza Hay's role as a French educated, "modern spokesperson," helped set a precedent as the role of FLOTUS slowly moved toward becoming its own distinct and powerful role (Anthony, 2014, para. 10).

Ida McKinley

Ida McKinley was FLOTUS with 25th President William McKinley from 1897- 1901 (TWH, 2021, sec. 26). Ida had a multitude of neurologic conditions that included seizure, stroke, migraine, TBI, and tremor. Ida's neurologic history started in 1873 when her infant died after a very difficult delivery. This same year, McKinley also suffered from her first hemiparetic stroke and developed depression and new onset seizures (NFLL, n.d, sec. McKinley, Ida ;University of Virginia, 2017).

The temporal association with Mrs. McKinley's pregnancy and the onset of her seizures suggests a hypertensive disorder as was suspected with Lucy Hayes. Yet Ida had other risk factors for epileptic seizures that include a history of stroke and TBI. Many times, McKinley's seizures were described as episodes of altered consciousness and abnormal vocal sounds, suggesting focal seizures with impaired awareness. McKinley was also described as having violent episodes characterized by a stiffening of her body that often left her in a coma-like state (Deppisch, 2015, chpt. 8, sec. 3). These episodes appear consistent with tonic-clonic seizures with a post-ictal state.

Tragically, Ida McKinley's loss of her youngest child in 1873 came just two years after the loss of her mother in 1871 and just two years before the loss of her first-born child in 1875 (NFLL, n.d, sec. McKinley, Ida; University of Virginia, 2017). While coping with such profound loss, Mrs. McKinley was also forced to cope with the onset of a debilitating neurologic illness, an illness that seems to have increased in severity with each loss. Considering this, the diagnosis of psychogenic nonepileptic seizure (PNES) disorder might be considered. To further support this, McKinley's doctor described her episodes as unusually prolonged and dramatic for a typical seizure (Deppisch, 2015, chp. 8, sec. 8). Non-epileptic seizures are often a manifestation of conversion disorder, wherein the patient is unaware that their seizures are psychogenic in nature.

However, it is also possible that McKinley's seizures were a manifestation of factitious disorder, with a secondary gain of being closer to her husband. Ida was reported to demand a lot of attention from her husband who promptly tended to her whenever she was reported to have a seizure (University of Virginia, 2017). There also seems to have been an increase in the severity of her neurologic illness when McKinley ran for president in 1896 and again in 1900 against her wishes. Perhaps the most compelling evidence, however, is that Ida was never reported to suffer from seizures again after the death of her husband in 1901(Deppisch, 2015, chp. 8, sec. 8, para 3).

Regardless, Ida McKinley's illness had significant effects on the Presidency. The stigma of epilepsy was feared, and the administration took action to decrease the chance that the public learned of Mrs. McKinley's condition. For example, Ida greeted people sitting down and holding a bouquet of flowers to hide her shaking hand (Caroli, 2010, p. 123). To be clear, Ida's seizures were not described as being overt convulsions that would be difficult to hide, rather they were more subtle seizures that could easily be missed by the undiscerning eye. At state functions, Ida strategically sat next to President McKinley. The POTUS would watch her closely to monitor for signs of a seizure. If she began to display seizure activity, President McKinley would drape a large handkerchief over her face until she recovered or could be silently escorted out (TWH, 2021, sec. 26). Moreover, concern about how the public would perceive Ida's illness resulted in the administration putting unprecedented focus on Mrs. McKinley during the campaign trail in order to increase the public's positive perception of her. This resulted in the addition of the first FLOTUS biography to be included in with the POTUS campaign biography. Ida McKinley also became the first FLOTUS included on a campaign pin ("Ida McKinley", 2020, sec. 5, para.

5). This inclusion of Ida set a precedent for future FLOTUS to be included in the POTUS's campaign.

Another way that Ida McKinley's illness affected politics was her influence on the President himself. President McKinley ran a "Front Porch Campaign" where he remained close to home and did not actively travel (Morgan, 2001). This was in stark contrast to his competitor, William Jennings Bryan, who toured throughout the United States. It is very likely that Ida McKinley's illness influenced his decision to limit travel during this time. Ida McKinley's neurologic condition also affected the public's perception of President McKinley. President McKinley was regarded by the public as an exceptional domestic partner. When President McKinley was governor of Ohio, each day he would stand on the plaza in front of the State capitol building. Ida McKinley would be looking on from the hotel across the street, and President McKinley would doff his top hat to her (NFLL, n.d, sec. McKinley, Ida); this became a public spectacle. This practice was one way for President McKinley to check to see that his wife was well. However, due to the successful attempts to conceal her diagnosis, the public did not view President McKinley's behavior as an act of service to his ill wife, but a reflection of his kind nature. President McKinley's devotion to his wife was considered to be a major political asset for him (NFLL, n.d, sec. McKinley, Ida). Although President McKinley was assassinated in 1901, he won reelection in 1900 just months before his tragic death. Prior to McKinley's Presidency, there had been a pattern of very close popular margins in Presidential elections since

Figure 4: Two FLOTUS who suffered from seizures. (A) is a portrait of Elizabeth Monroe in 1816 and is the work of Eben F. Comens after John Vanderly. (B) is a portrait of Ida Saxton McKinley in 1896 by an unknown photographer. These portraits are used freely with permission as found in the original licensing on Wikimedia Commons.

the Civil War (Gould, 2017, sec. 2, para. 4). It is possible that public opinions of McKinley's kind nature are what allowed him to be successful in his reelection. If this is true, the effects of this would be profound as history would be significantly altered without the reelection and assassination of McKinley.

Ida McKinley's condition created permanent changes in the White House as well. Before Mrs. McKinley, physicians only made occasional appearances to help with White House emergencies. With Ida's serious condition, President McKinley requested for Dr. Presley Rixey to be appointed as the first White House Physician (Deppisch, 2015, chp. 8, sec. 2). Since that time, it has been standard to have medical providers working in the White house.

Campaigns and Migraines

Headaches are a major cause of morbidity across the United States and the world. As expected from the high incidence in the general population, headaches were the most commonly reported neurologic symptom among FLOTUS. Primary headaches have no known underlying cause and are often characterized as migraines, which are estimated to affect up to 12% of the population (Burch, et. al., 2019, p. 361). Secondary headaches are due to an underlying diagnosis that includes conditions such as: temporal arteritis, hypertensive crisis, brain tumor or TBI. As previously discussed, First Ladies such as Hayes and Tyler may have had hypertensive disorders that contributed to their headaches. Hayes' differential diagnosis also includes temporal arteritis. Both Ida McKinley and Mary Lincoln were reported to have had TBIs which may have resulted in their chronic headaches. Jacqueline Kennedy suffered from headaches and died from Non-Hodgkins lymphoma that metastasized to her brain (Altman, 1994, sec. B, p. 10). Mamie Eisenhower, suspected to have alcohol use disorder or vertigo, may have also had headaches associated with these conditions. Many other First Ladies, however, did not have clear conditions contributing to a secondary cause of headache and thus likely would have been diagnosed with migraines. Some of these women include Abigail Adams; FLOTUS to second President John Adams (Evans, 2011, p. 1431), and Louisa Adams; FLOTUS to sixth President John Quincy Adams (Deppisch, 2015, chp. 5, sec. 7, para. 5)

Mary Lincoln

Mary Todd Lincoln, as seen in Figure 5A, was the wife of President Abraham Lincoln, and she served as FLOTUS from 1861 until his assassination in 1865. Mary had a complicated constellation of neurologic and psychiatric symptoms that affected her and President Lincoln profoundly. Mary suffered a life of tragedy as she lost her young mother, three of her sons, and her husband. She was described as moody as a child, but reports of mania and psychosis did not occur until later in her life. In adulthood, Mary suffered from delusions and mania. She was reported to have had an uncontrollable habit of spending an irresponsible amount of money (TWH, 2021, sec. 17). While Mary's symptoms appear to fit well into a psychiatric diagnosis of bipolar disorder or schizoaffective disorder, there may have been some neurologic insult that contributed to her condition as well.

In 1863, Mary threw herself from a carriage to avoid a crash after the driver was ejected. It took three weeks for her wounds to heal, and her physician described her injuries as "unambiguously grave" (Deppisch, 2015, chpt.5, sec. 14, para. 3). After this incident, she had an increased frequency of headaches and others became very concerned about her sanity. It is not uncommon for patients to develop post-traumatic headaches after blunt force trauma to the head (Paniak, et al., 2022, pp 320- 321). Her headaches and behavioral symptoms may be interpreted as part of postconcussion syndrome. Given the duration, this may have transitioned to chronic traumatic encephalopathy (CTE), a condition that has only been described in the past decade. Those with a history of TBI are at risk for developing CTE which can include features of depression, irritability, or impulsivity (Fesharaki- Zadeh, 2019, p. 1-2). Another possibility is that this near-death experience may have caused Post Traumatic Stress Disorder (PTSD). Mary's son Robert reported a detachment from reality in his mother after the accident (Deppisch, 2015, chp.5, sec. 14, para. 3), which is a well-established feature of PTSD. Mary's traumatic experience may have exacerbated an already existing psychiatric illness, which could explain her post-traumatic mental decline.

Another diagnosis that might explain Mary Lincoln's symptoms is pernicious anemia. Pernicious anemia is a condition characterized by autoantibodies against cells in the terminal ileum of the small intestine, resulting in an impaired absorption of the essential vitamin B12. Vitamin B12 is required for many biological processes including red blood cell production and neuronal myelination. As a result, in addition to anemia, those with vitamin B12 deficiency may experience neurologic symptoms as a result of impaired myelination- an important process that facilitates communication between neurons. In turn, this results in subacute combined degeneration of the spinal cord; a condition characterized by paresthesia, spastic paresis and gait abnormalities. Furthermore, psychosis and peripheral neuropathy are two other associated neurologic symptoms (Rodriguez & Shackelford, 2022, sec. 6).

In the case of Mary Lincoln, she was reported to have had symptoms that included: an irregular pallor, gait problems, delusions and painful sensations on her skin (Christensen, 2016). These symptoms correlate very well to the features of pernicious anemia. Her irregular pallor could be explained by anemia, her gait issues may have been secondary to subacute combined degeneration of the spinal cord, the delusions may have been a result of psychosis, and the abnormal skin sensations may be explained by peripheral neuropathy.

Irrespective of her diagnosis, the effect of her ailments on Lincoln's Presidency were very significant. The public was largely distrustful of Mrs. Lincoln because of her capricious behavior. Furthermore, Mrs. Lincoln's poor judgment may have detracted from the President's favorable image. Examples of this include her erratic spending habits that put the President in severe debt and her paranoia of others that led to public altercations (Caroli, 2010, chp. 3). Mary's emotional lability and tumultuous relationship with her husband undoubtedly affected his public image and placed an extra emotional burden on Lincoln as he navigated a divided nation. It also seems that Mrs. Lincoln's psychosis resulted in her having delusions against many political colleagues of President Lincoln. One such example was Secretary of State William Seward. Mary Lincoln had unfounded suspicions around Seward and she warned her husband

that Seward cannot be trusted (Deppisch, 2015, chpt. 5, sec. 11, para. 3). As Mary was once a trusted advisor of President Lincoln's, his decisions about which politicians to keep in his cabinet were likely influenced by his wife's mental state. The ramifications of this cannot be overstated as President Lincoln, with the support of his cabinet, made extremely influential decisions that contributed to ending chattel slavery and unifying a divided nation.

Mamie Eisenhower

Mamie Eisenhower, as seen in Figure 5B, was the wife of 34th President Dwight D. Eisenhower (1953 to 1961). While she was well-liked (TWH, 2021, sec.36) by the nation, she suffered from neurologic symptoms that included headaches and dizziness. Mamie Eisenhower's dizziness has been suspected to be a form of vertigo, a condition with an extensive differential diagnosis. Central causes of vertigo include insults to the cerebellum or the brainstem. Peripheral vertigo may be caused by insults to the vestibulocochlear nerve or semicircular canals. In the case of Mamie Eisenhower, it is more likely that she suffered from a peripheral cause as her symptoms were recurrent and she was asymptomatic between attacks. Although many sources have characterized Mamie's disease as Meniere disease (Deppisch, 2015, chpt. 12, sec. 4), there does not seem to be clear documentation of any cochlear symptoms and thus Benign paroxysmal positional vertigo (BPPV) may be a more likely diagnosis. Alternatively, if these

Figure 5: Two FLOTUS who suffered from migraines. (A) is a portrait of Mary Lincoln, date unknown by an unknown photographer. (B) is a portrait of Mamie Eisenhower in the White House in 1954 by the White House Photographer. These portraits are used freely with permission as found in the original licensing on Wikimedia Commons.

dizzy spells occurred concurrently with Mamie's headaches, these may have been episodes of vestibular migraines.

There has been speculation that these headaches and dizzy spells were a consequence of alcohol use disorder. Rumors of Mamie's alcohol use disorder were prevalent, yet there is no clear evidence that these rumors were true. Nevertheless, Mamie's vertigo had profound effects on her life quality. The role of FLOTUS came with a lot of pressure, and Mamie was constantly being judged on her appearance. These stressors, in combination with poor physical health, may have contributed to the episodes of depression and anxiety that Mrs. Eisenhower was reported to have suffered from (NFLL, n.d, sec. Eisenhower, Mamie). Mamie Eisenhower's neurologic and psychiatric illnesses likely contributed to her lack of involvement in politics. Mamie reportedly spent most of her time resting and essentially made no significant changes in her role as FLOTUS. This reinforced the 1950s expectation of women to keep a low profile and not involve themselves with public affairs.

FLOTUS: A New Focus

Overall, the neurologic ailments of the FLOTUS not only garnered more attention from the administration but also resulted in greater focus from the public, setting a precedent for future FLOTUS to receive similar recognition. Moreover, this research illustrates the widespread prevalence of neurologic disease among the FLOTUS. Figure 6 summarizes the diseases of the women discussed, as well as two additional FLOTUS (NFLL, n.d, sec. Ford, Betty, sec. Coolidge, Grace).

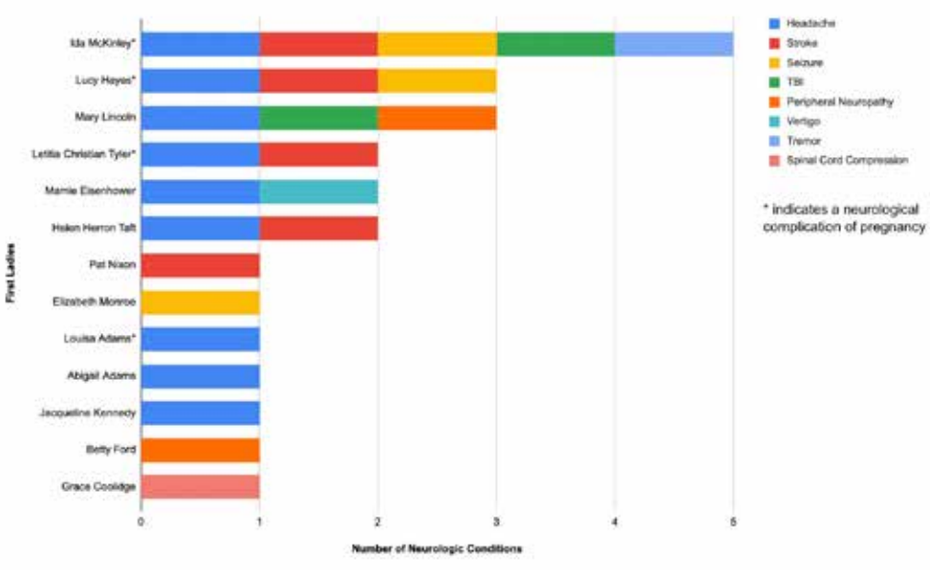

Figure 6: Neurologic conditions of each FLOTUS.

The impact of these conditions was multifaceted. At times, the health of the FLOTUS affected White House precedents, such as in the case of Ida McKinley and the appointment of the first White House physician. At other moments, their health impacted the choices of the President, such as in the case of Mary Lincoln's delusions affecting President Lincoln's choice of trusted advisors. Their illnesses also affected the expected role of the FLOTUS, such as in the case of Lucy Hayes' veering away from her role as a women's rights activist after the onset of her migraines. The impact of their neurologic conditions has been summarized in Figure 7.

Conclusions

Despite the large number of neurologic ailments suspected or identified in the US FLOTUS, the neurologic health of the First Ladies is remarkably understudied. Indeed, when someone in a high visibility position like the FLOTUS is associated with a particular ailment, that often serves to demystify and increase public awareness of that disease. It is not surprising that the most common ailments associated with the FLOTUS were migraines, seizures and stroke as these are among the most common ailments treated by neurologists. The women highlighted here do not represent an exhaustive list. However, this article attempts to illustrate clear examples of how neurologic disease in the FLOTUS may have affected United States politics and history.

A major limitation of this study is that the authors did not have direct access to the medical records of the FLOTUS to confirm the various diagnoses. A reasonable next step would be to visit the Presidential libraries of each prior President. By doing so, additional medical information available to researchers might be accessed that is not yet published in books or on the internet. This would help develop a more comprehensive account of the FLOTUS' neurological ailments that could then be made available to the neurology community and the general public.

Another limitation is that there are few autobiographical accounts of neurologic disease in the FLOTUS. Most of our information comes from reports by their physicians or loved ones. To gain deeper insight into how neurologic disease affects an individual, it is crucial to gather a personal account of their illness. Unfortunately, this may be difficult to attain, as FLOTUS who are still involved in politics may be reluctant to share their medical information. However, FLOTUS who have retired might be more amenable to sharing their feelings regarding any medical conditions they may have.

As our understanding of neurologic disease improves and society becomes more interconnected in the virtual world, there is hope that the public will become more accepting of neurologic conditions. This may allow political figures to feel more comfortable sharing their health experiences with the world. Encouragingly, there is some evidence that this may be where society is slowly headed, as evidenced by some current politicians who have publicly embraced their neurologic ailments. For instance, John Fetterman, the newly elected United States senator from Pennsylvania, has spoken openly about the lasting impact of his recent stroke on his speech. Instead of trying to conceal his disability, he has shared his story as a way

to connect with and inspire the public. Another political figure who has publicly addressed his speech disorder has been current President Joe Biden who has spoken extensively about his childhood stutter that he worked to overcome. While there certainly still exists a stigma against these politicians by some people, many Americans appear to be touched by the vulnerability and relatability of these politicians for sharing their stories. However, willingness to share this information may not be consistent among all politicians. Factors such as gender, age, race, or even party affiliation might influence their comfort level in speaking about their health. Expanding this research to include other politicians spanning these categories could provide greater insight into the factors that may be at play.

Overall, this research on the neurologic conditions of the FLOTUS has been a significant step toward understanding the history of neurologic disease and its impact on individuals, their loved ones, and society as a whole. Moving forward, additional research should be conducted on the neurologic histories of the FLOTUS and perhaps other political figures as well. This research will help both the medical community and the greater public to further their understanding of the profound impact of neurologic disease.

