New PTSD Treatment Technique!

**AAT:** Associative Awareness Technique

**INSIDE:**
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**Special Interview:**
Charlie Daniels
MUSIC LEGEND & AMERICAN PATRIOT

Also in the issue:

- Alternative Treatments for SRI Resistant PTSD
- Col. Kathy Platoni’s Retirement Celebration
The mission of AIS is to improve the health of the community and the world by setting the standard of excellence of stress management in education, research, clinical care and the workplace. Diverse and inclusive, The American Institute of Stress educates medical practitioners, scientists, health care professionals and the public; conducts research; and provides information, training and techniques to prevent human illness related to stress.

AIS provides a diverse and inclusive environment that fosters intellectual discovery, creates and transmits innovative knowledge, improves human health, and provides leadership to the world on stress related topics.
COMBAT STRESS

We value opinions of our readers.

Please feel free to contact us with any comments, suggestions or inquiries.

Email: editor@stress.org

Editor In Chief:
Daniel L. Kirsch, PhD, DAAPM, FAIS

Editor:
Kathy Platoni, PsyD, DAAPM, FAIS,
COL (RET), US Army

Combat Stress is a quarterly magazine, published in February, May, August and November. Each issue contains news and advertising designed with service members, veterans and their families in mind. It appeals to all those interested in the myriad and complex interrelationships between combat stress and health because technical jargon is avoided and it is easy to understand. Combat Stress is archived online at stress.org. Information in this publication is carefully compiled to ensure accuracy.

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AIS Combat Stress Board

Chaired by Colonel Platoni, the role of this board is to develop initiatives and communications to serve the stress management needs of Service Members and veterans.

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Watch now to understand how trauma affects, pain, depression and other chronic conditions.
A key commonality of chronic pain and PTSD is the element of unresolved trauma. Typically, treatment for these two disorders and related comorbidities (e.g., insomnia, IBS, fear, loss of sense of self) are carved out to various health care professionals, without an agreed upon treatment plan. A multi-disciplinary approach quite often does not work due to the lack of a common medical language and an understanding how the nervous system aberrantly functions for these traumatized individuals. Associative Awareness Technique (AAT) provides a safe and non-invasive approach to treating these mysterious disorders by providing a treatment process that is designed around the form and function of the central nervous system (CNS). Moreover, once a patient is trained, he or she can self administer the “tools” of AAT to make the necessary neuroplastic changes required to reduce or eliminate the physical manifestations of chronic pain and PTSD.

According to Scaer (2001), trauma can be defined as a “negative life experience in a relative state of helplessness.” The problem for those suffering from chronic conditions such as pain, anxiety, depression and/or PTSD is the repetitive activation of the instinctive processes of fight, flight and freeze over time that are quite often the result of a sustained stress response and/or a traumatic experience such as a motor vehicle accident, combat stress or catastrophic event inherent in the war time theater. When a person has been suffering for a long time, the brain has inevitably activated its “instinctive” protective pattern over and over again, resulting in a frustrating and cyclical syndrome. According to Scaer, this can be described as rapid cycling of the autonomic nervous system (ANS).
The ANS of the traumatized individual forms a habit of activating this instinctive protection inappropriately, like a false alarm. When this false alarm is activated so many times for prolonged periods, the habitual result is the brain always instructing the body to maintain a pattern of high level protection, which involves sustained muscular tension. Over time, the person begins to develop emotional associations with anger, helplessness, sadness, frustration, hopelessness, fear... throughout these experiences. In time, his/her emotions have a dramatic impact upon chronic patterns of pain, anxiety, fear, etc. For most people, when their stress levels increase, so do their patterns of physical symptomatology.

As one develops emotional associations to chronic medical conditions, experiential associations (memories) of their limitations and even anticipatory fears based upon those memories begins to develop (Lefton and Brannon 2006). This occurs within their conscious brain, or neocortex. This is where we live: our awareness, memories, creativity, logic, humor, problem solving, concentration all reside here. Our thoughts, memories and their associations, as well as anticipatory expectations can also heavily influence the activation of fight and flight protective patterns. So the very problems inherent in chronic conditions lives within all three divisions of the brain, which Kolb and Wishaw (2011) discuss in their text *An Introduction to Brain and Behavior*:

**The Brainstem:** Houses the autonomic (automatic brain) nervous system. This is the most primitive level of the brain and is charged with all things related to survival. *It requires no conscious permission or awareness.*
**The Limbic System** (emotional brain): creates emotional associations to experiences and memories. There is a conscious component to the emotional brain, as well as an unconscious component. For example, fear creates muscle tension, which elicits physical pain and perpetuates this frustrating vicious cycle.

**The NeoCotex** (conscious brain): This is where your conscious memories are stored; your anticipatory expectations, thoughts and beliefs. We cannot intellectualize instincts. No matter how hard a person tries to relax their muscles at a conscious level, the muscles will *never* stay relaxed, as when the brain stem perceives a threat in its sensory world (whether real or perceived) it will *always* activate the fight/flight/freeze response. This instinctive, reflexive response never requires permission from the conscious brain to be activated because it is a purely a survival instinct.

In order to reduce the potentially disabling effects of chronic pain, PTSD, anxiety, depression, gastrointestinal issues, etc.; Musgrave and Quinlisk submit that all three levels of the human brain must be addressed. This may be a reason why treating the body with medicines and therapeutic interventions that address one or two areas of the brain generally do not fix the problem(s). Unfortunately, most of the standard treatments for chronic conditions utilize a combination of approaches that are primarily geared towards management of chronic pain.

