STATEMENT OF
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WRITTEN TESTIMONY FOR U.S. SENATE COMMITTEE ON VETERANS AFFAIRS

Our nation has been at war for nearly 18 years — the longest stretch of conflict in our nation's history. Over that period of time, we have lost more service members and veterans to suicide than we have on the battlefield. This is true despite a great deal of attention and resources being poured into solving this problem across the public and private sector.

As a 21-year Navy combat veteran, and the Chairman of the EOD Warrior Foundation and Boulder Crest, which includes two privately-funded wellness centers – Boulder Crest Retreat Virginia and Boulder Crest Retreat Arizona – and the Boulder Crest Institute for Posttraumatic Growth, that serve combat veterans and family members struggling with suicidal thoughts and other mental health challenges, we have gained a unique perspective not only on the question of why suicides continue to happen, but how we can prevent them.

The Causes of Suicide

At its core, suicide is the result of hopelessness and loneliness. Suicide stems from a belief that tomorrow will always be the same or worse than yesterday, and that there is no path to a life that is worth living and that nobody really 'knows me or gets me'. Why is it that far too many veterans find themselves on the precipice of suicide? What contributes to their struggle?

We would be reticent to declare that we have all the answers. If there is one thing I can conclude after 21 years in the Navy and now 15 years of working closely with veterans and attending far too many funerals for my brothers and sisters who died by their own hand, it is that there is no such thing as a suicide expert. The data do tell us that depression – not PTSD – is correlated with suicide. Depression is perhaps best defined in the words of the psychologist, Rollo May, who said: *"Depression is the inability to construct a future."*

This focus on depression is consistent with the VA's research indicating that depression – not PTSD – is the biggest challenge affecting veterans, particularly during and after their transition.

Since opening Boulder Crest Retreat Virginia in September 2013, and Boulder Crest Retreat Arizona in November 2017, we have hosted more than 4,000 combat veterans and family members, and run more than 120 short-duration, high-impact programs. Before, during, and after those visits and programs, we have spoken with guests about their struggles, their experiences with the mental health system, and why they pursued a non-clinical approach. The insights they offered, integrated into our work at Boulder Crest, provide a powerful roadmap for ensuring that we end the epidemic of veteran suicides, and more significantly, enable veterans to create lives worth living – the true opposite of suicide.

As we reflect on all that they have shared, we see six major causes of struggle for veterans that put them at risk of suicide:

1. VA's Myopic Focus on PTSD

The idea that depression – not PTSD – is the biggest challenge for veterans might come as a surprise to many. That – in fact – is a key element of the challenge. As George Bonano and Meaghan Mobbs noted in a 2018 Clinical Psychology Review article, "*Even more problematic, despite the looming uncertainty of future treatment needs, currently available interventions for returning veterans have focused narrowly on extreme psychopathology, and typically only on Posttraumatic Stress Disorder (PTSD).*"

The assumption that when veterans struggle it must be PTSD-related contributes to applying the wrong treatment to the wrong person, and can, in fact, make veterans worse. The evidence-based treatments for PTSD are not the same treatments one would assign for depression; this is particularly true for Prolonged Exposure. This helps explain why many veterans will never seek treatment and often dropout prior to its conclusion – and struggle mightily as a result.

2. Transition Issues

A second and related issue to the first is the difficulty that many veterans have transitioning. Bonano and Mobbs explain:

One of the primary reasons for past failures in veteran treatments, arguably is that the dominant focus on PTSD has obfuscated other, often highly pressing transition issues. Research has documented, for example, that many returning veterans may struggle regardless of whether they have PTSD or not. Recent population survey studies have suggested that 44% to 72% of Veterans experience high levels of stress during the transition to civilian life, including difficulties securing employment, interpersonal difficulties during employment, conflicted relations with family, friends, and broader interpersonal relations, difficulties adapting to the schedule of civilian life, and legal difficulties (Morin, 2011). Struggle with the transition is reported at higher, more difficult levels for post-9/11 veterans than those who served in any other previous conflict (i.e.Vietnam, Korea, World War II) or in the periods in between (Pew Research Center, 2011). Crucially, transition stress has been found to predict both treatment seeking and the later development of mental and physical health problems, including suicidal ideation (Interian, Kline, Janal, Glynn, & Losonczy, 2014; Kline et al., 2010). What is more, the majority of first suicide attempts by veterans typically occur after military separation (Villatte et al., 2015).

