



Somatic Psychotherapy *Today*

Volume 1 • Number 2 • Fall 2011

The USABP Magazine

Inside this issue: A New Clinical Psy.D. Specializing in Military Psychology

- Post Traumatic Stress Disorder
- Letter from the new President of USABP
- It's Been a Long Walk Home



THE UNITED STATES ASSOCIATION FOR BODY PSYCHOTHERAPY

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About the Staff



Nancy Elizabeth Eichhorn, MA, M.Ed, MA is a writer, editor, ghostwriter, investigative journalist, and credentialed educator. Her business name, Write to Be, mirrors the importance of writing in her life. She has masters degrees in clinical psychology, education, and nonfiction writing. Pending IRB approval, she will begin a clinical trial investigating the use of Informed Touch to impact physiological sensations and resultant behavioral responses in humans for her PhD in somatic psychology.



Diana Houghton Whiting, BED worked for ten years in architectural design prior to answering the call to study somatic psychology. When not writing papers, she can be found camping and hiking with her husband and two dogs (a Labrador and a Pug).

She also loves to be on the mat practicing martial arts and teaching women's self defense. She hopes to work with military veterans and progress toward her PhD after graduating from Naropa University in 2013.



Robyn Burns, MA has been with the USABP for over 12 years in a variety of capacities juggling the needs of the growing organization and providing support as needed. She operates the USABP office out of her home in Houston, TX. She has three college-aged children and enjoys music, scrapbooking and reading.

Somatic Psychotherapy Today

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The 13th International EABP Congress of Body Psychotherapy

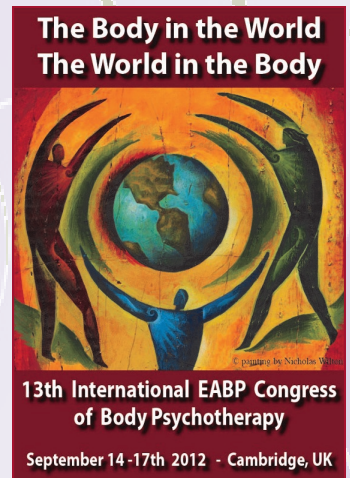
The Body in The World, The World in The Body

September 14 - 17, 2012 Cambridge, England

Register today at www.EABPCongress2012.co.uk

The Congress Planning Committee created an inner conference coherence that starts with a topic and takes participants onward in an organic process so the four-day journey acquires a "shape" that makes it a meaningful experience. Conference organizers are also strongly in favor of structures that allow all attendees to participate and bring themselves in, rather than just sit and listen. They created space for discussions both in smaller groups and in a larger audience inviting diversity to enrich the process.

Moving forward from Vienna, organizers are continuing to reach out and interact with other disciplines. In Britain, interactions with other psychotherapeutic modalities have resulted in a creative cross-fertilization for years. The focus of the Congress topic Relational Body Psychotherapy intends to continue this outward reach. Furthermore, the Congress will show how body psychotherapy is relevant to fields like social justice, conflict resolution, and the emerging discipline of eco-psychology. The idea is to show body psychotherapy's contributions have far-reaching consequences of interest for many outside the body psychotherapy world. Congress organizers anticipate opportunities to dialogue with many different professionals.



Call for Papers

Deadline December 31st, 2011

Delegates are invited to send proposals for workshops and poster presentations. Discussions of theory, sharing of practice, and experiential workshops based on the Congress theme "The Body in the World, the World in the Body" are welcomed along with the following topics:

- ♦ **Attachment and social bonding in infants and adults**
- ♦ **Relational body psychotherapy**
- ♦ **Embodied conflict resolution**
- ♦ **Eco-psychology and social justice**
- ♦ **Practice-related research in body psychotherapy**

Workshops will be 90 minutes in length (two-hour workshops will be considered).

Submit a Word file containing the following information:

workshop title ; presenter; contact details; **maximum** 1,000 character abstract; presenter biography maximum 500 characters; mini-abstract maximum 300 characters ; preferred length of workshop; language that workshop will be in.

Please submit abstracts in English. If English is not your native language, you can submit the long abstract and biography in your own language, but must add an English translation. The mini-abstract must be in English.

Participants must register for the main Congress before submitting proposals. Completed registration activates the workshop submission form on the website. Please send all proposals through the Website—if this is not possible, e-mail proposals to the congress administrator (conference@body-psychotherapy.org.uk). Please add registration confirmation to the proposal.

For information contact: Chiron Association for Body Psychotherapists: conference@body-psychotherapy.org.uk or the European Association for Body-Psychotherapy: www.EABPcongress2012.co.uk

The USABP Conference Summer 2012

The Body in Psychotherapy:
The Pioneers of the Past
- The Wave of the Future

Register Now!
August 10-12, 2012
Preconference August 9
Boulder, Colorado



Somatic Psychotherapy *Today*

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Readers Write

There are times friends, students, clients and colleagues write to express feelings, to discover thoughts, to make meaning of sensations. The writing style is not as important as the personal presence felt in the piece. Throughout the pages of this publication you will read poems, short stories, essays, notes and reflections that readers have offered.

Readers are invited to submit their writing as it applies to the current issue's theme. It does not have to address the theme directly. Let the theme be a guide for what comes in response to the theme. Because of space limitations, we cannot print all the submissions we receive. We will edit all submissions and writers will have the chance to approve or disapprove all editorial changes prior to publication. In consideration of invasion of privacy and libel, please change the names of the people involved in your writing—and inform us that you did.

~N Eichhorn

Please email your submissions to MagazineEditor@usab.org

Upcoming Themes /Deadlines/Pub Date

- *Wisdom of the Body*/Nov. 15, 2011/Jan 2012
- *Anatomy of a Conference*/Feb 15, 2012/ March 2012
- *Under consideration*/May15, 2012/June 2012

From the President

Reach
Touch
Receive

UNITED STATES ASSOCIATION FOR
BODY PSYCHOTHERAPY



As the incoming President of the Board of Directors, I am excited to bring my knowledge of this organization (almost from its beginning) and my dedication to the body in the

field of psychology together to promote this diverse and yet focused group of members in our effort to expand the organization in terms of membership and influence. I'm looking forward to working with an extremely competent group of board and committee members to help this organization flourish. I anticipate an energetic upcoming year as we prepare for a successful conference in Boulder in August of 2012.

Building on the foundation started by my predecessor, Virginia Dennehy PhD, and our other elected board members, I see our focus encompassing three critical domains: broadening our efforts to honor those who pioneered this field of body psychotherapy; growing our emphasis on research and publication; and including more clinicians in ongoing conversations, conferences, and connections via the internet as we expand our outreach not only to members in our association but also all who serve in the human and health services field.

Upcoming projects include finding appropriate means to acknowledge our heritage and those pioneering spirits who never gave up the body in therapy. As the title of our upcoming conference suggests, Body Psychotherapists and the USABP organization are pioneers in the field of Psychology. The conference will focus on honoring our roots and bringing the grounding of the body into the practice of psychology.

We are also developing several potential vehicles for honoring those who have come before and those who are currently making significant contributions to our field.

Our Lifetime Achievement Award stands as our centerfold with past recipients including: Peter Levine, the originator and developer of Somatic Experiencing® (SE) and Founder and Senior Advisor of The Somatic Experiencing Trauma Institute; the late Ron Kurtz, founder of Hakomi Therapy; Stanley Keleman, founder of Formative Psychology TM; as well as Alexander

Lowen, Ilana Rubefeld and John Pierrakos.

Other thoughts include a page on our website, www.usabp.org, honoring those in the field who have contributed be it teaching, mentoring, publishing, writing, creating new methodologies, presenting and so forth. There are so many outstanding practitioners here in the U.S., and in our sister association, the European Association for Body Psychotherapy, that we want to find the best means to honor all they do.

Another central focus for the future of this organization is a continuing and growing emphasis on research and the formation of The United States Association for Body Psychotherapy (USABP) and the European Association for Body Psychotherapy (EABP) new peer reviewed journal entitled the

International Body Psychotherapy Journal, The Art and Science of the Body in Psychotherapy (IBPJ) under the editorship of Jacqueline A. Carleton PhD.

The new publication provides the formal venue necessary for research to be shared. Publishing research is the lifeblood of any scientific field of study and Body Psychotherapy is no different. Letting others know we are here and what we can do through the use of body-oriented therapeutic approaches is critical to our practice and our presence as mental health care providers.

Since the field of Body Psychotherapy is such an experientially oriented field, I want to find a way to include clinicians in the process of research with a case study model that can showcase the techniques and applications available through the various modalities of body psychotherapy.

And I see the need to include students in all these efforts; through our guidance we will bring forward the next generation of body psychotherapists. Working in tandem—young and old, founding fathers and mothers, and present day pioneers willing to challenge theory through practice and clinical evidence—we will energize a new dawn for Psychology that does not leave the mind divided but rather comes together unified through the body.

Katy Swafford PhD is a licensed psychologist who teaches and practices Eidetic Image Psychology — somatic images that maintain mind

and body in a Psycho-Somatic model. She is the founder and director of the Eidetic Imagery Institute and serves as adjunct and/or part time faculty in two counseling psychology programs at St Edwards University and Capella, an online university in addition to maintaining a private practice with specialties in substance abuse and trauma.

About the USABP

The only national organization of its kind in the U.S, the USABP is practitioner-centered, member-driven, and committed to the goals of organizing, representing and shaping the emerging profession of Body Psychotherapy. Founded in 1996 by a steering committee of 20 clinicians and trainers, the USABP was incorporated as a nonprofit in 1997 and the first Board of Directors was organized in 1998.

USABP Mission

The United States Association for Body Psychotherapy believes that integration of the body and mind is essential to effective psychotherapy, and to that end, its mission is to develop and advance the art, science, and practice of Body Psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity.

Somatic Psychotherapy

The terms Somatic Psychology and Body Psychotherapy are used interchangeably in the literature and in the field. Clinicians often use the phrase Somatic as opposed to Body to avoid confusion with hands-on therapies such as massage therapy, cranial sacral therapy, chiropractic care and osteopathic medicine. Others hold close to the founders' original word choice. Either way, the therapeutic processes within this field of psychotherapy are based on 75 years of research and theory in biology, neurology, anthropology, proxemics, ethology, neonatology, perinatal studies, art therapy, dance movement, family and systems theory, existential, humanistic and gestalt psychology, Far Eastern philosophy and spirituality, and more.

For more information, visit our website at www.usabp.org.

From the Editor

Community Forum

Welcome to Volume 1, No. 2, of *Somatic Psychotherapy Today: The USABP Magazine*

As the deadline approached for this edition I felt a twinge of panic. I sensed fear creep in bringing its ancient message, "What if you don't have enough?" I flickered for a moment, reflected on the articles I had already written myself and resolved that I could do more. Then came the landslide. Writers submitted as promised, new stories were sparked, and as it stands we added ten pages to this issue. The response has been phenomenal—professionals want to write, photographers want to share their perspectives, and people need to tell their stories.

Military Mental Health is a "hot" topic in all health fields as experienced professionals grapple for the right words to convey the current confusion regarding the best therapeutic interventions and the lack of medical professionals steeped in military culture and lore. The need to find alternative interventions is here, now, not only for soldiers returning home but for those in-theater and pre-deployment along with retirees and military families.

Many of the voices you will hear in this issue belong to professionals with years of hands-on experiences in the field and conducting research. They are willing to bring their wisdom and practices to the forefront in a changing world with the passion and aspiration to live life from an embodied place of being.

Somatic Psychotherapy Today offers the space for all to share their story from long timers such as Peter Levine PhD and Gregory Johanson PhD to students currently enrolled in graduate programs, to therapists trained in specific modalities who have practiced their art with startling success, to soldiers willing to share their experiences.

It is my hope that Somatic Psychotherapy Today will offer a forum for all voices to be heard, professional or not. Here, on these pages, people can step forward and share their strength, hope and experience in order to foster collaboration among all fields of health care through better understanding of each others' ideologies and methodologies.

I invite you to explore *Somatic Psychotherapy Today* and join the conversations.

Warmly,

Nancy Eichhorn MA, M.Ed., MA



If you can dream and not
make dreams your master;
If you can think and not make
thoughts your aim;
If you can meet with triumph
and disaster,
And treat those two imposters
just the same;
If you can bear to hear the
truth you've spoken
Twisted by knaves to make a
trap for fools,
Or watch the things you gave
your life to broken,
And stoop and build'em up
with worn out tools;

Excerpt from *If* by Rudyard Kipling

Seeking Contributors

If you have something to say regarding our upcoming themes, we invite you to write an article or let us know you are interested in being interviewed. All submissions will be edited, and all writers/interviewees will have final approval before publication. We appreciate your knowledge and want to share your story. Please contact Nancy Eichhorn at MagazineEditor@usabp.org

Upcoming Themes /Deadlines/Pub Date

Wisdom of the Body/Nov 15, 2011/Winter 2012

Anatomy of a Conference/Feb. 15, 2012/Spring 2012



Join the Conversation



Communication is an essential part of all relationships, and the Internet affords opportunities to network with like-minded colleagues and participate in forums that challenge your thinking and ways of doing. Join the conversation and voice your thoughts on the USABP and the EABP websites as well as on Facebook, Google, and LinkedIn.



Ernest A Wahrburg

Stimulating conversations with clinicians and leaders in the field are offered monthly, free public access at: www.SomaticPerspectives.com.

You can join ongoing discussions with colleagues at: www.Linkedin.SomaticPerspectives.com

Students are Facebook-ing on the USABP Somatic Student and Alumni page and Google-ing, too contact mandrews@prescott.edu for a Google invite.

To join the USABP go to www.USABP.org/join

Military Mental Health Disorders Post Deployment for Providers, Combat Veterans & Their Families

The wars in Iraq and Afghanistan have tragically taken a profound toll on our country. Service members are surviving the enormous dangers of wars, returning to the United States, battling torturous psychological conditions and severe physical lifelong disability. In all too many cases this scenario has tragically ended in skyrocketing rates of suicide. In countless other cases it has lead to horrendous conditions like homelessness, chronic unemployment, homicide, domestic violence and other violent criminal activity, drug abuse, alcoholism and incarceration.

For all those who have been deployed into combat or support positions and have been physically and/or psychologically injured in the process of doing so, our country owes those individuals the restoration of their health, to the greatest degree possible.

PTSD is prominent in the news, but of course there are a huge and diverse number of other injuries suffered. Traumatic brain injuries (TBI), orthopedic injuries, amputations, spinal cord injuries, major depressive disorder, alcohol and other substance abuse dependence, military sexual trauma and other mental health disorders are just a few of the prominent conditions that our Active Duty Service Members and Veterans battle as a result of service to our country.

Military treatment facilities and the Veterans Administration are over burdened, over stressed and over stretched beyond their limits to provide screenings, diagnostic evaluations and treatment. Simply put, military healthcare needs significantly outweigh the ability of Military Treatment Facilities and the Veterans Administration to adequately provide healthcare treatment to this most deserving population.

This is why it is incumbent upon all concerned healthcare providers in the private sector to give their best efforts to fill this deficiency, and to do so from as strong as strong a foundation of knowledge, skills and understanding as possible.

Military healthcare needs have numerous highly unique aspects. Combat related PTSD, as an example, has a host of unique aspects that a provider needs to understand in order

to provide optimal treatment including an understanding of post traumatic insomnia, nightmares, co-morbid alcohol abuse, physical hyper-arousability, hyper-vigilance, exaggerated startle response, risk taking behaviors, a proclivity towards social isolation and the effects of all of these upon the Service member's family.

Similarly, screening for TBI and providing referrals to appropriate providers for comprehensive TBI evaluations, treatment and rehabilitation all entail specialized knowledge. This includes referral to a neuropsychologist to administer appropriate psychological testing, referral to a neurologist to undertake appropriate imaging studies, referral for cognitive rehabilitation to assist the patient with restoration of memory impairment, referral to a provider for vestibular rehabilitation for assistance with the restoration of impairment in balance, and so on.

Understanding, assessing and treating alcohol abuse and dependence needs to take place within the context of an understanding of military culture. And there needs to be an understanding that these conditions are likely occurring in combination with other deployment related health problems such as post traumatic insomnia, nightmares and full-fledged PTSD.

An understanding of military institutional resistance to mental health problems and mental health treatment will facilitate treatment so that a provider can be appropriately supportive, work to minimize potential setbacks related to stigmatization, and advocate for the Active Duty Service Member and his or her family. As needed, graduate school educational programs are adding much needed curriculum to address military healthcare needs as new problems and updated information and research is also emerging.

Professional organizations have been adding to and re-vamping their continuing educational offerings to meet all of these emerging needs to assist healthcare providers in enhancing their knowledge and skills to competently address military healthcare needs.



This is true whether talking about a primary care provider, psychologist, neurologist, case manager, ENT specialist, psychiatrist, pain management specialist, and on and on the list goes.

Treatment with civilian providers located off Military Treatment Facilities can have significant advantages. For a Service member suffering from combat related PTSD for example, all of the myriad of sights, sounds and smells on a military base can and do act on Service members in a very powerful detrimental ways. The sounds emanating from a firing range, the smells of diesel fuel, the sights of weapons and ammunition and countless stimuli prevalent on military installations can act as powerful triggers of PTSD symptoms. Flashbacks, hyper-vigilance, an exaggerated startle response, extremely distressing vivid and detailed memories of traumatic military experience are just a few of the symptoms that can be manifest by such stimuli.

Receiving treatment in an environment devoid of any such detrimental triggers, an environment of tranquility with calming and recuperative properties gives healing an opportunity to take place. An environment chock full of triggers forces treatment to take place at a distinct disadvantage as a mere function of its power in rekindling traumatic memories.

Getting off of a military base when one is suffering from a major depressive disorder, PTSD, TBI or other post deployment health related problems can provide a patient with a treatment setting far more conducive to healing, and an environment which naturally promotes hope and optimism to a far greater degree than is likely to be the case on a military base.

Issues discussed here just scratch the surface of the "iceberg of military healthcare needs."

Fortunately, civilian providers are being responsive in their efforts to bridge the gap between military health care needs and military healthcare treatment. And institutions of

higher education are modifying curriculum to address this disparity.

Thankfully, professional organizations are also providing more clinical presentations addressing military healthcare needs. The trend is moving in the right direction and efforts will need to continue for the foreseeable future to provide Service Members, Veterans and their families with the evaluation, diagnosis and treatment services they are so justly entitled to!

If this topic is of interest to you, consider joining the LinkedIn Group called "Military Mental Health Disorders Post Deployment".

It can be accessed at <http://www.linkedin.com/groups/MILITARY-MENTAL-HEALTH-DISORDERS-POST-2788736?mostPopular=&gid=2788736>

Ernest Wahrburg MA, LCSW received his BA in psychology from SUNY at Stony Brook, and his Master's Degree from Health Sciences Center @ SUNY at Stony Brook. He has worked in outpatient community mental health in New York and worked for four years as a research associate for the Medical College of Virginia, Department of Psychiatric Genetics. He is licensed in NY and NC, where he has worked primarily as a military mental health provider since relocating to Jacksonville, NC in 2001 (Camp Lejeune, Womack Army Medical Center at Fort Bragg, and for the Veterans Administration). He currently works in a group private practice specializing in treating ASDM and Veterans and their families.

Nordic Journal of Music Therapy



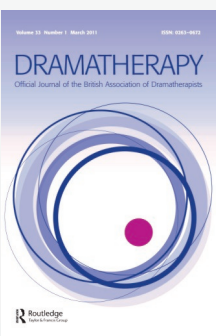
Follow Two New Journals on Facebook

Nordic Journal of Music Therapy

The **Nordic Journal of Music Therapy** (NJM) publishes articles for the international music therapy community on practice, theory and research, scholarly articles, dialogues and discussions, reviews and critique. The journal is published in collaboration with **The Gri Music Therapy Research Centre (GAMUT)**.