**AAT as an Alternative for Treating Chronic Pain and PTSD**

AAT has been developed by physical therapists (implying that touch is involved in the treatment) and has been designed to address all three levels of the human brain. AAT follows the form and function of the human nervous system and once learned by the patient, can be self-applied, allowing the individual to make the necessary positive changes in their brain, without continuous visits to healthcare practitioners.

AAT is potentially a front line approach that can be used to diminish the potentially disabling effects of chronic pain and PTSD, which in turn may render other treatments more useful because the ANS has moved closer to homeostasis. It is a three level treatment process that corresponds to three levels of the human brain. This self-directed treatment program is specifically designed for the patient who is not responding to conventional treatments such as physical therapy, acupuncture, chiropractic interventions, massage therapy, medications, cortisone injections, surgery and the like.
AAT Level 1
The first two steps of AAT (Level 1) are directed at the “first” brain or the autonomic nervous system (ANS). The ANS (also known as the reptilian brain) controls all the systems of the body without conscious control. For example, the heart beats, the individual breathes and the digestive process occurs involuntarily without conscious permission. During a traumatic event, muscles will instantly tense, the digestive system slows down and a person will become hyper alert to the current situation or conversely, shut down or become frozen and unable to respond or remember what just occurred.

The first step of Level 1 involves learning an exercise that when performed habitually throughout the course of the day begins to recondition the brain into believing it is safe as opposed to feeling threatened. The exercise is painless and easy to perform and can be done almost anytime, anywhere and in any position.

The second step of Level 1 involves the therapist administering safe, sensory input to the body in the form of warmth, gentle vibration, music and touch. When multiple types of sensory input are simultaneously perceived by the brain to be safe as opposed to threatening, the brain begins to let its guard down and relax. This important first step can provide a sense of calm and peace that is quite foreign to most patients afflicted with chronic pain, PTSD, anxiety, etc.

AAT Level 2
The second two steps of AAT (Level 2) are directed towards the second brain or limbic system. The limbic system (some people call this the emotional brain) is responsible for determining whether or not sensory information (sight, smell, touch, taste, hearing) entering the brain is safe or threatening. The brain organizes this information and compares it to previous experiences. If the brain decides the sensory information is safe, then the body will remain calm and balanced. Conversely, if the brain determines the sensory information is threatening, then the fight/flight/freeze response will be automatically triggered and the body will become tense and assume a protective posturing. This is a normal response to a threat and when short lived, ordinarily does not cause any associated physical problems. If this response is sustained for days, weeks, months or even years, the individual is highly likely to experience physical and mental health problems such as pain, insomnia, anxiety, depression, irritable bowel syndrome, restless leg syndrome, fibromyalgia, chronic fatigue syndrome, etc. Even though this step deals with emotions, one is not required to discuss the details of the trauma(s) that created these emotions.

During level 2, the patient is taught to become aware of how their physical state is negatively affected (triggered) by their emotions and the sensory associations of
previous experiences. For example, if someone has been in a motor vehicle accident the sound of screeching tires or crashing metal, the smell of burning rubber or the sight of someone driving too close can cause a person to become triggered. The two steps of level 2 (in addition to Level 1) teach a patient how to regulate their nervous system, which will in turn minimize or eliminate the deleterious physical effects of being triggered. Remember, all of these triggering responses occur automatically without any conscious input or control.

**AAT Level 3**

The last two steps of AAT (Level 3) are directed towards the “third” brain or neocortex. The neocortex (some people refer to this as the thinking brain) is responsible for conscious thought, self-awareness and one perceives themselves. Quite often, chronic conditions create a skewed sense of self that perpetuates the vicious cycle. For example, a person may feel responsible for the injury a fellow Service Member sustained. This may cause guilt and/or shame. These emotional states have concurrent physical responses that if sustained will contribute to the dysfunctional states of pain, anxiety, PTSD, etc. Once again, during this level of AAT, one is not required to discuss or re-live the details of traumatic events.

AAT is indicated for all of the following chronic conditions:

- Chronic Pain
- Fibromyalgia
- Chronic Fatigue Syndrome
- PTSD
- Failed Surgery (i.e., cervical and/or lumbar fusions, hysterectomy)
- Unexplained Pain Patterns
- Stress (self-induced or the manifestation of secondary stress created by others)
- Depression
- Anxiety

Chronic pain and PTSD create a conundrum for countless medical practitioners who attempt to treat these perplexing conditions. AAT proposes that part of the problem is due to the fact that there is not a common language among medical practitioners and the scientific community. Also, many medical practitioners lack an understanding of how the nervous system becomes dysfunctional for these individuals. When a patient learns AAT, he or she can begin to change their own nervous systems physical reactivity to sensory triggers, which are based on previous negative experiences.

**References:**


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Patient Self Reports: Alpha-Stim® vs. Drugs

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Percent of Patients Reporting Improvement

0% 20% 40% 60% 80% 100% Service Member Civilian

Patients who reported a positive response according to WebMD Drug Surveys, and Alpha-Stim Service Member and civilian surveys. Alpha-Stim Data from 2011 Military Service Member Survey (N=1132) and Alpha-Stim Patient Survey (N=1,743), Conducted by Larry Risco, PhD, Associate Dean of Research and Professor of Psychometrics and Statistics, Texas State University. Pharmaceutical Survey data from www.WebMD.com/drugs. Accessed on October 24, 2011.

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First we got your brain...

Now we need your heart.