As evidenced by much lower (albeit growing quickly) suicide rates of active duty service members, much about military service is fulfilling and rewarding. In fact, military service provides service members with many of the factors that contribute to strong mental health – identity, purpose, meaning, connection, growth, and service. Imagine for a moment a Marine – he joins at 18, and in a short period of time is transformed from an ordinary civilian into a

proud Marine. For perhaps the first time in his life, he knows who he is (a Marine), why he exists (to locate, close with, and destroy the enemy), and who his tribe his (his fellow Marines).

That Marine goes on to serve for four years or forty years with honor and distinction, and then gets out. He is thrust from a world of certainty, community, purpose, and meaning into the rather cold and uncaring civilian-dominated world. He begins to struggle as he navigates a deep, profound, and existential journey into who he is now, why he exists (or if he still should), and where he belongs. He has a job but hates it. The struggle starts to get the best of him – he begins to distance himself from his loved ones and friends, and starts self-medicating with alcohol. After an alcohol-related incident, he is persuaded to go see someone. After mentioning that he deployed to Iraq and Afghanistan, the therapist immediately circles in on PTSD as the cause of his issues. He is diagnosed and medicated and turns to disability payments for sustenance; and is now destined to live out the rest of his life as a diminished version of his once powerful and remarkable self. What was a temporary issue of adjustment has now become a permanent diagnosis. At some point, he might decide that this life – just barely getting by, surviving each day feeling numb, broken, and useless – isn't worth living.

This story is not merely an anecdote. It is the story of far too many veterans who struggle with how to transition effectively.

3. A Society Filled with Disconnection and Struggle

A third reason why veterans struggle is encapsulated in the remarkable work of Sebastian Junger. In his book *Tribe*, and in his other writings and TED Talk, Junger speaks about his belief that much of the struggle that veterans experience has far more to do with what they are coming home to rather than what they are coming home from. His belief is supported by the devastating statistics related to civilian mental health – from suicides (in 2017, there were 129 suicides per day, and a stunning 1.4 million suicide attempts – 3,836 per day) to opioid, drug, and alcohol overdoses.

When they leave the military, veterans depart a world filled with identity, purpose, meaning, connection, growth, and service and enter one filled with despair, struggle, and disconnection. This despair proves to be contagious – as misery loves company – and combined with transition challenges, overwhelms veterans. The result is self-medication and far too frequently, suicide.

4. Military Training

A number of researchers have studied the symptoms of PTSD and explored the connection between PTSD symptoms and the training service members receive to thrive in combat. One researcher, Dr. Charles Hoge, a retired U.S. Army Colonel and one of the world's most published authors on PTSD, identified the clear connection between military training and veterans struggle, depicted in the table below.

Military Training	*Symptoms of Struggle*
Sharply Tuned Threat Perception, Rapid Reflexes	Hyperalert, Hypervigilant
Intense Mission Preparation, Rigorous Training, After-Action Reviews (AARs)	Reliving Events, Guilt, Second Guessing
Attention to Details, Minimize Mistakes	Intolerance of Mistakes
Adrenaline/Intensity to Accomplish the Mission	Anger/Rage
Emotional Control in Combat	Detached, Numb
Unit Cohesion, Unit is Family	Social Withdrawal

On the left column of this chart are six key elements of military training that allow service members to thrive in combat. On the right side are the symptoms of PTSD. We take ordinary civilians and train them so they can function effectively in combat – the list of items in the left column. On this path to gain courage and strength, we call them Warriors. As they return home from utilizing, refining, and integrating that skill set and attempt to apply it at home, we call them broken. This is the ultimate Catch-22.

