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Journal of Health and Human Experience

Civil Rights… Then, Now & Always
Ever-Signing, Ever-Living

The Semper Vi Foundation

VSV

From Victim To Survivor To Victor

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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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MISSION

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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> ***Education:*** The Semper Vi Foundation convenes a community of international, interdisciplinary scholars and professionals who develop and promote a wide range of educational programs and resources for enrichment in the humanities, health and healthcare, the physical and social sciences, human development and human rights

across the globe. This Founation designs and provides workshops, seminars, webinars, podcasts, full conferences and continuing education courses at various international locations. Depending on resources, events are filmed and posted on the website.

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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!

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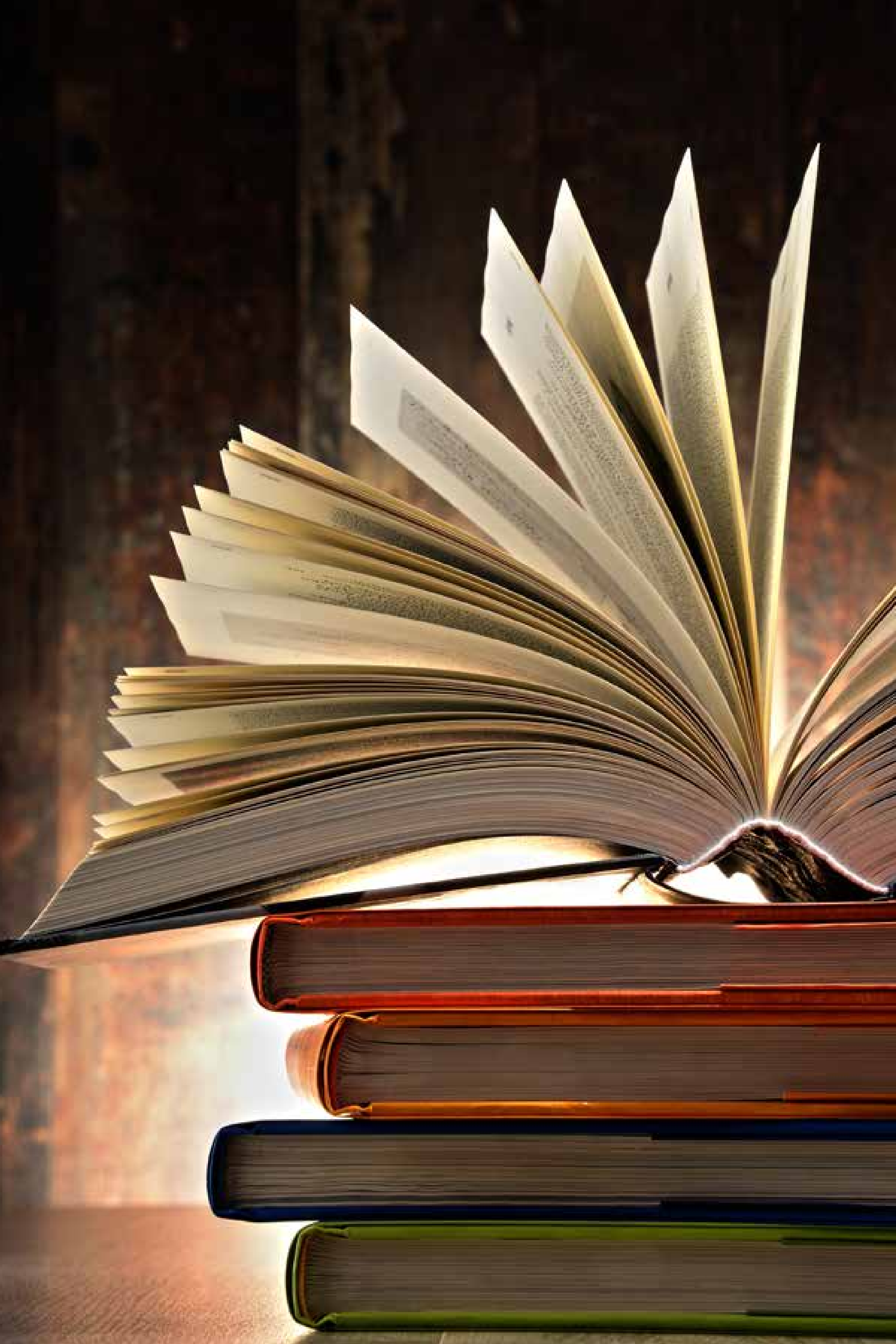

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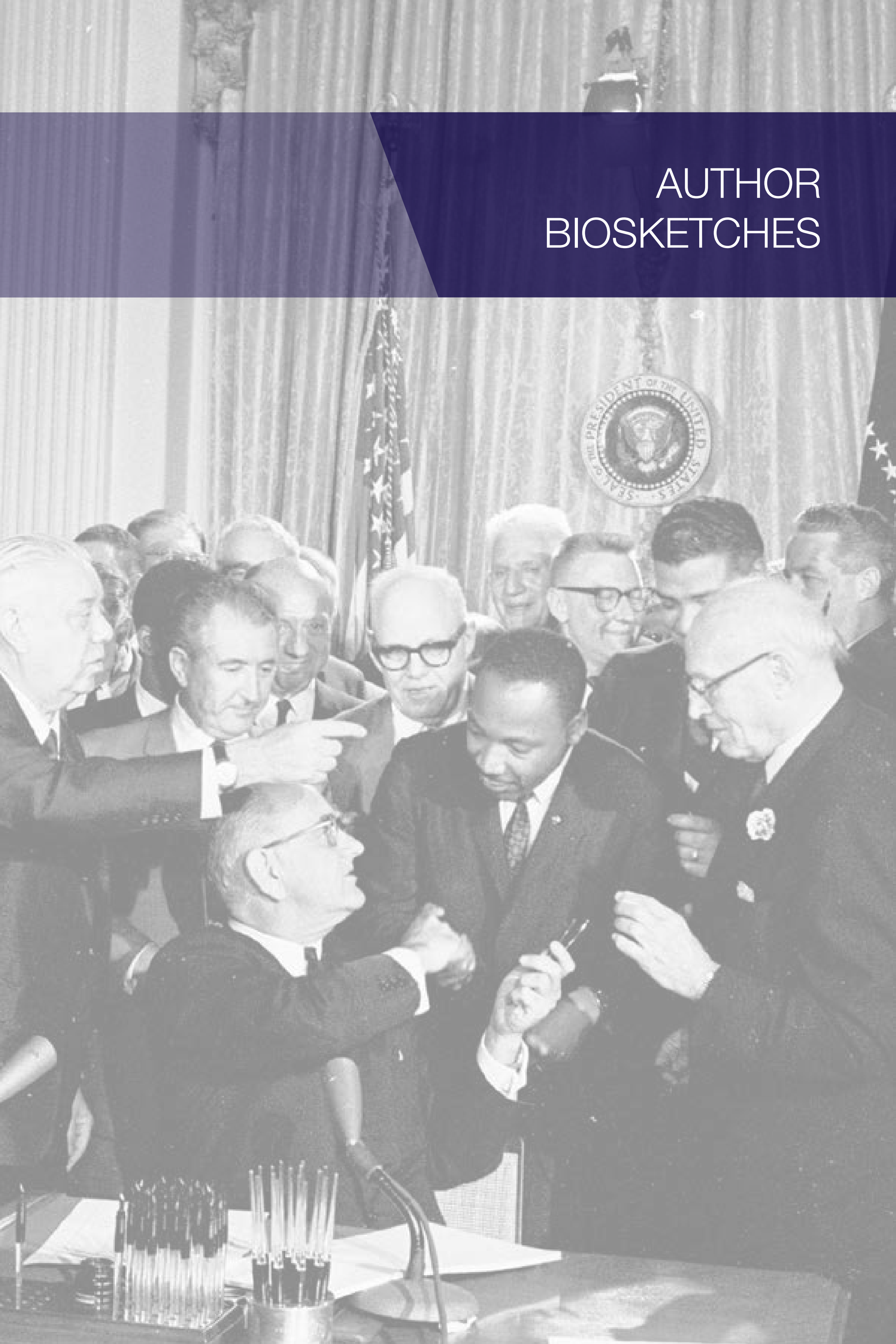

Author Biosketches

Haneen J. Alani, MA, is a dedicated clinical mental health counselor committed to customizing and integrating therapeutic techniques that fit each client's needs. Currently pursuing a doctoral degree in criminal justice, Ms. Alani focuses on victim advocacy and improving programs and initiatives by incorporating a holistic approach. Her extensive and diverse professional, educational, and cultural background prepares her to bring a unique perspective to both criminal justice and clinical/applied psychology fields.

Bruce R. Boynton, MD, MPH, PhD, is Editor of the Journal of Health and Human Experience. Dr. Boynton has had a distinguished career as a Naval Officer, pediatrician, researcher, and hospital administrator. He was Executive Officer of a Naval Hospital in Italy; Commanding Officer of a research laboratory in Egypt; Commanding Officer of a 1,000-bed hospital aboard USNS Comfort; author/editor of two medical textbooks, and Features Editor for Prune Juice, a Japanese poetry journal.

Frederick M. Burkle, Jr., MD, MPH, DTM, PhD (Hon.), is a Global Fellow, Woodrow Wilson International Center for Scholars, Washington, DC, and an elected member of the National Academy of Medicine. He has a distinguished record of service, education, and research in disaster medicine and humanitarian assistance. He is a retired Professor, University of Hawaii School of Medicine and Harvard Humanitarian Imitative; and retired Senior Scholar, Center for Refugee and Disaster Response, Johns Hopkins University.

Katrina A. Chenevert, MAEd, BS, BA, is a second career mixed media artist living in Asheville, NC. She is a retired Navy lieutenant commander with a 28-year career completing 14 years as a Hospital Corpsman and 14 years commissioned in the Medical Service Corps as a healthcare administrator. Taking advantage of her VA education benefit she completed a BA in sculpture at UNCA. Her work is exhibiting in galleries and collected throughout the United States.

Paul A. Finch, MSW, LCSW currently serves as a Readjustment Counselor at the Everett WA Veterans Center. Mr. Finch has worked for more than 40 years in many mental health, military and family support positions including 7 years at the Bureau of Navy Medicine and Surgery and 3 years directing the US Navy's Sexual Assault and Clinical Counseling Programs. He has completed coursework for a PhD in experimental psychology and is a US Army veteran.

Edward F. Gabriele, DMin, is President & Chief Executive Officer of the Semper Vi Foundation and the Journal's Editor-in-Chief. Dr. Gabriele has been a long-term educator in the humanities on all educational levels including leadership as an adult education curriculum inventor. He has held various executive positions in ethics, research and human rights. His services in these areas have been provided across the globe. Dr. Gabriele is extensively published and is an international visiting scholar.

De Fischler Herman, RP, SD, SM, is a rabbinic pastor and facilitator of Age-ing to Sage-ing®. She served as hospice chaplain, taught Jewish bioethics for the ALEPH Ordination Program, and presented at Smithsonian ethics conferences and the Tuskegee University Bioethics Center. She is a climate crisis activist in the non-profit Jewish Earth Alliance and in the Takoma Park, Maryland community. Rabbinic Pastor Herman is also a docent volunteer at the Baltimore American Visionary Art Museum.

Jan Herman, MA, holds a masters in history from the University of New Hampshire where he studied under a Ford Foundation Teaching Fellowship. He is the retired Historian of the Navy Medical Department. He has also produced many Navy Medicine historical documentaries, including The Lucky Few premiered at the Smithsonian in 2010. He is the 2015 recipient of the lifetime achievement Forrest C. Pogue Award for Excellence in Oral History.

Amir Khorram-Manesh, MD, PhD, is a university lecturer in surgery with a particular focus on disaster medicine, mass casualty management and trauma. Living in Sweden, he has working experience in Iraq, Ukraine, Iran, and Thailand, where he has lectured and conducted simulation training.

Michael J. Krentz, MD, MPH, FACEP, is an independent author and consultant in healthcare and public health. He is a retired Navy captain whose 43-year career in emergency, preventive, and executive medicine encompassed health services practice and leadership in civilian, academic, and military health systems. A past-president of the American College of Emergency Physicians, Dr. Krentz served as senior clinician for the Health Analysis Department of the Navy and Marine Corps Public Health Center, Portsmouth.

Gordon E. MacKinnon, PhD, a licensed psychologist, is Professor Emeritus of Psychology and former Chair of the Department of Psychology and Behavioral Sciences at Rochester University. He continues to work at the university's Psychology and Counseling Center. Dr. MacKinnon has long maintained a private practice in clinical psychology with children, adolescents and adults. His in-patient and out-patient psychotherapy experiences have included behavioral and neuropsychological evaluations, marital and family therapy, and adolescent residential treatment.

Paula M. Neira, JD, RN, FAAN, is a former naval officer, lawyer, and nurse. She was the founding clinical program director of the Johns Hopkins Center for Transgender Health and currently serves as the Johns Hopkins Medicine Program Director of LGBTQ+ Equity and Education. In recognition of her leadership in advancing LGBTQ+ inclusion in the U.S. Armed Forces and in advancing transgender healthcare policy, she is a Fellow of the American Academy of Nursing.

Susan Rachlin, MD, FACR, is Senior Associate Dean for Student Affairs and Associate Professor of Radiology at New York Medical College in Valhalla, NY. She has a distinguished record of teaching and has been recognized yearly with the Excellence in Teaching and Mentorship award. Dr. Rachlin is a member of AOA and GHHS and received the prestigious Leonard Tow Humanism award for recognition of her humanistic, compassionate approach to medicine and teaching.

Janis M. Riccardelli, AIHM, BA, in addition to being a Deacon with the AIHM religious community, works for CNA Insurance as a Sr. Underwriting Technician for the National Accounts Property division out of their Philadelphia Branch. When not at CNA, she enjoys being involved with the Society for Creative Anachronism (SCA), a group that participates in the historical reenactment of the Medieval to Elizabethan periods.

Loree Sutton, MD, is a lifelong public servant, decorated military physician, and veteran community advocate. As the Army's highest-ranking psychiatrist and founding commissioner of NYC's Department of Veterans Services, Dr. Sutton has led and pioneered integrative approaches for building resilience, enhancing recovery, and fostering community reintegration for over forty years. Her current focus is on accelerating relevant research, treatment model design, and clinical dissemination of breakthrough approaches to treating PTSD, including psychedelics.

Cheri C. Wilson, MA, MHS, CPHQ, is a nationally recognized diversity and inclusion, cultural and linguistic competence, and health equity subject matter expert. She is the former Program Director for Diversity, Equity, and Inclusion in the Johns Hopkins Medicine Office of Diversity, Inclusion, and Health Equity. Her interests include health and healthcare disparities and health equity as they relate to racial/ethnic, language, gender, sexual, and disability minoritized communities and culturally and linguistically appropriate patient-centered care.

PRELUDE

The Roads Before Us: Flamed Forward

Dr. Edward Gabriele
Editor-in-Chief and Executive Director,
Journal of Health and Human Experience
President and Chief Executive Officer,
The Semper Vi Foundation
Email: egabriele@mac.com

"Gotta look forward, that's what life is."
Patton Plame
(Played by Daryl "Chill" Mitchell)
NCIS New Orleans
"Broken Hearted"
Season 2, Episode 7
November 3, 2015

As we grow and develop, we often find particular images and metaphors that capture for us what it means to be human --- what it means to live. For myself, the image of the pathway and/or journey has always been most powerful. From the time I was first growing up and all through my life, the idea of journeying forward along various pathways has been deeply moving. Some of this continued to develop especially when I have had the honor of traveling to locations around the globe for efforts that I have been called upon to provide in my various lines of academic and humanitarian services.

However, the image of the journey or pathway is not just about seeing and visiting diverse locations. Not at all. In fact, I have come to appreciate that my entire life has been a calling to many journeys and pathways to discover continually and be amazed at the depths of what it means to be human and to live humanely. Indeed, as our colleague Daryl "Chill" Mitchell implied in one of his dramatic episodes per above, the journeys and pathways of our lives are invitations to enter into ever evolving depths of who and what we are. And we are all aware that these moments of going forward are lit up by deeply important discoveries. This includes both the positive and the negative.

As I have reflected on this, and continuing my opening thoughts in our previous Journal edition this year, two anniversaries in this calendar year of 2024 enflame for me many things. This includes the many "possibles" for the future. It also includes the depths into ourselves where we need to journey to see and work for newness especially for reforms and changes for us as individuals as well as being members of families, communities, social groups, nations, and the entire world itself.

This year marks the 60th anniversary of President Lyndon B. Johnson's signing the Civil Rights Act into law in 1964. This year is also the 70th anniversary of the Supreme Court's 1954 decision for the end of school segregation in Brown vs the Board of Education. Indeed, these are two very powerful moments in American history. And it strikes me with deep meaning how these two anniversaries stir up new flames to lead us forward into the pathways and journeys that are before us now in our times.

Prelude

We are all deeply aware of today's challenges. We have seen new levels of hate and discrimination that are shocking. The poor, the hungry and thirsty, the sick, and the abandoned whose cries and needs are not being heard or assisted have many of us wondering if we really know what it means to be American or even human. The many diverse forms of injustice and inhumanity that are invading our times are horrific. This is especially true in light of our common calling as Americans and as human beings to stand up for The True and The Good for the equality, life, liberty and happiness of and for all others --- without exception.

And as these times unfold, it has been striking me most powerfully that we all must embark on two critically important pathways --- the journey to see the positive possibles that are being revealed before us and which are most needed --- and the journey to look deeply within the individual self as well as in our communities and our nation where absolute change is needed desperately and most passionately.

Indeed, all of us must look forward and deep within. As Daryl Mitchell reminds us per above, this is what life is. We must look forward and we also must look within. And as we look forward and within, our pathways and journeys are lit up so that we see clearly that to which we are being called both in the new possibles and in the areas of life that need to be enflamed with reform and renewal.

In this spirit of what is before us all as individuals and as groups, this new edition of the Journal continues its dedication to promote the fulness of health in our human experience including social justice and human rights for all without exception. And this deeply includes our being enflamed and enlightened to move forward toward all we are called to do and who we are being called anew to be.

The pathways and journeys are before us. And truly we are being enlightened and flamed forward.

Onward to the Needed New, the Needed Now!!!

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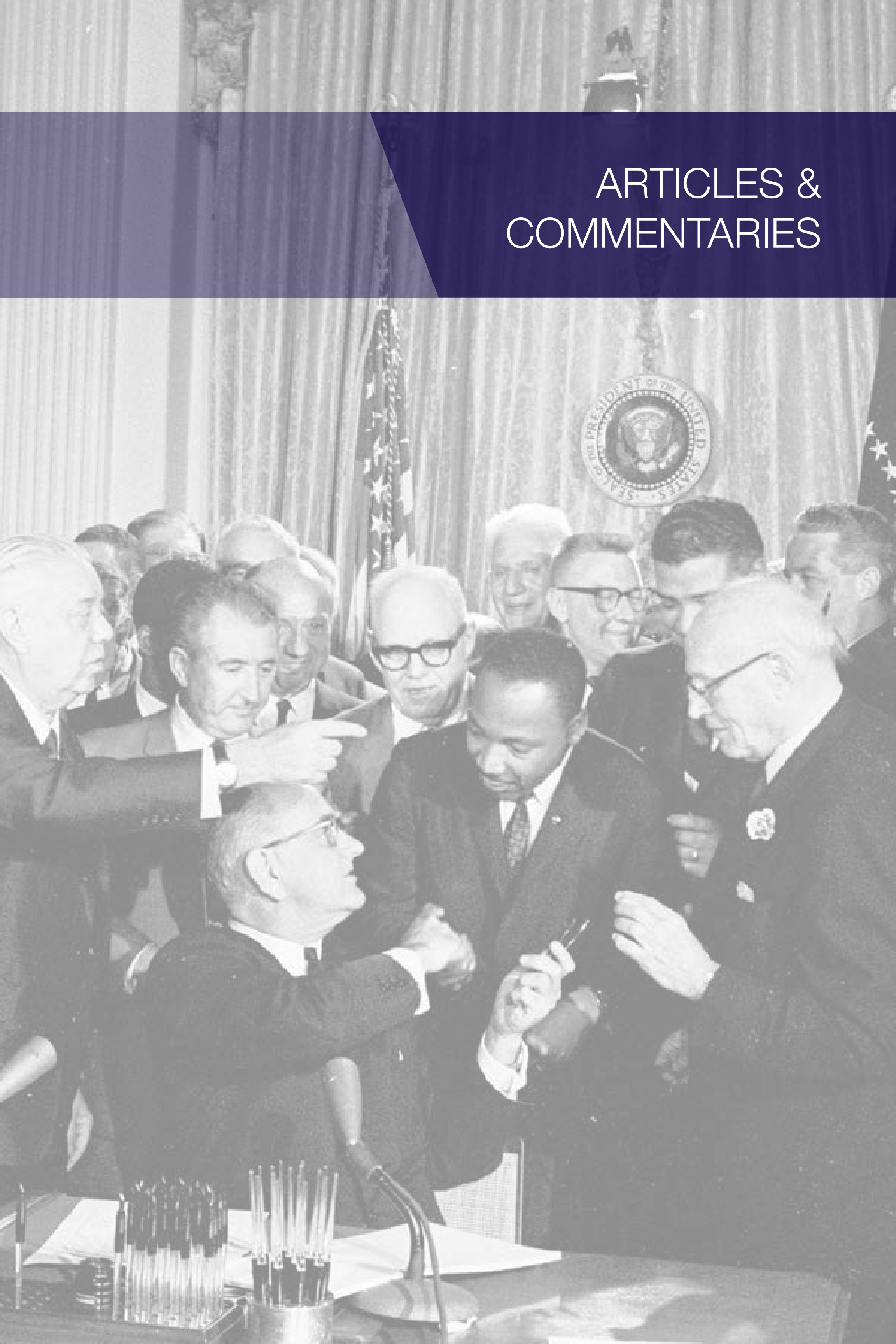


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Art Therapy and the Healing of Trauma for Military and Civilian Victims

Gordon E. MacKinnon, PhD
Professor Emeritus of Psychology
Department of Psychology and Behavioral Sciences
Rochester Christian University
800 West Avon Rd.
Rochester Hills, MI 48307
Email: gmackinnon@rcu.edu

MacKinnon Psychological Associates
17336 West 12 Mile Rd., Suite 101
Southfield, MI 48076
E-mail: MackGo77@AOL.COM

United Psychological Services
47818 Van Dyke
Shelby Township, MI 48317
Email: gmackinnon@unitedpsychological.com

Author Note

The author has no conflicts of interest. The author recently taught a graduate course for medical students where an art therapy, mask-making project was presented to focus on identity formation as a professional development task.

Abstract

Art defines culture and provides several benefits which include a mode of communication, promoting social cohesion, affective expression, challenging social norms, bringing to light hidden injustices, and a means of expression for disenfranchised communities (Estrada-Gonzalez, et. al., 2024). Art therapy, as a complementary psychotherapeutic intervention, is rooted in the recognition of trauma in World War II. Soldiers are exposed to a wide range of potential traumatic stimuli from the battlefield and therefore are vulnerable to Post-Traumatic Stress Symptoms (PTSS) and/or Post-Traumatic Stress Disorder (PTSD). Veterans and active-duty service personnel potentially suffer the “invisible wounds” of war (Tanielian, 2008; Lobban, 2014). Art therapy has gained increased acceptance as a complementary therapeutic approach for treating trauma in service personnel and the public sector. Specifically, mask-making is shown to be an art therapy approach that facilitates communication and expression of traumatic memories when language has been affected due to the neurological impact of trauma. Art therapy has made significant positive contributions for individuals and societies who are victims of traumatic events. Medical and psychological uses of art therapy in the public sector demonstrate the positive influence art therapy has in alleviating trauma symptomatology.

Keywords: Art therapy, mask-making, trauma, PTSS, PTSD, military, exposure therapy, cognitive processing therapy

Introduction

Art has been a defining characteristic of human culture since prehistoric times. Depictions of ancient art have been discovered and preserved. Art has many beneficial uses in culture such as a mode of communication, promoting social cohesion, as a means of affective expression, challenging social norms, bringing to light hidden injustices, and providing a means of expression for disenfranchised communities (Estrada-Gonzalez, et. al., 2024). Art describes different cultures, historic periods, and is a foundation of human symbolic expression. Early depictions of art present various creative and artistic efforts of early human beings beginning with human body decoration and images depicting animals and human figures in caves that, over centuries, have advanced as man's cognitive functions have become increasingly developed (Moriss-Kay, 2010). Traditionally, art has been evaluated by its aesthetic qualities and the affective experience it evokes while viewing artwork. Although art has a long history, the use of art therapy as a method of promoting healing and well-being, has a more recent and documented experience since World War II.

The development of art therapy, as a contemporary method of psychological and psychotherapeutic treatment, has been rooted in the contributions of military and wartime experiences beginning in the period of World War II. In recent years, the professional literature has shown how art therapy supports and promotes elements of healing. Considering art therapy's major contributions to the early treatment of trauma, as developed through military medical institutions, it is surprising that the literature that recounts this history is so limited (Lobban, 2014, 2018; Haeseler and Howie, 2017; Howie, 2017).

Military service personnel who suffered from physical and psychological trauma in the battlefield in World War II found improvement of their symptoms using art (Howie, 2017). The use of the term "art therapy" is attributed to Adrian Hill in 1942 in the United Kingdom (UK) because of his experiences in a sanitorium where he used art as part of his recovery from pulmonary tuberculosis. Hill was a war artist during World War I and later became an official war artist. As an artist, while in the sanitorium, he began to encourage other patients to draw and paint and observed how beneficial art had become with other patients in the sanitorium. Throughout his life, Hill promoted art therapy and was instrumental in the early development of art therapy as a field of study and practice (Howie, 2017; Lobban, 2016, Lobban & Murphy, 2019).

One art program founded to service post World War II veterans was the War Veteran's Art Center at the Museum of Modern Art in New York City. This program operated from 1944 to 1948 and offered a variety of classes and artistic media. Veterans were presented with artistic materials for "drawing, painting, fundamentals of design, jewelry making, metalwork, sculpture, and ceramics, to name a few" (Howie, 2017, p. 6). These art activities also included an expressive element which also was therapeutic.

The use of art therapy as a complementary treatment with veterans originated, concurrently, in the United States (US) and the UK's military health systems, following World War II. As military hospitals began to recognize the need for specialized treatment, art therapy became a practical intervention in working with traumatized veterans. Art therapists in the

UK were added to work with trauma units, operating in tandem with psychotherapists, which promoted healing through an art therapy focused on the "invisible wounds" of war (Tanielian, 2008; Lobban, 2014).

An example of treating soldiers in the UK occurred between 1977 and 1995 at Queen Elizabeth Military Hospital, Woolwich, England. Art therapist Nigel Hilton introduced art therapy in the trauma program presenting open studio groups and one-on-one sessions. The open studio approach allowed drawing and painting while facilitating a creative artistic process rather than an art interpretive process. Art therapy groups operated for two-and-a-half hours, where participants displayed their creative works on a wall and were free to compose their works without any discussion, although they were encouraged to reflect about their work. The group experience was seen as an important component of the therapy (Lobban, 2016).

In the U.S., beginning in the late 1950s, art therapy was becoming more established and developed through the Veterans Administration (VA) Medical Center in Connecticut where veterans, in their paintings, were found to be "very responsive and expressive in their artwork" (Haeseler and Howie, 2017, p. 17). In 1989, the VA Medical Center continued to develop with Dr. David Johnson, a drama therapist who created a Recreation and Creative Arts Therapy Section (RCATS) for the VA. An innovative therapist, he included drama, video, art, and poetry as therapeutic elements. The VA recognized the importance of the arts in facilitating the treatment of traumatic experiences. In 1989, Johnson became director of the newly established National Center for PTSD which was created within the Department of Veterans Affairs and included five creative arts therapists' positions.

Art therapy was introduced at the Walter Reed Army Medical Center in 1971. Activities designed to be artistically creative were incorporated into the daily schedule. Art therapy, in the Psychiatry service inpatient treatment, consisted of art (drawing and painting), recreation, and horticultural therapy programs. These services assisted patients to make their issues more manageable by helping them learn how to be more open and expressive with their feelings in the tangible form of creative art. As a form of communication, artwork reveals a person's "functional and developmental levels and their unique strengths and conflicts" (Haeseler and Howie, 2017, p. 25). This early work in art therapy became part of the treatment guidelines for beginning art therapists in other military facilities.

An innovative, new art therapy program developed in the UK in 1987 was introduced at the Royal Naval Hospital, Haslar, Hampshire, England for military service and emergency services personnel. The creative arts were incorporated to work with trauma patients in recovery. The members in the art-based groups were instructed to create a unique artwork that represented who they were before, during, and after the trauma. The media they used included art materials, newspaper articles, photos, and drawings. Some participants were quite innovative by using poetry and Celtic knots in their expression of self.

The Combat Stress Mental Health charity in England added art therapy in 2001 to their treatment of veterans from several conflicts and combat involvement. Art provided an alternative to the difficulty veterans faced with verbal expression and an attitude of "we don't talk about it." The attacks on 9/11, 2001 in the US had a significant impact on trauma treatment at the Combat Stress Mental Health charity that continues to the present day. Anecdotally, veterans reported art therapy as a vital part of their recovery (Lobban, 2018).

This veterans program facilitates evidence-based treatments and art therapy for trauma, grief, depression, anxiety, anger, and substance misuse. Modern directions in art therapy are rooted in its development through military applications since World War II as governments recognized the need to finds ways to assist service members in their recovery from trauma and other mental health issues.

The Experience and Treatment of Traumatic Injury from Active Combat

The experiences of war are unique and nuanced for each veteran who participated in active combat or was exposed to traumatic events while in active service. While civilians are "grateful for your service" or view veterans as "heroes" there may not be an accompanying feeling for the veteran. The stories that veterans tell are difficult for many to put into words and even harder for family members and civilians to understand or hear. Many veterans keep their stories to themselves because memories of those traumatic experiences can be activated in ways they do not want nor, at other times, expect. The human side of having been in combat is impacted by loss; loss of innocence, loss of body and mind, loss of safety and security, loss of a sense of family and social relationships, and losses involving mental health and cognitive processing abilities (Brunger, Serrato, and Ogden, 2013).

Moral injuries can be an additional problem for the service member when they are left with residual memories of acts and orders that have gone against their internal values and beliefs to which they feel intense guilt. There are clinical challenges in working with veteran's moral injury including, "1. being made witness to atrocities and depravity through repeated exposure to trauma narratives, 2. characteristic assignment of survivor's transference roles to clinicians, and 3. the clinicians' countertransference emotions and judgments of self and others" (Shay, 2014, p. 182). Clinical practitioners are not only treating trauma, in addition, they will need support as they are witnesses to the stories they hear of trauma that potentially affect them.

Veterans are faced with several potential barriers in accessing treatment in the VA for mental health and substance use issues. Hundt, et. al. (2018) reports that low engagement in evidenced-based psychotherapy (EBP) treatments for PTSD is a common problem with up to half of veterans failing to engage in EBP treatments. They identified barriers to factors that interfere with seeking treatment such as *practical barriers* (employment, attending college, transportation, physical health, and caretaking duties), *knowledge barriers* (no recollection that they were offered EBP options), *emotional barriers* (avoidance of potential fears of facing their trauma, lack of trust), *therapy-related barriers* (a sense of hopelessness about exposure therapy, poor alliance with a therapist, lack of continuity of care, veterans preference for alternative treatment options such as yoga, art therapy, or ongoing supportive psychotherapy), and *VA system-related barriers* (negative encounters with medical providers, lack of flexible scheduling, discomfort with the VA environment, and/or other veterans). These barriers were expressed by veterans who sought treatment outside of the VA.