You can read Volume 19, Issue 2 free now. <http://www.tandfonline.com/toc/rnjm20/19/2>

Follow the journal on Facebook: <http://www.facebook.com/nordicjournalofmusictherapy>



Dramatherapy

Have you heard about the new journal **Dramatherapy**? The journal joined Routledge in 2011 and is published on behalf of the **British Association of Dramatherapists**. It explores the diversity of Dramatherapy and aims to develop dialogues with other related disciplines in the fields of creative arts therapies.

As a taste of what is to come, you can read Volume 33, Issue 1 free at <http://www.tandfonline.com/toc/rdrt20/33/1>

Join the Conversation

Psychotherapy Networker is offering their subscribers a new way to "sharpen" their clinical skills and "strengthen" their professional networks through "Networker Excel Clubs." *Networker* Editor Rich Simon hosts free online video interviews with leaders in the field. Members are encouraged to form discussion groups with friend and colleagues (Networker members or not). The idea, according to Peter Fraenkel, PhD, who wrote about Networker Excel Clubs in their May/June 2011 issue, is to provide professionals the means to "experience a new professional community" as they "widen the quality and range of conversation in the field, and generate different perspectives on innovative ideas" (page 51).

Past selections included: Bad Couples Therapy and How to Avoid It, with William Doherty, Ethical Dilemmas for the 21st-Century Practitioner, with Mary Jo Barrett, and Are we Too Attached to Attachment Theory, with Jerome Kagan.

For more information check out www.psychotherapynetworker.org

The Role of Early Childhood Trauma in Combat Psychology

Terry Monell



In 2010, Eric Shinseki, Secretary of Veteran's Affairs, pledged \$5.2 billion for military mental health specifying that PTSD treatment is "central to the VA's mission" (Michaels, 2010); President Barack Obama's 2012 budget includes \$6.2 billion.

As a nation we are seeing that soldiers need the same level of training to develop psychological and emotional skills as they do for physical combat preparedness. During their tour of duty, some soldiers have noted that their coping tools are minimal and many feel helpless, consumed with fear, and struggle to find another way to channel emotions. As one soldier noted, "In order to do the things we did over there, and to live with the things we saw, you've got to be angry" (Michaels, 2010, p. 2).

VA statistics show that 86% of soldiers either know or have seen someone injured or killed, while 77 % have either shot at or killed an enemy combatant (Lukachick, 2010). Veterans who appear to be more vulnerable to mental disorders are those who are unable to integrate their experiences in the war zone and continue to be affected by them on their return home.

One in five veterans of the 1.7 million who have served in Iraq and Afghanistan required psychological treatment on their return—21% were diagnosed with PTSD (Barnes, 2008). Yet, the Pentagon's Task Force on Mental Health acknowledged that the "current complement of mental health professionals is woefully inadequate," both in the field and at home. Treatment for PTSD is available to only 1 in 3 soldiers and marines diagnosed post-deployment (Williamson & Mulhall, 2009, p12).

Compounding veteran care is an overwhelming increase in military suicide—

suicides among active-duty soldiers in 2009 was a record . . . 29 soldiers in all parts of the Army killed themselves in January 2009, nearly twice the 15 killed in combat that month. In February, 27 more committed suicide. The Marine Corps suffered a record 52 suicides last year (retrieved from http://www.usatoday.com/news/military/2010-01-28-suicide_N.htm)

An additional 1,000 suicide attempts are made each month, and the VA's suicide hotline continues to receive 10,000 calls per month. (Clifton, 2011). Statistically speaking, these numbers are considered low; in reality, as many as 50 to 60% of veterans do not seek treatment due to a military culture that is perceived as intolerant of weakness despite assurances by the VA to the contrary (Associated Press, 2004). Veterans remain fearful of being stigmatized and facing peer judgment if they seek mental health care. An even greater deterrent to seeking support, according to veterans at the Addiction Technology Transfer Center, is the belief that counseling will not remain confidential which could potentially damage their record or career.

Secondary effects of veterans' mental health concerns are also impacting families. Marriages are at risk with a 9.2% annual divorce rate among female marines (at three times the national average); two million children are experiencing the emotional absence of a parent overseas which often results in learning and behavioral issues at home and in the classroom. Effective therapeutic interventions are needed.

In order to determine the best treatment methods available, researchers are considering factors outside of direct war experiences that may contribute to the high number of veteran mental health problems. Regan, Barrett, and Gordon (2008) noted that combat-related PTSD appeared to be higher in veterans with childhood trauma histories than combat veterans without PTSD diagnoses. Bruce Perry PhD, founder of the Child Trauma Academy in Houston, stated that the age of exposure to trauma is the greatest predictor of long-term consequences across the lifespan. While experience may impact an adult's behavior, he noted, it creates the organizing framework for a child's brain. Taking his stance one step further, he offered that "if the brain's organization reflects its experience and the experience of the traumatized child is fear and stress, then the neurochemical responses to fear and stress become the

most powerful architects of the brain" (Perry, 2009, p.240-255).

Other researchers in the field of trauma and brain development support Perry's conjectures (Ford & Kidd, 1998; National Scientific Council on the Developing Child, 2005). Traumatologist Bessel van der Kolk (2010) offered that most people do not realize that trauma is no longer the story about what happened in the past but rather is the effect of physiological imprints still impacting the body's sensory and hormonal systems. Allan Schore's (2010) research at UCLA School of Medicine showed that early trauma involving physical abuse and threat to life often leads to PTSD, creating a lifelong state of hyperarousal or a dissociative helplessness in the face of trauma or stress.

The implications of early childhood trauma are also being researched by epigeneticists working with DNA and gene expression, interpersonal neurobiologists studying the social context of developmental disorders, and economists searching for the cause of skyrocketing health care costs.

Dr. Helen Egger (2010), a child psychiatrist and epidemiologist at Duke University Medical Center, states that, "Most if not all psychiatric disorders can be conceptualized as developmental disorders."

It turns out that genes, the DNA template by which our personalities are formed, are expressed in exact response to internal and external signals. This clinical perspective of experiential impact on gene expression has given way to the understanding that traumatic events, either single or repeated, during the last trimester of pregnancy through the second year of life when brain growth is most acute, results in neural pathways specific to that experience. Primary neurological development is almost exclusively in the right hemisphere, often termed the "emotional brain," which processes fear, terror, and pain. As the core of self-awareness and self-identity, the right brain is inherently predisposed to assess threat and enact self-defense (Cozolino, 2006). By evolutionary design, our brain makes connections that link similar experiences, whether real or imagined, as a safeguard for our protection inadvertently reinforcing a pattern of chronic overreaction or hypersensitivity, which over time generates a greater tendency to negative emotions and pessimism. This prompts a maladaptive feedback loop of constant alarm with a compromised ability to recover emotional stability.

Researchers at the National Center for PTSD appear to agree. Based on Litz and Orstills' (2007) research with veterans, "Subjective perceptual evaluations of life-threat are powerful predictors of post-war mental health outcomes."



When a stressor is identified, the sympathetic nervous system catapults the body into a mobilization response (fight or flight) that floods the body with cortisol and dozens of peptides and neurotransmitters. The hypothalamus, pituitary, and adrenal (HPA) axis engages, heart and breath rates increase, digestion shuts down, and muscles are fueled in readiness. If the sympathetic nervous system fails to resolve the problem through action, the parasympathetic nervous system goes into a rescue mode of trying to down-regulate the body's physiologic reaction.

But in trauma disorders there is seldom a middle ground—a state of hyperarousal becomes a state of hypoarousal or a plummet into a dissociated freeze or helpless, robbing the person of a sense of their own agency or self (Pert, 1997). This picture is one of an affective entrapment alternating between overwhelm and shut down that can dominate the life of a survivor.

Since childhood experiences may drive who we become, the repercussions of altered neural pathways, dysregulated autonomic and central nervous systems, and impaired social and emotional connections are only some of what our military personnel may be carrying into service. Compounded by the severity of the military environment and performance expectations, enlisted personnel may well replay their characteristic patterns of defense exhibiting anger, helplessness, avoidance, or pessimism. It has yet to be determined what percentage of military PTSD, anxiety disorders, substance abuse and other psychopathology is a vulnerability to combat exposure or a predisposition to co-morbidity based on early childhood trauma (Regan, Barrett & Gordon, 2008).

Current Advances in Treating Veteran PTSD

At the NICABAM (National Institution of the Clinical Application of Behavioral Medicine) conference in Hilton Head, SC, 2010, the catchphrase “its biology not psychology” was offered as a conceptual idea to help veterans with the intensity of their emotions and reactivity. Psycho-education for the active duty soldier or post-deployment veteran goes a long way to dissipating the feelings of “going crazy” when a dysregulated nervous system can be explained and understood.

“Time heals all wounds” does not apply in early childhood trauma according to Peter Levine PhD, the originator and developer of Somatic Experiencing® (SE). Levine (2010) believes that the body locks in the trauma memory both as an unintegrated fragment and an implicit somatic memory in the subconscious physiology until a way is found to free the burden. His work gently coaxes the nervous system into a gradual or titrated release often seen as neurogenic tremors shaking off blocked or frozen energy.

The traditional method of treatment for PTSD and other veteran psychopathology has been cognitive behavioral therapy yet Complimentary and Alternative Medicine's modalities are also being employed with increasing success. Body based approaches such as yoga, Somatic Experiencing, Sensorimotor Psychotherapy, Reiki, neurofeedback, EMDR, and acupuncture are just some of the approaches being explored with positive outcomes in veteran care.

Terry Monell BFA, MA candidate, CCSC, faculty at The Sophia Institute, Charleston, SC where she has conducted art workshops designed to access the subconscious. She is currently researching, writing and speaking on pediatric medical trauma while finishing her MA in Somatic Psychology.

Kripalu Center for Yoga & Health

Frontiers of Trauma Treatment

Bessel van der Kolk MD and Dana Moore LPCC, CADS

October 28-30, 2011

Based on the foundational practices of yoga and mindfulness meditation, the workshop will include current research on trauma, information on how overwhelming experiences change the capacity for self-regulation and are imprinted in the body, information on how brain function is shaped by experience and on how life itself can continually transform the organization of brain circuits. It will also offer techniques that address affect regulation, the integration of dissociated aspects of experience, chronic helplessness, and the reintegration of human connections. Designed for therapists, health professionals, yoga instructors and other individuals interested in studying the nature and process of trauma, CEUs are available.

For more information visit <http://www.kripalu.org>

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Somatic Experiencing and Military Mental Health

An interview with Peter Levine PhD

Nancy Eichhorn



There's no tried and true training manual for therapists working with today's terror-torn veterans returning from Iraq and Afghanistan. Hundreds of thousands of soldiers are filtering back into our communities who have survived multiple stressors from bomb explosions and amputations, to deaths and scenes of complete horror as well as experiencing excruciating hours of boredom and heat stress. Adding to all of this are multiple deployments. Their entire physiology, as well as their mental and emotional states have been impacted beyond their capacity to adapt. Reconnecting with spouses, offspring, extended family members, and professional colleagues and friends is challenging. Those who contemplate treatment may be cautious and dubious. And those who accept the responsibility of working with returning veterans may be assuming an undefined role.

"Therapists have to understand that they have no credibility at all," explained Peter A. Levine, PhD, the originator and developer of Somatic Experiencing® (SE) and Founder and Senior Advisor of The Somatic Experiencing Trauma Institute (<http://www.traumahealing.com>). After 40 years in the field, Dr. Levine has worked with many veterans from several wars. "Soldiers have their own code, and we're outsiders. We have to gain their trust and respect. They have to develop a confidence in our competency."

"Therapists have to make assessments when and where to go with an individual," he continued. "Some of that I can teach but so much comes from your own experiences, trusting your own intuitive sense."

According to the Somatic Experiencing Trauma Institute website, "Somatic Experiencing® (SE) is a body-awareness approach to trauma" based upon Dr Levine's "realization that human beings have an innate ability to overcome the effects of stress and trauma." SE is designed to help traumatized clients restore a sense of self-regulation allowing a renewed sense of aliveness, relaxation and wholeness. Dr Levine "has applied his work to combat veterans, rape survivors, Holocaust survivors, auto accident and post surgical trauma, chronic pain sufferers, and even to infants after suffering traumatic births" Embodied Practices

Passed over by the draft board in the 1970s because he was "fortunate enough to be involved in a medical scientific field that was deemed essential for national security," Dr Levine said he "felt obligated to give to people who didn't have that advantage and were drafted into the Vietnam War." His clients became his teachers as he listened to their stories, watched their embodied behaviors and in turn tracked his own physiological responses.

"This one guy came to my office, and I knew that I should not be between him and the door so I rearranged my office to give him direct access to the door. He was telling me horrific stories that I will not even hint at. As he told me these stories—I think in part to test me—I felt dizzy and nauseous and was almost ready to faint. I went inside, felt and allowed the sensations to move through."

"I told this vet, 'When you told me that story, what they made you do, I felt dizzy, nauseous, like I wanted

to puke. But I know how to deal with those kinds of feelings and, let them move through; and I guess you might benefit from learning that."

"Therapists have to be real; they can't fake it with people who have gone through horrific events," he added. "In our SE training we help therapists to differentiate their senses from their clients' (*sensations*); they become so familiar with their own inner landscape *that they* have a good idea when they pick up (resonate with) sensations of their clients."

If there was ever any doubt where trauma is housed, Dr Levine says it's clear when you work with returning veterans that the body is the repository. Therapists cannot simply sit down with a returning war vet and talk about things. Approaching the work from a purely cognitive behavioral perspective offers a limited scope, while extreme exposure treatments, where veterans are made to relive the terrors haunting them is not the direction to go in either. According to Dr Levine, it is often not in the client's best interest to dredge up the trauma, abreact them, and then get them to think differently about what happened. Certainly, cognitive approaches may be a valuable part of the process, but they are, by no means, the whole thing.

"What resolution really has to do with is 'renegotiating' these horrific experiences," he said. "Trauma isn't just coming from flashbacks, it is coming from the sensations in the fragmented, activated body reactivating. Then the body becomes the enemy. SE gradually helps people befriend and transform these sensations, and then to discharge the "locked-in" activation. This way equilibrium is reestablished. Rather than flood (*the client's body*) with emotions or change their thoughts, you have to gradually desensitize and integrate the imprints lodged in the body and then to help form a coherent narrative so they can weave it into the fabric of their lives."

Therapists working with veterans who have completed multiple deployments resulting in multiple layers of trauma need to be seasoned. This work is not something that can be "put on the shoulders of new SE practitioners without adequate supervision," Dr Levine said. "Senior clinicians can help guide newer therapists until they can get a feel for this kind of challenging work. It is only ethical to provide that support." There's also the reality of secondary stress as therapists face their own overwhelm of being exposed to the effects of stories absolutely foreign to their own experiences. They need to seek out peer support to avoid facing therapist burn out.



Bringing Therapy Home

While therapists and returning veterans need support, family members also need to learn ways to negotiate new realities with their loved ones. Partners may need to protect themselves and their children when their spouses flip out into reenactment states (flash-backs). And, if they are really feeling threatened, they may need to find ways to temporarily separate, despite having suffered deployment separations already. Furthermore, for the first time in U.S. war history, unprecedented numbers of parental units are being deployed—both parents are overseas in active duty—leaving their children in the care of relatives or close family friends. These children need ways to deal with their own sense of loss, their own stressors, both while their parents are absent and when they return.

Along with increasing numbers of female recruits are the unfortunate effects of intensified harassment—physically, emotionally and sexually. Female military personnel are often abused by men in their squadron, the very people who are supposed to be their source of safety are the ones abusing and threatening their survival and they are the ones who are abusive,” Dr Levine said. “It can feed back to early childhood when parents were supposed to love and protect them; yet, the real experience has to be validated, (*the therapists has to say*) ‘Yah you were raped and harassed.’ Therapists have to see which one (*the rape or war experiences*) is best to deal with first. There is no formula for that, you have to assess and go with one or the other, or even interweave them sometimes. Intuition comes from knowledge and lots of experiences; therapists have to trust their own organisms.”

Dr Levine noted that early life events can potentially impact the development of post-traumatic stress disorder. He explained that “certain experiences early in our relationships with our parents, even stressors while in-utero sensitize our nervous system to be more likely traumatized by events like war, rape and harassment.” As well, it is thought that some people are genetically more resilient to stress than others. However, when this is used as a “legitimate” argument against supporting what military personnel need in terms of mental health services then Dr Levine is clear that the military simply needs to provide help to all trauma sufferers or to no longer deploy anyone with these “pre-existing” problems. “You broke it; you have to fix it,” he said.

Discussing possible treatment approaches targeting children, he mentioned building on work being done internationally in war torn communities as well as disaster relief work (first responders to communities impacted by hurricanes, tsunamis, and earthquakes). He also referenced a video clip that he shares at conferences and trainings working with a young male veteran named Ray. Potential interventions may involve a team approach on military bases with someone like Ray working as a link between therapists and “these guys from a very different culture.”



Photo by Staff Sgt. Jason Bailey

Peter A. Levine PhD holds doctorate degrees in Medical Biophysics and Psychology. He received the USABP Lifetime Achievement award in recognition of his original and pioneering work in trauma. He also received an honorary award as the Reiss-Davis Chair for his lifetime contributions to infant and child psychiatry. During his 40-year study of stress and trauma, he has contributed to a variety of scientific and popular publications as well as authored and



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Sounds True many voices, one journey

Tami Simon interviewed Dr Peter Levine regarding his upcoming course on September 20, 2010. [Healing Trauma](#) is designed to teach listeners how to release energy from traumatic episodes and restore harmony and balance in the body. Levine will discuss his body-based approach to trauma, trauma's connection to stress, and offer advice on how to deal with trauma. To hear the podcast, go to <http://www.soundstrue.com/podcast/peter-levine-healing-trauma/?p=1820>

Simon founded Sounds True in 1985 “to disseminate spiritual wisdom” and “inspire, support, and serve personal transformation and spiritual awakening” by “embracing the world's major spiritual traditions, as well as the arts and humanities, embodied by the leading authors, teachers, and visionary artists of our time” (retrieved from http://www.soundstrue.com/aboutus/Our_Vision/).

Over the past two decades this lone woman and her tape recorder evolved into an independent multimedia publishing company with 80 employees. Their mission is “to find teachers and artists who serve as a gateway to spiritual awakening and to produce, publish, and distribute their work with beauty, intelligence, and integrity.” Their current library of more than 600 titles includes a wide variety of formats—spoken word audios; audio learning courses; books; interactive learning kits; music and instructional DVDs. The goal is to feature leading teachers and visionaries of our time via products that both provide information to the reader or listener and “preserve the essential ‘living wisdom’ of the author, artist, or spiritual teacher” while embodying “the essential quality of a wisdom transmission between a teacher and a student” (retrieved from http://www.soundstrue.com/aboutus/Our_Vision/).