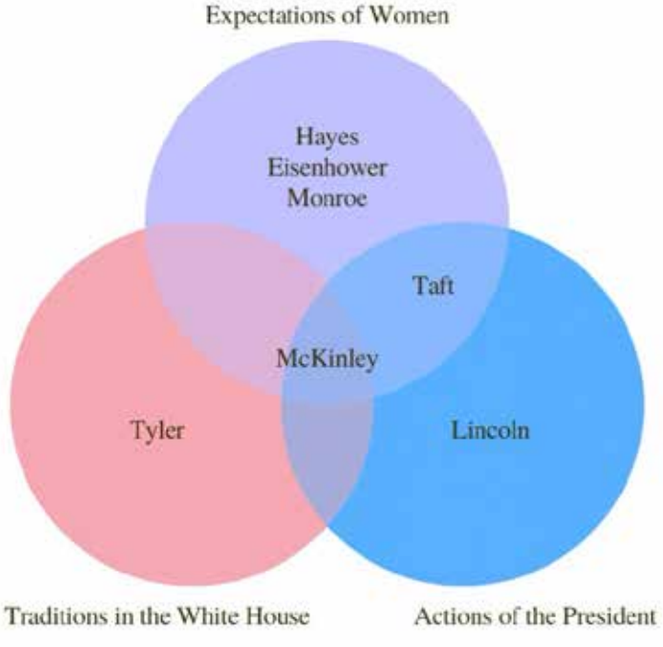

Figure 7: Influence of the neurologic diseases of the FLOTUS on different areas of politics, history and society.

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Special Notation

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Salutogenic Reframing as Grounds for Ethical Re-Evaluation of Placebo as a Therapeutic Intervention

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Abstract

The authors posit that the use of placebo (and nocebo) needs to be revisited and revised, both as concepts and as viable therapeutic considerations and tools in clinical medicine. Specifically, this article advances the thesis that the common usage of the term "placebo" (in clinical care) needs to take the Latin translation of placebo literally, and that the dictionary definition of placebo and its current understanding and historical practice is not accurate. Indeed, a placebo, in its conventional sense, is used to bring about physical and/or emotional relief, and even may cause a temporary mitigation of symptoms. Hence, the authors propose both re-evaluation of the placebo, and re-definition of the term beyond its "colloquial" and "plebian" understanding. Based upon evidence to date, the authors argue that either (1) "placebo" needs to be re-defined to emphasize therapeutic benefit consistent with its Latin definition and how the psychological and somatic domains are implicated; or (2) the term placebo in its current practice and usage should be redefined using another term that captures the aim of "benevolent deception," which can be utilized in defined patient populations, in and under particular conditions. Toward these goals, placebo responses are discussed as framed within philosophical and ethical constructs, and as relevant to medical research, health promotion, and clinical practice.

Keywords: placebo, nocebo, salutogenesis, medicine, research, bioethics, neuroethics

Introduction

Collective modern endeavors toward advancing medicine focus extensively on identifying and characterizing the mechanisms of health, disease, and injury. As consistent with core ontological bases of medicine, the reductionistic approach has proven instrumental in pioneering technological advancements for addressing acute and severe conditions (Patil & Giordano, 2010). However, mechanisms of subjective illness and to some degree, sickness phenomena arising from more chronic insult have been less thoroughly studied, due in part to a paucity of tools and methods available, and/or a somewhat narrow approach that has failed to apprehend and appreciate the bio-psychosocial/environmental reality of the patient-as-living organism (Giordano, Hutchison, & Benedikter, 2010).

To wit, pathogenic effects of various physiological systems' adaptations to disease and injury often manifest compounding, self-propagating cycles that require more holistic multi-layered biopsychosocial approaches to assessment and care. Addressing only one aspect of the cycle does not necessarily mitigate or prevent other aspects from occurring, or changing in ways that can fortify or re-initiate features that negatively impact functional wellness. As linguist and philosopher Noam Chomsky has noted, "... [through] the enterprise of science, ...[and] our intellectual culture, ... when we try to find out how the world works, we discard the concepts of common sense very quickly" (Chomsky, 2003). Apropos of Chomsky's invocation, the authors posit that this bio-psychosocial/environmental reality necessitates a "common-sense" approach to assessment, diagnosis, and care that more fully recognizes and seeks to engage the "systems-within-systems' dynamic(s) of the embodied organism that is embedded within its specific ecology of place, time, and circumstance(s). An inflexible adherence to absolute--versus inter-theoretic reductionism (coupled to a dynamic systems' construct that more capably

acknowledges synergistic, holistic interactions of components of a living organism) can easily succumb to fallacious concepts, approaches, and ineffective (and the authors believe, inefficient) clinical care outcomes. Simplistic comparison of the human (or animal) body to a machine fails to recognize the synergy of 100 trillion cells (Atkinson, 2018) with unique properties, working harmoniously to achieve physiological allostasis in diverse and spatio-temporally changing environments. Although a comprehensive comparison of reductionistic and holistic perspectives (and approaches) is beyond the scope of this essay, it is important to note these distinctions when addressing the ethical implications of any putative therapeutic intervention.

This is certainly true when considering the therapeutic viability, utility, and possible value of "placebo". The National Institutes of Health define placebo as "an inactive substance or other intervention that looks the same as, and is given the same way as, an active drug or treatment being tested" (National Cancer Institute, n.d.). The *Merriam-Webster Dictionary* describes placebo as "a usually ... inert preparation prescribed more for the mental relief of the patient [rather] than for its actual effect on a disorder" (*Merriam-Webster*, n.d.). These colloquial conceptualizations fail to capture both the most current understanding of the mechanisms of placebo, and the historical role of practitioners in health and healing (see, for example, Kienle and Kiene, 1997). It is argued that taken together, such an incomplete view tends to perpetuate the lay--as well as certain camps of professional--belief that placebo is nothing more than "benevolent deception" constituting withholding or actively mispresenting information--a violation of the physician's duty to provide the patient with information necessary for informed consent. The authors have opined that this apparent ethical improbity can be resolved by acknowledging the facts and facets of placebo that are neglected by such plebian definitions (Kohls, Leyva, & Giordano, 2023).

Considering Cognition in Clinical Context

Cognitive interpretation (as based upon prior experiences, subjective bias, expectation, belief and value sets, etc.) of both internal and external sensory input are fundamental to phenomenological experience and subjective evaluation (i.e., emotion) of settings, circumstances, and events. Neuroscientist Antonio Damasio has referred to this interplay of sensory and emotive dimensions of cognition as "the feeling of what happens" relative and relevant to the ways external events evoke neural and physiological responses, and how such responses are subjectively perceived by the organism experiencing them (Damasio, 1999; Kohls, Leyva, & Giordano, 2023; Giordano & Engebretson, 2006). These can incur salutogenic (viz., literally "health fostering/promoting") or maladaptive effects (Giordano, 2007), and contribute to the development of an altered somatic state, which in turn can evoke a resultant (interpretive) "mind state" (Kohls, Leyva, & Giordano, 2023). In this light, it is important to consider the dynamic and adaptive conditioning potential of neural systems (Maricich & Giordano, 2007). Thus, it is argued that clinicians should (1) understand these processes; (2) recognize their contribution to patients' physical and cognitive condition; and (3) seek to assess, access, and affect these mechanisms to promote the benevolent aims and goals of clinical care.

Historically, while mechanistic insight to these processes may have been lacking, awareness of their manifestations and effects were certainly acknowledged, and attempts were made to engage (whatever were thought to be) the involved substrates to induce beneficial effects as focal to early (e.g. shamanic) practices of medicine (Winkelman, 2004). Such "rituals," wherein an individual, regardless of health status, seeks consultation and assistance from those with some form of accepted, recognized knowledge and experience in health and healing, is fundamental to many, if not most philosophical and practical cultural contexts of medicine (e.g. traditional forms of Asian medicine; Ayurveda; curandera; and the Hippocratic tradition), which prioritize the good of the patient and the avoidance of intentional harm (Smith, 1979).

Perceptual Perspective in Placebo

At this point, the reader is invited to revisit the translation of the Latin word "placebo" to mean "*I shall please*" (Kohls, Leyva, & Giordano, 2023), so as to ground such benevolence to the subjective state of, and objective effects in the person that is the patient. In this way, placebo refers to the actions taken by the clinician within the context of the patient-provider relationship to (1) foster patient comprehensibility, (2) promote manageability, and (3) evoke meaningfulness (Giordano, 2008). These three factors are critical to the "sense of coherence" as proposed by Aaron Antonovsky (1979, 1987), and clinicians can, and the authors opine, should guide patients towards optimal health and healing by fostering resilience via coherence. Pro Antonovsky, potentially placebo-inducing actions identified by Barrett and coworkers instill the three pillars of comprehensibility, manageability and meaningfulness and by eliciting: "a feeling of security and support, emanating from the encouragement of others"; and "a sense of empowerment... [attained through] achieving health" (Barrett et al., 2006).

This conception of placebo, grounded in the exercise of positive dimensionality of the provider-patient relationship that incorporates compassion, encouragement, empowerment, and guidance without mis-communicating the severity of a patient's condition, affords a more rational basis for ethical consideration of harnessing placebo responses as a clinical tool. First and foremost, it distinguishes the induction of placebo responses from explicit expression of mistruth and/or intentional deception. To wit, placebo is not a "sham" treatment, but rather a genuine attempt to evoke both biological and psychological salutogenic pathways via skillfully positive social interaction and communication in the clinical encounter.

If the Hippocratic motivations of the clinician are considered, and their actions are reflective of the core duties of both medicine (Pellegrino & Thomasma, 1988), if not more broadly as regards respect for the autonomy of all individuals, then at no point does the clinician's attempt to induce placebo response(s) violate veracity, or introduce any intervention known to be either mechanistically inert or unrelated to the patient's presenting condition. And, in those circumstances wherein other interventions are either not possible or are futile, these stipulations also sustain the viability and value of such induction of placebo responses in accordance with the Principle of Double Effect (Giordano, 2009; Kamm, 1991).

To further evaluate and establish the ethical probity of this proposed conception of placebo, the authors believe it necessary to explore the issue of "manipulation." The term "manipulation" can be differently defined depending on the context of intent and activity. In psychology, the connotation of manipulation is entirely negative and defined as "behavior designed to exploit, control, or otherwise influence others to one's advantage" (American Psychological Association, 2018). However, it is important to note that this negative connotation does not extend to all applications of the term. For instance, in mathematics and engineering, manipulation refers to the engagement of variables, either into a simpler or more easily handled form (Li et al., n.d.). Thus, if one considers the act of medicine in the clinical encounter to be a "quasi calculus" of balancing benefit, burden, risks, and harms, so as to "engineer a prudent resolution of equipoise, then the use of appropriate behaviors to foster optimal conditions for achieving a goal through established ethical means provides a positive, or at the very least neutral, example of the term-in-practice. To be sure, one can (and arguably should) distinguish between negative and positive manipulation, such that the latter (in both means and ends) is focal to and consistent with the best interests of the patient.

Hence, it is critical to recognize that while deception can be considered a form of manipulation, positive manipulation does not entail deception (Bok, 1999). Yet, despite the absence of deception in the proposed conceptualization of placebo, establishing a logical framework to enable such positive manipulation in the clinical encounter can be provocative, if not contentious, given the asymmetry of the clinical relationship (i.e., the clinician inevitably possesses greater knowledge, skill, and therefore "power," and exercises some degree of control over the patient). Consequently, "manipulation" even in the positive sense, while certainly factually suitable, likely remains a conversationally unsatisfactory term to describe these benevolent actions of the clinician, and the resultant phenomenon and its beneficial effects.

Beyond Bedside Manner: The Bioethics of Placebo

Instead, the authors opine it better to employ "salutogenic reframing," as proposed by Luana Colloca (2014) describe means of facilitating optimal conditions within the patient and the patient-provider relationship that enhance the placebo outcome. Salutogenic reframing complements the concept of "therapeutic suggestion" proposed by Barrett et al. (2006) but more appropriately explicates the responsibilities of the clinician. The basis for this rests in the reality that clinicians inevitably possess and exert some degree of social influence; and in this way, bears responsibility of ensuring that such influence is devoid of negative and harmful effect or manifestation, inclusive, but not limited to those manipulation and deception (Mahoney et al., 2009). But characterizing this proposed conception of placebo to be merely an exercise of social influence in the form of suggestion neither adequately acknowledges the clinician's efforts nor recognizes the true complexity of this construct of placebo, and thereby ultimately fails to appreciate the physician's obligation to the clinical encounter. Therefore, the authors believe, pro Colloca (2014), that salutogenic reframing accurately conveys the extent to which the clinician must endeavor to foster placebo effects.

By distinguishing salutogenic reframing from more colloquial definitions of placebo, the authors conclude that the use of placebo as a therapeutic modality does not incur ethical abrogation involved in deceptively administering inert interventions with the intent to manipulate a patient's complex and unique neuro-cognitive and physiological response. Given this distinction, the ethical considerations for employing placebo as a therapeutic modality require an appreciation of the phenomenon's dual nature: (1) the magnitude of its ability to introduce salutogenesis to the patient so as to fortify beneficial treatment outcomes, and concomitantly, (2) the potential to harm the patient if exercised inappropriately, i.e., evoking a nocebo response, regardless of the clinician's intentions. Conceptualizing placebo in this manner shifts ethical considerations regarding its clinical application to the clinician's responsibility to remain self-critical and self-revising in their practice(s), as required to refine therapeutic prowess toward enabling the healing and health of their patients. The questions are no longer if it is ethical to "deliver placebo" and/or whether the use of placebo (as defined herein) undermines the probity and trust of the clinical encounter. The working definition provided here essentially renders such questions to be strawman arguments. In fact, the authors offer that the definition relating placebo to salutogenic reframing obtains something of a steel man argument *for* its therapeutic and ethical value. Hence, the authors opine that the question now becomes how to best educate and train clinicians to ensure the optimized care of their patients through engaging the potential therapeutic advantages afforded through maximizing the placebo response.

If one considers the (scholastic, technical, and ethical) value of the biomedical triune of reciprocally interactive education, research and practice, then we posit that research on salutogenic reframing as a therapeutic modality should aim to identify how best to entail the most current knowledge of placebo responses to inform patients as required to sustain their autonomous decision-making and consent. As noted, explaining the putative basis and mechanisms of such responses, while remaining truthful about what is known and unknown about "if and how" these processes may yield therapeutic benefit, certainly upholds clinicians' ethical requirements of veracity, intellectual honesty, and non-maleficence.

Moreover, the putativity of mechanisms, and therapeutically beneficial effects of placebo responses may represent a "mechanistic fallacy" (Giordano, 2010). In short, is it truly necessary to know (exactly) how something works, if, in fact, there are ample data to support "medicine-based evidence' grounded validation that an intervention is clinically effective (and without burden, risk, or harm). The possible harms are essentially avoided by the use of placebo and placebo responses advocated here (Giordano, 2008). To this point, the aforementioned actions clinicians can take to induce salutogenic reframing do not incur ethical improbity; and in fact, it is argued that the failure to teach, train and employ such methods and practices, given their recognized patient benefit(s), could be regarded as paradigmatically inadequate, and inept, if not frankly unethical.

Considering Nocebo

Clinicians do not need to provide patients with in-depth detail about the putative mechanisms underlying salutogenic reframing to obtain their full informed consent. Wells and Kaptchuk (2012) claim that providing too much information, particularly ambiguous or negative information, may trigger nocebo effect (from the Latin, meaning "it harms me;" nocebo effects are those factors that incur negative influence upon processes of health and well-being).To counter this possibility, Wells and Kaptchuk (2012) advocate emphasizing the positive information about the intervention, and defining the relative probability of any negative effects, in order to balance patient expectations. While this approach is consistent with the principles of salutogenic reframing, it is important to ensure that patients' expectations are not distorted to the point of believing that negative outcomes are impossible, as inducing such beliefs would extend beyond reframing and could be considered deception (Manchikanti et al., 2011). Wells and Kaptchuk (2012) also suggest incorporating alternative communication strategies, such as visual aids or narratives, to help patients better understand benefits, burdens and risks of a treatment without inducing nocebo responses. Providing patients information about salutogenic reframing may promote greater comprehension, foster additional coherence in the patient's goals and the clinical encounter, and in these ways facilitate therapeutically beneficial effects of placebo responses.

Conclusion: From Bedside-to-Bench-to-Bedside…and Beyond

These factors certainly require additional research. Mixed (qualitative and quantitative) methods should be applied for studying the clinically relevant aspects and effects of placebo responses, and their induction in various therapeutic settings (Giordano & Jonas, 2007; Giordano, 2004). Moreover, the concept of salutogenic reframing is incongruent with the current research use of the term "placebo" as a natural control. This needs to change. In light of the body of current information, and a broadened understanding of placebo responses, it is, and will be increasingly vital to refine interpretation of experimental outcomes that employ "placebo" as the basis for comparison, so as to be more inclusive of, and more directly address factors such as subjects idiosyncratic and collective (bio-psychosocial) characteristics and traits; environmental/situational variables that could influence subject(s') cognitions and/or physiology; and what similarities and differences in such contingencies and effects mean for evaluating the relative benefit of a particular intervention (Giordano, 2006).

The effectiveness of some compounds being utilized as "placebo" (viz. sham treatments), for example psychopharmacological substances such as anti-depressants, can often be ambiguous, as many drug-experienced patients can assess the side effects of drug therapy and frequently know whether they are in the "placebo" (sham) or the treatment group. Furthermore, in health promotion, it is extremely difficult to define a placebo control for certain psychological interventions such as mindfulness-based training. This should give pause for thought, as it raises the question of whether the current interpretation of "placebo" controls to identify causal mechanisms in longitudinal studies is really meaningful with regard to the epistemological and ontological concept of "causal effects." In other words, for those subjects who indeed responded positively to "placebo control," what is *really* inducing the observed positive therapeutic effect(s)? Thus, it becomes important to address both (1) the possibility of salutogenic framing, and (2) that placebo responses may be at least indirectly related to what are interpreted as an effect in empirical studies. Simply, it is argued that it is critical to more granularly study if, how, and why certain research subjects exhibit placebo responses, and to further investigate how such attribute-treatment interactions may be viable and valuable to access and engage to engender more personalized, precision care.

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Other D-Days: The World War II Reflections of Patrick H. Maas. An Honored Posthumous Publication

Patrick H. Maas
1923-2005
US Navy Corpsman in World War II
Phoenix, Arizona

General Introduction

In this 2024 year, America honors the 80th anniversary of the original D-Day. As one of the powerful historical anniversaries remembered and raised up in this edition, the Journal and its leadership are honored again to publish posthumously this special personal record written by one of America's World War II heroes. This article was originally published in 2019 in the Journal's Volume 5, Number 2. Permission has been given to publish the article once again by those who had approved its original publication.

Hospital Corpsman Patrick Maas, USN

Patrick Maas was an unlikely sailor, having been born and raised in Nebraska. Enlisting in the Navy after Pearl Harbor, he trained to become a Hospital Corpsman, also known as a Pharmacist Mate, and participated in many of the island campaigns --- many D-Days --- including Tarawa, Iwo Jima, and the landings on Leyte during the campaign to liberate the Philippines. Maas was also aboard an LST (landing ship, tank) during the last D-Day of World War II as the Okinawa campaign began on April 1, 1945. He, himself, became a casualty when a kamikaze struck his ship, splitting the landing craft in half and blowing Maas into the water without a life jacket. Although wounded by shrapnel, he managed to hang onto a floating barrel until rescued. What follows are excerpts from a document he wrote during the war entitled "Team Number Ten," the designated name for his LST medical group. Following the war, Patrick Maas attended college under the G.I. Bill and eventually co-founded, with his life partner William Benner, a successful design firm in Phoenix, Arizona. Mr. Mass passed over in 2005; and Mr. Benner, in 2013. Mr. Maas' obituary is included at the conclusion of this article.

This article is most powerful for this edition of the Journal as it was for the edition in which it was first published. This edition again raises up several major anniversaries in American and world history. Each reminds us of the catapulting that awaits each of us to launch forward into

new realms of personal worth and selfless service of others especially those most in need. Mr. Maas' service of the wounded in war invites each of us to question where and for whom we are being called today to serve others especially those crying out for social justice and human rights. Mr. Maas' reflections provide us with a very moving moment of courageous inspiration. The Journal is grateful to the friends and final beneficiaries of Mr. Maas for providing this article and promoting its original and now current publication as a special honor.