PTSS, according to the U.S. Department of Veterans Affairs (2023), affects 29 out of 100 veterans who are likely to be diagnosed with PTSD at some point in their lives, slightly more than in the general population. Serving in the military can expose service personnel to different traumatic experiences than those in the civilian population. The experiences of being deployed to a war zone exposes soldiers to traumatic risks as well as training accidents and military sexual trauma (U.S. Department of Veterans Affairs, 2023). The National Alliance of Mental Illness (2017) cites that 3.6% of the U.S. population are affected by PTSD which culminates in 9 million individuals. They add that about 37% of those diagnosed with PTSD are severe cases with women significantly more affected than men.

Soldiers are potentially exposed to a wide range of experiences that can lead to combat-related trauma and stress. Exposure to combat has the potential to alter soldier's physical and psychological functioning due to direct combat-related trauma and/or stress (explosion, enemy ambushes, IED events, flight deck plane crashes, or witnessing the death of a fellow service member) and indirect injury or stress (traffic collisions, training accidents, military sexual trauma, survivor's guilt, fear of hostile military encounters, and ongoing exposure to death and violence). Additionally, fears of facing the potential lethality in war contributes to ongoing pressures. PTSD did not appear in the modern nomenclature as a diagnosis until 1980. According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2022), following traumatic events, serious symptoms may arise such as avoidance of reminders of the traumatic event, emotional numbness or dissociation, hyperarousal, and re-experiencing of traumatic memories in the form of flashbacks and nightmares.

Herman's (1992) seminal work on traumatic sequalae described psychological trauma as "...an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning." (p.33).

When one faces a traumatic experience, the individual is overwhelmed with emotions under the threat or exposure of an actual physical and/or psychological assault. The body and mind respond with a physiological and cognitive processing breakdown, resulting in language and speech areas in the brain shutting down, affecting the ability of the individual to put a traumatic experience into words. The veteran suffering from trauma is faced with the impossible task of recalling and expressing memories that are highly emotional. The impact of trauma on the psyche potentially creates a split where aspects of the self become fragmented, resulting in dissociation. Some symptoms of trauma, notably flashbacks (reliving the traumatic experience) and rigid hypervigilance (heightened alertness to avoid danger), demonstrate how these split-off parts of the self are simply an attempt to maintain a sense of stability and security. Re-establishing an internal sense of one's boundaries is needed to function adequately in the environment (Dean, 2016; van der Kolk, 2014).

Combat veterans are potentially vulnerable to PTSS, which typically corresponds to Acute Stress Disorder (ASD) in the DSM-5-TR (APA, 2022). PTSS defines the characteristic symptoms immediately following a traumatic event and after a month, if symptoms persist, are more aligned with PTSD. Although PTSS is a precursor to PTSD it has a similar constellation of symptoms, namely, intrusive thoughts and flashback memories related to the traumatic event that was experienced. Treatment success is predicated on the severity of symptomatology. Although most persons exposed to a traumatic event, experience PTSS, less severe cases are likely to remit and not become PTSD. It is further noted that some individuals may not experience PTSD symptoms for months or years after the immediate trauma. Shih, et. al. (2023) report in their study that 20% of trauma survivors with PTSS reported severe symptoms. Additionally, 40% had moderate symptoms, 30% had mild symptoms, and 10% reported minimal symptoms.

When combat veterans and service personnel return home from combat they potentially face a most difficult challenge returning to the "normalcy" of home (Brunger, Serrato, and Ogden, 2013; DeLucia, 2016; Derefinko, et. al., 2019). It may become difficult to accommodate such contrasting traumatic experiences and images from war. The journey to return home with PTSD symptoms cannot be adequately put into words for many veterans and active-duty service personnel. Due to the sensory and cognitive nature of traumatic memories, veterans may find themselves in a situation where reconnecting to the experience and memories of unspeakable traumatic affects, physical and bodily sensations, and horrific images are too overwhelming to be exposed to the self or others. The images embedded in memory are often too difficult to put into words. An earlier work by Janoff-Bulman (1992) discusses trauma as shattering the fundamental assumptions that we have about life and the world, that is, we see the world as benevolent, meaningful, and we understand the self as having worth. When these assumptions are disrupted by trauma, the experience can fragment how one views and relates to the self and others in the world.

Veterans and active-duty service personnel suffer from the "invisible wounds" of war (Tanielian, 2008; Lobban, 2014). The Combat Stress charity in the U.K. was approached by the BBC to film an art therapy group of veterans followed by discussion with the veterans about their art/image-making. The theme was "The Invisible Wound." Lobban (2014) identified several themes that emerge as the "invisible wounds" expressed by veterans that included disconnection (feeling detached from people around them and putting up defenses to maintain distance); *issues around control and avoidance of feelings* (situations that are beyond one's control); *presenting one's self to present a mask/false sense of self to protect their vulnerability* (present a normal personality to the world but a split-off emotional personality); *frozen in time with traumatic memories* (veterans describe themselves as prisoners of time where traumatic memories continue to play out in their mind).

Controversy surrounds the use of pharmacology as a first-line approach for treatment of PTSD. Ehret (2019) recommends "Trauma-focused therapies and other psychotherapies should continue to be recommended first-line in all patients with a diagnosis of PTSD; medications should be used in cases when trauma-focused psychotherapies are unavailable or unsuccessful, a patient requests medication, or a specific indication compels a medication" (p. 380). As these treatment guidelines for psychotherapy are recommended as a first line approach, the use of medications continue to be frequently used as first-line treatments for PTSD.

Two art therapy groups were conducted, where participants were able to share their deep fears in a manageable way and that addressed themes that included, 1. *image-making/expression* (this allowed veterans to access non-verbal, emotional, intuitive, and sensory material to use as symbol and metaphor, increasing tolerance of difficult feelings and body sensations, and 2. *image-viewing/exploration* (images were explored in the group revealing contrasts and dilemmas between past and present self, inner and outer presentation, society and the veteran, and whether being open or interacting with others is safe or harmful). Veterans were able to process in the group and afterward more openly. This offered the opportunity to make a shift and open up feelings that mediate being stuck with traumatic memories and the negative cognitions that go with them.

When treatment has not been readily available, PTSD is associated with high morbidity and functional impairment. The use of meta-analytic studies has shown improvements in PTSD using Cognitive Behavioral Therapies which include Prolonged Exposure therapy (PE) where the patient is exposed to trauma related memories, thoughts, feelings, and situations allowing a patient the ability to confront their fears (McLean, et. al., 2022; Norman, Hamblen, and Schnurr, 2023). Cognitive Processing Therapy (CPT) assists patients in learning ways to modify and challenge negative and less helpful beliefs that are related to the specific trauma. Eye Movement Desensitization Reprocessing (EMDR) (Shapiro, 2018; Shapiro and Maxfield, 2002), permits the patient in developing a mental image of the traumatic experience and related negative cognitions and is paired with tracking a bilateral stimulus. These represent the type of evidenced-based therapies encouraged by the VA in treating trauma-related disorders.

A randomized controlled trial by Campbell, Decker, Kruk, and Deaver (2016) was designed to evaluate if art therapy, when combined with CPT was more effective for reducing symptoms of combat-related PTSD than CPT alone. Relative to the processing of traumatic memories, the participants in this research indicated they either "recovered previously blocked memories or gained insights and realizations crucial to their healing processes through art therapy" (p. 174). During the art therapy intervention, participants were able to externalize the trauma and associated emotions, thus creating the artwork which acted as an externalized reflection of the internal self. The sensory and nonverbally stored traumatic memories allowed access to and facilitated integration of the memories. Improved processing of the traumatic memories was shown to be a significant contribution of the art therapy intervention. Additionally, both depression and PTSD symptoms were reduced. This study suggests that art therapy was useful in symptom reduction when paired with CPT. The combination of evidence-based psychotherapies with the use of alternative treatments (including art therapy) suggests promising and positive effects for the treatment of PTSD.

A randomized clinical trial by Schnurr, et. al. (2022) comparing PE and CPT with 916 participants (730 were men (79.7%); 186 were women (20.3%) demonstrated that both therapies were effective with PE more so but not at a statistically significant level. PE was used in vivo and imaginal exposure was followed by processing the imaginal experience. "In vivo exposure is accomplished through the gradual and systematic use of having patients approach distressing and trauma-related situations, places, and people that have been avoided and remain in the situation until distress reduces by half. Imaginal exposure involves repeated revisiting of the trauma memory and recounting aloud the traumatic events in detail, while vividly imagining the events . . . CPT consisted of cognitive therapy and participants writing two trauma accounts of the event they read to themselves and the therapists. The initial focus is on challenging beliefs caused by hindsight bias, just world violations, and self-blame or erroneous other-blame and then shifts to overgeneralized beliefs about self, others, and the world" (p.5). These findings support the VA's strategy of treating PTSD with evidence-based treatments.

The Healing Characteristics of Visual Art Therapy for Traumatic Experiences

Art therapy is a complementary and therapeutic approach to psychological treatment using a visual arts process. It is one segment of a larger group of therapies known as Expressive Arts Therapies which include creative and expressive activities such as music therapy, theater, writing lyrics to music or poetry, journaling, and dancing. This approach to art can be spontaneous or prompted by a therapist to facilitate the individual's creative expression. A variety of art materials and art techniques are utilized and include such modes as painting, drawing, sculpture, modeling, collage, masks, etc. (Avrahami, 2006). Among the many beneficial uses of art, it can serve as a means of communication, a force for social cohesion, and a vehicle to express emotions. There are indications that art therapy has shown to be effective in reducing PTSD symptoms (avoidance, arousal, and re-experiencing), and reducing depression (Schouten, et. al. 2015), however, more empirical research is needed to evaluate art therapy's effectiveness with traumatic disorders.

The definition of art therapy posited by the American Art Therapy Association (2022) "is a mental health profession that enriches the lives of individuals, families, and communities through active art making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship" ("About Art Therapy," 2022). The British Art Therapy Association (2024) defines it as "a form of psychotherapy that uses visual and tactile media as a means of self-expression and communication. Art therapists aim to support people of all ages and abilities and at all stages of life, to discover an outlet for often complex and confusing feelings, and foster self-awareness and growth" ("Art Therapy," 2024).

Regarding the effectiveness of art therapy, Hamel (2021) posits several hypotheses about how art therapy influences individuals experiencing PTSD symptoms and chronic pain. These hypotheses include: 1. images created in art therapy elicit the expression of repressed emotions (*abreaction*); 2. the implicit processes (of the *right brain*) are more stimulated by art's ability to activate the right brain where traumatic memories, stored as images, can be expressed through art; 3. the art creation is a projection of internal experience (*isomorphism*), where the creative images express what cannot be consciously accessed; 4. that using art materials to externalize traumatic images (*objectification*), assists the client in establishing affective distance from the painful, traumatic content, 5. containment expresses a sense that projecting an image to paper creates a boundary, a transitional space in the form of the paper itself, where the image becomes contained within the paper and no longer contained within memory; and 6. security denotes the use of art therapy in the context of a safe, helping relationship, allowing the patient to experience greater or lesser emotional distance and allows for control over the pace, content, and depth of control in an effective way. As the patient experiences more control over their experience, intrusive re-experiencing of the trauma is reduced to just the memories.

The effects of trauma for military service personnel with PTSD face a succession of attempts at processing traumatic memories that have become fragmented, dissociated, and have only nonverbal recall of memories of the traumatic experience (van der Kolk, 2015). Visual art therapy, according to Avrahami (2006), is described as the:

> ". . .spontaneous or prompted creative expression using various art materials and art techniques such as painting, drawing, sculpture, modeling (clay or substitutes), collage, etc.

> It offers a nonverbal language to express emotions and focuses on the way the client works and creates.....At the heart of art therapy lies the healing power of the creative process and the special communication that takes place between the client, the artwork, and the therapist. Although the art expresses the suffering, it also calls to the creative, healthy part of the client, which enables an authentic, non-threatening expression, opening new possibilities for change and growth" (p. 6).

Lobban (2014) stated, "Art therapy is an action therapy that combines movement, tactility, vision, memory, and imagery in the creative process which addresses the non-verbal core of traumatic memories" (p. 11). Furthermore, art therapy offers a means of activating neural and sensory processing pathways to achieve a cohesive, holistic level of healing (Belkofer & Konopka, 2008; Lobban, 2014). The evidence indicates that art therapy is well-equipped to support veterans experiencing any mental health condition; however, the interventions and models currently used in the literature vary in format, length and setting.

A pilot study by Schouten, et. al., (2019) designed and presented a trauma-focused art therapy protocol with 12 patients that was administered in three phases. The first phase focused on stabilization and symptom reduction (reducing stress and arousal and increasing a sense of control); the second phase is trauma-focused (exposure-focus on expression of traumatic and positive memories); and the third phase focused on integration and meaning-making (focus on past, present, and future; this phase involves reorganization, integration, and farewell). The objective was to test the feasibility and applicability of this trauma-focused art therapy for clinical practice. Results indicate that some participants had a decrease in symptoms and others experienced an increase in symptoms, however, those with the increase of symptoms had long-standing, multiple traumatic events for more than 40 years previously.

A report on art therapy in an open studio group with veterans was addressed by Boatwright (2021). "When veterans feel disenfranchised, isolated, and secluded, art therapy can provide a safe refuge of hope and increased resilience through an open studio art therapy support group" (p. 79). The open concept allows for creative and psychological expression that originates from one's internal perceptions of trauma. The artwork is transferred to a sheet of paper, a mask, or a canvas utilizing specific mediums and colors (colored pencils, watercolor or acrylic paint, charcoal, oil, pastels, drawing pencils, chalk, clay and clay tools) which communicates various personal meanings in the story of the veteran's trauma. Lobban (2014) has stated, "Art therapy is an action therapy that combines movement, tactility, vision, memory, and imagery in the creative process and which addresses the non-verbal core of traumatic memories" (p.11).

Mask-Making as an Art Therapy Intervention with Military Personnel

Mask-Making is a specific art therapy intervention that has been a contemporary method of PTSD treatment with veterans, representing their personal and perceptual war experiences. Mask-making, although used in a variety of contexts throughout history (in theater, ceremonial rituals, and religious worship), and as a therapeutic strategy. Brigham (1970) addresses the roots of mask-making as a potential psychotherapeutic tool. Janzing (1998) describes the use of masks in psychotherapy as a, "Mediator between humans and the spiritual world, between culture and nature, between conscious and unconscious, between psyche and soma, the mask allows the staging of our fundamental ambiguities" (p.156). The development of mask-making as an intervention with service personnel is part of the National Intrepid Center of Excellence (NICoE) program at the Walter Reed National Military Medical Center in the Healing Arts program designed by Melissa Walker, a Creative Arts therapist (Walker, 2019; Walker et. al., 2017; Walker, 2015). "The use of metaphor in the masks correlated with less anxiety symptoms, possibly indicating a source of resilience when service members are able to reflect and use insight and imagination to explore their psychological experiences and identities" (Walker, 2019, p. 122).

Mask-making has become an important intervention for therapeutic appraisals involving traumatic experiences for military personnel. Dean (2017) notes that mask-making in a therapy setting allows for two important dimensions: boundary and mediating functions, particularly for trauma. She indicates that, psychologically, masks "act like an auxiliary skin, infusing positive introjects, as aspects of self are integrated, and self-concept and self-esteem are reestablished or created. Masks also provide an opportunity to put on and remove any unwanted aspects of self through the removal of the mask or even, if not worn, the ability to view the unwanted aspects of the self as a *part of* but separate quality or aspect of oneself" (p. 140).

When expressing feelings about oneself, mask-making has been particularly useful where the mask tells the external story created from the internal memory and experiences of military serviceman. Walker, et. al. (2016) utilized a mask-making art project designed as a case study for a serviceman suffering from traumatic brain injury (TBI) and PTSD. The serviceman in this study had a successful military career for several decades. However, while on his last deployment he suffered a moderate TBI when a mortar shell exploded near him on base. While trying to take cover, he was hit with shrapnel to his leg and a loss of consciousness/post traumatic amnesia for 30-45 minutes. He also reported seeing "death up close." In addition, he suffered the loss of his friend to an improvised explosive device (IED) in a convoy he was scheduled to be on. The patient asked his friend to take his seat in the convoy so he could attend a meeting which created a sense of guilt for him. The authors concluded that, 1. art therapy with other integrative therapies (acupuncture) allowed the patient to become more open to treatment; 2. that other integrative therapies concurrently can be helpful in working through physiological and psychological symptoms; and 3. art making (including mask-making) is useful in non-verbal discovery. Art-making, along with other integrative therapies, can awaken and unlock potential feelings that are fragmented, making it difficult to give voice to the trauma.

A larger study conducted with active military service members in creating art therapy masks was conducted by Walker, et. al. (2017). Their study focused on visual representations of masks for military personnel (n=370) suffering from "persistent symptoms from combat- and mission-related traumatic brain injury (TBI), PTSD, and other concurrent mood issues" (p. 4). They report that in a group art therapy session during the first week, participants created masks that were to represent any aspects of their experiences and/or identities. "The primary goal of the mask-making session in the first week is to provide an opportunity for a service member to artistically externalize parts of themselves in a safe and non-judgmental environment" (p. 3).

These art therapy sessions (Walker, et. al., 2017) were designed to promote self-expression and group cohesion, empathy, and mutual support. They identified that masks take on representations of the self across six domains. Masks are representations of the *self as an individual* (interests, attributes, physical and psychological injuries); *the self in relationships* (able to recognize support and mourn loss); *the self in the community* (military identity/division/unit and references to regional/ethnicity/sports teams, etc.); the self in society (cultural metaphors and existential reflections); *the self as represented over time* (the mask representing one's life story, questions/transitions); and *the self as conflicted or split* (this represents two selves from any of the other categories).

Psychologically, masks represent complex meanings for patients in a mask-making art therapy experience. Masks, as an art stimulus in the Walker, et. al. (2017) study indicated that the cognitive and physical tasks offer opportunities for assessment, improvement of outcomes, therapeutic, artistic, and verbal processing of physical and brain injury experiences. Some symptom reduction can be realized as the mask reveals an unconscious process which can be revealed cognitively and verbally. Some masks refer to the emotional difficulties in managing overwhelming emotions, "(e.g., anger and sadness represented frequently in shades of "darker" colors; explosive emotions in the form of fire, lightning, or explosions referring to anxiety as being "on edge") (p. 9). Many service personnel represented a feeling of "being broken" (e.g., literally cutting up and piecing together their masks).

Service members fragmented memories can be represented in the masks where pieces of the narrative story may be missing. Other themes that emerged were moral struggles of patients with expressions of grief and loss related to losing someone in combat. Other servicemen created masks that contained symbols of patriotism and military identity (US Flag, camouflage designs, one's unit, weapons, helmets, and dog tags). Service members had questions that emanated from their masks: existential questions and other questions about their overall health and treatment concerns. Many service members represented symbolism as a divided or dual sense of self (past/present, health/injured, military/civilian).

The creation of a mask, in an art therapy setting and with the support of the therapist, offers the opportunity to evaluate various aspects and representations of elements of the trauma experience at an emotional distance, therefore creating a sense of protection. There is a mediating function that the mask fulfils between the self, the self in the aftermath of the trauma, and the self in the healing process. Irrespective of how the mask is made (paper mache, plaster mold, or creating the mask from scratch), the development of the art therapy mask "circumvents the verbal skills that become compromised when emotionally charged, allowing for expression and reintegration of fragmented aspects of the self and experiences in a non-threatening way" (Dean, 2016, p. 140).

Psychologically, there is a protective function the mask can provide between the internal experience of trauma, memory, and the external image the mask represents. There are three specific roles that highlight the healing functions of masks: 1. containment of existing traumatic sequelae, that is, protecting the self from split-off traumatic effects; 2. mediation between the ego and traumatic effects, and 3. the ability to mediate or form a bridge between the person's experience and their interpersonal relationships with loved ones and society (Dean, 2016).

A recent, innovative study by Estrada Gonzalez, et. al. (2024) focused on emotionally expressive qualities of art with a military population experiencing PTSS. Art therapy has been shown to allow people increased expression of complex memories and emotions that cannot be easily facilitated by language. It provides an avenue for patients to externalize, reflect upon, gain insights into, and alter both cognitive and emotional experiences and expressions. A mask-masking protocol for military service members was designed to create masks in the first two and last two sessions of an eight-session art therapy program. The masks in the first two sessions and last two sessions were evaluated by independent raters. The raters were unaware of any clinical details of the patients who made the masks or when they were made. The masks created in the first sessions were perceived by independent raters as presenting more negative emotions and the masks evaluated in the final sessions were reported to present more positive emotions. The latter mask-making masks were considered more affectively positive indicating that the course of art therapy demonstrated improvement in expressions of emotion.

Visual Art Therapy's Impact on Individuals and Societies

The recognition of visual art therapy as a mode of psychological healing and promoting well-being has been recognized for several decades, particularly given the physical and psychological complexities of traumatic injury. The general population experiences, at least, some traumatic events during their lifetime, and PTSD should be of a major concern in the US. There has been a substantial increase in art therapy services that offer treatments for trauma within the general population. Historically, visual art therapy has offered antidotal studies which have presented only anecdotal support of art therapy as a means of healing since World War II. As military applications of art therapy flourished in both the UK and the US following the war, art therapy for the general public has benefited a variety of populations and disorders in society and health/mental healthcare.

A review of several studies using art therapy as an intervention with a number of different clinical populations was conducted by Regev and Cohen-Yatziv (2018). Their review focused on 27 studies measuring the effectiveness of art therapy. Although the articles utilized in this review were limited in scope and quality of research, it conveyed the challenges of conducting research due to the emergent nature of the field of art therapy. This research was limited by the inclusion of smaller sample sizes for some studies, a scarcity of studies utilizing diverse art therapy techniques, and a specified inclusion criteria which limited the number of articles included in the review. The studies were separated into seven categories which included cancer patients (predominantly breast cancer) medical conditions not cancer-related (advanced heart failure, obesity, and HIV/AIDS), mental health (schizophrenia and depression), trauma victims (exposure to a traumatic event, trauma with war veterans), prison inmates, the elderly (older adults with dementia, depression, older Korean-Americans' aging healthy), clients who face daily, ongoing challenges (those experiencing burnout syndrome in oncology units, stress and anxiety of healthcare employees, and infertility in women), and refugees and asylum seekers (Nose' et. al., 2017). The positive growth of art therapy in the public sector is evidenced by the variety of populations where there has been success with trauma victims in the decrease of traumatic symptomology.

The complementary use of art therapy for mental disorders was investigated by Hu, et. al. (2021). They conducted a literature review of 413 articles evaluating the use of art therapy for disorders including depression, anxiety, cognitive impairment, dementias, Alzheimer's dementia, schizophrenia, and autism. Painting can be utilized to assist cancer patients in the expression of anxious and fearful emotions. The use of projection, in one's artwork, allows for venting negative emotions, adds to the overall improved mood, and a reduction in symptoms of depression and anxiety. When evaluating cognitive impairment for dementia, the authors found that there was no sufficient evidence of improvement due to the difficulty that patients had to accurately remember or assess their own behavior or mental state and may lose the ability to use and enjoy art therapy. However, this may suggest art therapy is effective when cognitive impairment is in a milder form. Alzheimer's dementia is associated with chronic pain where art therapy could be used to reduce pain. Autism spectrum disorder is a neurodevelopmental syndrome where individuals present difficulties in social interaction, communication problems, and repetitive behaviors. The literature highlights how art therapy allows for communication in a non-verbal way. Creating images externally on paper helps children express internal images that may depict their fears while enhancing their imagination and abstract thinking.

Another use of visual arts-based approaches is the effective didactic approach in medical school education for increasing empathy and compassion with patients (Potash, Chen, Lam, and Chau, 2014) and professional identity formation (Stephens, et. al., 2020). It is known that physician empathy increases physician-patient relationships and more positive outcomes for patients. The focus has been on the development of medical curriculums incorporating arts-based teaching to facilitate increasing physician's empathy and compassion with their patients as well as promoting individual well-being. The recognition that medical students' empathy and compassion declines during their medical education, the demands of medical school curriculums, and the demands of hospital administrative pressures contribute to declines in empathy and compassion, and patient care (Wang, et. al., 2022).

An exploration of mask-making for promoting identity formation in the professional development of medical students was reported by Stephens, et. al., (2020) and Joseph, et. al. (2017). Mask-making allows for "metaphorical representation," is subjective and complex, and utilizes visual and tactile experience. Participants in the study were challenged to reflect on their personal experiences (and the emotions elicited by those experiences) during their medical school education. In addition, they were to consider what lessons they learned that could be applied to residency and use the mask to interpret and express themselves. The study design of these arts-based medical education activities creates the development of new meanings about the self and how this would translate to students' future medical practice.

There is an increasing focus toward worldwide initiatives to improve health-centered care throughout the world. Mollaoglu, Mollaoglu, and Yanmış (2022), at Cumhuriyet University in Turkey include art therapy as one of several areas promoting worldwide health. They indicate the importance of a health-centered care approach designed to protect, maintain, and improve the health of individuals, families, and society. They discuss the relationship between art and health and the role they play in developing health initiatives, the growth of the individual, and assisting individuals in recovery and restoration of health as a central theme. The use of art therapy is an avenue in which individuals can explore past and present experiences, take an inventory that reviews one's life, cope with, and adapt to changes across the lifespan. Additionally, finding ways to receive support during emotional and physical crises, such as significant loss in one's body, memory or mobility. They regard art therapy as an effective means of expressing repressed emotions and underlying conflicts with verbal expression.

An interesting study conducted by Kaimel et. al., (2019) focused on a conceptual framework for research on art therapy as an intervention with children and adolescents diagnosed with cancer or blood disorders, their families, and healthcare providers. Through an art therapy program titled "Tracy's Kids," a nonprofit that utilizes evidence-based research paradigms, the art therapists are integrated with the medical care team. Outcomes of art therapy interventions were tracked across pediatric patients, their families, caregivers, and healthcare providers who all were engaged in the art therapy process. In the dimensions of Biological, Psychological, Social, and Spiritual outcomes each dimension/group demonstrated improvements. Psychologically, pediatric patients were more resilient, showed improved adaptive coping and perception of their illness, reduced stigma relative to cancer, improved mood/affect, and improved cognitive skills which included attention, processing speed, working memory, and verbal/visual-spatial skills. Family members improved in their ability to cope as well in their mood/affect. Healthcare providers demonstrated overall improved health, reduced burnout and increased empathy for patients and families, improved communication, and improved quality of life.

Art therapy, as a non-pharmacological and complementary treatment has been beneficial in improving quality of life and mental health. Rigorous, evidenced-based research is beginning to emerge with various populations. Hu, et. al. (2021), regarding their research in art therapy and evidenced-based approaches suggests "it will be helpful to specify the details of art therapy and patients for objective comparisons, including types of diseases, painting methods, required qualifications of the therapist to perform the art therapy, and the theoretical basis and mechanisms of the therapy" (p. 7). It is important to note that art therapy, in numerous studies, continues to report positive improvement with patients experiencing trauma, numerous other physical and psychological disorders, and contributing to emotional well-being and quality of life.

Conclusion

The use of art therapy as a complementary treatment for PTSS/PTSD has an important early history in its development, particularly in the military health systems in the US and the UK. This history has been rich in terms of theory and innovation of art therapy techniques. Soldiers are potentially exposed to combat-related trauma and stress contributing to post-trauma symptomatology. The hallmark symptoms of post-trauma include avoidance of reminders of the traumatic event, emotional numbness or dissociation, hyperarousal, and re-experiencing the trauma in the form of flashbacks and nightmares (American Psychiatric Association-DSM-V-TR, 2022).

PTSS affects 29 out of 100 veterans who are likely to be diagnosed with PTSD at some point in their lives, slightly more than in the general population (U.S. Department of Veterans Affairs, 2023). The National Alliance of Mental Illness (2017) points to the occurrence of PTSD as affecting 3.6% of the population culminating in about 9 million individuals with women being significantly more likely than men to experience PTSD. Co-occurring issues with PTSD include suicide, depression, anxiety, obsessive compulsive disorders, borderline personality disorder, and substance use disorders. These statistics constitute PTSD as a major public health concern.

Service members may be reluctant to engage in psychotherapeutic treatment and/or art therapy due to experiencing the stigma associated with negative attitudes about seeking psychological healthcare. Many service members get inadequate care in the VA. Ehert (2019) suggests that medication is too often the first line treatment protocol for service members suffering from PTSD. She reports that the psychotherapies offered by the VA should be the first consideration for treatment of PTSD.

The stigmas that influence seeking help include, perceived public stigma, self-stigma (internalized stigma), and attitudes toward seeking help. Service members who are reluctant in seeking mental health intervention often have an attitude that treatment offers very limited benefit and they may have doubts about treatment. The stigma of treatment and attitudes about psychological health should be addressed in an initial session with a patient (Kaplan, 2019). Helping veterans engage in art-based and psychological treatment should be considered an important area of investigation.

Art therapy shows considerable promise as a complementary treatment for trauma with veterans, active-duty service personnel, and the public sector, including adults and children. Art therapy is a link where individuals can explore past and present experiences, review one's life, cope with and adapt to age-related changes, and receive support or physical care during emotional crises, such as loss, dementia, mobility and/or disease process (Mollaoğlu, S., Mollaoğlu, M., & Yanmış, S. 2022). Trauma research has made considerable progress in understanding the neurological mechanisms that operate and are compromised by the complexities of traumatic sequelae. The difficulties in treating trauma have encouraged complementary therapies such as art therapy to emerge.

Art therapy, as utilized in the public sector, provides increased opportunities for treating adults and children with a variety of physical and psychological disorders, diseases and conditions that impact one's physical and mental well-being. There is a consideration and need for art therapy to be utilized in the military, hospitals, mental health facilities, and education. As art therapy has become an increasing part of treatment efforts to relieve those who are suffering from trauma, continued research is needed to identify the mechanisms of trauma, neurological effects, long-term benefits, types of health conditions that are supported, and what patients can benefit the most from participating in creative art therapy.

Special Notation

The opening photograph presents a powerful artistic painting developed by a member of the US Marine Corps that raises up the nature of therapeutic art healing processes. The photograph is a work of the Department of Defense and is therefore in the public domain and used freely. The full information on the photograph can be found on Wikimedia Commons at: https://commons.wikimedia.org/wiki/File:Sergeant_therapeutically_paints_through_PTSD_healing_process_120403-M-OT671-890.jpg.

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Academic Commentary

Reconsolidation of Traumatic Memories:
The Best PTSD Treatment You've Never Heard Of

Loree Sutton, MD
Brigadier General (US Army, Ret.)
421 Highridge Court
Peekskill, NY 10566
Tel: (917) 280-3331
Email: loree.sutton@gmail.com

Haneen J. Alani, MA
PhD Candidate, University of New Haven
Henry C. Lee College of Criminal Justice and Forensic Sciences
300 Boston Post Rd.
West Haven, CT 06516
Tel: (508) 521-9555
Email: Halani@newhaven.edu

Author Note

The authors are responsible for the contents of this article. The contents of the article do not necessarily reflect the position of the institutions the authors serve. The senior author is an independent senior advisor for the Post-Traumatic Training Institute and Lykos Therapeutics.