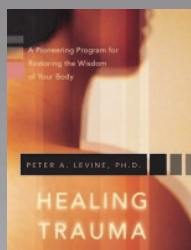
Nine Step Method for Transforming Trauma

From Peter Levine PhD

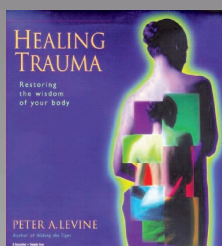
1. Create an environment of relative safety
2. Support initial exploration—touch into their sensations
3. Pendulation—the rhythm of contraction and extraction
4. Titration—touching into the smallest drop of survival based arousal
5. Provide corrective experiences
6. Uncouple the fear from immobility—contains a lot of activation arousal so need to help contain the sensation of arousal to help the client move back into balance, back into social engagement (seeking a state of equilibrium)
7. Help discharge and regulate the high arousal states
8. Engaging in self-regulation to restore dynamic equilibrium and relaxed alertness

Books By Peter Levine PhD

In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness (2010)



Healing Trauma: A Pioneering Program for Restoring the Wisdom of your Body (2008)



Trauma-Proofing Your Kids: A Parents' Guide for Instilling Confidence, Joy and Resilience by Peter Levine and Maggie Kline (2008)



Waking the Tiger: Healing Trauma: The Innate Capacity to Transform Overwhelming Experiences by Peter Levine and Ann Frederick (1997)

Dan Gottlieb graduated from Temple University with a PhD in psychology. He worked as an addictions specialist, married, had two daughters, directed a community based treatment program. The first decade of his professional career was cruising until a near fatal car crash in 1979 left him paralyzed from the chest down. Learning to accept life as a quadriplegic came with years of despair and depression as well as loss—his wife divorced him and soon died, his sister died, his parents died. Through this traumatic readjustment, he learned to observe life, to witness what it means to be human, and how to cultivate peace in the midst of intense suffering.

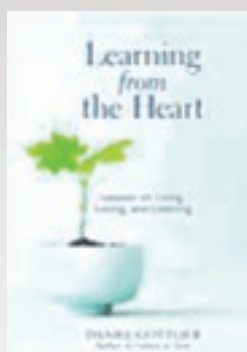
Today, Dr Gottlieb writes memoir and personal essays, hosts a radio show on Philadelphia's local radio station (WHYY-90.9 FM) called Voices in the Family, blogs, and lectures worldwide. He is noted as a teacher of life who walks the walk—metaphorically speaking—and combines wisdom with dry humor.

He leads writing workshops, limited in size, to allow writers to experience the power of writing together. For information contact Laurie Wagner at laurie@27powers.org or call (510) 703-4030 www.27powers.org.

Books by Dan Gottlieb, "Human"

Dan Gottlieb is a psychotherapist, author and teacher. His books include: Learning from the Heart and Voices of Conflict; Voice of Healing and The Wisdom of Sam: Observations on Life from an Uncommon

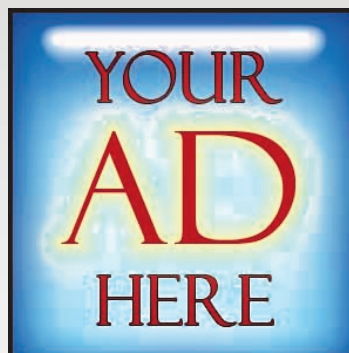
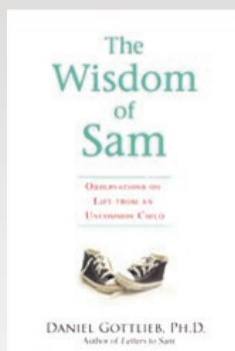
Child (lessons from an autistic grandson)



For more about Dan:

www.drdangottlieb.com

www.npr.org/templates/story



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Recognizing body sensations while treating combat Veterans

E.C. Hurley

In recent years the United States military has experienced multiple deployments of U.S. troops to combat zones such as Iraq and Afghanistan. The physical and psychological toll on military personnel has become more obvious with each deployment. Traumatic brain injury (TBI) has become the signature wound in current military operations. Posttraumatic stress disorder (PTSD) is experienced by a significant percent of those who serve. The symptoms of anger, irritability, impulsivity, nightmares, night sweats, flashbacks, emotional numbness, hypervigilance, memory and concentration problems, along with depression, substance abuse, relationship problems are presented in many of America's finest patriots.

For the past 37 years I have provided individual, couple and family therapy to military personnel first as an active duty soldier and later, following retirement from the U.S. Army, as the director of a private practice psychotherapy center known as Soldier Center near Ft Campbell, KY. I provide psychotherapy daily to members of the 101st Airborne Division (Air Assault), as well as special operations units. Today, as a retired soldier and a licensed psychotherapist, I treat soldiers who are dealing with life changing experiences such as combat traumas as well as family members coping with adjustments and life issues.

A few months after September 11, 2001, I began to treat soldiers as they returned for two weeks of rest and relaxation (R & R) from Operation Iraqi Freedom (OIF). Many of those OIF soldiers had been my clients for couple's therapy prior to their deployment for OIF1. A therapeutic relationship had previously been established with many of them prior to their combat deployment. When they returned home from their first combat deployment, many of my clients presented symptoms of acute stress and PTSD. Early on, many of my military clients presented with single-incident combat trauma. While I had been trained in numerous efficacious models of psychotherapy during my professional life, Eye Movement Desensitization and Reprocessing (EMDR) came to be my choice treat-

ment model in treating soldiers and military family members. EMDR is an evidenced-based eight phase approach for treating life difficulties. It is a 3-prong protocol which treats past trauma events, current triggers, and anticipated positive future outcomes. The theoretical model behind EMDR, known as the Adapted Information Processing model (AIP), suggests that a person's presenting symptoms are the result of maladaptively stored memories which continue to be activated and interfere with their present life experience. This causes clients with unresolved memories from the past to be triggered during current events in their life.

From the AIP perspective, the past is present. Memories of past events, both conscious and unconscious, intrude in soldiers' current lives and rob them of their potential ability to enjoy a present quality life. Much of my work using EMDR is time-limited treatment which focuses primarily

may be somatically expressed. Soldiers frequently report body sensations associated with the disturbing memories of their combat experiences. For example, a soldier reported feeling gastro-intestinal pain as he worked on the memory of a mass casualty event where he assisted in recovering bodies and body parts. Following the mass casualty response, as he was being treated with EMDR, he recalled going to the chow hall where he ate chili-mac and mashed potatoes. As he recalled the event during EMDR treatment in my office he experienced pain in his stomach. The stomach pain, associated with his trauma memory, cleared out within 5 minutes of treatment. The soldier recalled he had eaten his portion of the meal as well as his battle-buddy's left-over food. The soldier said to me, "This is deep doc; I am remembering things I had forgotten until now."

Also, that soldier noted he had a sensation in the middle of his chest. As he re-processed his memory of the event he recalled that his supervisor had punched him in the chest follow the mass casualty and told him "good job!" He then remembered carrying his weapon at the low ready, a position where he carries the weapon close to his chest with his hand near the trigger in case he needs to use it.

Additionally, other soldiers often recall the feeling of body armor against the back of their neck as they access the somatically stored part of their memory. During

combat operations with incidents such as firefights, the soldier is not consciously aware of sensations in the back of the neck where the protective neck shield is located on the armored vest. The sensory memory is frequently out of awareness until the overall experience is remembered during treatment. A combat veteran's body sensations (associated with the disturbing event) will shift in its location in the body and eventually dissipate entirely during EMDR treatment, often within a 15-20 minute period.

However, as the number of combat deployments increase, it is not unusual to treat soldiers who have been deployed four to six times. With each deployment comes the propensity for complex PTSD symptoms. A percentage of soldiers who internalize their experiences (rather than verbalize them) frequently identify more body sensations along with the need for additional time to reprocess those body



Photo by Lance Cpl. Michael Petersheim

on combat-related issues and any early life touchstone events. My goal is to restore the soldier-client back to a quality of life they had prior to their combat experiences. The overall goal is to provide a treatment which allows the client to reprocess unresolved memories, moving those memories to healthy resolution. The outcome of the EMDR treatment allows the soldier-client to recall the past experience without the reactivity previously associated in recalling the event. During the reprocessing of the memory the level of disturbance is diminished to a point where it is not longer upsetting as it is recalled. Additionally, the self-referencing positive belief becomes strengthened.

The EMDR treatment approach includes scanning the body for any tightness, unusual sensations or tension associated with the memory of the targeted event which

sensations.

Recently a soldier reprocessed his level of disturbance down to where no disturbance was being experienced, and the appraisal of his self-referencing positive belief about himself was as strong as he could possibly image. These aspects of treatment were accomplished in less than 40 minutes in the session. He identified his body sensations he began to report sensations in his forearm, then the middle of his spinal cord, then the back of his neck, then his stomach, and then back to his forearm. This process continued for two treatment sessions until all sensations associated with his targeted memory were completely reprocessed and he reported a clear scan of his body sensations. He was then at peace with the past event and free to move on with his life. When treating multiple combat traumas it is common for similar patterns of sensations to be reported during the EMDR body scan as each combat trauma as processed, as if there is a neurological imprint, i.e., as Donald Hebb suggested in 1949, *neurons that fire together wire together*.

I never cease to be amazed in using the EMDR body scan phase as the body sensations reveal additional unprocessed material relating to the targeted memory. It is a privilege to serve our military personnel whose bear the burdens of service and sacrifice on behalf of our nation. I comment everyone in our healing communities who have the goal of caring for those who have sacrificed so much for our freedoms as Americans.

Reference

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E. C. Hurley, DMin, Ph.D, is the founder and director of Soldier Center, a psychotherapy center located in Clarksville, TN, near Ft Campbell, KY, which specializes in the treatment of soldiers, veterans and military families with combat trauma issues. He is an Army veteran who completed 33 years of military service ranging from enlistment as a Private during the Vietnam era to retiring as an Army chaplain with the rank of Colonel in 2003. He holds numerous military awards including the Bronze Star, the Legion of Merit and the Army's Air Assault medal. He is an Approved Consultant with the EMDR International Association (EMDRIA) and an EMDR trainer for the EMDR Humanitarian Assistance Program and the U.S. Army Medical Command where he trains military mental health professionals.

In addition to maintaining a weekly psychotherapy case load, E. C. leads intensive 1 and 2 week treatment programs for military personnel, veterans and their family members who travel to Soldier Center seeking to resolve their posttraumatic trauma issues and regain their lives. For information visit www.Soldier-Center.com or email E. C. Hurley at hurleyec@gmail.com.



Photo by Spc. George Hunt



Photo by Spc. Daniel Herrera



Photo by Cpl. Tommy Bellegarde



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Many of the photos in this issue are from the Defense Video & Imagery Distribution System (DVIDS), a public service operated by the Third Army/U.S. Army Central on behalf of the Dept. of the Army in support of all branches of the U.S. Military: Army, Navy, Air Force, Marines, Coast Guard and the National Guard. The resources are up-to-date, with blogs and photos posted active military personnel. There are videos-on-demand, webcasts, ipodcasts, still photos, news from the front and more. To learn more check out Facebook, Twitter, UTube, Flickr or visit www.dvidshub.net. We offer our sincere thanks for permission to share their photographs. ~N Eichhorn



Body Insights: Military Culture: Viewpoint on the Body

Bobbie Brooks

The increase in U.S. military deployments over the past ten years has stretched the resilience of our military personnel and their families. It has also caused military leaders to rethink policies and, as a result, the military culture is slowly shifting its perspective by taking a holistic view of a soldier.

I have spent the last 25 years working for the military in various capacities ranging from training soldiers, working for Combatant Commands, working in the Pentagon, and most recently serving as a senior advisor to military leadership. My experience has allowed me to gain insight into the daily lives of military life, spanning from enlisted personnel to four star generals, and it has given me a unique viewpoint to understand the subtleties of the military culture.

To develop this article I interviewed officers and enlisted personnel who served in the Vietnam War, Iraq (Gulf War & Operation Iraqi Freedom) and Afghanistan (Operation Enduring Freedom). I looked at a cross-section of personnel spanning from elite combat forces like Delta Force and other Special Forces to those who predominately “fly a desk” working in support roles. For privacy, their names have been omitted.

I will discuss the military culture’s changing view of the physical body, how doors are opening for increased consideration of mental health regarding the body, and potential opportunities for employing body psychotherapy techniques.

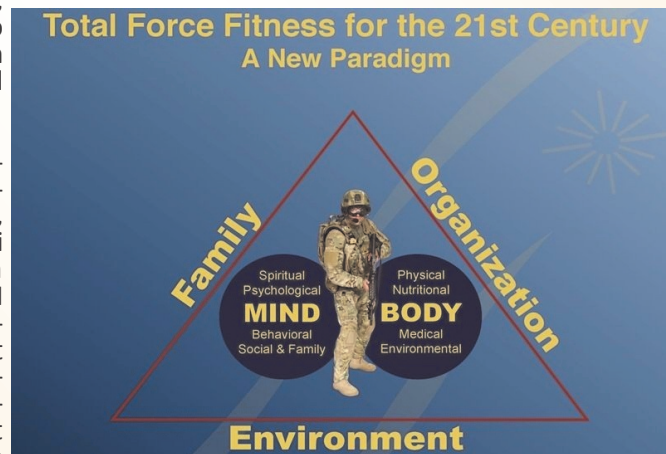
Military Mindset About the Body – Shifts in Policy and Culture

In earlier decades, military culture reflected ideas about fitness such that extreme physical fitness was the norm and bruised and beat up bodies were believed to be good. One retired Special Forces commander explained that until about 20 years ago “beating the snot out of [the body] was a great thing to do.” He said that Airborne and Special Forces units were really about fitness by training soldiers to run through pain, discount discomfort, and basically desensitize the body.

He shared a story about one of his subordinates who carried on with the mission after breaking his ankle in a parachute jump. After the mission was over, the sub-

ordinate approached him to apologize for the broken ankle. This soldier was embarrassed about the injury. The Commander said that (at the time) this behavior was *not* considered extreme. He explained that a soldier was “not allowed to hurt himself, and if he did, he didn’t let it get in the way of the mission.”

Military training taught soldiers to push their bodies beyond what they thought their limits were and not give up. Mental health was not totally ignored but only emphasized when mental issues were degrading soldier or unit performance. Like most of the U.S. population at the time, a separation of mind and body was definitely reflected in military ideas and training during this time period.



Today, however, the paradigm is changing. The sustained conflict of recent years has caused an increase in deployment length, an increase in dwell time (number of deployments over five consecutive years), and caused a rise in issues such as suicide rates, divorce rates, and drug use.

The old paradigm for fitness is failing (Jonas, O’Conner, & Deuster, 2010), and military leaders are looking for new methods that rebalance health with an outcome that provides optimal performance, resilience, and recovery (Jonas et al., 2010). Partly in answer to this challenge, the Joint Chiefs of Staff (JCS) introduced the Total Force Fitness program which moves beyond a focus on the physical body and includes a holistic approach for the overall well being of the warrior – physically, mentally, socially, and spiritually (Jonas et al., 2010).

Total Force Fitness addresses eight domains including the following: physical, nutritional, medical, environmental, behavioral, psychological, spiritual, and social, with family embedded in many of these

domains (Jonas et al., 2010).

As ADM Michael Mullen, Chairman of the JCS, states, “The key seems to me to be the ability to maintain a balance both emotionally and physically under a variety of rapidly changing demands” (Mullen, 2010).

Physical fitness in the military is still measured in terms of strength, endurance, mobility, and flexibility (Department of the Army, 1998), but in the Total Force Fitness model it is also considered within the context of other enhancing factors such as the psychological domain (Jonas et al., 2010). Military training regarding how the physical body is viewed now reflects a paradigm shift so that the body is no longer considered separately from the mental and spiritual dimensions.

One subset of the population that warrant consideration involves wounded warfighters recently returning from the battlefield. What are their beliefs about their bodies?

Daniel E. Hickman teaches a mindfulness based yoga therapy class at Walter Reed Army Medical Center in Washington, D.C. to wounded warfighters. When asked how wounded soldiers approached their bodies Hickman said that “learning how to be with their new self and body is one of the major challenges. Learning the preparation and care it takes on a

regular basis every day” is a significant task to realize, he said.

Most of Hickman’s classes are performed on the floor in a non-traditional spontaneous way that reflects how soldiers move. He said participants are basically working with breath and energy using movements that are different from the rote linear and angular methods provided by resistance training. He encourages them to learn how to let the movement inform them to get in and out of shapes.

Hickman said that he does not force postures, and the primary emphasis is on inducing relaxation and calming the nervous system. There is still a stigma about exposing weaknesses with this population because military training is designed to expose the weak links and weed them out, he said. Hickman said that the training of the elite forces (e.g., Special Operation Units) seemed to be more open to psychotherapy and holistic methods. He also stated that it is important to take care in the language he uses.

Words like “surrender” or “retreat” are not acceptable with this population.

He also stressed the need to reframe wording and be sensitive to soldiers’ situations. For example, you can’t say “touch your toes” because many of them no longer have toes. This population views the body in a very different way and a holistic view helps them to recognize the whole person.

The incoming generation of military personnel is ushering in the change towards a holistic view of the total person. According to Hickman, one Special Forces soldier said that kids entering the military today have different forms of physical outlets such as skateboarding, snowboarding, extreme sports, etc. It is no longer the typical “jock-aholic” who grew up playing football, basketball, and baseball entering the Armed Forces.

This soldier mentioned that the new generation had a different physicality and with that came a different mental outlook. There is a sense of agility and a sense of mindfulness not present before. So as the U.S. culture is adopting martial arts, yoga, and other mind-body physical practices, the men and woman entering the military are reflecting this.

With this new holistic outlook and change about how the body is viewed, is the military is ready to absorb methods like body psychotherapy into its training programs, medical communities, and in daily life of military personnel, be it on the battlefield or at home with the family?

Start With the Soldier

The military uses a multi-tier approach to increase mental resilience, identify those with mental health issues, and provide them with mental health services. Each branch of the service has its own procedures. In the Army, one of the most basic levels is the Battle Buddy system in which a soldier is paired with another same gender soldier so they can rely upon each other for personal support and encourage each other physically and mentally (Department of the Army 3rd ACR, n.d.). The Battle Buddy system was designed to help with suicide prevention, sexual assault, and accident prevention (Department of the Army 3rd ACR, n.d.).

Another tier of support comes from chaplains deployed with the units. “Providing comprehensive religious support to soldiers in combat includes assisting in the prevention, treatment, and assessment of soldiers suffering from battle fatigue and stress-related illnesses” (Department of the Army, 2003). A Unit Ministry Team (UMT) is assigned directly to the battalion; they know and understand the soldiers in the unit (Department of the Army, 2003). This gives them the opportunity to identify potential stresses that may affect the unit



and individual soldiers and coordinate with mental health providers. The UMT helps the command identify battle-fatigued soldiers and provides a treatment plan (Department of the Army, 2003).

Worship, counseling, and command consultation contributes to “spiritual fitness.” Religious Support (RS) is a major component of combat stress control and battle fatigue prevention and treatment (Department of the Army, 2003). One officer who commands a support element said that at one point on his second deployment when he was under extreme stress from making high level decisions he found himself sitting on his bunk with a 9mm gun pressed against his temple. When asked how he made it through that time, he said that he connected with the chaplains and used the church as a support group. Chaplains work closely to help boost morale and increase fitness. In one unit chaplains even led P90X fitness classes for the troops. They are said to be an integral part of the unit.

The next tier provides mental health providers not normally deployed with the units. This creates some distance and provides time for issues to percolate before soldiers bring them to the attention of the mental health providers. There are also procedures in place to connect military personnel and their families with mental health providers who are contracted by the Military to check on the families via phone calls. However, one soldier said this was counterproductive and did more to scare his wife into thinking he was injured or dead rather than helping. He told his wife just to ignore the calls. Hot line numbers are also available for military personnel and family. As well as available counselors. One officer shared that the he wanted the Army to pay for his marriage counseling upon return from deployment. He and his wife already had a trusted relationship with a counselor; but upon inquiry, he was told that they had to use the Army contracted counselor or there would be no funding provided for outside counseling.