The American Institute of Stress helps people learn to manage their stress every single day. We help veterans returning from war find a sense of normalcy again. We help students who are stressed about exams, busy schedules and bullies reach their fullest potential. And we help people like you deal with whatever life throws at you! With your ongoing support, we will continue to be there providing people with relief for today and hope for tomorrow.

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Exclusive interview with:

The Music
The Man
The Patriot
KM: First all Mr. Daniels thank you for taking time out of your schedule to visit with me today. I know you are touring and I appreciate the opportunity to speak with you. I am beyond excited to speak with you because I am personally a huge fan of your music and have attended your shows in Oklahoma. My daughter is 11 and has played the fiddle since she was 6. The reason she asked for lessons is because she heard and loved “The Devil Went Down to Georgia.” Before this interview was scheduled, I knew a lot about you from your music, but in preparation to speak with you today, I have learned that you bleed red, white and blue and have very strong political opinions and are not in the least afraid to share them.

CD: To me that is what being an American is about. You are supposed to be able to state your beliefs without worrying about any kind of repercussion. To me it is not only a right, it is a duty. It is a duty for people to find out about things and to form their own opinions. To many people form their opinions by what they hear and what is in the press or what is on TV. They don’t really form an independent thought. I try to do my own thinking.

KM: At AIS, we too have very strong political opinions when it comes to service members, veterans and their families. We work every day to make sure these people that have sacrificed so much already, are very well informed and fully supported to navigate the long healing process ahead of them.
CD: Well I salute you because it’s a much needed thing.

KM: A lot of what we do focuses on non-pharmaceutical therapies to heal Post Traumatic Stress Disorder. Things like art therapy, military family retreats, cranial electrotherapy stimulation, Biofeedback—and a big one is music therapy—educating people on the scientifically proven stress relief benefits of both listening to and making music. The way people can connect through powerful music and lyrics, and also the way people can express their feelings through music can be very helpful in the healing process for PTSD and also just with daily life stressors. You have some hits that make some bold statements that resonate and connect with a lot of people—your songs put into words what people are feeling and thinking.

Back in the 80’s you wrote and recorded the hit "In America", the song was a reaction to the varying difficult issues facing America in the late 1970s – the fall-out from the Watergate scandal, the simultaneous double-digit inflation, unemployment, and prime interest rates (leading to the misery index), and the 1979-1981 Iran Hostage Crisis. Listing all the problems America was facing, the song described a patriotic, united America which would overcome the obstacles and return to its greatness ("we'll all stick together and you can take that to the bank / That's the cow-boys and the hippies and the rebels and the yanks"). The song experienced a revival following the September 11 attacks, when it was floated around the Internet as "F*** Bin Laden."
**CD:** It is actually a direct reaction to the Iranian hostage crisis. That particular song I remember a lot about writing because I remember what got me to write it. We had gone through a very unhealthy lag in patriotism. There was draft card burning all through the Vietnam War and during that era. I have always been a patriot. I have always loved America and respected the flag and the military service. I just got the point where I wondered if this was ever going to end. Are we ever going to be a patriotic America again? Are we ever going to be proud of our country and our flag? When the Iranian hostage crisis was happening I remember hearing people talk it and say things like we ought to go over there and do this and that... it was like a revival of patriotism and people were taking up the United States. Instead of blasting it, they were taking up for it. People were saying this is the greatest country on the face of the earth and no one can do that to us.

**KM:** Do you use your music to vent, and let off steam or make a statement?

**CD:** I don’t think of music in those terms, since it has been such a big part of my life for so long. I have been a professional musician for 56 years. Song writing is a daily part of my life. I always have ideas for tunes in my head. It is an ongoing process with me. In fact, there are songs that I have written that I can’t even tell you where the motivation can from. The music just happens. So I don’t really put it in those stringent of terms. It is a way of life for me. I tend to think about things in music. I start with a guitar riff and an idea and go with it.
**KM:** Does your music play a role in how you manage your own stress?

**CD:** I am sure it does, it plays a role in everything I do. But there again, I don’t necessarily think about it in that way. I take great joy in entertaining people. If you ask me what I do, I tell you I am a musician, a song writer, I am an entertainer. I have strived to be an entertainer. I is such a joy to me to go on stage and play music with my band. So I guess it would be, but I look at it as a form of enjoyment. I thoroughly enjoy making music. I am sure it does have some bearing to be able to sit down and pickup and instrument, start being creative with it and get your mind off everything else. I am sure that would play a part.

**KM:** You have a lot of tunes and songs that you have written and recorded. They all seem to have a very strong patriotic theme. Did you or anyone in your family serve in the military?

**CD:** Well people in my family have served, but I never served myself. I was five years old when Pearl Harbor was bombed. I was too young for the first wars in my lifetime and too old for the others. I didn’t want to go into the service because I wanted to play music. As soon as learned a few chords on a guitar all I ever wanted to be was a successful professional musician. I didn’t go to college. I think going to college would have been a waste of time for me. I just wanted to play music. But, I have always been a huge supporter of the military. I have been a lot of places in the world to entertain our troops. That is kind of my way of serving. I can’t carry a gun anymore, but I can carry an instrument.

**KM:** In doing research to interview you, I see that you have performed in a long list of USO shows, it is clear you strongly support our troops and love America—What fuels your patriotism?

