Sentinel

NEWSLETTER OF THE QUIET PROFESSIONALS

SPECIAL FORCES ASSOCIATION CHAPTER 78
The LTC Frank J. Dallas Chapter

VOLUME 16, ISSUE 3 • MARCH 2025

A flawed system:
How Army Special Forces mental health care is failing elite soldiers

"Remember only my name"

"You have the opportunity to change the world."
– MSG Leroy Petry, MOH

Repetitive Blast Exposure and Mental Health:
The Challenges for Military Veterans

Book Review:
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Doctors in the Vietnam War:
The Ultimate Training Ground

YouTube: What's new at @sfachapter78?

SENTINEL

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US ARMY SPECIAL OPS COMMAND

US ARMY JFK SWCS

1ST SF COMMAND

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5TH SF GROUP

7TH SF GROUP

10TH SF GROUP

19TH SF GROUP

20TH SF GROUP

8TH SF GROUP

11TH SF GROUP

12TH SF GROUP

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FRONT COVER: Flames erupt as Army combat engineers blast through a concrete wall during demolition training at Fort Hood. The Pentagon released new rules for how close troops should be to blasts from explosions and their own weapons and announced regular assessments of troops' cognitive abilities both early in their careers and later to measure the effects of blast exposures. *Task & Purpose,* AUG 12, 2024, https://taskandpurpose.com/news/pentagon-releases-rules-on-safe-distances-for-blasts/ (Photo by Maj. Carson Petry)

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From the Editor | March 2025

How Miller
Sentinel Editor

This month we lean heavily into medical, and especially mental health, issues.

But before digging into those topics, we congratulate SFQC Class 338 graduates. The graduates donned their green berets in January. DOL!

We feature two articles about Vietnam from author and frequent *Sentinel* contributor Marc Yablonka.

First, Marc reviews *The Unlikely Hero: A Vietnam War POW's Story of Courage and Resilience in the Hanoi Hilton* by Marc Leepson. In the review, Marc describes Doug Bergdahl, one of the many heroes being held in Long Hai prison, the Hanoi Hilton. Bergdahl consistently put on an act, playing dumb with his captors. That, along with his superb memory, allowed him to outfox the North Vietnamese. They never suspected that he was capable of bringing extremely valuable information back home with him.

Next, "In Doctors in Vietnam," Marc relates experiences of doctors who served in Vietnam and what they did with that experience "Back in the World."

In "A flawed system: How Army Special Forces mental health care is failing elite soldiers," chapter member, author, and investigative journalist Greg Walker is interviewed by Mary Shinn of the *Colorado Springs Gazette*. Greg relates to her his view that a flawed mental health system contributes to hideous results, such as when outstanding Green Beret Matt Livelsberger killed himself just before his bomb went off in Las Vegas in front of the Trump Hotel.

Gregg cites Matt's case along with that of Mike Mantenuto and Greg's own professional experience in trauma care to demonstrate an urgent need for improvement of the system.

On page 12, we provide you with a link to an interview on YouTube channel *Truth Social* with Matthew Livelsberger's widow. Matt Tardio, himself a former Green Beret, respectfully guides Jennifer through the interview in which she speaks out to refute misinformation being broadcast online and in the media.

Another article by Greg Walker, "Only Remember My Name," adds more depth to the subject. A link is provided at its conclusion to learn more about these two soldiers and more like them in "Losing the Last Great Battle," also by Greg Walker.

Greg Walker also shares another article, "You Have an Opportunity to Change the World," about Medal of Honor recipient Leroy Petry. Leroy encourages his fellow Special Ops members to seek help for combat-related problems. He lists contact info for several excellent and willing resources.

Bruce Parkman, another former Green Beret, brings news of advances being made in categorizing and measuring the cumulative effects of Repeated Blast Exposure, especially on the brain. Usually referred to as blast overpressure, this can be experienced during various training activities, without much attention being paid to it. He shows some of the physical effects and some of the ways we attempt to mitigate the damage.

And last, but not least, we announce a new video posted on our YouTube channel—Earl Plumlee, Medal of Honor recipient, telling his story at our Special Forces Association Chapter 78 Luncheon last year. We will soon post more videos of the top-notch speakers we've been fortunate to have at our Chapter meetings in the last year. Stay tuned…

As always, we close with pictures of our chapter meeting and speaker.

Please enjoy and continue to send us your stories. ❖

How Miller, *Sentinel* Editor

SFA Chapter 78 Monthly Meeting

March 15, 2025

Breakfast – 0800 • Meeting – 0830

Courtyard by Marriott

5865 Katella Ave, Room A
Cypress, CA 90630

2025 Meeting Schedule

April 19 • May 17 • June 21
July 19 • August 16 • September 20
October 18 • November 15
December (to be announced)

Return to TOC ⮌

SFQC GRADUATION

CLASS 338

January 23, 2025

U.S. ARMY JOHN F. KENNEDY SPECIAL WARFARE CENTER AND SCHOOL

The Special Operations Center of Excellence

Congratulations to the first SFQC graduates of 2025, who donned their new Green Berets for the first time on January 23. DOL!

Two days prior, the graduates were the guests of honor at the SFQC Graduation BBQ jointly sponsored by SFA Chapters 78 and 1-18, on Chapter 1-18's campus in Fayetteville, North Carolina.

At the BBQ, Chapter 1-18 member Eli Olivas displayed his custom race car, pictured below, which he races to honor his fallen SF brothers and to raise awareness of suicide of Special Forces soldiers. ❖

Chapter 1-18 member Eli Olivas' custom race car. He was recently invited to compete in the Broadmoor Pikes Peak International Hill Climb, also known as The Race to the Clouds, an invitational automobile hill climb to the summit of Pikes Peak in Colorado. This has been a dream of his, and he races to honor his fallen SF brothers and to raise awareness of suicide of Special Forces soldiers. (Photo courtesy Michael F. Locklear)

The Gabriel Field Legacy Project: Correction Notice

The February 2025 Sentinel reported incorrect information regarding those to be honored by the new Special Forces Group (Airborne) Vietnam Veterans Memorial, which will be built next to Gabriel Field in the headquarters area on Ft. Campbell, in Kentucky.

Please note: ***the memorial will recognize ALL Special Forces men lost during the Vietnam War, not just those from the 5th Group.***

Please consider making a donation to:
https://www.sfa38.org/products/gabriel-field-project-donation

For information about the Gabriel Field Legacy Project
visit https://www.sfa38.org/pages/gabriel-field-legacy-tribute

Return to TOC ➲

Book Review

The Unlikely War Hero: A Vietnam War POW's Story of Courage and Resilience at the Hanoi Hilton by Marc Leepson

By Marc Yablonka

In the 1999 film *Return with Honor*, then Commander Jeremiah Denton, told documentarians, "We were tortured to give them something. But we didn't give them anything. We made them torture us again. We gave them as little as we could the next time. The idea was to return with honor."

And that is exactly what U.S. Navy Seaman Apprentice Douglas Hegdahl did, even though he didn't want to at first because, in addition to returning with honor, the POWs' codes also included "No Early Releases." Just why Doug Hegdahl acquiesced and left before others who'd been captured before him is informatively and eloquently illuminated for readers in historian and Vietnam War veteran Marc Leepson's latest book *The Unlikely War Hero: A Vietnam War POW's Story of Courage and Resilience at the Hanoi Hilton* (Stackpole Books, 240 pp. $32.95 Hardcover, Kindle $31.00).

The reason why Doug Hegdahl agreed to an early release lay in the fact that he had an uncanny memory, which enabled him to memorize names, ranks and other information about of 254 fellow POWs/ After coming home in August 1969, Hegdahl shocked his debriefers by rattling off the names. With that vital information, 63 missing servicemen were reclassified to Prisoners of War.

How Doug Hegdahl came to be a POW was not the way most POWs were captured. He was not a pilot, and he was not shot down, as we learn in *The Unlikely War Hero*.

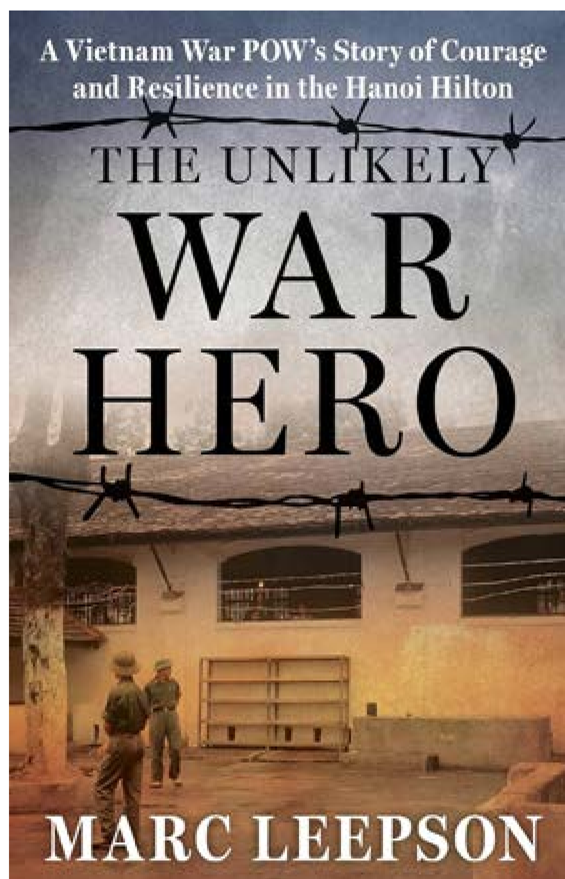
"Twenty-year-old Seaman Apprentice Douglas Brent Hegdahl lay wide awake in his bunk below decks on the USS *Canberra*, a guided missile cruiser patrolling the coast of North Vietnam in the South China Sea. The war in Vietnam had been raging for nearly three years," author Leepson, who also serves as the Arts and Entertainment Editor of the *VVA Veteran* magazine, wrote.

The details of how Hegdahl, who was assigned as an ammunition handler on the *Canberra*, would have his life altered forever are described in graphically cinematic tones in *An Unlikely War Hero*.

Here's how Leepson describes it: "Zero dark thirty on April 6, 1967. Doug struggled to get some sleep on his triple bunk mattress as the *Canberra*'s guns bombarded enemy positions more than a dozen miles away on the mainland. They called it Harassment and Interdiction fire—H & I. Supposedly a spotter somewhere or a forward air control (FAC) pilot sees something fishy on land, radios a report, and the guns start booming. It can happen any time, day or night. Who knew what they were firing at? Who cared, anyway?

"He'd spent that day below decks doing his job feeding the ship's twenty-foot-long, five-inch guns in the aft ammunition handling room. He was a member of the crew that jammed the five-inch-round shells into the breaches of the guns, followed by two cloth bags filled with gunpowder. Then the gun crew would slam the breech shut and fire."

Hegdahl's ears and sleep were constantly invaded by the booming canons on the *Canberra*'s deck, blasting away in the dark at targets,



The Unlikely War Hero: A Vietnam War POW's Story of Courage and Resilience in the Hanoi Hilton
By Marc Leepson
Stackpole Books (December 17, 2024)
240 pages
Available in Kindle and hardcover

whether real or not, off the coast of North Vietnam, but he'd never seen them from on deck. He'd been told by his shipmates that it was an amazing sight.

"So, Doug decided to take a look for himself," Leepson writes. "He slowly rolled his six-foot, 225-pound body out of his cramped bunk, careful not to bonk his head on the metal rack frame just inches above him. He didn't even bother to look for his thick, black-framed glasses. He stowed his wristwatch and wallet in his locker, and made his way up to the deck to the gun line to take in his first night bombardment."

As Hegdahl walked toward the booming guns, he remembered a Chief's orientation after coming aboard the *Canberra*. He warned the sailors about going on deck when the guns were being fired. "Something about the concussion blowing on your eardrums or even knocking you overboard," as Leepson puts it

Hegdahl got closer and closer to the guns that were blasting away as he headed toward one of the massive gun mounts. "And the next thing I remember I was in the water," Hegdahl said.

We learn that Hegdahl struggled to stay afloat, at one point beginning to sink only to bolt back to the surface because of the frigid waters of the South China Sea. After about four hours in the water, he realized that he couldn't stay afloat much longer.