Team Number Ten

Another D-day in the Pacific. Stomachs are comfortably full of steak and eggs after weeks of dehydrated food. We know that the next few days will be busy ones. For weeks we have been "procuring" gowns, Penicillin, instruments, and other essential supplies by hook or crook, mostly by crook. One of our pharmacist's mates finally had to employ a little ingenuity and detoured the red tape of navy forms. Donning a captain's bars and officious stature, he called at a base hospital and demanded our essential Penicillin. Yesterday, the hospital radioed our ship and invited "Doctor" Traweek to their mess. We had to do some explaining, [and] the army nurses were disappointed that the handsome officer could not be located, but we had accomplished our purpose. *(See Endnote 1)*.

We have done well. Our operating room, such as it is, is spic and span. Instruments are sterilized and we have a fair amount of supplies. What we still have will not be enough. Even this morning's steak does not hold down that knowledge.

In two more hours we will hit the beach. Planes and our fleet have been softening the long stretch of enemy land. All morning I have been working to the steady thunder of our guns and theirs. As we near the beach I hear more vivid sounds. The crack of rifles, the thud of bombs, and the sharp explosions of ships' artillery are distinct.

An LST disgorges its cargo on an invasion beach.

It is almost time for the amphibious ships to lumber in. Most of these are LSTs with their sagging weight of tanks, trucks, jeeps, artillery, and previous troops of fighting men. We have lived with these men for many days and they have our good wishes --- for many of these boys it is their first invasion, for many it is their last. They have been playing cards and shooting craps during the day and they sing during the darkened ship hours at night. Our trip back will not have games and songs.

While we, of the surgical team, work frantically below we feel the scrape of sand under the ship and we lurch on our feet. We know that we are on the enemy's shore. Now our eight corpsmen and two doctors drop all medical duty and rush to help get the load on the beach. We must unload before the enemy gets our range. Every man grabs up equipment, ammunition first, and wades ashore. We throw this down anywhere in the labyrinth of materiel and run back for another load.

The materiel of war piles up.

The heavy trucks come rumbling out of the bowels of our ship. Many bog down in the sand and men work feverishly to pry them on to the beach. After we drop our last load, and the last truck has rolled down the ramp, our team returns to its pressing duty inside. Very soon we will be loading an entirely different kind of cargo. The doctors call the corpsmen together and assign duties. I am assigned to the operating room. I must assist in operations, do the sterilizing, and administering of plasma and whole blood. Two men are assigned to the operating room as assistants. Two more are assigned to bring the wounded from the beach, one is assigned to medications, and two are in charge of all muscular shots and intravenous feeding. These duties are in addition to our regular nursing care. Soon we have things perfectly organized, but we realize that no amount of organization can spread the work of eight corpsmen and two doctors over two hundred helpless men.

Corpsmen move casualty aboard an LST.

Two pharmacist's mates join the beach party and shortly the first ambulance rolls through the great bow doors and on to the tank deck.

Our first casualty is hauled through the hatch into the ward. He is followed by an endless stream of stretchers, passing under the doctor's eyes. Some smile, some don't, some talk, some joke, some not so badly hurt, and some with wounds indescribable. Some, you know, will never talk or smile again. Our bunks are rapidly being filled, our corpsmen running helter skelter trying to keep up with the

orders the doctors are screaming. We are already in a state of confusion and our ship is not quite half full. Suddenly there comes an order from the captain to retract the ship from the beach. The enemy has us in range of their mortars. We pull away, leaving lines of ambulances still full of suffering men.

Meanwhile, we have the first operation for critically wounded on the table--a belly case, intestines exposed and perforated. I already have an ether mask over his face. I made it myself out of a shower drain and some gauze. The ether drips out of the can, controlled by a safety pin. The operation is tense and swift. Especially so, with enemy shells landing close to our ship. The doctor orders a special type suture. I remind him that we are not at Mayo's [Mayo Clinic] and over his mask he gives me a look of reproach. Finally the incision is closed and the next patient slides on the table. One after another they are carried in and out, until we can land once again and pick up some more.

Our quota is filled rapidly and then to overflowing. Eight men have no bunks and we must resort to laying them on the tank deck. Plasma bottles swing above almost every patient. Already we are beginning to feel the inadequacy of our help and supplies. Needles are running low so they must be returned at once to the sterilizer. Ten bed pans and urinals for more than two-hundred men is not a happy thought. We must use plasma cans, glucose bottles, and canned beef tins.

We can't possibly handle another patient, so we pull off the beach for the last time and anchor in the harbor awaiting orders to join a returning convoy. It is late afternoon and we are still operating. Now a young boy with a badly mutilated arm is on the table. The doctor gives me the sign for amputation and somehow the kid understands. He smiles as I put the mask over his face. The amputation is a neat job, the doctor is skillful and leaves the patient with a good stump. When the boy returns to the states, he will readily use an artificial arm.

It is almost midnight and by this time there is considerable sweating and swearing over the operating table. The doctor picks up a rusted hemostat, curses, and slams it on the deck. Under the strain, he forgets that everything molds and rusts in this climate. There are often sharp words between the doctors and corpsmen. The needles are either too large or too small, the scalpels are never sharp enough. We do not have the correct instruments to perform the operations that we must do. Since the operating room separates the wards and the head, we have a parade of corpsmen carrying bed pans and dirty dressings through this ten by twelve room during operations. We all know that this is a necessity, but it still irks us. We have only two doctors. All of their time is spent in the operating room during this period and the wards are left without expert medical assistance. The doctors must constantly give advice and orders over the table. Two men have died, but the doctors cannot leave a patient, open, on the table. Finally the last suture is applied. The last dressing is done. The operating room staff tear off their gowns and gloves and fall on the deck. We steal this delicious rest, knowing that our work has just begun.

Now our operating room will become a dressing room and I must clean up the filthy

dressings and bloody sheets. The gowns and towels must be taken to the gallery to be "autoclaved" --- in the cook's pressure cooker. Buckets of residue from our operations are standing everywhere. Within another hour, I have the instruments scrubbed and sterilized once more and everything is ship shape.

The ship is in motion and we have joined our convoy. The stench from the wounded, below, is so great that a few of us go above; and from the slowly moving ship we can see the burning village, spurts of fire from flame throwers in the hills, and flashes of artillery from ship to beach. Suddenly there is a warning. Enemy planes are approaching and soon we can see flashes of anti-aircraft from different ships in the convoy. Soon all ships will take up the fire and the sky is completely filled with a zig zagging red glow. The cross fire from our own ships is almost as dangerous as the fire from the enemy. There is an explosion in the air, a mass of flames, a red streak to the sea, and then a few glowing embers on the water. We have hit one! Several more such explosions follow. The all clear signal sounds and the fire in the sky dies away. It is debatable which is best, the lack of air below, or the action above, but the pressing knowledge of so many things to be done carries us back to our patients. Once more, we have more requests and orders than we can handle.

Tonight our patients are in such pain that it becomes a problem to determine the amount of morphine each should have. An overdose can kill a man. One of our corpsmen will have this fact to face the rest of his life. Should he be pitied or censured?

Dawn at last and a new problem arises. Food for two hundred and eighty men--special diets for many. On an LST how can we fill a doctor's order for special diets? Anyway, it is comforting to know that at least half of these men must be fed Glucose through their veins. The rest will have to eat canned soup, meat and dehydrated potatoes. Oatmeal and orange juice? Not a chance.

Feeding these men in four tiered bunks, on a tossing ship, requires the skill of a contortionist. The operating room now becomes a galley. The operating table is soon full of sloppy eggs, meat, potatoes, corn, milk, and soup. I think that one of the greatest ordeals is chow time. If only the patients did not have to eat. While serving the trays, we grab bites of this and that and relish a hunk of the cook's good bread. Before all of the patients are fed, the doctors have arrived and demand to know why their "dressing room" is in such a condition. Almost before I can sweep off the last piece of bread, a third degree burn patient is placed before the doctor and we are ready to begin our day.

This man was dressed on the beach. From head to foot he is wrapped like a mummy. He faints when the multitude of gauze and cotton is removed from his hands. He is as surprised as we are to find that he has lost all of his fingers. It's hard to take, but in two days he will be joking about his misfortune. He requires help in all he does and it is only through the use of great amounts of plasma that we are able to save him.

Unfortunately, we aren't always rewarded with such gratifying results. Our little operating room soon becomes a morgue. We are forced to keep bodies, covered with blankets, on the deck. We have one under our operating table. It is not so tough for the corpsmen, but the patients hesitate to be dressed in such an atmosphere. One negro boy rolls his eyes at every shapeless hulk as we remove the sutures from his small wound. It is very difficult for us to have time to do reverence to the dead. Before tonight endless forms must be sent out on all of these lost. We must fingerprint them, sort and record their effects. This is not always easy. We find pictures of his home, his family, his wife, and baby. We cannot afford to stop and think.

At midnight our ship drops back from the convoy. We have sewn the bodies in army blankets and we carry them up to the dark and windy deck. They are slowly dropped over the side as a carpenter's mate reads the Twenty Third psalm. The dull sound, as they strike the black swirling waters, leaves me with a sick and empty feeling.

This morning our whole convoy has a moment of silent prayer for those buried last night. It is an impressive ceremony. The sea is calm and the gentle slap, slap of the water against our bow is a peaceful sound. One of the ships blows taps over its loud speaker, the flags are all lowered to half mast, and again our little carpenter's mate says a few words. We take a few moments after the ceremony to sit topside and watch the other ships as they sail through the morning sun.

It is strange how a man can work constantly for four days with little sleep and rest, but now the trip is almost over and tomorrow morning we will drop anchor in a friendly harbor. There, a gleaming white hospital ship will take our patients. They have nurses aboard! Women! The first white women that most of these men have seen in over a year. This will add to their morale more than anything else. It is good to see the men smile a little and hear a little hope in their voices once again. Even the corpsmen are showing less signs of strain and today one of our paralyzed patients said his first words. We have been giving him Penicillin shots every few hours for days. The poor man could talk only with his eyes, but we could tell that he did not like shots. As the mate plunged the needle in the man's buttocks, he asked, in a matter of jest, "Does it hurt, old man?" We were taken aback, but very pleased to hear the patient growl, "Damn right it does!"

Today we discharge our patients. Above, I can hear the familiar sounds that go with a homecoming. Seamen are running here and there, orders are barked over the speaker, and chains are being dragged over the steel deck. This "music" tells us that it will not be long. Our patients have all of their gear close to them on their bunks and are dressed in what we can find. As I hurry from compartment to compartment, they stop me, and give thanks. Addresses and plans to meet in the future are hollered back and forth. I look at each one and imagine I note a better color. Some look as if they even have gained weight. Is it possible?

There is a sudden jar. I know that we have pulled alongside of our destination. I hurry topside and already our two doctors are clambering over to give their reports. The seamen are telling sea stories of action at the front. The hospital ship towers over us like a great building and clean and smiling faces line its rail. I glance at the shining deck, the clean white uniforms of the corpsmen, and look longingly at their white tiled modern operating suite. I feel self conscious in my dirty shorts and boots, so I go below.

Already the first stretcher is at the hatchway and its burden is trying to catch a glimpse of the sun. The order is given to start unloading and the stream of stretchers starts out of the ship. We work for several hours and it isn't until we have the last stretcher over the side that I feel the pain in my shoulders and arms. The last reports have been taken to the doctors on this floating hospital and we are now untying and pulling away. Our surgical team stands topside and, as the hospital ship grows smaller in the distance, we are filled with a warm glow of accomplishment. One more look, and then we plod down below to clean up and get ready for another trip.

Evening

It is October 19, 1944. The evening general quarters has just sounded. Nervous men quickly find their places at battle stations. Darkness will soon relieve these men of their watch. A

beautiful tropic sun is setting, and all eyes are turned in its direction. It is not the beauty of the scene that holds the attention of these men. Enemy planes, like angry hornets, come zooming out of that mellow sun. If they come, they are expected from that direction. (See Endnote 2).

The men watch and wait. The silence is deadly. The slap, slap of the water on our bow is the only sound. Sweet twilight slowly makes silhouettes of the crews in the gun tubs. Steel helmets and life jackets make grotesque bulks against the purple sky. The men light cigarettes. Smoking will be prohibited after the darken ship signal.

In the west, the sun touches the sea. It seems to hesitate there, bid the world goodnight, and then plunges into the water. One can almost imagine he hears it hiss and sizzle as it hits the swirling black ocean. A great artist has smeared every conceivable color across the sky above the sinking sun.

Solemn darkness covers the ship. The men relax. All clear is sounded and the men throw off their helmets and jump from the tubs. There is conversation and laughter. It is a hot night and small groups of men gather topside. The men talk far into the night. They talk of all sorts of things. All subjects are discussed but one. They want to forget tomorrow. October 20, 1944 is another D-Day; another operation on an enemy beach.

The Fort

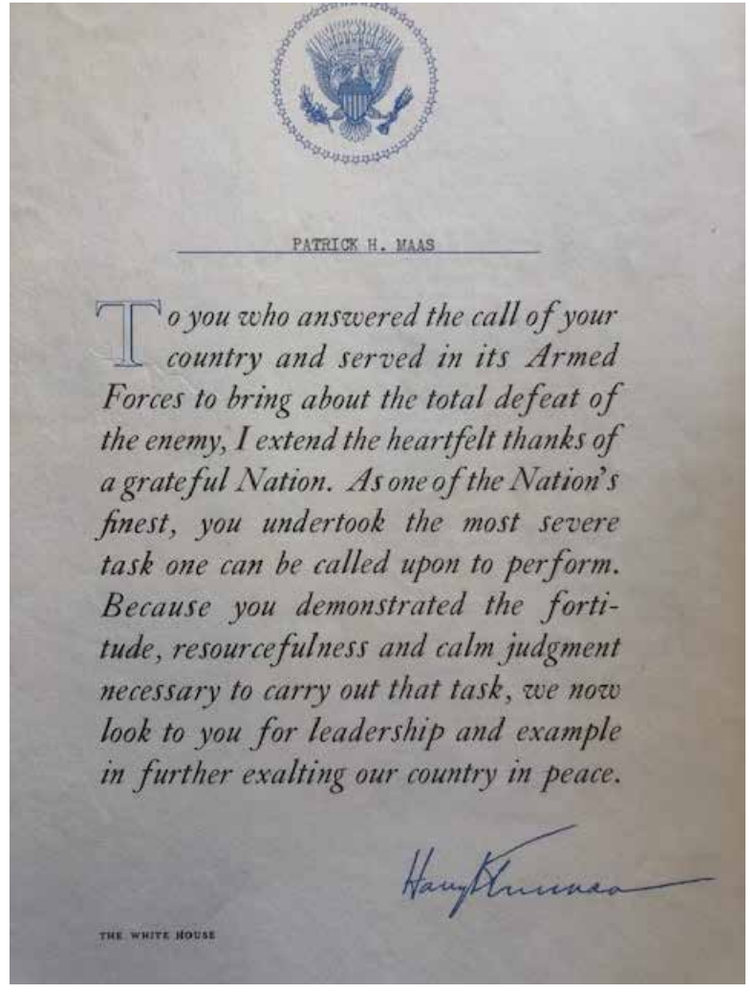
She perched on the top of a hill overlooking the gulf. During the day, she gazed with amusement at our comings and goings. At night, she slept in silhouette against the star-scattered sky. I'm sure that she was never aware of her beauty. It was several days after I first saw her that I had a chance to pay my respects.

My first liberty gave me the opportunity to climb the hill and see if this little stone fort was as charming as it pretended to be. It was very hot. The sun was high, and the faint trace of clouds did not help much. I found a path through the jungle and started on my climb. It was almost straight up. I went slowly, but with a certain steadfastness and singleness of purpose. The trip took several hours, but I was rewarded.

The fort was magnificent and I could understand why the Spaniards had built it at this point. A wonderful view of this Philippine island could be seen from here. Below and ahead I could see the bay filled with ships. Almost every conceivable kind dotted the water. The destroyers, skimming around the bay, reminded me of trim polo ponies. Great cargo ships, surrounded by small boats, looked like mother hens with their baby chicks. LSTs lined the white beach, and men, like ants, swarmed in and out of them.

Palm trees covered much of the island, and an occasional thatched hut would break their green carpet. I could see the village of Tacloban. Its haphazard streets and jigsaw buildings made an interesting pattern.

The sun became a vague prick on the horizon. Like fresh water, the air became cool and clear. I decided to spend the night with the fort. As I dozed off, I seemed to hear her whisper. Was it just the wind or was she telling stories of Spaniards and Japanese who had also spent a night with her?



PATRICK H. MAAS

To you who answered the call of your country and served in its Armed Forces to bring about the total defeat of the enemy, I extend the heartfelt thanks of a grateful Nation. As one of the Nation's finest, you undertook the most severe task one can be called upon to perform. Because you demonstrated the fortitude, resourcefulness and calm judgment necessary to carry out that task, we now look to you for leadership and example in further exalting our country in peace.

Harry Truman

THE WHITE HOUSE

A Special Presidential World War II Service Honor.

Obituary

Patrick H. Maas
1923 - 2005

The following obituary was published in The Seattle Times on 2/3/2005 & in The Arizona Republic on 2/12-13/2005. It remains available at: https://www.legacy.com/obituaries/name/patrick-maas-obituary?pid=3148366.

Although a kamikaze plane blew Patrick Maas off the LST where he was a member of a surgical team in the South Pacific during World War II, he remained fond of boats the rest of his life. But Maas was born far from the ocean, in Omaha, Nebraska, to be precise, on April 7, 1923, and led an uneventful life until Pearl Harbor. As a U.S. Navy corpsman, he saw action in the vicinity of many South Pacific Islands, including Iwo Jima, Tarawa and Okinawa, where he went ashore with the first wave of U.S. Marines. That kamikaze attack split his LST in two, sinking it and Maas without a lifejacket, and though wounded from shrapnel, he managed to hang onto an empty floating barrel from his ship until rescued.

After World War II, Maas returned to Nebraska, enrolled in the State University there under the G.I. Bill, and graduated with a M.A. in psychology. After moving to New Mexico and living in Albuquerque and Santa Fe, Maas went to Phoenix, Arizona, where he met his life and eventual business partner, William Benner, who survives him. In 1959 they founded Est-Est Inc., a design firm which became one of the most successful design firms in the area, with a roster of well-known clients. In the succeeding years, Maas and Benner traveled all over the globe, both for business and pleasure - and by boat whenever possible. In 1982, however, Maas was diagnosed with myasthenia gravis. When that went into remission, he was diagnosed with multiple sclerosis. Both diseases are neuro-muscular, affected by both heat and cold. And in 1984 the two men sold their company.

Over the years, Maas and Benner lived in both Mexico and Italy and in 1981 bought and remodeled an old farmhouse in Anacortes, Washington. It became their summer home for the next 10 years, at which time they sold it and bought a condominium in Seattle. They still spent their winters in a classic adobe house built by Lon Megargee in the 1920s in Paradise Valley in Arizona. Regretfully, they sold it in 2000, moving to a gated community nearby. But Maas still indulged his love of travel, most recently in trips - by boat, naturally - to Australia and Hawaii. Maas had a life-long interest in the arts, having served as the president of the board of Scottsdale Center for the Arts and, in Seattle, as a strong supporter of the Seattle Men's Chorus, where he and Benner are members of the Directors' Circle. No services are planned as Maas became a member of the Neptune Society early this year. Special thanks to the staff at Virginia Mason Hospital and the Care Center at Horizon House, also to Providence Hospice of Seattle. Remembrances may be made to the M.G. Society of Phoenix or the M.S. Society of Arizona, or Guide Dogs For The Blind, in San Rafael, CA.