Although military policy may recognize that today’s incoming soldiers embrace a modern and holistic approach, military culture formed by hundreds of years of tradition and esprit de corps is often slower to embrace new ideas. There is still residual bias against psychotherapy and the use of mental health services. One officer I interviewed explained that he needed prescription drugs to help with a psychological issue, but he was forced to use a doctor outside of the military health system to prevent the diagnosis from being reported on his Officer Efficiency Report (OER). An officer’s entire career rests on his OER, and in today’s competitive environment one small mark against you can prevent a promotion and/or ruin a career. Had the military culture fully embraced mental health treatment plans there may have not been an issue regarding OER and upward mobility of the officer’s career.

Areas to Incorporate Body Psychotherapy

A journal search showed that recent body psychotherapy research is already underway with the military regarding PTSD, battle fatigue, and suicide prevention. Research exists on family issues to include interpersonal partner violence, family separation, and similar issues. To interrupt the cycle of psychosomatic issues that are arising, it may be helpful to identify these issues as they arise. The next opportunity area to integrate body psychotherapy techniques into the military culture may be to train chaplains. They have access to soldiers by deploying with them. They understand the multi-dimensional aspects of a person, and they are looking for creative ways to be relevant in increasing morale and helping the soldier. They may be a direct point of entry for the body psychotherapy community.

Bobbie Brooks BSME, RYT500 is a certified yoga therapist and PhD somatic psychology student at The Chicago School of Professional Psychology. She lives split-based between Huntsville, AL and Nosara, Costa Rico.

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Doors Closing and Opening

Nancy Eichhorn
and Bobbie Brooks

Santa Barbara Graduate Institute has ceased operations.

SBGI students received several options last June when a temporary hiatus was announced. Meridian University in Petaluma, California, offered to accept transfer students into their programs including a PsyD in clinical psychology and a PhD in psychology with a concentration in somatic psychology. And, as an affiliate of TCS Educational System (a nonprofit educational system founded in 2009), SBGI negotiated an articulation agreement with The Chicago School of Professional Psychology (TCSPP) allowing eligible SBGI students to transfer to one of three degree programs in Somatic Psychology to be offered at its Los Angeles Campus.

"I have been working closely with The Chicago School over the past few months," said Dr Hoffman, SBGI president. "And I

education centers." (The Esalen certification program is no longer available; program approval from Esalen was institution-specific.)

Established in 2000 by Marti Glenn and Ken Bruer, SBGI's mission was to provide excellence in education, research, and leadership from an embodied perspective—they maintained the belief that the mind, body, and spirit were inextricably linked and must be treated in its entirety to effect deep and lasting change. They created a unique learning environment based on a progressive academic curriculum that blended traditional and alternative approaches, incorporated experiential learning methodologies, and emphasized interpersonal relationships. Guided by three core values—relationship, scholarship, and leadership—SBGI faculty adhered to the school philosophy known as "synergistic education." Course curriculums were designed to integrate students' personal and professional experience with academic

Allan Schore PhD, Peter Levine PhD, Bruce Lipton PhD and Thomas Verny PhD.

Overall, the SBGI faculty, be it full time, adjunct, research or contributing, included educators who strove for excellence such as Wendy Anne McCarty PhD, Rae Johnson PhD, Christine Caldwell PhD, Stella Resnick PhD, Susan Aposhyan MA, Dyrian Benz-Chartrand PsyD, Keith Witt PhD, Leslie Lunt PhD, Judith Schore PhD, Michael Sieck, PhD, and more. All of the faculty members (many remain unnamed in this article) lent their knowledge and expertise to SBGI's vision and mission. The school offered both a monthly on-campus format and a hybrid format that blended on-campus courses with online learning, catering to a diverse population of local, non-regional and international students.

SBGI began with 35 students and ended with over 200.



know they are very pleased to welcome SBGI transfer students to the TCSPP-Los Angeles community beginning this fall."

SBGI History

SBGI was an academic pioneer with its dedication to somatic psychology (SOM) and prenatal and perinatal psychology (PPN) training and research. It was one of the first institutions in the United States to offer masters degrees in SOM and PPN, as well as the first to offer a doctorate in somatic psychology. It also earned the distinction of being one of only two schools (Harvard being the second) to present certification programs as Esalen Institute, which is noted on the Esalen website as "one of the world's oldest and most respected alternative and experimental

knowledge and research as well as incorporate "multiple ways of knowing, learning and healing with the unique contribution of every participant interacting together to create a nurturing, supportive and intellectually stimulating educational community." Every student who attended on-campus classes experienced Ken Bruer initiating the session by reading David Whyte's poetry (he always read a poem twice, letting the words fill the room) and the closing ritual lead by Dr Glenn as hand-in-hand students followed her lead, snake like, winding in and out creating a unified whole (laughter and tears were often woven in, too).

The SBGI faculty included many visionary pioneers in the fields of PPN and somatic psychology such as the late Ron Kurtz, the late Bobbie Jo (BJ) Lyman PhD,

Hopes and Dreams

Sadly, visionary educational approaches were not enough. Despite the school's approval status in the State of California that allowed students to seek licensure as marital and family therapists in that state, SBGI needed to gain accreditation from the Higher Learning Commission to continue attracting students (nationally as well as internationally) and to offer students necessary supports such as the ability to apply for student loans and student health care. SBGI started the accreditation process by applying to the Western Association of Schools and Colleges (WASC) which oversees California, Hawaii, Guam and the Pacific Basin. During this initial phase, however, another plan evolved.

Continued on next page

The Chicago School Education System

Part of SBGI's strategic plan to gain accreditation involved an affiliation with TCS Education System. TCS Education system was founded in May of 2009 and is marketed as an "entrepreneurial not-for-profit educational enterprise." According to their website, they offer a "mission-based educational approach" that emphasizes academic quality and social responsibility as well as offering what they consider to be a prototype of inter-institution collaboration considered "critical to success in today's competitive higher education environment."

Four specialized colleges are part of the TCS Education system, each focused on a particular discipline including the following: psychology; health and human services; education; and law. Two schools for children—the Pacific Oaks Children's School and the Garfield Park preparatory academy—are also part of the TCS system as well as a formal foundation that grants research funding and a global network that supports international research and interventions.

The Chicago School of Professional Psychology (TCSPP) is part of the TCS Education System. TCSPP advertises their institution as the nation's leading nonprofit graduate school devoted exclusively to psychology and related behavioral sciences. TCSPP programming maintains their organization is "not strictly focused on research or traditional clinical practice, but on preparing students to be extraordinary practitioners, equipped to make a lasting impact on individual lives, in business settings, in diverse and underserved communities, and around the globe" (retrieved from <http://learn.thechicagoschool.edu/california/Chi-8TK-623JC.html>). They have campuses in Chicago, Washington D.C., Los Angeles, Westwood, and Irvine (all in California). Students can attend classes on campus, participate in a blended program (on campus and on line) and totally online. TCSPP is accredited by the Higher Learning Commission, and is an active member of the National Council of Schools and Programs of Professional Psychology

The merger was considered philosophically appropriate and after "due diligence" paperwork was finalized on July 15, 2009. According to Matthew Nehmer, Senior Director of Communications for TCS Education System (and the spokesperson for TCS Education System), when TCSPP first announced its relationship with SBGI, the goal was to maintain SBGI's brand identity and become an affiliate of The Chicago School. SBGI still needed to pursue accreditation with the Higher Learning Commission of the North Central Association of Colleges and Schools (HLC) on its own merits, he said.

Students, however, mistakenly thought they would be granted accreditation status because of the affiliation; the collective energy of finally achieving accreditation as well as a collective sigh of relief thinking financial assistance was possible as well as internships in other states was quickly quelled.

In February 2010, the Department of Education issued a policy letter changing practices in place for recognizing campuses that operate across regional accreditation lines—it tightened its reviews of complex organizational structures and resulting accreditation applications. SBGI was mandated to apply for accreditation by the Western Association of Schools and Colleges which oversees California, Hawaii, Guam and the Pacific Basin, first, and then HLC second.



This approach was thought to "allow SBGI the autonomy and flexibility to grow and serve its community, while still benefiting from the services from and connection to the TCS Education System," Nehmer said.

Over the years, students had been told that WASC was a well-structured, multi-step process institutions must follow in order to be granted accreditation. The process is time and resource intensive; Jill Kern PhD, the former director of research for SBGI, was known to work long hours completing documents for the accreditation process. SBGI did make progress in its pursuit of regional accreditation becoming WASC-eligible in January 2011. The reality, however, meant another two plus years and a considerable financial investment (\$20,000.00 was needed to start the next step) to complete the process.

According to Nehmer, they decided to "pause enrollment and undertake a comprehensive self-review and analysis – both in light of the timing and resources the college needed to advance the WASC accreditation process, and also based on the primary challenges our students told us they were facing: access to additional financial support options, and their interest in receiving a degree from a regionally accredited institution."

New this Fall

As part of the transition, SBGI curriculums were reviewed and it was decided that TCSPP would offer the following degrees as a part of its new Somatic Psychology program:

- MA in Clinical Psychology, Marital and Family Therapy, Somatic or Prenatal and Perinatal Psychology concentration
- MA in Somatic Psychology, Somatic or Prenatal and Perinatal Psychology concentration
- PhD in Somatic Psychology with either a Somatic or Prenatal and Perinatal Psychology concentration

These degrees will be offered initially in a hybrid format blending on-campus sessions with online course work as well as the option to complete necessary credits completely online. Incoming SBGI transfer students (109) must complete 30 units at TCSPP; it was estimated that the current student body would complete all required course work by the summer of 2015. TCSPP is only enrolling approved SBGI students in the new Somatic Psychology program.

Dr. Martin Harris, Dean of Academic Affairs, The Chicago School of Professional Psychology, Los Angeles, Westwood and Irvine Campuses, explained the current restriction. "Like all TCSPP academic programs," he said, "these new programs will be reviewed and assessed in light of professional licensing standards, evaluation of the future labor market and the need for additional professional competencies in a variety of areas, and continued market viability and interest, among other factors."

Despite numerous changes, students were greeted by many familiar faculty members including Jeanne Rhodes, Christine Caldwell, Rae Johnson, Edmund Knighton, and Marlon Sukal. According to Dr. Harris, "SBGI faculty are among the most knowledgeable in the country in the field of Somatic Psychology, so The Chicago School was pleased to be able to hire several of these distinguished faculty to teach in these programs. In addition, three faculty members who have been teaching at The Chicago School and have significant and relevant content expertise will also be teaching in the Somatic Psychology programs."

"We will, of course, continue to seek faculty for these programs who are experts in the field," he continued. "And we are excited about strengthening the program through the addition of new faculty and areas of expertise."

As TCSPP's Somatic Psychology program grows, one might envision migration between this program and other existing TCSPP's curriculums such as neuropsychology, forensic psychology, and applied behavioral analysis. Dr. Harris noted that "students may be eligible to

Continued on next page

take certain other courses offered at The Chicago School, but as with all students enrolled in a particular degree program at The Chicago School, they will need the appropriate permissions of Department Chairs." Dr. Edmund Knighton is the Department Chair for the MA and PhD Somatic Psychology programs at TCSPP; students have been directed to contact him regarding degree requirements and interest in coursework outside the degree program.

Advances in the Field of Somatic Psychology

As the field advances and academic needs increase, SBGI's closure and its program migration may provide a roadmap for other institutions following its lead with somatic and prenatal and perinatal programs by serving as a pathfinder modeling ways to integrate body psychotherapy programs into more mainstream academic infrastructures and curriculum.

"Somatic psychology is still nascent and the burden of producing competent clinicians at the masters level and rigorous researchers at the doctoral level lies with the faculty and students who will further this work," said Dr. Knighton. "Unquestionably, the strength and scope of The Chicago School provides a promising platform to showcase the benefits of affective neuroscience, attachment theory, and trauma resolution within the psychological community. We have hard but exciting work ahead of us.

"Students drawn to the field of Somatic Psychology most often fall into two populations," he continued. "The first are those drawn to an inclusive field that complements rather than opposes allopathic models, and seeks best practices from an unbiased perspective. This outcomes-based competence approach aligns with insurance, business, and community needs. The second population of students tends to be clinicians who recognize the need for research and practices that include more of the human experience, as evidenced by emerging terms such as psychoneuroimmunology. Both populations tend to be pioneers. The gap between advances in quantitative neuroscience and qualitative clinician effectiveness is shrinking, but students drawn to Somatic Psychology must continue to be bridge builders."



Jennifer Frank Tantia

Current Research Reviewed

Research in the fields of medicine and mental health is finally growing toward a closer understanding of the body/mind continuum. This column is dedicated to sharing new research that may impact our work in the field of body psychotherapy.

Military Mental Health

Article Reviewed: Mansfield, A. (2010). Deployment and the Use of Mental Health Services among U.S. Army Wives, *New England Journal of Medicine*, 362(2), 101-109.

Until now, most military mental health research has focused on the symptoms of PTSD exhibited by military personnel returning from duty and the effects that these symptoms have on their families. Only in the past few years has attention been given to the deleterious effects of deployment on the family that is left behind. In lieu of secondary trauma in the way we know it as mental health professionals, new findings show that spouses of military soldiers are developing symptoms of a type of "apprehension trauma" when their loved one is deployed. This article from the *New England Journal of Medicine* articulates the alarming increase of mental health diagnoses of military spouses (Army wives in particular) when left to deal with the unknown status of their loved one upon deployment for military service.

The authors collected medical records from outpatient care facilities from wives of military employees between the years 2003-2006. The participant sample consisted of 250,626 records from Army wives between the ages of 18-48 (see article for details on sample selection). Findings showed an increase among four particular areas of mental illness diagnoses: depressive disorder; sleep disorder; anxiety and acute stress reaction; and adjustment disorder. In addition, a correlation was found between increased numbers of cases in each of the four aforementioned diagnoses and the length of the spouse's deployment. The time span for deployment was divided into two segments: 1-11 months of spousal deployment and over 11 months. These findings were then compared with mental health reports of Army wives whose spouses were not deployed, showing that those whose husbands were deployed showed higher incidences of

mental health difficulties, particularly in the four diagnoses mentioned.

The authors make a strong claim for a correlation between mental health diagnoses and spousal deployment; however, I think they failed to include one essential factor—the reason these Army wives sought mental health care in the first place. Comparing wives of deployed personnel with wives of soldiers who were not deployed is not a valid comparison without adjusting for confounding variables such as the reasons for seeking mental health or not seeking it. Some wives may experience greater mental health while their partners are at home, while others may avoid reaching out for support because of the husband's influence to shun mental health care because of the well-documented stigma associated with military personnel and mental illness. Both of these potentially contradictory suppositions may be worth the time to investigate and may add to the current study's strength.

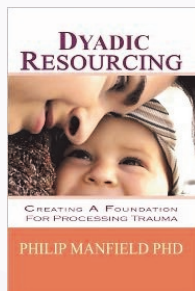
Although these findings do not appear surprising, it is an important study that will hopefully expand the ways in which mental health professionals view military families *beyond* spousal mental health while a loved one is deployed. Thinking forward, in addition to Army wives (and therefore, potentially wives of all military divisions) whose mental health is affected by their loved one's absence, their children also feel the strain of watching their mother's mental health stagger.

From an attachment perspective, there is an obvious trickle-down effect that destabilizes the mental health of military families. Children's autonomic nervous systems that are still developing can become impacted not only by their mother's behavior, but even the implicit communication between the child and mother who is struggling with a developing mental illness. Even further, the child's destabilization may transfer to his or her cognitive and social well-being and may even manifest in somatic symptoms at a later time. If not addressed in psychotherapy, (particularly somatic psychotherapy), over time this could create a generation of children with destabilized autonomic nervous systems. The multiple and frequent deployment of military soldiers over the past ten years is enough to have already created a generation of military families dealing with depressive disorder, sleep disorder, anxiety and acute stress reaction and adjustment disorder. We have a lot of work to do.

Jennifer Frank Tantia MS, BC-DMT, LCAT is a dance/movement therapist and somatic psychotherapist in New York City and serves on the faculty of both Pratt Institute and Adelphi University. She works in private practice and leads Authentic Movement groups while completing her Ph.D. in Clinical/Somatic Psychology at Santa Barbara Graduate Institute. All responses and comments to this article are welcomed. Please contact Jennifer at: JFTantia@gmail.com

Resources

Jacqueline Carleton PhD
and the USABP Interns

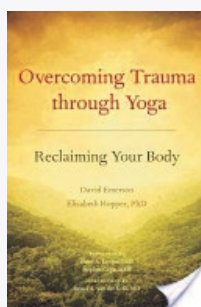


Dyadic Resourcing

Phillip Manfield.
2010. 299 pages. Paperback. ISBN13: 97801453738139. United States of America, On-Demand Publishing.

Reviewed by Alyssa Mayhew, Hunter College-CUNY

In *Dyadic Resourcing*, Dr Manfield writes for psychotherapists as he details ways to establish a resourced foundation from which doctor and patient can process relational trauma (in the patient). Manfield states that if a patient is overburdened with the demeaning messages that were internalized as a child, he will not be able to see his childhood in a positive way until his adult perspective is readjusted. Manfield offers a way of helping patients work through their trauma. *Dyadic Resourcing* involves the creation of an internal working model of a loving adult and a loveable child, while also adding the tactic of frustrating the patient's attempt to identify with either of these roles. The book is divided into three sections: Case Conceptualization; *Dyadic Resourcing*; and *Dyadic Resourcing with Morphing*. This book would be of interest to psychotherapists looking for a new perspective from which to understand and process trauma.



Overcoming Trauma through Yoga

David Emerson, Elizabeth Hopper, PhD.
2011. 143 pages. Paperback. ISBN: 978-1-55643-969-8. California: North Atlantic Books.

Canfora

People often initiate their first step on the yoga path because of a deep sense of personal suffering. However, given the popular yoga culture, a typical yoga class may be overwhelming to newcomers and those seeking personal healing. There is a real need to extend yoga to those affected by traumatic experience and this book is a guide toward that action serving yoga practitioners, yoga teachers, and clinicians who are interested in working somatically. This guide fills the gap in the

Reviewed by Dawn

yoga student's training with a solid knowledge base of trauma and offers ideas about creating a trauma-sensitive yoga class. Furthermore, clinicians can gain insight into working with the body in the therapy session. Traumatologists such as Bessel van der Kolk and Peter Levine emphasize the importance of working somatically with the body / mind because trauma essentially gets stored in the autonomic nervous system. The yoga skills presented here are designed to center, to ground, to increase mindful awareness, to encourage curiosity about experiencing the present, to help regain a sense of empowerment, enhance affect-regulation and to befriend the body, all in a trauma informed way. From a yoga perspective, this guide presents how to work with an individual suffering from symptoms associated with traumatic experience as a fine balance between knowledge and sensitivity.



The Essential Guide to Overcoming Avoidant Personality Disorder

Martin Kantor M.D. 2010. 229 pages. Hardcover. ISBN: 978-0313377525. Santa Barbara, CA: Praeger/ABC-CLIO.

Reviewed by Dustin Chien, New York University

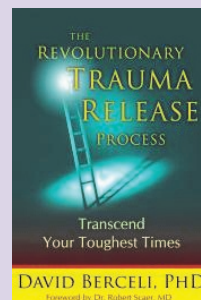
Using examples from a wide range of clinical cases, including patients, family members, and personal acquaintances, Kantor describes the characteristic symptoms of classical and atypical avoidant personality disorder (AvPD), the inner thought-processes of avoidants, and their maladaptive behavioral tendencies. Significant discrepancies are made to separate the overlapping qualities of AvPD and other disorders such as borderline personality disorder and social phobia. Multiple approaches using the DSM-IV, PDM, and other clinical theories are investigated and used to specify categories for the symptoms of the subtypes of AvPD. Kantor illustrates his therapeutic approach, which he terms "avoidance reduction," that combines developmental, psychodynamic, cognitive-behavioral, interper-

sonal, and existential-philosophical aspects of psychotherapy. He also includes a self-help manual that instructs patients through the avenues of change in overcoming AvPD.