"Then he heard faint voices and an object closing in on him. He took off his white T-shirt and waved it over his head. He saw Vietnamese men on a primitive fishing boat."

"It looked like a Viking ship coming through the swells," Hegdahl said.

Hegdahl then raised his arms so the fishermen could see him. They pulled him aboard, took him ashore, and turned him over to the North Vietnamese Army.

"I didn't think of myself as being captured…I thought of myself being rescued," Hegdahl later said.

Two days later, Doug Hegdahl found himself in the Hanoi Hilton. Immediately, his interrogators, not believing his story of falling overboard, took him for a spy. But very soon, they realized that they had a low-ranking enlisted man on their hands who had no information on Navy operations to offer then. He was no CIA spy.

How he convinced them is one for the history books.

"He conned the North Vietnamese into believing that he was a bumbling fool by playing it dumb when they interrogated him—so much so that the guards starting referring to him as `The Incredibly Stupid One,'" Leepson writes. "But Doug Hegdahl was far from stupid."

Everett Alavarez Jr., the first and longest held POW at the Hanoi Hilton, and Gerald Coffee, weighed in on that in *The Unlikely War Hero*.

"Falling off a ship was a dumb thing to do," Alvarez Jr. said, "but Doug was playing dumb. He was a smart kid."

"Dumb like a fox," added Coffee.

Because Hegdahl played dumb, that saved him from being subjected to the same level of physical or mental torture as his fellow prisoners, but he certainly witnessed it, which was undoubtedly traumatic in itself.

Ev Alvarez's own accounting of his time in the Hanoi Hilton in his book *Chained Eagle: The Heroic Story of the First American Shot Down Over* North Vietnam describes his torture.

"J.C. [one of the guards], flung the door open, and, accompanied by other guards holding rifles and fixed bayonets, stormed in. While some of them held Tom [Barrett, Alvarez's cellmate] at bay, J.C. motioned me outside and quickly set upon me, lashing out with clenched fists and pounding my head and body with wild swings. A succession of swings slammed into my jaw and I felt it give as I tried shielding my face with open hands."

Hegdahl was subjected to long periods of solitary confinement, limited food and water, and, at one point started to escape. However, a sleeping guard awoke and forced him back into his cell. His transgression was apparently never brought to the attention of interrogators.

He was also the "star" of a propaganda film that was never released. It proved to be an incident during which Hegdahl got back at his captors, as this passage details:

"The following morning a Vietnamese film crew showed up and set up on the beach. A crowd of friendly village women, older folks, and small children showed up and the documentary's director ordered them to line up on both sides of a path leading to the shore. He told Doug to run, shoeless, down the gauntlet, reenacting what the director guessed was what happened after Doug hit the shore about a year earlier," Leepson writes.

"The jolly villagers pretended they were angry as Doug did his shoeless perp trot. The director then moved the villagers to the water's edge to watch the next scene, which would be Doug arriving, dazed and confused, on shore after being rescued by militiamen. The director told Doug to wade out into the water, get into a small boat sitting close to the shore, then jump out and dejectedly march to shore and into the clutches of armed militiamen.

"But Doug had another idea. When he jumped out of the boat, he returned toward the beach with his head held high and a look of steely determination on his face.

"The infuriated director sent Doug back into the water a second time, but Doug marched back to shore with a big grin on his face waving to the civilians gathered there who greeted him with big smiles.

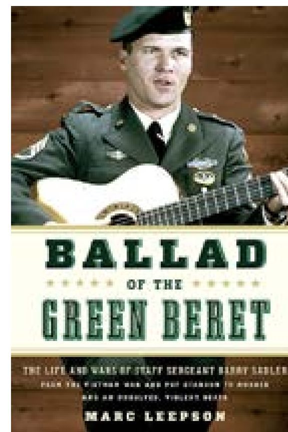
"That didn't work for the director, so he changed the script and told two actor/militiamen to take custody of Doug in the shallow water and ordered Doug to pretend to struggle with the men, then give up, and dejectedly traipse back to shore.

"But the former high school heavyweight wrestler flipped the script again. He waded out, saluted the men with his left hand, then pushed one aside and grabbed the other one and held him under the water for a few seconds, then let the guy go. Doug later said that the director screamed obscenities at him, but the crowd of extras loved the show he put on"

"I acted like I was really 'Uncle Tomming' it all the way, running all over the place, [pretending to try] to get it right," Hegdahl later said.

"The day at the beach ended with Doug `chattering and laughing' with the village children—and even posing for a picture with a small child on his shoulders. The disgusted director called off the shoot. There was no beer on the long ride home, the propaganda film never got made, and Doug was dumped back in solitary."

Hegdahl was ordered by his commanding officer to return home in order to share the valuable information he had acquired at Hỏa Lò, and was released with two other POWs on August 5, 1969.



As with his previous Vietnam War-related book, *Ballad of the Green Beret*, about the life of Staff Sgt. Barry Sadler, singer/songwriter of the hit song "The Ballad of the Green Berets," Marc Leepson delves deeply into the captive experiences of Douglas Hegdahl and many of his fellow POWs in *The Unlikely War Hero*. It's a book that will enrich the personal libraries of anyone who served in Vietnam, others old enough to remember the war, or those who are teaching and studying it today. ❖

DOCTORS IN THE VIETNAM WAR:

THE ULTIMATE TRAINING GROUND

By Marc Yablonka
Originally published in the February 2002 issue of *Vietnam* Magazine; https://www.historynet.com/doctors-in-the-vietnam-war-the-ultimate-training-ground/

U.S. Army Captain Doctor Eugene Fishman had been in Vietnam only two months when the Bell UH-1 he was flying in down Highway 1 ('friendly territory') from Nha Trang to Cam Ranh Bay took a round in its rotor, forcing the pilot to autorotate the Huey to the ground.

"I remember the pilot saying, `Hold on, I'm taking her down,' said Fishman. "It was an unconscious feeling: I didn't think we were going to die. I knew the Huey could feather it". Dr. Fishman and the others aboard were lucky. Thanks to the pilot, they landed safely and were evacuated out on another chopper.

Terrifying as it must have been, Fishman's experience was soon alleviated by the sort of humor combat veterans deem necessary. As he later described it: "I remember turning to my medic afterwards and saying, `I feel so embarrassed. I pissed in my pants.' He turned to me and said, `Don't feel bad, Doc, I shat in mine!'"

Fishman, who had never been out of his native Los Angeles, except for training at Ft. Sam Houston, TX, before being assigned to Vietnam, was considered one of the old guys when the then 27-year-old physician hit the beach, World War II style, in a Navy landing ship at Cam Ranh Bay in 1966. "When we landed, we pitched our tents in the sand," he remembered. Obviously, a buildup was happening. Cam Ranh was turning into a major port.

The next morning Fishman got a hell of an awakening. To shake up the newbees, a GI discharged dynamite in the distance. "And, of course, we turned around and did it to someone else the next day," he said, laughing. He was soon off to the arid Top Cham region of Vietnam, where he ran a nonsurgical dispensary unit for GIs at the 101st Airborne Division compound at Phan Rang Air Force Base.

L.A. area Internist Gene Fishman at Phan Rang AFB seen here imbibing in a habit he no longer imbibes in. (Photo courtesy Gene Fishman)

They moved in on the 101st, since the Airborne were always out on patrol, according to Fishman. Humor abounded, but Vietnam quickly became…Vietnam.

With a standard-issue sidearm holstered on his hip, Fishman would often go out on Medical Civil Action Program (MEDCAP) operations in the area near Phan Rang to dispense medicines to the indigenous population and to set up public health programs. MEDCAP missions included treating sick village chiefs and providing entire villages with anti-malarial medication, topical creams for a variety of skin conditions, and antibiotics.

Pondering those patrols, Fishman later recalled how villagers would often invent reasons to see him, such as pinching their skin until it bruised. Culturally, it was an honor to be treated by the "Bac Si Hoa Ky" (American doctors), and, so villagers thought, it would have been insulting not to respect their presence with a visit. Fishman marveled at the often-traded story among Vietnam doctors of packing off down a hill, only to turn around to witness villagers trading little blue pills for little yellow ones.

"It wasn't altogether altruistic," Fishman now concedes. We wanted to provide American personnel with a safe-as-could-be environment. To that end, Fishman, a Los Angeles-area internist, also implemented a system whereby an American GI who contracted venereal disease could identify the prostitute who gave it to him and keep the hooker off the streets until she was cured.

"Every town in South Vietnam had its strip with the Hollywood Bar, New York Bar," he recalled. When a GI came in with a case of VD, he would be asked who his sexual contact had been. Invariably he would say, "She was about 5 feet tall, had long black hair and slanted eyes, and I met her at the Playboy Bar."

Of course, that description matched practically every woman in Vietnam, working girl or not.

So, Doc Fishman saw to it that prostitutes were given photo IDs with their name, a number, and the club in which they worked. If a GI then got VD, the notorious White Mice (South Vietnamese police) would pay the girl a visit, get her treated by Vietnamese doctors, and require that she stay out of the bars for 10 days.

While it was true that evacuation hospital medical personnel worked from one dustoff to the next, carting traumatized soldiers with head, limb or torso wounds off Hueys and into surgery, Fishman believed most of the doctoring done in Vietnam paralleled the type of work he did and that many Americans have a misconception about physicians who served there.

"The war wounded went to field hospitals set up for major trauma," he said, "but most people don't understand that most docs were in fairly safe areas treating run-of-the-mill colds, skin infections, diarrhea and self-induced injuries like accidental gunshot wounds."

Perhaps the most difficult pill Fishman himself had to swallow before his tour of duty was up in July 1967 was something that occurred one day after he heard a gunshot in the distance.

A Korean artillery unit was stationed on the western perimeter of the base. Somehow the Koreans always knew, even before their American counterparts, when a new shipment of goods had arrived at the PX. They would pile aboard a 3/4-ton or 2-ton truck and race there to load up.

"I was going back to my detachment and heard the shot about 200 yards away," said Fishman. "A Korean GI had been late for the truck and come running as it pulled out. His buddy gave him the barrel of his carbine to hold onto–intending to haul him aboard. When he grabbed it, the trigger jerked."

The soldier was not killed, but, as Fishman painfully recalled, "The bullet went into his right eye and exited his left. When I got there, he was conscious and talking, but the orbits had been shot out. He was lying there vomiting up the rice that he had for lunch through what remained of his eye sockets. I lost it too," Fishman admitted.

Later, a Korean doctor came to Fishman's hooch to present him with a bottle of Korean ginseng liquor in a beautifully lacquered box as thanks. He never could drink it.

Although Gene Fishman was not through with the Army when he left Vietnam in 1967—he was reassigned to the Defense Language Institute in Monterey—his tour of duty affected him deeply, as it did every doctor in-country. Years later, he still had vivid memories of how the people of the anti-war movement had greeted returning Vietnam vets with their spit and curses.

"I'd heard about it from my brother's roommate, who was the liaison officer at Travis Air Force Base," Fishman recalled. "He advised me to change out of my fatigues. I did, took the bus to San Francisco and flew home to L.A."

Fishman has visited the Vietnam Veteran's Memorial Wall in Washington, D.C., several times during conferences he has attended at the Bethesda Naval Hospital, but does not plan to do so again. "It's just too painful. I can't do it anymore," he said, holding back tears. "I know some names on that wall, but it's not a matter of knowing the names. It's just so powerful seeing them."

Fishman stated that Vietnam completely changed the rest of my life. "Before 'Nam, I had been offered a fellowship at the National Cancer Institute in hematology/oncology. If I hadn't gone [to Vietnam], I would have ended up an oncologist–and hated it!" When asked if Vietnam had given him his sense of compassion, Fishman was not sure. "I guess after Vietnam I knew I had seen enough of death and dying," he suggested.

Doctor James Turpin, who headed up two hospitals in the Montagnard villages of Dampao and Rolom, in Vietnam's Central Highlands, for the San Diego-based Christian humanitarian group Project Concern, had also seen enough death and dying by his first Christmas Eve in-country in 1964. Rumors had been circulated that local VC cadres would have his head and the heads of five of his medical staff by Christmas Day.