Abstract

The persistent rise in suicide rates among military personnel and veterans, despite extensive efforts to combat this crisis, highlights a critical gap in the effectiveness of current PTSD (Post-traumatic stress disorder) treatments. This article examines the potential of memory reconsolidation therapy, focusing on the innovative Reconsolidation of Traumatic Memories (RTM) Protocol™ as a promising alternative to conventional methods. Traditional therapeutic approaches/methods like Cognitive Processing Therapy and Prolonged Exposure Therapy often fall short, with limited success and significant patient drop-out rates. RTM, by contrast, shows considerable promise in reducing PTSD symptoms more effectively and with greater patient retention. The article advocates for a more dynamic research approach that accelerates the development and integration of novel PTSD treatments, stressing the urgency of addressing this escalating mental health crisis within the military and beyond. The need for a more effective response has never been more pressing, as the lives and well-being of countless individuals--the military service members, veterans, family members and civilians--hang in the balance.

Keywords: Post-traumatic stress disorder (PTSD), Reconsolidation of Traumatic Memories (RTM) Protocol, military, Veterans Administration, mental health, suicide prevention, memory reconsolidation, neurostimulation

Introduction

Despite the best intentions and billions of dollars invested over the past two decades, suicide rates within the military and veteran communities continue to increase far beyond pre-9/11 levels, a fact that should spur accelerated innovation to address this scourge more effectively. Many of these suicides in veterans and service members are linked to PTSD, and developing better approaches to treating PTSD is a national challenge. This article focuses on the topic of reconsolidation of traumatic memories as a new promising approach to treating PTSD, with one such treatment (Reconsolidation of Traumatic Memories (RTM) Protocol™) dubbed "the best PTSD treatment you've never heard of" by Garry Trudeau in his July 2023 *Washington Post* op-ed (Trudeau, 2023).

The epidemic of suicide among veterans is a devastating national tragedy; however, it is only one facet of a more significant, more complex issue. Suicide in US society at large has increased by over one-third since the start of the 21st century. As we all continue to face the aftermath of the pandemic, we must confront this challenge head-on to navigate the resulting collective trauma tsunami. As the US Surgeon General Dr. Vivek Murthy recently stated, “Mental health is the defining crisis of our age” (Murthy, 2023), and most Americans polled on this issue are in strong agreement (Lopes et al., 2022). As a nation and world, we are in uncharted territory.

Need for Improved PTSD Treatment

Post-traumatic stress disorder extends well beyond the military, impacting not just veterans but also civilians; it can be best understood as an injury inflicted by overwhelming trauma, affecting police and first responders, survivors of sexual assault and other crimes, school shootings, terrorism, accidents, and natural disasters. If left unaddressed, its effects can linger for decades, devastating relationships, families, workplaces, and communities. The prevalence of PTSD among veterans from recent wars in Iraq and Afghanistan has been conservatively estimated at 400,000 persons. Among veterans from all eras of service, those with PTSD number well over 2 million, and among US civilians, roughly 15 million individuals suffer from PTSD. This national challenge demands a whole-of-America response (Schein et al., 2021).

Rationale for Innovation

Urgent change is needed. After all, the approved VA/DoD treatments, the official standard of care for PTSD, have achieved limited improvement, elicited distressing symptoms, and have demonstrated high drop-out rates. As a result, veterans are increasingly seeking integrative, non-drug, and psychedelic treatments outside the VA system, even outside of the country, often incurring significant personal costs to themselves. This creates a conundrum of legitimacy and ethical concerns for the VA as an institution, placing its hard-earned reputation for healthcare leadership at risk (Jacobs, 2021).

Currently, the main therapeutic options approved by VA/DoD for treating PTSD involve Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (P.E.), Eye

Movement, Desensitization and Reprocessing (EMDR), and/or pharmacological agents, most commonly selective serotonin reuptake inhibitors (SSRI), which are even less effective than the psychotherapies; further, only two SSRIs have obtained FDA approval in more than 20 years.

In recent years, these modalities have come under increasingly negative scrutiny. Medications commonly cause side effects before therapeutic effects, leading to early discontinuation. Moreover, classical pharmaceuticals require continuous use; they do not work when not taken. Approximately two-thirds of clients receiving CPT or P.E. retained their PTSD diagnosis after treatment (Levi et al., 2021). Up to half the patients cannot tolerate the treatment experience--i.e., logistics, time load, homework exercises, re-traumatization impact--and drop out before completing the therapy (Steenkamp et al., 2015).

These interventions are costly and time-intensive (e.g., 12 to 16 weekly 60- to 90-minute sessions with matching homework commitments for P.E. and CPT), and although symptom reductions are deemed significant, many are not lasting and result in symptom relapse. Further, these modalities are not suitable for everyone and can be traumatizing and intolerable, resulting in high drop-out rates and continued suffering. Finally, much of the research supporting PTSD treatments has been conducted with civilian populations; individuals suffering from combat-related PTSD, often more complex and multi-dimensional, do not respond as favorably, thus creating the need for different and varied approaches (Barnes et al., 2019).

Implications for Suicide Prevention

It is well established that trauma survivors, including those suffering from trauma spectrum disorders such as PTSD, depression, and anxiety, carry an increased risk for suicidal thoughts, suicide attempts, and suicide (Akbar et al., 2023). The weight of our inadequate response in developing next-generation therapeutics to meet the needs of PTSD survivors is mounting. At a time when our nation is experiencing nearly 50,000 suicides annually, an increase of over 30% since the year 2000, PTSD has turned from a silent crisis to one of epidemic proportions. Multiply this level of suffering by 2 million veterans of all eras and 13 million civilians estimated to have PTSD --and you begin to get an idea of the human costs at stake.

There is no cookie-cutter solution, no magic pill or therapy that works for everyone; however, the prospect of new tools in the PTSD toolkit has generated fresh hope and impassioned advocacy. Given that the vast majority of those who die by suicide suffer from a mental health disorder, accelerating innovations in clinical treatment is imperative. Suicide prevention efforts are also increasingly recognizing the impact of moral injury, that is, the violation of one's deeply held values or beliefs in what is right and wrong (Bellfy & Kwapis, 2020).

Emerging Treatments

Despite emerging evidence for a range of PTSD treatment approaches, the most recent edition (2023) of the VA/DoD PTSD clinical practice guidelines (CPG) has reduced the number of recommended treatments (from seven to three) and offers no new recommended strategies. This development, while unsettling, aligns with recent public comments made by the Executive Director of the National Center for PTSD. Despite recognizing the necessity for improved treatments, the Executive Director remarked, "I'm not sure we need additional treatment options" (Sippel et al., 2023).

This uncertainty is particularly perplexing, given the high drop-out rates of 46.6% (215 of 461 individuals) for CPT and 55.8% (257 of 455 individuals) for P.E. in a recent significant (916 subjects) randomized clinical trial published in 2022 of which the aforementioned senior executive was the lead author (Schnurr et al., 2022). Despite these trial results, P.E. and CPT remained prominently recommended in the 2023 revision of the Clinical Practice Guidelines, for which she served as the workgroup leader (Lang et al., 2024).

Remarkably, the authors of a recently published critique of the new CPG conclude their article by recommending that clinicians will better serve their clients by continuing to use the previous CPG, published in 2017, rather than adopting the new version. To state the obvious, VA and DoD clinicians deserve better than "the reification of a limited status quo" (Hoge et al., 2024). Given that there are 636,120 ways to have PTSD, broadening treatment options to expand effective options would seemingly be an obvious goal (Galatzer-Levy & Bryant, 2013).

Disturbingly, the limited status quo may be even more limited than realized. Many early published clinical trials on the use of P.E. and CPT in the treatment of PTSD excluded noncompliant subjects and drop-outs from the final analysis rather than analyzing results by use of the standard, preferred intention-to-treat (ITT) principle, which includes every subject who is randomized according to randomized treatment assignment. Analyzing the data by the subset of treatment completers rather than all who were randomized can result in substantial bias (Kip et al., 2013). In 2011, it was estimated that the 60-80% recovery rates among treatment completers (P.E., CPT) declined to about 40% using ITT analyses. Given the high drop-out rates for P.E. and CPT, immediate resolution of this discrepancy is needed to ensure accurate reporting and valid comparisons of treatment outcomes (Hoge, 2011).

Memory Reconsolidation Overview

Memories are thought to be initially modifiable when they are first acquired and then solidify through the synthesis of new proteins in a process known as consolidation. Thus, consolidation therapy aims to disrupt traumatic memories before the consolidation process occurs. The traditional theory in the memory field was that memories could not be changed once the consolidation process had occurred. This theory was displaced after literature was published that showed that after memory retrieval, previously consolidated memories become destabilized and require protein synthesis for long-term storage in a process termed reconsolidation (Farrell & Mahood, 2022).

Early neuroscience insights regarding memory reconsolidation were published over 50 years ago, in the late 1960s, and then "rediscovered" decades later in the 1990s (Bellfy

& Kwapis, 2020). Emerging research shows that trauma memories are different from sad or neutral memories; often experienced as occurring in the present moment, trauma memories are processed and stored differently in the brain (Perl et al., 2023). Further, gently retrieving trauma memories under certain conditions can open a 1–6-hour window during which reactivated memories can be updated and modified. This process, known as reconsolidation, may have important implications for PTSD treatments, including RTM, Accelerated Response Treatment (ART), EMDR, and other rescripting approaches that explicitly target the intrusive symptoms of PTSD, e.g., nightmares, flashbacks, heightened reactivity (startle response), and hypervigilance, and are thought to work at least in part through this mechanism (Merlo et al., 2024).

Using RTM as an example, treatment begins with briefly visualizing the traumatic event to 'open' the reconsolidation window; rigorous monitoring throughout the process minimizes distress and yields low drop-out rates, averaging <10%. Through a series of guided visual imagery exercises, the client engages in restructuring the traumatic memory in a manner that ultimately allows for recall of the event without triggering emotional hyperarousal and distress. A recent meta-analysis identified RTM as "the most promising reconsolidation therapy and with, by far, the largest effect size," clearly warranting further research (Astill Wright et al., 2021).

Recent head-to-head studies have evaluated RTM compared to Trauma-Focused Cognitive Behavior Therapy (TFCBT) and P.E., demonstrating positive comparative RTM findings. In the King's College London study, the RTM group experienced a mean 18-point reduction on the PCL-5 compared to 8% in the TFCPT group; 48% in the RTM group no longer met the diagnostic criteria for PTSD compared to 16% in the TFCPT group. In the Walter Reed study, RTM demonstrated superior results to P.E. in all study criteria, including symptom reduction, diagnosis remission, and length of treatment (Roy et al., 2024; Sturt et al., 2023).

Since 2015, four published peer-reviewed wait-list controlled studies have yielded promising results, with roughly 90% of individuals experiencing complete loss of intrusive symptoms / PTSD diagnosis; these study results are analyzed using the preferred ITT principle. Typically, the RTM protocol is completed within three to five 60-90-minute sessions administered over a 5-10-day window; no medications are required (Gray et al., 2019). Further, since 2022, 117 therapists in Ukraine have completed RTM training and reported positive results using RTM in their war-torn country.

The neurobiology of PTSD is complicated, with multiple brain regions and circuits showing dysfunction. Of note are limbic circuits involved in the emotional regulation of behavior, including regions like the amygdala, hippocampus, anterior cingulate, and orbital frontal regions. There is also evidence of dysfunction in circuits mediating neuroendocrine responses and homeostasis. Electrophysiological methods like EEG and MEG reveal abnormal power in the high beta band generated by emotional regulation circuits. Successful RTM treatment normalizes activity in the circuits (Lewine, 2024).

A Pragmatic Research Strategy

Since there is broad agreement that better PTSD treatments are needed, the question is how best to responsibly accelerate and advance knowledge to meet the enormous and growing needs of the military and veteran communities. While randomized controlled trials (RCT) determine efficacy or how well a treatment works under ideal conditions, there is an urgent need for pragmatic trials, where the question is whether the intervention works in real life. This is particularly important given the efficacy-effectiveness gap, reflecting the higher remission rates in randomized controlled efficacy trials than in real-world effectiveness studies (Hengartner, 2018).

Increased investment in comparative effectiveness research models (CER)--comparing standard P.E. & CPT psychotherapies with novel treatments featuring memory reconsolidation, neurostimulation, mindfulness practices, and medications, including psychedelics--represents a strategic and timely opportunity to apply this underutilized approach to achieve translatable real-world clinical research findings and foster the rapid uptake of evidence-based clinical practice within the healthcare setting (Williams et al., 2016).

A recent network meta-analysis addressing the comparative effectiveness and acceptability of pharmacological, psychotherapy, and combination treatments in adults with PTSD showed no significant superiority of any treatment approach in the short term. At the longest available follow-up, standard psychotherapeutic treatments (e.g., P.E., CPT) were significantly more effective than pharmacological treatments, and the combined treatments were slightly but not significantly superior to psychotherapeutic treatment alone; remarkably, the combined treatments were significantly more beneficial than pharmacological treatments alone. This critical finding highlights several issues, including the need for more effective pharmacological agents, increased reporting of long-term findings, and the inclusion of novel emerging therapies in meta-analytic reviews (Merz et al., 2019).

Accelerated research is urgently needed to better understand how to leverage the reconsolidation mechanism, either using psychotherapy alone or augmented with a medication that acts explicitly on memory pathways. Novel treatments must be tested against standard treatments in rigorous clinical trials and field research studies.

The limitations of the current research process, including the high costs, time constraints, and inefficiencies of RCTs, have led to the evolution of CER, which can serve as the cornerstone of patient-centered care, allowing for individual patient variations and preferences and involving both the healthcare provider and the patient in the decision-making process. Importantly, CER supports using archival records of thousands of interventions in multiple clinical contexts for fast, low-cost comparisons to help clinicians determine what works best in a given clinical situation (Dang & Kaur, 2016). Moreover, CER may incorporate whole health principles and practices designed to build resilience--including attention to sleep, pain, fitness, fuel consumption, self-care, and peer and community support--as essential components of care that strengthen the foundation for PTSD recovery (Krist et al., 2023).

Unfortunately, institutional gatekeepers often dismiss emerging novel therapies, citing a lack of evidence and denying research funding for robust studies or even small pilot demonstration projects. However, unless and until a promising novel treatment has been tested on its merits and fallen short based upon valid scientific research, it is counterproductive to block support due to a purported "lack of evidence"; in short, the absence of evidence is not necessarily evidence of absence. At a time when the military and veteran communities are desperate to find better ways to recover from PTSD, this blocking tactic, a clear example of bureaucratic malpractice, is maddening and must change.

Call to Action

Principled leadership and courageous fortitude are necessary to reach all who are suffering from the ravages of PTSD. Stronger together, we must serve as an active and informed voice to speak for those afraid or unable to do so, illuminate places within darkness and despair, and boldly break through bureaucratic obstacles impeding progress.

Over 20 years have passed since 9/11; as suffering and suicides continue to occur at epidemic levels within the military and veteran communities, a greater sense of urgency, evidence of innovation, and acceleration over equivocation are desperately needed. Enrolling individuals with refractory PTSD, for whom P.E. and CPT have been tried without success, in CER studies using emerging novel treatments would be clear evidence of innovative progress characterized by due urgency and acceleration. The recent FDA decision to delay approval of MDMA-assisted treatment for PTSD pending more extensive research further increases the need for demonstrable improvement in advancing progress for non-drug PTSD treatments (Reardon, 2024).

In closing, this is a time for coming together and joining forces in collaboration to accelerate vital change. Trusted veteran service organizations--American Legion (A.L.), Vietnam Veterans of America (VVA), Disabled American Veterans (DAV), Iraq and Afghanistan Veterans of America (IAVA), and many others at all levels throughout the country--must ramp up collective advocacy for this issue, as a team of teams, on Capitol Hill and beyond. There is much work to be done--and no time to waste.

Now is the time to act. How will you answer the call?

Special Notation

The photograph found after the references that concludes this special commentary is a 2009 artistic work from the Department of Defense. It elevates to our awareness profound patient care being given by an Air Force physician's assistant to a fellow USAF comrade while serving in Afghanistan. Being a DoD photograph, it is in the public domain and is therefore used freely. The full information on the depicted powerful moment is found at: https://www.dvidshub.net/image/1205989.

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The Civil Rights Act at 60:

Aspirations and Obstacles in LGBTQ+ Health
Part 1

Paula M. Neira, JD, MSN, RN, CEN, FAAN
Program Director of LGBTQ+ Equity and Education
Johns Hopkins Medicine
Office of Diversity, Inclusion and Health Equity
Assistant Professor, Department of Plastic and Reconstructive Surgery
Johns Hopkins School of Medicine
1812 Ashland Avenue – 4th Floor
Baltimore, MD 21205
Tel: (301) 503-4429
Fax: (410) 367-2439
Email: pneira2@jhmi.edu

Cheri C. Wilson, MA. MHS, CPHQ
Diversity & Inclusion, Cultural & Linguistic Competence,
& Health Equity Subject Matter Expert
Former Program Director, Diversity, Equity and Inclusion
Johns Hopkins Medicine
Office of Diversity, Inclusion and Health Equity
Tel: (443) 616-6170
Email: cwilson366@comcast.net

Author Note

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Abstract

In this first of a two-part series, the authors discuss the legacy of the Civil Rights Act of 1964 enacted to eliminate legal discrimination targeting many marginalized people. However, the Act and its progeny omitted protections based on sexual orientation and gender identity, allowing for discrimination and inequity to persist for LGBTQ+ people. The failure to correct this omission has perpetuated health disparities and magnified the negative impacts of the social determinants of health. The political rhetoric about human rights, including health, is not aligned with governmental policy and actions. The failure to reduce the gap between words and deeds has caused LGBTQ+ people, especially transgender people, to endure increased health risks, pernicious barriers to nondiscriminatory care, and to fight for basic human dignity and acceptance. Part one provides historical background and presents the current challenges facing sexual and gender minority people to lay the foundation for part two. Part two will provide health care practitioners with recommendations to improve care to LGBTQ+ patients. Further it will encourage fierce allyship and advocacy to reduce health inequity and promote human rights, social justice, and maximal health for all, especially marginalized communities such as the LGBTQ+ community.

Keywords: LGBTQ+, transgender, civil rights, social determinants of health, gender-affirming care

Introduction

Three score years ago the United States enjoyed a new birth of freedom with the passage of Public Law 88-352, the Civil Rights Act of 1964. This Lincolnesque phrasing highlights that achieving a nation where all people benefit from the Declaration of Independence's promise of "life, liberty and the pursuit of happiness" remains a work in progress. On the 60th Anniversary of this landmark legislation, we see both the progress as well as the remaining work needed to achieve its objectives. While centered on the United States (US) situation, the article's discussion is global in application.

As part one in a two-part series, this article will discuss the meaning of health and why civil and human rights are essential for people to be truly healthy. Further, the impact of the Civil Rights Act, its progeny, and the current status of the law and litigation will be discussed. The US government's statements supporting human rights are lofty but do not reflect the gap between the rhetoric and marginalized people's lived experience. The absence of nondiscrimination on the basis of sexual orientation and gender identity in civil rights laws has fostered and perpetuated health disparities and contributes to the negative impacts of social determinants of health (SDOH) facing lesbian, gay, bisexual, transgender, queer/questioning (hereinafter LGBTQ+ in this article) people and other communities based on sexual orientation, gender identity, or sexual characteristics. The terms gay and transgender will be used as umbrella terms to describe communities based on non-heterosexual sexual orientations and non-cisgender gender identities respectively. In part two, the authors will offer implementable recommendations for health professionals across disciplines to improve the care provided to LGBTQ+ people and reduce the health disparities and care barriers they face.

Background – Looking Back

The Meaning of "Health"

For many, health means not suffering from illness or an injury (Sartorius, 2006). However, health is now understood to be holistic and encompasses all aspects of life that allow a person to maximize their ability to achieve self-actualization, fulfillment, or realization (Svalastog et al., 2017). The Constitution of the World Health Organization, implemented in 1948, states that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (World Health Organization [WHO], 1946, Preamble). The World

Professional Association for Transgender Health (WPATH) recognizes that health depends on more than access to high-quality medical care but is reliant on a social and political environment that ensures tolerance, equality, and full rights. The ability to achieve health is advanced through policy and laws that eliminate stigma and discrimination (Coleman et al., 2022). The current standards of care for the health of transgender and gender diverse (TGD) people were designed to promote health equity and human rights (Coleman et al., 2022).

The US federal government has not defined health. Several of the primary federal agencies responsible for health promotion and health care delivery such as the National Institutes of Health (NIH), the Department of Health and Human Services (HHS), and the Centers for Medicare and Medicaid fail to provide an explicit definition (Fiscella & Epstein, 2023). That said, many agencies use holistic language when discussing health. The Department of Veterans Affairs (VA) has an Office of Patient Centered Care & Cultural Transformation which seeks to create a "personalized, proactive, patient-driven" care model advancing a veterans' whole health (VA, 2021). In defining whole health, the VA speaks to health and well-being that matters to the individual based on their "values, needs and goals" (VA, 2024). The National Academies of Sciences, Engineering and Medicine (NASEM, 2023) in its report, *Achieving Whole Health: A New Approach for Veterans and the Nation*, recognized that whole health "spans physical, behavioral, spiritual and socioeconomic well-being" for "a person, family, and community to achieve what they want from life" (NASEM, 2023, p.37).

In defining health holistically, the parties involved in achieving health are more than merely the patient and the health care professionals from whom they seek care. All actors contributing to the full sphere of factors impacting health are engaged in creating the environments that promote or inhibit health, including executive, legislative, religious, judicial, cultural, media, and business policy-crafters and decision-makers. This broader understanding of health implicates the social and structural factors impacting people and communities (i.e., SDOH). These include poverty, gender bias, racism, oppression, cultural, structural, and legal factors (NASEM, 2023, p.46). These factors that must be addressed because they are the causes of health inequity (NASEM, 2023). Relevant to the topic of this article, while the NASEM report called out racism and gender bias explicitly, it did not do so for anti-LGBTQ+ bias and discrimination. "It is widely accepted that the denial of rights can impact sexual and gender minority health and well-being" (Coleman et al., 2022).

Health as a Human Right

Essential to health are the ideals of liberty, freedom, equity, and personal autonomy. Given that understanding, it should be without question that the US should view health as a human right. Sadly, that is not the case. The environment created by recognizing all people's inherent human dignity, their innate human rights, and the need in society for social justice for those who have been/are marginalized is fundamental to a person's ability to flourish. That said, the rhetoric of health as a human right and the reality of societal structures, systems, and actions implementing that belief are not aligned in the US. Human rights are universal and without exclusion. The "right to health and other health-related human rights are . . . enshrined in international human rights instruments" and the WHO Constitution recognizes the right to health (WHO, 2023). Humans have a right to attain the highest level of health and countries have the legal obligation to develop laws and policies to facilitate this achievement by addressing "the root causes of health disparities, including poverty, stigma, and discrimination" (WHO, 2023).

The US history of civil rights and its embrace of universal human rights is checkered with cyclical progress and regression. There is a gulf between the lofty rhetoric of our foundational documents and the lived experience of many marginalized people. The US does not recognize health as a human right in practice (Gerisch, 2018). Franklin Delano Roosevelt, in his State of the Union Address of January 11, 1944, proposed a series of rights "be established for all regardless of station, race or creed," including "The right to adequate medical care and the opportunity to achieve and enjoy good health" (Roosevelt, 1944). With FDR's death in 1945, no further government action on implementing this right was taken (Gerisch, 2018). While the US adopted the United Nations (UN) Declaration of Human Rights, which includes a right to health and access to health care, it has failed to ratify international laws which promote health as a right such as the Covenant on Economic, Social and Cultural Rights (CESCR) as well as failing to identify health as a human right in its periodic reports to the UN (Gerisch, 2018). In 2023, the UN Human Rights Committee (UNHRC) concluded a review of the status of human rights in the US and expressed grave concerns about the discrimination that LGBTQ+ people continue to face, including the restrictions on accessing gender-affirming care (Thoreson, 2023).

While the argument that health is a human right and that LGBTQ+ rights are human rights should be made when arguing for domestic legislation and policies, such arguments must recognize that progress will only be made within the confines of the US Constitution and the rights that the judiciary hold are contained therein. With few exceptions, international treaties and judicial decisions are not binding in US courts. At best, they are persuasive precedent. The Supreme Court has found that only self-executing provisions of international treaties are viewed as domestic law (Congressional Research Service, 2023). Most international human rights treaties to which the US is a signatory are not self-executing and require some action on the part of Congress to make them enforceable within the US (Congressional Research Service, 2023).

Civil Rights Laws and Health in the United States

Because health is not seen as a fundamental human right within the US, it must fall to the state and federal branches of government to enact and enforce laws and regulations designed to ensure the civil rights of all citizens which in turn impacts their ability to be fully healthy. Those actions then are reviewed by the judiciary with the context of their constitutionality in accordance with either the respective state or federal constitution. That history has unfortunately seen the promise of rights which would promote holistic health and well-being be denied through structural and legal barriers. The need for the Civil Rights Act of 1964, the Voting Rights Act of 1965, the Equal Employment Opportunity Act of 1972, and the Education Amendments of 1972 (Title IX) was due to chronic legal discrimination, which eroded the protections of the 14th Amendment and was enshrined into law by Supreme Court decisions such as *Plessy v. Ferguson* (1896) (allowing segregation based on race), *Buck v. Bell* (1927) (allowing the eugenics of state-ordered sterilization) or *Korematsu v. United States* (1944) (allowing internment of Japanese-Americans because of their race).

In response to the backlash to the end of desegregation in schools (*Brown v. Board of Education*, 1954) and in the continuing racial discrimination in public accommodations, employment, and federally-assisted programs, the Civil Rights Act of 1964 was enacted over severe opposition (National Archives, 2022). This Act sought to enforce the right to vote without discrimination (Title I), prohibit discrimination in public accommodations on the basis of race, color, religion or national origin (Title II), public facilities (Title III), public education (Title IV), and programs receiving federal assistance (Title VI). The provisions of Title VII prohibited discrimination in employment, added sex as a protected class in employment, and created the Commission on Equal Employment Opportunity (Civil Rights Act of 1964). The Patsy Mink Equal Opportunity in Education Act (Title IX) prohibits sex discrimination in any education program or activity receiving federal funds (United States Courts, n.d.). The Civil Rights Restoration Act (1987), enacted over President Reagan's veto and maintaining provisions for religious exemptions, clarified that a "program or activity" meant all operations of a university or corporation that provided, among other things, health care, housing, and social services.

Section 1557 of the Patient Protection and Affordable Care Act (ACA) (commonly referred to as either the Affordable Care Act or Obamacare) addresses nondiscrimination in healthcare. The text states that no individual can be discriminated against on any ground prohibited by Title VI or Title IX as well as other federal laws. It gives the Secretary of Health and Human Services (HHS) the authority to create regulations to implement this section (ACA, 2010). The text of the law does not define protected classes in any further detail. The lack of explicit listings of protected classes and the delegation of such identification to the HHS secretary has been problematic and has resulted in the perpetuation of anti-LGBTQ+ discrimination in healthcare. The regulations promulgated by HHS have never been fully enforced by the federal government as each attempt to do so has been enjoined by the courts.

In May, 2016, the Obama administration issued its version of the regulations to implement §1557. These regulations included sex discrimination protections in health coverage and included gender identity discrimination within sex discrimination; codified guidance on access for people with limited English language proficiency; incorporated existing law that required reasonable actions to avoid disability-based discrimination, and prohibited discrimination in health insurance benefit coverage for transgender people. It did not include a prohibition on the basis of sexual orientation alone within the definition of sex discrimination but acknowledged that discrimination on the basis of gender stereotyping was included under the protections of the section (Cornachione, Musumeci, & Artiga, 2016). On the day before the regulations were to go into effect, a federal district court judge in Texas issued a nationwide preliminary injunction against their implementation in a case (*Franciscan Alliance, Inc. v. Azar*) brought by several Republican state attorneys-general and sectarian plaintiffs who claimed that the antidiscrimination protections on reproductive rights and transgender people violated their "religious liberty" (Musumesci et al., 2020). In 2019, the same judge vacated the rule in his final opinion in the case (*Franciscan Alliance, Inc. v. Azar*, 2019). While HHS was barred from enforcing the proposed regulations, private actions claiming civil rights violations under the section were allowed to proceed based on the statute itself. Cases on behalf of transgender plaintiffs were successfully brought for blanket exclusion of insurance coverage for gender-affirming care as well as damages from repeated misgendering (Musumesci et al., 2020)

When the Trump administration issued its version of the implementing regulations for §1557, these were also challenged in the courts and enjoined in part (Musumesci et al., 2020). When elected, the Trump administration furthered the efforts to roll-back any gains made by LGBTQ+ people including healthcare matters (Neira & Lee, 2021). In its final rule implementing §1557, Trump's HHS stripped away antidiscrimination protections for LGBTQ+ people by eliminating prohibitions against discrimination on the basis of sex-stereotyping and gender identity; adopting blanket religious exemptions for healthcare practitioners; eliminating rules against insurers discriminating against LGBTQ+ people in health coverage; and eliminating protections against discrimination on the basis of sexual orientation and gender identity in other federal laws (Musumesci et al., 2020).

In April, 2024, the Biden administration issued its final rule on §1557 re-establishing the LGBTQ+ protections contained in the 2016 final rule (HHS, 2024a). This most recent attempt to implement protections in healthcare for LGBTQ+ people, as well as for other marginalized people, included provisions that reinstated §1557 applicability to health insurance issuers that receive federal financial assistance and the nondiscrimination rules to all HHS programs and activities, reaffirmed discrimination protections for LGBTQ+ people, and clarified the prohibition on sex discrimination aligned with the *Bostock* decision, and respected guarantees regarding religious freedom and conscience as outlined in other federal laws (HHS, 2024b).

Upon its release and before its implementation, at least three court challenges to the rule, all objecting to provisions to ensure civil rights protections for LGBTQ+ people, specifically transgender people, were filed in various federal district courts (HHS, 2024a; Dawson et al., 2024).

Civil Rights and LGBTQ+ Health

The Yogyakarta Principles + 10, first promulgated in 2006, and updated in 2017 state that all human beings enjoy human rights, that sexual orientation and gender identity should not be the basis for the denial of those rights, and outlines state obligations (The Yogyakarta Principles, n.d.). In 2011, with the support of the US, the United Nations recognized the human rights of LGBTQ+ people and expressed "grave concern" at the discrimination targeted at people based upon sexual orientation and gender identity (US Mission to International Organizations in Geneva, 2011; Zeldin, 2011). "The human rights of all LGBTIQ+ people, as equal members of the human family, must be respected" (UN Human Rights Office of the High Commissioner, n.d., May 17, 2023, quote from Volker Türk, UN High Commissioner for Human Rights). Despite the rhetoric on protecting LGBTQ+ rights globally, no federal civil rights law explicitly prohibits discrimination on the basis of sexual orientation or gender identity. The Civil Rights Act of 1964, Title IX, and ACA §1557 do not include protections for LGBTQ+ in their text. Arguably, protecting gay or transgender people likely was not intended by the legislators who crafted these civil rights documents. This omission reflects the societal, cultural, and legal animosity towards LGBTQ+ people when these pieces of legislation were enacted. This omission is used as justification for the continued proposition that anti-LGBTQ+ discrimination, particularly when justified by "religious liberty," is legally permissible in healthcare such as exclusion from insurance coverage and in denial of care. Twenty-nine states do not provide anti-discrimination protections for LGBTQ+ people (The White House, 2021).