End Notes

1. During World War II, the designation D-Day was traditionally used for the date of any important military operation or invasion whether in the European or Pacific theaters. The "D" simply stood for "day." But Maas does not indicate which D-Day or amphibious landing this is.

2. The following day, October 20, 1944, the invasion of Leyte began to liberate the Philippines.

Editorial Note

As previously indicated, this article by Patrick Maas is published posthumously. Personal friends and final beneficiaries of Mr. Maas and his life partner provided the article to the Journal for its first publication in 2019 and now again. The Journal is especially thankful to Dr. Elizabeth Holmes who initially obtained the article from these individuals, and facilitated all of the necessary communications including obtaining various photographs some of which are used in the above. The original and now current publication of this posthumous work is directly due to Dr. Holmes' forward thinking.

The initial photograph of Mr. Maas' Navy portrait as well the photograph of his World Word II Presidential Honors Certificate were provided from Mr. Maas' personal and historical effects by his friends and beneficiaries. The remaining photographs are courtesy of the United States Navy.

Finally, the Editors again give very special thanks to Mr. Douglas Carroll for his exceptional keyboarding of the original manuscript from its typed origins, and to Mr. Jan Herman for his outstanding and unparalleled copyediting and literary/historical review.

USS John S. McCain
A US Navy photograph from the Commander of the Seventh Fleet. The photograph was taken by Mass Communications Specialist Seaman Abbey Rader. Originally found with its license at: https://www.flickr.com/photos/us7thfleet/10149154885/.

OPEN FORUM

The Unprecedented Purposeful Targeting of Health Systems and Hospitals in Wars and Conflicts: An Immediate Call for Global Intervention

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Author Note

This article is based on the authors' research concerning war and armed conflicts, both authors' experience of global humanitarian assistance, and the second author´s experience of wars and armed conflicts. The authors have no conflicts of interest.

Abstract

Interstate wars and civilian conflicts result from political decisions that involve innocent civilians and bring suffering to the most vulnerable populations, including children, the elderly, women, and people with physical or mental handicaps. These political decisions result in human injury, deaths, and chronic morbidities, and consume healthcare resources, increasing the inequity of care and threatening medical professionals' lives. This is the time for the medical community to take a stand against violence and the consequences of war and conflicts that directly or indirectly engage healthcare systems.

Keywords: healthcare system, hospital, hybrid warfare, military, Geneva Convention, humanitarian Law

Addressing Current Wars and Conflicts

The current war on Ukraine imposed by the Russian government and the ongoing civil conflict in Iran have at least two things in common. They involve innocent citizens, and they invade the healthcare territorial and global immunity (Council of Europe, 2022; Center for Human Rights in Iran, 2022). The ultimate and appropriate reaction from all human beings, irrespective of their organizational, cultural, or religious beliefs and backgrounds should be the same: that is, whatever the causes or backgrounds of any incident, healthcare professionals should be granted the right to exercise their profession in saving lives. The common refrain, "Enough is enough" is being heard globally.

With the Russians targeting hospitals in a war between two countries, the immediate impact of a hybrid war was clearly highlighted for all to witness. The direct targeting of civilians and civilian services, such as hospitals, welfare, energy, and the economy sections have become commonplace tragedies. Moving patients to the underground corridors in the absence of an appropriate secure facility of care, not only increases the rate of mortality and morbidity among the civilians but also emphasizes the repeated violation of the international humanitarian law (IHL), the principles of the Geneva Convention (GC) and the core of human rights (Khorram-Manesh & Burkle, 2022).

The current conflict in Iran differs from the Ukrainian war since it is a war between the government and its own people, the majority of whom were born in Iran and grew up there under the same rules and laws. Iranian protective agencies (e.g., police and paramilitary organizations) instituted to protect people from any harm, are now purposely harming and killing their own citizens, including the wounded and those who demonstrate for their rights. Many of these are arrested in hospitals and transferred to jails, irrespective of their medical condition. And to compound the harm already done, ambulances are repeatedly used to transfer those arrested to jails and police stations (Council of Europe, 2022).

The laws of war prohibit the inhumane treatment of captured combatants and civilians in custody. In addition, belligerent armed forces that have effective control of an area are subject to the international law of occupation and international human rights law (International Committee of the Red Cross, 2016). These actions are severe violations of human rights and all internationally accepted laws, rights, and conventions that the governments of Russia and Iran have an international legal obligation to impartially investigate (International Committee of the Red Cross, 1949; International Committee of the Red Cross, 2014; United Nations, 2021). Whereas all 196 countries comply with the new Geneva Convention (GC) provision, Russia withdrew itself from Article 90 of Protocol 1 in 2019. This Article obligates all countries to comply with any international fact-finding mission or inquiry concerning any alleged violation of the GC. Russia's withdrawal from this protocol enables them to refuse access to records or resources that can hold Russia accountable for the breach of the Geneva Conventions (International Committee of the Red Cross, 1977).

This ongoing pattern of brutality and negligence of internationally accepted laws and human rights is not limited to Ukraine and Iran but is on the rise in several other countries

worldwide. While nations with developed democracies are often too naïve or slow to condemn countries that violate basic human rights, violating countries claim to be the keeper of human rights and only interested in the security and faith of their people. The current pattern of double moral standards and hypocrisy exercised by these countries, while unimaginable to the free world, correlates directly to the rise of authoritarianism and the decay of democracy (Khorram-Manesh, Burkle, 2022). In many instances it appears that the benefits of having trade and business agreements are more important than defending the most basic rights of vulnerable and affected people.

Attacking healthcare workers inside or outside hospitals has been a recurrent pattern of abuse and must immediately be stopped. Violence against hospitals and places where the sick and wounded are collected, provided they are not military objectives, constitutes a war crime in both international and non-international armed conflicts (Khorram-Manesh & Burkle, 2022; Khorram-Manesh & Burkle, et al., 2021). All citizens and representative international societies must revisit the definition of the following terms to understand the need for taking a stand against violence and the impacts it makes on healthcare:

1. International Humanitarian Law: "International humanitarian law is a set of rules which seek, for humanitarian reasons, to limit the effects of armed conflict. It protects persons who are not or are no longer participating in the hostilities and restricts the means and methods of warfare. International humanitarian law is also known as the law of war or the law of armed conflict (International Committee of the Red Cross, 1949).

2. Geneva Convention: The Geneva Conventions and their Additional Protocols are international treaties that contain the most important rules limiting the barbarity of war. They protect people who do not take part in the fighting (civilians, medics, aid workers) and those who can no longer fight (wounded, sick, shipwrecked troops, and prisoners of war) (International Committee of the Red Cross, 2014).

3. Human Rights: These include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more that guarantee the equity and safety of human beings globally. Everyone is entitled to these rights, without discrimination (United Nations, 2021).

With all these internationally accepted and signed documents, no one should be afraid of helping another human being in need. Human life as well as diversities in beliefs, ideology, and the right of healthcare staff to rescue the lives of those in danger should be praised, promoted, and respected. According to the Hippocratic Oath, all physicians swear by GOD to fulfil this covenant to the best of their abilities and to serve their patients with respect and dignity as inherently described in many cultures and religions (Greek Medicine, 2012).

This is the time for the medical community to take a stand against violence and the use of war and conflict to engage healthcare systems. Such political decisions result in human injury, deaths, and chronic morbidities, and consume healthcare resources and skills, thereby increasing

the inequity of care and threatening the lives of medical professionals. The invasion of hospitals and the use of hospitals and ambulances must be similarly condemned, especially in the current conflicts in Ukraine and Iran. Grave crimes in violation of the Geneva Convention, such as war crimes described above and violence against hospitals and healthcare providers are subject to "universal jurisdiction" under international law. This refers to the ability of another country's domestic judicial system to investigate and prosecute certain crimes against humanity wherever the crime takes place. Russia is counting on their withdrawal three years ago from Article 90 of Protocol 1 of the GC to protect them from prosecutions in Ukraine. Given the gravity of the current Ukraine abuses, most never seen in previous conflicts except for Syria's and Chechnya's hybrid wars, the unified and collective global community of medical professionals must consider taking unprecedented legal action as a unique global force of professionals, if nothing more than to educate the global community of the existing unique and unprecedented rape of global health protections. We have no choice.

Special Attribution

The opening photograph captures the message of this special editorial that healthcare itself must reach out to defend, secure and promote its actual purpose, namely human care. The photograph is the artistry of Kristin DeSoto. It is listed on Pexels as free for use per: https://www.pexels.com/photo/grayscale-photo-of-man-woman-and-child-736428/

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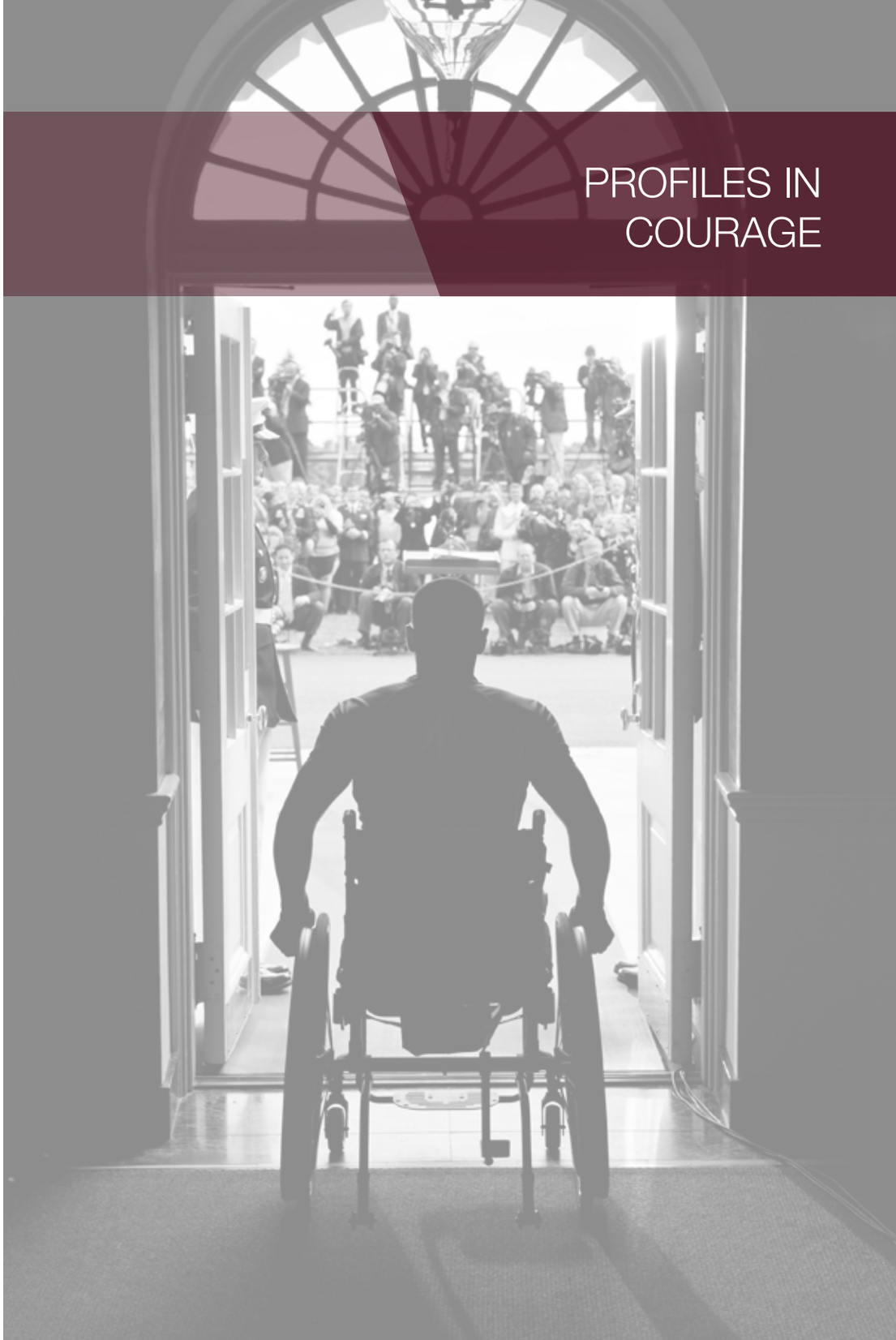
PROFILES IN COURAGE



Sailors Dressed Like Soldiers: A Veteran Remembers D-Day

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The Americans who first breached Hitler's "Fortress Europe" on June 6, 1944, were predominantly troops of the U.S. Army. But D-Day was not solely an Army show. Navy ships brought soldiers and their equipment from England. Navy battleships, cruisers, destroyers, and rocket-firing amphibious assault vessels pounded German fortifications to clear the way to the beaches and beyond. Most of the men who landed on Omaha Beach that day to begin the liberation of Europe are long gone now.

In 2000, as the Navy's Medical Historian, I began the production of the documentary series, "Navy Medicine at War," which chronicled the Navy Medical Department's role in providing support to the Navy and Marine Corps during World War II. One video in that series was entitled "Navy Medicine at Normandy." Even before I began the research phase, I had learned from the son of a Normandy veteran that an entire unit of Navy personnel supported the initial landings on Omaha Beach. That unit was the 6th Naval Beach Battalion. I had not been aware of what this battalion accomplished on D-Day and its aftermath. Although Kenneth Davey's father, Dr. J. Russell Davey, had died shortly after the war, Ken Davey had maintained close relations with his father's comrades over the years. Luckily for me, the 6th Naval Beach Battalion veterans were holding a reunion that fall in Myrtle Beach, South Carolina, and I was invited to attend. Since research for the video was still under way, the timing was perfect.

My audiovisual team and I spent several days at the reunion interviewing on camera a number of those veterans. Several would play key roles in the finished video. The interviews were emotionally riveting. At one point when I asked my videographer how the vets looked through his viewfinder, he replied, "I don't know. It was hard to see through the tears."

One particularly memorable testimony came from Dr. Richard Borden. His recollections as an 18-year-old Navy Hospital Corpsman, who had been assigned to the 6th Naval Beach Battalion, were particularly characteristic of what other servicemen in the first wave witnessed that historic day, regardless of their service affiliation. Among many other names, June 6 has become known as "the Longest Day." However, Borden was a non-combatant assigned to saving lives, and that job made his observations notable. The quoted excerpts in this article are from my interviews with Richard Borden [October 28-29, 1999; November 1, 1999] and his on-camera testimony [September 12, 2000] at Myrtle Beach.

A Teen Training for War

Richard Borden was born in Goldsboro, North Carolina, on October 29, 1925. He enlisted in the Navy in 1943 at age 17. Not yet 18, he required his father's signature. Since the Navy was very short of Hospital Corpsmen, Borden went directly to Bainbridge, Maryland, in the northeast part of the state. He was in boot camp not as a seaman but as a hospital apprentice 2nd class (HA2c). He remembered being so tender and frail that he was embarrassed by his physical weakness and his 118-pound hairless body. But vigorous exercise and the Navy's emphasis on being in shape--push-ups, pull-ups, boxing, and volleyball--soon made him physically fit. And as with all other Navy recruits, he studied the *Blue Jacket Manual*, learned to tie knots, and read signal flags. Borden was then assigned to Naval Hospital Bainbridge to get on-the-job training as a Hospital Corpsman. His first assignment was on the surgical ward.

Just before Christmas 1943, he was reassigned to Camp Bradford near Little Creek, Virginia, northeast of Norfolk. He learned that he would train at this camp as part of the 6th Naval Beach Battalion, and, most likely, that unit would participate in the invasion of Europe.

Sailors of the 2nd, 6th, and 7th Beach battalions, all attached to the U.S. Army Engineer Special Brigades, had a momentous job ahead of them. They were to establish all ship-to-shore communications, clear and mark sea lanes for landing craft, repair small boats, and treat and evacuate casualties from the invasion beaches. As a Corpsman, Borden and his fellow Corpsmen and Navy physicians would have to contend with every wound that modern warfare could produce--high-velocity small arms and artillery fire. He would also have to deal with penetrating wounds, fractures, burns, and blast injuries on the beach. In addition, the liberators would be facing an experienced and well-entrenched enemy whose reputation for invincibility had become legendary. The beach battalions were unique and unlike any other amphibious military unit of World War II.

When the young Corpsman arrived at Camp Bradford, he could barely grasp what awaited him. His future as a medical responder in a war zone was still a mystery, but what lay ahead became increasingly clear.

> I was still in Navy whites with a Red Cross [emblem] on my shoulder with my sea bag, which I could barely carry. It was a white duffel bag with a laced hammock around it. Everything I owned was in there.
>
> I went into a filthy, dirty double row of eight-man squad tents with a little heater stove in the middle with a pipe through the top. It was raining and there was so much mud, it splashed up on the cuffs of my white pants. Being a Corpsman, I went from the sterility of the hospital into this mud. When I opened the tent flap, there wasn't a soul in that tent. They were all on a weekend leave. My memory [of the sleeping arrangements] is that they were double decker bunks painted olive drab. I seem to remember not just rifles and carbines but even Tommy guns hanging on them.
>
> Everything was filthy with nobody's bunk made up. Even though there was no one there, it smelled of nothing but human sweat and smoke. Everything was khaki. I thought to myself, "Dear Lord, what am I into here?" And that was my introduction to the amphibious forces.

6th Naval Beach Battalion

Although his new comrades had already been at Camp Bradford for three to five months of training and had practiced several amphibious landings, HA2c Borden received little or no training at Camp Bradford--and time was running out. The unit mustered two days later and headed for Lido Beach, Long Island, a way station to a West Side pier in Manhattan where they boarded the British liner SS *Mauritania*, now a gray-hulled troopship. On January 7, 1944, the 6th Naval Beach Battalion sailed for Britain.

After a fast passage alone across the North Atlantic, *Mauritania* landed in Liverpool. After a night-long train ride south from Liverpool, Borden and his comrades arrived in Salcombe, a picturesque town in Devon on the English Channel. From Salcombe, the men of the 6th would then continue their military training. Since they would land and then occupy the beaches with invading Army troops, even as Navy personnel, they had to wear Army uniforms. But they donned black jerseys under their field jackets. As with Army medics, they wore the standard Red Cross armband. In fact, these sailors seemed indistinguishable from soldiers. What identified them was the painted gray band and a stenciled USN on their helmets. Also on their helmets was a red arc that differentiated the Corpsmen from Army engineers whose helmets showed a white arc. The Naval Beach battalion number was under the arc. Once ashore, the Corpsmen would make no distinction among the wounded Americans. It was their job to save lives whether soldier or sailor.

At their camp in Salcombe, Borden and his fellow sailors and their officers had to learn how to read maps, deal with potential poison gas, and hear lectures on identifying Allied and enemy aircraft. The Corpsmen even had to dig slit trenches [narrow trenches to accommodate several men]. And as part of their beach training, they had to become familiar with the many diabolical German obstacles they would encounter going ashore. Even as Corpsmen, all were trained to some degree in doing another man's job.

As Borden recalled: "That training seemed quite appropriate because we were all pretty much expendable as we hit the beach." A few practice amphibious landings rounded out the general training.

The Corpsmen continued to hone their medical skills. They were also issued their medical bags, which contained battle dressings, sulfa powder, and morphine syrettes, which were small toothpaste-like tubes with a needle affixed on one end. The bag also held casualty tags and a basic surgical kit.

The Corpsman's job was as follows: After performing first aid, that is, applying a battle dressing and a tourniquet, if needed, he might have to administer morphine. He then had to mark an "M" on the casualty's forehead and fill out a casualty tag. Armed with litters, a two-man team would next carry the wounded to the water's edge so the injured could be loaded aboard the now empty landing craft heading back out to the transports.

The Corpsmen were as ready as they could be. On June 2, 1944, the men of the 6th Naval Beach Battalion, carrying their heavy equipment, boarded the troop transport USS *Henrico* as the ship prepared for the Channel crossing. However, bad weather postponed the landings until June 6. *Henrico* departed for the French coast on June 5. Before dawn on June 6, the troop

transport stood off the Normandy beaches with HA1c Richard Borden and his mates about to encounter war for the first time.