"It was very tense," recalled Turpin, "but we just stood around a mortar pit the Green Berets had left, singing hymns and holding each other. He also thought God might have heard their prayers, because Special Forces Captain Vince Triano, who ran a strike force 25 kilometers from Rolom, having heard that same rumor, came down from his headquarters at Psourr and heavily fortified the village. No one from Project Concern would die that day.

Return to TOC ➲

When Turpin first arrived in Vietnam from Project Concern's mission in Hong Kong, he, like Fishman, was deeply affected. "In Vietnam I saw people with nothing," he said. "I thought that there was a better way to relate to them than by fighting. Many times the GIs whom we would treat would say to me, `If I could only spend my year here…

During his time in-country, which lasted until 1972, Turpin was made an honorary Montagnard brother. In a ceremony for the occasion, he was required to imbibe the notorious Montagnard liquor called "Nam Pe," sipped from a huge jug through a long communal straw, and dress solely in a loincloth. "I kept hoping the thing would hold together," he recalled.

Turpin and his staff of Vietnamese nurses and medical assistants led very busy lives for the eight years Project Concern operated in Vietnam. Every day they would don emergency room attire, scrub and start rounds at the 18-bed Lien Hiep Hospital.

"You had to be careful where you stepped because of all the round-worms that had been vomited up during the night, Turpin remembered.

The Montagnards had thousands of roundworms swallowing their GI [gastrointestinal] tracts. The Montagnards, too, had to take care where they walked. Kids walked around barefoot and often stepped in hookworm-infested dog feces," Turpin said. "The worms then bored through to their stomach linings. It was so bad that we even had worms that showed signs of malnutrition."

In the afternoon, Doc Turpin, whom the Montagnards called "Bac Si Hakkah" (doctor who remembers us), manned an outpatient clinic in which locals were treated for various ailments, including starvation, cholera, typhoid, malaria, tuberculosis, intestinal parasites, iron deficiencies and anemia. "The level of hemoglobin in their blood was often so low," he said, "that the Montagnard kids had…not even enough to sit in school and think."

When it came to surgery, Project Concern's facilities were primitively equipped. Nonetheless, Turpin and his staff were often able to perform miracles. One that he never forgot was delivering a Koho Montagnard woman's baby.

"It was midnight," Turpin recalled. "The baby presented itself upside down. Our generator had little fuel. When it died, we switched to batteries. They lasted 15 minutes. Then we used candles. At 3 a.m. we had a healthy baby and mother, but wax had dripped inside her. I tried to get it out but couldn't. So we closed her and, luckily, her tissue never reacted to the wax."

Turpin was ecstatic that night, for it had been a triumph in more than one way. "We lost so many babies brought to us. It was tragic," he said.

As time passed, Turpin was increasingly critical of what he observed in Vietnam. Years later, however, he preferred to call himself pro-nation building as opposed to anti-war.

James Turpin examining a Montagnard baby. (Photo courtesy James Turpin)

Return to TOC ➲

"Every time we turned around, the war interfered with our work," Turpin lamented. "We were not allowed to go to villages unless a Huey would take us. But we were not high priority. There were so many frustrations. I often thought, `What I could do if there weren't a war.' It got increasingly dicey. Though we were in a pacified area, there was increasing potential for harm."

One day in 1972 a Katusha rocket accidentally fell upon the village, killing two nurses–one American and the other Vietnamese. At that point, the Project Concern administrators ordered all its personnel out of Vietnam.

Much like his predecessor Dr. Tom Dooley, who had been on a similar mission during the First Indochina War, Turpin wrote two books about his tenure–*Vietnam Doctor* and *A Far Away Country*.

According to Turpin, Project Concern had carried no banners during the war. But it was still a bit of a surprise to him when, 20 years later in 1992, on the first of his two trips back to Vietnam since the war–with Hanoi continuing to scrutinize requests for travel to the Central Highlands by those who had served there–not only was a visa to return granted him with ease, but, mysteriously, without the usual fees attached. Permission to travel about at will in the region was approved as well. It seemed that a Dr. Thien, who during the war had been the VC doctor for the same province, was responsible. One night over dinner at the elegant Dalat Palace Hotel (once one of many retreats for the late emperor, Bao Dai), Thien confided to Turpin that Project Concern had in fact not only trained Vietnamese loyal to the ARVN, but had also unknowingly trained several VC.

"I told him, `So we have you to thank [for] keeping us alive,' said Turpin. He answered, `Oh, we'd have fought to protect you.'"

On his trip, Turpin found several of those whose loyalties he had never questioned still employed at Lien Hiep. Today the 70-year-old Bahai physician and resident of Fairview, N.C., provides medical services for inmates at two of the state's correctional facilities at Marion and Craggy, with 1,000 and 500 prisoners, respectively, under his care. Turpin insists that his staff refer to those he treats as patients, not prisoners, saying, "When you salvage people, you salvage yourself."

Doctor Amos Townsend, a retired U.S. Air Force colonel, had occasion to salvage a lot of soldiers and locals during his tour of duty in Vietnam between 1969 and 1971. The Lee, N.H., resident ran medical facilities at Pleiku, at the U.S. Air Force headquarters for II Corps, just outside the Army evacuation hospital, and at Phu Cat Air Base, in Binh Dinh province.

His doctoring took place on the ground as well as in the air, since, as a flight surgeon, he was also required to ride shotgun in OV-10 Broncos over the Ho Chi Minh Trail as they attempted to spot VC for the bombers who waited upstairs. He never forgot one such flight.

"They put me with a green, hyperactive lieutenant," remembered Townsend. Farther up the trail I heard him chat with bomber pilots. Then he put a rocket into the jungle so they would know where to lay their loads. We circled hard. He put the nose down a bit and then quickly veered off to the right," Townsend said.

"All of a sudden, a dozen tracers whizzed by to the left. We watched the bombers do their thing. I could see the VC shooting at them. When we landed, I asked him, `What was that stuff off the left wing?'

Amos Townsend after assisting a Montagnard woman give birth. (Photo courtesy Amos Townsend)

`What stuff?' he asked me."

But the bitter memory of another pilot, whose job it was to lay down fire suppression from his McDonnell F-4 Phantom to aid the rescue of downed choppers, remained with Townsend years later. "He came to me and said, `Doc, I feel funny about this mission.' His plane never came back, and I could kick myself for not grounding his butt."

"The hazards of duty were unpredictable. They never allowed us to fly over North Vietnam," said Townsend. "But if you flew over the Ho Chi Minh Trail, you often didn't come home." His cousin, CBS-TV cameraman Dana Stone, had been killed in Cambodia along with flamboyant photojournalist Sean Flynn (son of Errol) in 1970, after the two motorbiked off into the Indochina sunset.

Like Fishman's, Townsend's routine on the ground was not overly exciting. He and the two general medical officers and two flight surgeons under his command had sick calls, did physical exams [and] headed downtown to the provincial hospitals to `play obstetrician. "Then [we] would help out at the Buddhist and Catholic orphanages," he said.

When Townsend was not treating orphans and delivering babies, he was combating black plague, leprosy and gastrointestinal problems. As with Turpin, Townsend and his staff may also have inadvertently treated the enemy, since, as has been well documented, it became increasingly difficult to distinguish friendlies from the VC. This deception was especially problematic at Phu Cat, which, Townsend learned, had been infiltrated by the other side. Still, he worked on.

"My job was to cure people. I had to do what was medically appropriate. We may have shown a side of ourselves which had a beneficial effect in the long run," he said, echoing Fishman's sentiments. "Look at the tremendous exodus of Indochinese refugees who came to us as total strangers."

And it is with those refugees that Townsend, still bitter about the way the war ended, chose to continue his work. In 1979, two weeks after he retired from the Air Force, both he and his wife volunteered through the International Rescue Committee to go to the United Nations High Commissioner for Refugees (UNHCR) Khao-I-Dang camp along the Cambodian border with Thailand. They remained there to help the refugees for nearly five years.

"We did it out of a sense of obligation," he explained.

During his time in the camps Townsend's connection to Indochina and its people deepened. Prior to Vietnam, he had been attached to the Army Chemical Corps at Camp Detrick in Frederick, Md., where he studied biological warfare. "We looked for ways to soup up bugs and things more dangerous that protected the other guy [and] would do the same for us. We tested protection equipment. But we didn't do any harm, he stressed."

In 1981, Townsend was appointed chief medical officer for all UNHCR camps. Shortly after that he was in the Mekong River town of Nongkhai, Thailand, about 30 kilometers downriver from the Laotian capital of Vientiane, on loan to the U.S. State Department. One night Townsend was approached by a former U.S. Army Special Forces lieutenant colonel and a man from British Intelligence, both in their civvies.

"They wanted me to do a job that should have been done by the DOD [Department of Defense], CIA or DIA [Defense Intelligence Agency]," Townsend recalled. "But Uncle Sam didn't want to play the intel game and get his hands dirty," he said.

Ultimately, what Townsend did, at a time when the United States aligned itself with the murderous Khmer Rouge against Vietnam, was travel the banks of the Mekong, attempting to contact Lao escapees as they came across and before the notoriously corrupt Thai police apprehended them. "We had been hearing reports from the hill tribes in the camps about how they had been hit with chemicals, he said.

Townsend also packed into Cambodia on an elephant, ironically with a Khmer Rouge escort, as deep in as Battambang to investigate the reports of Yellow Rain, a chemical warfare agent supplied by the Soviets and dropped by the Vietnamese, predominantly on the Hmong hill tribes of Laos.

"The Hmong, who were tenaciously protected by the mountains, had no love lost for the Vietnamese, and after 1975, the Viets controlled the skies," he said. "It's easy to see how they could have incapacitated, even killed, some people who already had two or three indigenous diseases and were already semi-starved. They didn't even have to aim."

While in the Indochinese jungle he did indeed encounter and examine tribes who had come into contact with mycotoxins commensurate with what could have come from chemical attacks.

"The logic seemed so reasonable, it infuriated me," said Townsend. "I found sick people. However, whether or not their illnesses were due to chemical warfare, I have no way to know."

What he did know, as Vietnam had taught him and, as it had taught Fishman and Turpin, was that his medical work in Vietnam had changed his life and brought him unexpected rewards. ❖

ABOUT THE AUTHOR

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Between 2001 and 2008, Marc served as a Public Affairs Officer, CWO-2, with the 40th Infantry Division Support Brigade and Installation Support Group, California State Military Reserve, Joint Forces Training Base, Los Alamitos, California. Marc's decorations include the California National Guard Medal of Merit, California National Guard Service Ribbon, and California National Guard Commendation Medal w/Oak Leaf. He also served two tours of duty with the Sar El Unit of the Israeli Defense Forces and holds the Master's of Professional Writing degree earned from the University of Southern California.

He is the author of *Tears Across the Mekong*, a book that profiles the lives of many Hmong, Lao, and Americans who took part in the secret war in Laos. His latest book *Hot Mics and TV Lights: The American Forces Vietnam Network* was published by Double Dagger Books in 2023. For more information on Marc's published work visit WarStoriesPress.com.

A flawed system: How Army Special Forces mental health care is failing elite soldiers

Retired Special Forces Sgt. 1st Class Greg Walker details how a flawed mental health care system has yielded what he calls 'hideous results' for soldiers like Green Beret Matthew Livelsberger.

Master Sergeant Matthew Livelsberger. Image Credit: United States Army

By Mary Shinn
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Numerous combat deployments, a cultural reluctance to seek help, and a structure that allows commanders to pressure mental health professionals led to mental health care failings within U.S. Army Special Forces, according to an expert and advocate of the troops.

Retired Special Forces Sgt. 1st Class Greg Walker, who also advocated for the care of Special Forces troops as a civilian case manager with Special Operations Command's Care Coalition, detailed what he said were the dynamics of those problems following the high-profile suicide of Master Sgt. Matthew Livelsberger, a Green Beret, who traveled from Colorado Springs to Las Vegas and blew up a Tesla Cybertruck in front of President-elect Donald Trump's hotel on New Year's Day.

Problems with Special Forces mental health care have also been highlighted in government reports that found these elite troops died by suicide at higher rates than the broader armed forces and the general population. A Defense Suicide Prevention Office presentation showed that suicide deaths have increased among Army Special Operations Command troops with 18 deaths in 2022, up from six in 2017 and 12 in 2018.