**CD:** I grew up in a very patriotic time. When everyone in America was patriotic. There was no two ways about it. Everybody supported America. I remember the day Pearl Harbor was bombed. Those were my formative years. I came up during that time. I came up in a very strategic place in North Carolina. It was a seaport town and a lot of shipping that had to do with the war went out of there. We had the German U boats just off our coast that sunk ships out there. The war was very real to us. We had air raid drills, blackouts and rationing. The war was very real to us, it wasn’t something we looked at, at arms length. Things weren’t as sophisticated as it is now with all the satellite technology. We never knew exactly were the enemy was or where he was coming from. This was not something happening faraway it was going on very near to us. I became aware that there were two things protecting us: the grace of God and the United States military. It was that way then, it is that way now and it will be that way as long as there is a free America.

“I became aware that there were two things protecting us: the grace of God and the United States military. It was that way then, it is that way now and it will be that way as long as there is a free America.”
KM: You have a blog called the Soap Box and you recently authored a book called “Ain’t No Rag: Freedom, Family and the Flag”—it seems you have a lot to say and people want to hear it—Do you write all those blogs? What do you hope to accomplish with the blog and the book?

CD: It is just one of the things that I do. It is another talent that God gave me that I discovered some years ago. I just discovered this talent that I could write and communicate. I communicate through words and music.

KM: You are very generous and give a lot of your time and money to supporting the troops and their families through various fundraisers and camps for military children, the USO concerts etc.-I am sure you know that your team has worked out a very generous package of donated tickets to some of your upcoming shows. We (AIS) are putting together small “get-a-way” vacation packages around the show dates and hosting a free drawing on our Facebook page so ONLY service members and veterans and can enter to win them and come to your shows for fun and relaxation.

CD: That is the least we could do. We owe these people an unpayable debt of gratitude. We can never pay them back for what they have done. We can never approach anything to repay them for what they have done. This is just our way of saying thank you.

KM: Through your music you directly impact the emotions of people, your lyrics get people thinking, your music makes a difference. Is there anything you would like to say or any kind of direct message you would like to give our readers. They are from all branches of service.

CD: I just want to say thank you. I am aware of what you have been through. I have been among you in some pretty desolate parts of the world and whether your based in this country or some hell hole over in Afghanistan or Iraq ... You folks are the best we’ve got. There are no finer Americans than the ones in uniform. We are beholden to you and we thank you. Anything we can do for you, we try to do it.

“There are no finer Americans than the ones in uniform. We are beholden to you and we thank you.”
Enter the FREE drawing to win getaway trip to see Charlie Daniels in concert in either San Antonio, Branson or Las Vegas!!
We're giving away tickets, August 29th!!

3 winners for the San Antonio show September 17th
1 winner for the Branson show, November 7th and 1 winner for the Las Vegas Show, December 12th!

Winners each receive two tickets to see The Charlie Daniels Band in concert, two nights hotel stay and $200 cash!!
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2. Leave a **comment** on the Charlie Daniels Band Getaway Giveaway post—stating your branch of military service and the location of the concert you want to win
3. Then **Share it** on your page!

**Winners will be notified via Facebook message! This drawing is open ONLY to service members or veterans. Must show Military ID to receive tickets. You can enter as many times as you'd like. Good luck!**

Mr. Paul Huljich, AIS member and author of “Stress Pandemic”

Dr. Heidi Hanna, FAIS, Founder of Synergy, author of Stressaholic
The National Institute of Mental Health (n.d.) describes Post-traumatic Stress Disorder (PTSD) as distress from memories of extreme trauma that an individual has witnessed, experienced, or learned about, particularly a trauma that causes physical harm or is life-threatening. Whether it was a single event, or a repeated experience, these memories will not go away and interfere in
the functions of daily life and the individuals coping abilities, affecting mental and emotional aspects of the individuals’ life, as well as their physical well-being.

According to Pare´ (2011), PTSD can happen to anyone, at any age; however, the prevalence of PTSD in military members and veterans is two to four times higher than for the general population.

The PTSD Foundation of America (2014) puts out an annual statistical report. In its most recent report it states that one out of every five military personnel returning from combat has PTSD. Twenty percent of those that were deployed within the past six years have been diagnosed, equaling over 300,000 individuals. In the past year there has been a 50% increase in rate of Chronic PTSD diagnosis. Yet, a staggering 50% of those with PTSD do not seek treatment.

There are four different symptoms associated with PTSD. The first symptom is Intrusion Symptoms. These symptoms involve reliving the traumatic event. Disruptive memories of the traumatic event that come back when not expected, causing both physical and emotional reactions. Sometimes referred to as, “Flashbacks”, they have the tendency to cause intense feelings of horror, fear, and hopelessness. The second symptom is Avoidance. This is best described as the efforts that are made to avoid the traumatic event. This involves avoiding places where the trauma may have occurred, sights, smells, sounds or people that may be reminders of the event. The third symptom is Negative Alterations in Cognitions and Mood. This includes dissociative amnesia, where the individual has the inability to recall key elements of the traumatic event. Negative beliefs about oneself, persistent negative emotions and the alienation from others. The fourth symptom is the Alteration in Arousal and Reactivity. This symptom refers to symptoms involving hypervigilance, aggressiveness, reckless behavior and sleep disturbances.

The diagnosis of PTSD cannot be made until symptoms have persisted for at least one month and the individual meets the diagnostic criteria for PTSD, and can be classified as Acute (less than 3 months), Chronic (greater than 3 months) or Delayed Onset (appearing greater than 6 months following traumatic event), as specified in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-V).
According to Cohen (2006), there are two primary methods of treatment for PTSD, psychotherapy and pharmacotherapy. Psychotherapy assists the individual in learning skills to manage their symptoms and develop coping skills. The techniques included are group psychotherapy, cognitive-behavioral therapy and hypnotherapy. Pharmacotherapy is used in conjunction with psychotherapy, as it helps reduce symptoms and has been known to enhance the effectiveness of the psychotherapy and improve quality of life.