The Odor of Battle

An LCT [landing craft tank] came alongside and that's when about 150 of us went overboard in the cargo nets and down to the LCT-600. The sea was quite choppy, not a storm, but very choppy--three- to five-foot swells. Then, suddenly, one of the control boats [small boats that directed landing craft to their assigned zones], which was a light gray, came up and someone screamed out, "What unit?" And all in unison, we yelled, "6th Beach!"

And they replied, "Easy Red, follow me." [Normandy beaches were coded. Units were assigned to one of the code-named sectors.]

We saw smoke and occasional explosions on the beach. As we approached, I became more and more aware of the odor of cordite [explosive compound used in ammunition] and the haze. During our training, we had studied maps and silhouettes, but we didn't see anything we were looking for because of the smoke and haze. The heaviest smoke came from the 15-inch guns of the battleships. As we got closer, we became more confused.

Nobody wanted to look over the gunwale [the top edge of a hull on a ship or boat] at all. And everybody was just very quiet. Not yells, not "Take it easy." Not that at all. But just "See ya. Take care." I recall muttering to myself, "God, please help me do it well."

I didn't sense my heart racing or anything, but I was very much aware of my nostrils dilating at the odor and probably apprehension of knowing that we were really there. Then there were the individual puffs of mortars and '88s [high velocity German artillery] hitting the beach. Splashes of machine gun and rifle fire hit the water about us.

Still closer, we heard the rumble of the stern anchor dropping off the stern of the LCT. And the ramp dropped with another loud rumble of chains running through the chocks. These are sounds that are still very vivid to me today.

After the ramp dropped, there was an unbelievable sight, a pall of haze. Instead of being right up on the beach, we were several hundred yards out, and as the boys went out in front of me, they dropped in the water about to their waist. All of a sudden, we had the Germans' attention and the machine gun fire began hitting. I was so innocent. Hey, that looks just like throwing pebbles at Scout camp--walking along the dam and just throwing gravel out into the water.

The horrible thing was that as we stepped off and started moving toward the shore, we were under fire. As I went off the ramp, one of the first things I did was to look down where I was putting my feet. There were posts with Teller mines [German anti-tank mines] pointing to seaward and lots of bodies. I remember the coagulum of slimy blood in the water, and the odor was a mixture of burning marsh, burning bodies, and cordite. I can smell it now.

There were some people, [who were] trying to hide behind the posts and the jack rocks [obstacle made of metal I-beams], trying to get ashore. There were a number of bodies on the sand, and even two or three that were actually on stretchers. Once we got through most of the posts, it was just hard-packed wet sand.

My first attention and my friend Rick's [Morris Rickenbach] were stretchers with wounded that had been left there on the sand. They had been dropped as someone who was carrying them either was killed or ran back to shore. Immediately, we picked up those litters and put them on the LCT that we had just left.

We heard a shell explode nearby. And someone called "Corpsman!" I skipped over to him and did what had to be done. It was a matter of exposing the wound and then sprinkling it with sulfa powder. Then jam him with morphine, get a tight dressing on, and get him the hell off the beach.

My stretcher mate, Rick, and I carried a single, typical, khaki canvas stretcher. Anyhow, we would zigzag back and forth and squat behind either a dead tank, a dead truck, or a dead vehicle of some sort for protection as we heard a shell coming in.

There was a burned-out tank we were getting ready to get behind. It was very definitely in my field of view. And then we heard something coming in. Both of us took a dive from the stretcher, I to the right and Rick to the left. It was absolutely the loudest noise I've ever heard in my life--a high-pitched crack, probably an '88. I raised my head and found my whole head and face numb, especially on the right side. I reached up across my forehead with my right hand and brought it down across my right ear looking at my hand for blood. There wasn't any. The right side of my face was numb and tingling, a burning kind of thing. The stretcher was between us. Maybe 10 feet to my left was Rick who had spontaneously taken the dive.

I screamed, "Rick! Rick! Let's move it!" And he didn't move. I called again, "Rick! Rick! Come on, let's move over there by that tank." And he didn't move. I picked up one of the rocks on the beach and threw it, hitting him between the shoulders. He still didn't move.

I scrambled over to him. I don't remember really looking him in the face, but as I turned him, his helmet went to the side and in it were two handfuls of gray matter--his brain. I just looked at it in horror.

I said, "Oh, my God--my friend!"

I started scrambling in my side pouch for serum albumin. We had been told it was a new lifesaving tool that we had for an immediate super lifesaving, super-shock condition. I hooked it up and put the tourniquet on and was getting ready to stick the needle in his veins. This man is dead. He doesn't need me anymore.

At that point, with gray matter just laying there in his helmet, I slowly wrapped up the vial of serum albumen and put it back in my pouch. I was still in an obvious state of shock.

I looked up and saw the haze and the chaos, the dark green of the foliage on the hillside where the German trenches and gun emplacements were. I stood up trembling, with tears streaming down my face, and screamed at the hillside, "Goddamn you, every one!"

And then an absolute warmth and peacefulness came over me. I remembered that Rick had a wife and a little girl. And I stood there muttering, "God, please let it be me. Please let me trade places with him."

Perhaps it was just a few moments later that Borden heard someone cry "Corpsman!" Being among so many Army troops, he recalled that what he probably heard was "Medic!" But that cry for help quickly snapped the anguished Corpsman back into action.

Borden then responded to another catastrophe that had just occurred offshore. Thirteen men of an all-African-American barrage balloon battalion had prematurely stepped off their landing craft in deep water and appeared to have drowned. All were pulled ashore immediately. Corpsmen and medics employed the old-fashioned artificial respiration, the prone pressure technique taught by the American Red Cross. Twelve men were resuscitated. Borden hastily rolled the one man over who hadn't responded and continued the prone pressure treatment, but the man wasn't reacting.

Borden continued, "Finally, I rolled him back over and gave him mouth-to-mouth resuscitation. I had never been trained to do this and never even heard of it. I can both taste and feel the coldness of those lips to this day. You do what you do without any thought. But, sadly, I did not get him back. I didn't do anything heroic, no heroic actions of any kind, but really went to work in a controlled frenzy after that."

What Borden did the rest of D-Day until dark was to move casualties aboard any landing craft that was unloading.

Borden shouted at the top of his lungs, "Hang on for just one more! He's right over here! Just one more!"

As with other Corpsmen and medics, Borden worked nonstop for two days, tending to the injured and carrying them on litters to the beach for evacuation. On June 8-9, a temporary airstrip was laid out behind the bluffs for air-evacuating the wounded. Once all resistance from the enemy ceased and German prisoners rounded up, it took several more days for mines and other unexploded ordnance to be removed or made safe. Only then was Omaha Beach declared "secure." On June 28, 18-year-old Borden and the other surviving members of the 6th Naval Beach Battalion were finally relieved and returned to England aboard an LST (landing ship tank).

* * *

Dr. Borden was awarded the Bronze Star in October 1944 for his service on June 6-7, 1944. Less than a year later, he would also serve in the Pacific preparing for the invasion of Okinawa. In June 2004, for the 60th anniversary of the Allied landings, he returned to France with 99 other American veterans to be awarded the French Legion of Honor medal. During that trip, he visited the grave of his older brother who was killed in action during the Battle of the Bulge. Richard Borden died in 2012 at age 87.

During his videotaped interview at the 2000 reunion of the 6th Naval Beach Battalion, I asked then-retired Dr. Richard Borden how he reflected on his role at Normandy. He hesitated for just a moment, then proudly declared: "I've been a family physician for 45 years and delivered over 2,000 babies. I'll borrow from Churchill now. "'D-Day was the greatest moment of my life.'"

Landing craft approaching Omaha Beach on D-Day, June 6, 1944.

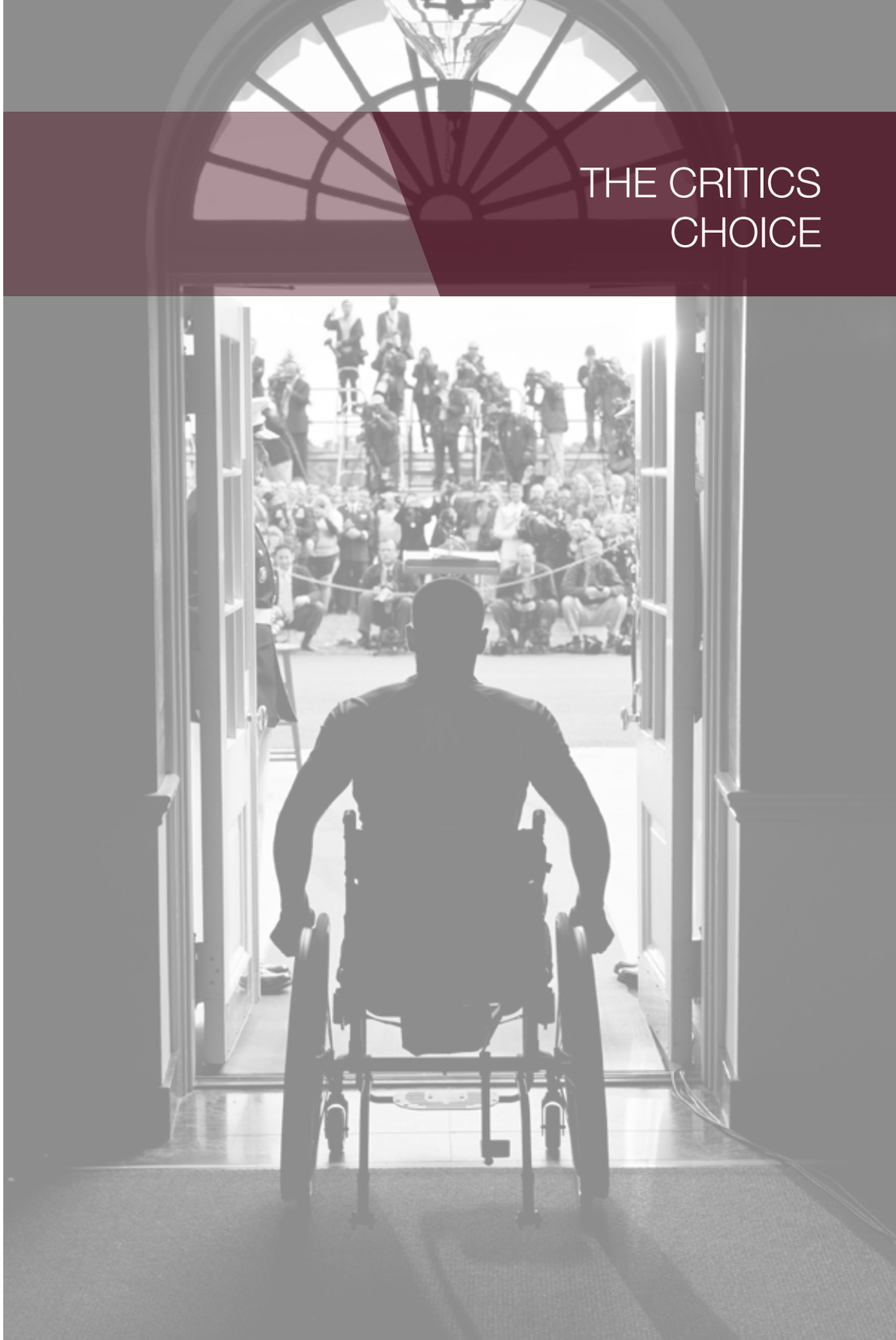
Author Note

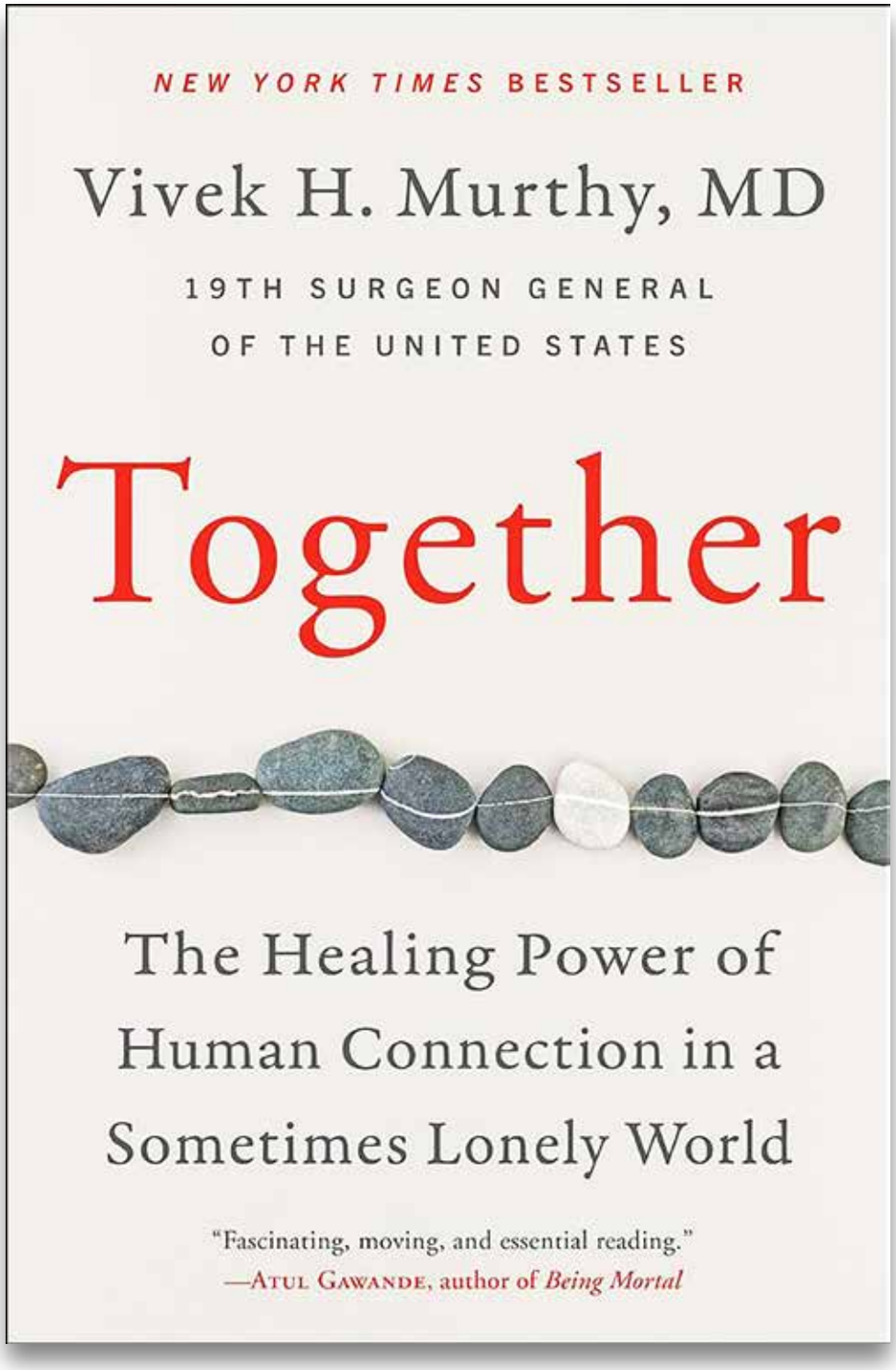
The opinions expressed in the above are those of the author alone. The author has no financial conflicts of interest.

Special Attributions

The opening photograph is that of Dr. Richard Borden taken when he was a Hospital Corpsman in the United States Navy. It is from the archives of the USN Bureau of Medicine and Surgery. The WWII photograph at the article's conclusion is from the National Archives. Both photographs are from the federal government and, as such, are in the public domain.

THE CRITICS CHOICE





Book Review

Together: The Healing Power of Connection in a Sometimes Lonely World

By Vivek Murthy
HarperCollins Publishers Inc.
New York
2020

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Author Note

The insights and views expressed in this review are those of the author and do not reflect official policy of the organizations and institutions he serves. The author has no conflicts of interest.

Introduction

If ever an author penned a book integrating "health and human experience," Dr. Vivek Murthy nails it. Focusing the reader in the "Author's Note," he writes:

> This book is about the importance of human connection, the hidden impact of loneliness on our health, and the social power of community. As a physician, I felt compelled to address these issues because of the rising physical and emotional toll of social disconnection that I have watched throughout society over the past few decades. (Murthy, p. 8)

Together addresses loneliness and its effects on health. This book makes the most sense when understood as part of a through-line. The through-line begins from Dr. Murthy's personal and family history, notes observations in his clinical practice, draws on his service (twice) as Surgeon General, and culminates in the May 2023, "Surgeon General Advisory" as an official, US government public health statement.

Dr. Murthy put the finishing touches on his manuscript for *Together* just as the COVID-19 pandemic made physical human contact a potentially mortal threat. Getting close enough to breathe on another person, singing hymns in a choir, or sharing a ride in an elevator became synonymous with putting oneself in danger. The public health imperative was clear: to save lives, stay away from one another.

During COVID, we settled on social distancing as an imperative: maintain physical separation to avoid spreading disease. Mask wearing became a life-saving decision (at least in healthcare settings). Masks, vaccines, and decisions about how and when to "reopen" became points of social, organizational, and even familial conflict. For Murthy, the challenges of this pandemic offer context for a possible reversal of the more enduring and pervasive distress in our day: loneliness.

Moving forward, Murthy's hope is that communal ingenuity may enable us to emerge (from both the pandemic and the malaise of isolation) feeling closer to family members and friends. Murthy explains, "...the current pandemic isn't the first and won't be the last time our social connections are tested... And if we learn from this moment to be better together, we won't just endure this crisis. We will thrive."

The "why" of this book is to diagnose and analyze the pervasive and pathological loneliness afflicting people in our world today followed by a treatment plan to pursue health by relating, connecting, and cohering.

Summary

Unsurprisingly for a physician, the book is conveniently divided into these two sections, diagnosis and treatment. However, Dr. Murthy does not rely on medical language but uses accessible language. Section I is, "Making Sense of Loneliness" and Section II, "Building a More Connected Life."

Throughout the diagnostic section, Murthy uses two principal tools. He summarizes findings of many accessible, inter-disciplinary resources spanning classic images, social sciences, epidemiological patterns, and genetic studies. His second tool, interspersed throughout the book, is the use of personal vignette. He punctuates nearly every topic with relatable examples featuring lonely people from his childhood and family life, medical practice, and tours as surgeon general.

Dr. Murthy's diagnosis follows three main considerations: the subjective experience of loneliness, biological roots and risks of isolation, and social determinants of loneliness. He defines loneliness as *"the subjective feeling that you're lacking the social connections you need."* He begins with the subjective experience of loneliness. His bottom line is loneliness is both a public health root cause and a co-morbid contributor to illness. Loneliness is as devastating as smoking, and alcohol and drug abuse. Loneliness connects to depression and anxiety. Loneliness intersects with violence from bullying to workplace and intimate partner conflict.

The subjective experience of loneliness isolates individuals and widens the gap between people creating a cyclic effect. Shame and fear of loneliness diminish engagement with or joining others. As social connections weaken, incipient loneliness overdetermines the likelihood of self-destructive behaviors and efforts to cope.

In his second element of diagnosis, Dr. Murthy elaborates on the biological imperative for social connection. Togetherness is rooted in our evolution as a species. When disrupted, well-being, even survival, is at stake. He describes how our ancestors quickly learned we were more

likely to be attacked or starve separated from our groups. But social groups also provided the numbers for mating, teaching, development of culture and, of course, protection. In short, our survival depended on social connection. We have carried forward this encoded pattern into our biology in the modern world.