For approximately 50 years, since the mid-1970s, legislation has been offered in repeated congressional sessions to address this omission by calling for the addition of sexual orientation and gender identity to be included by amending the civil rights laws. The first attempt to enact legislation was the introduction of the Equality Act of 1974, which only addressed discrimination against gay men, lesbian and straight women, and unmarried people in employment, public accommodations in housing; transgender people were not included. The bill did not get out of committee. Other efforts to include protections based on sexual orientation in the 1970s also failed (Hunt, 2011). Anti-LGBTQ+ animus, the AIDS epidemic, and the control of the federal government by social conservatives who opposed LGBTQ+ rights forestalled any progress until introduction of the Employment Nondiscrimination Act (ENDA) in 1994 (Hunt, 2011). The new bill focused only on employment discrimination and continued to exclude transgender people. It failed to be enacted and, with the exception of the 1996 congressional session, it was continually introduced to no avail. In 2007, a version that included transgender people died in the House committee. A subsequent attempt, intentionally excluding transgender people, was introduced by Representative Barney Frank (D-MA). While this bill did pass in the House, it died in the Senate (Hunt, 2011). There was immediate backlash within the broader LGBTQ+ community against the cynical abandonment of transgender people in the attempt to enact this civil rights legislation (Juro, 2013).

Recent attempts to pass the Equality Act have not been fruitful. In 2021, the bill passed in the House but stalled in the Senate because of partisan politics. In the current Congressional session, the bill has not passed the Republican-controlled House (Migdon, 2024). The Equality Act would explicitly codify in Title VII the Supreme Court decision in *Bostock v. Clayton County* (2020) that discrimination on the basis of sexual orientation and gender identity is unlawful (The White House, 2021). The Court found discrimination on the basis of sexual orientation and gender identity were impermissible forms of discrimination on the basis of sex (*Bostock v. Clayton County*, 2020). While the Equality Act remains stalled, some protections recognizing the rights of LGBTQ+ people have been codified. The Respect for Marriage Act (2022) was enacted to ensure that same-sex and interracial marriages would be protected in the face of threats from some supreme court justices who would repeal *Obergefell v. Hodges* which made marriage equality the law across the US (The White House, 2022).

However, it is not established that the existing prohibitions against sex discrimination in Title IX cover sexual orientation and gender identity in the same way. The US Department of

Justice Civil Rights Division in 2021 issued a memorandum stating that the reasoning of the *Bostock* decision applies to Title IX and noted that two federal circuit courts of appeal had cited *Bostock* in finding Title IX protected transgender students against discrimination based on their gender identity. In 2024, the legal landscape on the rights of transgender people, particularly adolescents, to be protected from discrimination based on their gender identity and their ability to use restrooms, access evidence-based, medically-necessary gender-affirming care, and participate in sports aligned with their gender identity, all of which is covered by Title IX, is convoluted. There is significant disagreement among the federal circuit courts, in the various federal district courts, and in state courts. Ultimately, the decision on whether Title IX protects transgender people will be decided by the Supreme Court. The Court has granted *a writ of certiorari* to hear a case involving the Tennessee law banning gender-affirming medical care for transgender youth. The Court will make its decision later in 2024 (ACLU, 2024). Further, the results of the upcoming presidential election in November, 2024 will have major implications for the status of civil rights and the impact on health for all marginalized people.

The Current Status of LGBTQ+ Health care

LGBTQ+ Fundamentals

Demographics

The importance of obtaining sexual orientation or gender identity (SOGI) demographics in either health systems or in greater society cannot be understated. Historically, neither the states nor the federal government had an interest in being able to describe the size of the LGBTQ+ population and to address its needs. The population size data we have is based on statistical analysis of self-reported data. Through either benign neglect or intentional exclusion, most governmental surveys have not included SOGI demographic data collection. The history of discrimination, maltreatment, harassment and violence directed at LGBTQ+ people pose risks to those who disclose this information (NASEM, 2022). Due to a rational fear of potential discrimination and thus nondisclosure, any population size estimate is an undercount. The estimated adult LGBTQ+ population size in the US ranges from 13.9 million (5.9%) (Flores & Conron, 2023) to 19.7 million (7.6%) (Jones, 2024). People who identify as bisexual comprise the largest percentage of the LGBTQ+ population (57.3%) while nearly 20% of Gen Z adults, those ranging in age 18 to 26, identify as LGBTQ+ (Jones, 2024). The size of the adult US population identifying as TGD is approximately 1.6-2 million (≈ 1.4%) (Herman et al., 2022). Approximately 300,000 adolescents (ages 13-17) identify as TGD (Herman et al., 2022). For adults under 30, 5.1% identify as TGD (Brown, 2022).

The recent increases in population size estimates may reflect increased societal acceptance that has encouraged LGBTQ+ people to come out. More TGD people may be identifying as such due to this increased acceptance (Meerwijk & Sevelius, 2017). Younger people are also more likely to identify as a member of the LGBTQ+ community (Brown, 2022; Jones, 2024). An analogous situation is the increase in the number of people who identified as left-handed once anti-left-handed stigmatization ended in the 20th century (National Health Care for the Homeless Council, 2023). Health professionals should recognize that the increase in adolescents identifying as TGD is not due to "social contagion" or rapid onset gender dysphoria (ROGD), an idea which has no scientific evidentiary support (WPATH, 2018; Turban et al. 2022, WPATH 2023).

Terminology

The terminology used to describe LGBTQ+ people is ever-evolving and is often highly individualistic. Language that was used in the past may now be considered offensive (Neira & Bowman, 2022). This is exemplified by the pathologizing language used in the past and may still be found in use within health records, billing, and coding. As part of delivering patient-centered care, health professionals should be aware that many people may use terminology to describe themselves or their anatomy that will mean different things to different people. English is an imprecise language and often terms are used interchangeably or as synonyms when they are not. A good example of this is the use of sex and gender as interchangeable when they are interdependent but not synonymous (Michigan State University [MSU], n.d.).

Sex is the term to capture the complex interplay between chromosomes, genetics, in-utero hormone exposure, and the presence or development of primary and secondary sexual characteristics. Most humans have never had genetic or chromosomal testing or in-utero hormonal assessments. There are more permutations of chromosomes than only XX or XY and defining a person's sex in only those two categories is simplistic. For most humans, their "sex" was assigned to them at birth based on nothing more scientific than a cursory observation of the external genitalia present. Thus, a more appropriate term is "sex assigned at birth." Biology is real and those who support LGBTQ+ rights and improved health care do not deny this. That said, while phrases such as "born a boy" or "born a girl" apply to most people, boy or girl are gender terms and not anatomical terms. A more accurate description is that a child was born with certain anatomy. As the child grows, and they develop their gender identity, whether they are a boy, a girl, or a nonbinary person will be determined then. Health professionals should also be cautious when using the phrasing of describing someone as a "biological male/female." While this may be appropriate language in some scientific contexts, that context must be clearly articulated. Practitioners should understand that in the current socio-political climate, those who oppose TGD acceptance in society use these terms to deny the reality of TGD people. An example is the argument that a 'biological male' (i.e., a transgender girl/woman) should not be allowed to play sports or use the restroom aligned with their gender identity (Neira & Wilson, 2024).

Intersex is a term that may describe an individual, or the community of people, who's primary and/or secondary sexual characteristics do not lie in a binary male/female category. Intersex is neither a sexual orientation nor a form of gender identity as intersex people may have a range of sexual orientations and gender identities (InterAct, 2020; Neira & Wilson, 2024). Terms such as "hermaphrodite" or "disorder of sexual development" are offensive and should not be used (GLAAD, 2021).

Gender is the term describing a social construct based on a societal/cultural understanding, often binary, of masculinity or femininity. Gender identity, gender expression, gender roles, gender stereotypes, gender attribution all affect our notion of gender (MSU, n.d.). A person expresses their gender (gender expression) through their appearance (clothing, hair style, mannerisms) and their actions/behavior (speech patterns, social interaction, assumption of gender roles, conformity to gender stereotypes aligned with their gender identity) (Neira & Lee, 2021; MSU, n.d.). The notion that gender can only be binary is a product of Western European / North American culture. Indigenous peoples across the globe have viewed gender as a spectrum and recognized people may not be exclusively masculine or feminine (Neira & Lee, 2021).

Sexual Orientation describes a person's multidimensional attraction to other people encompassing physical, romantic, or emotional dimensions (GLAAD, 2021). Everyone has a sexual orientation. Depending on how someone identifies and how the person(s) they are attracted to identify, different descriptive terms will apply. Gay, while specifically referring to men who are attracted to other men, is often used as an umbrella term for all people whose sexual orientation is something other than heterosexual/straight (men attracted to women and vice versa within a binary gender worldview). *Homosexual* is considered by many to be an outdated and derogatory term and is often used by those opposed to LGBTQ+ rights in an attempt to color non-heterosexual sexual orientations as a pathology. While some patients may use this term to describe themselves, the term should generally be avoided. Use the term that a patient uses but only after confirming use with the patient. Health professionals should not describe sexual orientation as a *sexual preference*. This is an offensive term that is used to imply that sexual orientation is a choice and if a person is not heterosexual/straight then they did so by a voluntary choice which can be "corrected" or "cured" (GLAAD, 2021). If the clinical situation calls for inquiry into sexual behavior, the practitioner should ask about behaviors and not assume that sexual orientation is a proxy for behavior. Due to societal stigma, some men who have sex with men will not identify as gay or bisexual.

Gender Identity describes a person's deeply held knowledge of their gender (GLAAD, 2021). This self-understanding develops over time as an individual grows. There is no evidence that social factors are drivers of sexual orientation or gender identity development (Swaab et al., 2021). Others posit that there are biological, social, cultural, and psychological influences that shape that development timeline (Cabaj, n.d.). It may be fairer to state that neurologically there are no social factors in determining sexual orientation or gender identity formation but that those other factors influence acceptance of one's sexual orientation or gender identity due to both societal and internalized stigma. *Cisgender* describes people whose gender identity aligns with their sex assigned at birth. This describes the majority of humanity. *Transgender* describes people whose gender identity does not align with their sex assigned at birth. Nonbinary people, those whose gender identity is not exclusively male/man or female/woman with the binary may identify as cisgender or transgender, with a majority identifying as cisgender (Wilson & Meyer, 2021). *Gender modality* is a newer term that has been proposed to reflect that cisgender and transgender are modalities describing the association or relationship between a person's gender identity and their sex assigned at birth (Ashley, 2019). Most people, including most transgender people, identify as women/females or men/males within the binary. There are numerous terms that people who do not identify within the binary (nonbinary or gender-expansive people) may use such as nonbinary, genderqueer or gender fluid. Two-Spirit is an indigenous term that has deep cultural meaning reflecting "tribally specific gender and sexual orientation identities that are centered in tribal worldviews, practices and knowledges" (NASEM, 2022, p. 22).

Queer is a term that some people may use to describe their sexual orientation, gender identity, or both. Many people have, and some still do, view the word queer as a pejorative term. However, many people within the LGBTQ+ community have reclaimed the use of the word as a sign of autonomy and empowerment (MSU, n.d.; GLAAD, 2021). When a patient uses the term to self-describe either sexual orientation or gender identity, it is acceptable to ask, "What does queer mean to you when you use it to describe yourself?" to help clarify their meaning because the word may have differing meanings to others.

There are many other terms that are used when discussing sexual orientation and gender identity. There are also terms and phrases that should be avoided because they are outdated, offensive or are used to imply that LGBTQ+ people's sexual orientation and gender identity are "correctable" or "curable" pathologies. Several resources are available online that define additional terms and offer suggestions for affirming and supportive language:

- GLAAD Media Reference Guide – 11th ed. (https://glaad.org/reference/terms);
- Michigan State University: The Gender and Sexuality Campus Center Glossary (https://gscc.msu.edu/education/glossary.html);
- National LGBTQIA+ Health Education Center Glossary of Terms for Health Care Teams (https://www.lgbtqiahealtheducation.org/publication/glossary/); and
- LGBTQIA+ Glossary of Terms for Teaching in Health Care – Yale School of Medicine (https://medicine.yale.edu/lgbtqi/curriculum/2021-07-04-lgbtqia_glossary_417482_37430_v3.pdf).

Health Disparities – Looking Around

Persistent Disparities

The WHO defined health inequities as avoidable inequalities in health between groups of people that are created because of inequalities within society. Social and economic conditions impact lives and determine the risks of illness and the health/lack of health of people and communities (WHO, 2013). The organization of society based on the multidimensional aspects of people including socioeconomic status, education, job, race, ethnicity, gender [and sexual orientation and gender identity] affects the conditions in which people "grow, learn, live, work and age, their vulnerability to ill health and the consequences of ill health" (WHO, 2013). "Every aspect of government and the economy has the potential to affect health and health equity" (WHO, 2013).

The LGBTQ+ community is not a monolith but rather a broad, diverse population that crosses all dimensions of humanity including "racial, social, cultural, socioeconomic and geographic backgrounds" (Cabaj, n.d.). In discussing the persistent health disparities and inequities facing LGBTQ+ people, the list of disparities should be appreciated through the lenses of intersectionality and minority stress. The concept of intersectionality initially focused on a Black feminist perspective but has since evolved into the insight that the many aspects of a person, which provide both favor or disfavor in society, are interdependent (McConnell et al., 2018). Intersectionality recognizes that people are simultaneously part of multiple social communities; the interaction of multiple social identities occurs within the context of intertwined systems and structures of power; and structural inequalities result from these interactions (Scottish Government, 2022). When an individual is a member of multiple marginalized communities, those facets of the individual cannot be separated into distinct components to ascribe percentages of the cumulative discrimination and health inequities they may face. (McConnell et al., 2018). Arguably, the discrimination is not linear but exponential.

Minority stress is the additional stress a member of a marginalized community endures due to societal structures and the social environment that fosters prejudice, stigma, and discrimination (Meyer, 2003). This added stress negatively impacts health by increasing health risks (Meyer, 2003; McConnell et al., 2018). LGBTQ+ people experience higher rates of psychological distress and mental health comorbidities than those who are not in the LGBTQ+ community (McConnell et al., 2018). LGBTQ+ people experience the same stressors as other marginalized groups such as prejudice, rejection, external and internalized stigma (McConnell et al. 2018). While Meyer in 2003 was focused on lesbian, gay, and bisexual people, the minority stress model also applies to TGD people (McConnell et al., 2018).

With *Healthy People 2020*, the federal government for the first time addressed health topics impacting the LGBTQ+ community, including TGD people. Over a decade later, the health disparities identified by HHS persist. These findings included:

- **Increased risk of suicide** (HHS, 2013; Medina-Martinez et al., 2021). Being gay or transgender does not make a person inherently suicidal; the increased risk comes from societal stigma and prejudice that for some is then internalized. The 2015 US Trans Survey found that 48% of adult respondents reported suicidal ideation in the previous 12 months with 82% having had suicidal thoughts and 40% had attempted suicide at some point in their life (James et al. 2016). The KFF/Washington Post Trans Survey in 2022, reported that 43% of respondents had suicidal thoughts in the month prior to responding, which is more than double the rate for cisgender people. For those without supportive families, the percentage increased to 50% (Kirzinger et al., 2022). For LGBTQ+ adolescents and young adults, the risk of suicide is four times greater than their non-LGBTQ+ peers with approximately 1.8 million considering suicide each year reflecting that 41% had suicidal ideation within the prior year (The Trevor Project, 2024). In one study (n=372), 86% of transgender youth reported suicidal ideation (Austin et al. 2022).

- **Increased risk of violence** (HHS, 2013; Medina-Martinez et al., 2021). LGBTQ+ people are four times more likely to be victims of violent crime than non-LGBTQ+ people (Flores et al., 2020). For transgender people of color, 31% reported being physically assaulted compared to 25% of transgender people. Verbal assaults were reported by 64% of transgender adults (Kirzinger et al., 2022).

- **Increased risk of HIV/STI** (HHS, 2013; Medina-Martinez et al., 2021). While any sexually-active person is at risk for HIV or other sexually transmitted infection (STI), men who have sex with men (MSM) are at higher risk. This group has higher rates of syphilis infection and constitute half of new HIV infections (Centers for Disease Control and Prevention [CDC], 2024a). Almost 20% of transgender women are HIV+ with almost 50% of Black transwomen living with HIV (Klein et al., 2020). The increased risk for Black transwomen is grounded, in part, in discrimination, care-access barriers, poverty, violence and homelessness (Gaffney & Merelli, 2024; Hershow et al., 2024).

- **Increased risk of substance use disorders** (HHS, 2013; Medina-Martinez et al., 2021). Due to the harassment targeted at the LGBTQ+ community, often bars and clubs were the main places to gather in relative safety. This contributed to issues of alcohol use disorder in gay communities (HHS, 2013). Having to find coping mechanisms to deal with stigma, discrimination, harassment, and trauma increase the likelihood of substance misuse or developing substance use disorders (National Institute on Drug Abuse, 2024).

- **Increased risk of mental health concerns** (HHS, 2013; Medina-Martinez et al., 2021). “Depression, anxiety, suicidality, general distress and substance abuse show the largest disparities by sexual orientation and gender identity . . .” (Bränström et al., 2024, p. 46). These impacts must be viewed through an intersectional perspective and disaggregate the risks for mental health comorbidities due to variance between the different subgroups that comprise the LGBTQ+ community (Bränström et al., 2024). The risk for depression, anxiety, and substance use disorders in LGBTQ+ people is two-three times greater than the risk for straight/cisgender people (Bränström et al., 2024).

In addition, other health disparities impacting LGBTQ+ people have been identified. These include a higher probability of eating disorders or obesity (Medina-Martinez et al., 2021), an increased risk of tobacco use (CDC, 2024b); increased health risks from lack of screening for breast cancer, cervical cancer, and heart disease (Gillespie, 2020); and the lack of collection of SOGI data (NASEM, 2020; Servinga, 2022; National Science and Technology Council, 2023).

Social Determinants of Health

“Social justice is a matter of life and death” (WHO, 2008, Executive Summary). The WHO identifies SDOH to be the influencers of health outcomes that are non-medical (WHO, n.d.). While health and health equity may not be the primary focus of policy, health and health equity is affected by “every aspect of the government and economy . . . finance, education, employment, transport and health . . .” (WHO, 2013, What is health equity in all policies?) These influencers can be positive or negative and include, among other factors, access to quality health care, education, employment (working conditions, unemployment, job security, education and development, housing, food security, environmental concerns, inclusion, and nondiscrimination (WHO, n.d.). When *Healthy People 2020* was released over a decade ago, the US identified several SDOH that were negatively impacting LGBTQ+ health. These included legal discrimination in various areas of life (health insurance access, family structure (marriage and adoption), employment, or housing); a lack of anti-bullying protection in schools; a lack of LGBTQ+-focused social programs across the lifespan; shortages of culturally-aware and clinically-competent healthcare practitioners; and physical environmental concerns such as unavailability of, or lack of access to, safe schools, neighborhoods, housing, sports participation and facilities, safe spaces to gather, and health services. (HHS, 2013).

In 2024, these SDOH still impact LGBTQ+ health, most often negatively. It is only within the past decade that any progress has been made. Some issues were only addressed through judicial decisions. Marriage equality and the right to equal marital benefits were only recognized in 2015 and 2013, respectively. (*Obergefell v. Hodges*, 2015; *United States v. Windsor*, 2013). Three sitting members of the Supreme Court, Chief Justice Roberts, Justice Thomas, and Justice Alito all dissented in these cases and supported continued anti-LGBTQ+ discrimination. In the wake of the *Dobbs v. Jackson Women's Health Organization*, the 2022 case overturning *Roe v. Wade* and harming reproductive rights, signals from the justices indicating that they would welcome the opportunity to reimpose anti-LGBTQ+ discrimination in marriage issues led to the enactment of the Respect for Marriage Act. Further, these same justices were part of the majority which upheld discrimination against LGBTQ+ people in matters of foster parenting (*Fulton v. City of Philadelphia*, 2021) and in allowing businesses to deny services to LGBTQ+ people (*Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission*, 2018). Both of these cases allowed "religious liberty" to be used to justify LGBTQ+ discrimination.

These SDOH negatively impacting LGBTQ+ health "largely relate to oppression and discrimination" (HHS, 2013, Understanding LGBT Health). The health disparities facing LGBTQ+ people, as suggested by research evidence, are linked to "stigma, discrimination, and the denial of their civil and human rights" (HHS, 2013, Overview). This anti-LGBTQ+ discrimination continues to persist in the US in 2024. The situation has become so grave that the UN Human Rights Committee condemned the spate of anti-LGBTQ legislation in the US (Thoreson, 2023). The Human Rights Campaign (HRC), the largest US-based LGBTQ+ civil rights organization, issued travel warnings and a state of emergency in response to the unprecedented legislative attacks on LGBTQ+ people (HRC, 2023). Over 725 anti-LGBTQ+ bills were introduced across the states in 2023 and, as of June, 2024, 527 had been introduced in 2024 (Movement Advancement Project [MAP], 2023a; American Civil Liberties Union [ACLU], 2024). A main focus of these laws is to attack the health of TGD people through barriers to accessing care, denial of access to facilities and public accommodations, and governmental refusal to recognize the legal existence of TGD people (MAP, 2023b). As a result, 40% of respondents to the 2022 US Trans Survey had considered moving from their residence due to experiencing discrimination, 47% considered moving due to governmental actions to ban access to healthcare, facilities or sports participation, and 5% had moved (approximately 4-5,000 people) (James et al., 2024). The Trevor Project (2023) reported that the ongoing debates about TGD human rights and access to healthcare has caused a negative impact on the psychological health of 86% of transgender and nonbinary youth with 45% experiencing cyberbullying.

The toxic combination of fundamentalist religiosity, in the US primarily "Christian Nationalism," and partisan politics, embraced by Republicans, fuels these attacks on LGBTQ+ health, with particular emphasis on TGD rights and health (Neira & Lee, 2021; MAP, 2023b, Southern Poverty Law Center [SPLC], 2023a; SPLC, 2023b; Neira & Wilson, 2024). At the Conservative Political Action Conference (CPAC) in 2023, a far-right commentator stated, "for the good of society . . . transgenderism must be eradicated from public life entirely" (Luneau, 2023; Goetsch, 2023). Denying that this was a call for the genocide of transgender people, this same speaker suggested that it could not be genocide because being transgender is not a "legitimate category of being" (Luneau, 2023). In issuing a permanent injunction barring implementation of the bans on access to transgender care in Florida, US District Judge Robert Hinkle noted that "Had there been no animus, gender-affirming care probably would not have come before the Legislature at all . . . The same is true of [Medical] Board Members: but for animus, gender affirming care would not have been addressed at all . . . " (*Doe v. Ladapo*, 2024, p.63).

This unholy alliance between religiosity and partisan politics can be found in the language of documents such as the Heritage Foundation's *Project 2025. Project 2025* is a 900+ page blueprint for federal policy implementation that seeks, among other discriminatory proposals targeting many marginalized communities, to roll back LGBTQ+ rights and implement policy that will perpetuate and enhance existing health inequity. The document uses sectarian language to justify anti-LGBTQ+ marriage and family policies stating "maintain a biblically based . . . definition of marriage and family" (Heritage Foundation, 2023, p.481). It also promotes the denial of the existence of TGD people by stating "Enforcement of civil rights should be based on a proper understanding of those laws, rejecting gender ideology . . . . (Heritage Foundation, 2023, p. 322). This playbook is a product of a coalition of organizations, several of which have been identified as anti-LGBTQ+ hate groups by the SPLC including the Alliance Defending Freedom, the Family Research Council, and the Center for Family and Human Rights, (Heritage Foundation, 2023; SPLC, 2023c). After the extreme positions of the playbook were publicized, and Republican presidential nominee Donald Trump attempted to distance himself from the proposals though many of his associates were main contributors to the work, the Heritage Foundation ended the Project 2025 policy work in July 2024 and the project director departed (Arnsdorf & Dawsey, 2024).

The 2024 Texas Republican Party Platform and Resolutions states that "Homosexuality is an abnormal lifestyle choice" (Texas Republican Party [Texas GOP], 2024, p.24). Further, it rejects the existence of TGD people and denies them their human dignity by stating, "We oppose all efforts to validate transgender identity" (Texas GOP, 2024, p.24). It justifies its cisheteronormative bias and anti-LGBTQ+ bigotry in sectarian language by stating, "We affirm God's biblical design for marriage and family . . . ; "We support the definition of marriage as a God-ordained, legal, and moral covenant between one biological man and one biological woman"; and "we are opposed to same-sex parenting . . . and other non-traditional definitions of family" (Texas GOP, 2024, p.30).

The Movement Advancement Project in its *Under Fire Series: The War on LGBTQ People in America* outlines the anti-LGBTQ+ attacks which have the intended consequence of perpetuating the heath disparities and SDOH negative impacts facing LGBTQ+ people (MAP, 2023b). The SPLC through its *CAPTAIN (Combating Anti-LGBTQ Pseudoscience Through Accessible Informative Narratives*) report highlights the pseudoscience and junk science being used to justify attacks on the LGBTQ+ community, creates a resource to counter the misinformation and fabrications put forth by those championing these attacks, and calls out those groups behind the attacks on TGD people and their health (SPLC, 2023a; SPLC, 2023b).

Conclusion

“. . . the arc of the moral universe is long, but it bends towards justice” (King, 1968). Sixty years on from the passage of the Civil Rights Act of 1964, Dr. King’s words provide hope that the fundamental promise of rights, equality, and inclusion for all will someday be achieved. Until then, “Injustice anywhere is a threat to justice everywhere” (King, 1963). These oft-quoted words are a call to action to fight for social justice, civil and human rights, and as a consequence, for the health care equity of all marginalized people. Society suffers if we do not do so. LGBTQ+ people were not explicitly included in the original civil rights legislation. The omission of protections against anti-LGBTQ+ discrimination, and the failure to correct this error since, has fostered the health disparities and negative SDOH impacts that impair LGBTQ+ health. The increased health risks and disease burdens facing LGBTQ+ people are the result of pernicious issues stemming from a lack of social justice. In the current sociopolitical environment, the threat to LGBTQ+ health arises from a toxic mix of religiosity and partisanship that nurtures the spread of misinformation and fabrications about marginalized people in a rejection of science, medical expertise, and human dignity. In part two of this series, implementable recommendations for action will be presented to improve person-centered, culturally-aware and clinically competent care. Further, health practitioners will also be encouraged to become fierce LGBTQ+ allies and advocates for social justice and human rights to bring about the societal change necessary to reduce and ultimately eliminate health inequities and barriers to care.

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Academic Commentary

A Matter of Courage: The Sisterhood of Salaam Shalom Pursues Peace

Rabbinic Pastor De Fischler Herman
Chaplain, Spiritual Director and Sage-ing Mentor
E-mail: deherman@me.com

Author Note

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Abstract

Heroic individuals abound and often are unsung. The acts of courageous women, mostly quieter than those of their male counterparts, model strength, fierce determination, humor, spirituality, and a deep sense of social justice. Their voices need amplification to effect the changes needed to heal the current global conflicts and existential crisis

Keywords: Courage, women, activists, human rights, peace makers, Jewish, Muslim

> *"In our time of disturbance and radical change, we are crossing a threshold, a portal, or an unseen bridge from one world to another. It could be said that the bridge is either collapsing beneath us, or being made as we walk together, in the long twilight hours when one civilization gives way to another."*
> Geneen Marie Haugen

To Begin…Again

Three years ago, wanting to lift up women who have done extraordinary things in the face of seemingly impossible odds, I published a piece in this Journal on six of them I had the honor of interviewing. For many years, I was struck by the voluminous publicity extolling brave men and the dearth of material about courageous women. The article inspired further exploration and led to more interviews.

Two years ago, a close friend mentioned she was planning a trip to Morocco with members of the Sisterhood of Salaam Shalom (SOSS), a group of Muslim and Jewish women of whom I was only vaguely aware. Sensing my yearning to travel to that ancient and culturally rich place, my friend invited me to go. I did not hesitate to post my application. Two months later a busload of women, half of us Jews, half Muslims, landed in Casablanca. It was there we met our tour guides, Aziz Abu Sarah, a Palestinian peace activist and co-founder of MEJDI Tours, and his colleague Elad Vazana, an Israeli Jewish man of Moroccan descent and fellow peace activist.

The weeklong pilgrimage presented the group with an immersive experience in the history of the two faiths as they once dwelled peacefully side by side, supporting one another through their daily lives and vocations, foodways, and holy day observances. We visited the awe-inspiring Islamic Hassan II Mosque, shopped in the famed medina (labyrinthine market) of Marrakesh, toured the beautiful Slat Al Azama Synagogue that no longer holds religious services, and walked the crumbling Jewish quarter in the port town of Essaouira. We asked our guides many questions about the history of the two cultures over the centuries, particularly what eventually drove out the 2,000 year-old Jewish community, reducing its vibrant population from 250,000 in the late 1940's to about 2,000 today. The founding of the State of Israel in 1948 lured many Moroccan Jews to the Holy Land and, for those who stayed, their offspring have mostly left for France, Canada, the United States and Israel. Hoping to restore their sense of inclusion and safety, King Hassan has restored equal rights to the Jews of Morocco, the only north African country to do so.

Traveling with this unusual group sparked a curiosity to learn about the courageous women who founded the Sisterhood and lessons learned since the group's founding in 2010. On the eve of embarking on my second pilgrimage with the Sisterhood in September 2024, this time to Andalusia Spain, I became conscious of the enormous challenges to the members of the Sisterhood and its leadership since Hamas terrorists massacred nearly 1200 unsuspecting people and took more than 200 hostages, mostly civilians, from Israel, on October 7, 2023. Seventy-two hostages were reportedly killed that day. During a temporary ceasefire ending December 1, 2023, Hamas released more than 100 hostages. Still, the resulting war in Gaza has claimed tens of thousands of Palestinian lives, wreaked incalculable devastation, and has spread to the West Bank and Lebanon.

Now, upon the first anniversary of the attack, 101 hostages remain in Hamas captivity in the Gaza Strip. Israeli forces have escalated retaliatory attacks beyond Gaza, striking Hezbollah targets in Lebanon. National Director of the Anti-Defamation League Jonathan Greenblatt reports more than 10,000 antisemitic incidents have been documented since October 7, 2023, a 200 percent increase over 2022, including more than 1,800 incidents of vandalism and 150 incidents of physical assault. Similarly, the Council on American-Islamic Relations (CAIR) reports more than 8,000 incidents in the United States in 2023, a record high, and a six-fold increase in the United Kingdom. Given the heavy toll the war between Hamas and Israel has wrought upon Palestinians and Israelis, Muslims and Jews, whether living in Israel-Palestine or in diaspora, I wondered whether the Sisterhood of Salaam Shalom would make it through the emotional upheaval of the terrible conflict. How would the ongoing war affect relationships within the chapters? How might it shape the evolution of the organization? And, how might it alter the trajectory of the process toward resolution and peace between the warring parties?