The FDA has approved two treatments for PTSD, those being Selective Serotonin Reuptake Inhibitors (SSRI’s), Sertraline (Zoloft) and Paroxetine HCl (Paxil), all other operatives are used off-label. In 2010, the Department of Veterans Affairs and the Department of Defense (VA/DoD, 2010) updated their guidelines for the management of Post-Traumatic stress. According to the new guidelines, it is recommended that SSRI’s be used as first-line treatment with TCA’s (Tricyclic Anti-depressants) and MAOI’s (Monoamine Oxidase Inhibitors) as a second-line treatment.

However, the SSRI’s have not been proven an effective method of treatment for cases of Chronic PTSD and off-label use of Second-Generation Antipsychotics (SGA), such as Risperidone, are being prescribed for individuals with SRI-resistance. Second Generation Atypical Antipsychotic Medications are FDA approved to treat psychiatric conditions, such as: schizophrenia, bipolar disorder, and schizoaffective disorders, just to name a few. Risperidone was approved in 1993 for the treatment of schizophrenia.

In 2009, Leslie, Mohamed, and Rosenheck conducted a study on the Department of Veterans Affairs usage of off-label SGA’s and discovered that of the 279,778 individuals being treated in 2007 with SGA’s, 42.8% had PTSD. This number has since climbed to 90%, according to the National Center for PTSD (2011). Krystal et al. (2011) took this knowledge and spent six months testing 296 participants from 26 VA outpatient medical centers, who were diagnosed according to the Diagnostic and Statistical Manual of Mental
Disorders, fourth edition (DSM-IV) for military-related Posttraumatic Stress Disorder with SSRI-resistant symptoms, to see if the commonly used SGA, Risperidone, is more effective than a placebo in reducing the symptoms of PTSD and improve overall quality of life. Clinician-Administered PTSD Scale (CAPS) primary outcome measures from baseline to the end of the 24th week, showed no significance between the Risperidone and the placebo groups. The Risperidone produced a mere 3.74 point reduction from baseline to completion in the CAPS score. There was no significance found in any of the secondary measures. This study found that Risperidone is no more effective than a placebo.

The military has spent over $74 million in the past decade on Risperidone. Recently, the Army Surgeon General’s office cautioned against the prescribing of SGA’s for PTSD, as they could actually exacerbate and intensify symptoms, potentially leading to long-term health effects such as weight gain, muscle spasms and heart disorders. (Brewin, 2012).

**Alternative Treatments and Therapies**

The adrenal glands secrete glucocorticoids in response to stress. An elevated level of glucocorticoid hormones has been found to have an inhibitory effect on memory retrieval. Cortisol (hydrocortisone) is the most important human glucocorticoid, as it is essential for life. A key characteristic of PTSD is the presence of excessive retrieval of traumatic memories. Individuals diagnosed with PTSD often show low baseline cortisol levels.

Aerni et al. (2004), supported by a grant from the Swiss National Science Foundation, investigated the administration of cortisol in order to dissipate traumatic memory frequency and magnitude. Three individuals meeting diagnostic criteria for chronic PTSD according to the DSM-IV, with exclusion criteria including changes in pharmacotherapy, psychotherapy, or alcohol substance abuse within the three months prior to start of the study, signed written informed consents for the three month study. A double blind, placebo-controlled, crossover design of low-dose cortisol (10 mg/day) was administered orally for one month. One participant received treatment once a day in the late morning, and the other two participants received treatment twice daily (5 mg/noon, 5 mg/pm). The measure of treatment effect was the use of a self-administered self-report of the PTSD scale questions, to assess the daily rating of frequency and intensity of their physiological distress. Each month for three months, the participants were rated using the PTSD scale, by a trained interviewer, to measure hyper-arousal, as well as avoidance and re-experiencing/intrusion symptoms.

The administration of cortisol was found to have beneficial effects with a 38% reduction in at least one of the daily rated symptoms of traumatic memory retrieval. Improvements were also recognized in the clinician-administered PTSD scale ratings for both avoidance and re-experiencing, with speculation being that avoidance was re-
duced by the reduction of re-experiencing. Hyper-arousal symptoms showed no improvement; however, the researchers found evidence that cortisol treatments may be an effective preventative, by reducing the risk for delayed onset PTSD, as people with reduced levels of cortisol, in response to a traumatic event, are more susceptible to the development of PTSD.

There were no adverse effects and the administered cortisol was not found to suppress endogenous cortisol production, making it a low risk treatment at this dosage. Small sample size and short treatment period were seen as limitations in this study. The adrenal glands also release the hormone, Norepinephrine, in response to stress. The increase in Norepinephrine affects both cognitive alertness and response actions. Prazosin, a sympatholytic drug FDA approved to treat hypertension, is an Alpha-adrenergic blocking agent, specific for Alpha-1 receptors responsible for vasoconstrictive action of norepinephrine.

Southwick et al. (1993) discovered significance in the pathophysiology of PTSD, in that the enhanced postsynaptic adrenergic receptor responsiveness to CNS Norepinephrine, is a contributing factor to the disease. Essentially, if the postsynaptic alpha-1 receptors could be pharmacologically blocked, there may be symptomatic relief from PTSD. The functional role of the alpha-1 adrenergic receptors, in the CNS, is important in both the startle and sleep responses, contributing to the PTSD nightmares. Raskind et al. (2007), with the support of the Department of Veterans Affairs and the National Institute of Health (NIH), utilized the concept of sleep disturbances and nightmares in PTSD sufferers, and the association these have with the release of Norepinephrine, primarily at night. By exploiting the use of the alpha-1 adrenergic receptor antagonist, Prazosin, in an effort to reduce the amount of sleep disturbances and improve the quality of sleep of those suffering with the disorder.