Socialization also shows up in the biochemistry of human brain activity. Functional MRI studies of the brain show social brain pathways when we seek well-being. A similar conclusion can be drawn at a biochemical level. Social contact releases endorphins, while dopamine acts as a social motivator. On the other hand, our mind-body responses seem patterned to perceive isolation as an emergency. When faced with loneliness, our bodies release cortisol and raise our blood pressure and blood sugar levels so we have energy available. Over time, our mind-body reaction to loneliness appears to produce long-term destruction through stress and inflammation. Loneliness undermines sleep as we experience more "micro-awakenings." These effects of loneliness coincidentally surface both depression and anxiety, which make it difficult to isolate root causes.

The third major dimension of his analysis addresses loneliness influenced by social norms and individual needs. Here, Dr. Murthy contrasts patterns which can vary dramatically between different cultures.

Murthy draws the comparison between Southern Europe, where family and community ties are strong and fewer people live alone, with Northern Europe, where these are less true. The human experience of loneliness is relative. In other words, someone who lives alone in Greece or Italy may feel lonelier than in Sweden or Norway.

Murthy urges cultures to find the right balance between individualism and collectivism. He argues that we have moved too far towards individualism and must focus on communities and groups to foster social connections once more, without undermining individual liberties. But several trends militate against getting together.

With technological advances, we can enjoy the conveniences of community without actual interaction. Murthy describes technologies, like social media, that have been linked with higher rates of loneliness. New technologies can also create distractions, encouraging the illusion of multi-tasking. Some technologies advance efficiency but can actually harm communication, empathy, fostering a comparison culture. Significant social commentary today focuses on such harms among youth. Murthy accepts the positive contributions of technology but urges that our use of technology be shaped to foster connections.

> The point is that the more our lifestyle evolves to maximize efficiency at the expense of human interaction, the more focused we must become in directing our use of technology to facilitate deeper personal connections. (Murthy, p. 71)

Other modern challenges are displacement and migration which can also create a unique sense of loneliness. Migration often amplifies language barriers, loss of identity and status, along with cultural differences. Further, the reality of longer life and deep socio-political divides, exacerbates the loneliness epidemic.

Reflections On Healing

In *Together*, it is impossible to read the numerous stories and Murthy's analysis of loneliness and ignore three public themes--the three-year journey of the COVID pandemic, experiences of women and men currently or having completed military service (veterans), and the decline, divisiveness, and death-dealing realities in our public life.

As noted, Dr. Murthy finalized this book as the pandemic exploded. Now, in his second appointment, and as the public health emergency concluded, he issued the "Surgeon General Advisory" centering loneliness as an urgent public health concern.

For many veterans, military experiences during 20 years of compartmentalized wartime brought intense cohesion while in service and fragmented efforts of integration afterwards. When Dr. Murthy writes of the collateral and related impact of loneliness, the parallels for elevated risks among veterans seem apparent. Loneliness, he writes, is "...as devastating as smoking, alcohol and drug abuse. Loneliness connects to depression and anxiety. Loneliness intersects with violence from bullying to workplace and intimate partner conflict." VA health care providers frequently treat these concerns among veterans.

Plenty is circulating in our culture about political division and social hostility in our nation and worldwide. In his analysis, Dr. Murthy points out that humans are inescapably social, which presents both the problem and the solution. Loneliness fosters isolation and can amplify breakdowns in community. In the book, and even more explicitly in the "Surgeon General's Advisory," the solution for societal polarization is a pillar of public health: socially connected communities. Murthy specifies six pillars to advance social connection as treatment for and healing from loneliness.

Finally: Remembering the Heroism of Our Wounded Healers

This book's topic fits well with some special remembrances from late in 2023 as well as with this edition's 80th anniversary remembrance of D-Day. In 2023, our nation remembered the 20th anniversary of the founding of the Wounded Warrior Project, tied directly to the healing and hope possible for veterans traumatized by wartime military service. As a nation, in 2023 we also looked back on the life and experiences of President John F. Kennedy.

Those of a certain generation carry the collective wound from last year's 60th anniversary of President Kennedy's assassination. Also, in his military service during World War II, Lieutenant Kennedy commanded PT 109, perhaps the most famous small-craft engagement in naval history. Last year's 80th anniversary of the PT 109 conflict remembered Kennedy and the men who survived as wounded warriors. In typical veteran understatement, when asked how he became a military hero, he laconically replied, "It was involuntary. They sank my boat." He and the crew bonded in their war-time danger and determined pursuit of survival and rescue.

Examples of wounded warriors becoming the allies and instruments of genuine healing abound. In his insightful book on pastoral care and therapy, Father Henry Nouwen wrote concisely of the hope embodied by those attuned to their own human experience, sharing their vulnerability, and discovering healing in community. Two renowned VA psychiatrists, Drs. Larry Dewey and Jonathan Shay, both practiced their healing work emphasizing group therapy

with veterans. Many are familiar with the twin books of Dr. Shay, *Achilles in Vietnam and Odysseus in America*.

As the central pillar of healing and togetherness, Dewey summarizes the power of connection. In War and Redemption, Dewey writes to any of us "...hoping to live a healthy, good life."

> We all find meaning and purpose in life through productive work, useful service, spiritual exploration and connections, and loving relationships. A rich and abundant life is blessed with all these things. We cannot enjoy any significant happiness without at least some of them. (Dewey, p. 231)

A generation later, Dr. Murthy provides a coherent pathway for healing loneliness in our day--togetherness through socially connected communities.

For Further Reading

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Book Review

Finding Waypoints: A Warrior's Journey Toward Peace and Purpose

By Terese Schlachter and Colonel Gregory Gadson (ret.)
Schaffner Press, Inc.
2023

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The opinions in this review are those of the author alone and do not represent the views of the College of Nursing, the University of Colorado, Anschutz Medical Campus, or other institutions or organizations the author serves. The author has no financial conflicts of interest.

Introduction and Background

This is a story of finding wholeness in the face of extreme physical and psychological loss. Terese Schlachter immediately captures the attention of the reader by beginning her story from the moment Colonel Greg Gadson's Humvee was blown up in Iraq, when he was serving as a lieutenant colonel, and he was bleeding to death from severe leg injuries. She details the dedication and sheer determination of his team members in saving the life of their commander during evacuation to a combat support hospital and finally to Walter Reed Army Medical Center.

To provide context for the remainder of the book, Terese Schlachter then goes backward to Gadson's life as a boy and his time as a football player at the US Military Academy at West Point. She skillfully paints a picture of how Gadson's tenacity was shaped to prepare him for the minute his life was to change so drastically. She portrays how his resolve would be tested in ways he could not have imagined and describes the journey that Gadson and his family took to find healing, success beyond their wildest imagination, and finally peace.

Summary

On the surface, this book is like many of the books written about tragedy and the subsequent transcendence of life-changing situations. It is not a unique situation, and this comment is not meant to diminish in any way the catastrophic events Colonel Gadson and his family endured. However, one does not have to look far beyond the printed word to discover that the book, Gadson's life, and that of his family are about much more than simple perseverance and healing from a tragedy. The book portrays extraordinary drive, fortitude, and the coming together of several timely circumstances that created his ability to rise above and move beyond his immediate surroundings, and create a life of purpose in a direction quite different from what he planned. The book chronicles the events of his life, but it is peppered throughout with the wisdom he gained from self-reflection and from the people around him who modeled him. These became his waypoints.

Gadson began to show the ability to change course early on after he had been crushed by his failure to receive a scholarship to his university of choice, but instead was offered a chance to play football at West Point, a school he did not even know about. Little did Gadson know this change was going to set him up to manage the ultimate test of losing the legs that had propelled him. Undeterred, he set off for West Point after his father reminded him that he had given them his word and he was meant to keep it.

Several examples can be found in the book to describe the mindset of Gadson. Not having started out to dedicate his life to the Army, he learned it was not dissimilar to that of being on a football team. As it turned out, the military values learned at West Point were familiar to Gadson: leadership, loyalty to the team, camaraderie, selflessness, integrity, and being your best self. At first, Gadson only saw his time at West Point as a delay on his way to playing professional football. However, because of the similarity of the Army and football values, he quickly became entrenched in the military way of life and took seriously the values both taught. Gadson immersed himself in his new sense of duty, one that would leave him feeling alone at times, but that would provide the scaffolding for the strength that he did not yet know he would need. Little did he know he would instill those values in all those he touched, and who touched him. It would pay him back in spades as his team in Iraq found him on the roadside and labored hard to stop the bleeding and prevent him from dying in front of them. They did not intend to leave their comrade behind.

Once saved, but with no legs below his thighs and with a non-functional right arm, Gadson had his dark days. When he had nothing to do but lay in his hospital bed, he found nothing but uselessness and "stumps." He saw in himself that he was lacking his waypoints and any direction in his life. Gadson was once skilled with a camera, using it to find meaning in the world. Now, he could not even operate it. He knew he metaphorically had to learn to refocus to find what had been taken from him by the Improvised Explosive Device (IED). He had to refocus to find himself, not the legs that had pushed him through many football plays in his days playing for the Black Knights of West Point.

It is said that the military is a family, one that will surround those members who need help like a cocoon. Gadson stated, *"The Long Gray Line—as a cadet you can't wrap your head around it and I didn't really until I was wounded. Army icons like Petraeus and Odierno all wrap their arms around you and lift you up in a way you didn't understand before."* (Schlachter & Gadson,

2023, p. 94) He remarked how he and his family felt "cocooned" by his fellow military members and his caregivers and finally began to see himself as part of something larger, even though he did not yet know what. He was learning to take the days as they came and to put everything of himself into each day.

What followed was triumphant for Gadson and his family, including being made an honorary co-captain of the Super Bowl winning New York Giants football team after truly inspiring them, speaking engagements, remaining on active duty to take a post command and finally retiring on his own terms, and various acting roles. However, for this reviewer these things are not the point of the book. As stated earlier, there are numerous books detailing triumph from tragedy, and many more unpublished stories on the same topic, including the experience of this reviewer's own father. More deeply, the book points squarely to one person's ability to transcend himself, and despite life-altering injuries, move forward toward a better self. In this, Gadson had entrenched within himself a set of values that allowed him to inspire others toward their better selves. What he learned along the way was the point of the book.

Reflection

Having been stationed at Walter Reed Army Medical Center at the beginning of the wars in Iraq and Afghanistan, I saw countless service members with catastrophic injuries. Some were never able to get past their injuries, and some of them had family members who left them because of the injuries, but many of them were able to triumph. I could never tell which ones they would be, because I may have seen them on one of those dark days they all suffered. However, what I did observe was how they banded together and held each other up. They encouraged each other, admonished each other, and celebrated each other's accomplishments. I particularly remember escorting one of the numerous celebrities that came through the hospital, and we entered the occupational therapy lab. Three service members with various limb losses were making amputee jokes with each other. The VIP I was escorting began to try to make a joke, but I stopped him, while politely letting him know those jokes were between the amputees and no one else. This was one of their ways of rising above their injuries to feel a bit more normal. Though I never met Gadson, having been stationed elsewhere in late 2006, I knew many of the characters in the book and they were well portrayed. As Gadson described Dr. Pasquina as never having a hair out of place, I was transported back to a meeting I had with him and had noted the same thing. I worked for then Colonel Horoho and could see she was destined for bigger things. I also knew about the "Long Gray Line" and the brother/sisterhood created by West Point graduates, having married a graduate myself. The brother/sisterhood lasts for life. So, in this way the book was more than just a story. I had been there.

Though the context for Greg Gadson may be unique, in a sense, this is everyone's story; it is of loss, of adversity, of adaptation, of resilience, of overcoming, and of inspiration. It is a story of heroics. The Merriam-Webster Dictionary describes a hero as "a person admired for achievements and noble qualities" or "one who shows great courage" (Merriam-Webster, 2024). In today's world, we seem to be looking for heroes or idols, but perhaps it is in the wrong places. We elevate celebrities or great sports figures to hero status. While we cannot dismiss their accomplishments, it is those who seem to fly under the radar who should really be raised up. We find heroes in the everyday actions of people who, like Gadson, serve and inspire others. Gadson's "woundedness" necessitated his reaching deep to call on his initiative and his courage

to embrace the struggle and find a new normal. He stated, *"Struggle is okay. It means you're living."* (Schlachter & Gadson, 2023, p. 269). Schlachter does an excellent job of portraying this in her book, though Gadson did not really need this. His character, his values, and waypoints did this for him. He showed us that anyone is capable of such heroics. His courage and his qualities by definition would make Gadson a worthy hero to emulate.

One unintended message of the book that I saw while at Walter Reed was how the healers cared for the injured. They were the physicians, the nurses, the physical and occupational therapists, nutritionists, and family caregivers. They were heroes in their own right, finding new waypoints from which to adjust to a new population of very broken patients, patients they had no experience caring for. They had to learn to allow these patients to have their dark days, when to give them the tough love they needed to move forward, when to cry with them, and when to laugh with them. These healers rose to the challenge so that the Greg Gadsons of their new world could heal and transcend. But they also had to deal with their own feelings of caring for such injured, previously fit, and healthy service members. They too, had to dig deep to find the courage to deal with the war-wounded and survival of catastrophic injuries in such young patients.

Terese Schlachter strews bits of wisdom throughout her portrayal of Greg Gadson that we should all attend to in order to create our own waypoints. One primary lesson of the book stood out, a repeated reference to what Gadson learned during his early days in the Army. It was the trifecta of "pride, poise, and team" (Schlachter & Gadson, 2023, p. 180). Gadson referred to these, not as things to do, but values to incorporate into one's character. He referred to them again and again in the inspirational speeches he gave to various football teams, explaining that it allows one to have accountability, give one's best, and achieve more through teamwork. It is about giving and service to others, not gaining recognition. This lesson he learned was what made Greg Gadson stand out from the crowd. He not only healed but he excelled and eventually found peace and purpose in his life. We would do well to incorporate these values into our own lives.

Book Review

Light One Candle: A Survivor's Tale from Lithuania to Jerusalem

By Solly Ganor
Kodansha USA
New York
2003

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Introduction

The memoir written by Solly Ganor follows his life story starting in a Lithuanian Jewish ghetto and describes the experience and aftermath of surviving two concentration camps during WWII. The author weaves stories of his harrowing experiences and the experiences of friends and family during this time. Having survived life in the Slabodke ghetto and the Dachau concentration camp, his life intertwines with a Japanese-American soldier who facilitated Solly's liberation during a death march from Dachau. Clarence Matsumura, the Japanese-American soldier who rescued Solly, fought to liberate individuals held in Nazi concentration camps while at the same time, his own family experienced unjust detention in internment camps in America.

Prior to Clarence Matsumura entering active duty in the U.S. Army, the U.S. reeled from attacks on Pearl Harbor on December 7, 1941. President Franklin Roosevelt issued Executive Order 9006 which directed internment of all individuals deemed a threat to national security. This policy resulted in the forced relocation of Japanese-American families to internment camps. At the time Clarence entered the Army, he was residing in an internment camp and left his family to join the fight in Europe.

Summary

Solly Ganor, was born on May 18, 1928 in Heydekrug, Lithuania. His memoir discusses his experience as a Jewish Lithuanian during WWII. Solly's story starts in Kaunas, Lithuania where Solly recounts the events leading up to WWII. He describes the changes in treatment and attitudes by friends and neighbors he grew up around in Lithuania as well as his family's attempted escape to the United States. Solly discusses a shift in humanity when Germany invaded Lithuania at the start of the war. He describes Lithuanian militias comprised of neighbors who began murdering Jewish people early in the war.

At the start of the war, Solly and his family were forced to relocate from their home to a small apartment in a Lithuanian ghetto. They shared this small apartment with another family and were provided decreased rations of food. While there, they provided manual labor for the German military and survived mass killings where they lost friends and other family members. Conditions in the Lithuanian ghetto worsened over time and the Jewish residents were stripped of freedoms and small joys, like having all books removed from the ghetto. Solly discusses what it was like to live around death and the toll it took on his own humanity at a young age.

After a couple of years in the Lithuanian ghetto, Solly and his father were forced into the Dachau concentration camp while his mother and sister were separated from them and forced into the Stuffhof concentration camp. Solly and his family experienced worsened living conditions and harsher treatment by the German Schutzstaffel (German SS) during this time. He faces increased challenges of surviving week by week on decreased food rations, outbreak of disease, inadequate winter clothing and much more.

He and his father were eventually sent on Dachau Death March where Solly was officially liberated from the Nazis in 1945 by U.S. soldiers in the segregated Japanese-American 522nd Field Artillery Battalion. One of these soldiers was Clarence Matsumura. Solly shares his experience adjusting to freedom and recovering from years of enslavement, abuse and living near death. His time reading books in the Lithuanian ghetto and learning English from other Jewish residents resulted in his being able to translate language for U.S. soldiers who were treating survivors.

Reflection

Although Solly and Clarence had starkly different wartime experiences, the kinship and understanding of the other's circumstances forges a lifelong friendship. Understanding the complexities of two different, yet similar stories of wartime persecution based on racial

discrimination facilitates discussion and reflection for how society today can learn and change based on its history. Solly Ganor's story illustrates the darkest and the brightest sides of humanity. He touches on stories and experiences which facilitate reflection on how humans can choose to act as shepherds for one another and what happens when they do not. Solly's memoir depicts horrors and evils that human beings are capable of. He shared personal accounts of death and loss at the hands of other people that define history for many groups of people Solly's experience in concentration camps watching the extermination of friends and family is unique to Jewish holocaust survivors. These experiences are vastly different and bare no comparison, but did contribute to Clarence's sympathy to what Solly experienced at the hands of German and Lithuanian citizens. The comparison between the two experiences lies solely in the deprivation of liberty and confinement to one space.

The interactions between Solly and Clarence highlight the vital role that cultural humility plays not only in forming and maintaining friendships, but also within professional relationships. Those serving in the helping profession, such as psychiatric doctors of nursing (psychiatric DNP), psychiatric social workers, and psychologists, routinely provide therapeutic services for individuals and groups from a variety of cultural backgrounds who hold values, beliefs, and attitudes that diverge significantly from their own. In order to provide ethical and successful behavioral health care, psychiatric DNP's, psychiatric social workers, and psychologists must be able to accurately attune to their own cultural values, beliefs, and attitudes while also remaining open and curious about those held by others (Hook et al., 2017). At the intersection of self-reflection and humble appreciation for differences, psychiatric DNP's, social workers, and psychologists and their clients collectively create a meaningful professional relationship in which treatment goals can be met, suffering alleviated, and growth can occur. Failing to approach differences in others with such openness can result in therapeutic relationship ruptures, premature termination of therapy, and even discourage the client from seeking future behavioral health services.

Over the past several years, our nation has become increasingly polarized with Presidential politics and ready access to social media playing important catalytic roles. Various reports by leading policy institutions, such as the National Academy of Medicine, have described an eroding lack of trust and respect for scientists and health care providers that is simply unprecedented. Colleagues around the world who have been "targeted" by those with conflicting views report highly uncomfortable professional and even personal threats, including physical confrontations with highly volatile accusations. Verbal threats and violent attacks upon various ethnic, cultural, and demographically defined populations (for example, Asian Americans, Blacks, Hispanics, LGIBQIA2S+ individuals, etc., as well as those seeing certain politically charged health services such as abortion or sexual change consultation), including at their places of social gathering or worship (i.e., churches and synagogues) are becoming almost common in the national media. As a direct result, our society is seemingly becoming increasingly inoculated and almost accepting of such acts of confrontation and random violence, even including the random shooting of innocent children. One must only wonder what the impact of Artificial Intelligence (AI) will be as extremists begin to appreciate its unique potential.