A 2020 report on suicides within the Special Forces community found elite troops did not seek help because they feared "being separated from their unit or singled out for problems." The report called for reforms including better suicide prevention, saying online training was seen as just a check in the box.

In addition to a cultural reluctance to come forward among Special Forces soldiers, Special Forces Group commanders have also directed their embedded mental health professionals to minimize conditions to ensure more soldiers can continue to deploy, Walker charged. Mental health providers might overlook drinking too much, or swap out medications to ensure troops could still deploy, he said.

The attitude became: "Anything you can do to make sure a guy stays in the fight is OK with us," Walker said. "It's had hideous results."

There are strong hints that Livelsberger's death and the explosion that injured seven people can now be counted among those failings. Writings found on Livelsberger's phone and observations from a former girlfriend that he was in touch with in his final days, also underscore his poor mental state of mind.

"There was not a time during my two years in Afghanistan where I had a clear understanding or rational feeling in my heart of why my brothers were fighting and dying. We failed and the credibility of military and political leadership was shredded and no one was held accountable," he said in a note on his phone released by the Las Vegas Metropolitan Police Department.

At the time, Livelsberger planned to kill himself at the Grand Canyon, he wrote.

Army Special Operations Command did not respond to questions about whether the suicide prevention training had changed or about the problems with group commanders overseeing providers.

Long-term pressure

The first significant emphasis on behavioral health and substance abuse in Special Forces started in 2005 after multiple deployments started to take a significant toll on frontline troops and they began to act out in serious ways, such as committing acts of domestic violence and getting DUIs.

Special Forces was not designed to assume the operational tempo experienced during the War on Terror, a frequency that has continued to this day, Walker said. In one case, he served as case manager and advocate for an Army Ranger who was deployed to combat 14 times, he said. A 2020 independent study found that it's not unusual for an operator in Special Forces to have 15 deployments over 10 years.

To address the problem, Army Special Operations Command and its parent group Special Operations Command, which oversees the joint force, started embedding mental health and substance dependency programs so that soldiers could talk about the classified events they had been a part of with professionals who also had clearance. It also functioned as an incentive for Special Forces soldiers to seek help within their own unit.

As Special Forces started to address the problem, more troops needed to be moved into support roles or to receive longer-term care, Walker said, and it created a shortage of people to carry out missions.

Starting in 2011, the high number of combat deployments to fight the War on Terror caused increased behavioral health and substance dependency issues among the troops, Walker said, reducing the number of people available to carry out missions.

"The group commander is now carrying people on the rolls he can't do anything with. … There's only so many support slots you can put them in," Walker said, and long-term care can easily be upward of a year if the unit is intent on keeping the operator as a useful asset. "It's a conundrum."

That's when the pressure to start minimizing mental health and substance dependency issues on the individual level started, he said.

As a former Special Forces senior enlisted officers who served for 20 years and later a civilian advocate for Special Forces, Walker said he saw how a good idea to embed mental health providers has been manipulated and contributed to a system that does not function well.

Walker retired in 2005 before working for the Warrior Care Program under Special Operations Command to advocate for Special Forces troops who suffered serious physical and mental health injuries. This program, also known as the Care Coalition, functioned well because it did not face the same pressures as embedded providers, he said.

Walker retired fully in 2018, but remains well connected to the Special Forces community.

Since group commanders oversee their embedded mental health professionals, those providers' ability to follow Army policy — as their counterparts in the broader force do — can be and has been compromised, Walker alleged, and as a result the embedded programs do not have proper oversight.

Broad questions about mental health care and substance abuse treatment within Special Forces are typically only raised when high-profile events such as Livelsberger's suicide happen, he said.

Walker said that the traumatic brain injury (TBI) symptoms and post-traumatic stress disorder that Livelsberger's ex-girlfriend said he experienced are hallmark "invisible wounds" within Special Forces.

A 2020 observation study published in a scientific journal found that 85% of Special Forces operators experience TBI from training alone, based on anecdotal estimates. It also found the high number of deployments contribute to a consistent pattern of struggles, including depression and suicide, among many other symptoms.

Peer leader's suicide

The pressure that embedded mental health providers face eroded the trust among Special Forces troops in their mental health care, Walker said, as favoritism and "working the system" with approval from the command became apparent.

So, when a well-known former movie star and Special Forces soldier, Staff Sgt. Mike Mantenuto, who was also experiencing mental health and substance use problems, was authorized by his group commander to create a peer-support group and offered nonclinical counseling in 2016, it was embraced by the unit and foisted upon its embedded clinicians to support — contrary to all best practices, Walker said.

Mantenuto starred in the 2004 film "Miracle," about the U.S. men's hockey team upsetting the prohibitively favored Soviet Union team in the 1980 Olympics, before enlisting.

The peer approach appealed to soldiers, because it could keep their issues completely off the radar with the Army's conventional mental health and substance dependency clinicians who were not under the influence or control of a Special Forces Group commander, Walker said. The leadership at the Washington state-based 1st Special Forces Group embraced, authorized, and promoted it for similar reasons, Walker said.

But it was completely unethical to allow someone with no formal training and a current mental health patient to start a program, he said. When Mantenuto died by a self-inflicted gunshot wound in a park at age 35 in 2017, it left soldiers feeling betrayed and abandoned. Army

mental professionals reached out to those Mantenuto was talking with officially and unofficially, and discovered his influence reached well outside his parent group.

Several of these soldiers expressed renewed suicidal ideation in the wake of Mantenuto's death.

Walker investigated the death as the military liaison for the private-sector hospital where Mantenuto received in-patient treatment as a referred patient by his group medical team. He then, along with the senior civilian program director at the hospital, met with the group commander and his staff, which was conducting an after-action report, given the high public profile of Mantenuto as a former actor and movie star before joining the Army and coming to Special Forces.

The Army report about Mantenuto's death said he was not a patient, despite reaching out for concerns about attention deficit and hyperactivity disorder care shortly before his death because of problems concentrating and participating in Alcoholics Anonymous, points raised by those interviewed for the report.

'We're like flashlight batteries'

When it comes to Livelsberger, Walker believes the medical professionals at his unit in Germany could have taken preventive steps, such as not allowing him to leave his base in Germany for Christmas break if his true behavioral health issues urged caution over compassion.

"If he was well enough to return to Fort Carson, did his mental health provider in Germany conduct a warm handoff with the embedded behavioral health clinicians at Fort Carson, to include the group surgeon?" asks Walker. "Where was the clinical safety net for Matt Livelsberger who'd been in the Preservation of the Force and Family Program in Germany?"

The program includes a broad swath of physical and behavioral health care, such as brain health monitoring and access to embedded clinicians, as well as chaplains that provide counseling, among other services.

The Army released a statement last week that said Livelsberger did not display concerning behaviors while using the Preservation of the Force and Family programs. But the Army declined to say how long he received care through the program, citing privacy concerns. Since he was on leave when he died, he would not have necessarily been connected to mental health services.

While Mantenuto's and Livelsberger's cases received public scrutiny, Walker said, he wanted to speak out because there are so many soldiers who have experienced similar trauma and other medical issues who have likewise fallen by the wayside because of the shortcomings and manipulation of the embedded group clinical teams within Special Forces.

"As Matt's ex-girlfriend has pointed out since his death," offered Walker, "the Army does not 'fix' its soldiers per se. And especially in our Special Forces units. It uses them up until they break or become nonessential and then moves them out of the ranks and into the Department of Veterans Affairs medical system.

"We're like flashlight batteries. They just put a new battery in once the old one is drained dry and it includes officers as well as enlisted service members."

It's a culture that's led to losing many men and women to suicide, who did not need to die by their own hand, the veteran operator said.

Major reforms needed

Walker would like to see major reforms to help fix the problems within the Special Forces health care.

He believes that Special Operations Command could take some pressure off the group commanders to provide troops for missions if they are facing a shortage due to mental health and substance use concerns. "If they truly want to preserve the force, they need to be far more discerning in what missions are essential."

He would like to see the command send out a directive that says: "We are not going to put guys in the field that are going to sooner or later break as a result," he said.

Walker would also like to see the Army inspect the Special Forces' embedded mental health units and, if gross manipulation of clinical findings is found, return the oversight of that care to the conventional mental health teams within the larger Army, he said.

Conventional-force clinicians can treat those with classifications with proper collaboration with unit doctors, he said. Commanders also must start listening to therapists and behavioral health teams.

"If they don't, we will continue to see tragic and often preventable deaths like those of Mike Mantenuto and Matt Livelsberger take place," he said. ❖

Matthew Livelsberger's Widow Breaks Silence, Refutes 'Misinformation About My Family'

In an interview with *Speak the Truth* podcast host Matt Tardio, Matthew Livelsberger's widow, Jennifer Davis, spoke out against what she sees as defamatory and untrue stories about her late husband and their family.

To view the interview on YouTube visit:
https://youtu.be/kklJUzDTXjY?si=9Y9SLGeK3Whfqjge

If you would like to support Jenn and her child, please click the following link: https://www.gofundme.com/f/hope-and-healing-for-jennifers-family

"It is understood that what occurred in Las Vegas is a complicated case involving local, State, and Federal authorities. It is also understood there will be no "one good answer" and that Livelsberger's motivations, driven by his mental, physical, and spiritual states, represented a multi-layered mix of motives, associations, communications with family/friends/teammates and others yet identified. This being said—the onus is on the Army, the Special Operations Command overall, and 10th Special Forces Group's senior leadership as to what was missed, overlooked, downplayed, or outright ignored prior to Matt's taking leave. And what is or will be corrected in a positive and healthy sense within the Command/and its SF Groups in specific regarding behavioral health/SUDCC issues—which the two suicides (Mantenuto and Livelsberger) reveal must take place to truly "preserve the Force and Family"

Return to TOC ➲

“Remember only my name”

Despite having a background of suicidal ideation Mantenuto kept the firearm he used in his quarters at JBLM. (Des Moines Police Department)

By Greg Walker (ret) USA Special Forces

> *“Bottom line, failure by the entire chain of command [in both cases]. This isn’t the time for excuses but rather a time to reflect, review and look for solutions to prevent other possible suicides.”*
> —Major General (ret) Kenneth R. Bowra
> USA Special Forces, 1/25/2025

When our warriors implode

Staff Sgt. Michael Mantenuto, 1st Special Forces Group (Airborne), took his own life on April 24, 2017.

His suicide note read:

“I’ve been running from one question
“What’s the difference between suicide and taking one’s own life?
“One is based in Fear, and the other is based in Love
“I wasn’t afraid
“Remember only my name
“There is only Love”

The break-out star of the 2004 blockbuster Disney film “Miracle,” who became a Green Beret in 2013, had for years endured and fought against deeply entrenched behavioral health and substance dependency issues. Hospitalized for 28 days in 2015, Mantenuto returned to Fort Lewis, Washington, with great hope and a desire to help others like those he’d met over the previous month.

https://www.dailymail.co.uk/news/article-4463082/Disney-s-Michael-Mantenuto-left-K-9-unit-suicide.html

Mantenuto would successfully promote a formal peer group model, beginning at 1st Group and then expanding, with the blessing of Madigan Army Medical Center’s behavioral health chief, throughout Joint Base Lewis-McChord (JBLM). Mantenuto titled his program World Addicts Revolution, or W.A.R.

At 1st Group, he was provided an office and given access to the best behavioral health and substance addiction specialists on post. His widow told me her husband was “totally into” his new role and the W.A.R. program. “He knew everything about what was going on with the soldiers and their families,” she recalls. “He researched the smallest details. He even knew on a monthly basis how much alcohol was being sold at the on-post convenience stores, by category. He put all of this into his [PowerPoint] presentation.”

Staff Sgt. Michael Mantenuto

Mantenuto’s passion and his devotion to taking care of his teammates and their families was borne of his own troubled family life while growing up and the positive impact of his hockey coaches, especially in the Division One ranks at college. He was a team player, but he was also the first one there to help a teammate out off the ice. He brought that cultivated compassion and determination to Special Forces upon his arrival at 1st Group.