Origin and Mission of the Sisterhood

In 2010, Cheryl Olitzky, a middle-aged Jewish woman from New Jersey, traveled to Poland to witness the history of the Holocaust with her own eyes. She was not prepared for the emotional impact it would provoke. She writes:

> *Nor was I prepared for the enormity of the planned hate and destruction that I saw. I left Poland knowing that I had to do my part to stop hate and negative stereotypes. It was the hate of the "other" that created the devastation of the Holocaust. The Talmud (oral law) asks, "Who is a hero?" and answers, "One who makes one's enemy into a friend." The Rabbis communicated that it's possible to change people's attitudes and that it is desirable to strive to do so. I knew I had to change attitudes.*

Returning to her home intent on fulfilling her revelation, Cheryl called the local mosque and spoke to the imam, a spiritual leader with whom she was acquainted. She asked him for a referral to a Muslim woman in his community. He recommended she speak with Atiya Aftab, professor of Islamic law at Rutgers University, who served on the board of his mosque. Atiya, working fulltime and mother of three young children, did not readily respond to Cheryl's calls. Only upon the third attempt did the Muslim woman finally agree to meet with the Jewish woman. Cheryl explained her desire to get to know a Muslim, to reach out across their different faiths and stand up to hate. Given the similar challenges Muslims and Jews have faced being minorities in America, Atiya felt a religious obligation to accept Cheryl's invitation. They would start a grassroots group composed only of women from Islam and Judaism to meet and dialogue outside of their religious institutions. Atiya says, "All of these things were critical. It wasn't a bunch of men in the room, because it's usually men in these spaces, who walk in and talk about religion in either an academic or theological kind of way." This is what psychologist and couples' therapist Hedy Schleifer refers to as speaking "from the penthouse," disconnected from the internal elevator that emotionally integrated people employ with facility, moving down to the "lobby" (the heart) and the "basement" (the gut) and back up as appropriate.

Cheryl and Atiya inaugurated the first chapter of what would be named the Sisterhood of Salaam Shalom. Cheryl writes, "It was clear that there was a need to take this successful model and expand it to include more women. We had proven that you could take women from two faith groups who had little, if any, contact with one another, and bring them together to create something much greater than the sum of their parts!" Word spread of their intention. Chapters composed of an equal number of Muslims and Jews began meeting in members' homes to dialogue, to listen, to share culinary and holiday traditions, to form bonds of friendship and sisterhood, and to engage in advocacy. Cheryl notes:

> *Women navigate the world through relationships. The relationships that are built by bringing together Muslim and Jewish women, who share so many practices and beliefs, are life-changing and can help put an end to anti-Muslim and anti-Jewish sentiment. We influence family, friends, and the general public about our strength in coming together to build bridges and fight hate, negative stereotyping, and prejudice. We are changing the world, one Muslim and one Jewish woman at a time!*

Turning History into Herstory

Among their common beliefs, both monotheistic religious traditions teach that saving one life is equivalent to saving the world. Arabic and Hebrew, both Semitic languages, also share the common linguistic trait of trilateral roots where, typically, three consonants form the basis of the roots. Words are constructed by adding vowels, prefixes, and suffixes. Similarities abound, as in the greeting for peace: Salaam in Arabic, Shalom in Hebrew. Both traditions extol the values of compassion; charity; justice; honesty; patience; responsibility; caring for the widow, orphan, and stranger; environmental stewardship, and modesty.

Historically, Muslims and Jews have coexisted, albeit not always harmoniously, in Morocco, Spain, Bosnia, Palestine, Israel, Iraq, Iran, and the United States. According to the Oxford Dictionary of the Middle Ages, the Spanish term, *convivencia*, "meaning coexistence or more literally 'living together,' has come to be associated with the complex interplay between religious, social, and cultural practices of Muslims, Christians, and Jews." Convivencia prevailed in Andalusian Spain for 700 years beginning in the year 711 CE and fueled the Golden Age of Jewish Culture under Muslim rule. Despite religious differences, Muslim rulers allowed the Jewish people to practice Judaism in their communities. Alongside their Muslim counterparts, Jewish philosophers, mathematicians, astronomers, poets, and rabbinical scholars contributed immeasurably to the advancement of human knowledge and art. Moses Maimonides, prominent and respected 12th Century rabbi, philosopher, astronomer, and physician from Cordoba, served as the personal physician of Saladin, the famed Sunni Muslim sultan of Egypt and Syria.

Many separate kingdoms existed in Spain, easily conquered by Muslim forces in the 8th Century. The Reconquista of Spain beginning in 722 CE by Christians lasted until the Alhambra decree of 1492 by the Catholic monarchy expelling the Jews and Muslims from Spain who refused to convert to Catholicism. Under the rule of King Ferdinand and Queen Isabella, the Spanish Inquisitors flushed out and tortured their non-compliant victims. Attempting to flee their pursuers, some sailed across the Atlantic to the New World. Others, the Crypto-Jews, outwardly exhibited signs of conversion while secretly retaining their Jewish practices, such as not eating pork, lighting candles on Friday night, and refraining from work on Shabbat. In some homes, the secret Jews even kept a *mezuzah*, the door ornament housing a small scroll on which are written two biblical passages, hidden in the foot of a porcelain Madonna by their doorway to remind them of their covenant with God. Throughout the succeeding generations grandmothers passed down the practices, though they had long been disconnected from their religious roots. Five hundred years later, the state historian of New Mexico, Dr. Stanley Hordes, who wrote his PhD dissertation on the Crypto-Jews and co-founded the Society for Crypto-Judaic Studies in 1990, revealed the long-kept secrets about Jewish ancestry in families that have been practicing Catholicism since the expulsion. Some descendants have reconverted to Judaism and one of them, Yosef Garcia, immersed himself in study, received rabbinic ordination, and in 2003 founded Congregation Avdey Torah Haya in Portland, Oregon, the first Crypto-Jewish congregation.

The long relationship of Jews and Muslims and the many commonalities they share in their values, practices, and teachings, have suffered with ongoing and escalating persecution, most notably since the terrorist attacks of September 11, 2001. The Global War on Terrorism initiated under the George W. Bush administration mainly targeted militant Islamist movements like Al-Qaeda and the Taliban. The resulting incarceration of nearly 800 persons in the United States military prison at Guantanamo, a holding place for "illegal enemy combatants," only fueled animosity. The voices of women could not be heard in the maelstrom that followed until after October 7, 2023.

Reporters from major media outlets such as NPR, Slate, The Guardian, and USA Today have sought out members of the Sisterhood of Salaam Shalom from New Jersey to Wisconsin to California for responses to the Hamas attack. On October 15th, Scott Detrow of NPR aired his interview with Jewish SOSS member Allyson Freedman, asking about her family and friends and the difficult conversations taking place. She said:

> *I would say that there's so much polarization right now. It's so hard to talk about these issues. I support people that are in pain...And I think it's very easy right now to say, I stand with Israel or I stand with Palestine and to not necessarily think about how complex these issues are and how you can stand with all people that are in danger, that are being killed, that are not - don't have the right, you know, to self-determination...I mean, there are so many things that are wrong right now. And so I've been having a lot of conversations where I have just been telling people to take a breath and...trying to re-humanize both Israelis and Palestinians.*

Pediatrician Dr. Lama Rimawi, who is Palestinian, and Rabbi Amy Eilberg, a Jew, met and learned each other's life story in the SOSS Palo Alto chapter and have become dear friends. Of their bonding, Rimawi said, "It was so important to see that other people had experienced not the same thing, but what we had experienced was very similar. It helped see the compassion for each other and see beyond the differences."

In November, 2023 they spoke to KQED journalist Brian Watt. During the interview titled, "'It is Possible to Love People and Disagree': For These Two Friends, Hard Conversations Are Key Right Now," the women acknowledged the obstacles they currently face. Yet, working toward peace remains their unifying goal. Watt asked, "How have you stayed friends during this conflict and the unfolding humanitarian crisis in Gaza?" They responded:

> *Rimawi: I think the vast majority of the world doesn't want innocent children to die. It doesn't matter where they come from or what religion they are. So I always hang on to that.*
>
> *Eilberg: Maybe a couple of days after Oct. 7, Lama wrote to all the women in our Sisterhood of Salaam Shalom chapter in this beautiful lyrical way that she had been looking at some pictures of some of the children, in particular, who had been attacked and whose families had been attacked. She invited us all to come to her house and to just talk and be together.*
> *I wasn't surprised that Lama reached out in that way, but I was so moved. It was just so beautiful. This is what peace looks like.*

Do relationships such as this one make a difference in the larger picture? All SOSS programming is based on the social psychology theory of change of contact and extended contact which suggests that greater interaction between members within and outside of groups lessens prejudice and enhances cross-group friendships. Indeed, a 2018 independent study of 405 SOSS members supports the theory, as participants reported "better inter-group attitudes,...more comfort with others, are more dedicated to speaking out against divisive rhetoric, are more committed to protect the stranger," and "perceive that they share much more in common than differences between groups." Further, nearly all of the research participants shared their positive attitudes towards Muslims and Jews with others outside the Sisterhood and invited them to get involved. While the events of October 7th have stressed the chapters, some beyond their capacity to remain intact, others have deepened their commitment and resolve to strengthen their bonds and partner with other peace activists and organizations.

Aziz Abu Sarah, the tour guide and co-founder of MEJDI Tours, sharing his harrowing experiences of being detained and strip searched at an airport, and his colleague Elad Vazana, who found himself with a cancelled flight home to his Israeli family right before the High Holy Days, are more determined than ever to pursue peace. Aziz travels globally spreading his message of using tourism to break down barriers and build genuine relationships across differences. He has shared his story on the TED stage, has been interviewed by numerous broadcast and print journalists, and has had an audience with Pope Francis, ending it intentionally with a hug that was caught on camera. Elad, invited to speak to The Nantucket Project at its September 2024 gathering of 500 selected influencers who can afford the $10,000 registration fee, wrote this after his talk:

> *I had 15 minutes and I felt people are deeply touched. I got amazing feedback. My main message was that we need a new story:* ***From the river to the sea Palestinians and Israelis can be safe and free.*** *In the end I asked them not to clap. Instead, to stand in silence and choose a person from the region (Gaza, Israel, the West Bank, Lebanon, other) and be now with this person. Then after one minute of silence I asked them to share about this person with the people around them. It was very powerful.*

The players in the current conflict and the media reporting on it appear stuck in a binary view: one side is right, the other wrong -or- a two-state solution is the answer. The truth is, the answer is not known. What is known is that Palestinians and Israelis have a long, fraught story and both have legitimate claims to the Holy Land. Trying to divide it into two separate parts would only continue the strife that threatens all the inhabitants far into the future.

Elad's unusual approach exemplifies working through a process to get to a new story. Couples' therapist and esteemed elder Hedy Schleifer, a Jewish woman who was conceived during the Holocaust to parents who escaped from a concentration camp, offered this inspiring teaching about solving problems she learned from her father: "When you see only two options, pick the third." The third option, she explained, is the one you don't yet know or can't yet imagine. Citing the work of Otto Scharmer, senior lecturer at Massachusetts Institute of

Technology and co-founder of the Presencing Institute and its u-school for Transformation, Hedy shares Scharmer's method of "learning from the emerging future." In other words, if one imagines a problem sitting atop one arm of the "U," problem solvers typically want to jump to the top of the other arm of the "U" with a quick solution, without going through a process that involves delving down into the challenging emotions residing at the bottom before the emergent future begins to reveal itself. Only then can a solution, the third option, become apparent.

Upon Reflection…

This article is intended to raise awareness and generate new possibilities in the quest toward human rights for all. I am a woman of faith who believes each of us is unique and has talents, attributes, and skills to offer towards repairing the broken places in our world. This is the challenge each of us faces to make meaning of our limited time on Earth, the place where each of us makes our temporary home, and to take responsibility for the damage we humans have wrought upon her. I am moved to use my unique gifts to engage joyfully in the process towards peaceful coexistence of all beings on Earth and encourage you who are reading this to identify and similarly use yours.

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Atiya Aftab, Esq., September 4, 2024, via Zoom.

Roberta Elliott, Executive Director of the Sisterhood of Salaam Shalom, September 4, 2024, via Zoom.

Cheryl Olitzky, September 11, 2024, by phone.

Hedy Schleifer, September 19, 2024, in person, Seville, Spain.

Aziz Abu Sarah and Elad Vazana, September 22, 2024, in person, Cordoba, Spain.

Elad Vazana, September 29, 2024, text message via What's App.

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The Influence of Russia's Feminist Antiwar Resistance to Putin's Impact on the War in Ukraine

Frederick M. Burkle, Jr., MD, MPH, DTM, PhD (Hon.), FACEP, FAAP
Global Scholar
Woodrow Wilson International Center for Scholars
Washington, DC
Captain (MC) USNR (Ret)
Institute of Medicine, National Academy of Medicine: Elected '07
Tel: (808) 262-2098
Email: Skipmd77@aol.com

Amir Khorram-Manesh, MD, PhD
Department of Surgery, Institute of Clinical Sciences.
Gothenburg Emergency Medicine Research Group
Sahlgrenska Academy, Gothenburg University
41345 Gothenburg, Sweden
Email: amir.khorram-manesh@surgery.gu.se

Author Note

This article is based on the authors' research about abusive antisocial personality, especially in current dictators. Both authors have experience in both psychiatry and war. The first author is, among others, a specialist in psychiatry.

Abstract

Sociopathic leadership may not only result in domestic oppression but also in international conflicts, affecting civilian lives internally and globally. In this article, the authors inform the consequences of such Russian-led leadership in previous wars and conflicts to those involved in the current war in Ukraine focusing on the unique and persistent Russian female civilian-led organized opposition to the war.

Keywords: Ukraine, anti-war, conflict, narcissism, resistance, war

Introduction

Since February 2022, the Russian invasion of Ukraine has resulted in over 23,000 civilian, 120,000 Ukrainian military, and 200,000 Russian military casualties (Remondelli et al., 2023). Additionally, hundreds of thousands have left Russia. Although most Russians may report that little has changed in the tenor of the country despite the imposed international sanctions, sanctions have affected prices and left people with no freedom of speech or information-sharing with nothing but silence, making it impossible to tell if people are being honest. Many Russians chose to stay away from politics and let the Kremlin decide for them, further acknowledging that "most ordinary Russians are in the middle, trying to make sense of a situation they didn't choose, don't understand, and feel powerless to change" (Goryanov, 2023).

However, in February 2020, the beginning of the war, after President Vladimir Putin announced a "special operation" against the neighboring sovereign state of Ukraine, the Feminist Anti-war Resistance (FAR) launched the" first and one of the largest pacifist movements through a manifesto that reads: "Russian citizens and feminists, we condemn this war. Feminism as a political force cannot be on the side of the war of aggression and military occupation." (Koltsova, 2022; Europe Solidaire Sans Frontieres, 2022). The FAR authors emphasize that the Russian history of cult-like support and admiration of their leaders has resulted in a current "ruthless hyper-masculine image" of which Putin is now seen as the "epitome." The FAR coordinator's response was to endorse that "war crimes are occurring in Ukraine, domestic abuse has been decriminalized, and policemen have a license to torture and beat their fellow citizens." Citizens can even be imprisoned just for discussing the war (Koltsova, 2022; Kirby, 2022).

A few may know that there is a long tradition, dating from World War I, of female activists and others in opposition to war in Russia. An opposition that was shared with many other countries, resulting in the Hague Women's Peace Conference with worldwide attendance. Similar feminist groups sprang up across nations to demonstrate against nuclear weapons. Fewer in Western countries are aware of the history of the Committee of Soldiers' Mothers of Russia (CSMR) and their efforts, through activism, to mitigate and trace the mother's organized response to both the loss of their sons as well as the purposeful violence they endured and were subject to (Elkner, 2004). It was especially evident in the reign of Gorbachev, beginning in 1985 when the CSMR helped expose to the public the "widespread systems of informed power hierarchies that operated in Soviet barracks and the associated violence in which senior conscripts bullied and victimized recruits." (Elkner, 2004). Over the decades significant resistance has grown against Russian militarism catalyzed by a feminist dissident group in 1980 that has since demonstrated first condemning the war in Afghanistan in 1980 and again as a "Feminism led political force" demanding military reform and resistance to the First Chechen War in the 1990s (Talaver, 2023).

In responding to the war in Chechnya, CSMR, which had experience in rehabilitation, responded to the soldiers leaving for health reasons. As in the past, the mothers-led organization "expanded and diversified to include human rights education, especially human rights violations, including non-violent public protests and prevention of anti-democratic changes in the Russian military legislation that fought against involuntary conscription (Right Livelihood, 2023). The formation of such a powerful group of mothers and women originates from the Russian long history of developing permanent female gender roles that are anti-masculinity in both war and household responsibilities, clarifying Russia´s history of "cult-like support for the military and admiration of leaders who project a ruthless hyper-masculine image." Meanwhile, Russia has also a history of high domestic violence problems with little support for women trying to flee these relationships (Europe Solidaire Sans Frontieres, 2023). These factors together with both psychological and physical impacts have been highlighted in Russian society, resulting in strong female organizations, e.g., CSMR with strong opposition to war and violence (Stewart & Robinson, 1998).

Addressing the Current War in Ukraine

Fast forward to the war in Ukraine. Thousands of Russian soldiers have been conscripted and over 300,000 reservists were called up to fight the declared "special operation," denying it a war status. This prompted a meeting between President Putin and the powerful CSMR on Mother's Day November 27, 2022. While Putin organized the meeting to be surrounded by supporters, he was faced with accusations by FAR of seeding the audience with those strongly faithful to the war. In a video later circulated widely, the FAR President asked Putin "Do you have the courage to look us in the eye, not with hand-picked women and mothers in your pocket, but with real women, who have traveled from various cities here to meet with you?" The FAR women publicly sought to "quell fears about the poor treatment, inadequate training, and other dangers faced by Russian Troops." Criticisms ran high. Veteran soldiers' rights activists had previously reported that they expected that the Kremlin would handpick--or even fake--its roster of soldiers' mothers for the event to prevent a scandal from unfolding. In this meeting, all responsible reports suggest that Putin simply chose women with proven pro-Kremlin bona fides who would not challenge the Russian president over the war (Roth & Sauer, 2023).

One cannot deny the power of the decisions made by "Mothers" and their often-visible citizen support. As retired veterans of war and conflict, we are not immune to the struggles these organizations must face to have their voices heard. Thus, being a voice for these women, we should tell the mothers, sisters, and wives of deployed Russian soldiers to Ukraine, "We sincerely feel your pain and anxiety. As professional experts on sociopathic leaders, we have witnessed global wars and conflicts led by so many autocrats since the end of World War II. Vladimir Putin is one of those despots, currently probably the most terrifying dictator in the world (Burkle, 2016). You deserve to know how and why Putin is driven to rule, how far he will go to maintain power, and how he longs to take control of other nations. All sons, husbands, and brothers are among many who will be victimized to satisfy Putin's obsessions. While he claims to be a savior or patriot, his final psychological framework differs little from those tyrants responsible for World War II and the Cold War that followed (Khorram-Manesh & Burkle, 2022).

Putin's Impact

Readers should better understand why sociopathic leaders exist and, importantly, why they are incapable of change or mediation, factors inherent in a narcissistic sociopath's behavior. Unfortunately, a certain percentage of the global population can be identified with unique, often troublesome, and yet poorly understood personality characteristics early on in their lives. During normal childhood, children learn to experience personal anxiety, doubt, shame, depression, guilt, etc., and establish both age-appropriate neurologically and socially beneficial developmental tasks, resulting in a healthy curiosity, critical reflection, perception, sound judgment, and foundations of ethics, morality, and empathy. However, the absence of such development results in narcissism, deteriorated ego, and immaturity in a certain portion of the young population. You may only know of their presence as a subset of the population who are driven to seek the ultimate opportunity to control, dictate, and live out their fantasies of power on the world stage. Their attempt to control others, whether they be individuals or countries who challenge them, most always culminates in violence. The dictator's continued antisocial presence, influence, and the levels of violence they unleash must be seen as a global security issue. Unfortunately, this issue is not amenable to any conventional diplomatic intervention, negotiation, or international sanctions. All of you have witnessed this fact for months, if not the entire two decades of President Putin's rule (Burkle, 2016; Khorram-Manesh & Burkle, 2022).

You should know that the traits displayed by such individuals are not that of a mental illness but of discernible character disorders beginning at a young age with socially undesirable behavior, poor control of impulses, and an inability to maintain emotional relationships, especially in marriage. Such individuals also display the absence of anxiety or guilt. Prominent is an inflated sense of self-importance, a need for constant attention, an expectation of special treatment, exaggerating achievements, being intolerant of criticism, and obsession with power (Burkle, 2015). This "narcissism" is further distinguished by excessive admiration for oneself, selfishness, a sense of entitlement, lack of empathy for others, need for constant admiration, and self-centeredness that fails to distinguish or consider the needs of others.

You should know that the discernable character disorder you have witnessed with Putin is not a mental illness. His narcissism drives him to think only of himself. The protracted conflict in Ukraine ensures a political impasse that results in ever more persecution, violence, destruction, fleeing refugee populations, and death (Khorram-Manesh & Burkle, 2022; Khorram-Manesh & Burkle, 2023). Putin's narcissistic sociopathy is playing out on the world stage for everyone to ponder. Strong sociopaths such as Putin can transfer their "logic" onto an unaware population. It is the reason he met with you publicly to make his case: You are sacrificing your loved ones for him, not for Russia. We are all easily impressed and fooled by a narcissist's impassioned dictates, and either we collectively feel powerless to do anything to prevent his obsessions, or we are frightened by the consequences of challenging the leader's constant demand for power.

Only the masses of his victims and potential targets hold the key to demanding a collective cessation of his malignant behavior. The Soldier's Mothers of Russia is a critical start, and the base of resistance remains. One recent report reveals that some of these unexpected protestors were once Putin supporters; others still believe the war in Ukraine is a just one and want their men to come home (Sauer, 2024). Although severely stifled it speaks for the mothers, sisters, and wives of soldiers in the war in Ukraine.

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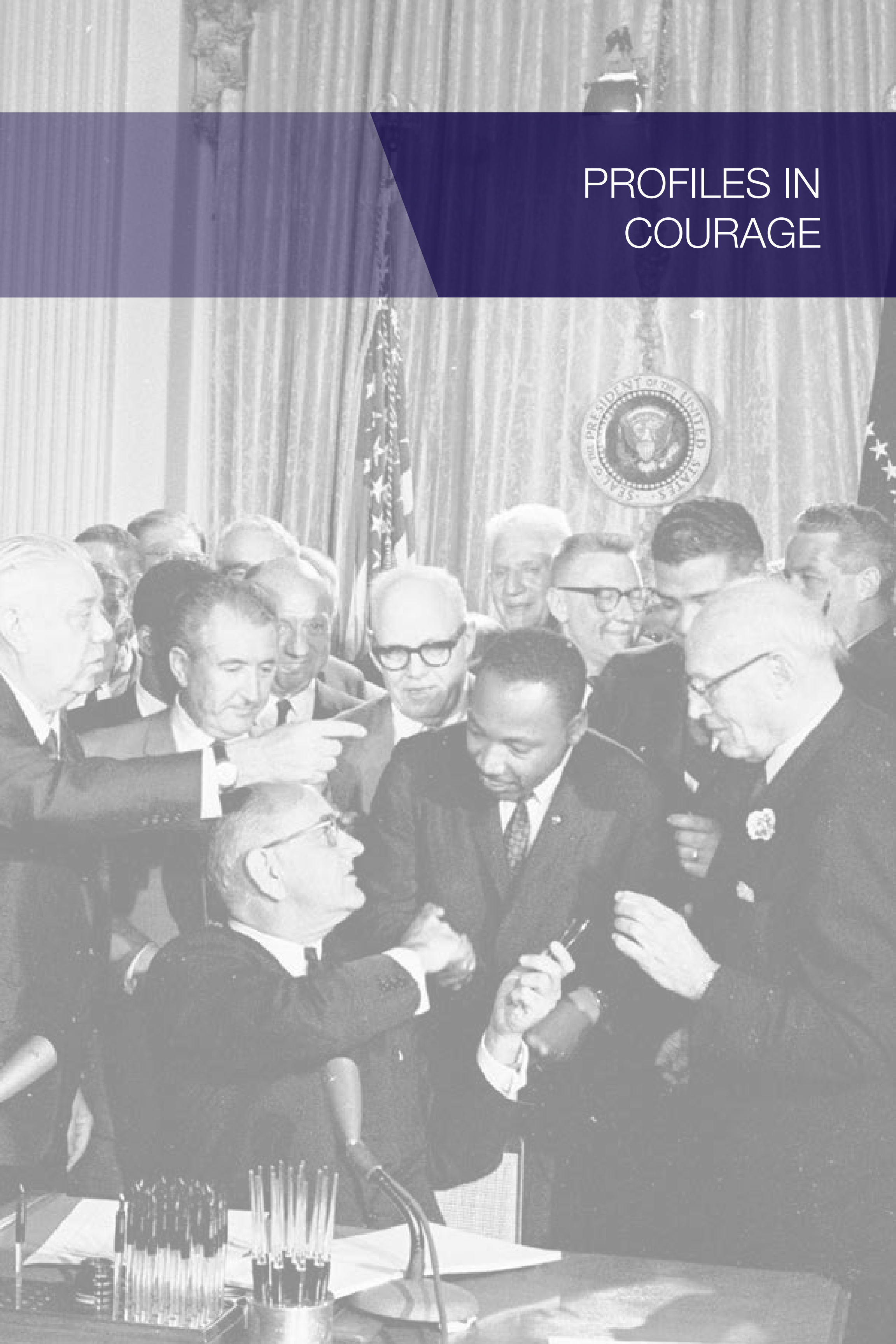
PROFILES IN COURAGE



Removing the Mask:
A Marine's Courageous Life Journey

Jan K. Herman, MA
Historian of Navy Medicine (ret.)
Tel: (202) 431-6901
Email: histguy45@yahoo.com

I had just run the San Diego Half-Marathon in January 2002 and was about to run the Los Angeles Marathon in March. On Wednesday, February 20, I left the Camp Pendleton base for the day and was driving home. As I entered I-5, I pulled alongside a semi speeding south in the second lane. A driver in a black Jetta sped past the other side of the truck. I was unaware of the driver's actions until he suddenly crossed four lanes of traffic to barely catch his exit. The truck swerved to miss him. My reflexes weren't as fast though. Imagine being in the slow lane and a semi suddenly swerves to close in on you, and you've got nowhere to go. I tried to evade the collision, causing my Mustang to spin out like the whip ride at an amusement park, then flipping three times before landing on its roof. What actually happened in a matter of seconds still plays out in agonizing slow motion in my mind as I recalled regaining consciousness on the day everything changed.

Opening Reflection from Sherman Gillums
Spring 2023 Interview

Introduction

Sherman Gillums, Jr., was born in Bay Village, Ohio, in 1972, shortly after which his family moved to Buffalo, New York. Tragedy struck the Gillums family when Sherman's father, who was in the U.S. Army at the time, was fatally shot by a rookie police officer during the height of racial tensions in the early 1970s. "He died when I was a baby, so I never got to meet him. Thankfully, though, I was named after him."

Sherman's mother raised him, aided by his maternal grandfather, a Korean War veteran. His grandfather became the boy's father figure. Sherman recalls a hard-working, middle-class upbringing during most of his youth. After graduating from high school, he recalled, "I didn't want to burden my mom with paying for a college education. I was also determined to join the Marine Corps."

Sherman Gillums, Jr., USMC

At age 17, he did just that. Because he was underage, his mother had to sign the paperwork for him to undergo the initial screening at the local recruiting office in downtown Buffalo.

"Next thing I knew, I was on a plane to Savannah, Georgia, with nothing but a pair of black jeans and a shirt with five dollars in my pocket that my mom had slipped to me. It was likely that five dollars was all she had at that time. Beyond that, I didn't really have time to say goodbye to anybody. After that flight and being greeted by a couple of serious looking Marines at the airport in Savannah, I found myself on a bus taking a quiet ride to Parris Island, South Carolina, in the dead of night."

While the three months of boot camp seemed like an eternity, in retrospect, it flew by for Sherman. Before he knew it, his senior drill instructor was dismissing his platoon on the field as his mom sat in the stands waiting to see her oldest son in dress blues. After graduating from boot camp, Sherman was assigned to Marine Corps Air Station, Cherry Point, North Carolina, as a crash photographer. It seemed a good fit for the young Marine who had taken high school classes in photography.

But the images he would capture as a Marine were of the investigatory type, a far cry from taking candid shots of his classmates for the yearbook. He found the duty challenging but, at the same time, it could be emotionally grueling. During the day he photographed the tragic and immediate aftermath of fatal jet crashes on the airfield or in the middle of the Atlantic. On-call at night, Sherman found himself documenting a victim of domestic violence or an autopsy.

"As an impressionable 18-year-old, I was often looking at the underbelly of society through the lens of my 35mm Nikon at the Cherry Point community. I was seeing all the terrible things people were doing to each other, such as child abuse and spouse killings. Or I'd be in a van with the chaplain and the on-scene commander discussing how they would notify the wife of a pilot who had just crashed on the flight line. These images defined my early experience and have stayed with me ever since."

After serving another three years as a photographer, he was deployed to Japan to serve on humanitarian missions in response to the Kobe earthquake in January 1995 and during the military exercises called "Operation Tandem Thrust" in March 1997. "That was the first time I'd ever seen a Humvee and what it could do on rough terrain."

Sherman was subsequently assigned to Drill Instructor duty at Marine Corps Recruit Depot Parris Island where he had once been a recruit. Going from being a photographer back to boot camp as a drill instructor was an ironic and jarring experience.

"I got to re-create all the things that had happened to me seven years prior, but this time the roles had been reversed. I was now charged with making Marines instead of being made."

Typically, a drill instructor would be older with much more experience in the Corps. Even as a fairly senior sergeant by that point, Sherman was still in his early 20s.

By his fifth training platoon, he was a senior drill instructor with the rank of sergeant, which was rare. He was meritoriously promoted to the rank of staff sergeant and recognized as "Battalion Drill Instructor of the Year" in 1999. Soon thereafter, now 10 years as a Marine, Sherman was appointed a warrant officer and assigned to The Basic School (TBS) at Marine Corps Base in Quantico, Virginia, for training as an officer. After graduating from The Basic

School, he was later assigned to head the Combat Visual Information Center at Camp Pendleton, first as Deputy Director before being entrusted with the role of Director, a major's billet.

In 2001, a year into his assignment, he was hand-selected by Colonel Lee Farmer, the base's Chief of Staff, to head the Marine Corps' new Martial Arts Program. But first, Sherman needed to earn the fighting system's highest designation: Marine Corps Martial Arts Instructor-Trainer. While training at Quantico, he endured the daily rigors of the program: water grappling, bull-in-the-ring cohesion drills, ground fighting, and weapons handing. He had to perform all these exercises with a full combat load, in extreme climate conditions, and during the occasional pepper spray drill. This school prepared instructor-trainers before sending them out to teach other Marines the full complement of fighting skills they had learned. Sherman described it as one of the most rigorous, physically challenging training programs in the Corps.

"We fought all day like our lives depended on it, which is how Marines train and prepare themselves for the worst--on land or in water, with or without weapons, injured or healthy. No excuses. No surrender. One mind. Any weapon."

Sherman pointed out that the course was not limited to learning fighting techniques. The course also taught a core value system as being foundational to how Marines fight.

"A well-trained Marine also had to have a moral center that had been refined and tested to a point where one wouldn't recklessly use this acquired ability to become dangerous to society."

Once he graduated, Sherman Gillums, the drill instructor turned newly minted warrant officer, had now become an MCMAP [Marine Corps Martial Arts Program] instructor-trainer. He was the ideal image of a proud Marine--well-trained, physically imposing, and more than ready to teach the martial arts skills. He had bestowed these proficiencies upon every Marine assigned to his course at Camp Pendleton. His fighting skills and prowess would come in handy in a way he had never imagined.

On February 20, 2002, the car crash, which nearly killed him, would prematurely end his still-young Marine Corps career. In the interview that follows, which I conducted in 2023, Sherman describes the aftermath of that day and the improbable journey he has since embarked upon.

Clinging to Hope

What do you remember following that horrific crash?

When I first regained consciousness in the car, I noticed the airbags pointed to the sky. I'd never seen an airbag deployed before. I didn't even realize I had been in an accident. I wondered why those airbags were pointing upward.