What is clear is that there is nothing wrong with many of our service members and veterans – they are merely a function of their training and experiences. They are struggling because of what happened – not what's wrong. This understanding – which is a foundational element of our Warrior PATHH program at Boulder Crest, the subject of more discussion below – liberates combat veterans to realize that they are far from broken or damaged; they simply need additional training to learn how to apply their unique set of skills, strengths, and abilities at home. This training is particularly important as it relates to one of life's most important skills – the ability to self-regulate. We do know that in the absence of the capacity to self-regulate, most humans will self-medicate. This self-medication often creates a vicious and downward spiral that ends in self-destruction or suicide.

5. An Accumulation of Trauma

As Bonano and Mobbs noted above, the struggle of veterans is viewed nearly exclusively through the prism of PTSD. Some devastating event from the battlefield is claimed to be the cause of all that ails the combat veteran, and with the right treatment and medication, all will be well. Unfortunately this view of life is simply not supported by data.

A great deal of research conducted in recent years explores the childhoods of members of the all-volunteer force, working to understand the range of reasons why people join. These reasons include a yearning for discipline, community, challenge, purpose, and service. It is also clear that a key reason that many join is to escape a dangerous or abusive situation. Members of today's military have experienced more childhood trauma than members of the general public — by a factor of at least two, and possibly more.

As the American Psychological Association notes, *"High rates of suicide among military service members and veterans may be related to traumatic experiences they had before enlisting, making them more vulnerable to suicidal behavior when coping with combat and multiple deployments…"*

The growing science related to childhood trauma – known as Adverse Childhood Experiences (ACEs) – speaks to how such trauma affects core belief systems as well as an individual's capacity to deal with future trauma. By attributing combat veterans struggle solely to what happened on battlefield, we fail to recognize that what they struggle with is an accumulation of traumatic experiences – not a single event.

6. Failure of Treatment

The final factor I want to discuss as it relates to why veterans are at risk for suicide relates to our nation's approach to mental health. In short, our mental health system – and approach – simply is not working – for depression, PTSD, and suicide.

This is not my opinion, but the findings of the world's most prestigious medical journal – the Journal of the American Medical Association (JAMA). In August 2015, JAMA called for a new and innovative approach to PTSD for veterans. In January 2017, JAMA Psychiatry declared that, "*These findings point to the ongoing crisis in PTSD care for service members and veterans. Despite the large increase in availability of evidence-based treatments, considerable room exists for improvement in treatment efficacy, and satisfaction appears bleak based on low treatment retention…we have probably come about as far as we can with current dominant clinical approaches."*

The reliance on evidence-based treatments, noted in the JAMA Psychiatry quote above, has proven to have serious limitations. Jonathan Shedler, PhD, noted in a 2015 article entitled "Where is the Evidence for 'Evidence-Based' Therapy?", *"Research shows that "evidence-based" therapies are weak treatments. Their benefits are trivial. Most patients do not get well. Even the trivial benefits do not last."*

Shedler continues: *"In the typical randomised controlled trial for 'evidence-based' therapies, about two-third of the patients get excluded from the studies a priori (Westen et al, 2004). That is, they have the diagnosis and seek treatment, but because of the study's inclusion and exclusion criteria, they are excluded from participation. Typically, the patients that get excluded are those who meet DSM criteria for more than one diagnosis, or have some form of personality pathology, or are considered unstable in some way, or who may be suicidal. In other words, the two-thirds that get excluded are the patients we treat in real-world practice. So two-thirds of the patients who seek treatment get excluded before the trial begins. Of the one-third that do get included, about half show improvement. So we are now down to about 16 percent of the patients who initially sought treatment. If we consider the percentage of patients who actually get well, we are down to about 11% of those patients who originally sought treatment. If we consider the percentage that get well and stay well, we are down to roughly 5 percent."*

The concerns expressed by many of the best and brightest in the field are proven out in the statistics. The veteran suicide rate has barely budged from 20 a day for several years. More concerningly, of those 20 suicides a day, only six are in active VA care. This unwillingness to seek care keeps at least 50 percent of veterans who might benefit from mental health from ever going to see someone. Of those who do access mental health, between 40-80 percent will dropout prior to the conclusion of the treatment, often due to a lack of provider-patient connection, or a sense that treatment is making them feel worse. As noted above, the near-exclusive focus on PTSD (rather than transition struggles) may contribute to this fact. Only 40 percent of those who complete treatment will experience any benefit, which is often fleeting, as Shedler noted above.