Mantenuto only shared his presentation with one person, a civilian who was in the civilian support group he’d co-founded. She handled the administrative aspects of W.A.R. to include arranging to have the program’s wrist bands made. His concern with giving a copy to anyone else, particularly Madigan’s behavioral health clinic, was to protect what little time he had at home. However, others involved in its evolution included Maj. Ryan Shubat at the Special Operations Forces Embedded Behavioral Health Clinic at Fort Lewis.

On May 17, 2017, I was one of roughly 12 attendees at a closed meeting at Group Headquarters at JBLM. The purpose of the meeting was to review, informally, all that had led up to Mantenuto’s suicide. Other attendees included the group commander and command sergeant major, Dr. Bill McNulty from the SF medical clinic, Major Shubat, and the Group JAG officer. Along with me were two other civilians, including Mario Bolivar, director of the in-patient program in Oregon that Mantenuto had attended, and a now-former manager from the Wounded Warrior Project.

Over the course of the meeting, it was determined that no one at Group possessed the working PowerPoint Mantenuto used in his highly popular presentations. Indeed, no one present could really recall what the acronym “W.A.R.” stood for. What was determined was the program was essentially overseen by the Group command sergeant major who was a strong supporter of having an alternative within the compound’s confines for the enlisted and commissioned to attend. In a private conversation after the meeting, the CSM confided to me that he had not seen what was coming regarding his subordinate’s suicide

and he was questioning how he'd missed the cues given. One of the reasons the CSM failed to notice anything was because he'd arranged with Mantenuto to only see him on Monday and Friday mornings to "check in". Otherwise Mike was essentially unaccounted for.

And as with MSG Matthew Livelsberger who shot himself in Las Vegas on January 1, 2025, USSOCOM issued this statement regarding Mantenuto's suicide. "He displayed no concerning behavior prior to...".

However, both Mantenuto and Livelsberger did indeed display the classic behavioral health warning signs predicting suicide. These within the embedded behavioral health clinics they were being seen by and outside these by friends and family members.

Warning Signs

- Possession of firearm or other weapon
- Suicide threats or statements, gestures, or recent attempts
- Detailed recent threats of violence
- Severe rage for seemingly minor reasons
- Severe destruction of property
- Serious physical fighting with peers, family, or others
- Rehearsing an attack or ambush

W.A.R. - What is it good for?

What, then, was W.A.R.? We know the peer group continued after Mantenuto's death at 1st Group and met once a week at the compound. It was no longer an officially-sponsored meeting by the Group commander and was closed to all but participating members. It was chaired by an active duty Special Forces senior non-commissioned officer who worked closely with Staff Sgt. Mantenuto on the original W.A.R. program of instruction. According to Sgt. 1st Class Chris Harper, PAO NCOIC at 1st Group then, when asked by me about ongoing suicide intervention and prevention at Group, I received this reply: *"Our approach to suicide prevention is to promote healthy, productive behaviors through engaged, compassionate leadership."* Offline, SFC Harper went on to say Mantenuto's loss was still deeply felt at Group and was a constant reminder for the operators to remain in touch with each other and be vigilant about their own perhaps undisclosed challenges.

Mike Mantenuto's day pack contents contained some of the W.A.R. research he was doing at the time of his death. It was also where he'd carried the pistol he would take his own life with. (Photo by Des Moines, Washington, Police Department)

In reviewing what few things were possible, to include a close examination of the police photos provided me of Mantenuto's day pack and its contents, we know Mantenuto was seeking to change how Special Forces – and then the Army – conducted its mental health and substance programs. "Michael said they [the programs and approaches] were all outdated and ineffective," said one source. "He had seen what worked so well while he was in-patient in Oregon and that opened up his eyes as to what more was possible."

For example, Mantenuto wanted to see the AA 12-Step program re-written specifically for soldiers. This due to the Soldier's unique environment (Special Forces) and challenges to include the effects of wartime trauma and substance use. He was quietly studying and experimenting with cutting-edge drugs in their early trials for PTSD, suicidal impulses, depression and anxiety. Mantenuto was able to do this as he was exempt from drug tests at his unit despite his 28-day inpatient stay in Oregon. These included two of the non-prescribed drugs found in his system at his autopsy. His website searches included The Influence, a 21st Century news and opinion site regarding substance use, addiction, rehabilitation, recovery, and new treatment models.

And he was readdressing the spiritual role in addiction and behavioral health treatment.

"Mike was all over it. He was respected for his stand regarding his own demons and he was known to be 'on call' whenever someone needed encouragement or help," another source told me. "He never really pushed you. He'd come by or call or text and say, 'Hey, what are you doing tonight? I'm going to a meeting. Wanna' come along?'"

Undue and inappropriate Command influence

Sadly, on April 24, 2017, Mantenuto ran out of energy, passion, and steam. His own demons re-surfaced and in large part, due to Madigan Army Hospital's behavioral health leadership not listening to the wiser voices beneath them to make sure Mike was first and foremost treated as a high-risk patient in his own recovery. "He should never have been placed in the position he was," a senior SOF EBH therapist told me.

Roughly four months before Mike's suicide I was visiting SUDCC-JBLM as part of my duties as military liaison for Cedar Hills Hospital. While meeting with the former director, Ms. Michelle Hooker, she asked if I would visit Ross Echterling then at the SOF EBH on JBLM.

Ross and I knew each other from past referrals made by the SOF EBH to Cedar Hills and its military program. He was described as becoming very concerned about the W.A.R. program and in particular, Mike as a BH/SUDCC patient who'd been seen by Echterling.

Ross wanted to approach the Group CDR about his concerns as he was Mike's therapist. But, as a civilian and with no SOF military background, he felt he had little "throw weight" to do so.

His concerns raised at the EBH level had been deflected/ignored by his immediate superior, a "green suiter" at the EBH.

The author at 1st Group after a two-hour Command review of Mike Mantenuto's suicide. (Photo courtesy Greg Walker)

I met with Ross for about an hour. He shared his observations and concerns. He reaffirmed Mantenuto having a patient history of BH and SUDCC issues—which is why he was in-patient for 28 days—to include heroin addiction. Ross offered he was directed to help Mike with the W.A.R. program's content to include professional clinical opinions/insights/information. This conflict of interest was nagging at him greatly but he had little support with in the Group's leadership to include the Group Surgeon.

We discussed options. He asked me if I would go to the Group Commander. He knew I sometimes interfaced with commanders at all levels on cases—something we did at the SOCOM Care Coalition as a matter of course. I declined—offering Mike had been back from our program since 2015, and those at the SOF EBH to include Major Ryan Shubat, its OIC at the time and Mike's mentor at W.A.R., knew of his problems.

I had no former affiliation with the Group Commander and it would have been inappropriate for me to act as the messenger for his EBH team or, for that matter, for the JBLM SUDCC director, Ms. Michelle Hooker, whose professional concerns were likewise being ignored by both Madigan Behavioral Health and 1st Group.

We then talked worst case scenario regarding Mike, the W.A.R. program, and those SF and SF support soldiers as well as others not known about that Mike was meeting with, presenting to, and offering non-clinical advice and counseling to. What would be the fallout if he (a) relapsed himself and (b) took his own life?

Catastrophic on many levels as we were to find out four months later, to include several Special Forces soldiers at JBLM, Fort Bragg, and on Okinawa whose reaction to Mike's suicide re-triggered their own similar thoughts. No one knew Mantentuo's W.A.R. network had reached well outside the gate at Fort Lewis. Swift intervention took place as Army behavioral health experts tracked down those they became aware of.

Michael Mantenuto and Matthew Livelsberger

What is Michael Mantenuto's legacy then? His widow shared with me it is two-fold. The first were their children who Mantenuto loved and cared for above all else. The second was emphasized in our last communication on the subject.

"Doing good, taking care of those struggling, healing. Otherwise his death was in vain. We know the shame associated with those struggling with compulsions [and] addictions...Michael shared the message of AA. The idea that you're not alone in the struggle and that we rise up for one another. That is where we get our strength, hope and courage from."

As with MSG Livelsberger's suicide the official statement from USSOCOM was that Mantenuto appeared fine—"no concerning behavior"—when in fact his Command and others at JBLM chose to turn a blind eye to the warning signs he'd displayed.

Tragically SSG Michael Mantenuto did not have to die. His death, his suicide, was enabled by Army leaders and clinicians, as well as civilian therapists, who either saw being associated with the former actor and diagnosed addict as somehow beneficial for their own agendas, or were simply cowered into professional submission at the uppermost Command levels.

Who speaks for Matt Livelsberger?

As with MSG Livelsberger's suicide the official statement from USSOCOM was that Mantenuto appeared fine—"no concerning behavior"—when in fact his Command and others at JBLM chose to turn a blind eye to the warning signs he'd displayed.

According to USSOCOM no documents or information regarding MSG Livelsberger's suicide will be released for at least 90 days from the publication of this article. With the caveat the timeframe may be longer. This due in part to the growing questions being asked of the Army and USSOCOM / USASOC about the specifics of Livelsberger's acknowledged request to have entered the Command's Preservation of the Force and Family program in Germany. A program he had been a part of for a year before requesting Christmas leave and returning to Fort Carson, Colorado, and the 10th Special Forces Group there.

The same drawn out process occurred with Mike Mantenuto's case given the 15-6 investigation's findings regarding the truth about what took Mike over the edge in 2017. In short, the accusing finger was found to be pointing back at his Command and JBLM/Madigan Army Medical Center and we may find the same holds true regarding MSG Livelsberger.

And for now here we are once again.

Trust but verify

Matthew Livelsberger was a professional soldier and one of the truly best "Green Beret" operators to have served and fought in our global war on terrorism. He was highly skilled, exceptionally well educated, a devoted husband and father, and decorated twice for valor under enemy fire.

This is what we must remember about him.

We must also remember and now demand the Army and USASOC/ USSOCOM present in all transparency what this dedicated patriot was suffering from when he raised his hand for help and what his diagnosis' were, to include any and all medications he may have been prescribed leading up to his suicide.

And if an autopsy is performed of his brain we may discover he was also suffering from CET—a trademark injury for all SF/SOF operators with multiple exposure to blast and other concussion causes.

And that those accountable for missing key warning signs both in Germany and at Fort Carson are appropriately addressed. This to include placing the SOF embedded behavioral health and SUDCC clinicians back under the direct command and control of "Big Army" on-base mental health professionals.

The sadness of suicide notes

MSG Matthew Livelsberger
10th SFGA

SSG Michael Mantenuto
K9 handler, 1st SFGA

Matthew Livelsberger, 37, wrote that he needed to *"cleanse"* his mind *"of the brothers I've lost and relieve myself of the burden of the lives I took."*

Michael Mantenuto, 35, left his final thoughts and a request of us all.

"I've been running from one question
"What's the difference between suicide and taking one's own life?
"One is based in Fear, and the other is based in Love
"I wasn't afraid
"Remember only my name
"There is only Love"

We can ill afford to leave these fallen comrades of ours behind. We must remember and honor their names. We must do better.

https://www.specialforces78.com/transforming-the-terrible-secret-of-suicide/ ❖

Editors Note: I would encourage you to take the time to read Greg Walker's "Losing the Last Greatest Battle—Why Military and Veteran Suicide Isn't Going Away." This excellent article digs into the circumstances and details of the deaths of several Green Berets, including Matt Livelsberger, and the huge obstacles that will need to be overcome if really significant progress is to be made.

Visit https://www.linkedin.com/pulse/losing-last-greatest-battle-why-military-veteran-suicide-walker-6autc/?trackingId=%2B-vQxpelAx6%2BuAFfpmR8n7A%3D%3D

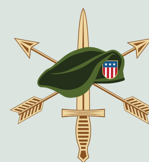
ABOUT THE AUTHOR

Greg Walker served with the 10th, 7th, and 19th Special Forces Groups during his 24-year Army career. His awards and decorations include the Legion of Merit, the Combat Infantryman Badge (X2), and the Special Forces Tab. Greg is a Life member of the Special Operations Association and Special Forces Association.

He is a family survivor of suicide and has written and spoken on military service related suicide and attempted suicide in an array of venues.