Forty military veterans meeting DSM-IV criteria for PTSD, with diagnosis based on the results of the Clinician-Administrated PTSD Scale (CAPS), and with an average score of 70, and the Combat Exposure Scale (CES) with an average score of 9. Exclusion criteria include drug or alcohol abuse within three months prior to the study, history of schizophrenia, bipolar disorder, other psychotic disorders, or suicidal ideation. A stratified permuted block randomization procedure with Prazosin or indistinguishable placebo capsules was utilized.

Baseline measures were taken on day 1 and participants were given 1mg of either treatment or placebo, at bedtime for three days, on days 4 through 7 the milligrams were increased to 2, followed by an increase to 4 mg from day 8 to day 14. Day 15 to day 21, dosage was 6mg per day, days 22 to day 28 the dosage was at 10 mg, with a final increase to a maximum daily dosage of 15mg on day 28 to be continued for 8 weeks. Behavioral ratings were done on day 1, the end of week 4 and end of week 8. Blood pressure, after 5 minutes in supine position and again, after standing for 2 minutes, was taken at baseline, each titration visit, and at the
The primary outcome measure for this study was based on CAPS “recurrent distressing dreams” item, Pittsburgh Sleep Quality Index (PSQI) and the Clinical Global Impression of Change (CGIC). Secondary outcomes measures were the 17-item CAPS score, Nightmare Frequency Questionnaire-Revised (NFQ), PTSD Dream Rating Scale (PDRS), and the Hamilton Depression Rating Scale (HAM-D). Following the 8 week trial, it was determined that Prazosin produced significant and substantial improvement over placebo in all 3 primary outcome measures. The secondary measures found that Prazosin reduced military-related nightmares over other kinds of nightmares, shifting to more typical dreams, with a great reduction in depression.

Adverse effects of transient dizziness was reported, however, there proved to be no significance between the two control groups, as 9 were from the Prazosin group and 6 were from the placebo group. Nasal and sinus congestion was significant in the treatment group, as was the report of headaches. Limitations to this study were listed as the size of the study and time of administering the treatment. A larger placebo-controlled study, with both mid-morning and evening Prazosin dosing to help define the efficacy of the drug and the tolerability, would be beneficial.

One of the most abundant neuropeptides in the CNS is Substance P (SP). SP has connections in both physiological and pathophysiological processes, one of which includes the stress response. Its preferred receptor is Neurorokinin 1 (NK1), which regulates stress and anxiety responses. Funded by the National Institute of Health and designed in collaboration with GlaxoSmithKline, Sanjay et al. (2011), conducted a study with the hypothesis that by inactivating or interfering with the NK1 receptor (NK1R), with an NK1R antagonist, it could supersede the role it plays, reducing the symptoms of PTSD.

Thirty-nine individuals meeting the DSM-IV criteria for Chronic PTSD, with a score of greater than 50 on the CAPS and greater than 4 on the CGIS, were selected to participate in this research study. Exclusionary criteria included history of psychotic symptoms, schizophrenia, schizoaffective disorder, bipolar disorder, current anorexia/bulimia, alcohol or drug abuse within the prior three months, and must be free of all psychotropic medications for at least 1 week prior to the placebo lead-in. A fixed dose, randomized, double-blind, parallel-arm, placebo-controlled design, was conducted between, NK1R antagonist, GR205171 (5mg/day) and placebo. Baseline measurements included a physical and neurological exam, vital signs, weight, ECG, blood tests, urinalysis and toxicology and a lumbar puncture. The lumbar puncture was used for the determination of SP, as significant elevations were known to be found in combat veterans with PTSD. No psychotherapy was permitted during the trial.

A 2-week placebo lead-in period was completed, followed by the 8 week trial period of 5mg/ day, placebo or treatment. Weekly assessments were done for efficacy and side effects, as
well as blood tests for hepatic function. Adherence testing was also done weekly for the entire 8 week trial. Primary efficacy outcome measures utilized CAPS and secondary efficacy outcomes were used to measure the rates of response with a greater than 50% reduction in CAPS from baseline to completion and CGI scores of a 1 or 2, signifying “very much improved” or “much improved”.

There was found to be significant improvement in the primary efficacy outcome measures in CAPS scores. The secondary measures for both the treatment group and the placebo group were: Treatment 40%/Placebo 21%, met CAPS response criteria, Treatment 25%/Placebo 11% met remission criteria and Treatment 55%/Placebo 42%, although no significance was found, rated numerically higher on CGI-I. There was no statistical significance between the treatment group and placebo group in CAPS total scores at week 8, although a greater reduction in severity was reported. There were no serious adverse events reported.

The limitations with this study were the small sample size of 39 participants and the brief eight week duration of the study. This essentially created an insufficient time frame to test the efficacy of GR205171 for chronic PTSD. The fixed dose design and lack of pharmacokinetic data created a scenario in which drug metabolism differences could have impacted the outcome.