Notably, in June 2018, in response to a CDC report indicating that suicides across the United States had increased 33 percent since 1999, Dr. Thomas Insel – the former director of the National Institute for Mental Health – asked, "Are we somehow causing increased morbidity and mortality with our interventions?"

When we have asked combat veterans who have attended programs at Boulder Crest Retreat Arizona or Virginia why they didn't benefit from traditional treatments, they shared the following reasons:

1. Veterans report that they have been trained not to acknowledge weakness and are experts at suffering in silence. Seeking mental health treatment while on active duty is often a career ender, and that thinking follows them out of the military.
2. Veterans are unable to connect with their providers (often civilians who lack a strong understanding of the military culture and have no basis for understanding combat experiences); this results in a lack of trust, safety, and an unwillingness to return for further treatment.
3. Veterans report that mental health treatments focus on helping them manage and mitigate their symptoms through a combination of talk therapy and medicine, rather than on living a great life. The majority of veterans are not interested in learning how to live with a diminished version of themselves.
4. Veterans report that a diagnosis-focused approach means that therapists and clinicians only want to hear enough to label and judge them, and have little interest in listening to them.
5. Veterans are seeking direction and purpose, and find that consistently talking about past experiences leaves them stuck in their struggle, and unable to move forward.
6. Veterans report that most programs and therapies they experience are catch-and-release. They feel better while they are at a program or in treatment, but as soon as it ends, they return back to their prior baseline.

In sum, of the 900,000 post-9/11 combat veterans who are struggling with mental health related challenges, only 3 percent will find meaningful and sustained help from the current mainstream approaches. We can and must do better.

What Can We Do?
I have shared six of the reasons why the veterans suicide epidemic is continuing to go from bad to worse. The critical question that the Committee is asking – as are many who are gravely concerned about the state of veteran's well-being – is what do we do about it?

This question is what I have worked to answer since starting the EOD Warrior Foundation in 2004, opening Boulder Crest Retreat Virginia in September 2013, Boulder Crest Retreat Arizona in November 2017, and the Boulder Crest Institute for Posttraumatic Growth in September 2018. Our mission is to ensure we provide combat veterans with what they require to live great lives – filled with passion, purpose, growth, connection, and service. This is truly the opposite of suicide.

In May 2014, after nine months of operating Boulder Crest Retreat Virginia, I began a journey to understand what actually worked when it came to mental health, PTSD, and suicide. I traveled around the country and met with leading psychiatrists, psychologists, social workers, life coaches, and trauma experts. Time and time again, when I asked them, "What works to allow people to live great lives in the aftermath of trauma?" – I was told, "Nothing."

In principle this is true because it is not what our mental health system – broadly speaking – is focused on accomplishing. The mental health system is nearly exclusively focused on one thing when it comes to its clients and patients – managing and mitigating the symptoms associated with times of struggle; often through a combination of medication and talk therapy.

The first glimmer of hope I encountered on my journey would be found at the University of North Carolina, Charlotte, in the person of Dr. Richard Tedeschi. Dr. Tedeschi, along with his colleague, Dr. Lawrence Calhoun, coined the term Posttraumatic Growth (PTG) in 1995 to describe the ways in which people reported growth in areas of their life in the aftermath of traumatic events and experiences.

I asked Dr. Tedeschi if he was interested in partnering with us to develop a training-based program for combat veterans that would, for the first-time ever, be designed to cultivate and facilitate Posttraumatic Growth in those who were struggling. Dr. Tedeschi agreed, and since 2014, we have been hard at work on the development and delivery of Warrior PATHH.

A New, Innovative, and Effective Approach to PTSD and Suicide
Warrior PATHH is an 18-month program that begins with a 7-day intensive and immersive residential initiation for combat veterans who struggle with a range of challenges – from depression to PTSD, transition issues to suicide. The 7-day initiation is supported by Boulder Crest's custom-built myPATHH technology platform, which connects and supports students through the remaining 77 weeks — providing ongoing training, connection, and accountability.