The Revolutionary Trauma Release Process.

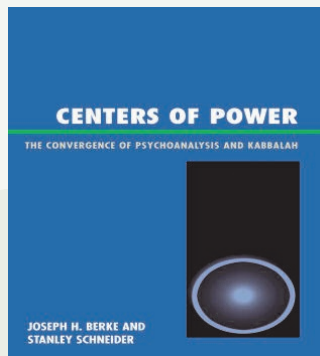
David Berceli, PhD.
2008. 207 pages. paperback. ISBN13: 9781897238400; ISBN10: 1897238401. Vancouver, Canada: Namaste Publishing.

Reviewed by Ryan Hendricks, New York University



Pa-

Dr. David Berceli uses a unique combination of personal experience, real-world examples, and an illustrative guide to discuss the concept of trauma and its treatment. The first section of the book primarily discusses the ways in which human beings become traumatized and global effects trauma has on their lives. Using examples such as Hurricane Katrina and his own experience of living in Lebanon during a time of war, Dr. Berceli draws connections between traumatic events and the body's natural instincts. From a simple observation of the natural reactions his body made while hiding in the basement of a building during a mortar strike, Dr Berceli formulated a new method for trauma treatment. Berceli's Trauma Release Process uses the natural instinct of the body to release energy through tremors to help treat the underlying trauma. Reasons why this method is effective are discussed in great detail with case examples showing the effectiveness. The second section of the book is focused on the actual trauma release process and includes a step-by-step guide for various exercises, with pictures illustrating each step, aimed at eliciting the natural tremor response of the body in an attempt to treat underlying tension and trauma. This book could be a great tool for body psychotherapists looking for additional therapeutic methods and for body workers in general.



Centers of Power: The Convergence of Psychoanalysis and Kabbalah

Joseph Berke & Stanley Schneider. 2008. 261 pages. Paperback. ISBN13: 9780765705013; ISBN10: 076570501X. Northvale: Jason Aronson.

Reviewed by Josué Cardona, Walden University

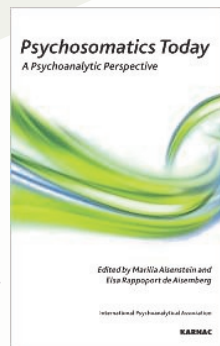
Berke and Schneider remind us that many of the “modern” ideas we use today are based on ancient and accepted concepts. In *Centers of Power*, the authors give a brief yet detailed history of psychoanalysis and Jewish mysticism, focusing primarily on the works of Freud and Jung and the teachings of Kabbalah. What follows is a series of discussions that continually interweave and overlap psychoanalytic and Kabbalistic ideas in a way that supports the authors’ claim that Kabbalah was one of the foundations of psychoanalysis. Whether you accept their theory or not, the parallels made are worth contemplating. Anyone with an interest in psychoanalysis or Kabbalah will find a detailed introduction of both along with a variety of perspectives from which to view them

Psychosomatics Today: A Psychoanalytic Perspective

Marilia Aisenstein and Elsa Rappoport de Aisenberg (Eds.). 2010. 211 pages. Paperback. ISBN 978 1 85575 861 2. London: Karnac Books Ltd.

Reviewed by Anna Kreiter, Binghamton University

As part of the Psychoanalytic Ideas and Applications Series compiled by the Publications Committee of the International Psychoanalytical Association, the authors aim to share with both clinicians and researchers in the psychoanalytic community and related fields, contemporary controversies in psychoanalytic theory and application, with a focus on psychosomatic diseases and the challenges they present to the psychoana-



lyst. The articles in this collection come from thirteen authors selected to represent the major themes in the field of contemporary psychosomatics. Each offers theoretical, clinical, original, and personal contributions.

Although the articles focus on contemporary psychosomatics, this book maintains close ties to classic Freudian thought and somatic symptomology: conversion hysteria symptoms; somatic symptoms of the actual neurosis; hypochondriac symptoms; and organized organic ailments. Post-Freudian trends and influences in psychosomatics are presented including, among others: Sandor Ferenczi and his work on the psychoanalysis of organic illness; Georg Groddeck, who proposed that the id could produce neurotic symptoms and character traits as well as somatic disturbances; and Franz Alexander and the research conducted by psychiatrists and psychoanalysts in the United States in the 1930s, leading to the founding of the Chicago School of Psychosomatic Medicine.

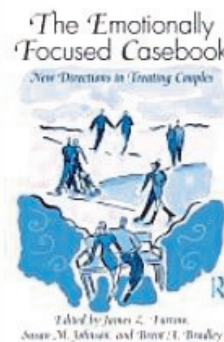
Psychosomatics Today includes an abundance of clinical material to support its focus on present-day practice, but the book is nevertheless informed by the fundamental papers and subsequent generations of psychosomaticists. The concepts reflect the varied psychoanalytical orientations of each author, which, in some cases, exposes the reader to different interpretations of one phenomenon. The inclusion of multiple frameworks lends itself to a discussion of what is fundamentally and “properly” human and the theory and practice that best supports it. The material encourages the reader to re-evaluate his own theoretical standpoint and interpretation of somatic phenomena.

The Emotionally Focused Casebook: New Directions in Treating Couples.

James L. Furrow, Susan M. Johnson, & Brent A. Bradley. 2011. 397 pages. Paperback. ISBN13: 978-0-415-99875-8. New York: Routledge.

Reviewed by Lindsay A. Blevins, Marist College

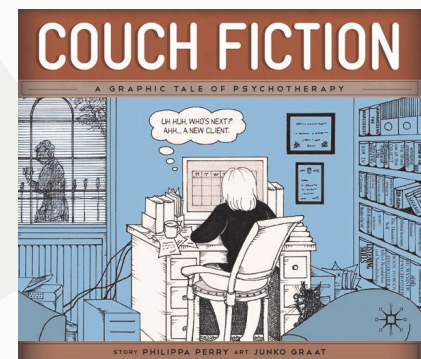
The Emotionally Focused Casebook is a resource for practitioners, instructors, and students. The authors provide in-depth insight into emotionally focused therapy (EFT), as well as strategies for the application of EFT in couples’ therapy. This type of therapy integrates the devel-



opment of a secure attachment with the rediscovery of clear communication and proper emotional expression. Together, these key skills assist couples in dealing with distress, i.e., daily pressures, infidelity, and traumatic events.

This book is the first of its kind to combine a variety of diverse applications of the EFT technique into one guide in order to be utilized for many unique concerns. It is divided into three sections: An overview of EFT (complete with possible challenges one might face when employing EFT), model dialogues of EFT for a variety of issues and circumstances, and ways to use EFT with certain populations such as culturally diverse couples and same-sex couples.

This casebook is not simply a complement to current EFT literature; it is a thorough and comprehensive guide to the inner workings of emotionally focused therapy and its practical benefits.



Couch Fiction

Philippa Perry with Artwork by Junko Graat. 2010. 149 pages. Paperback. ISBN13: 9780230252035; New York: Palgrave Macmillan

Reviewed by Aakriti Malhotra, New York University

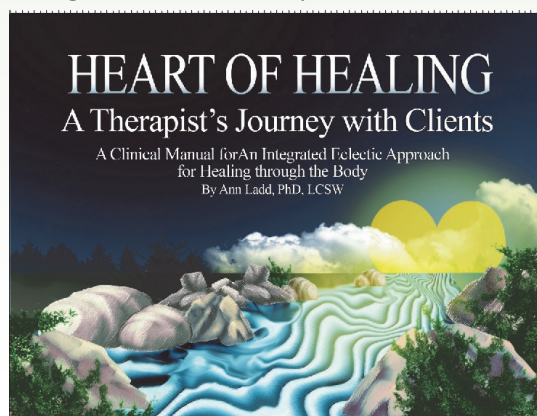
Philippa Perry created this graphic novel to help patients understand the process of psychotherapy from both sides of the couch. Her notes at the ends of the pages explain different theories, common mistakes made by Patricia, the therapist in the book, and interpreting the progress made by the client, James. Junko Graat’s illustrations give the book a lighter feel, while providing significant details that could not be expressed solely through text.

Books published by members

Heart of Healing: A Therapist's Journey with Clients. Ann Ladd. (2010). 279pp. Softcover. Pueblo West, CO: Self-published.

Reviewed by Sofia Vasilakos, New York University

Ladd creates a clinical manual that serves as a guide into the healing process of therapy through the body. Her manual provides body psychotherapists with Heart of Healing (HOH) insight on how wounding and healing happens, how to transform emotional intensity into deep intimacy, a step-by-step guide of mat process work, handling special cases of extreme, complex trauma, and finally how to use touch in the healing process. Ladd also provides "maps" of specific concepts that would aid body psychotherapists in teaching their clients about the various stages of healing. Ladd offers examples from her clients to illustrate the healing process. The HOH therapeutic approach is suitable for individual, couple, and group sessions.



The Miraculous Achievements of Bodywork. Ronan M. Kisch, Ph.D. (2011). 328 pp. Hardcover. Kindle. Bloomington, IN: iUniverse

Reviewed by Nancy Eichhorn, The Chicago School of Professional Psychology

The *Miraculous Achievements of Bodywork* documents the coming together of body, mind, and spirit and the making of miracles through "miracle-consciousness." Twenty-seven hands-on practitioners share stories of miraculous healings—moments where the improbable became not only possible but real. Faced with clients saddled with grave medical diagnoses, these practitioners came to the table with love and faith, skill and experience, a sense of knowing what is doesn't have to remain, and that life can change in an instant within the quantum/spiritual link between practitioner and client, between themselves and the Divine. Blindness was replaced by sight; death and life reunited to allow healing and release; chronic pain dissolved into physical well being; and the disabled walked unaided. Kisch's mission is to bring spirit back into the formula of psyche, and he does so based on the acceptance of a "certain mindset or frame of reference" (p. 285). Kisch challenges readers to open their mindset to the experience of miracles, to the phenomena that some discard as heretical and others embrace as truth and light. Through anecdotal examples, Kisch offers readers insight into the power of bringing our embodied consciousness and loving feelings to all aspects of our lives by connecting with the spiritual belief of oneness and honoring the Divine that runs through us all.

New Body Psychotherapy Publishing House



Courtenay Young has started a publishing house specifically for body psychotherapy entitled: Body Psychotherapy Publications. The title, he explained, might shift depending on which side of the Atlantic you're on—USA: Somatic Psychology Publications or UK: Body Psychotherapy Publications. According to Young, his intention is to:

- 1) reprint significant articles that focus on body psychotherapy that are no longer easily accessible and reprint these articles as an anthology: for example, *The History of Body Psychotherapy*; *The Science of BP*; *About Touch* in BP; etc.
- 2) provide a possible venue for new authors writing about body psychotherapy
- 3) have body psychotherapy themed articles translated from their language of origin into English and then published

Currently Young is working solo. However, he wants to collaborate with contributors (authors, editors, investors, translators, marketing suggestions, etc.) as long as "people are energetic and enthusiastic," he said.

Marketing plans involve a primary internet presence, with links and adverts from the USABP & EABP websites and similar organizational websites. "I also plan to use postcards and (possibly) bookstands at body psychotherapy conferences," he said. "The next significant step would be to get marketing through Amazon and Google. Very few books are being sold nowadays through bookshops."

Young has been writing and editing the first anthology which is entitled, *Historical Basis of Body Psychotherapy*. It includes essays and articles from multiple writers such as Barbara Goodrich-Dunn and Elliot Greene, Ulfried Geuter, Nick Totten, David Boadella, Bernd Eiden and Young. He has another three volumes in mind also incorporating multiple authors' work.

Submissions for the anthologies are invited. Standards match those of any Peer Reviewed Journal: proper English; abstract; key words; references, etc., with a length between 3,500 - 7,000 words. Ideally submissions will have been reviewed and published already. Young will publish the exact published article (with permission) or an earlier (or later) version. Extended articles, longer essays, small books and so forth are also welcome and will be considered for publication. Nothing will be published without the author's specific written permission, and authors will retain the copyright on the original material; the publisher will retain copyright on the published material; there will be specific arrangements about royalties, but these will not be high, Young said.

For information regarding this new publishing venture (authors, editors, investors, translators, marketing suggestions, etc.), contact **Courtenay Young at courtenay@courtenay-young.com**



~ N Eichhorn

A several main themes are leading our steps. Our first focus is to develop Body Psychotherapy as a professional modality and marketable brand. Our goal is to inform the public and the research world about Body Psychotherapy.

Our second aim is closely connected to the first—developing a common language between the sub modalities of Body Psychotherapy. Until now sub modalities have mainly promoted themselves. The result is that few people recognize all of the individualized names. In order to promote Body Psychotherapy (or Somatic Psychotherapy as it is called on the other side of the ocean) as a brand, we need to develop a common language and a common theoretical and practical base.

This leads us to our third theme—collaboration—which entails creating ways to contact and connect with practitioners who practice various sub modalities, training institutes, researchers and theoreticians and also different regions in the world.

One of the most exciting developments in recent months is the collaboration growing between the EABP and the USABP. SKYPE, email, and document sharing programs make keeping in touch and working on joint initiatives much easier.

The EABP Scientific Committee is organizing a Research Symposium entitled: *The Science of Body Psychotherapy: From Research to Practice and from Practice to Research*. It will be held on Tuesday, September 18, 2012, directly after the September Congress. They are developing contacts with colleagues from the USABP.

More information is available on the EABP website under the Scientific Committee. www.eabp.org/research-scientific-committee.php

For many years now, Serge Prengle has offered audio interviews with body psychotherapy practitioners which have been accessible on the USABP link entitled, Somatic Perspectives, some of which we have advertised in past EABP newsletters. Jacqueline A. Carleton has also been involved with this initiative since the begin-

ning, with interview suggestions as well as organizing transcripts. Herbert Grassmann is now joining the team, and Somatic Perspectives has become a joint USABP/EABP initiative. Plans are being developed for a new Trauma series. So check it out and enjoy the interviews: somaticperspectives.com/Congress

We welcome contact on any of these matters.

Lidy Evertsen

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International Body Psychotherapy Journal The Art and Science of The Body in Psychotherapy

Jacqueline A. Carleton, PhD

The United States Association for Body Psychotherapy (USABP) and the European Association for Body Psychotherapy (EABP), are pleased to announce their new peer reviewed journal entitled the **International Body Psychotherapy Journal, The Art and Science of the Body in Psychotherapy (IBPJ)**. Semi-annual publication begins in 2012. The online Journal will be available free to members of both associations.

The joint publication evolved from the U.S. Association for Body Psychotherapy Journal (USABPJ) in response to tremendous growth in the field of body psychotherapy worldwide over the past ten years. It fulfills a process started by Michael Heller and Christine Caldwell who initiated the idea for a joint journal many years ago. At that time, the USABP could not afford to participate. As negotiations floundered, Robyn Burns and I volunteered to start with a USABP Journal on a very modest budget. The USABPJ grew both in quality and in size as body psychotherapists found their writing arms. This has been an exciting 10 years as I worked to grow the USABPJ and forge links with the EABP, in which I was also an enthusiastic member of the publications committee. I am now looking forward to working with the new IBPJ Editorial Committee.

I enjoyed working with the Editorial Committee to hammer out a name and subtitle that captures the essence of our work. We are working on cover designs, administrative procedures, etc.

As the field continues to expand, the Journal's aim is to broaden its readers' horizons by inviting submissions of original theory, qualitative and quantitative research, experiential data, and case studies, as well as comparative and secondary analysis and literature reviews from clinicians and researchers practicing in all health care fields across the globe.

The Journal's mission is to support, promote and stimulate the exchange of ideas, scholarship and research within the field of body psychotherapy as well as encourage an interdisciplinary

exchange with related fields of clinical theory and practice through ongoing discussion.

Submissions for the first issue are due October 15, 2011 to jacarletonphd@gmail.com. They welcome submissions from beyond the confines of Europe and the US. See the Authors' Guidelines on both EABP and USABP websites for information. All identifying information removed from articles before being sent to three members of the peer review board. Comments will be forwarded anonymously to authors either accepting the article as written, suggesting revisions, or denying it for publication and suggesting possible alternatives. The IBPJ has an international Editorial Committee, an Advisory Board and a Peer Review Board.

The Editorial Committee includes: Nancy Eichhorn (USABP), Christine Hayes (EABP Secretariat), Michel Heller (Honorary EABP Member), Elizabeth Marshall (EABP), Jill van der Aa (EABP Board).

The International Advisory Board includes: Regina Axt, Joachim Bauer, Marianne Bentzen, Malcolm Brown, Fabio Carbonari, George Downing, Lidy Evertsen, Stanley Keleman, Rubens Kignel, Alice Ladas, Peter Levine, Jerome Liss, Clorinda Lubrano, Gustl Marlock, Frank Röhrich, Maurizio Stupiggia, Halko Weiss and Courtenay Young.

The Peer Review Board includes: Christina Bader (Switzerland), Jeff Barlow (Australia), Marianne Bentzen (Denmark), Fabio Carbonari (Italy), Ruella Frank (USA), Lawrence Hodges (USA), Inge Joachim (Germany), Rubens Kignel (Brazil), Alice Ladas (USA), Jerome Liss (Italy), Linda Marks (USA), Elizabeth Marshall (Germany), Marjorie Rand (USA), Frank Röhrich, Asaf Rolef Ben Shahrar (Israel), Nick Totton (UK), Halko Weiss (Germany), Courtenay Young (UK).

If you are interested in being considered for the Peer Review Board, translation skills welcomed, please send your CV, special areas of interest, language competencies and how many articles you would be willing to review per year to me at jacarletonphd@gmail.com.

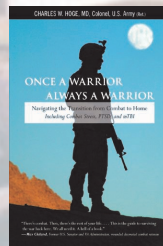
Crossovers

Writings, Media, and Alternate exposure to Psychological Themes

Reading books that talk to the experience of war, of the fighter facing day to day military tactics may help therapists understand more about what they are dealing with than reading a thousand treatment manuals. However, it must also be said that the experience of combat is not a universal theme for veterans seeking therapeutic intervention—many soldiers are also distressed by their lack of combat, the absence of danger, the lack of a sense of purpose when deployed to a rear area or not deployed while others fight the battles.

Books

- *War* by Sebastian Junger
- *A Rumor of War* by Philip Caputo
- *Horse Soldiers* by Doug Stanton
- *The Last Stand of Fox Company* by Drury and Clavin
- *Citizen Soldiers* by Stephen Ambrose
- *The Good Soldiers* by Finkel
- *Men Against Fire* by SLA Marshall
- *With the Old Breed* by EB Sledge
- *The Devil's Secret Name* by Jim Morris
- *On Killing* by Dave Grossman



Once a Warrior Always a Warrior: Navigating the Transition from Combat to Home

By Charles W. Hoge, M.D. Colonel, U.S. Army (Ret.)
This is a book written by an Army psychiatrist who directed the U.S. Military research program on the mental health and neurological effect of the wars in Afghanistan and Iraq from 2002 to 2009. The book is written directly for those that have served in these wars and it gives a plain language account of research, therapies, and interventions to help those who deal with the effects of Post Traumatic Stress Disorder. It also discusses transitioning from a war zone to home.