I looked out the window at the beautiful blue San Diego sky. While lying upside down, I heard someone say, "Stop moving!" According to my medical records, I gave my rescuers all my personal information. I told them who I was and who to contact. But I don't remember any of it, including when the so-called "jaws of life" carved me out of the car and then I was medevaced to Scripps Memorial [Hospital La Jolla] for emergency surgery.

When I woke up, three days had passed. I knew something was wrong when I was coming to. I was on my back looking at the ceiling in the dark and could hear something breathing next to me. I didn't know what it was. I didn't realize it was me until I tried to take a breath, and then the machine kicked in and forced me to slow my breathing. I felt like I was drowning and being sucked in by the machine that was trying to kill me. I panicked but was paralyzed and couldn't call for help. A male nurse walked by and I tried to yell--but couldn't talk. I was intubated and on a ventilator. And then I passed out.

At some point, a doctor came in and explained what had happened. He said that I was in a car accident and that I had broken my cervical spine. At the time, I didn't understand what had been broken, but later I learned my spinal cord was damaged around C-3, C-4 [cervical vertebrae]. For those first few months, I was in what's called "spinal shock" with no movement or feeling below my neck.

Did the doctor offer a prognosis?

When they tell you about your prognosis in percentages, you always go to that 3 percent that says you'll walk again. You never look at the 97 percent. So I thought I'd be at the 3 percent clinging to hope like most people in that situation. Compared to most people, though, I didn't feel that bad off. My face wasn't damaged and I hadn't broken any bones except those on my vertebrae. It was just that one whiplash moment. But I was in marathon shape, I thought, and that may have spared me in this accident. I had a few bits of glass in my forehead and a broken neck. That's it.

How long were you in the hospital?

I was in Scripps for 12 days. They'd sit me up and I'd pass out because all the blood would rush to my feet. My body was wrapped like a mummy. Because I was having spasticity, which is involuntary movement, they couldn't actually tell if it was voluntary or involuntary movement. Frankly, neither could I so I'd tell myself it was a good sign that I'd be in that three percent. In my head I was telling myself that I was okay.

Then they moved me to the spinal injury unit at Naval Medical Center San Diego, adjacent to Balboa Park. That's where I wanted to go rather than the San Diego VA Hospital, which I thought was for the old guys, the old veterans. I was evaluated at Balboa and it turned out to be the wrong place. But that was to be my home for the next six months, a place where I felt safest, or so I thought. I felt like a fetus in the womb who had evolved and come out to begin learning all over again how to perform every daily function. These functions ranged from how to use the bathroom to how to feed myself--and everything else in between. My body was now a foreign thing to me, which included my imagination.

The very first dream I had added to the misery. I was in a wheelchair coming upon the crest of a hill and began to roll down the hill in sort of free-fall fashion. As I picked up speed, the chair tumbled. As I jumped from the chair, I began to run with my legs, like I'd done just months before. The dream would recur around four or five in the morning just as the sun was coming up. I'd wake up and wonder whether or not I was waking up from a nightmare where I'd become paralyzed but was okay in reality. Or was I living the nightmare and the dream of me walking was a fantasy? With the shock, the painkillers, and the hope I held onto, my mind felt beyond my control, consciously and subconsciously.

I was confined to a hospital bed for the first seven weeks in a Philadelphia collar to prevent rebreaking the fracture as it healed from spine fusion surgery. During those weeks, I couldn't move, couldn't shave, and with all the medication, I was out for most of the day. And I would have the same dream and same routine over and over again. And when I woke up, I wanted to go back to sleep so I could repeat the pleasant part of the dream, the part where I felt myself running, but I couldn't. After three months of clinging to hope, I finally began to turn the page.

Emerging from the Womb--Again

What did "turn the page" mean for you?

If you don't start rehabbing hard now, I thought, it's going to be harder for me later. That meant getting with the program, starting with learning how to get around in a wheelchair, like it or not.

It got much easier after I met Mark Cordova. He had broken his neck early in training as a Marine. He and I had the same level of injury. And although he was still in a wheelchair years later, he was just living life like there was no tomorrow. Mark gave me a different perspective. I began asking him a ton of questions. How do you do this? How do you do that? And he told me all the ways he got through each day living by himself. I think that was it. If I have to be in this chair as long as Mark, I figured at least I want to be doing what he's doing. I have no excuses for not doing it. He had been injured a lot longer than I had. But he looked so powerful because he could do all those strenuous activities on his own--and living alone in his own house.

What was he able to do?

We'd go off to the physical rehab gym that had a big mat raised about two feet off the floor. Because he and I were about the same level of injury, I couldn't envision how I could put on a pair of pants until he did it. There was just no way I could even imagine it until Mark got on the mat and put on his pants. That process seems so small in the grand scheme of life. But he sat there and put on his pants! Once I saw him do it, it made sense. But I assumed there's no way he could put on his shirt. But again he showed me the way when I thought there was none.

The most terrifying thought I had in those days was falling out of my wheelchair and hitting the ground. He told me, "If you fall out of your chair, there is a way you can get back in it."

Even after seeing him dress himself unassisted, I still thought there was no way that was possible. That was just too much. Then he did the most amazing thing. Then he did what good Marines do. He gave the odds the middle finger and showed me how to get up off the floor and get back into his wheelchair. It seemed to take him forever but he did it. And that was the real turning point for me. After I fall, if I could look up, then I could get back up every time, no matter what. And that's how I've been living my life ever since, literally and figuratively.

Would you say that Mark was the inspiration which turned your life around?

Yes. The saying is true about never give up because you never know who's watching. Because we were so much alike, he showed me the way out of my situation by allowing me to picture myself in his situation, such as putting on pants, putting on a shirt, and getting up off the floor and back into the wheelchair. Those three accomplishments meant everything to me, including the freedom to live on my own terms.

From that point on, would you say your rehabilitation had completely changed?

Yes, but only in the hospital. There are other chapters. Now I've got to do this out in the world. And that was a lot different. Now I'd be walking the high wire without the net. You've been birthed out of the womb and protected as an infant. Mom's still there but she's not feeding you. You have to eat on your own. When I got to my first apartment downstairs where I had lived before, that first night at home I lived in terror. I wondered what would happen if I did anything reckless and nobody was there to help me. I can be okay with that as long as I can just sit in my apartment and watch TV all day and not do anything because there was too much risk.

I had a caregiver assigned to me. She was with me the whole time I was in San Diego, about 10 years. But it was hard to be around me. I wasn't happy about needing a caregiver. I didn't talk to her and just waited for her to leave. I'd leave notes about where to put items. I criticized every little thing she did, like the way the pitchers were positioned in the refrigerator or the way the utensils were arranged in the drawers. I'd have to spend hours to will myself to turn the pitcher to get the water or lift a spoon out to eat something. Little things like that. Something could be off just an inch, and it would change the course of my entire ability to drink or eat. Even the way the TV remote was turned made a difference, affecting my ability to vegetate while watching ESPN or C-SPAN literally all day and night.

In those early days I learned to be a problem-solver in the broader scheme. Problem-solving became very important because every little thing mattered in order to make something happen. I'd spend hours obsessing over problems. I'd have to think ahead as if I were playing chess, like thinking every move in anticipation of the next 10 moves I'd have to make depending on what happened.

As you pointed out earlier, it was as if you were an infant and had to learn everything all over again.

Yes, I'd become an entirely new person. Looking in the mirror was hard because I didn't recognize the person I had become. When I was at the San Diego VA Medical Center [renamed the Jennifer Moreno Department of Veterans Affairs Medical Center in 2022], I was working with the occupational therapist to learn how to shave again. I remember the nurse rolling me into the bathroom. Above the sink was a mirror. When I looked up, I was severely emaciated in just a few weeks. I went from being a 190-pound marathon-ready Marine to someone who looked like he had been in a refugee camp without food for a long time. I felt like the guy in the mirror was a stranger. It was terrible. There was no way that that reflection was me. It was as though I was looking through a window instead of a mirror.

My mind was working to normalize my life in a way that wasn't healthy, but it's what I needed in that moment. I didn't need to see me as that person who wouldn't be worth working hard to rehabilitate. I needed to see me as that person I was, the person I remember. But it would take me some time before figuring out how to cope with it.

How long did the rehab process take until you were able to feel comfortable functioning by yourself ?

About two years--six or seven months as a patient and the rest of the time as an out-patient. The DAV [Disabled American Veterans] would pick me up in a lift van every week. They would send a social worker to my house. Their presence in my life became like an umbilical cord to the safety of the distant hospital. I decided to talk to a psychologist and that was the change--the tipping point for everything.

Journey of Recovery

How did that psychologist change you?

The war in Afghanistan [2001-2021] had been going on and the war in Iraq [2003-2011] had started. Young men were coming back to the spinal cord injury unit with paralysis, brain injuries, gunshot wounds, and severe PTSD. I began to see what wounded warriors looked like fresh off the battlefield. They would come to the VA right from Walter Reed [now Walter Reed National Military Medical Center]. Their mentality was similar but different from mine. I was paralyzed but I hadn't been shot or blown up. You could almost see the emptiness and loss of hope. Some had families that hung in there. Others who had spouses would tap out and leave. And I felt really bad about that.

Maybe it was a version of survivor's guilt because I was not injured in combat. Later on, I was thankful for that. Up to that point, I thought I wanted to be war-wounded, not some car crash victim. But the best way to honor those who had been wounded was not to fetishize it to a point that made it about me. It wasn't about me. It wasn't about the glory. It was about finding another way to give my life purpose.

So as I continued my own journey of recovery, I began to write stories about these men. Trying to find meaning in what had happened to them. The more I heard the details, the more I wanted society to respect these men--and respect their families for what they had endured. I didn't always see that respect happen. Society loved the troops at ballgames and concerts. But the day-to-day plight of veterans who had become antisocial and angry left many being treated like outcasts in the democracy they had given so much to defend. Eventually, I felt useless just writing stories. As the death toll rose in Iraq and Afghanistan, I felt even more useless as an American citizen who had once worn the uniform.

I had become ashamed of my identity and I'll tell you why. Everywhere I went, people saw me in my wheelchair. And all I heard was, "Thank you for your service." "We love you, sir." "God bless the troops." I would tell them, "I was in a car accident." I just got tired of saying it over and over again--as if all they wanted to do was immerse themselves into the lives of those men I saw--but through me. They didn't care about me. They cared about how I made them feel by the perceived proximity to real heroes--not athletes or celebrities. The heroes were those who had responded to the attacks on 9/11. They were our version of the "Greatest Generation" after Pearl Harbor. A hero I was not. And I had to find a way to be okay with that despite what was happening around me.

That didn't happen until I went to a veterans' support group facilitated by a psychologist. The first time I attended, I encountered a bunch of veterans talking about how bad their lives were. I was experiencing the same feelings they were going through, but I had my "mask" on and wasn't ready to talk. When the facilitator arrived, we started the session with a depression screening questionnaire. We had to check boxes that indicated whether we had characteristic features of depression. I checked almost every single indicator of depression. I asked the doctor what that meant. She said that we should set up an appointment and talk. It was at that point that the mask came off. She diagnosed me with depression and anxiety, and I was able to open up to her. More importantly, she helped me realize that it was okay to forgive the person I had to be when I was in survival mode. But most of all, she reinforced the idea that my life was meant to be lived, not survived.

She sent me to a psychiatrist who prescribed an antidepressant, which I took only for about a month. It was very scary because suddenly everything looked brighter and more hopeful. It was frightening because this happened so fast and it didn't feel real. I wondered what the drug was doing to my brain. After a month, I went back to my psychologist and she talked me into staying on this antidepressant, even though I don't like taking medicine in general. But with the treatment, I felt I could be doing other things besides sitting at home and maybe not needing that med. In fact, I got my first job with the Paralyzed Veterans of America [PVA] later that month. The position was as a service officer at the PVA office in Mission Valley, north of San Diego. And that started a whole new chapter of my life.

Were you still in the Marines at this point or had you been retired?

When a service member suffers an injury, it is not always immediately clear what the outcome will be. In those instances, the military places the service member on the Temporary Disability Retired List [TDRL]. You have to go back every 18 months to be evaluated to determine what your status is and whether you will be retained. I had a DD-214 [discharge document] issued to me pretty early on so I thought I was retired. My DD-214 indicated that I was in TDRL status, but I didn't know what that status was and no one explained it to me. But a few years later, I got a document signed by President [George W.] Bush along with a retiree pin and final orders moving me into the PDRL [Permanent Disability Retired List] or permanent retirement. By that point, I had been in the Marines for 12 years.

By the time you got your job with the PVA, had you been rehabilitated to the point where you could function fairly well?

I was wearing suits, writing arguments on behalf of veterans, and got good at handling disability and medical malpractice claims. By then I had studied spinal cord injuries so much that I could help prosecute tort claims and lawsuits, like an attorney, on behalf of claimants. So I was winning cases in San Diego for a few years until I decided to go back to school. I enrolled at the University of San Diego School of Business and got my masters degree in business. I did that while still working at the PVA.

I think the real key to my comeback was getting back behind the wheel and driving. For me, that ability to drive was the final frontier I had to conquer. I was all in. I could go anywhere and take those kinds of chances just to see if I could do it. That was what my life had become from 2004 until 2009 or so. I continued to hang out with Mark and a few other guys who had been injured in car accidents. I learned that most veterans who are paralyzed are not combat injuries but mostly stateside car accidents. That's one reason why veterans find membership in PVA. The guys I hung out with had the same injuries as I did and we created a brotherhood.

The desire to beat each of our catastrophic disabilities was our shared goal. A real turning point was when I went skiing twice with a couple of veterans' organizations. We went to Big Bear Lake in California and to Aspen, Colorado. I saw so many veterans with missing limbs, paralysis, traumatic brain injuries--living like people who had everything to live for. And they did indeed. That really opened it up for me. I truly had no more excuses after that revelatory experience.

Did seeing people, who may have been worse off than you, make you feel even more functional?

I'll tell you what made me feel most functional. I saw people who were less worse off and couldn't function. They were people with full bodily function but suffered severe mental illness. That's when I started to see the divisions and subdivisions in the veterans' community because we were seeing folks who could kind of walk but couldn't care for themselves. I think it was because they weren't given the same level of sympathy that we were given. If you could walk with a cane, that was almost worse than using a wheelchair. You still had that sort of gimpy gait, and it looked different than if you were pushed in a wheelchair. You're still a veteran but you weren't a wounded warrior, as seen in the minds of many who wanted to touch a hero.

I sought to confront that problem as a leader in an organization that could speak with authority as to what these men and women--of all walks in life--were going through. And because I was in a wheelchair myself, I started to see it as a veritable "seat of power" where I was still standing in my own way. I was "standing" with others who shared my plight, and that awareness gave us strength in numbers.

I think the reason for fewer suicides among paralyzed veterans is because they get the care and sustained support early. I would find that this early care and support is important to note for anyone with a disability, especially at a very young age.

Veterans' Advocate

Had you gotten your degree from the University of San Diego by this time?

I told PVA that I couldn't come to Washington until I finished the degree program. I left once I got my graduate degree from the University of San Diego School of Business. When I arrived in Washington in 2010, I began arguing cases before veterans' law judges at the Board of Veterans Appeals. Some of these cases could potentially end up at the U.S. Supreme Court. Those complex medical cases were my forte so that's where I distinguished myself. I wasn't a lawyer--but I did represent people legally before the VA. That was the closest I'd ever come to being an attorney, which for some time had been my goal.

It seems that you were really enjoying this aspect of your job. You were advocating for veterans. And here were vets who have thus far been unsuccessful with getting their VA benefits. Were you advocating on their behalf and getting them what they had earned and deserved?

It was so gratifying because these were cases that had been around for a long, long time. At the time, the backlog was so bad. There were all these ways that the system was caving in at the expense of veterans. I saw so many boxes on shelves that were breaking under the weight. When I came in, I asked for the oldest cases first, and I wanted to work my way to the newest ones. A lot of times, the oldest cases were ones that had been denied and re-appealed. Some were so complicated that people just didn't want to deal with them. I remember one claim that went on for seven years because of a misspelled name. Eventually, we won her case, but the case had dragged on for so long that by then the veteran had moved to the Far East so she could totally detach from society. I don't recall if she ever got the money she was due.

I had become the Associate Executive Director of Veterans Benefits, the biggest department in PVA at that time. That was in 2011. I was in that job for three and a half years. It was a job that I coveted because I never thought I would get it. I thought that would be the height of success because I love this work. It was at a time when a lot of change was happening. I was the first veteran of that era to be in a senior leadership position. All the others were of the Vietnam or peacetime era.

I was able to bring a different kind of face to the scene. All the other organizations--the DAV [Disabled American Veterans]) AMVETS [American Veterans organization], the American Legion--were all getting older and didn't have young leaders. I was the first of the young leaders to have access to the older group who knew the politics of Washington. They had the respect of every congressional official on both sides of the aisle, and I was now in the room with them watching them talk policy, using their leverage. I was a fly on the wall for a lot of it. I wasn't there to say much but I was there to observe and learn.

Whether you liked it or not, did you feel you were now becoming acquainted with politics?

Yes, I began attending congressional hearings and watching my role models and mentors interact with representatives and senators. It was a learning experience. I sat through and observed the workings of joint House and Senate committees. I literally got a back seat to the action each time I sat right behind our PVA national president during his annual testimony before the joint committee. I wondered what my place was in all of this. I'm not a very good politician. I can't raise money. I don't lie real well. I'm not going to be good at this. I had the expectation that I would get used to it. But I had to get conditioned because I really didn't understand. I was a fish out of water coming from San Diego.

I had experienced all this as President Obama came into office [January 2009]. I got to watch all this on TV when all the higher-ups from PVA were sitting next to him during bill signings. My mentor, Homer S. Townsend, Jr. [PVA National President 1998-2000], started taking me to meetings, and I got to meet a lot of people. I sat quietly and didn't want to say anything dumb. I just wanted to listen and learn. I not only watched Townsend but also observed all his contemporaries. And they were all Vietnam-era vets. I was the first post-9/11 era veteran to be in that circle. I was still fairly young, probably in my mid-30s. These guys were in their 60s and 70s. And I was watching these professionals at work, giving a master class in diplomacy and hardball negotiation. These men were the brain trust for the entire veterans' community across the country.

Was that intimidating for you?

Yes, but I had a great mentor who knew me better than I knew myself. I didn't realize that Homer Townsend pulled me in as early as he did because of something he said later. Townsend stated, "For you to be a 20 something-year-old Marine Corps warrant officer, you had to be special." And he picked me out for that reason. He had been a staff sergeant in the Corps and knew how rare it was to be a "Mustang" [prior enlisted] officer at such a young age.

What did you learn at these high-level meetings while being "a fly on the wall," as you've described yourself?

I really wanted to be a contributor or keep my mouth shut. I remember my first big meeting. It was with VA Secretary Eric Shinseki. That's when it all really came together for me. That's when I saw the power these men had. The VA secretary was a cabinet appointee with direct access to the president. At that time, it was President Obama. But the brain trust commanded the respect of these elected and appointed leaders who sat at the top of government.

What was special about this meeting?

That meeting occurred early on during the Phoenix scandal, which would have a seismic impact on how VA healthcare was to be delivered after the resignations of the VA's top three leaders. [In 2014, allegations surfaced that as many as 40 veterans died while waiting for treatment in the VA Phoenix Health Care System.] I watched my senior colleagues do their best to finesse two seemingly conflicting interests. One was to allow the VA system to cave because it wasn't working at the time. A VA claims backlog was crushing the lives of veterans. Since I was in the appeals office, I had a lot of insight into the claims backlog--and that's what it was all about. The other was to preserve the VA healthcare system by giving it more resources instead of privatizing care for veterans.

While I was in San Diego, we were doing site visits to all 24 spinal cord injury centers in the VA system. I understood the inner workings of the rehab cycle for catastrophically injured veterans--both as a patient and now advocate. I also knew where all the gaps were across the healthcare system. So I was distinguished by having this keen insight not only with veterans' benefits and appeals, but also with veterans' healthcare. That's one advantage I had over just about anybody else at any table where the discussion centered on veterans' benefits. None of those other leaders had an insight into new claims processes in the post-9/11 era. I think that's where I really began to see my place in the grand scheme because I had become a resource that the older guys could now lean on. I could speak with authority on the major parts of the VA system as a whole that were having the biggest problems.

And I was young so I would have time and the energy to work on that. Homer Townsend saw that before I saw it. He knew that I just needed time. I had taken all those site visits--physically going into the spinal injury centers to question all the staff from top to bottom. I had become sort of a rolling encyclopedia with an understanding of this very intricate system. This was a system that the VA secretary was never going to hear about and never learn the truth about as to what was going on. I wasn't a fly on the wall anymore. I had become a bullhorn that needed to be heard.

What was it like when you eventually testified before congressional committees?

My first testimony was before Bob Filner, Chairman of the House Committee on Veterans' Affairs. I got to the witness table and my mouth had dried up. But I knew what I was talking about. I could speak with some authority. But that night on "The Rachel Maddow Show," he embarrassed us. I knew what he was saying was wrong about how we "drank the VA Kool-Aid" because of the problems in the VA.

That's the first time I understood that this is what national politics is about. It's all about optics. It doesn't matter who you are or how smart you are. It matters who you know and what it looks like to the public. These folks are actors in a play. I think that's true, especially if they are members of Congress. I've watched them debate and argue. Some of them are good people and some are not. Under the lights, they pretend that they're enemies but they're not enemies. They spend a lot of time together. Their relationships are different when they're not on the House or Senate floors where they argue and act as though they were enemies. By the time I had my second hearing, I was way better prepared. I felt like I brought to bear everything I had learned.

Executive Director Paralyzed Veterans of America

When did you become Executive Director of PVA?

I became Executive Director of PVA after the death of Homer Townsend in 2016. I never wanted to replace him. But when it came time, I was ready--solely because of him. I had the honor of eulogizing him and arranging his burial at Quantico National Cemetery where he was laid to rest with full military honors.

You've talked at length in our previous conversations about being a senior official with the PVA and your relationship with the VA in that the VA is the big player on the stage in the kind of work you do. What other agencies have you worked with in a close relationship?

I've worked with the Department of Labor when we were trying to fix the veteran unemployment problem. I worked with DoD [Department of Defense] when those officials were working on the Wounded Warrior Battalion concept. And I also worked with DoD to help that department figure out the transition problems it was having to get guardsmen and reservists back into society. There was no gateway similar to what the active duty had. These were people who were just being released back into their neighborhoods. So I did a lot of work on these issues over the years. I also worked with the Social Security Administration. We were trying to ensure that veterans got fairer decisions in their non-VA disability ratings.

You made a reference to the Wounded Warrior Battalion as a concept. What became of that idea?

At the time, the military branches were contemplating how they could keep service members on active duty with injuries that would normally get them discharged. We were starting to see amputees who were remaining on active duty for years. The Wounded Warrior Battalion was the support hub for them. There was also a process in which these wounded warriors were evaluated for fitness to remain on active duty with waivers. That went on for some years and then the idea kind of died a natural death. As fewer service members were getting injured, there were fewer people being assigned to the battalions. A lot more service members were simply getting out and moving on with their lives. When you get a bunch of soldiers, sailors, and Marines sitting around for a long time, you start having a lot of problems with morale, isolation, untreated mental illness, suicide risk, etc. And that was it. I don't think there are the battalions today, or if they do exist, they are very few and far between.

FEMA

You probably spent some time dreaming about what you wanted to accomplish and maybe not yet having achieved some of your goals. Do you now have objectives in your job that you'd like to accomplish before you retire?

Those fears or concerns really peaked the first time I got infected with COVID 19. That's when I felt like I've still got too much to do. This can't be it. I was in my late 40s and people were dying from the virus. I thought that if you got COVID, you were dead. As I lay there in our apartment, it got really quiet and I became really introspective. I thought if I make it through this, I'm going to finish up my doctoral program and I'll never work a job I don't like. I'll only do work that's truly gratifying.

I came out of the illness in about three weeks. At the time, I was working in a job I didn't think I'd be in long-term anyway. When the FEMA [Federal Emergency Management Agency] job opened up in the summer of 2022, it just felt like it was the right calling because it had the "military mission" feel.

What was your new title?

Director of the Office of Disability Integration and Coordination.

What did that job entail?

I advise FEMA's administrator and senior field leaders on meeting the agency's commitment to equity in emergency management for people with disabilities. That includes older adults and others with access and functional needs.

Well before I started working for FEMA, I had a few opportunities to be involved in disaster response when I was on active duty, and also when I went to Houston after Hurricane Harvey [August 2017]. In retrospect, I almost felt the role was preordained by my earlier exposure to disasters, which also harkened back to my experience as a crash photographer when I first joined the Corps. And I'm at FEMA now because of a calling.

But even now, I feel like there's something waiting around the corner to derail everything, such as the car accident, a school shooting, a plane crash. Those tragedies still trigger that fear in me every day that something bad is going to happen. And I have to manage it. That's probably the consequence of getting older and feeling more vulnerable while managing the effects of post-traumatic stress from my crash. I almost don't want to sleep for a long period of time because I feel like I'm wasting time or sitting around just waiting for something to happen. Or maybe I just don't want to dream anymore. Just stay in reality and face head on whatever awaits me.

Do you think that your life experience has put you in a mindset where you feel you've got more to do?

When I hear about these misfortunes, such as the suffering of so many and other catastrophes, I think it's constantly telling us that every day someone around the country is hurting or needs help in some way. I'm afraid too many of us have become numb to it. But I don't ever want to become numb to all this so there's always more I can do in my mind.

And then you throw in climate change to complicate the overall picture--hurricanes, tornadoes, floods, etc.

At FEMA, we do an 8:30 call every morning to get an update. There are over 70 or so active disasters around the country on any given day. A lot of people don't know that. A tropical storm forming off the coast of Africa that turns into a hurricane may pass through the Caribbean and hit Texas, Louisiana, or Florida. Or the cool dry air from the Rocky Mountains might collide with the warm moist air coming up from the Gulf, which is how tornados form in the breadbasket of America. Not to mention human-made disasters like train crashes or wildfires. We get all these calamities in detail. In my job, I'm subjecting myself to what I thought I was distancing myself from at one point. But the upside of all this is that now I don't have a fear of death. If it happens, I'll just go with what God intended, just like the men and women who stand the watch in defense of our country.

In closing, I'd like to know some of the projects you're working on right now.

I want to change expectations for people in society with disabilities. I want them to use their masterful problem-solving acumen and skills to help solve some of society's most vexing problems. The problems include how we can best bring about universal access in every corner of living in America and eventually abroad. One of the theories I have is that the Americans with Disabilities Act [1990] has been what we've always needed to open access and opportunities for all--not just for people with disabilities. We just don't realize it yet. It's a mindset, not just a law. Now I'm talking about that in terms of community resiliency in disasters. If you have a universally designed community, that means everybody has access whether it's someone in a wheelchair, a pregnant woman, someone with epilepsy, someone with heart issues, or an older adult who simply wants to find safety during a storm.

I think about all the innovations we've had--from the electric toothbrush--to Siri--to audio books. Those were all designed with the disabled community in mind but ended up benefitting so many in society. With disasters, everybody becomes disabled to some extent, whether it's paralyzing fear or a sense of helplessness when someone is isolated. The few who can get through it without some sort of accommodation or help from others are extremely fortunate.

If there's anything I hope to leave behind, it's a legacy of finding resiliency in the most unusual ways and places. I would start with people who eat, sleep, and breathe resilience--those who become stronger in their broken places and those who have proven that ability is a mindset, not a diagnosis. That's what I concentrate on at FEMA. And after FEMA, I hope to teach those lessons to future leaders and educators at a university. I want to become the kind of role model I had who helped shaped me once I'd learned to remove the mask and embrace the person I would eventually become.

Dr. Gillums earned his doctoral degree in education at the University of Dayton in 2024. He and his wife Tammie, herself a U.S. Army veteran of Operation Enduring Freedom [Afghanistan], have two sons and four daughters. One daughter is a U.S. Naval Academy graduate and 2nd lieutenant in the Marine Corps. Another daughter will graduate from George Mason University soon. The Gillums also have two granddaughters.

Author Note

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

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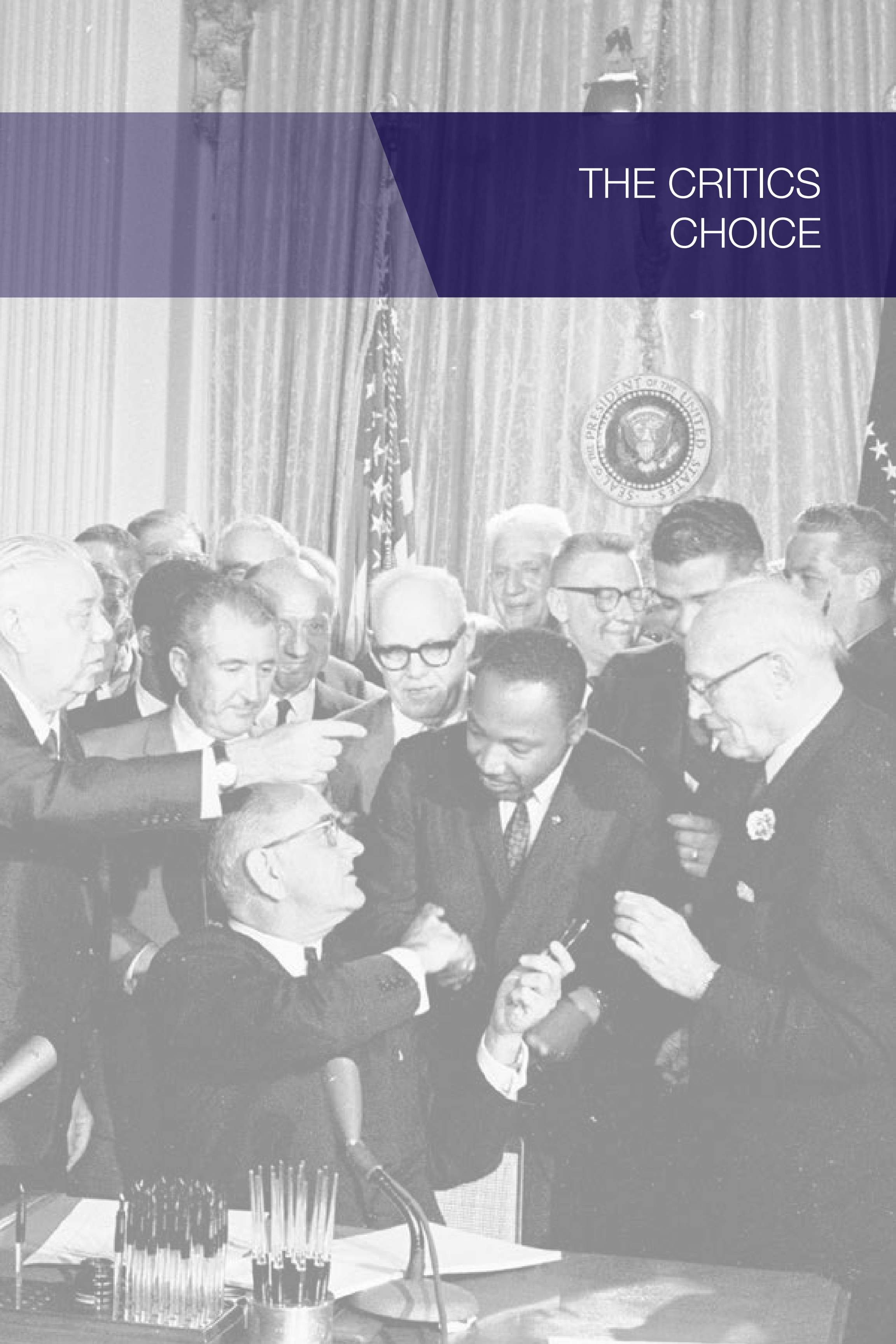
THE CRITICS CHOICE



NEW YORK TIMES BESTSELLER

THE THREE MOTHERS

How the Mothers of MARTIN LUTHER KING, JR., MALCOLM X, *and* JAMES BALDWIN *Shaped a Nation*

ANNA MALAIKA TUBBS

Book Review

The Three Mothers

Anna Malaika Tubbs
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Janis Riccardelli, AIHM, BA
Deacon
Birdsboro, PA 19508
Tel: (610)462-1993
Email: arrows4u2@gmail.com

Author Note

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

Introduction

On Valentine's Day evening in 2019, the author, Anna Tubbs, and her husband were in Washington, DC, for the Frederick Douglass 200 Awards Gala. After attending the Gala, they went on to celebrate Valentine's Day with a dessert-and-wine reservation and then a quick stop at the local CVS. That evening, Anna Malaika Tubbs and her husband Michael Tubbs, Mayor of Stockton, California, learned they were expecting their first child.