Warrior PATHH trains combat veterans through the proven framework of PTG: educating them about the value of struggle and what stress and trauma do to the mind, body, heart, and spirit;

teaching proven non-pharmacological techniques designed to self-regulate thoughts and emotions; creating an environment of trust and safety to facilitate disclosure of past challenges from childhood and military service, which is supported by a delivery team composed of combat veterans; beginning to craft a new story that harnesses the lessons of the past and looks forward; and a renewed commitment to service – to one's family, community and country – here at home.

In January 2016, after more than two years of research, development, piloting, and success, the Marcus Foundation funded the development of the first-ever curriculum effort designed to cultivate and facilitate Posttraumatic Growth. The curriculum effort included Student and Instructor Guides, a Journal, Syllabus, and Schedule; four pilot programs; and an 18-month longitudinal study.

The 18-month study, led by Dr. Tedeschi and Dr. Bret Moore, was completed in January 2019, focused on exploring the impact of Warrior PATHH in three key areas: Symptom Reduction, Quality of Life improvement, and Posttraumatic Growth experienced. With responses at the pre, post, 1, 3, 6, 12, and 18-month marks and the use of 24 well-respected and bespoke measurement tools, this effort represents one of the most robust evaluations of a mental health effort ever initiated. The evaluation effort included 8 Warrior PATHH Programs (49 students) and a response rate of 95 percent. Key highlights include:

Symptom Reduction:
- 54% sustained reduction in PTSD symptoms
- 52% sustained reduction in depression symptoms
- 41% sustained reduction in anxiety symptoms
- 39% sustained reduction in Insomnia
- 44% sustained reduction in drug use
- 24% sustained improvement in positive emotions experienced; and 25% sustained reduction in negative emotions experienced

Quality of Life Improvement:
- 14% sustained improvement in Couples Satisfaction
- 33% sustained reduction in stress reactivity
- 11% sustained improvement in physical activity
- 26% sustained improvement in nutrition
- 12% sustained improvement in financial wellness

Posttraumatic Growth:
- 56% sustained improvement in Personal Growth (PTG)
- 78% growth in Spiritual-Existential Change
- 69% growth in Deeper Relationships
- 58% growth in New Possibilities
- 36% growth in Personal Strength
- 26% growth in Appreciation for Life

• 32% sustained improvement in ability to change perspective/psychological flexibility
• 23% sustained improvement in capacity to integrate problematic life experiences.
• 22% sustained improvement in self-compassion
• 40% sustained increase in reading
• 9% sustained decrease in disruption to core beliefs

In short, we have a program that achieved the vision that we set forth – to ensure combat veterans could be as productive at home as they were on the battlefield, and live great lives – filled with passion, purpose, growth, connection, and service – at home. In response to this unparalleled success, we are now working with partners so that Warrior PATHH can be scaled to ten locations across the country.

Why Warrior PATHH Works
Warrior PATHH is modeled on military-style training. It is intensive, immersive, and team-based, and provides participants with a new fire team to support their road to wellness, strength, and thriving.

Warrior PATHH is based on the decades-old science of Posttraumatic Growth, and provides veterans with a pathway to a life that is more authentic, fulfilling, and purposeful than ever before. This opportunity to continue growing and contributing speaks to the deepest needs of veterans, and allows them to feel valued and needed on the home front.

Warrior PATHH is delivered by a team of combat veteran peers who leverage the inherent understanding, trust, and connection that is implicit within the brotherhood and sisterhood.

Warrior PATHH is sustained over 18 months, and ensures that participants build connection, confidence, and capabilities over the long-term. The impact of this approach is demonstrated in the program evaluation study.

Warrior PATHH focuses on training not treatment, allowing veterans to harness the power of the military training and combat experiences and be Warriors and leaders in their own lives, and the lives of their families, communities, and country.

Ultimately, Warrior PATHH works because it acknowledges the wise words of Dr. Vikram Patel, a pioneering psychiatrist who has developed incredibly effective, peer-based programs across the developing world: “Mental health is too important to be left to mental health professionals alone.”