Dog Tags: Service Dogs for Those Who've Served Us

By Diana Houghton Whiting



The Dog Tags program provides Psychological Service Dogs to military veterans diagnosed with Post Traumatic Stress Disorder (PTSD), traumatic brain injuries (TBI) and/or physical issues resulting from active duty in Iraq and/or Afghanistan free of charge; donations cover the \$20,000 training cost.

The Dog Tags program placed its first service dog with a veteran in February of 2008. Since then, they have placed 21 dogs with veterans nationwide.

The dogs are trained to help their veteran owners with a myriad of tasks. Simple duties include reminding veterans to take their medication while more complicated roles include waking and comforting them from nightmares, placing themselves between the veteran and a crowd when they sense emotional overwhelm, and assuming a “vigilant” stance watching for people invading their personal boundary space and making adjustments.

The Dog Tags program is a subset of the Puppies Behind Bars (PBB) Program which was started in 1997 by Gloria Gilbert Stoga after adopting a Labrador retriever that failed the cut as a service dog. Intrigued by service dog requirements, she spent months researching the training, time, money, and effort involved. She then established PBB with the notion that those in prison owed it to society to help society. Eight-week-old puppies spend 12 to 18 months living and working with inmates. The dogs learn approximately seventy commands such as “block” (the dog puts themselves between their person and another person or crowd) and “light” (switching on and off a light).

Since the establishment of the Dog Tags Program, anecdotal evidence reflects the positive influence these canine companions have on their veterans. Researchers are now looking at the science behind what makes relationships successful.(1)

This program carries a secondary impact on the inmates training the puppies. They report that given the responsibility of a life, of teaching and being a good influence on another's existence has been reparative in their own life.(2) The unconditional love that the dogs give the inmates is in some cases the first time the person has felt loved.

For information visit: www.puppiesbehindbars.com/news.asp

<http://online.wsj.com/video/service-dogs-for-vets-unseen-injuries/B084423E-9AD6-419E-9583-00D805F861BC.html>

References:

- 1) <http://abcnews.go.com/GMA/video/marines-best-friend-12259219>
- 2) <http://news.bbc.co.uk/2/hi/americas/7522211.stm>



Nancy Eichhorn

Write to heal. In the given context, the act of writing is typically defined as journaling, which is often recommended as part of therapeutic treatment programs. However, the results are not always therapeutic. Trauma survivors often write horrific details while isolated on the blank expanse of a white page. Most are unable to regulate the immensity of the physiological overwhelm as they re-explore their terror. The end result is often re-traumatization. Journaling neglects the relational piece—the part of the interaction that involves an audience—someone to witness, support, provide a container to titrate the incoming information and bodily response.

Internet support groups, blogs, and writing groups have the potential to offer this support, depending on the structure and facilitator(s). While the experience may not be therapeutically designed nor intended, the impact of writing with others who know the truth, who have experienced similar situations and receiving their response, hearing them hear you, can have a powerful effect.

Real Combat Life is one such online forum. Its mission is to provide a place for veterans to “share their experiences and to educate the public on what life is like in combat from firsthand experience.” There

are stories, poems, pictures, links, and resources for active military personnel, veterans, their families and anyone else interested to learn.

The executive director, Patrick Nelson, started the website as a personal blog so he could share his military experiences. He had enlisted in the Na-

tional Guard right after his 17th birthday, then walked into the recruiter’s office the week of 9/11 and transferred to active duty. He was stationed in Babenhausen, Germany, for about six months then moved to Vicenza, Italy. After four years in Vicenza, he moved to Bamberg, Germany where he completed his enlistment.

“Between all of those moves, I was deployed three times: one tour in Iraq from March 2003 to March 2004, and two tours in Afghanistan with the first one from March 2005 to March 2006, and the second tour from May 2007 to August 2008. That makes for a total of 39 months out of 5 years,” he said.

When he came home, he said he was “sick” of responding to the same questions over and over again, and there were times he honestly didn’t feel like talking. Creating the blog gave him a point of reference, and it fulfilled two other needs: his passion for military history and the importance of capturing/archiving stories while the details were still fresh; and finding a release for everything going on in his mind.

“Although I may not have wanted to talk about it all the time, I had a lot going on and felt it was important to get it out in some medium,” he said. “I wanted my fellow Americans to know of the service and sacrifice of our brave warriors. I was disappointed at the media coverage as it only

focused on the negatives (i.e., 6 dead in IED strike, 2 KIA in ambush, etc.). I wanted to try to focus on what life was really like ‘over there’ from a first-hand perspective.”

Reading the postings and the responses on this website offer insight into soldiers’ experiences in the moment and back at home. Visitors are encouraged to share their responses and to ask questions either posting directly on the website after reading an entry or emailing Patrick Nelson at patrick@realcombatlife.com

To read their stories visit
www.realcombatlife.com



Photo by Sgt. Coltin Heller

Rockets on the Drop Zone

The forward operating base that I was stationed on my first deployment to Afghanistan was located far from any hard surfaced roads or large cities. Logistical support to our base was a nightmare and mainly consisted of helicopters and heavy drops by aircraft on a small drop zone outside the wire. We did have some jingle trucks driven by locals that would take a 3 day drive from the larger airbases to bring us some supplies. However, these trucks did not have any security and were often ambushed and hijacked. I even recall one brave driver who was shot in the shoulder but continued to drive on to our base. Once he arrived within our gates, he passed out due to blood loss.

We were shooting our howitzer cannons everyday and this required frequent ammunition resupplies. It soon came to the point that most of our ammo was coming in the form of para-

chute due to different variables effecting helicopter operations. Our drop zone was located just outside of our tiny base but required a good number of troops to quickly and effectively account for everything that was dropped. Of course we still maintained firing capability within the base . . . because you never know what will happen.

We had experienced several bundles “burning in” from our previous resupplies. A “burn in” is where a parachute does not fully deploy, thus the bundle burns in at a high rate of speed to the ground. It seemed that there was always at least one on every drop that burned in. This particular morning was no different as we geared up and prepared to head to the drop zone. We patiently waited on the edge of the drop zone as our Air Force guy made contact with the aircraft.

Continued on next page

Rockets on the Drop Zone continued

As the aircrew released the bundles from the back of the aircraft, we saw the all too familiar site of a bundle coming down with no parachute. As soon as all the other bundles hit the ground, we all divided up and began to account for all our new supplies. As I was working on one successful bundle, I heard a small "boom" in the distance and saw white smoke rising from a hill that was either in or on the border with Pakistan. We all knew what was coming our way and we just froze as we listened to see where it was going to impact. The all too familiar sound of an incoming rocket screamed in towards our position. The first one impacted a short distance away from where we were. However, there were still more that was coming and we were in one of the few flat areas outside of our base.

This flat area offered no protection what-so-ever. For some strange reason, I found myself hunkered down next to a bundle of 105mm high explosive artillery rounds. Of course I knew that if that was hit, that would be the end. It must have just been a reflex to take cover against something that provided some short of shield. As soon as the first rocket impacted, I realized my decision and quickly stood up and sought cover by an unarmored humvee that we had on the drop zone. From what I can recall, a few more rockets impacted but were not close enough to cause any casualties.

About a minute had passed as we dusted ourselves off and began to get accountability of all our personnel. All of a sudden, a much louder "boom" was heard coming from within our base. It took a second for me to register what it was, but I realized that it was my buddy Woogie and Deaner returning fire with our howitzers on the rockets point of origin. I like to think that we were already moving fast to get the bundles loaded up and back in to the base but the incoming definitely lit a fire under our rear ends and we quickly loaded everything and returned to the base.

I cannot say for certain that we were specifically targeted due to our position on the drop zone because many of these rocket teams will put the rockets on timers which enables them to be clear of the area when they are fired. They do this because of the quick, precise and deadly fire that we return on their positions. I do know that it

scared me pretty good as this happened after we had lost 2 soldiers to a rocket attack and 8 of us were wounded. However, this was just part of life for us on this deployment as we would continue to take rocket attacks on a consistent basis.

<http://www.realcombatlife.com/2009/12/30/rockets-on-the-drop-zone/>

Reprinted with the author's permission



Photo by Sgt. 1st Class Kevin Doheny



Photo by Pfc. Timothy Childers

For information visit
www.outwardbound.org
~ N Eichhorn

Free Outward Bound Wilderness Expeditions for Veterans

Post deployment veterans who have served in Afghanistan and Iraq can enroll in outdoor programs designed to be "physically, mentally and emotionally challenging in order to build the self-confidence, pride, trust and communication skills necessary to successfully readjust to life."

The goal is to help veterans build supportive communities with other vets; facilitate conversations on readjustment and transition challenges; and learn skills that bring back the energy and the life that active duty on the front line can destroy. The expeditions blend common wartime experiences (such as carrying heavy packs, sleeping outdoors and hearing strange noises, living with constant sweat, dirt, frustration and anger) with "authentic achievements" to revise the negative war time scenes stored in veteran's bodies with more "positive emotional and mental outcomes."

Outdoor activities are "used as metaphors for daily life. Many veterans experienced courage, brotherhood and a real sense of power and competence while in combat. Outward Bound offers Veterans the opportunity to re-experience these strengths in themselves in a different context, thus helping them to transition back to civilian life" (retrieved from <http://www.outwardbound.org/index.cfm/do/vets.about>)

One veteran who deals with the VA's military health system wrote that no other therapies resulted in such a "dramatic and immediate beneficial impact on my motivation, self-confidence, and overall state of mind."

Another said that this program, did to restore his ability to function independently and to think positively. He cited mixing physical and mental challenges with teambuilding and retrospective exercises helped him think of himself "not as a victim, but as a rescuer of myself."

According to the website, "Outward Bound's first courses for veterans were established through collaboration with Veterans Administration Post Traumatic Stress Disorder (PTSD) units to serve Vietnam War veterans. Outward Bound renewed the program in 2006 to serve Iraq and Afghanistan veterans, running one such course each year."

Outward Bound received a three-year, \$4.3 million grant from the Military Family Outdoor Initiative Project (MFO) in 2008. The grant, in addition to support from the federal government and others, allowed the number of veterans enrolled from 13 in 2007 to 1,400 in 2010."

Crossovers Continued

A Brief History of PTSD

PTSD has been documented in returning combat veterans since the early 1880s. While behavioral responses have primarily remained the same (i.e.: hypervigilance, startle response, flashbacks, insomnia, heart arrhythmias, the "1,000 yard stare," as well as co-morbid diagnoses of anxiety, depression, and substance abuse), the name official diagnosis has experienced numerous make-overs.

- 1880s: exhaustion after battle
- Civil War: soldier's heart
- World War One: shell shock
- World War Two: combat/battle fatigue
- Korean Conflict, 1952: DSM introduces stress response syndrome
- Vietnam Conflict, 1968: DSM-II offered situational disorder with a caveat that if symptoms persisted longer than six months the soldier was considered to have a pre-existing condition therefore the mental health issues were not considered combat related
- Post Vietnam, 1980: The DSM-III arrived at Post Traumatic Stress Disorder

Reference
Hoge, C. W., Castro, C. A., Messer, S.C., Cotting, D. I. Koffman, R.L., & McGurk, D. (2004). Combat duty in Iraq and Afghanistan: Mental health problems and barriers to care. *The New England Journal of Medicine*, 351(1).



Overall Statistics of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) (Afghanistan)

- Currently there are 1.8 million veterans of Iraq and Afghanistan wars
- 41% are between the ages of 18 and 25 years old

As of January 18, 2011

- Iraq had 4,427 deaths, and 32,900 wounded
- Afghanistan had 1,378 deaths and 72,666 wounded
- Total TBI 320,000
- Total PTSD 171,000
- Known as "The Long War." In its tenth year, this is longer than any conflict in American History

- U.S. Department of Veteran Affairs: 153 Veterans Hospitals, 773 outpatient centers

- 260 vet centers. Number of mental health professionals the VA employs is up from 14,000 in 2005 to 21,000 also now projecting 300 vet centers in rural and underserved areas

Post Traumatic Stress Disorder Current rates:

- Adult population in the United States 3 to 4 %
- Vietnam Veterans 15%
- 1991 Gulf War 2% to 10 %
- Somalia 8%
- Current Iraq War 15.6 to 17.1 %
- Current Afghan War 11.2 %
- If you add in anxiety increases (Iraq and Afghanistan) to 27.9%
- Army suicides set record in July
- The suicide rate now three times the rate of any prior military conflicts
- U.S. Army suicide rates surpassed the rate for the overall population
- And in July the 32 suicides included 22 active duty and 10 reservists
- In the first 7 months of 2011 there were 160 active duty and reserve suicides

Latest statistics from the VA: 6,500 veterans commit suicide each year. Slightly more than 6,000 troops have died in Afghanistan and Iraq since 2001.

Retrieved from http://www.linkedin.com/news?viewArticle=&articleID=700102895&gid=2788736&type=member&item=66040814&articleURL=http%3A%2F%2Fwww.washingtonpost.com%2Fworld%2Fnational-security%2Ffarmy-suicides-set-record-in-july%2F2011%2F08%2F12%2FgIQAfbGIBJ_story.html&urlhash=UMtz&trk=group_most_popular-0-b-shrtrtl

Post Traumatic Stress Disorder

Ode to Combat Boots

Nancy Tammik Smith

They stand at attention
Beneath his cot
In the crowded barracks
Ready to be deployed
Employed.
Combat boots and lacings,
Waterproofed, prepared
To face the elements
Natural and human.
Boots of rugged, thick leather,
With interior, reinforced
Heel protection
Will carry him to and through
Peaceful and violent missions.
The young soldier steps into
The weapons on his feet
Pulls them up with force
To mid-calf.
He aligns the lacings with precision
Grasps and firmly tightens them.
He ruminates over their impending role.
Boots prepared to confront
Diverse terrain, adversaries,
To pursue and evade them
Through rivers, mud, sludge, sand.
Boots to navigate through
Treacherous minefields,
The unseen enemy.
Footsteps as light as a bird's
Will determine the soldier's fate.
Next move
Forward, backward,
Left, right, halt.
Shoes of might will negotiate
Perilous crevices, ridges
Mountains, deserts
Dust storms, rain
Snow and ice,
Afghanistan, Iraq.
They will confront nature's extremes.
The soldier's friends, protectors
All will earn their return;
Some to their homeland
At the end of their journey,
With honor, stories, fatigue and woe
Other boots will carry their
Comrades to the
Most serene
turf,
To remain to-
gether as one,
always



It's Been a Long Walk Home

by "The Unknown Veteran for PTSD Awareness"

It's been a long walk home, I'm almost there,
I see that flash, I hear that scream,
I'm right back there again,
lost in that same damn firefight,

It's been forty years,
When will it end?
Every night it's that same damn
firefight,
We lost Sam and Bill,
Tag'em and bag'em,
we were told,
we'd never seen 'em again,
but every night, it's their faces that I
see,
and I ask myself why wasn't it me?

My name should be etched in that cold
black wall of stone,
It's been a long walk home,
I'm almost there,
But I hear that chopper so near,
Raining tracers down,
Can't they see us here?
Marine down, corpsman up,
But silence is all I hear,
Why am I the only one left,
Screaming GOD get me outta here?

It's been forty years,
I still see that day,
We were almost there,
The edge of the jungle,
I see that flash, I hear that scream,
Tag'em and bag'em, the list goes on,
Too many to remember,
It was their last firefight,
I'm the only one left,
Lost and running looking for my way
out.

It's been a long walk home,
My family, don't understand
When I say that this can't be real
Just let me wake up one time and this
not be,
But it's that same damn firefight every
night,
I wake up shaking like a leaf in the
wind,
Tell'n my wife that it was just a chill,
Not that rage to kill,
But she sees it in my eyes,

That same damn firefight,

It's been a long walk home I'm almost
there,
I was telling her good-bye,
When she realized I didn't fear death

anymore,
It was my life I was about to take,
She cried out for me to come out of that
jungle, out into the daylight,
Think of the kids and what this would
do,
She took me by the hand helping me
make that first step,
Coming out of that jungle into the day-
light,
It's been a long walk home,

Forty years and I'm almost there,
I see that flash, I hear that scream,
but this time it's a younger brother
yelling out,
trying to find his way out into the
daylight,
Out of that smoky fog of that same
damn firefight,

It's been forty years for me,
I see that flash, I hear that scream,
It's their pain that I feel,
Knowing that this damn firefight is not
real,
I'm here to help lead my younger
brothers out,
Not to walk forty years as I,
Lost in that same damn firefight of
PTSD!

Reprinted with the poet's permission.



To respond to this piece, visit:
<http://www.realcombatlife.com/2011/08/15/its-been-a-long-walk-home-by-the-unknown-veteran-for-ptsd-awareness/>

Grant Awarded

The International Association of Yoga Therapists received a \$30,000.00 scientific conference grant from the National Center for Complementary and Alternative Medicine. The grant will provide funding for the Symposium on Yoga Research to be held at the Kripalu Center for Yoga & Health. The award closely follows the momentous announcement that the International Journal of Yoga Therapy was added to the PubMed/Medline database of biomedical literature, which is managed by the National Center for Biotechnology Information, which is part of the National Library of Medicine at the National Institutes of Health.

In the News

The FDA proposes guidance for Certain Mobile Medical Apps

A draft was released in July by the US Food and Drug Administration (FDA) proposing limiting the scope of mobile medical applications including medical apps that:

- Are used as an accessory to medical devices already regulated by the FDA (i.e.: an app that allows a doctor to make a diagnosis after viewing an image on a smartphone or tablet)
- Transform a mobile communications device into a regulated medical device by using attachments, sensors, or other devices (i.e.: a device that would turn a smartphone into an electronic stethoscope or an electrocardiogram machine that can detect abnormal heart rhythms).

The FDA is seeking public input and accepting comments through October 20, 2011. Electronic comments can be submitted at <http://www.regulations.gov/#!documentDetail;D=FDA-2011-D-0530-0003>

For more information visit <http://www.regulations.gov> and reference: Mobile Medical Applications Draft Guidance; Public Workshop: Document ID: FDA-2011-D-0530-0003 Document Type: Notice : Docket ID: FDA-2011-D-0530

The American Association for Marital and Family Therapists is participating in the Alliance of Military and Veteran Family Behavioral Health Providers which is comprised of AAMFT clinical members and staff, representatives from government agencies and other mental health professions. The purpose of the Alliance is "to optimize the preparedness of behavioral health providers working to enhance the resilience, recovery and reintegration of Service members, Veterans, and their Family members and communities throughout the military, post-military, and family life cycle" (retrieved from <http://www.mamft.org/supportourtroops27.html>). Online resources for care providers include a guide that lists continuing education workshops available to MFTs, healthcare provider resources, and guides pertaining to domestic violence and family support. "Future activities of the Alliance will involve the development and dissemination of additional materials that will benefit MFTs who work with military and veteran families" (retrieved from <http://www.mamft.org/supportourtroops27.html>). AAMFT members who wish to join the Alliance can sign up by visiting the Alliance/Marriage and Family Counseling Collaborative (MFCC) website at <http://deploymentpsych.org/resources/marriage-family>.

The American Psychology Association (APA) is partnering with the University of Utah and its new National Center for Veteran's Studies to host a Best Practices Conference that will be focused on suicide risk assessment, management and treatment in active military and veteran's populations.

~ N Eichhorn

Webinars

Core Beliefs on Trial: A Cognitive Therapy Approach for Psychopharmacologists

Learn how your patients can put their distorted negative core beliefs on trial. Using techniques inspired by the famous author Franz Kafka, your patients can understand how their core beliefs are distorted by their internal prosecutor. Patients can reduce their anxiety by developing an effective internal "defense attorney."