Conclusions
There is both scientific and clinical knowledge about which treatment techniques may be most effective for individuals diagnosed with chronic PTSD. This knowledge is based on both limited data and theoretical mechanisms of action involving antihistamine effects, dopamine and serotonergic systems and alpha-adrenergic receptors. The National Collaborating Center for Mental Health (NCCMH, 2005) felt the need to emphasize the importance of being aware that in conjunction with the pharmacological approach comes a wide variance in efficacy. Pharmacotherapy should be used as an adjunctive treatment, when trauma-focused psychological treatment has failed to work.

Although considerable debate exists regarding the relationship between PTSD and suicide, data analyzed from the National Comorbidity Survey showed that out of six anxiety diagnoses, PTSD alone was significantly associated with suicide attempts or ideation. (Sareen, Houlahan, Cox, & Asmundson, 2005).

Suicide is the tenth leading cause of death in the United States, with the National Alliance on Mental Illness (n.d.) reporting that veterans now account for 20% of that number. Maze (2010) proclaimed an average of 18 suicides daily and 950 attempts per month among veterans receiving services through the VA. Each of these veterans suffered from the symptoms of Chronic PTSD.

Returning to the numbers, of the millions of people diagnosed with PTSD, and Berger et al (2009) reporting only a 60% response rate to SSRI’s and fewer than 30% achieving full relief, further research needs to be done into safer alternative therapies for the treatment of Chronic SSRI-resistant PTSD.
REFERENCES


Dr. and Mrs. Kirsch recently traveled to Beavercreek, OH to join in honoring COL Kathy Platoni’s many distinguished years of service in the US Army. They attended a joyous celebration of her retirement and Dr. Kirsch spoke a few words of thanks on behalf of all of us at AIS and in recognition of their very long personal friendship.

If you would like to send a personal note of congratulations to COL Platoni, please send your email directly to her at editor@stress.org.
Pictured from left to right: Lt. General Dick Reynolds, USAF (Retired), Mike Santolla (Kathy’s nephew), Lt. Col. John Hutchinson, USAF Retired (spouse), Michele Vannote, Dr. Ray Scurfield, Lt. Col. Robert Chabali, Assistant Chief of Police, Dayton Police Department, and Chaplain (COL) Dave Fleming, US Army Retired


Reverend Joseph Colon, Retired NYPD Homicide Detective and 9/11 Hero, congratulating COL Platoni.

Wendy Hameroff-Cohen, a life long friend of COL Platoni, offers her congratulations.

Lt. General Dick Reynolds, USAF Retired offers final congratulations to COL Platoni.
Retirement SPEECH

AND TRIBUTE TO THOSE WHO SERVE

of Katherine Theresa Platoni, Psy.D., Colonel (Retired), US Army
Former Army Reserve Psychology Consultant
to the Chief Medical Service Corp

July 19, 2014, Beavercreek, Ohio

Retirement....such an ugly word in my vocabulary. Out to pasture. Gone to bed. Removed from the work force. Taken out of circulation. Sending the old battleship out to the mothball fleet. None of these terms sound the least bit appealing.

According to Webster’s Dictionary, retirement is defined as a pullback, pullout, recession, retreat, withdrawal. Related words include flinch, recoil, revulsion, disengagement, disentanglement, shrinking. Those seem aptly descriptive of the process, though God forbid that I dwindle further in size. I already have pedal extensions in my car. Go look.

Retirement has also been defined as seclusion from the world; privacy; the act of going away or retreating. If that’s retirement, I’m failing miserably....not going anywhere.

Onset of old age. Hell, I’m still mastering acting my shoe size and not my age.....no goodness of fit there! How am I doing??

Retirement is the time when everybody calls you for crap you don’t want to do because they think you have more time.

Richard Armour states that, “Retired is being twice tired; first tired of working. Then tired of not.” Nope, don’t want to try that.

I’ve mastered five current jobs and the 95 hour work week. According to LTC (RET) MP Glenda Hull, we’re all still waiting for the “RE” in tired to show up. So far I’m just tired.

Mary Brownworth attended a lot of seminars when she retired. These are called naps. Where’s my milk and cookies, damn it?

American painter, Grandma Moses, was born in 1860. Having lived all her life in New York's farm country, she took up painting when she was in her 70s and too frail to do the manual work of the farm. Hell, I can still jump 4 feet into the back of an MRAP, but I can’t paint worth a damn.

So for me, retirement has meant finding a new habitation to fill up the tank and further fuel my adrenalin addiction; and so I have found a new home, where police officers roam. It has been within the Dayton Police Department that I have been so very privileged to have found a newfangled place to wear my boots, hang my hat, and fulfill the need for such glorious camaraderie. And so tonight I also offer my tremendous thanks and gratitude to Dayton and Trotwood’s very finest and my brethren and sisters in blue. Bring on the SWAT callouts! My gear is already in the trunk. Bring on the SWAT callouts!
So all in all, I am very poorly suited for this thing called retirement.

On an emotional level, retirement from the Army has been an ending that has set in motion a perpetual mourning process. Dark days have ruled. I think of it more like an amputation.....firstly of a 34 year career that I was not ready to relinquish and secondly, of spirit. Regardless, I have no choice but to adjust fire, suck it up, and drive on. It’s an Army thing. Here is the ticket, though. I was transferred to the Retired Reserve, so if the balloon goes up, Uncle Sam, please call me. Put me at the top of your list. Here are all my phone numbers. Bring all the documents in quintuplicate or however many 17 copies equals. I’ll bring the pen. Just show me where to sign. Let’s do this again. This is because being a Soldier is the grandest, most humbling, very most splendid job on the planet. It transcends everything else, beats every bit of what is good and right with the world.