For those who do not appreciate the lessons of the past, we would only suggest that they reflect for a moment upon how during the recent COVID-19 pandemic our nation's highest level public health authorities recommended, actually insisted, that our most vulnerable disabled and elderly citizens forgo their fundamental civil rights and be forcefully isolated from their loved

ones, notwithstanding the overwhelming scientific data that social isolation is extraordinarily harmful psychologically and physically. During times of perceived national crises, it is far too easy for authoritarian instincts to directly impact far reaching governmental policies.

Within this evolving societal context, several Past Presidents of the American Psychological Association (APA) have begun to publicly voice concern that the collective prejudice and intolerance for differences frighteningly evident during World War II might once again surface within the United States. The Holocaust and the U.S. Supreme Court approved Internment of Japanese Americans may resurface once again. At that time in history, far too many people believed that these horrific events could not happen in their lifetime and especially not near their own homes and family. In retrospect, too many voices were silent and too many failed to speak out. National command authorities and leaders have to take lessons from the past and work towards protecting and maintaining the constitutional and human rights of their citizens.

Fortunately, leaders of the American Psychological Foundation (APF) recall those days and recently established the APF Psychology of Antisemitism Fund. The Psychology of Antisemitism Fund was established by the APF in conjunction with the Association of Jewish Psychologists. This effort will support annual grants for psychology researchers and other concerned scholars to use psychological theory and evidence to develop or implement interventions aimed at the reduction of antisemitism and/or mitigating its effects.

At the 2023 annual American Psychological Convention, former APA President Dorothy Cantor expressed her excitement at seeing organized psychology coming together for the first time to address the horrific problem of antisemitism. In her view, APF will be the right psychological organization to tackle the problem because of its vast reach to researchers and clinicians who can take advantage of the funding opportunities, and because of its capacity for disseminating the results to the broader public. APF President Terry Keane: "We are proud to address this important cause. The rise of antisemitism worldwide is a pressing concern and we look forward to funding programs that will successfully combat this trend (personal communication, 2023)."

Psychologists and psychiatric DNP's and social workers are among the international experts on human behavior and their collective expertise must be utilized to mitigate this growing and very serious concern. One wonders if more psychologists had publicly spoken up and objected to the incarceration of Japanese Americans who were incarcerated merely because of their race, if this sad chapter in our nation's history could have been avoided.

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Book Review

The Wounded Healer

By Henri J.M. Nouwen
Image Books
DoubleDay
New York
1972

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Author Note

The opinions expressed in this review are those of the author alone. There are no financial conflicts of interest.

Introduction

Henri Nouwen (1932-1996) was a Dutch Catholic priest, professor, writer, and theologian. His interests were rooted primarily in psychology, pastoral ministry, spirituality, social justice, and community. His advanced studies included religion, psychology, and clinical pastoral education. Nouwen took part in the historic March from Selma to Montgomery with Martin Luther King and was known to have a collaborative friendship with Jean Vanier of the L'Arche network and community, who delivered Nouwen's eulogy at his funeral.

Before his death Nouwen published 39 books and authored hundreds of articles. His books have sold over 7 million copies worldwide and have been published in more than 30 languages. *The Wounded Healer* is one of his best-known written works. Although written from a specific, faith-based context, it has powerful implications for anyone in a role or profession of service, justice, or healing and, indeed, for anyone on a path of self-discovery and human development. *The Wounded Healer* attempts to ask questions and provide answers to several important quandaries of human development, service, healing, and community revolving around our own human woundedness as a source of self-understanding and empowerment to help others.

Major Themes

Nouwen begins by identifying what he calls the predicament of the Nuclear Man (sic). Nuclear Man references the Nuclear Age of the second half of the 20th Century and its psychological, spiritual, and social impact on human existence. Nuclear Man refers to the understanding and self-realization of human beings that their creative and intellectual powers also have the potential for self-destruction. The Nuclear Man, as such, cannot feel secure in any long-lasting social, religious, or societal constructs or institutions. He calls these feelings of dislocation and fragmentation.

Nouwen contends that the Nuclear Man's liberation from this dislocation and fragmentation is through one of three paths: the mystical way, the revolutionary way, or the combined way. The mystical way seeks a reintegration of the deepest meaning of being human through silence, meditation, and other ways of transcendence where Nuclear Man "finds a center from where he can embrace all other beings." The revolutionary way occurs when humanity becomes aware that "the choice is no longer between his world and a better world but between no world and a new world." The revolutionary way requires radical new thinking and upheaval of traditional ways of existence and social structures to unlock the fullest potential of human existence and becoming. Finally, the combined way realizes that revolution cannot be meaningful or transformative without transcendence; and transcendence is not truly powerful or effective without some form of revolutionary action. The combined way, then, is the fullest way to liberation because it calls humanity to both personal introspection and collective transformation of societal systems.

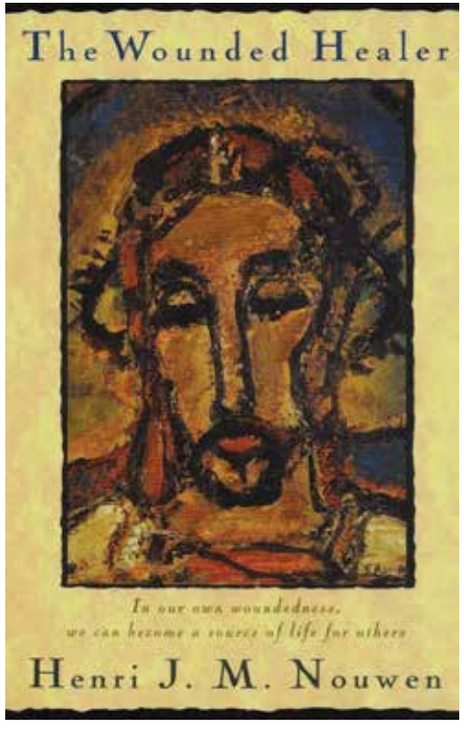
The bottom-line result of Nuclear Man's problem is isolation, loneliness, and despair. This root cause of woundedness brings about or allows for the growth and spread of injustice, disparity, violence, inequality, and suffering. Those who wish to address these conditions through service and leadership need to cultivate certain inner fortitudes: connectedness/community, compassion, and contemplative criticism. The healer needs to connect with others through their pain and loneliness and be able to communicate at this basic level to make a connection. Nouwen says this most basic task is to "offer men creative ways to communicate with the source of human life."

The next fortitude is the cultivation of compassion. Every human's desire to be loved is a primal need of every other human, and the hurt that comes from love deprived is also shared by every other human. Nouwen says that compassion "pulls people away from the fearful clique into the larger world where they can see that every human face is the face of a neighbor." Finally, the servant healer of today needs to have the reflection and courage to see their own woundedness and the woundedness of the world and call it out; or, as he says have "the courage to show what the true situation is."

In the service of others, new life and deeper connectedness to the meaning of life is created. But this service cannot be genuine without the servant healer being connected to their own loneliness, hurt, and suffering. It is the true path to being connected both to the other and to one's true self. It is the path to ending isolation and healing the hurt of another and in oneself. It is what Nouwen calls the price of admission into true and meaningful healing service. It is what allows the healing servant to be hospitable or pay true and real attention to the needs of the other.

Reflection

Although we have crossed into a new century, humankind is still plagued by the disability of Nouwen's Nuclear Man, as he termed it. Some of the symptoms have mutated or metastasized, but the root cause is still there. Racism continues to plague most cultures, with the rise of Christian Nationalism in our own country over the past 10 years as evidence. Misogyny continues to be malevolent, from women's healthcare and autonomy to equal pay. The persecution of refugees fleeing war and poverty across the globe highlights the disparity of the haves and have-nots. The continued assault against the LGBTQ+ community continues to fester; and we continue to wage war against those who are different or to gain an advantage over the weak to secure the gluttony of the strong.



All of this occurred while we have the ability through technology and innovation to end hunger and homelessness across the globe, and to eradicate the needless epidemic of AIDS still found in parts of the world, particularly Africa. We also have the ability to communicate within seconds with any part of the globe to bring education, awareness, and messaging anywhere through many mediums. Yet, we stand on the precipice of climate destruction, political oligarchy and dictatorship, and continued threat of mass destruction from nuclear, chemical, and biological warfare and terrorism.

Yet, if we look closely and more intimately at certain movements, organizations, and leaders, we can see that the message of the wounded healer is alive and helping to promote the meaningfulness, connectedness, and hope that Nouwen urged some 50 years ago. Movements like Black Lives Matter, #Me Too, Marriage Equality, The Women's March, and others, empower and give voice to those who had been injured, isolated, and deprived, and to reach out to each other and for each other. These movements invite others to feel their empowerment to both follow a mystical and revolutionary way to reflect on their own injustice and seek out others to empower change.

Organizations like Wounded Warriors Project, Human Rights Campaign, Trevor's Project, National Alliance Against Suicide, NAACP, Southern Poverty Law Center, the Carter Foundation, and countless others have formed formal agencies and organizations to help bring education and awareness of the systemic problems as well as revolutionary solutions by members who, themselves, have suffered physically mentally, or socio-politically from the isolation of Nuclear Humanity. In fact, this past year, Wounded Warrior Project celebrated 20 years of healing service to injured veterans.

The Wounded Warrior Project was founded in 2003 in Roanoke, Virginia by John Melia. Melia had been severely wounded in a helicopter crash while serving in Somalia in 1992. Melia assembled backpacks distributed to injured veterans at the former Bethesda Naval Hospital (now the Walter Reed National Military Medical Center) and Walter Reed Army Medical Center. As of August 22, 2021, Wounded Warrior Project self-reported that they served 157,975 registered alumni and 40,520 registered family support members.

Finally, the past 50 years have given us some monumental and heroic figures as wounded healers. As we approach Black History Month, we remember those towering figures like Martin Luther King, Jr. and Rosa Parks who embraced the scourge of systemic racism to transfigure a national movement for civil rights. Also, having just passed Presidents Month in February, we remember world-wide, international healer-servants like Presidents Kennedy and Roosevelt who battled physical disabilities to empower the downtrodden to hopeful futures; President and Rosalyn Carter who empowered those in economic suffering inspired by their own childhood experiences in rural poverty; Bishop Desmond Tutu, imprisoned by national apartheid, who inspired a national transformation in South Africa; Harvey Milk, scourged by homophobia, whose political service and death pushed a movement forward for LGBTQ+ rights, and so many others touched by their own brush with suffering to empower healing in themselves and others.

That leaves only the questions for each of us:

1. How are we reflecting mystically to discover our own woundedness? Where are we disconnected from our own sense of meaningfulness and inclusion? How are we lonely or in despair? Discovering our own sense of woundedness is where and how we can connect to the brokenness in others.

2. Has our embattlement in the condition of the Nuclear Person made us a source of loneliness or isolation for others? Has our own woundedness been a source of hurt for others? Understanding our own vulnerabilities and fears and how we have hidden from them in the treatment of others can make us more honest and approachable to others.

3. How can we embrace our woundedness as a call for a revolution in the way we live our lives and engage to transform the systems of our society for ourselves and equally for others? Where are we being called to be wounded healer servants for others? We cannot change everything that is broken in the world, but we can seek to heal that part of the world that has affected us because we reach out from our own powerful experiences.

As we engage in the healing service of others from a mystical foundation of self-reflection on our own woundedness, we will find the healing of revolutionary new ways of living and hope for ourselves, as well.

Special Notation and Attribution

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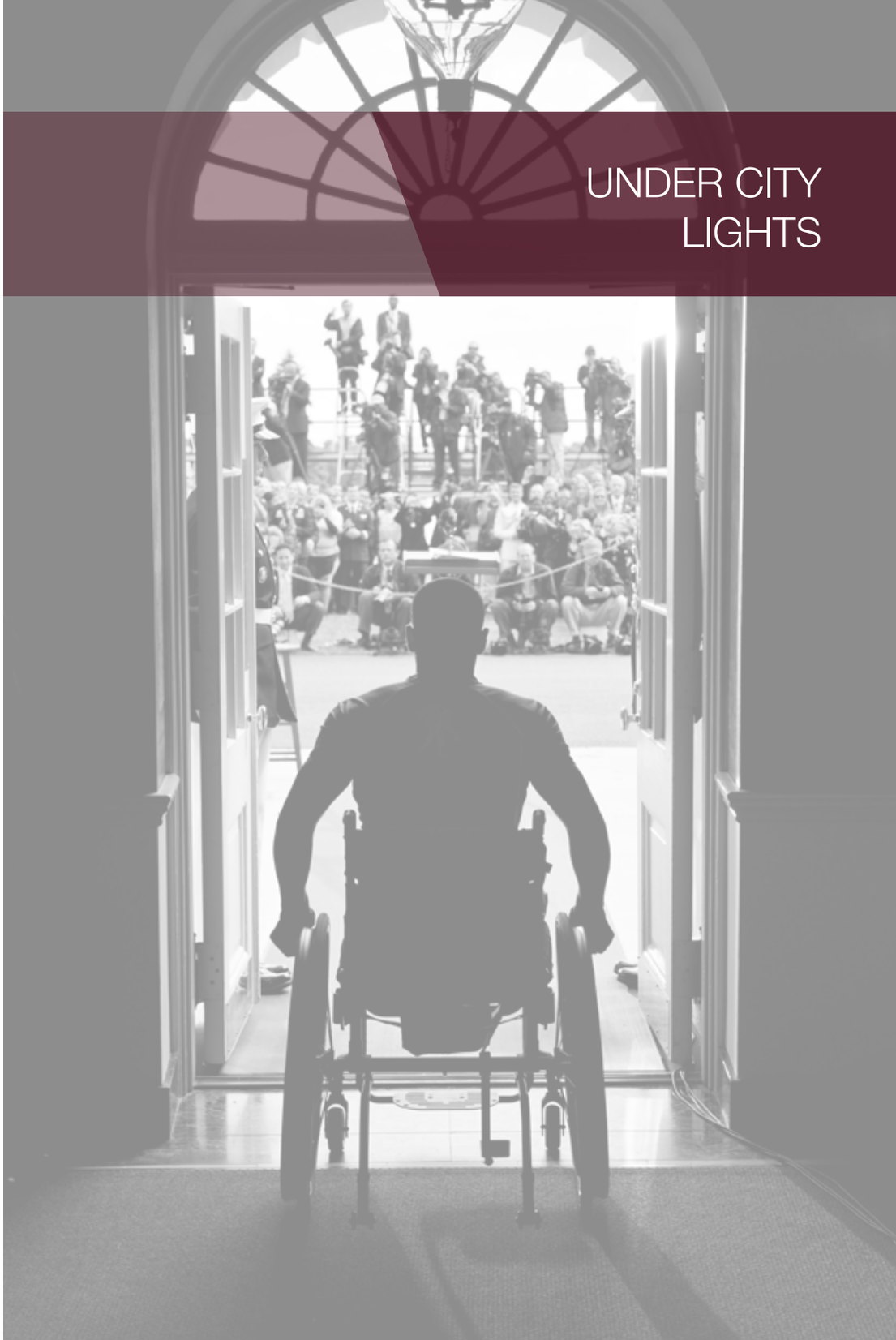
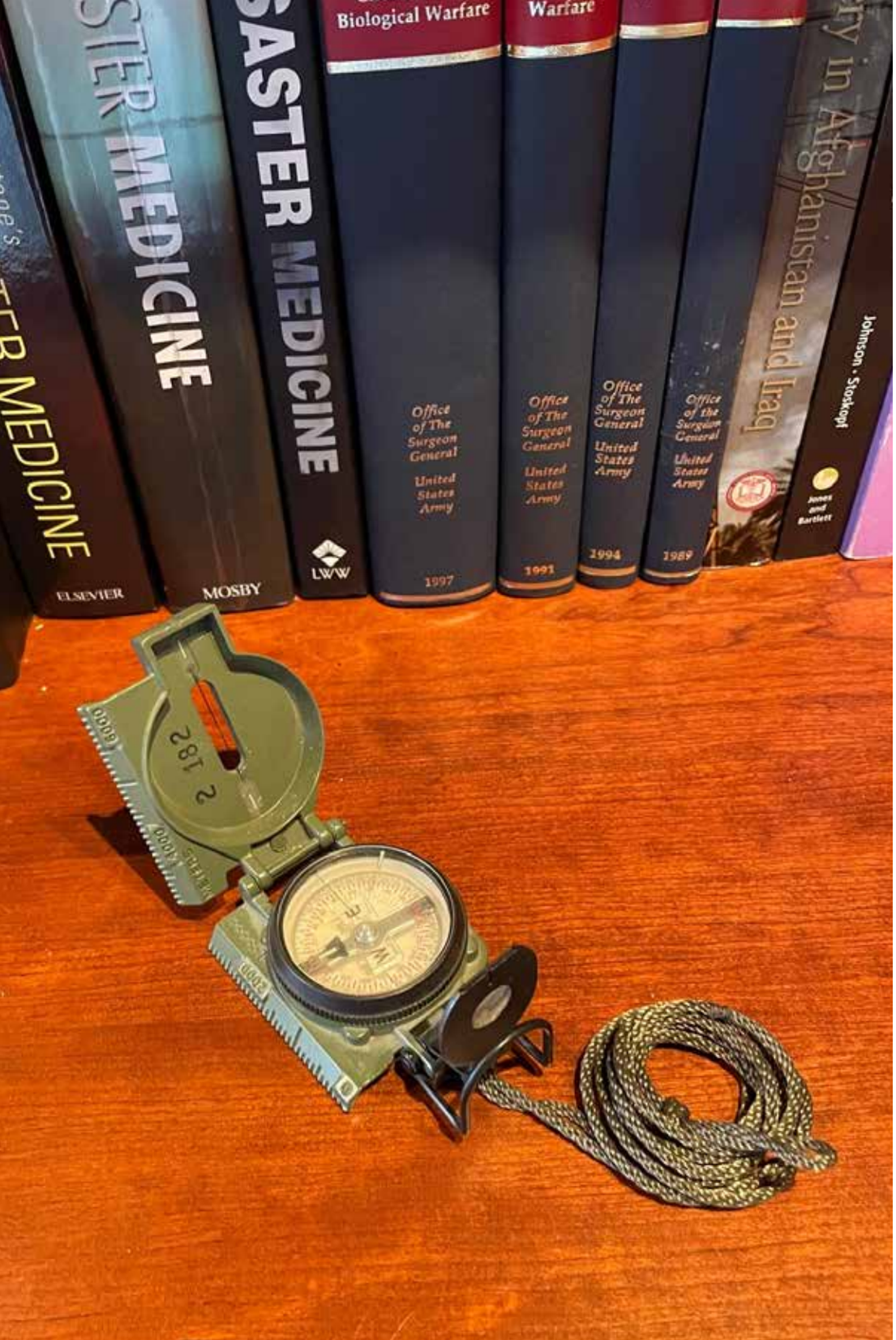
UNDER CITY LIGHTS





A Reflection

A Historical Reflection: Seaman Warner Lundahl and the Moral Compass

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In his 1977 book *Servant Leadership*, Robert K. Greenleaf addressed the failure of modern institutions to meet the needs of those they serve and employ. He argued that institutions and the individuals who are tasked to lead them should prioritize their *followers'* needs in order to enable them not only to achieve their own goals, but empower them to be of service to others in turn. The net to society would be of dramatic improvement in every facet of life. Most in positions of leadership are familiar with the term *moral compass* -- a reference to a person's ability to judge what is right and wrong and act accordingly. The story that follows takes a lesson hard-won from a World War II sailor who managed to survive the sinking of his warship and applies it to the both an individual officer's own life and our broader society's needs in these times of deep political uncertainty of our collective future.