Taught by **Irismar Reis de Oliveira, MD, PhD** Professor of Psychiatry, Department of Neurosciences and Mental Health, Federal University of Bahia, Salvador, Brazil, Post-Graduation Program, Professor Edgar Santos University Hospital, Salvador, Bahia, Brazil

Broadcast available on Friday, September 30, 2011. To register, call (888) 535-5600 (Join NEI—the Neuroscience Education Institute—and attend the webinar for free)

Register Now for the Fall 2011 NMT Case-Based Training Series

The Neurosequential Model of Therapeutics (NMT) Case-Based Training Series is a clinical case-based training experience **led by Dr. Bruce Perry**. Two formats are offered: live or recorded.

Each series consists of ten 90-minute case staffings in which Dr. Perry uses the Neurosequential Model (NMT) to conceptualize cases and illustrate the use of the model in a variety of clinical settings and situations. Dr. Perry and CTA Fellows teach on a variety of case-related topics. The training series is said to serve as a good introduction to viewing maltreated and traumatized children through the "lens" of neurodevelopment.

The teaching model is stated to be useful for helping clinicians and front-line staff better understand the neurodevelopmental principles involved in many of the primary symptoms as well as strengths in the children they serve. Their teaching model provides an opportunity for ongoing capacity building within an institution or for individuals. Also, the NMT Case-Based Training Series is a prerequisite for participation in the NMT Training Certification program and access to the NMT Clinical Practices Tools. Webinar specifics: All live sessions will take place of Fridays from 11:30 - 1:00pm CST. Recorded sessions are available the same day that each live session is conducted. Viewers can stop, pause and/or replay each session. Live sessions cost Organizations \$1,825 and Individuals \$650, recorded sessions cost Organizations \$1,525 and Individuals \$500.

For more information check out The Child Trauma Academy at www.childtrauma.org

To post news and webinars contact Nancy Eichhorn at MagazineEditor@usabp.org

Cruising for Credits



Debbie Bryan

Nancy Eichhorn

Unique-ness is coming to the forefront of military mental health care—psychologists, counselors, therapists and other allied health care professionals can now earn continuing education units while cruising abroad the Carnival cruise ship “Glory.”

The cruise line idea came over a year ago as Debbie Bryan sought ways to teach professionals how to deal with military mental health needs. A Vietnam Era veteran stationed in Germany in the mid 70s (a Specialist 4), Bryan worked as a pharmacy technician setting up IVs in the burn ward. She later became a Military Family Life Consultant along with her fellow teacher, Sallie Trecek. They have worked worldwide on military bases supporting airmen, marines, soldiers and their families. One or both of them often travels and works 45 to 90 days a stint meeting with soldiers in one-to-one counseling situations as well as with their family members. Bryan often works with children at stateside military day care centers and youth facilities just “hanging out and talking about their issues.”

“One young girl who was turning 10 years old shared that last year her father was in IRAQ on her birthday, and this year she just found out that her mother will be deployed missing her birthday,” Bryan said, emphasizing that it is a difficult time for families. Young children, ages 2 and 3 years old, have both of their parents deployed in IRAQ and are living with grandparents, aunts, cousins.

“Repeated deployments are creating an immense amount of stress,” Bryan said. She explained that veterans used to endure one or maybe two tours of duty. Today, soldiers, ages 18 to 55, experience four to five rotations, and it’s often not their choice. Furthermore, Reserves who signed up to support situations state side are being deployed to Iraq; many age 55 or older are facing active duty for the first time. Both the Reserves and the National Guard have been hit hard, Bryan said.

“Spousal pressures include both being deployed and feeling guilty about what they are missing, wondering what’s happening and being left at

home to manage the family and household as a single parent while wondering if their spouse is okay and will return okay,” she said.

Today’s trauma issues have also intensified because of advances in medical care. During the Vietnam War, soldiers with head injuries were often listed as fatalities. Today, with state-of-the-art interventions, soldiers are surviving with massive brain injuries, amputations, and traumas so horrific that many can’t speak about it. They are not only dealing with the war itself but also the abuse their bodies and minds have experienced. Many soldiers are living



Photo by Seaman Apprentice Tyler Wilson

with physical deformities and need constant care. Elderly parents are once again primary caretakers for their children with traumatic brain injuries.

“How do you talk about their missing leg, their brain injury, holding their buddy in their arms as he dies,” she said. “Therapists have to be present to be available for their clients, to stay focused on staying present with clients in the face of horrific terror. It’s very traumatic for the therapist to deal with their own issues that get triggered from the stories they are hearing. They have to live in the here and now to escape the tragedy and heal the pain.

“Counselors need to know just what to expect,” Bryan added.

She explained that therapists are dealing with a multifaceted culture to start with; adding in the military culture itself magnifies everyday issues. For instance, military life is often unstable.

If personnel are lifers, they generally move from base to base every few years so their spouses and children contend with continual separation issues. Families not living on base often experience feelings of isolation lacking the supportive community that base housing offers. Even people who live in small towns where their spouse may be the only person deployed often live in isolation. The war may feel like something intangible to their neighbors and friends leaving no one to turn to for support.

Financial issues also come up, Bryan explained, as some folks lose money with deployments while others earn more money than they ever have and uncertain how to handle their finances they get into trouble.

Because the war involves physical, social, emotional, financial and marital situations, Bryan designed the course content to cover an overview of this unique culture. She offers ways to work with military personnel and their families focusing on topics such as PTSD, divorce, mindfulness practices and children’s issues.

People from all over the country have attended Bryan’s classes over the past year, she said. The fall cruise will be the first time she is offering trainings in military care. The program is limited to 25 participants to facilitate networking opportunities—the program affords participants ways to learn how to approach military mental health care from multiple perspectives including nurses, physical therapists, ministers, doctors, and psychotherapists.

For information visit www.CruisingforCredits.com



Photo by Seaman Helen Frank

A New Clinical Psy.D. Specializing in Military Psychology

Nancy Eichhorn



ADLER
SCHOOL of Professional Psychology

Courtesy Adler School

The shortage of therapists equipped to meet military need has mental health associations joining forces with government agencies, universities and private organizations to focus on best practices for management and treatment in active duty, reservists, National Guard service members and veteran populations. Creative programs are being devised to train licensed therapists in military culture as well as evidence-based interventions for PTSD and traumatic brain injury, both of which are experiencing documented increases (PTSD is currently double the rate of prior conflicts) (Troiani, 2010).

While a plethora of stop gap measures continue to be discussed, the Adler School of Professional Psychology launched the first graduate program in clinical psychology with a specialization in military psychology this summer. Twenty-seven students representing a cross section of veterans and civilians have enrolled in the new five year track.

Developed by Joseph E. Troiani, PhD, MHA, MA, MSSJ, CADC, a retired U.S. Naval Commander, the curriculum is advertized as the first military psychology concentration in a Psy.D. program beyond the scope of doctoral programs at the Uniformed Service University of Health Sciences (Dept. of Defense and U.S. Public Health Service) Bethesda, Maryland. "Basically we're formalizing what we've been doing for the past ten years," Troiani said in reference to the new program.

Adler's elective track originated in part from a student group established in 2008 by now 2nd Lt. Mike Brennan. Brennan wanted to focus on military-related issues, so he gathered students under the tutelage of Dr Troiani to discuss combat stress, evidenced-based treatments, job opportunities in the military for enlisted as well as civilian psychologists, traumatic brain injury and treatment options for military families. The current program is designed to prepare students to enter into either uniformed services or work in the government or private sector providing services to current or prior military personnel and their families.

It is not about students experiencing actual conflict. The program's overarching goal is to shed light on what it is like being part of the military culture and to understand how that experience combined with active duty impacts service personnel and their families. Student will take courses such as Introduction to Military Psychology, defined as the science and application of human behavior as it relates to the military, to "gain an integrated understanding of the professional and scientific literature with the practical aspects of the field in order to provide a comprehensive understanding of the psychological needs of the military, veterans and their families," Troiani said.

Because the military has its own judicial system, students will learn about Mental Health Law and the Uniform Code of Military Justice. Another class focuses on the Department of Defense & the Veteran's Healthcare Systems as well as other local government units and private sectors providing services to military personnel, retirees and their families. As Troiani noted, the VA is the largest health care system in the United States with the DOD running a parallel second. Whether students sign up for active duty or work as contract psychologists, they must understand the VA and the DOD. There's also Mental Health Disaster Response, Special Topics in Military Psychology, and PTSD in regards to current research and best practices to intervene pre-deployment, in-theater, and post-deployment.

Guest speakers such as a former POW (now a full time therapist) captured in 1944 at the Battle of the Bulge when he was 18 years old and confined in a concentration camp come to talk. The National Veteran's Art Museum (formerly the National Vietnam Art Museum), which opened in the 1980s after the welcome home parades, is on the list of must visit. Once strictly filled with artwork from Vietnam vets, it has expanded to include vets from Operation Enduring Freedom and Operation Iraqi Freedom. Troiani noted that it was a powerful experience for students to walk down a hallway lined with 54,000 dog tags (belonging to soldiers

killed in Vietnam) and talk with veteran artists about their experiences.

The depth of the program is highlighted in two core classes: the Psychology of Combat and Conflict, and the Psychology of Terrorism. Troiani retired in 2010 from a 32.5 year stint as a U.S. Naval Commander in the Naval Reserves. As a Naval Intelligence officer, he worked as a terrorism analyst specializing in the Middle East. He was one of the few officers in his unit who also had a doctorate in psychology, as well as a Master of Science in Strategic Intelligence from the Naval War College. His primary assignment (2001 to 2010) was in Washington, D.C. where he taught graduate programs to the Naval intelligence community at the National Defense Intelligence College.

"We examined the psychosocial roots of terrorism," he said. The goal was to explore and understand the psychology of ethnic and tribal rivalry, the psychology of religious differences through a cultural lens, and to step back and look at the psychology and broad range of factors that contribute to create terrorist situations as well as suicide bombers. One course he taught focused on the psychological consequences of terrorism; it looked at the impact on victims and on secondary victims such as first responders and targeted populations. Troiani said he worked primarily with intelligence officers, 40% military and 60% civilian, from various governmental agencies such as the FBI and the CIA. "All the intell agencies as well as the State Department," he said.



Joseph Troiani, courtesy Adler School



According to Troiani, the first symposium on psychopathology and terrorism was held in 1979 at the University of Chicago. Questions such as who becomes a terrorist and why, have become the focus of current research as well as investigating the psychological grooming process that results in suicide bombers. Troiani noted there is a lot of psychological research available and cited a French investigator who was interviewing suicide bombers before they blew themselves up—he had a connection with Palestinian forces, Troiani said.

Along with Troiani, the Adler core faculty includes a 20-year veteran retiree, (Naval, Vietnam conflict), a former Air Force Intelligence officer stationed in Da Nang at the peak of combat, and the newest faculty member, a neuropsychologist from Bethesda Naval Hospital.

The Adler reading list even includes books by former graduates. *Wheels Down: Adjusting to Life After Deployment* was written by Adler graduate Bert Moore and C. Kennedy. Troiani said Dr Moore did two tours of duty in Iraq (for a total of 27 months) where he won a Bronze star. As a civilian, his is doing psychological resiliency research and writing, Troiani said.

Dr Troiani acknowledged the five year gap before this first cohort graduates (class work, dissertation and internship), and said they are looking at the possibility of an online certification program in Military Psychology for current therapists potentially beginning in the next academic year (2013-2014).



Photo by Spc. Edward Garibay

Psychological Impact of Combat

Heightened factors:

Excitement, war zone adrenaline
Radar trigger fingers
Death factor, confirming a kill
Thrill of danger, the rush of getting shot at and surviving

Stressors:

12 to 16 month deployments with 18 hour work days
4 to 5 tours of duty
Sleeping with a loaded weapon



Photo by Staff Sgt. Ryan Crane



Photo by Senior Airman Jessica Lockoski

Living in the field: extreme heat, cold nights, the rainy season, bugs

Surrounded by unpredicted sniper attacks, rocket and mortar attacks

improvised explosive device attacks (IEDs)

Firefights and hand to hand combat

Dealing with terrorist and insurgents who desire to die in the jihad (holy war)

Ongoing heightened vigilance and fear--Not knowing who the enemy is

Terror of combat --Your reaction when face to face with the enemy

Witnessing attacks against civilians

Gathering body parts after unit members step on landmines--

Witnessing the death of a fellow soldier

Grieving while still in combat

(Troiani, 2010)

Resources on Military Psychology and Treatment Options



Photo by Cpl. Charles Mabry

Military Psychology: Clinical and Operational Applications

Edited by Carrie H Kennedy PhD, ABPP and Eric A Zillner PsyD (2006). Guilford Publications, Inc ISBN: 1572307242

The role mental health professionals fill working with veterans is crucial—they need to understand the ins and outs of working within the military system. The essays in this anthology offer clinical applications for fitness-for-duty evaluations, suicide risk assessment and prevention, substance abuse treatment, and brief psychotherapy. Operational applications include such topics as combat stress, survival training, hostage negotiation, and understanding terrorist motivation.

Wheels Down: Adjusting to life After Deployment

By Bret A Moore PsyD ABPP and Carrie H. Kennedy PhD ABPP (2010). APA. ISBN: 978-1-4338-0872-2

This handbook for military service members is designed to help ease transition difficulties into "normal" life. Starting with the acknowledgement that they are "not the same person" they were before deployment, the authors (military psychologists) present a down-to-earth guide advising that one size does NOT fit all when it comes to making the transition. They offer tips for dealing with unwanted surprises like relationship break-ups, financial problems, and kids who are suddenly strangers as well as discuss commonalities with all returning vets like sleep disturbances, anger management, and learning to live with "hyperstartle." More intense transition difficulties are included such as identifying the signs of PTSD, living with disturbing memories, and seeking relief from suicidal thoughts. A final appendix is the definitive guide to support services for military members, with resources on everything from kid's books to financial management web sites.

Indiana National Guard Staff Sgt. Stephen Gillard of New Lebanon, Ohio, infantryman for the Security Forces Platoon, 3-19th Agribusiness Development Team, hugs his family Aug. 10, 2011, at Stout Field, Indianapolis, after returning from a one-year combat deployment to Afghanistan. Joint Forces Headquarters Indiana National Guard

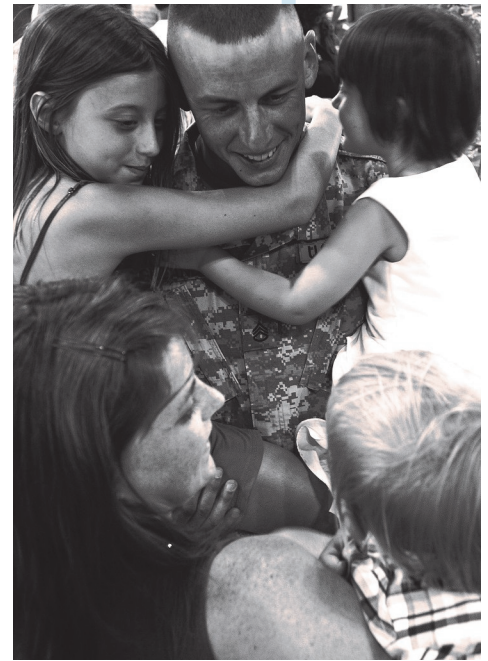


Photo by Sgt. John Crosby

Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military

Edited by Amy B. Adler, PhD, Paul D. Bliese, PhD and Carl Andrew Castro, PhD (2010) ISBN: 978-1-4338-0881-4

Essays in the text examine ways to moderate the negative impact of combat on military personnel and their families. Based on a broad occupational health model of prevention topics discussed include individual screening, training, peer support, leadership and organizational policies, as well as developing and implementing large scale mental health programs to enhance service members' well-being and resilience. Citations reference research on delivering mental health services in pre-deployment, in-theater settings, and VA hospitals. The publishers offer this book as "the first comprehensive review of mental health interventions across the deployment cycle and will help guide the field of military psychology in developing a much-needed support system for service members in the years to come."

Treating PTSD in Military Personnel: A Clinical Handbook

Edited by Bret A. Moore, Sally Johnson, Walter E. Penk and, Matthew J. Friedman. Available Oct 03, 2011. Guilford Publications, Inc. ISBN-13: 9781609186357

This handbook focuses on effective treatment and implementation for PTSD with service members and veterans—meeting this population's unique, specific needs. Norms and values of military culture are discussed as well as choosing appropriate psychosocial or pharmacological treatments ranging from prolonged exposure therapy to EMDR, virtual reality exposure therapy, group therapy. They also discuss co-morbid occurrences such as alcohol and drug abuse, depression, anxiety, sexual assault and traumatic brain injury and effective interventions.

The Veterans and Active Duty Military Psychotherapy Treatment Planner

By Bret A. Moore and Arthur E. Jongsma Jr. (2009). Wiley, John & Sons, Incorporated ISBN-13: 9780470440988

The Veterans and Active Duty Military Psychotherapy Treatment Planner offers empirically supported, evidence-based treatment interventions organized around 39 of the main presenting problems associated with treating veterans and active duty military personnel including substance abuse, adjustment to killing, anger management and domestic violence, pre-deployment stress, survivors' guilt, and combat and operational stress reaction. Over 1,000 treatment goals, objectives and interventions will help professionals develop formal treatment plans meeting health insurance mandates, third-party payers (CARF, The Joint Commission (TJC), COA, and the NCQA), and state and federal agencies. It is designed to correspond with The Veterans and Active Duty Military Psychotherapy Progress Notes Planner.

~N Eichhorn



War's Betrayal

Amber Elizabeth Gray

"War is war."

These words, spoken by a former client during one of our sessions, don't speak or spell the reality or meaning of the phrase. What my client meant to convey, not only with words but also in his struggle to tell a story of horrific pain, abuse, conflict and suffering, and in his courage to forge a restorative pathway through the shard-like minefield of memories that his body had become for him, was that there is no other experience on earth like war.

Sitting together in my office, he described his service, his capture and his torture-related suffering in terms of the most blood-curdling memories of physical and emotional pain and the ongoing pain of disconnect from his own humanity (body, mind, heart and spirit, as he said) and his external world—family, community, place.

As often occurs in the restorative process with survivors of violence and war (civilian and combat), therapeutic techniques are secondary to the primary purpose of coming together in the context of human relationship—restoring meaning and one's sense of belonging. Which then begs the question—where do we belong? And how do we know the meaning of our own belonging, or of any of our life experiences, if not through our own physicality? Quite literally, it is through the placement of our bodies that we locate and find ourselves.

When I am teaching the "uninitiated" about somatic psychology, dance movement therapy, or Continuum Movement, I always say: "The human body is the site of all human experience, from the most mundane to the most sublime." When we are exposed to the extraordinary violence of war or the types of physical violation and abuse that can accompany war (like torture), we cannot even begin to think about addressing their impact on our humanity without full inclusion of the body.

A Sniper's Story

I worked with a professional sniper who had served, proudly, in his country, and was captured by opposing forces and held for three years. As part of his captivity and torture, he was forced at gunpoint to snipe entire villages of his own women and children.

Notice your response to that last sentence, right now. When I share this story verbally, many people gasp, recoil, or say, "How could he?!" My answer is: "I don't know." And if I were asked, "How could he not do it?" I would answer the same: "I don't know." What I do know is that I am not willing to judge this act, and in learning to bear witness to the often untenable choices war demands any of us—civilian or soldier—make, I have learned that for both therapist or healer and client or patient, the body's role in the action, in the traumatic experience, in the

response to histories, and in the healing or restoration, is core to the therapeutic process.

My client lived in never-ending conflict. He had fled the country where his wife and three children lived (they all had to flee their home because of what he had done), and he was seeking asylum in the US. There was a warrant out for his arrest (and death) in the intermediary country. He wanted nothing more than to go home, to the belonging of his family. He knew he could never return to the belonging of his land.