Measuring Impact
As a retired bomb disposal specialist, I come from a world with the unofficial motto: Initial Success or Total Failure. Bomb techs simply cannot make mistakes; if we do, and are lucky enough to survive, we certainly don’t make them again. Throughout my journey – 15 years of supporting combat veterans and the establishment of two non-profits – I have grown immensely frustrated by the willingness of advocates and so-called experts to insist that we

continue to do the same thing over and over again when it simply does not work. Albert Einstein called this “insanity”.

The current mental health community approach is not working. The data are beyond clear about that. As we explore new and innovative approaches, however, we must move beyond anecdote. The story of the horse or the dog that saved a veteran’s life simply is not good enough. We need concrete and conclusive evidence of what does work so we can scale it to meet the massive need that exists.

We believe our comprehensive program evaluation represents an important first-step in that direction for several major reasons.

First, we must get beyond exploring just symptom reduction. Veterans who struggle are not simply looking for the absence of particular symptoms – they are seeking the existence of positive elements in their life; things like growth, joy, love, connection, passion, meaningful work, and the ability to be of service again. The evaluation methodology we utilize explores outcomes in three ways: symptom reduction, quality of life improvement, and Posttraumatic Growth/cognitive flexibility experienced. This explicit focus on improvements in a veteran’s quality of life speaks to the way in which any kind of intervention is meaningfully impacting their day to day life. The focus on growth is critical; as humans, we yearn for two things: to be able to grow and to feel like we are making a contribution to the world.

Second, we must measure the impact of what we are doing, with a focus on each individual veteran. One of the most stunning parts of the independent evaluation conducted as a result of the Clay Hunt Act was the lack of VA data and tracking related to the well-being of individual veterans. If we aren’t asking them how or if treatment is working, how can we possibly adapt or alter it?

Third, we must listen to the voices of those who struggle. In my testimony, I have sought to share the first-hand views of the thousands of veterans who we have hosted over the past six years. Our belief in listening – versus acting as an expert who sits on the sidelines – is how Posttraumatic Growth came into existence (with bereaved parents) and the source of Dr. Vikram Patel’s innovations in the developing world.

Importantly, we must be willing to listen to veterans so we can understand why they do not seek treatment; why they dropout early; why they fail to benefit from traditional approaches; and what they are seeking in terms of support, guidance, and training.

We must not hide behind evidence-based treatments to proclaim that any patient who doesn’t experience meaningful progress must be “treatment-resistant.” Veterans surely deserve better than a label that evokes hopelessness and despair.

Fourth and finally, we must explore how veterans respond to interventions over the long-term. Our evaluation was an 18-month exploration across seven different collection points with a 95

percent response rate. We understand the trajectory of a Warrior PATHH graduate and how their life ebbs and flows over time, and what additional support, guidance, and training they may require.

I believe deeply in the power of research and the importance of data. Throughout my Navy career, my business, and nonprofit life, I have used such information to guide me in the pursuit of effective solutions and strategies. Research and data only work, however, if they are collected with an open mind and a focus on solving a problem, not propping up institutional interests or protecting the way things are done.

We must stop doing the same thing over and over again and expecting a different result. Far too many veterans have paid the ultimate price as a result, and the impact on their families, friends, and communities is incalculable.

Conclusion

Rather than focusing on suicide prevention and more of the same in terms of mental health services, we should focus to ensure veterans can live great lives at home – lives filled with joy, passion, love, service, and purpose. We should ensure my fellow veterans can use the great military training they receive as a launching pad for a productive and purposeful life as a Warrior at home.

We must ensure that, to paraphrase the words of a good friend and USMC General officer, their time in the service cannot be the greatest accomplishment of their lives. Doing so requires an integrated and collaborative approach, and we look forward to being a part of the solution and any questions that arise from this written testimony.

Finally, I have personally hosted the last three Secretary's of the VA at Boulder Crest Retreat, Bob McDonald, David Shulkin, and most recently, Secretary Wilkie. ALL three Secretaries have sat at a table in our kitchen and within minutes of their arrival to our Virginia Retreat said "this is exactly what post 9/11 veterans want". Let's make this happen together!