Anna was in her second year of doctoral studies at the University of Cambridge. Coincidentally, her research and field work centered on Black motherhood. Correlating her research with her own newly discovered pregnancy, Anna focused on three examples of Black motherhood to guide her personally through this momentous stage of her life.

The three women she chose to concentrate her research on were Alberta King, mother of Martin Luther King, Jr., Berdis Baldwin, mother of James Baldwin, and Louise Little, mother of Malcolm X. One would think that since their sons were well known, finding information on their mothers would be easy. But Anna found the opposite; their history had been erased. This book changes that.

All three women were born within six years of each other. Their sons were born within five years of one another. This allowed Anna to focus on Black womanhood in the early 1900s and Black motherhood in the 1920s. Reflecting on these three lives gives the reader a different perspective on World Wars I and II, the Great Depression, the Great Migration, the Harlem Renaissance, race riots, police brutality, welfare, and the effects of politics.

Book Summary

The author breaks her story into eight parts and ends with a conclusion. Part One discusses the birth and family life of each mother. She begins with the Caribbean Island of Grenada where Louise Langdon Norton, the mother of Malcolm X, was born. Anna describes some of the history of Grenada so the reader can have a sense of its story, its resistance to European domination and the bravery of the residents.

Louise's grandparents were "Liberated Africans" who settled on the island. Jupiter and Mary Jane Langdon had been abducted in Nigeria, rescued, and then released by the British Royal Navy. Jupiter and Mary Jane raised six children in the small village of La Digue. Yet even though they had been freed and living in Grenada, they still encountered colonialism and racism every day.

One of their six children, Edith, gave birth to a female child in the late 19th century. This little girl stood out from the rest of her family because of her almost-white skin and straight hair. Rumors were that she was the product of rape by a white man. Unfortunately, this was commonplace, and in 1897, Edith gave birth to her only child, Louise. Jupiter and Mary Jane helped Edith to raise Louise. Then tragedy struck in 1901, when Louise's grandfather passed away, leaving her grandmother to raise six children and one grandchild alone.

From Grenada, the story moves to Atlanta, Georgia, when on September 13, 1903, Alberta Christine Williams was born. Alberta was the daughter of the head pastor of Ebenezer Baptist Church, founded in 1886. Alberta's father, Adam Daniel Williams, became the head pastor in 1894. He married Alberta's mother, Jennie Celeste, in 1899. Both her parents were well educated and helped to grow their church from the 17 members Adam found when he took over to what it is today. They realized the church had a responsibility to their community and helped to fight racial injustice and empower its members all in the face of Jim Crow.

Alberta was the only child of Adam and Jennie that survived past childhood. She was very much loved. Alberta was born into a family of love, faith, vision, and means. She was raised in what is now known as the Sweet Auburn District of Atlanta, at one time known as "the richest Negro street in the world."

Being a black family in the early 1900s was not without its dangers. In 1906, when Alberta was only three, they experienced one of Atlanta's worst moments in history. On September 22, white mobs formed and began a rampage through Black neighborhoods, destroying everything in their path whether business, building, or human. This riot lasted for two days before the governor finally instructed the authorities to end the violence, but not before the Black community and economy in Atlanta were destroyed.

The author then moves the reader to Maryland to introduce the third mother of our group. On Deal Island, Maryland, Emma Berdis Jones was born on Christmas Day, 1903, to Leah Esther and Alfred Jones. However, shortly after Berdis' birth, Leah Esther passed away after hemorrhaging, leaving Alfred to raise their five children. Berdis spent her early years out on the water with her father and all the residents of Deal Island.

In Part Two, the author takes the reader through the raising of our three mothers during the first decade of 1900 and into World War I, the Great Migration, and the expansion of Black Nationalism. Location affected how each mother was influenced by these moments in history. We start with Louise on Grenada. Her late grandfather was a carpenter and taught his family the importance of self-sufficiency and land ownership. Louise also had access to education at the local Anglican school. There she developed a deep love of words and languages. According to her granddaughter, Louise spoke five languages.

In June 1917, Louise left Grenada and immigrated to Canada at the invitation of her uncle. Through her Uncle Edgerton Langdon, she is introduced to Garveyism. Marcus Garvey was a Pan-Africanist born in Jamaica in 1887. He founded the Universal Negro Improvement Association that advocated for racial unity, financial independence from whites, and the formation of independent Black nations in Africa. In this movement, Louise heard echoes of all she learned while growing up. She found a home and a place to use her writing to advance the cause of her people.

In Atlanta the Williams family fought their battles against racism. Rooted in their faith, they were committed to human rights for all. Alberta’s parents raised her to be an activist. Reverend and First Lady Williams taught by example. Alberta’s father was one of the founders of the Atlanta chapter of the NAACP. Her parents led the drive for the first Black high school in Atlanta. They also led a boycott with their church of the businesses their congregation patronized when it was discovered these same businesses advertised in a publication that disparaged Black residents.

Through her active participation in Ebenezer Baptist Church, Alberta developed her love of music and became a very talented musician in the church. She was also a brilliant student. After her primary years in public school, she followed in her mother’s footsteps and attended Spelman Seminary. Alberta developed a passion to become a teacher. After graduating from Spelman Seminary, she enrolled in Hampton Normal and Industrial Institute where she obtained her teaching certificate. Alberta wanted to share her privileges with others and felt teaching was the best way to do so.

It was during this time period, 1910 to 1920, Black people in Atlanta experienced the rebirth of the Ku Klux Klan. In 1915, inspired by the movie *The Birth of a Nation*, the KKK celebrated their second founding at Stone Mountain, less than a mile from Ebenezer Baptist. In the same year, 1915, what has become known as the Great Migration began. This was one of the largest internal migrations in history and encompassed the years 1915 to 1960. Approximately five million Black residents moved north to Chicago, Philadelphia, and New York, or west to Los Angeles, Oakland, and Seattle. This movement was a result of the continued racial violence and oppression as Black Americans saw little change in their lives more than 50 years after the signing of the Emancipation Proclamation. The Williams family stayed put and made a commitment to change Atlanta, hoping to further the case for Black freedom across the United States.

Black residents in Maryland faced the same racial terror, Jim Crow, World War I, and the Great Migration. The beginning of the “New Negro Movement” found its way into Maryland’s more urban areas. The Baltimore branch of the NAACP was established in 1914. The residents of Deal Island, especially the Jones family, enjoyed a degree of economic autonomy that was not common for most Black families. Berdis's parents were able to acquire a half-acre of land in 1884. And like the Langdons and Williams, the Jones family saw land ownership as an important way to gain dignity.

In 1906, Alfred Jones married his second wife, Mary. At this time, it was not unusual for the children from the first marriage to move in with other family members. Berdis and Alfred, Jr. moved in with their older sister Beulah and her husband, Samuel. In 1911, Alfred, Sr. and Mary sold their property and moved from Deal Island.

During this time, almost all the Black Deal Island residents were educated at the John Wesley Methodist Episcopal Church. Berdis likely attended church and school there. In her early years she developed a love of writing and poetry. In a few years, like Louise, Berdis joined the Great Migration and headed north. She first stopped at a cousin's house in Philadelphia, before ultimately ending up in New York City.

Parts Three, Four, and Five discuss the men these strong mothers met and married, the birth of their children, and the trials and tribulations they faced while raising their sons. We meet up with Berdis as she travels north to New York City in the 1920s. She arrived there during the Harlem Renaissance, an explosion of Black literature, music, performance, art, and more. During this time, Berdis met her first lover and gave birth to her first son, born out of wedlock in 1924. She was left alone to raise him.

It was during this time that Berdis met David Baldwin, a preacher, laborer, and fellow migrant from Louisiana. One generation removed from slavery, he witnessed and experienced the worst of Jim Crow. David found God while seeking relief. He also saw the white man as the devil and became a preacher in the Pentecostal tradition. David had at least two children from a previous relationship. When they met, David and Berdis found the potential for a new beginning. David did his best to provide for his wife and growing family but was thwarted by the lack of opportunities and fair treatment for Black men. His inability to control his circumstances deeply affected him. His righteous anger was revealed in his sermons and in the mistreatment of his wife and children. Through this turmoil, Berdis maintained her sense of calm and her view of humanity while being stifled by her husband's anger and paranoia.

For Alberta, we find a young woman passionate about music and a career in education, a woman focused on the future of the children in her community, her schooling, her family, and her church. She left no room for distractions. She continued her education at Spelman Seminary and then obtained her bachelor's degree at Morris Brown College. It was during one of her visits home that she met the brother of one of her classmate's, a young preacher named Michael King.

Michael was the son of two sharecroppers in Stockbridge, Georgia. His father turned to drinking and his mother held on to her faith never losing sight of the Lord. Michael admired his mother's strength, and church was his way of avoiding a descent into bitterness. Michael was a licensed preacher by the age of 18. He followed in his sister's footsteps by leaving Stockbridge and heading to Atlanta. His sister encouraged him to continue his education by attending Bryant Preparatory School, where he was introduced to activism.

In the summer of 1920, Michael began his courtship of Alberta. Their courtship lasted for six years before they were married. Alberta's parents didn't want Alberta to give up on her education and teaching career. At the time, once a woman married, she had to stop teaching. Wanting to ensure the relationship between Alberta and Michael was a serious commitment, they sent Alberta to Virginia to obtain her teaching certificate. For a year and a half the couple was able to communicate only through letters. When they were finally reunited, it is said Michael swept Alberta up into a hug and stated, "My bunch of goodness is back with me again." Michael shortened the phrase to "Bunch," making this his nickname for Alberta. They were married on Thanksgiving Day, 1926.

During their engagement, Alberta insisted Michael complete his education and she even tutored him. Even though Alberta was no longer allowed to teach in schools, she still used her schooling to teach her husband, her church, and her own children. They moved in with Alberta's parents and followed in her parents' footsteps as the eventual leaders of Ebenezer Baptist Church.

Louise arrived in Montreal, Canada, in the summer of 1917, and found her community, although a small one, away from home. Canada was not exempt from racism and the enduring effects of slavery, but Canada was a symbol of freedom for Black Americans trying to escape the fierce indignities in the American South.

Louise cultivated relationships with Black Americans, Black Canadians, and fellow Caribbeans making their way north. Along the way, she discovered and developed her activism and became an influential member of the Universal Negro Improvement Association. Because of her education and how she carried herself, she was able to write for the Negro World, "a paper devoted solely to the interests of the Negro race," founded by Marcus Garvey.

It was in her community she met Earl Little, a young man just a few years older than she at an organizing meeting for their local chapter. The two were very much alike in their care for social justice and activism. Earl Little came to Montreal from Reynolds, Georgia, where he witnessed violence firsthand. Four of his six brothers died as a result, three at the hands of white men, and another was lynched.

Louise and Earl were married on May 10, 1919. They dedicated their lives to each other and to spreading Garvey's message of African empire and Black self-reliance. Garveyism offered Black people a hope for the future and a sense of pride. It advocated for Black independence from whites through economic independence and self-reliance. Louise grew up with these lessons from her grandparents and Earl practiced them through his carpentry. Louise and Earl started their mission of spreading Garveyism in the United States by first moving to Philadelphia where they lived for two years before moving to Omaha, Nebraska in 1921. There they continued their journey as field organizers. During this time their family grew, and they were able to pool their money to buy a home where they could plant a garden and hunt for food.

Despite hardship, they continued their Garveyism work. Earl was an active speaker and organizer, and Louise was branch secretary. Organizing took Earl around the country forcing him to leave Louise and the children alone. They spent several years in Omaha and then moved to Wisconsin, Indiana, and then Michigan.

As Louise and Earl continued their work for Garveyism across the United States so did their family. Their first child, Wilfred, was born in Philadelphia in 1920. The family fled to

Omaha after a violent race riot broke out in 1919, when a white mob burned down the county courthouse and lynched a Black man. The Black community responded by fighting back with their own guns. Despite this violent situation, Louise and Earl welcomed three more children; Hilda in 1921, Philbert in 1923, and very soon thereafter, they were expecting their fourth.

One evening after the children were in bed while Earl was away traveling for work, Louise heard horses galloping toward the house. A very pregnant and seemingly unafraid Louise opened the door. The intruders demanded to speak to Earl. As the white men hurled insults and threats at her, Louise held her head high and told them she was alone with her children. After answering the men, she turned and reentered her home and closed the door. The men surrounded the house and broke windows and yelled more threats before leaving. When Earl returned home he became enraged after hearing about the attack. But because of the impending birth of their fourth child, Earl resisted retaliation. Louise gave birth to their child, a third son, on May 19, 1925. Louise and Earl named him Malcolm. After his birth, the family moved to Milwaukee, Wisconsin where they found a budding Black community. Here they welcomed another son, Reginald, into their family.

Undeterred, the Little family kept pushing forward. Their next move took them to Lansing, Michigan, where Wesley was born in 1928, and Yvonne was born in 1929. Louise and Earl were able to purchase a small farmhouse on the outskirts of town. However, they did not realize the deed contained a racial exclusion clause that voided the sale if the owners were black. Earl and Louise sought the help of a lawyer to file an appeal. As they waited, the family experienced another tragedy. One night as the family was asleep, they were awakened by a loud explosion. Their house was on fire. Louise and Earl gathered all their children and made it out of the house, but they lost all their possessions. A group of white men had doused the back of the house with gasoline, not caring if anyone was killed.

Rattled but determined to get back on their feet the family recovered. Earl used his carpentry skills and built a new house in a different part of town where they were able to acquire a cheap piece of land. Louise and Earl used the tribulations they had faced as lessons to instill the value of Black lives and the principles of self-determination, self-reliance, discipline, and organization. Louise taught the children about her culture and had them recite the alphabet in French.

Parts Six and Seven follow each of the families as the mothers raise their children and instill in each of them strong values and the ability to stand up for and advocate for what is right. When the Littles' children came home from school each day, Louise retaught them what they had been taught by their white teachers. This way she ensured they would not think of themselves as being inferior to anyone else. It is during this time the author shows us that Louise recognized herself in Malcolm, and was stricter with him because he was so strong-willed. But her son, like his mother before him, was a rebel who did not allow rules to restrict him.

In the King household, family sit-down dinners were mandatory. It was at dinner that the King parents taught their children about the injustices of segregation and the importance of playing their part in changing these inequities. When Martin, Jr. was young, his best friend was the son of the white family that ran the corner grocer. When they restricted Martin and his friend from playing together, Martin was hurt. Alberta helped her son to understand he was just as worthy of the same respect and encouraged him to turn this into something positive.

James Baldwin did not have much of a childhood. Being the oldest, he had to grow up fast and help his mother raise and support his siblings. But education was very important to Berdis and she instilled this into her children. James was the one that took after her with his love for words and language. After several years of working menial jobs, James moved to Greenwich Village in New York and began networking with other writers, artists, and mentors. In 1948 he went to Paris on a Writing Fellowship, where he spent 10 years learning and better understanding who he was. James returned to the US in 1957 in order to report on what was happening in the South. It was during this trip, while in Montgomery, Alabama, that James Baldwin and Martin Luther King, Jr. met. It would be a few more years before both men would meet Malcolm.

In March 1964, between Martin, Jr. being named *Time* magazine's Man of the Year and being awarded the Nobel Peace Prize, Martin and Malcolm finally met face to face. It was at this meeting that Malcolm let Martin know he was finally "throwing myself into the heart of the civil rights struggle." On February 21, 1965, as Malcolm was giving the opening remarks at a rally in Harlem, he was assassinated at age 39.

Martin, Jr., continued his participation in marches and demonstrations around the country. On March 7, 1965, in Selma, Alabama, Martin led 600 people in a peaceful march toward Montgomery. Two days later, undeterred by the extreme violence toward earlier marchers in Selma, Martin led 2,000 marchers over Selma's Edmund Pettus Bridge. He participated in as many events as he could, until his assassination on April 4, 1968, in Memphis, Tennessee, where he had planned to give a follow-up address to his iconic "I've Been to the Mountaintop" speech.

James Baldwin was deeply distressed by Malcolm's death, but when he heard about Martin's assassination, he could not find the words to mourn his friend. James continued to write through the 1970s and the early 1980s, and lived his life fully, mostly abroad. While in France in 1986, he was diagnosed with cancer of the esophagus. He had a laser treatment that temporarily improved things and allowed him to eat and drink. He continued to work until his final week of life. On November 30, 1987, James quietly slipped away surrounded by his younger brother and friends.

In Part Eight, the author brings us, the reader, to the end of each of our mother's lives. On June 30, 1974, Alberta was at the church playing the organ while preparing for Sunday services when she was shot by an unknown intruder. Louise Little lived for an additional 26 years after Malcolm's death. She passed away quietly in 1991. At her request, her family had her cremated and spread her ashes where she had lived. Like Louise, Bertis Baldwin lived for about 11 to 12 years after the passing of James. Her life revolved around her children and her grandchildren. She even reconnected with other relatives on the Eastern Shore of Maryland. Berdis quietly passed away on February 27, 1999.

Upon Reflection

This book introduces us to the three remarkably strong women who brought into this world, three remarkably strong men who stood up for their beliefs, their convictions, and the proper treatment of all people regardless of race. These women had strong faith, believed in education, and taught their children through personal example how to be strong and stand up for the less fortunate.

We see how their early lives shaped them and how they became the women who refused to allow circumstances define them or their children. When the author began to write this book, she was challenged to present the stories of three forceful women who gave us three equally dynamic men who made their place in history.

By writing this book, the author hoped to raise their names as historic figures worth knowing and studying. This book is a tribute to the lives of Lousie Little, Alberta King, and Bertis Baldwin. May their names be raised alongside those of the sons they gave to the world.

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Book Review

The Anatomy of Peace:
Resolving the Heart of Conflict
4th edition

The Arbinger Institute
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Paul A. Finch, MSW, LCSW
Readjustment Counselor
Everett Washington Vet Center
Everett, WA
Tel: (703) 867-5302
Email: Paul.finch2@va.gov

Author Note

The opinions in this review are those of the author alone and do not represent the views of the Veterans Administration, the Everett Vet Center, or other institutions or organizations the author serves. The author has no financial conflicts of interest. Special Notation: The quotations in this review are from the Preface of the book itself.

Introduction

An Arab man whose father had been killed by Jews in the Yom Kippur War and an Israeli immigrant to the United States are the two teachers and mentors in this timely and timeless fictional tale about the change of heart required to truly resolve conflict and make peace. We learn "how they came together" (p. xiv), observe closely "how they help others come together" (p. xiv) -- and by reading this book, how each of us "can find our way out of" the conflicts and struggles of our lives as we navigate unprecedented and challenging times and find peace.

In the story itself, the reader will find that "the characters portrayed in this book are each of us. They share our strengths and our weaknesses, our aspirations, and despair" (p. xiv), and how we too often unsuccessfully seek solutions to the problems that weigh on us. This is an important and necessary experience for them--and for us as readers--to have, because their problems, like ours and many of the problems of our families, organizations and even the world today, are not what they seem. Reading and applying the healing wisdom conveyed carefully titrated to our hearts and minds in the story of this book is both "our challenge and our opportunity" (p. xiv). Will they and we accept it? Will they and we learn the substantive lessons so powerfully taught, like little else available today? If so, it can bring real hope for healing relational/people problems on every level--within us, in our intimate and familial relationships, in our workplaces, our communities and even our world. The bottom-line-up-front message is to experience it for yourself, by reading what this book concisely conveys, what the characters in the story and those who have read it before have discovered. Former readers have shared their comments in the third edition of the book, and I will share some of them in this review. Besides this book's message, I also will touch on the other works and programs of the Arbinger Institute for those who might want to learn more and investigate other applications that will become apparent as you read this story. My hope is that you will be inspired to read this important book so that in countless ways you too can be changed by it.

Book Summary

The book was written by the Arbinger Institute as a team and not by a single author, continuing the method they used in their earlier book, *Leadership and Self-Deception: Getting out of the Box*, which is coming out now in its expanded 4th Edition, and their later work, *The Outward Mindset: How to Change Lives and Transform Organizations* in its 2nd Edition. *Anatomy of Peace: Resolving the Heart of Conflict*, 4th Edition has been "the #1 Conflict Resolution Bestseller for over a decade" (Front Cover); and can be instrumental today given all the political polarities, conflicts, and wars going on inside us, our relationships, our organizations, communities, countries, and the world. Bennett and Koehler's publication of the first edition was in 2006, and now--without changing much of the main story--the book has been translated into more than 30 languages, and in 2022 was published in its 4th Edition. What has changed between earlier editions was not the story but primarily the appendices and covers, each edition providing different rich and practical materials based on requests for help in applying the ideas by readers who were deeply impacted by the story. "This fourth edition includes revisions throughout the book to increase its relevance and usefulness" (p. xiii), while adding "new detailed discussions that illuminate the origin of bias and the pattern of dehumanization that lies at the heart of today's most pressing societal and organization challenges" (p. xiii).

Some potential real-world applications of the ideas taught in this simple story can be hinted at by examining the list of some of the readers of the 3rd edition published in 2015. These include a general manager of the Boston Celtics, a Programme Manager of Rolls-Royce, a Senior Vice President of Capitol One, a Professor Emeritus of the Harvard Business School, a former Dean of Canterbury Cathedral, a professor of psychology and fellow emeritus of Linacre College at Oxford University, a US Navy captain, two former Directors General of the Israel Ministry of Foreign Affairs (one also President of the Peres Center for Peace in Tel Aviv), a rabbi and Professor of Talmud at Yeshiva University, a Catholic nun and Dean of Admissions and Academics for Cor Jesu Academy, a Former Chief of Staff of the Prime Minister of Israel and Chief Negotiator with the Palestinians, several coaches, and many more. Why would these praise this book? You need to read it to see.

As the fictional story opens, we are introduced to a group of diverse parents attending a two-day parent education program that is required for enrolling their troubled adolescents in a unique outdoor wilderness treatment program named Camp Moriah. Learning from the teachers, and each other, they each realize their own self-deceptions and learn how to heal from them.

It is hard both for the characters and for us to hear how solutions to problems with others begin with change in ourselves. And despite our defensive protests, what we can learn from this tale--if we have ears to hear and an open heart--as the preface states, is that ALL "people in conflict value something more highly than they value solutions" (p. xii). And we can see clearly why all of our behaviors and efforts, despite our time and money, have not worked. The story illustrates just how this self-deception develops and demonstrates how ALL conflicts, internal and external, stem from this one root cause. That is a powerful realization as the book shows how we "systematically misunderstand that cause and unwittingly perpetuate the very problems we think we are trying to solve" (p. xii). But the book does not abandon us in our dismay. It goes on and artfully and systematically describes how to heal from this error.

This *self-deception*, really self-betrayal, was first revealed and introduced in an earlier book by the founder of the Arbinger Institute, a Yale-trained professor of philosophy now an emeritus professor C. Terry Warner PhD: *Bonds that Make Us Free: Healing our Relationships, Coming to Ourselves*. I was a student in the 1980s in his philosophy class focused on this problem when he was first trying to understand how we deceive ourselves on all these levels, but more importantly, how we can heal from it. Those discussions, early manuscripts and chapters shared, were eventually reworked and published into his book by the Arbinger Institute in 2001.

Now *Anatomy of Peace* presents time-tested and "proven methodologies" (p. xii) that several generations of Arbinger consultants have successfully used for "bringing people together and resolving conflict in fundamental and lasting ways" (p. xii) in all kinds of relationships. The charts and diagrams are simple and concise. Even more timely, the book…

> …has been instrumental in overcoming inequity, conflict, and cultural dysfunction in all kinds of organizations. Its ideas have also been successfully implemented to successfully break down silos in organizations, transform law enforcement procedures and results, provide the framework for college conflict curricula, heal labor-management rifts, reinvent nonprofit initiatives, reimagine corporate cultures, heal communities. and save marriages and other relationships. Business and governmental leaders, parents, professors, and conflict professionals alike have used this book as a guide for finding solutions to their most challenging problems (p.xii).

This book is really an extension of an earlier story--a prequel of sorts--of the realization of one fictional character named Lou Herbert found in the earlier *Leadership and Self-Deception* book. Now we learn how Lou, one of the parents resisting the two-day class experience in his mind and heart, was first introduced to the ideas that later transformed his company and life that is discussed in that earlier book. This fourth edition includes "revisions" (p. xiii) that "increase its relevance and usefulness" (p. xiii) for our time with wars, a deeply divided and entrenched society, "and an urgent need to combat racism and prejudice in their many manifestations" (p. xiii)--not as clearly pointed to in the earlier editions. This 4th Edition also includes "new detailed discussion that illuminates the origin of bias and the pattern of dehumanization that lies at the heart of today's most pressing societal and organizational challenges" (p. xiii) that will not "be solved until the origins of the bias and discrimination, evidenced in racism, sexism, ableism, homophobia, religious bigotry, and divisive othering of all kinds, are properly understood and addressed" (p. xiii). "To assist in the practical application of these concepts to increase diversity, equity and inclusion in organizations" (p. xiii), they "have included a practical guide in the *Resources for Readers* section at the end of the book" (p. xiii). There is also a study and discussion guide available for further developing insights if reading or studying the book in groups from the Arbinger Institute. Its website is also a target-rich environment for other tools and training to learn and apply the ideas found in this important book, also the *Leadership and Self-Deception and Outward Mindset* books, and other products they have developed.

Hence, if you are ready for a tale that will change your life, your relationships, and way of seeing and influencing your world as you are transformed with an awakened but not burdensome responsibility in life (without guilt, shame or the heaviness of that one-more-thing-I have-to-do thought), adding instead a lightness at every level of your influence in the wider world, I highly encourage you to obtain and read this book.

Reflection

Currently serving as a Vet Center readjustment counselor with many years working in mental health, community and family support programs for the Navy, Army, and Air Force, I still find everyday applications for this story's wisdom at home, at work, in all of my relationships, like those readers I have cited. And it still gives me the light for understanding and participating in our sometimes weary and challenging world today. Given the strife and challenges all face today, I believe you, as so many others before you, will be changed by reading this book and realizing a new perspective that will impact your lives in many ways. For more information beyond the book, *LinkedIn* carries reports about ongoing Arbinger Institute developments as well as new insights and continually expanded insights from a former Arbinger leader now serving at the Withiii Leadership Center, James Farrell, whose works I also highly recommend to readers of this *Journal of Health and Human Experience*. Another inducement to read the book is that it was influenced by two important philosophers. The book does mention and gives credit to Martin Buber for some of its ideas. It does not specifically mention Emmanuel Levinas, but I believe both philosophers clearly influenced the leaders of the Arbinger team and that you can and will sense that influence while reading this much needed tale for our time. Their understanding of our humanity is a major gift that is given in this book that will benefit your life today.