Mr. Walker, after raising his own hand for help in 2005, received superb care and treatment for his invisible wounds and physical injuries/illnesses from the VA and private sector. From 2009–2013 he served as a USSOCOM warrior care case manager and non-clinical advocate representing the Pacific NW, Alaska, Hawaii, and South Korea/Japan. Greg fully retired in 2018 after working as a military liaison in the behavioral health private sector.

Today he lives and writes from his home in Sisters, Oregon, along with his service pup, Tommy.



GREEN BERET
FOUNDATION

From Travis Wilson
Director of Mission and Community Services
Green Beret Foundation:

"Any Green Beret, past or present that seeks the need for suicide prevention, addiction issues, PTS issues can reach out to the foundation using the request for support link found at www.greenberetfoundation.org or they connect with me, Travis Wilson at travis@greenberetfoundation.org or 210-202-7343.

"We also facilitate payment and coordinate other treatments, therapies and devices. Such as (SGB) Stellat Ganglion Block, GammaCore, Alpha Stims, MeRT therapy, family therapy. If it's needed and meets the requirements of our mission and bylaws, we will do everything we can to ensure help to our Green Berets and their families. And as the only Green Beret in a director position at the GBF, I take this role and the care of our GBs very seriously."

Return to TOC ➲

"You have the opportunity to change the world."– MSG Leroy Petry, MOH

MSG Petry and the author at a past JBLM presentation. We also traveled to Alaska where Petry spoke on the continuing challenge of military service related suicide and why this issue must be addressed. (Credit: Author collection)

Master Sergeant (Ret.) Leroy Petry, Medal of Honor recipient, at Eielson Air Force Base where he shared his story and outlook on mental health and taking care of our brothers and sisters in arms.

By Greg Walker (ret.) USA Special Forces

I was blessed to spend 10 years working with our most seriously wounded, injured, or made ill Special Operations soldiers, sailors, Marines, and Airmen as a DoD trained and certified Warrior Care case manger and advocate {2009–2013}. This as well as in the private sector {2013–2018).

Along the way I was educated by many truly skilled and objective advocates, clinicians, hospital staffs, military commanders, and family members of those in care and treatment. Specifically, those engaged in both suicide intervention and prevention, a topic I am aware of being a survivor of a suicide in my own family many, many years ago now.

There are no memorial walls for those active duty, reservists, National Guard, and veterans who take their own lives. The stigma of suicide ensures silence, shame, and secrecy. Unfortunately, this stigma continues to hold sway despite significant changes in our cultural branding of military service related suicide. Today, we know far more about what brings our loved ones to the precipice of death by their own hands. And we are, we must, learn how to more properly care for those left behind. This in order to break the chain that suicide in a family.

And military units are a family as so many of us know.

Some years ago MSG (ret.) Leroy Petry, Medal of Honor recipient and past President of the Congressional Medal of Honor Society, shared with me the far more accurate number of those service members and veterans lost to suicide is 33 a day, eclipsing the 22 a day statistic most often presented. Petry's information came from his work with the DoD and the VA, among other agencies and NGOs working this issue. Petry himself has lost close friends to suicide. It is a heartfelt issue for him as a result.

"You have an opportunity to change the world" —
https://www.youtube.com/watch?v=ZMXSr8S-nVQ

USSOCOM

United States Special Operations Command

In the aftermath of Matt Livelsberger's suicide in Las Vegas USSOCOM must ensure its clinicians are separate and apart from undue Command influence.

Suicide is not painless

To kill the most terrible secret that is suicide we must expose its causes and its effects on our families, our friends, our military, and ourselves. We must expose military service-related suicide to the powerful, healing light of Love, Truth, and Self-Care. We must band together with like-minded warriors to include our family members to fight the good fight on behalf of those who are stumbling and reaching a point in their internal suffering where death seems the only option left.

They are people, not statistics

In January 2017, Oregon National Guardsman and decorated combat medic Will Naugle disappeared in SE Portland. A month later hikers discovered his remains at the Powell Butte Nature Park. Naugle, a combat veteran of our war in Afghanistan, had taken his own life. He had ended his life in the peace and solitude of a state park, his body not found for some time after he'd shot himself. His sister, Terry, says her brother wasn't the same once he returned from Afghanistan after serving with the Oregon National Guard, but they had no idea how badly he was hurting."

https://katu.com/news/local/family-of-national-guardsman-found-dead-theres-no-shame-in-asking-for-help

In April 2017, "Green Beret" Michael Mantenuto, also took his own life after suffering for years from behavioral health and drug dependency challenges. He, too, sought out a place of quiet and solitude before ending his life with a Glock 23 in the driver's seat of his SUV. Unlike Will Naugle, however, Mantenuto's unit Command and behavioral health team knew of his challenges but failed to properly address them.

https://www.armytimes.com/news/your-army/2019/08/20/he-was-a-special-forces-self-help-guru-then-he-took-his-own-life/

Most recently, well decorated combat veteran MSG Matthew Livelsberger, 1/10th Special Forces Group (Germany), and a behavioral health patient in the Preservation of the Force and Family program at his unit, took his own life in Las Vegas, Nevada, while on Christmas leave.

https://gazette.com/news/a-flawed-system-how-army-special-forces-mental-health-care-is-failing-elite-soldiers/article_0f4a0992-ceb9-11ef-845f-bbfd6e33314a.html

"Suicide is not an answer, it's destruction." — Al Green

Specialized Support for Special Operations Forces

In the dynamic and demanding world of Special Operations Forces (SOF), the challenges faced by operators and their families are unique and complex. Recognizing the need for tailored support, SOF Support offers a range of specialized services designed to address these specific needs, ensuring that our heroes and their loved ones receive the comprehensive care and assistance they deserve.

https://sofsupport.org/sof-resources/specialized-support/?gad_source=1&gclid=Cj0KCQiA4rK8BhD7ARIsAFe5LXJAxgXVcryDOfwnE7W6-5R0qjor4H3fgSL2806OL7Ugl7dGLqFb5ggaAlN6EALw_wcB

"There is no shame in asking for help"

At the grassroots level we are indeed our brothers and our sisters' keepers. "We have horrifying numbers of suicides from our recent wars," writes Dr. Edward Tick, founder of Soldier's Heart. "Yet as bad as the reports are, the suicide rate among veterans is likely much higher. Many after-conflict deaths result from self-inflicted wounds, accidents, legal or illegal drug overdoses, or alcoholism—with no messages left behind."

Indeed, there are no accurate numbers kept of SF/SOF veterans who after their military service take their own lives. It can be said if we had numbers we'd be stunned at this invisible metric's immense size.

Family members who kill themselves out of grief for the loss of a loved one to suicide represent numbers that no one truly has a grasp of to date, either. "The existence of a report is a step in the right direction. However, this report raises a lot of questions. We need more information on how this is tracked and who is included in these counts…"We know this is an imperfect science and incredibly difficult to track. It is clear that future studies and greater detail around the 2018 report are necessary."

https://www.militarytimes.com/2019/09/27/heres-what-first-ever-data-shows-about-military-family-suicides/

The author served in 10th Group (1981) and provided non-clinical case management and advocacy for the Group (Fort Carson, CO) from 2009–2013. Credit: Author collection

Who can help us?

Of the many organizations and agencies seeking to provide education, opportunities for care and treatment, and ongoing guidance and direction for those seeking it the following resources are available. I have used them in my own past work in this field, and with measurable encouraging results.

USSOCOM Warrior Care Program — https://www.socom.mil/care-coalition/Pages/Warrior-Care-Program-Mission.aspx

Veterans Crisis Line — https://www.veteranscrisisline.net/?gclid=CjwKCAiA0cyfBhBREiwAAtStHEABOZm1RKjPSrvbE_IjvAwJ1JmxRXgz2E8s-ybqa3RMW9h7SgimARoCkd0QAvD_BwE

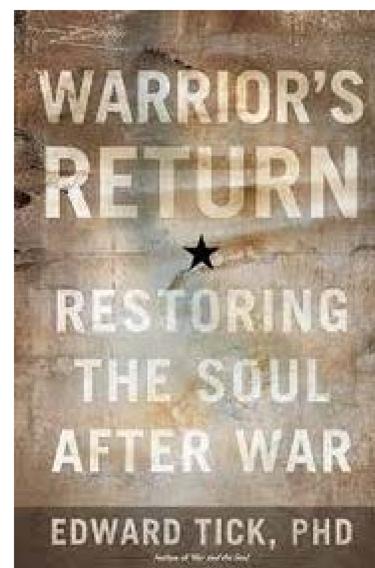
Wounded Warrior Project — https://www.woundedwarriorproject.org/programs/mental-wellness/veteran-ptsd-treatment-support-resources

For those seeking to become a resource in this area there is the **ASIST program** — https://www.livingworks.net/saving-lives

The message?

Again, from Dr. Ed Tick — "It is helpful to feel painful emotions but not to end your life."

Reach out — ***"Warriors are not meant to spread war's infection to their society…the warrior's core purpose is to preserve and protect society and all that is most precious to it."***



Warrior's Return: Restoring the Souls After War
By Edward Tick, PhD
Sounds True Adult; 1st edition
(November 1, 2014))
328 pages
Available in Kindle and paperback

Dr. Tick's second book is highly recommended—we can be restored after war and discover our "New Normal" can be healthy, happy, and a life-long mission of benefit to friends, family, and our nation. ❖

Return to TOC ➲

Repetitive Blast Exposure and Mental Health:

The Challenges for Military Veterans

SYRIA— 06.03.2017: A U.S. Marine fires an M777-A2 Howitzer in the early morning. (U.S. Marine Corps photo by Sgt. Matthew Callahan)

By Bruce Parkman

Foundation Note: *The following information is recommended for Veterans to consider for further evaluation of the effects of past RBE on their brain and mental health and should not be used for self-diagnosis. A diagnosis of the impact of RBE should be left to a qualified medical practitioner, and treatment protocols developed with them and other qualified professionals. Please do not try any treatment for your brain unless you have been advised on the risks and thoroughly understand them before trying them. Some of these, like plant medicines and psychedelics, could be harmful if proper preparation methods are not followed.*

Repetitive Blast Exposure (RBE): An Overview

Have you ever wondered about why the suicide rate and mental health of our veterans continue to remain one of the significant challenges to military veterans? Despite hundreds of millions of dollars spent on treatment and therapy, we continue to lose 22 (estimates range as high as 42[i]) veterans a day, and no other issue has dominated the press and conversation amongst military leaders and politicians as the epidemic of mental illness and suicide has. If these estimates are even close, we have lost more than 13 times the number of lives to suicide or overdose than have died in combat. What have we overlooked that could be contributing to this tragedy? The answer: Repetitive Blast Exposure, or RBE.

RBE refers to the waves of pressure, usually called Blast Overpressure that result from the firing of high-caliber weaponry, indirect fire systems, explosive ordnance/breaching, artillery, and armor. These waves of pressure, which we as veterans remember pounding our bodies (and actually enjoying it), can have detrimental effects on the body, primarily the brain, producing significant changes such as alterations to cortical thickness, decreases in white matter integrity, damage to the prefrontal cortex, cognitive and behavioral challenges, and more.[ii][iii] Currently it is thought that the primary injury is the impact of the blast wave that moves through the brain faster than the speed of sound on the organic components of the brain.[iv][v] These waves are now known to negatively impact the brain, and while there are different theories around the effects of the blast wave i.e., cavitation, astroglial scarring, and/or neuroinflammation on different components of the brain, research shows that there can be no doubt that significant changes are caused by blast exposure.[vi] Due to the lack of symptoms that occur in a soldier experiencing RBE through training and combat, it is now understood that these changes, incurred through long periods of intense exposure, cause changes to the brain that are known to be associated with mental illness, to include suicidal and homicidal ideation.[vii]

RBE is significantly different from a Traumatic Brain Injury, or TBI, which refers to an incident, like an IED, vehicle rollover, or bad parachute landing, where the brain is impacted in such a way that symptoms appear. Depending on the grade, a TBI can range from a concussion all the way to a grievous combat injury like a gunshot or blunt force trauma. Because RBE doesn't produce symptoms, it has been assumed to be harmless for years, like its cousin Repetitive Head Impacts from contact sports, martial arts, boxing, etc. While the brain can, depending on the severity of the injury, recover and heal from a TBI, long-term exposure to RBE produces changes that are more permanent in nature. In fact, studies show that servicemembers suffer from mental illness that have been exposed to RBE that have never had a TBI, nor have been exposed to combat.[viii]

Understanding RBE Exposure and its Impacts on the Brain and Mental Illness

So why is this now an issue? We have been in wars before; why are these veterans so vulnerable to this condition? The reason: since 9/11, the amount of exposure to RBE to the GWOT veteran is unprecedented in the history of this country due to the level, quality, and quantity of training as well as combat exposure. The GWOT veteran

not only trained for combat continuously; if they were not training, they were fighting. This means that, for most of their military careers these veterans have been exposed to continuous and relentless blast exposure from weaponry, indirect fire, IEDs, explosions, and more. Unlike older veterans or older wars, the long-term exposure simply wasn't there, whether it was from a lack of resources (post-WWI, WWII, and Vietnam) or duration of wars (Iraq 1, Grenada, and Panama).