He had interpreted and processed and intellectualized his actions over and over again. He continued to commit small acts of violence against others in moments when he "snapped" because someone said something provocative or challenging.

We talked and talked because he was unwilling, and at times, unable to enter the container of these experiences in the space of his own body. I partnered with other therapists—EMDR, CBT—and made small progress in terms of his tendency to snap. But, he was still ridden with conflict, angst, and at times violent moments. His biggest issue was: What to do? Where to go? Should he remain in the US, trying for asylum—and perhaps never see his beloved family again (they being a reason he chose to remain alive, despite the cost to his conscience)—or return to the place where his family resides, where his heart longed to be, risking death? This conflict tormented him emotionally and psychically, and physically. He had developed extremely dense musculature, and often described feeling "trapped in the hell" of his own body without movement or ability to breathe.

One day it escaped that he had an interest in yoga and had "dabbled." Being a one-time yoga teacher, I began to practice his favorite asana. He taught me; I taught him. The exchange—reciprocity—is essential to establishing any trust between two people. As yoga became a more integral part of our

work together, I began to invite him to notice sensations and internal bodily experiences in relationship to the asana, to his understanding of them, and to the meaning of them in his life. Strength. Accuracy. Truth. These were values he understood from our simplistic yoga practice, and these were values he cherished as a soldier, a sniper, a father, and a husband.

We revisited the memories—of family and home; of service to his country; of his annihilation of his own people—and the deep layers of embodied betrayal that are inherent to torture and some acts of war which can be at the root of the internalized and embodied conflicts of soldiers, torture survivors, and civilian survivors of war.

We cannot ignore the body. Any time I integrate any somatically based psychotherapy into individual or group sessions with veterans or civilian survivors, I learn how deep the violence can



Photo by Lance Cpl. Michael Petersheim

Amber Elizabeth Lynn Gray, MPH, MA, ADTR, NCC, LPCC, provides training and consultation nationally and internationally on clinical treatment for survivors of severe, interpersonal trauma. Her most recent roles include the following: Director of The Program for Victims of Organized Violence and Torture in Haiti; a psychotherapist at Rocky Mountain Survivors Center, Denver's torture treatment program, for almost six years as well as Clinical Director of the program for over three years. Amber is adjunct faculty at Southwestern College, and was Visiting Faculty at New York Universities Trauma Studies Program for three years.

Continued next page

be carried and how alone they can feel when their treatment ignores the very place that carries it.

Betrayal

Understanding betrayal is as core to working somatically as the body itself. One thing I have come to see in this work is that the most challenging cases are those in which the body becomes the betrayer. This is true for many survivors of torture because good torturers know how to re-wire the body and its endogenous rhythmicity in ways that betray our body's usual experiences (hunger, longing, desire, love, elimination) and the range of function and feeling we might otherwise take for granted. One can talk about betrayal conceptually, but to live and breathe it in one's own body undermines the meaning, belonging, and loving we all long for as humans.

Many service members and veterans who I have worked with speak of a betrayal and know its existence through the rages, the uncertainties, the fears, and the dark places their minds and souls go once they come home to a society that continues the betrayal. We have no right as a society or as a country to ask young (or old) people to fight a war and then bring them home to collective expectations that they will "be the same." It's even worse for those who experienced betrayal in their service.

As a collective, we owe it to those returning from wars, and those we welcome to the US as refugees fleeing persecution from war and violence elsewhere, to really bring them home, which means supporting their bodies (flesh, mind, heart and soul) to carry the experiences they have endured and to apply the skills they have acquired practically and functionally in the context of non war. As the VA and other organizations contemplate how best to provide support to our returning troops, and grapple with the emphasis on evidenced-based therapies and experimentation with alternative therapies, it seems clear to me, from many years as a clinician working with survivors of war, that the concept of practice-based evidence must be considered. Simply put: When I am challenged with the question, "How evidenced-based are somatic therapies?" My response is, "The evidence *is* the body. Without it—we are nowhere."

Transitioning

As my client learned to notice and observe his internal landscape through our yoga practice, I taught him many simple structured methods from the somatic and creative arts framework I teach. Working with spine, breath, contemplative practice, and his sense of weight as a metaphor for his presence, I gradually encouraged him to re-associate with his feelings of remorse, grief and loss for his captivity, for the things he had to do to survive his captivity, and his deep longing to be home. In slowly coming home to his own body, he recognized that his need to be with those he loved was the strongest, and the conflict he had carried for years began to smooth its ragged edges. He was able to feel and express his emotions, often with less verbiage than he originally used to express the rampant ruminations, and thought and belief patterns that weighed on his mind; in doing so, he also experienced greater lightness and range of motion in his entire body. He described "finding the core of who I am, and respect for myself as a person."

As he was able to connect the actual lived experience of his own body with the weight of feelings he carried from the past,



and locate himself, through sensation, weight, breath and gesture, in present time and space, he began to cultivate the ability to take action regarding his future. He shared how he practiced many of the somatic methods we did together at home, and in so doing he found ground for his thoughts and feelings. He said, "As I grow stronger, I also become clearer; and as I get clearer, I feel myself stronger."

He came in for his regularly scheduled session one day, and as I started to speak he put his fingers over his lips and hushed me. He then handed me a plant—one he had purchased as part of his "home-play" from a session where we encountered tenderness—and he bowed. Bowing was a full-body gesture of respect he had often spoken of, and only once demonstrated in our previous session. He said he did it when he was in despair in captivity and asked forgiveness of his God; he did it when he spoke of his love for his wife and children; and he did it when he recalled his fellow soldiers with whom he had served. In dance movement therapy, gestures and postures, especially in relation to others, are a key informant of the internal experience of both resource and traumatic memory. Bowing for him was a full-body gesture of the deepest peace and comfort because it could only occur when he was present enough to respect another.

I tried to speak again, and he hushed me. He said, "Remember, words can get in the way. I am speaking to you with my body. I'm going home. Thank you."

He bowed, and left.

I never saw him again. I have no idea, and

never will, what happened when he returned to his family, but because of his courage and commitment to unraveling the deep betrayal, the deep conflict and trauma his body held, I know he made the correct choice.



Amber was on the faculty at the Colorado Center for Social Trauma from 1999-2001. She is a graduate of The Naropa University Somatic Psychology program, and has a Masters in Public Health from Columbia University. She has over twenty-five years experience in human service and working with displaced people, refugees, and survivors of human rights abuses, and over 13 years experience working with survivors of civilian and combat-related war trauma, torture, domestic violence and ritual abuse. Her expertise is in the development of individual and community-based culturally congruent treatment models for trauma recovery that reinforce individual and communal resilience. She has presented nationally and internationally and provided training for health and mental health professionals and paraprofessionals on such topics as working with traumatized refugee children, models for the cross-cultural application of psychotherapy, innovative approaches to trauma recovery that integrate local, individual and community resources and traditions, clinical issues in work with survivors of combat, war and political violence, and stress management and secondary trauma for individuals and organizations serving survivors. She has taken her work to Indonesia, Darfur, Haiti, Kosovo, India, Croatia, Norway, Mexico, Sweden, Australia, Denmark, Lebanon, and New Zealand. She is Past President of the Board of Directors for TASSC International, Refugee Mental Health Coordinator for the Department of Health in New Mexico, and Director of Restorative Resources Training and Consulting.



Creative Struggling

Gregory Johanson



Ben showed up for a veterans' group feeling stressed and wound up, especially over issues of re-entry with his wife and four-year-old son post deployment. He knew he needed help but was not sure exactly what he needed, what sort of support would help him feel a sense of grounding and connection in his life again.

In my work with veterans, I have noticed that many are often terrified of the thought of becoming uncontained and hurting others, yet there is simply too much tension to find that quiet place of consciousness that can be compassionately aware of how one is organized. One of the somatically focused therapies I use helps clients become mindful in order to get distance on their experience, as opposed to being at the mercy of it. With war veterans this can be problematic because their bodies are so stressed from being hypervigilant and from holding back impulses and uncompleted action tendencies (Ogden, Minton, & Pain, 2006). This was Reich's (1961) main point, that tension or body armor masks sensitivity, and sometimes one does not want to be sensitive to certain signals that are causing distress.

One technique I have found to be helpful in such instances was devised by Ron Kurtz (1990) in his Hakomi Therapy called "creative struggling." It translates into doing something for someone that they are already doing for themselves, which means it is a form of nonverbal joining. With veterans it often means helping them hold back tensions in such a way that they can safely explore them and release them. Since holding tensions is normally unconscious, the awareness of the client is focused on the body, and not verbal meanings, which may or may not come later. What is creative in this process is that one is asked to struggle in a way that feels good, which serves to enjoin mindfulness of large motor muscle groups.

It is difficult to both be the one who tenses and the one who searches for the meaning of the tension at the same time. The therapist's instructions are constantly directed toward what feels nourishing, right, and positive as opposed to any form of a struggle of wills, of force against force. If one can struggle in a way that is satisfying on a bodily level, there is a welcome sense of release of tension, as in doing a satisfying stretch. The resultant reduction of stress feels good in itself on a physical level, so no harm has been done, and it often allows the spaciousness for internal emotional signals to arise that want attention.

Based on my experience working with vets, I feel that creative struggling is best done in a group setting where there is enough physical power available to provide a safe enough container that allows one to explore their impulses and fully engage their musculature. What follows is a transcript from a recent group session with Ben as he dealt with his current feeling state both cognitively and bodily. Ben has been with the group for two months now and has trained to take part in the creative struggling experience from a supporter's side. Today was his turn to feel that support from others.

Creative Struggling in Action

Ben: I find myself mad at the kid, nervous about what he is doing, and ordering him around like a recruit. I hate it, but I keep doing it over and over again!

Therapist: So, it seems that you are wound pretty tight. How about we use the group to do a little creative struggling, and see where that leads us?

Ben: Yah, getting physical is good.

Therapist: Okay, so let's all stand up.

You know the drill. Your buddies here can provide resistance for you in any way that feels right, that feels good. Notice if your body gives you any hunch about how we might start . . . or we can always just do something, and then check to see if it is right, or needs adjusting.

(There is no standard protocol for how one should struggle. It is highly unique to each individual. By asking the experimenter to access what is pleasurable, even though it might involve great effort, the process touches bodily-cellular information that is organizing the system and knows what it needs to deal with (Damasio, 1999). Some participants want to struggle against a force in front of them, or behind them. Some want force coming down vertically on their shoulders that they can struggle up against. For some, it is being pulled in two different directions at once. And, for others they want to move forward with resistance to their legs. It is all quite organic and unpredictable. So, the group members who have been trained in this technique stand around and wait for Ben to give precise instructions.)

Ben: It feels like I want to struggle against something in front of me.

Therapist: Okay. So, here is Ted providing resistance to both your right or left shoulders with his arms. Check that out and see if it is most right or not.

Ben: It is close, but I think it would be better with his hands more in the middle of the chest.



Photo by Petty Officer 3rd Class Kayla Jo Guthrie

(It is a good sign that Ben is mindfully involved in the process and listening to the wisdom of his body to be able to fine tune this adjustment, even though nobody knows what it might mean.)

Therapist: Okay, let Ted do that. (Ted puts his hands more in the middle of Ben's chest, and then Ben moves them with his own hands to be more directly over his heart.)

Therapist: So, that is closer to what is needed, huh? Experiment with struggling against the hands now, and notice if it feels resonant, or if something else is needed.

Ben: There is something about the arms that needs something.

Therapist: Oh. Would it be more like we could help you hold back from hitting, or hold back from reaching out?

Ben: It is more reaching out.

Therapist: Okay. You are a strong guy, so why don't we get two guys on each arm, and you direct them how it feels best to give you resistance.

Ben: Yah, it is like I want to reach out, but am holding myself back, so maybe they can do the holding back as I try to move them forward.

Therapist: Sure, let's do that. You adjust their holds so that it feels best, and let yourself move against the resistance when it feels right.

Ben: Oh, yes, this is good. Let me do this some more.

(Ben struggles in a satisfying way. Four more vets are involved to provide resistance around both legs to help him feel more safe, more contained, and he finally quits struggling with some satisfying deep breaths, and shows some signs of collapse.)

Therapist: Now it looks like your body wants to go the other way and lean against these guys. Is that okay to do that?

Ben: Yah, that's good. Wow. Much more relaxed.

Therapist: So, don't force anything, but just check to see what might be coming into you awareness.

Ben: It is a vision of my son . . . watching him in a park or something . . . and wanting to go and hug him . . . but, holding back . . . struggling against reaching out.

Therapist: (On a hunch) So, as you are hanging out there with that image, would it be okay if Ted put a hand back on your heart where you had it before?

Ben: Yah that would be good.

(Ted puts his hand back on Ben's heart, who adjusts it slightly, while two other vets are supporting Ben from both sides. Therapist and group stand with Ben in silent support and allow his unconscious to lead him where he needs to go. Emotion wells up in Ben's face all of a sudden, and he covers his face with both hands. The two vets on each side provide increased support.)

Ben: He could die! The bastard could die!

(The other vets nod their heads in the common knowledge that one they love today could be killed in the next moment or next day, and sometimes they just have to steal themselves against caring too much.)

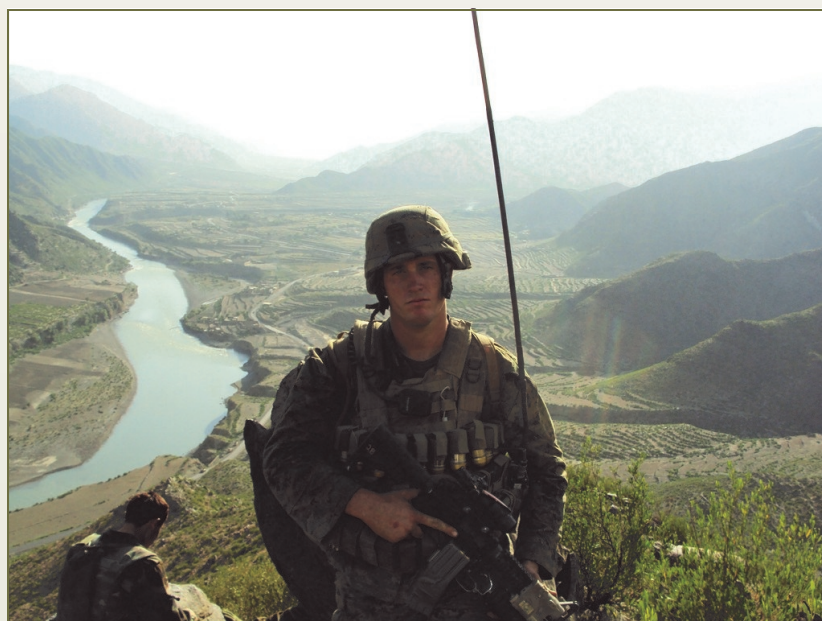
Therapist: Oh, so letting your heart go out to the little guy fully could leave you open to catastrophic heart wrenching grief, huh?

Ben: I don't know if I could bear it. I'd die or go crazy. . . . But, I don't want to live numb and cheat him out of a father . . .

The rest of the session deals with Ben's and everyone else's in the group profound and natural ambivalence about being vulnerable to love. The path to this core issue was facilitated by the body wisdom embedded in the creative struggling exercise that lowered the stress and tension enough to allow the issue to arise in a manageable way.

Greg Johanson, PhD has a background in therapy and theology; he is a member of the American Psychological Association and the American Association of Pastoral Counselors, a Licensed Professional Counselor and a pastoral psychotherapist with special interest in Integral Psychology. He has published over 150 items in his related fields, and is on the editorial board of six professional journals including the *Hakomi Forum* and the *USA Body Psychotherapy Journal*. He currently advises PhD students' dissertation work at The Chicago School of Professional Psychology and George Fox University D.Min.

Sgt. Dakota Meyer will receive the Medal of Honor for Valor on September 15, 2011 in Washington, D.C. from President Barak Obama. Stationed in Ganjgal Village, Kunar province, Afghanistan, Meyer is the first living Marine recipient since the Vietnam War.



Sgt. Dakota Meyer deployed during Operation Enduring Freedom



Masters of Arts in Somatic Counseling Psychology

Cohort Model: An Intimate Learning Environment

By going through the program together with their classmates, students have the opportunity to develop their interpersonal skills, identify their own patterns, and learn to offer and receive support and encouragement.

Experiential Learning

In a setting of collaborative inquiry, students engage in a learning process that focuses on making room for direct personal experience, application, and integration in the process of growth and professional development. Mindfulness and awareness practices are a foundation of the program, assisting students in making compassionate contact with their own experience. Experiential learning helps to embed these qualities in the context of working with others.

Engaged Somatics: Community-Based Learning/Citizen Therapist Model

Community-based learning is an educational strategy that incorporates meaningful service into students' understanding of what it means to become therapists in this world—therapists who understand the collective body, the community body. Community-based learning provides students with basic exposure to listening to the communities that they live in. It creates an opportunity to ask questions about what the needs of the various communities are and how students studying somatic counseling psychology can help. On the basis of their own interests and passions within the field of somatic counseling psychology, in addition to the answers they receive from the community, students will establish practicum and clinical internship placements in the mental health community. This process enables students, as therapists in training, to explore with the community what it means to be a citizen and an effective agent of change. Students will also receive assignments from various courses throughout the curriculum that integrate and enforce the symbiotic service relationship between the classroom and the community body.

Theoretical Knowledge

Theoretical approaches rooted in attachment theory, object relations, self psychology, creative systems theory, and Gestalt-based modalities serve as the common ground for all Somatic Counseling Psychology students. The theoretical portion of the program also focuses on the work of dance/movement therapists and body psychotherapists who have contributed to our understanding of how the body lives, heals, and transforms. The theoretical portion of the program also exposes students to an understanding of the neurobiology of relationship and the scientific underpinnings of somatic psychology born out of the fields of clinical neuroscience and behavioral medicine.

Clinical Skill

The department focuses on teaching the application of theoretical knowledge in the form of sound verbal and nonverbal clinical skills. Courses address the essential therapeutic skills of attention, listening, embodied responsiveness, attunement, intuitive and empathic response, and awareness of how to work with transference and counter-transference.

Professional Identity

Students are trained to manifest and practice ethical and professional standards for the fields of counseling and either body psychotherapy or dance/movement therapy. In addition, students will learn to accept and integrate supervision, self-supervise, and be effective members of a treatment team. The department is committed to inspiring students to become contributing members of the profession who can educate and introduce the work to the world at large. As a means of cultivating professional identity, students will learn to internalize values that respect multiculturalism and sensitivity to populations and individuals different from themselves.

Diversity and Service

Focusing on the important skill of manifesting pluralism and multicultural competency as an integral part of clinical and professional practice, courses create opportunities for students to examine their own culture, biases, and internalized oppressions. Courses are designed to prepare students to be of service to the underserved and disadvantaged members of their community and society.

During the course of their studies, students will study and learn how to appreciate ethnic, gender, age, class, sexual orientation, and racial differences in people's experiences of their bodies and their movement patterns.

Contemplative Practice/Mindfulness in Psychotherapy

Courses are designed to teach students how to use contemplative practices for personal and professional development and self-care, as well as be able to embed contemplative values and practices into their work as body psychotherapists or dance/movement therapists. Courses are designed to develop personal clarity and self-acceptance, allowing students to practice moment to moment embodiment, compassion, and discipline in therapeutic settings. Students are encouraged to engage in sitting meditation and to work with a meditation instructor throughout the program.



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To find out more about the Somatic Counseling Program follow this link:

<http://www.naropa.edu/academics/graduate/psychology/somatic/index.cfm>