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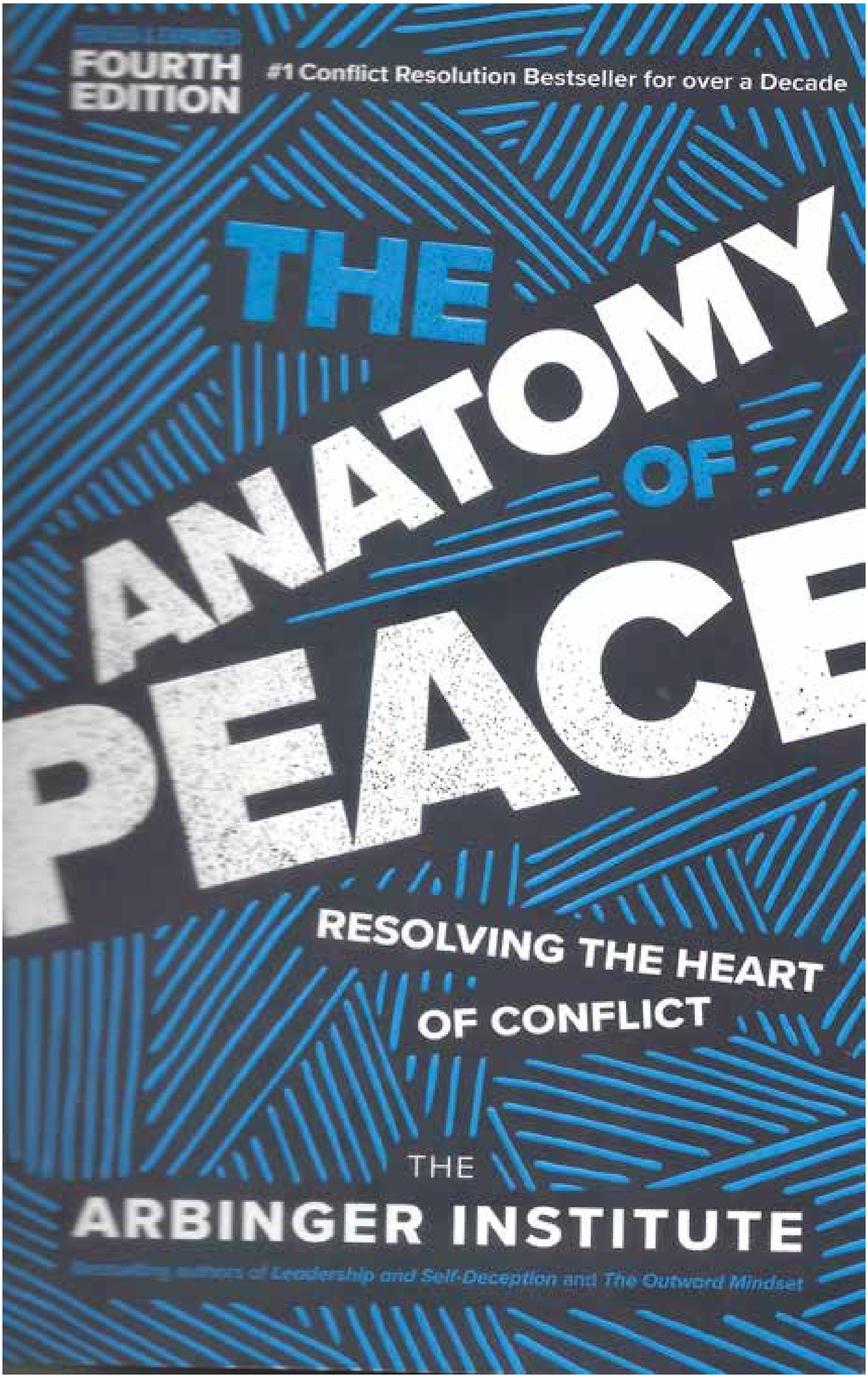
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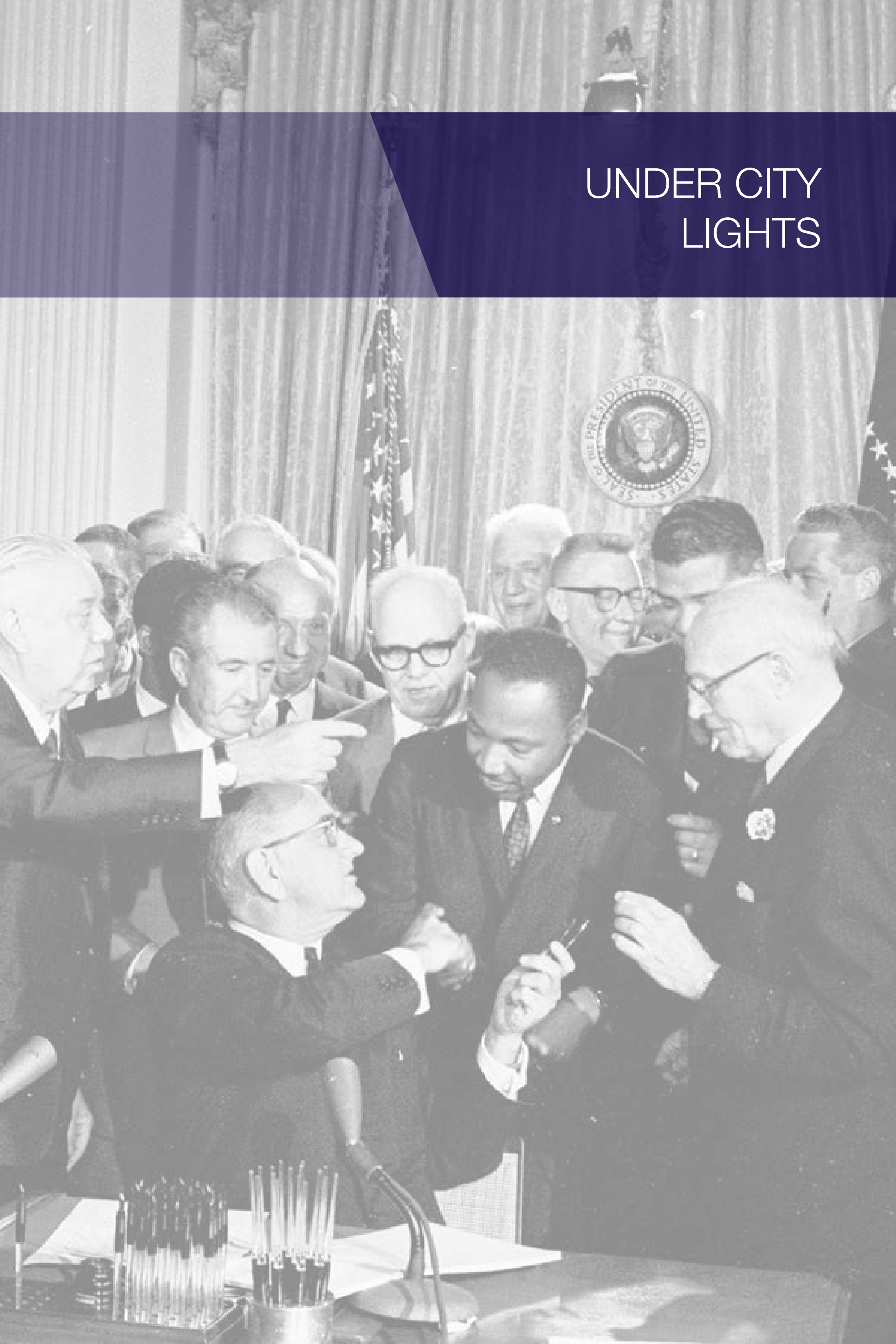

A Poem

The Unbroken Chain

Susan Rachlin, MD, FACR
Senior Associate Dean for Student Affairs
Associate Professor of Radiology
New York Medical College
40 Sunshine Cottage Road
Valhalla, NY 10595
Tel: (914) 594-4498
Email: susan_rachlin@nymc.edu

Introduction: We Must Remember

Sixty years ago, the United States experienced the pivotal Civil Rights Movement. People throughout the country demonstrated courage, bravery and even the willingness to die to protect Black constitutional and voting rights. There will always be those willing to stand up for what they believe in and for the rights of others.

Today we see people demonstrating in support of their rights and beliefs as we did sixty years ago. Yet throughout history, we also see suppressive and discriminatory actions repeated. We see hatred and violations of people's rights continue. Although the Civil Rights Act gave all minorities the right to vote, is it reasonable to make it illegal to give voters in line on a hot day a drink of water? We have watched as decisions are made that limit human rights rather than support them, such as the overturning of affirmative action and the establishment of the Dobbs decision against women's rights. Sixty years ago, we recognized the need to support human rights for all and that need is paramount today.

Much of what led to the Civil Rights Movement was lack of equality. Despite the changes in equality that have occurred, there continues to be a rise in hate crimes, as well as racial and religious persecutions. We have watched the murder of George Floyd and others, antisemitic actions including the Pittsburgh Synagogue attack, and a rise in Asian persecution following COVID.

There continues to be overt acts of discrimination, racism, and hatred as there have been throughout history. Humanity vows to remember these acts so as not to repeat them. But do we? Do we remember? Or, is history destined to be a rerun of past mistakes?

Abraham Lincoln, in his efforts to bring this great nation together stated in the Gettysburg Address, ". . . this nation.... shall have a new birth of freedom and that government of the people, by the people, for the people, shall not perish from the earth." Lincoln urged the birth of a new freedom. He challenged our country to be one of unity that stood for all people, for people to rise up and support one another, rather than work against each other. Lincoln chose to stand up for the rights of others, to protect people while others tried to destroy them, so they would not perish from this earth. Our goal should be to emulate and follow these legendary words: "by the people, for the people." This is what we should continue to fight for today…To have our voices heard in unison to protect those that continue to be oppressed and treated unfairly.

In the words of this great man, the following poem contrasts his elegantly stated ideals of freedom, by the people, for the people with the reality of repeated, recurrent attacks of inhumanity throughout history against the people.

The Unbroken Chain

The unbroken chain is created.
By the people, for the people.

By the people, for the people, shall not perish from this earth.
Against the people, destroying them at will.

By the people, for the people, inhabit a new land.
Against the people, by eliminating those who live there.

By the people, for the people, all shall be free.
Against the people, who continued to be treated unfairly.

By the people, for the people, equality for all.
Against the people, who are the wrong kind of person.

By the people, for the people, give me your tired, your poor, your homeless.
Against the people, who are turned away from our borders.

By the people, for the people, a new leader to bring hope.
Against the people, who unleash demons beyond anyone's worst fears.

By the people, for the people, leave your home due to hatred.
Against the people, only to find that same hatred again.

By the people, for the people, create a new land for people to live in peace.
Against the people, yet attack that land over and over again.

By the people, for the people, be all you can be.
Against the people, who choose to be different.

By the people, for the people, love and kindness to all.
Against the people, who love the wrong kind of person.

Created by the people and then destroyed for the people.
This is the Unbroken Chain of Repetition.

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.

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Short Story

PROCEED WITH CAUTION

Michael J. Krentz, MD, MPH, CAPT (ret), MC, USN
Katrina Chenevert, MAEd, LCDR (ret), MSC, USN
1111 Rockbridge Ave
Norfolk, VA 2350
Tel: (202) 997-4757
E-mail: mjk@mjkrentz.com

Special Introduction

On June 26, 2024, President Biden issued a pardon to service members convicted of violating a subsequently repealed ban on consensual gay sex. "Today, I am righting an historic wrong … to pardon many former service members … convicted simply for being themselves." While we laud the Commander-in-Chief's action, we avow that many non-convicted gay military members — despite their stellar service to this nation — endured heinous discrimination, abuse, and negative consequences for being themselves. No official action can assuage what these honorable military members suffered. The historical short story that follows, underscoring its basis upon actual life events, provides a deeply moving opportunity to reflect upon the needed call in our lives today to stand up for social justice for all people in our nation and world. Its message in this edition is important considering this year's anniversary of the Civil Rights Act and the Journal's ongoing commitment to human rights across the full spectrum of humanity.

Sailor of the Quarter!

In October 1985, US Navy Hospital Corpsman Third Class (HM3) Katrina Chenevert admired the walnut plaque with the bronze embossed icon of the Bethesda Naval Hospital and her name engraved just below it. Earning the Sailor of the Quarter (SOQ) award at a major medical command like Bethesda meant a significant career boost. She had placed the plaque on her desk just a week ago. The pride and satisfaction of the recognition had buoyed her confidence, despite the dark clouds gathering on her horizon.

Katrina worked in the Administrative Department of the Naval Hospital, the "Flagship of Navy Medicine." Not the role she had trained to do. Every day, she missed her prior duty in the surgical suites upstairs, performing actual patient care. She missed the work, but not the environment, and especially not the hateful rumor mongering.

"Excuse me, HM3."

A young sailor stood next to Katrina's cubicle. Different from his familiar gay flamboyance, his body seemed frozen in place, except for the embarrassed shuffle of his feet. He held one of the ubiquitous light blue folders used throughout the Navy.

"I, uh, need to give you this." A sigh. "Sorry."

The expected official document arrived like a sucker punch to Katrina's gut. She took a deep breath, reached out, and took the folder from the sailor's hand.

"Thank you."

The sailor pivoted and hurried away, as if to escape an approaching tidal wave.

The folder contained an official US Navy memorandum. Katrina read it three times before her heart left her throat and settled somewhere near its proper place in her chest. At age twenty-five, six years into a promising career and fresh from the SOQ award, her world crashed around her like a frame house in a hurricane. The memorandum's sections are text boxed below.

The stilted words on the paper cut into her Catholic-bred, guilt-nurtured soul like a cutlass.

7 October 1985

From: Commanding Officer, Naval Hospital, Bethesda, MD

To: HM3 Katrina A. Chenevert, USN

Subj: NOTICE OF ADMINISTRATIVE BOARD PROCEDURE PROPOSED ACTION

Ref: (a) MILPERSMAN 3630400

1. Per reference (a), you are being considered for an administrative discharge from the Naval Service by reason of Homosexuality as evidenced by engaging in, attempting to engage in or soliciting another to engage in homosexual acts.

2. If separation is approved by the Commander, Naval Military Personnel Command, it will result in discharge.

3. If separation is approved, the characterization of your service may be under other than honorable conditions.

Other than honorable? Katrina's hands trembled, but she continued reading.

4. You are entitled to the following rights and privileges.

Rights? Privileges? Katrina's head spun as she read the list. Consult counsel. Copies of documents. The right to request an Administrative Board and present written statements. Retain civilian counsel at my expense.

The notice gave her two working days to respond. Failure would cause a waiver of all "rights."

The last paragraph made her seethe with anger.

> 5. You are advised that, should you begin a period of unauthorized absence following delivery of this Notice, the separation processing in your case will proceed in your absence. You are further advised that your unauthorized absence will be considered a waiver of your right to appear personally before the Administrative Board.

I'm a flight risk?

She read the notice one more time, then called Jane, who was working elsewhere in the hospital.

"Did you get—?"

"Called down to admin? Yeah. So did Kareen." A pause. "Haven't gone yet. Is it?"

"Yeah. Notice of pending ADSEP and convening of an admin board."

"Damn. Okay, I'll get Kareen and we'll come down."

"Are we screwed, Jane?"

"Wurth's revenge, I say."

"We fight it."

"Damn right we do."

That evening, fear and anger perfused the atmosphere in the loft condo the three women shared in Laurel, MD. The offensive official notifications had surprised none of them. They knew the rumors that swirled around them in the close-knit environment of the surgical suite of the Bethesda Naval Hospital.

The printed documents each now held in her hand had crystallized those rumors into hard-core reality. The threats to their reputations, careers, well-being, and self-worth could be no less daunting than if their accusers held knives to their throats.

Patriotism and strict Catholic upbringing had motivated Katrina to enlist in the US Navy six years earlier at age nineteen. A top-performing recruit, she'd achieved selection to OR technician training. She had been proud to serve her country in a capacity in which she excelled. Her recognition as Sailor of the Quarter showcased her passion for Navy core values of honor, courage, and commitment.

She had received notification of the "proposed action" against her while serving in a different capacity: a so-called "admin weenie" no longer assigned to patient care. Rumors and bullying had forced her to flee the toxic environment of the OR.

"At least we have our certification as OR techs," she said to the others. "If, God forbid, we're forced out of the Navy, we can get surgical jobs as civilians."

Kareen scowled. "Hello? Did you not see the part about 'other than honorable'? How do you think that will affect your employability in the civilian sector?"

Jane huffed. "Yeah. Employers won't need to understand the reason for that characterization. They will see we got forced out of the Navy with our tails between our legs under dark clouds of disgrace. We could be criminals for all they will know."

"We're not criminals," Katrina said, voice on fire. "We're just . . . who we are."

"Lots of Navy folks don't like who we are," Jane said.

"They don't like what we are," Kareen said. "It scares the shit out of them. Especially a-holes like Wurth."

"It's not right," Katrina said. "We haven't hurt a soul."

Jane laughed. "I don't think Ralph sees it that way. His soul was plenty hurt."

"Because you left him?"

"Because and why I left him. More than his fragile male ego could stand."

Kareen raised a hand. "Hey, he's not the only one, and it's not just men."

Katrina shook her head. "When I joined the Navy, I didn't know who, or what, I was. How does anyone know at age nineteen?"

"Or in their twenties," Kareen said. "Half our detractors are probably upset because we do what they fear deep inside they might want to do. Or be."

Jane let out a long breath. "Nevertheless, here we are. What do we do now?"

"I've half a mind to tell them to stuff it and get out," Kareen said.

Katrina buried her head in her hands. She looked up with face flushed, eyes moist. "I can't do that. The Navy and my career mean too much to me. What they are doing to us is not right. I will stay and fight until they carry me out the door and dump me in the middle of Wisconsin Ave."

Jane put an arm around Katrina's shoulder. "Me too, babe. They won't get rid of us that easy."

Kareen shrugged. "Okay. We take it to them."

The three sat in silence, pondering the import of what they had just decided.

"Okay," Katrina said. "Let's look at this without emotion. First, we each need to get a lawyer."

"Not a Navy JAG," Jane said. "They work for the enemy."

"Right, we hire our own civilian lawyers. Damn the cost."

A gleam appeared in Kareen's eye. "Why not take the offensive? Sue them for defamation of character. This isn't the Middle Ages. Twentieth century rules apply. Let's take it to them."

"Good thought," Jane said. "We can get support from the LGBT League, right?" She paused. "Advocates. If we look around, we can find plenty to silence or at least intimidate the haters."

Katrina bit her lip and stared into space. Intense conflict stormed inside her. "You know what we're going to have to do if—no, when—they convene those boards?"

Jane caught her gist. "You mean what we *can't* do?"

Katrina nodded. "Yeah. We can't say what defines us."

* * *

"Homosexuality is a mortal sin. Those lost souls who practice it will suffer eternal hellfire."

How many times had teenager Katrina heard those words, or similar, spoken from the pulpit of the Catholic Church she attended every Sunday with her parents and two older brothers? Or by the nuns at the Catholic school in Exeter, NH?

No matter. It didn't affect Katrina. Girls couldn't be homosexuals. That was a boy thing. Her brothers often tittered about it. They used words like "queer, fag, homo," or worse, "cocksucker, butt-banger." The very thought of boys doing those things with other boys was such a turnoff.

It was not Katrina's problem. Not John's either. Her boyfriend was a one-hundred percent American male.

"Pre-marital sex is a mortal sin. Those lost souls who practice it will suffer eternal hellfire."

Similar sermon/lesson, but with a relevant twist. That one did concern Katrina. She and John had gone steady since she was sixteen and he was nineteen. Of course, they fooled around, exploring each other, learning intimacy, discovering passion, brushing the threshold of "going all the way."

"I have to wait until I'm married for that," she told him.

Although he didn't hold the same value, John never pushed her. Even when he'd been drinking. They all drank in those days. Sometimes lust and alcohol tempted Katrina to surrender, but she always stopped. Even after a heavy petting session, when her whole body wanted it, her fear of eternal damnation pulled her away from the brink.

Sure, she could go to confession and get pure again. Except she wouldn't be pure. Never, after even one time. She must save herself for marriage, like a good Catholic girl.

A year passed. Katrina had taken notice of a young man, Bob, who shared a trailer with her brother. She wanted to pursue him, but . . . John.

At seventeen, Katrina was still a "kid," new to relationships. How could she pursue her interest in Bob without making John jealous or angry? How would he react?

The angst and conflicting desires reached a climax on a November night that would forever change Katrina's life. It happened in front of the trailer that Bob shared with her brother. Where John used to live. Katrina wanted distance from John, the freedom to pursue Bob. The argument with John didn't last long, and Katrina never mentioned her interest in Bob. She just told John she needed space to see other people. Furious, John agreed.

Later that same night, John, Bob, and Katrina's brother went to a bar. John drank heavily, left the bar intoxicated, climbed into his truck, and drove toward his grandparents' house.

On her own, Katrina slept fitfully. She dreamed of a friend's mom telling her that the woman had only so long to live. Headlights shining through her bedroom window awakened Katrina in mid-dream. Seconds later, her brother banged on their door, sobbing.

"John's dead!"

Driving from the bar, John had fallen asleep at the wheel. His truck left the road, careened down a hill, and struck a tree. The steering wheel crushed him. Dead on impact. Just after his twentieth birthday.

"My fault," Katrina wailed. "My fault." For the first time, Katrina thought about killing herself.

After the tragedy of John's death and her own pervasive guilt feelings, Katrina drifted through life and thoughts of death. She often drank to excess and sometimes experienced suicidal thoughts. Those induced some futile attempts at cutting her wrist.

Besides her staunch Catholic upbringing, Katrina had also inherited a strong sense of patriotism. A military career seemed an enticing re-direction for her life. A better choice with a more promising future than the aimless existence she'd suffered in the two years since John's death.

She checked out the US Air Force as an option. They offered her an enlistment as an aircraft mechanic.

Not only no, but hell no.

She investigated the US Navy. The recruiter showed her a pathway to become a hospital corpsman.

Sold.

The Navy enlistment paperwork included a stamp with two check-off sentences (yes or no): “Are you a homosexual? Have you ever smoked marijuana?”

Katrina answered “no” to both questions. Although she still drank, she’d only experimented with drugs. Homosexuality? No issue. US Navy recruit, Katrina Chenevert, considered herself as straight as any woman could be.

In 1979, nineteen-year-old Katrina checked into bootcamp at the Navy Recruit Training Command at Orlando, Florida. Upon completion, she transitioned to US Naval Station Great Lakes, near Chicago, IL, to begin Hospital Corpsman School. Thus began a twenty-eight-year Navy career.

After she completed training as a basic hospital corpsman, Katrina got accepted for specialty training as an operating room technician. In 1983, full of expectation, Hospitalman (HN) Chenevert transferred to the US Naval Hospital in Bethesda, MD, as an OR Technician. Little did she expect how her life would change in the next two years.

* * *

While still in OR technician training, Katrina dated and got engaged to a male sailor. Somewhere amid the prevailing culture of partying, drinking, drugs, and fraternization involving officers attending enlisted parties, Katrina had a niggling sense that her engagement didn’t feel right.

One night, she stood duty with a Hospital Corpsman First Class (HM1), Jill Carp, a career counselor. Katrina became attracted to the woman. Jill later received her commission as a Medical Service Corps officer. Soon after, they hooked up, and—despite everything she’d believed in the past—Katrina relished the experience. Although for a while she wavered back and forth, she came out to herself and pursued a relationship with Jill. She flew to California, where Jill now lived. Katrina’s world crashed when she discovered Jill had a live-in girlfriend.

“What have I done?” Katrina did what any good Catholic girl would do. She confessed to a Navy chaplain.

“We cannot condone homosexuality, either in our faith or in the United States Navy,” the man said.

Once again, Katrina entertained thoughts of suicide. She clandestinely checked into the Walter Reed Army Medical Center in Washington, DC. After four days there, she resolved to continue her Navy career, and her homosexuality.

The OR milieu that Katrina joined as a certified technician turned out to be a hotbed of dysfunctional personalities and relationships. The mid-1980s culture featured a continuous cycle of partying, drinking, fraternization, and sexual acting out. Rumors abounded in the close-knit community. Undaunted, Katrina began a relationship with another female OR tech, Jane Burseg. Working through her own sexual ambiguity, Jane took up an affair with a male corpsman, Ralph Wurth.

In a hierarchy dominated by narcissistic, arrogant males, none came more self-important than Wurth. He mentioned within the first few minutes of meeting Katrina that his father was a cardiothoracic surgeon. As if that conferred special status, he had gotten himself assigned as an OR tech in the cardiac surgical suite. Ralph regarded any woman in the department as a potential sexual conquest. By the time Katrina's administrative board convened, Ralph had dated or had sex with other women in the department, including Jane Burseg.

Wurth had heard rumors about Jane and Katrina being gay lovers. He claimed not to care, yet later asserted that Jane had told him she was gay and in love with Katrina. Wurth continued his intimate relationship with Jane. He found her "exciting," and believed that her continued relationship with him implied she would reject her homosexual dalliances. Later, he claimed she had an aversion to coital sex, which wounded his ego.

After six weeks of dating, Jane Burseg ended her relationship with Ralph Wurth because she was too confused to continue. He would later claim that his opinion of her degenerated from love interest to low regard because of the choice she made, but he would testify he had seen no homosexual acts between Katrina and Jane.

Not long after Jane ended the relationship with Wurth, he approached the OR department head. He expressed his opinion that Katrina and Jane were guilty of homosexuality, a violation of Navy regulations. He also claimed that the department's leading chief petty officer had shown favoritism to the female petty officers. (The chief had advanced Katrina to a position of higher responsibility.)

The OR department head responded that if Ralph believed what he asserted, he must report it to the Naval Investigative Service (NIS). Ralph Wurth's formal complaint to NIS began the process that landed Katrina in the administrative board hearing that threatened her naval career.

* * *

Six months after she received notice of the board, Katrina fussed with her summer white uniform in the ladies' room at Bethesda Naval Hospital. She adjusted the blouse so that the buttoned edge bisected the waist of the skirt; a proper "gig line." Her right hand brushed across the Good Conduct and Pistol Proficiency ribbons above the left pocket, then to the rate and rank insignia adorning the left sleeve. She traced a finger over the black woven eagle with wings spread, head facing forward, symbolic of the United States of America. Her nation, whose constitution she had sworn to defend against all enemies, foreign and domestic.

She touched the woven caduceus just below the eagle. It symbolized her commitment to her pledge when she completed hospital corpsman school. To "hold the care of the sick and injured to be a privilege and a sacred trust," and to "dedicate heart, mind, and strength" to the work before her. To do all within her power to show in herself "an example of all that is honorable and good" throughout her career.

The single woven chevron below the caduceus signified her rank as third-class petty officer. If she had worn her service dress blue uniform, a single red stripe would adorn the left sleeve, symbolic of four years of honorable service. She would get a second red stripe the next year, marking eight years of service since her enlistment as a starry-eyed nineteen-year-old in 1979.

Those insignia on Katrina's left shoulder represented the core values and goals of her life since she raised her right hand and swore the oath. By the end of the day, the Navy could take it all away from her. Not for malfeasance or for dishonoring her enlistment oath or the corpsman's pledge; not for misconduct; but for no reason other than an arbitrary regulation drafted by men who believed they had just cause to fear someone different.

Katrina took a deep breath. She had done all she could to thrive in her chosen enlisted classification as a surgical technician. The hostile environment of the Bethesda OR suite had undermined those Navy core values of honor, courage, commitment. Katrina took one last look in the mirror, then left the restroom and walked down the hall toward the board conference room.

Master Chief Corpsman (HMCM) Ted Price approached her just outside the door and offered a warm hug. "You've got this, Katrina. We're all behind you, a hundred percent."

Katrina fought back tears. She and Ted had been friends in the past, and he looked out for her. He was in love with her, even though he knew about her sexuality. The two had been the target of an earlier NCIS investigation. Navy rules and regulations considered a "relationship" between a master chief and third-class petty officer as "fraternization." That investigation had gone nowhere because no such fraternization existed. The two remained friends. Did it matter that HMCM Ted Price had assigned the members of Katrina's admin board? Favoritism, or doing the right thing against an unjust procedure?

After some minutes, the door opened, and Katrina's assigned Navy JAG counsel approached her.

"The board is ready to convene," the woman said.

Katrina heaved a sigh, straightened her gig-line, called up her courage, and followed her counsel into the boardroom.

The board heard testimony from Ralph Wurth, Jane Burseg, Katrina, and others, then recessed. It took them less than an hour to consider the evidence and generate their findings.

When invited back into the room, Katrina looked for clues in the faces of the board members. She found none. Almost trembling, she stood at ramrod attention to hear her fate.

As soon as the Board chairman spoke, his calm tone of voice caused her to relax.

“By a vote of three to zero, this Administrative Discharge Board finds the respondent has not committed any acts of homosexuality and is not a homosexual. By a vote of three to zero, the Board recommends the respondent be retained.”

In the hallway, Katrina hugged her attorney. “Thank you, thank you.”

Jane came around the corner. The two women hugged, then the JAG joined the hug.

When they released, the JAG turned serious. “It’s not over. The recommendation goes to the Bureau of Navy Personnel. They have the final say.”

The blood drained from Katrina’s head. “How long will that take?”

The JAG looked between Katrina and Jane. “Don’t be holding any breath.” She sucked on her lower lip. “And for God’s sake, watch yourselves. Lie low. Don’t just stay out of the rumor mill. Stay away from anyone who might stoke it.”

She looked each of them in the eye. “Understood?”

“Aye, ma’am,” Jane said.

“Aye, ma’am,” Katrina said.

When Katrina and Jane left the hospital campus, they did not look at each other.

* * *

Two months later, the official naval message of adjudication arrived, confirming the decision of the administrative board exonerating Katrina and confirming her retention in the United States Navy.

My nightmare is finally over!

Except it wasn’t.

Not by the time Katrina retired with honor from the Navy as a Lieutenant Commander in 2007. Four more years would pass before the repeal of the ineffectual “Don’t Ask, Don’t Tell” policy in effect since 1993. Two years later, 2013, would see the repeal of the Uniform Code of Military Justice Article 125 ban on consensual gay sex, enacted in 1951. Eleven years later, the President of the United States would formally pardon former US military members convicted and discharged under that act.

None of those events glimmered over the horizon as Katrina labored to rebuild her nearly derailed Navy career in mid-1986. That formal naval message of exoneration and retention had minimal effect on the ongoing rumors, innuendos, and threats that would plague her for the rest of her service to the nation.

It's as if I'm wearing an indelible 'gay' neon sign on my back.

The Navy world is small, and the Navy medicine community is a microcosm. An event as dramatic as an administrative board for homosexuality, no matter the outcome, will follow anyone who survives it. Katrina was no exception.

The milieu of partying, drinking, and fraternization endured through the 1980s. Still assigned to the Navy Hospital in various rotations, Katrina continued to drink, often to excess and with consequences. Thoughts of suicide again emerged, not because she was gay, but because of the terrors and threats she perceived after the humiliation of the administrative board.

When will the next one hit? Who knows about the admin board? How do I interact with others?

Friendships with other military members never felt real. She could not discuss her sexuality, even with those who might accept her, for fear of some future action that might force them to disclose their knowledge. Often, friends who truly didn't care if she was gay would bait her by implying that they knew. Katrina always cut off those conversations.

As Katrina came due for orders, she expected to be assigned overseas per the typical Navy rotation. This became another source of anxiety. The Navy assignment process requires interaction with a Navy detailer, an officer who reviews the sailor's record, considers their assignment preferences against available positions, then assigns the sailor to the "best fit" for the needs of the Navy and the sailor's wishes. The system lacks checks and balances. A detailer can scuttle a career for no reason. Katrina's detailer would have a copy of the administrative board proceedings and adjudication.

What could he do to me with that information?

Two events clarified what Katrina must do. The first happened when she saw Jane flirting with another woman. Katrina reacted by putting her hand through a window. She had to make up stories about the resulting injury. The second event occurred after her interaction with the Navy detailer resulted in orders to Bermuda. She was drinking heavily, got arrested, and charged with her second DUI. She lost her driver's license.

Katrina quit drinking in 1987. Sober and committed to success, but still uncertain about that neon "gay" sign on her back, Katrina reported to her new duty station in Bermuda. She would face another attempt to sully her career.

In a precursor to every duty station where she would serve, in Bermuda Katrina faced the wrath of a chief petty officer—a former Catholic seminarian married to a corpsman the same age and rank as Katrina. The wife had heard about Katrina's past and reported it to her husband. Later, the officer in charge told Katrina that the chief had informed him about her administrative board and her being gay.

"I don't care," that officer said.

The chief's attempts at derailing Katrina's career thus spoiled, he took out his anger by giving her, the gay single kid, all "the crap duties" such as cleaning the urinals in the men's head (restroom) and putting her on call for all holidays.

Katrina's qualification for the Navy dive school became her ticket out of the Bermuda situation. Subsequent duty stations were also onerous, but as time passed, she encountered less homophobia. The nation and the Navy were growing up.

She eventually applied for and received a commission as an officer in the United States Navy.

Newly commissioned Ensign Katrina Chenevert, Medical Service Corps, USN, reported to US Naval Hospital, Jacksonville, Florida, in 1990, to an immediate problem: Her secret clearance, a requirement of her new job, came up for renewal. This resulted in a damning interview by an NIS officer, who questioned her at length about her past administrative board and her sexuality.

"It has been brought to our attention that you have participated in something other than normal sexual activity," the investigator said.

Katrina went into an immediate fight-or-flight reaction. "Who said that?"

"Several people."

"Clever," Katrina said. "Is this how you frame the question under 'Don't ask, don't tell'?"

The investigator was not amused. He repeated his question.

"We were all exonerated by an admin board in 1986." Katrina feared the worst.

The secret clearance came through and Katrina embarked on the next phase of her career. Although the rumors, innuendos, questions, and anxiety-provoking situations continued, they were less often and less onerous in the officer community.

* * *

In 1995, Katrina met, dated, and fell in love with Elaine, the woman she would eventually marry and with whom adopt a child.

With Elaine, Katrina found a new comfort, self-acceptance, and peace. But even that relationship suffered through the persistent anti-gay atmosphere. Navy personnel who worked for Elaine fomented rumors about the two of them living together as a gay couple. They had to phrase their introductions of each other depending on the audience or group. They would characterize themselves as either "my friend," or "my partner" as the situation dictated.

When they moved in together, they rearranged the house, so it looked like they had separate bedrooms and personal spaces whenever they had company. Their next-door neighbor, a foreign military member, posed what turned out to be an imagined threat. But how could they be sure?

Finally, after twenty-eight years of honorable service in the United States Navy, Lieutenant Commander Katrina Chenevert put on her service dress blues for the last time and engaged in the traditional retirement ceremony. Still shackled by the culture of the time, she could not properly address her life partner or enumerate the many influences Elaine had over Katrina's life and career.

Instead, she gazed at her partner, choked back a tear, and said, "Elaine, thank you for always being there."

Author Note

The insights and views expressed in this vignette are those of the authors and do not represent the views of any communities the authors serve. The authors have no financial conflicts of interest. This vignette details real incidents in the military career of LCDR Chenevert, who has chosen to use her own name in the story, as well as that of her partner, Elaine (without surname). All other names in the story are pseudonyms.

Special Notation

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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.

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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.

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