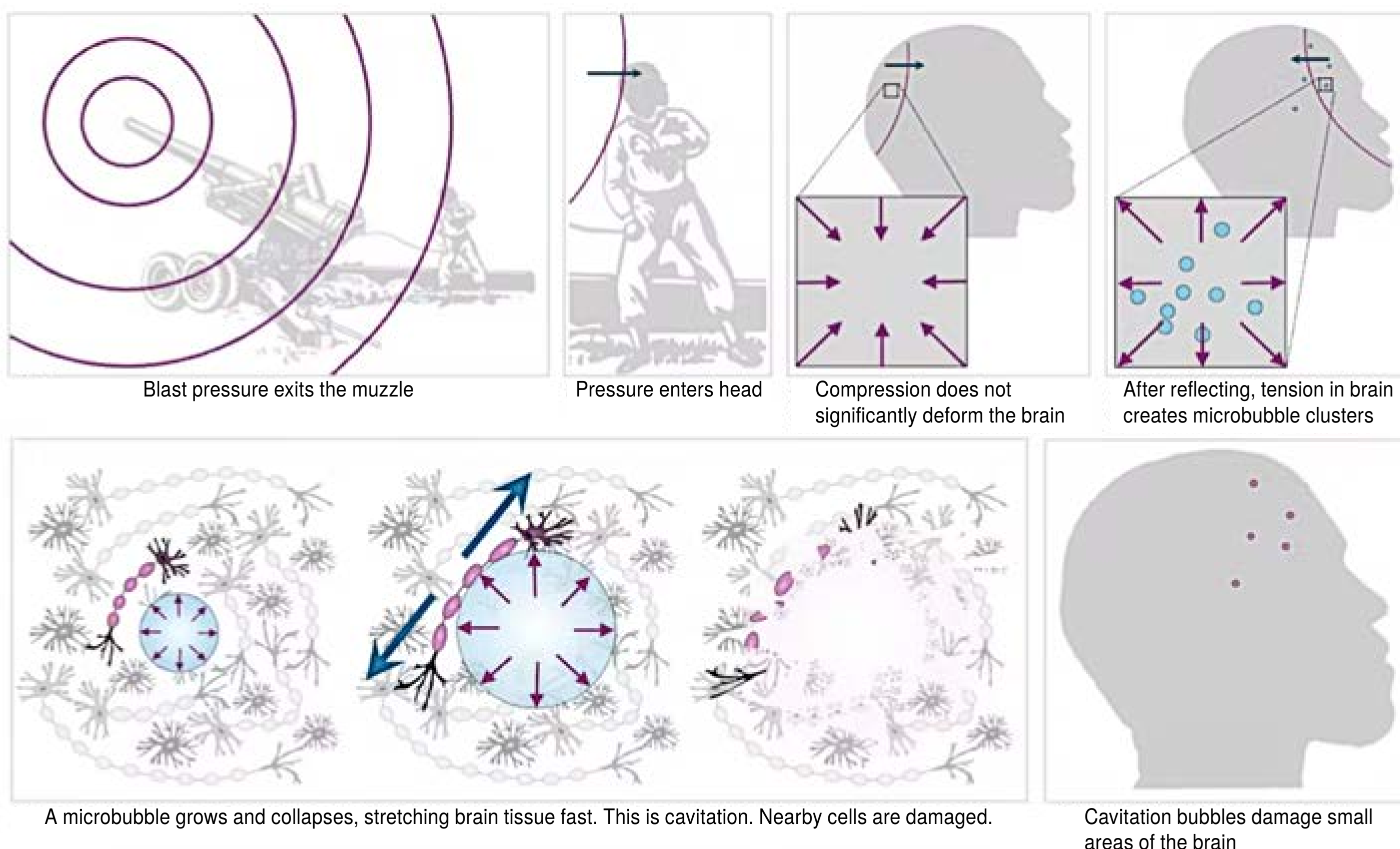
Unfortunately, this exposure has had a significant impact on the brains, mental health and lives of our veterans and until recently, it has not been understood by the military that this was even an issue. The term blast overpressure was first acknowledged in research around 2010 and was considered fringe knowledge for years. It was not considered a risk by the military, VA or National Health Agencies as a threat; the Nation was fighting two wars, and evidence that RBE was an issue was nascent at best. As a matter of fact, until around 2018, after almost 20 years of combat and combat-related training and an unprecedented rise in mental illness among troops has the military started to focus on this issue. In the last several years, research on soldiers and RBE has provided significant evidence that this is a threat to force readiness and has resulted in changes to training and measures to reduce blast through suppression and new technologies.

While this is good news for those that have entered the military in recent years, these changes cannot impact the lives of those who entered years ago or those that have already left the military. Many of these service members have served in occupations with known elevated levels of blast exposure and multiple combat tours. With over 2M men and women that have served in Iraq and Afghanistan, many of them with years of combat and combat-related training, the numbers of affected veterans are assumed to be very high.

Limited Awareness of RBE and Its Impacts

This is compounded by the fact that RBE and its impact on the brain and contribution to the epidemic of mental illness is not a well-known subject in the medical, nursing, and psychological fields. As a matter of fact, there is minimal awareness outside of the few TBI Clinics, the NICO and other cutting-edge facilities that understand TBI and the impact of RBE on the brain. Due to the recency of this knowledge, RBE is not trained in any medical or psychological courses at this time, which means that most of the providers that the veteran may come across are not trained in this issue. In recognition of this issue, in 2023 the VA started an outreach program to contact veterans that may have been assumed to have been exposed to RBE during their careers.[ix]

This situation is exacerbated when it comes to mental health, as while RBE knowledge is constrained in our medical fields, the relationship between RBE and mental illness is even less recognized. There is a minimal understanding across the medical and psychological fields of the linkage between the damage to the brain that results from RBE exposure and the links from that damage to mental illness. This causes mental illness, one of the largest risks to our veteran population, to be treated as well, mental illness with no thought of the correlation between physiological damage to the brain and the resulting behavioral, psychological, and cognitive disorders. We know from countless surveys that mental illness is rampant in veteran populations; we hear about it and read about it every day, and many more are in jail (estimates range as high as 180,000 veterans[x]), have suffered broken marriages, lost their children, businesses, and more. There is no doubt that we have an issue with mental illness in our veteran population.



This diagram depicts how blast pressure from a gun can result in brain trauma. Alice Lux Fawzi and Manik Bansal, CC BY-NC-ND

Marines with Combat Engineer Company detonate an oval charge and prepare to enter a building during urban mobility breaching training. (Photo by Lance Cpl. Daniel Valle, III Marine Expeditionary Force)

While the VA and others seem to be making great strides in improving awareness of RBE, the critical issue at hand is ***HOW*** we treat mental illness, especially considering the lack of knowledge of the link between RBE and brain damage, and this is key to understanding why change is necessary, for here is where we are failing our veterans.

Current Treatments for Mental Illness Fail to Address the Impacts of RBE

For years, the standard protocols for dealing with mental illness have relied on the combined approach of therapy and pharmaceutical intervention. While this is considered "by the book" and approved by the Food and Drug Administration (FDA), this approach has not been effective in dealing with the epidemic of mental illness from a RBE perspective, particularly when we consider suicidal and homicidal ideation. The problem is that these modalities do nothing to improve the origin of the mental illness, which is a damaged brain. While pharmaceuticals are critical where suicidality, or where there is a risk of harm to self or others, the use of pharmaceuticals overall does nothing to improve brain health or healing, and for that matter, neither does therapy. In fact, when it comes to a veteran that is struggling with a mental illness that could be caused by a damaged brain, these modalities provide the veteran with little relief, as therapists, usually civilians, usually cannot relate to the veteran's issues and the pharmaceuticals come with black box warnings (usually not disclosed) and significant side effects, which only lead to more prescriptions or exacerbate the Veterans mental health condition. It is not uncommon for veterans that have spent significant time under VA or Tricare care to have multiple medications (I have talked to Veterans with over 17 different medications) that do nothing to improve the actual health of their brain, and they have tried everything.

While the VA has taken steps to increase awareness of RBE, it is obvious that those is the area of diagnosis and treatment where significant change is needed to improve the qualitative level of care. This will require an approach to care that, regrettably, is not one that the military, or, in that case, health care, is familiar with or favorable of accepting. Unfortunately, the VA and Tricare approach to "FDA Approved" modalities bring us back to the problematic issue of pharmaceutical intervention and therapy that has not impacted our suicide rates at all. While, to the average person, it seems logical that you only need to study an issue so much to understand it. However, science and medicine want to work in terms of a definite understanding of the problem and they want "evidence-based studies" and "protocols" that can be used to diagnose and treat a condition. However, these studies take years, even decades, before treatments and protocols are approved, and while Healthcare is willing to wait on them, we cannot. TBI has been studied for well over a decade, and the standard protocols for veterans suffering from the effects are still not having a definite and scalable impact.

That is because the brain is like space, a frontier where some things are known and many things poorly, if not completely, understood. A broken brain is not like a bone; there are so many variables and conditions that there can be no guaranteed outcome of any known treatment that is provided to someone. It is so complex, with over 100,000 miles of myelin and almost 100 billion neurons all contained in a gelatinous organ that is contained in a hard bony case. In fact, despite billions of dollars spent on research and pharmaceutical development, many psychiatrists will tell you that they only have a 25% expectation that any pharmaceutical that they prescribe will work. Yes, 25%. And we want to wait another 10 to 20 years for a definite answer to treating the issue of RBE-induced mental illness? NO.

Because it's going to take decades to deliver what the scientists want, we need to think outside the box when it comes to alternative forms of diagnosis and treatment, especially when it comes to veterans. We can no longer accept the current levels of suicidality and mental health as something we need to live with. There are novel approaches to diagnose and treat RBE-related mental illnesses that have been around for decades that are available without pharmaceutical intervention. Many of these have been used by thousands of veterans, and they have successfully improved their brain and mental health. While these treatments do not work for 100% of the veterans, there is an overall positive effect that is extremely high, much higher than the expectations for pharmaceuticals.

Additionally, there is minimal risk associated with these treatments. Unlike most SSRIs and SSNEs, and benzodiazepines that have black box warnings of depression and suicidal ideation and have been shown to be ineffective, these treatments, like electronic stimulation of the brain, Hyperbaric Oxygen Treatment, plant medicines, or supplementation programs, have minimal risk to the brains or health of veterans when conducted under the proper level of medical care. In fact, current response rates of favorable impact on the brains of veterans that have undergone treatments that we have talked to are well over 80 to 90%. Others, like Ibogaine and Ayahuasca, have shown to be absolutely critical to saving veterans' lives who have tried all other options offered by our current military and healthcare systems.

Veterans Must Understand the Impacts of RBE and Treatment Options

So, what is a veteran to do, may you ask? First, the veteran has to be educated in several areas surrounding the issue of RBE so that they can talk to their provider about their exposure and discuss options for diagnosis and treatment.