But this event is about so much more about this than that retirement thing. It’s about the Warrior Ethos and the Soldiers’ Creed and the very values that have provided the most basic foundation for the majority of my life since the day I raised my hand and took the Oath of Office in September of 1979. For chrissakes, I have boots older than most of the people in this room.

**Soldiers’ Creed**

I am an American Soldier.
I am a warrior and a member of a team.
I serve the people of the United States, and live the Army Values.
I will always place the mission first.
I will never accept defeat.
I will never quit.
I will never leave a fallen comrade.
I am disciplined, physically and mentally tough, trained and proficient in my warrior tasks and drills.
I always maintain my arms, my equipment and myself.
I am an expert and I am a professional.
I stand ready to deploy, engage, and destroy, the enemies of the United States of America in close combat.
I am a guardian of freedom and the American way of life.
I am an American Soldier.
And in the months since my actual retirement date, I learned yet another lesson. I discovered that the Soldier cannot be separated from or surgically removed from the grunt. My blood runs green. I’m a lifer.

It is about that very basic belief system that, "A Veteran - whether active duty, discharged, retired, National Guard, or Reserve - is someone who, at one point in their life, wrote a blank check made payable to "The United States of America," for an amount of "up to and including my life." Ladies and gentleman, this is what bona fide valor looks like.

It is about what is inscribed on the hero bracelets that those of us who survived the Fort Hood Massacre that reveals the mark of distinction for those souls brave enough to answer the call of duty: **WHOM SHALL I SEND, AND WHO WILL GO FOR US?** Then this man, Isaiah, replied: "HERE AM I! SEND ME." It is about being ashamed to die until one has done something, many things for humanity and so I am far from done here. Mission not yet accomplished, though I have been made rich by the voyage. And so this is the genuine reason for this epic event and tonight’s ceremony. We have gathered here so that I may honor and thank all of you magnificent individuals who sit before me here this evening. It is high time that I pay tribute to that overflowing banquet table of family, friends, colleagues, neighbors, SWOCISM members, and Army buddies who have sustained me through the years and who have actually believed in and celebrated my military service. It is indeed a rare trait to be able to fully and genuinely
appreciate the rigors and trials inherent in military service and to recognize the magnitude of the hardships and adversities and sacrifices, yet I have been surrounded and encircled by those who have so willingly done so with such mercy and grace. Homecoming is such a desperately lonely and desolate place, fraught with the demons of war that demolish the spirit and cling to the soul. Neither have I been abandoned in the process of traveling each next 10,000 miles of difficult terrain. Life has too often been a sinkhole waiting to happen, but I never fell in. I had you as my life preservers. There is no one in this room who has not played some significant part in breaking my fall. For this, thanks and gratitude will never be sufficient.

I would now like to take a moment to introduce to you, the long green and blue lines of the company of US Army, US Marine Corp, US Air Force, and US Navy heroes who have worn or still wear the uniform. Please stand as I call your name. If I missed anyone who has served in this capacity, please raise your hand so that I can give you a shout out too.

It is during the moments of abject horror, of not only the wartime theater, but sadly, on American soil as well, that true greatness so often reveals itself and where lessons that could not be learned elsewhere become the most formidable of teachers. It is because of the stuff of which such valiant human beings are made and what is inscribed upon their souls that what is benevolent and decent still exists. In a world gone wrong, overrun with entitlement, self-indulgence, self-promotion, greed, and ineptitude of colossal proportions, how extraordinary it is to witness such gallantry among those courageous enough to wear the uniform. You, my fellow Soldiers, Airmen, and law enforcement officers, are the best that America has to offer. That places you in the category of national treasures. Though we comprise such a miniscule percentage of the American populace, you are the company of heroes, those remarkable souls who thrust themselves into harm’s way without a moment’s hesitation and who rush headlong towards the danger, among whom I have been privileged to walk. How blessed am I to march with those so willing to die for something than from something.

Kathy Platoni, Psy.D.
COL (RET), US Army
The color guard salutes COL Platoni and her years of dedication.

COL Platoni made her grand entrance in a WWII jeep.

This medal is the Legion of Merit. The Legion of Merit Medal was authorized by Congress on July 20, 1942 to award to members of the Armed Forces of the United States for exceptionally meritorious conduct in the performance of outstanding service. Superior performance of normal duties will not alone justify award of this decoration.

This bronze statue was given to COL Platoni in memory of her fallen colleagues at Fort Hood.

This Sledge Hammer was awarded to COL Platoni by the 2/69th Armored Regiment, 3rd Infantry Division in 2006.
Col Platoni’s husband Lt. Col. John Hutchinson takes a dramatic bow during the festivities.

Above left: COL (RET) Platoni and her husband Lt. Col. John Hutchinson, USAF Retired enjoying themselves on this momentous occasion.

Above right: Phyllis Friend, presents COL Platoni with a RETIRED blanket. Ms. Friend created the blanket, and Terry Borger, counted all 30,000 stitches as it was being made. Both are dear friends of COL Platoni.

Far right top: Martha Wilmer presented COL Platoni a beautiful quilt.

Far right center: The tables were decked out in red, white and blue. Flowers and flags topped off the festive décor.

Far right bottom: A delicious cake with a Chinook on top! Just perfect for COL Platoni!
GET INSIDE OUR HEAD

It’s Not Our Credentials That Make AIS So Impressive, It’s the Fellows That Go with Them.

The American Institute of Stress is a non-profit organization established in 1978 at the request of Dr. Hans Selye (the Founder of the Stress Concept) to serve as a clearinghouse for information on all stress related subjects. AIS Founding Fellows include:

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