In the summer of 2003, I was promoted to Navy commander (0-5). For the ceremony, I invited Warner Lundahl, my sister Patricia's (now) late father-in-law. Warner had served as a deck seaman in the Navy during World War II. At the very young age of 17, he was a crew member aboard the aircraft carrier USS *Yorktown* northeast of Midway Island in the Pacific. On June 4, 1942, during the Battle of Midway, the naval engagement that turned the tide in the Pacific war, the *Yorktown* was critically damaged by Japanese dive bombers and torpedo bombers. The Japanese submarine *I-168* torpedoed the carrier two days later. The Yorktown went down on June 7, 1942, around 7:00 a.m. Fortunately, Seaman Warner Lundahl survived the sinking.

Only a few people can lay claim to such a simultaneously remarkable and horrific experience while at war, but Warner Lundahl certainly earned the credit. Equally remarkable to me was the fact that I had known Warner Lundahl since his son Peter had begun dating my sister in the late 1960s. However, I had never heard this story of Warner's ordeal, even after I had enlisted in the Navy in 1985. I would only learn about his experience in the Pacific just a few years before my 2003 promotion.

Prior to my promotion, I had asked my superior on the Joint Staff, Vice Admiral Gordon Holder, a Surface Warfare Officer, if he would be my promoting officer. A week before the ceremony, the Admiral's aide asked for a copy of the proposed guest list for him to review. He specifically wanted to know if anyone coming to the ceremony was a veteran with any special

status. He was thinking along the lines of a member of the Legion of Valor, someone who had been awarded a personal decoration, such as the Navy Cross or the Congressional Medal of Honor, a former prisoner-of-war, or a Purple Heart recipient. When Admiral Holder learned that Warner Lundahl would be attending the ceremony, I was immediately summoned to his office, ostensibly to tell the Admiral all I knew about his service aboard the *Yorktown*.

During my promotion ceremony, Admiral Holder treated Warner as if he were a reincarnation of Fleet Admiral Chester Nimitz, the man who led the Navy to victory in the Pacific. He spent at least 15 minutes of the 20-minute promotion ceremony lauding the old sailor and his miraculous survival tale. I wouldn't have had it any other way!

On the morning of the promotion ceremony, Warner and his wife, Inge, came to our house for coffee. I was already dressed in my "choker whites," the Navy's summer dress uniform for officers. Before we headed to the Pentagon where the ceremony was being held, Warner took my arm and asked for a minute alone. We walked back into the kitchen. Warner smiled broadly as he held out a small package, gift-wrapped, of course, in Navy blue and gold.

"What's this?" I asked with great curiosity.

"Oh, just a small gift from an old sailor to mark this important occasion," Warner casually responded, smiling all the while.

* * * * *

Promotion to the rank of commander in the Navy marks an officer's transition into the ranks of "Senior Officer." Warner might have just been a junior enlisted man during his time in the Navy, but he knew its customs and traditions. He recognized that this promotion would mark an important moment for me in my Navy career. He also realized what it meant for an officer to uphold the mantle of responsibility that would now be expected of me. Warner had seen war firsthand, and perhaps even more importantly, he knew what it meant to be a good officer under life-and-death combat situations.

At that moment in the kitchen, he was about to present me with something to serve as a reminder of the obligation I was about to undertake. I took the package from his outstretched hand, nodded in respectful appreciation for his thoughtfulness, and opened the gift.

Beneath the gift wrapping was a simple black box. I looked inquisitively at Warner for a moment as he signaled for me to open it. Inside was an Army field-green sateen case with a snap button. I was more than a little surprised to lay eyes on an official Army-issue field compass. It was the kind of device an Army infantry captain or senior non-commissioned officer might carry as he led his troops through a complex field maneuver. I wondered immediately what I, as a Navy Medical Service Corps commander, was supposed to do with this Army compass. To date, I had spent the sum total of zero days leading the dirty-boots-infantry-troop-crowd through combat maneuvers.

Nonetheless, I felt compelled to express my sincere gratitude at this kind gesture, so I shook his hand and offered my thanks. I told him how happy and appreciative I was that he would be

at the ceremony to share this important and meaningful day with me. Warner smiled, warmly patted my shoulder, and turned to leave the house. But before we left, I placed the compass in a kitchen drawer, still questioning why he chose to give me this gift. The compass sat in that kitchen drawer for the next two years.

One morning, I was rummaging through that same drawer and came upon the black box. I gently pulled out the small instrument to examine it more carefully. In an instant, the light *finally* came on in my head. I immediately called Warner.

"Well, well, Commander!" he said before I even got off "Hello." "If you're calling me for the reason I *think* you're calling me, it sure took you some time to finally figure it out!" I could hear him chuckling softly to himself over the phone.

"It's the Moral Compass!" I declared. "The gift was meant as a message --- an important message --- and I had missed it completely."

"Aw, don't be so rough on yourself, Commander," Warner retorted. "When I served in the Navy, we junior enlisted sailors were pretty much convinced that you officer types really didn't start getting any smarts until that rooster, the silver eagle insignia of rank, began to nest on your collar and people started calling you Captain!"

I would have expected this type of teasing directed at me from an Old Salt. That sailor had made every attempt to give an officer, that is, me, the benefit of his experience and the knowledge represented by the hard-earned hashmarks, stripes on the uniform representing length of service.

As a sailor, Warner once again had a close brush with death in the war after a Japanese kamikaze had blown his warship out from under him. After a lifetime of astutely observing the full range of the human condition and experiencing the enemy up close and personal, Warner Lundahl understood these relatively simple truths better than most. First, the more senior a person rises in one's career, the greater the temptation to put one's own needs or desires before the wants of others, especially one's subordinates. This perception is the polar opposite of servant leadership. Second, situations requiring profound decision-making ultimately come down to this: You can do what's right or you can do what's easy.

* * * * *

As a student at the U.S. Naval War College in Newport, Rhode Island, I had the great fortune to secure a seat in one of the best and most competitive classes offered during the intense year officers spend there -- the "Foundations of Moral Obligation" class. This class is better known as the "Stockdale Course," which was named in honor of Vice Admiral James Bond Stockdale. This fighter pilot/former prisoner of war (POW), vice admiral was a man I consider to be one of the finest officers ever to wear the uniform of our nation's armed forces.

James Stockdale was shot down in September 1965 over North Vietnam while on a combat mission. Imprisoned in the infamous "Hanoi Hilton," he languished with other American military captives for more than seven years. Stockdale realized at the very beginning

of his ordeal that he was the "Senior Officer Present Afloat." He quickly informed his fellow prisoners that he was now their commanding officer. All protocols associated with the observance of the chain-of-command would consequently be strictly followed.

During his captivity, Stockdale spent much of that time in solitary confinement. Nevertheless, he made it known that none of his jailers could "interrogate" any of his men without going through him first. During the Vietnam War, as in all other wars, "interrogate" is often a euphemism for torture. As a result, Stockdale endured almost continuous and unspeakable acts of torture, including having both legs broken and re-broken. His wrists were lashed together by wire behind his back as his body was raised off the floor until bones in both his arms fractured and his shoulders separated from their sockets. He also suffered frequent, if not daily, beatings at the hands of the guards.

Toward the end of the war, the North Vietnamese grew anxious that their treatment of prisoners would have a negative effect on how the so-called "peace talks" played out for them. They therefore planned to have Stockdale read a propaganda statement that would affirm that he and his fellow prisoners had received "excellent treatment" during their incarceration.

Stockdale would have nothing to do with this villainous scheme. Moreover, to prevent any chance of the enemy being able to film him, Stockdale broke apart a small mahogany stool in his cell and beat himself so badly about the face and head that he fractured his nose, his jaw, and both orbits of his eyes.

After allowing his self-inflicted wounds time to heal, his captors once again tried to force Stockdale to renounce his country and deliver North Vietnamese propaganda on film. This time, the steadfast officer broke apart a shaving razor, which each prisoner had been provided, and sliced his wrists. He stated that he would rather kill himself than become a traitor to his beloved country. Thankfully, James Stockdale survived.

American POWs were finally released and returned home in early 1973. They had all endured years of imprisonment with their commanding officer. To honor Stockdale's heroism, every former POW signed a document recommending that he be awarded the Congressional Medal of Honor, (MOH). The MOH is the nation's highest decoration for valorous action in combat against an enemy of the United States. After being presented the award by President Gerald Ford in March 1976, Stockdale was promoted to two-star Rear Admiral and appointed as the 40th President of the Naval War College.

In one of his first acts as head of this service college, Admiral Stockdale created the "Foundations of Moral Obligation" course, a survey of the great works of moral philosophy derived from the works of Epictetus, Seneca, and Marcus Aurelius. These ancient truth-seekers were all considered to be the founders of stoicism, a philosophy that espoused virtue as being essential to a well-lived life. Some of the giants of 20th century moral thought were also included in the curriculum, including Albert Camus, Soren Kierkegaard, and Alexander Solzhenitsyn. From 1945 to the mid-1950s, Solzhenitsyn endured similar torture and solitude in the Siberian Gulag. His sufferings and brutalization mirrored Stockdale's dehumanization in Hanoi.

At the heart of the course's creation was Stockdale's unwavering belief --- officers on their way to positions of high command would likely lead men and women into harm's way. These officers would likely be confronted with the temptation to use their positions of power and influence. They would exploit their office to serve their own selfish needs before devoting time and attention necessary to care for and support their subordinates. Many of those serving under them were responsible for hoisting those officers to commanding positions in the first place.

The simple aphorism then comes into play. You can do what's right or you can do what's easy. These few words may sound straightforward but they are anything but. In recent times, all we have to do is observe the lapses of moral leadership by some of our nation's most senior leaders that threaten the very fabric of our democracy. We therefore can understand how dangerous and divisive the failure to carry forward the weight of moral obligation can be. This breakdown of ethical duty puts the very democratic ideals that fortify this nation at risk.

Seaman Warner Lundahl is no longer with us. He passed away in 2020 at the age of 93. I would like to think his last years were spent doing his best after his prayers of deliverance were answered by surviving the ongoing aerial bombardment off Midway. Later in the war, the fiery crash of a Japanese kamikaze on his ship incinerated many of his fellow shipmates.

The compass Warner gave me now sits in a place of honor in my home office. I pick it up often as a reminder of my own obligation as a leader, a husband, a father, a grandfather, a former naval officer, and forever a citizen of this great nation. Warner's gift from long ago is an ever-present symbol of what the concept of moral compass is all about.

Author Note

The opinions expressed in this historical reflection are those of the author alone and do not represent those of the institutions he has served previously. The author has no conflicts of interest.

Special Attribution

The opening photograph of the moral compass has been provided by the author himself for inclusion in this reflection.

A Poem

The Unspoken Voice

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Introduction: The Wounds We Carry

John F. Kennedy SHOT!!! Jackie held her husband while he lay dying. The doctors did everything they could to treat his wounds. Jackie is now left to find a way to go on alone raising their young children with wounds no one can see.

As humans, as healers, we answer the call to help the wounded. Dr. Jerry L. Long, Jr. had a diving accident at the age of 17 leaving him paralyzed from the neck down, ending his promising baseball career. During his recovery, he learned about Dr. Viktor Frankl and read his book "Man's Search for Meaning." Long then goes on to continue his education and earn a Doctorate in Clinical Psychology. He wrote a letter to Dr. Frankl, a renowned Jewish-Austrian psychiatrist and Holocaust survivor, saying "The attitude I adopted on that fateful day has become my personal credo for life: I broke my neck, it didn't break me." Frankl often spoke of Long's dedication, perseverance, and service to others as "a living testimony to .... the defiant power of the human spirit".

The United States of America is the land of the free and the home of the brave. Some of our bravest are the members of the military who serve to protect the freedoms we value and treasure. These same people face unspeakable wounds that often lead to life altering changes and new challenges to overcome. Danielle Green, a U.S. Army veteran, is one such individual and is a story of perseverance, as both an athlete and soldier. She grew up with a drug-addicted mother but refused to become a victim of circumstance. Green joined the ROTC in high school and received a scholarship to the University of Notre Dame, where she played Division I women's basketball. Following graduation, Green joined the U.S. Army. While stationed in Bagdad in 2004, Green lost her left arm to a grenade, but she never lost her resolve. In 2016, Danielle became the first female member of The Wounded Warrior Amputee Softball Team (WWAST). WWAST, which began in 2011, is an amazing group of individuals that have not only learned to live with their wounds but use their experiences to help others. As a member of WWAST, Green said. "It's about inspiring and giving people hope that no matter what cards you've been dealt that you can overcome and conquer that. For me it's about getting out there and showing people the possibilities." WWAST is now known as the USA Patriots Amputee Softball Team and exists to motivate and inspire individuals with similar wounds, working with young

amputee athletes. Their motto is "A life without limbs is limitless." Matt Kinsey, a former Army sergeant and member of the team stated, "We wanted to show them that it's possible to compete even if you're missing a limb." These individuals are the bravest of the brave. They are the ones with wounds we can see.

However, one in three veterans live with Post Traumatic Stress Disorder. The Wounded Warrior Project (WWP) through interactive programs, rehabilitative retreats, and professional services, helps veterans suffering from these invisible wounds. The WWP also helps their family members who have their own emotional wounds to deal with. These are the wounds we do not see.

The wounds people carry are both the seen and the unseen. People live every day with their wounds. Wounds of countless varieties from the physical to the emotional. The unseen wounds can cause people to suffer in silence not knowing how to ask for help. We as humans must answer the call to help the wounded. We must strive to help each other, especially those with unseen wounds.

Yet, despite the wounds we carry, the human spirit is miraculously resilient. Every day people find a way to go on; find a way to survive. Taking one step at a time, one breath at a time until we find the courage to move forward. This courage can come from the help of others or from a voice within us propelling us forward, especially when our wounds cut the deepest.

The Unspoken Voice

Just one more breath, just one more step.
A sunrise, a sunset; a feeling of calm.
But a storm is brewing with ominous thunder;
It keeps pounding and pounding;
The sound won't stop; block it out, block it out.
Then finally there is a clearing;
A rainbow with promises for the future.
But the promises are broken;
A tornado of emotions,
Immense damage, immense pain.
The sun tries to peek through, only to be pushed away.
So many thoughts, so many voices.
The sound won't stop, block it out, block it out.
Then finally the sun takes hold.
The trees begin to bud, the flowers start to bloom.
In the distance, a bird is singing,
A quiet yet piercing sound; a calling.

This time the sound won't stop; this time it cannot be blocked out.

It gets louder and louder;

It cannot be unheard;

It takes over everything;

It is - The Unspoken Voice.

It is - The Will to Live.

Author Note

The author is solely responsible for the contents of this poem. The contents do not necessarily reflect the position of any organizations and communities that the author serves. The author has no conflicts of interest.

A Poem

Number 9

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A Beginning Reflection

No life is devoid of trauma; but in some, the trauma, through either its intensity or duration, becomes the defining experience of life. And long after trauma ends its imprint remains, destroying our perceptions, our relationships, and our innermost selves. Although the aftermath of such disabling trauma cannot be completely erased, it can become the catalyst for a newfound life of determination, resilience, and service to others. The popular image of post-traumatic stress syndrome (PTSD) is drawn from those who have been traumatized in combat, but as this poem shows, PTSD originates more often in the hidden recesses of ordinary life. The images of these traumas are raw, as if the scab from a festering wound is being removed in public, and the language to describe them equally so.

Number 9

"That number doesn't define you," I read
the results of the small font from the
assessment of childhood
trauma report.

I sit back, horrified by the score.
Panicking, thinking,
clicking-frantic,
I search for the other number.

9 out of what? 100, not so bad.
9/50, still not horri...

And then I find it.

I sigh deeply through my nose,
feeling fast hard heartbeats
in realizing thuds,
And my breathing
has become
a shallowed mess of
fractured panic.

I breathe deeply,
trying to digest the other number,
to connect to my shaking breath,
to my new reality.

9/10. 90% positively assured
my childhood was
extremely traumatic.

"That number doesn't define you," I read aloud.

And then I answer it,
as if speaking to a person,
as if my rebuttal would
magically fix the
numbers on the screen.

Maybe you'll think and
change your minds.
Maybe you'll give me a
Leave It To Beaver childhood.
Numbers can do that,
you know, ask a statistician!

Maybe my talking back
to the numbers will
erase this excruciating
and painful realization....

I breathe deeply
through my nose,
inhaling
in acceptance.

"That number doesn't define you." Through watering eyes, I read aloud.

Bullshit, I scream at the screen!

That number absolutely DOES define me!

Anyone who knows Math
knows how cool number 9 is.

That number means I know
how 90% of humanity feels
under most traumatic circumstances.

Why?

Because I've been through most abuse and trauma categories before I hit age 12!

That number makes me an empath.

That number means I'm a Warrior.

My number 9 means
I survived and adapted to a
horrific childhood from Hell,
I yell to the screen.

I'm a decorated veteran of abuse!

My number means I refuse to be a victim.

I won't settle for being a survivor.

I am a thriver.

My number means—
no matter how hard shit is,
no matter how afraid I am,
no matter how many times I fail,
I get my ass back up
and try again.

Why?

Because my original trauma,
what got me here,
to my favorite number,
is far worse and more scary
than my fears I feel in facing and
in changing my patterns.

That's what my number 9 means to me!
You know why? I scream at the blinding screen.

Because my number says I can.

And so I shall!

Author Note

The author is solely responsible for the contents of this poem. The contents do not necessarily reflect the position of any organizations and communities that the author serves. The author has no conflicts of interest.

In Conclusion: A Special Editorial Notation

The above creative work makes reference to The Adverse Childhood Experiences (ACE) Study, a 17,000-participant investigation of the linkage between adverse childhood events such as child abuse and neglect, and unfavorable adult outcomes. The researchers not only found a direct link between childhood trauma and behavioral/mental health problems such as depression, suicidality, incarceration, alcoholism, and illicit drug use but, surprisingly, were also able to link childhood trauma with increased risk of lung cancer, diabetes, autoimmune disease, heart disease, liver disease, chronic obstructive pulmonary disease, and early death. Risk was directly correlated with the number of childhood traumas experienced.

Henry M. Jackson Foundation Special Military Health Film Series Continues…

The new YouTube series on military medicine and healthcare continues to be produced and directed by the Henry M. Jackson Foundation for the Advancement of Military Medicine. Information for the first two short episodes that have been completed thus far is found below. These episodes are immensely powerful. They demonstrate how military medicine/healthcare enriches healthcare for all people across the globe. For more information or for submitting suggestions regarding future topics, please contact the Creative Design Department at HJF c/o (240) 694-2000.

2018 Heroes of Military Medicine Ambassador Award

The Air Force's 99th Medical Group was awarded the Hero of Military Medicine Ambassador Award for its heroic response to the October 2017 Las Vegas mass casualty shooting.

Web Address: https://www.youtube.com/watch?v=9O7sL5WPPV0

The Veterans Metrics Initiatives

TVMI—The Veterans Metrics Initiatives is a novel public-private collaboration that unites multi-disciplinary research experts from the Departments of Defense and Veterans Affairs, academic medicine and social science, and industry to develop an evidence-based

Web Address: https://www.youtube.com/watch?v=U2PP1QqFFSM

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The three inside front cover photographs are of and about President John F. Kennedy.

…One is from his service in the US Navy and was obtained from Wikimedia Commons: https://commons.wikimedia.org/wiki/John_F._Kennedy#/media/File:1942_JFK_uniform_portrait.jpg.

…The other is an official White House portrait by Cecil Stoughton and was obtained from Wikimedia Commons: https://commons.wikimedia.org/wiki/John_F._Kennedy#/media/File:John_F._Kennedy,_White_House_color_photo_portrait.jpg.

…The third photograph is of a stone memorial with a famous quote from President Kennedy. This photograph is the 2009 artistry of Stilfehler and was obtained from Wikimedia Commons for general usage: https://commons.wikimedia.org/wiki/John_F._Kennedy#/media/File:John_F._Kennedy,_White_House_color_photo_portrait.jpg

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