Exposure: In the area of RBE, there are many studies out there that cover the issue; you can google RBE or Blast Overpressure to understand that the U.S. Government has spent millions of dollars on this issue and that there is a lot to read on it alone. In fact, some studies state that RBE should be a consideration when mental health issues are present.[xi] Suffice to say that if a veteran served in any of the following MOS's: Tanker, Artillery, EOD, Special Forces, or Infantry where there is significant presence of RBE, the veteran should be cognizant of both the amount of time they spent in the MOS as well as the amount of time spent in combat. To provide a value to the amount of exposure a veteran may have Researchers came up with a Generalized Blast Exposure Value, or GBEV, that can be calculated by any facility that is familiar with the model. (Someone needs to create a free version of this tool.) An additional consideration is the amount of time spent in combat, as depending on the frequency of deployments, exposure and its impacts are even worse, as everyone knows that there are no restrictions in combat regarding anything, especially firing of weapons and explosions.

Diagnosis: Once it can be ascertained that there is exposure, the next step is diagnosis. While the DoD wrestles with this, there are several steps that a veteran can take. The first is to take a look at the exposure and proof that one has, i.e., DD214, combat records, medical records, etc. The second is to get a brain scan to determine the extent, if any, of damage done to the brain. There are several scans that can be used to do this:

- A Diffusion Tensor Imaging Scan, or DTI
- A Functional Magnetic Resonance Imaging, or fMRI scan
- A Single Photon Emission Computed Tomography (SPECT) Scan can be done by any of the Amen Clinics.
- A Quantitative Encephalogram, or qEEG

These scans can be accomplished by any brain center or hospital, but it's important that they are read by a neurologist who is knowledgeable of the issue of RBE. Most of these can be found in major cities, and unfortunately, most of these will be out of pocket unless you can convince your VA or Tricare provider to pay for the scan or test. With the right amount of evidence and explanation, you will have a good chance. It is important to note that the CDC has recently declared TBI to be a "chronic" condition, opening up the diagnosis to coverage under Tricare and the VA. The impacts of RBE can be classified as a mTBI, so it is important for the veteran to have that understanding when they appear before the VA or when talking to their physician during their transition. In 2022 the VA also updated billing codes, stating, "the 2023 ICD-10-CM code updates, effective on October 1, 2022, contain a series of codes for 'S06.8A—Primary blast injury of brain,' not elsewhere classified."[xii]

Soldiers assigned to 1st Stryker Brigade Combat Team, 4th Infantry Division, stack up against a simulated door for a silhouette charge (U.S. Army photo by Capt. Daniel Parker)

Treatment: Here is where there can be information overload, but it's up to the veteran to consult with specialists, their mental health team, or other veterans to determine what set of treatments they should explore to determine how to treat their health. It is not advisable to just start trying many of these treatments, especially psychedelics, without an understanding of what to expect. We can break down treatment into several areas:

•Brain Supplementation and Diets—programs designed based on dietary knowledge and blood tests to identify deficiencies in nutrients and chemicals and to balance brain health with nutraceuticals, vitamins, and minerals.

- Outpatient Procedures—minor surgical procedures like Stellate Ganglion Blocks (SGBs) known to improve brain health.
- Brain Health Treatments—technical modalities designed to stimulate the brain to increase plasticity, stimulation and promote healing. Include a wide range of options from Transcranial Magnetic Stimulation, Hyperbaric Oxygen Treatment, Vagas Nerve Stimulation, Heat/Cold Therapy, Breathing Exercises,
- Psychedelics
- Therapy: there are now modes of therapy that have had amazing effects on veterans but are not approved by the VA. Trauma Resiliency Protocol, Emotions Management Process, and Eye Movement Desensitization and Reprocessing (EMDR) are some of them known to be used by veterans and first responders.

While it is beyond this article to go over every one of the options here (maybe we can run a series), suffice it to say that there are numerous treatment options known to treat and benefit brain health. While there is no "set' combination of protocols, it is up to the veteran.

This lack of progress on the mental health of veterans, coupled with the continuous prescription of ineffective and mind-numbing drugs, the tragic stories of veteran homicide or suicide, and the never-ending focus on the suicide rate, has created an environment of mistrust and animosity between many veterans and the VA, and that needs to be fixed as we move ahead. We have millions of veterans that have served in the last two wars and millions more that have served before them that have never been assessed for the impact of their careers on their brain health, nor have they been properly treated for any mental illness that they may have displayed as a result of any damage to their brain. These veterans have committed no crime; they signed up to serve their country, and many of them paid for that service with their lives, others with broken bodies, and many, many more with broken brains. We need to lean forward, educate our medical and psychological communities, and make these alternative treatments available to our veterans now. ❖

Endnotes

i. https://missionrollcall.org/veteran-voices/articles/the-state-of-veteran-suicide/

ii. Neurological Effects of Repeated Blast Exposure in Special Operations Personnel; *James R. Stone, Brian B. Avants, Nicholas J. Tustison, Jessica Gill, Elisabeth A. Wilde, Kiel D. Neumann, et.al* Journal of Neurotrauma 2024 41:7-8, 942-956

iii. Impact of repeated blast exposure on active-duty United States Special Operations Forces. Gilmore N, Tseng CJ, Maffei C, Tromly SL, Deary KB, McKinney IR, Kelemen JN, Healy BC, Hu CG et. Al, Proc Natl Acad Sci U S A. 2024 May 7;121(19)

iv. https://neurolaunch.com/blast-brain-injury/

v. Shively, Sharon Baughman et al. "Characterisation of interface astroglial scarring in the human brain after blast exposure: a post-mortem case series." *The Lancet*, Neurology Vol. 15,9 (2016): 944-953. doi:10.1016/S1474-

vi. https://theconversation.com/low-level-blasts-from-heavy-weapons-can-cause-traumatic-brain-injury-2-engineers-explain-the-physics-of-invisible-cell-death-220267

vii. https://www.research.va.gov/currents/0222-Teasing-out-the-effects-of-blasts-on-mental-health.cfm

viii. https://pmc.ncbi.nlm.nih.gov/articles/PMC9529318/

ix. https://www.nytimes.com/2023/12/13/us/veterans-weapons-blast-exposure.html

x. https://www.ncja.org/crimeandjusticenews/commission-to-study-why-so-many-veterans-end-up-in-jail-prison

xi. Rowland JA, Martindale SL. Considerations for the assessment of blast exposure in service members and veterans. Front Neurol. 2024 Apr 15;15:1383710. doi: 10.3389/fneur.2024.1383710. PMID: 38685944; PMCID: PMC11056521.

xii. https://www.research.va.gov/currents/1022-Primary-Blast-Injury-of-the-Brain.cfm

ABOUT THE AUTHOR

Bruce Parkman entered the Army in 1980 and spent 21 years in the service, including 18 years as a Green Beret serving in the 7th and 10th Special Forces Groups and USAJFKSWCS before retiring as a Sergeant Major in May of 2001. He participated in the El Salvador Conflict as a Combat Advisor and deployed as the Sergeant Major for the 1st (SOCCE) to Kosovo to enforce national policy. In 2020, his son Mac took his life after suffering from undiagnosed mental illness that has been contributed to his extensive exposure to subconcussive trauma from contact sports. To honor his son, he started The Mac Parkman foundation which focuses on the issue of Repetitive Brain Trauma in kids, athletes and veterans and wrote a book called *Youth Contact Sports and Broken Brains: Understanding the Hidden Risks of Mental Illness from Early Exposure to Concussive Trauma*. He has worked with legislatures, researchers, scientists, parents, doctors and psychologists to spread the work about the risks of subconcussive trauma to make sports safer and to provide improved treatment to veterans.

Mr. Parkman is also the CEO of Blue Fusion Technologies (https://bluefusion.com) a data integration company and a founding Director of the Green Beret Foundation, Chairman of the Board for the Global Special Operations Forces (SOF) Foundation (https://gsof.org) and remains involved in numerous initiatives to focus on protecting our children.

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Whats New On YouTube @sfachapter78?

NEW!

Medal of Honor Recipient Master Sergeant (Ret.) Earl Plumlee Delivers Keynote at Special Forces Association Chapter 78 Luncheon

The SFA Chapter 78 was honored to host Medal of Honor recipient Master Sergeant (Ret.) Earl Plumlee as the keynote speaker at its Special Forces Association Chapter 78 Luncheon, a fundraiser held on April 28, 2024, at the On The Greens Conference Center in Cypress, CA.

MSG Plumlee's distinguished career began in Marine Corps Force Recon before transitioning to the U.S. Army Special Forces. As a Green Beret, he served with C Company, 4th Battalion, 1st Special Forces Group (Airborne), deploying to Afghanistan. During his deployment, he played a pivotal role in the battle of FOB Ghazni, an engagement in which his skills as a Special Forces sniper were put to use, for which he was awarded the Medal of Honor.

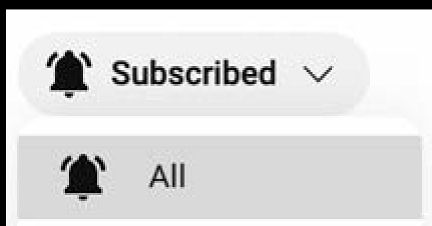
Beyond his military service, Master Sergeant Plumlee remains a dedicated advocate for veterans, continuing to inspire future generations through his leadership and mentorship. Thanks to his support and the generosity of the community, Chapter 78 successfully raised funds for Sunburst Youth Challenge Academy, as well as for the ACL Afghan refugee community, Afghan allies who served alongside Special Forces in Afghanistan. Additionally, the chapter secured resources to continue hosting guest speakers at its monthly meetings.

Thank you to our event sponsors for making this event possible: Preisker Ranch, HomeXpress Mortgage Corp., ATVLS (Advanced Technology Vehicle Logistics Services, Inc.), American Veterans Assistance Group, Expert Home Loans, and Tennis Serves Others.

Stay tuned for more videos of our excellent meeting speakers:

- Horse Soldier MSG (Ret.) ChrisSpence
- Frank K. Sobchak, PhD Author of Training for Victory
- Nate Palin of Any Given Day (agdready.com)
- Henry L. (Dick) Thompson, Ph.D. AKA SOG Codename "Dynamite"

Just a few examples—there will be more...



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SFA Chapter 78 January 2025 Chapter Meeting

Photos by James McLanahan, How Miller, Debra Holm, and Art Dolick

Guest Speaker, SFC (ret) Scott J. McHugh

1 **2** SFC (ret.) Scott J. McHugh, a retired 18F, is a Cleveland, Ohio native who joined the Army in 2002. He spent a majority of his time in 1st SFG, but also was the Senior Enlisted Medical Advisor for 1st SWTG (A), Voting Member of the Joint Enlisted Medical Advisory Commission (JMEAC) for USSOCOM, and voting member for the Committee for Tactical Combat Casualty Care (CoTCCC). 2019 he had the opportunity to establish a program for 1st SFG members returning from Afghanistan to address the continuous threat of moral injuries and post traumatic stress.

3 **4** Stefanos Kafatos, a friend of Chapter VP James McLanahan, shot video of the meeting, which will eventually be posted on our YouTube channel. Stefanos is the owner of Macroframing, Inc, a Director of Photography and Director. The chapter appreciates his service, especially in light the recent loss of his home in the Eaton fire.

5 Chapter Secretary Gary Macnamara

6 Left to right, Chapter Treasurer Richard Simonian and Nimo Aslami, Project Manager of ACL Refugee Housing, discuss recent developments in the Afghan refugee community.

7 At right, chapter member Mark Griffin with his guest, Derek, at left.

8 Left to right, Steve Bric and Bill Reed

9 Left to right, Art Dolick and his wife, Lani

10 Nimo Aslami

11 Ramon Rodriguez

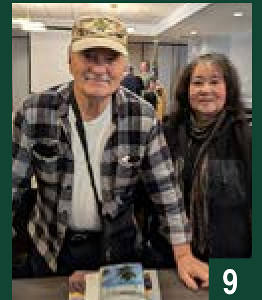
12 Left to right, Ham Salley, Mike Jameson, and Don Deatheridge

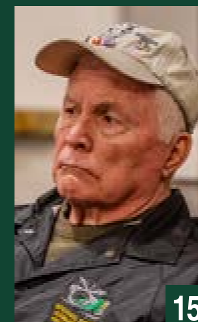
13 Frank Boyd

14 *Sentinel* Editor, How Miller

15 Mark Miller

16 Left to right, Lani Dolick and Debra Holm





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