

Military Culture and Body Psychotherapy: A Case Study

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Abstract

The military has its own culture and teaches it to all recruits as soon as they step onto their first training site. The norm within military culture is to suppress signals from the body in order to complete the task at hand. Therefore body psychotherapy (BP) is helpful for uncovering what the body holds to help facilitate healing in those that have experienced trauma. This case study explores the intersection of military culture, how veterans hold trauma, and how body psychotherapy can be used in the context of this culture to help the population heal from trauma.

Keywords: military culture, body psychotherapy, evidence-based practices

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Introduction

Military personnel come from diverse backgrounds and are brought together under a single culture with its own language and ethics. A cultural norm of “ignore the body to complete the mission” is ingrained in the veterans. Body psychotherapy (BP) facilitates healing by utilizing both mind and body to explore what memories the client holds. This case study examines the intersection of military culture and body psychotherapy, and how veterans can use BP to heal from trauma given their enculturation within the military.

The United States military culture is taught to all personnel the minute they step onto their first training site. For the enlisted ranks this happens in basic or boot camp, and for potential officers in military academy, the reserve officer training corps, and/or officer candidate school. Military values and ethics, bearing, customs and courtesies, as well as history of their branch of service, are all taught alongside control of emotions, mind, body, and discipline of the recruits’ actions and words (Halvorson, 2010). The military culture depicted in the pages below is a broad description of the principles and values taught to all personnel. There are differences in the culture for those who serve in the enlisted ranks versus officer ranks as well as differences in each branch, but this is a portrayal of the commonalities.

The mission during training is to transform the recruit from a civilian to a service member. The trainers break down the individual and then build him/her up in the image of their branch of service. The expectation is that all personnel will think and act similarly to everyone else (Volkin, 2007). The intent is to prepare these new service members by increasing physical and mental toughness and removing ego and pride so that they will follow given orders. Recruits are no longer individuals, but members of a well-oiled machine. This is ingrained in recruits and becomes part of who they are; when they leave the military to reenter civilian life, they tend to use this same mindset in their interactions in life, at work and at home.

Veterans are a diverse population, presenting different socio-economic statuses, races, ethnicities, genders, ages, sexual orientations, educations, and abilities. Many volunteered for the military and some were drafted into the armed forces. The common thread is service to their country and the culture of the military, which becomes the core of their mind, body, and spirit. Part of the training and expectations of the military person is that they will silence the body if it is fatigued or in pain, so that the job can be done and the objective achieved. How does this training and cultural expectation affect the body of a veteran? Is body psychotherapy a viable modality of treatment for trauma and posttraumatic stress disorder (PTSD) for this population?

Body Psychotherapy with Service Members

Body psychotherapy operates under the theory that there is a functional, nonhierarchical unity that exists between the mind and the body. “There is no living human without mind — no soma without psyche” (Totton, 2003, p.24). It is from this perspective that body psychotherapy uses the explicit memories (those held in the mind that can be examined and discussed) and the implicit memories (those stored in the body that are communicated through movement) in the healing process. When the therapist approaches the human body, he/she also approaches the human mind (Totton, 2003).

The military views the body of an individual as a tool, like a weapon or a vehicle. It is to be kept in good physical condition, making it as effective as possible. Unlike a vehicle or weapon, the soldier has a mind/body that remembers what has been endured. Body psychotherapy tries to uncover the messages transmitted by the body, helping the person integrate troubling or traumatic experiences and recover mind, body, and spirit.

According to the National Institute of Mental Health, trauma can be categorized in two types: physical and mental. “Physical trauma includes the body’s response to serious injury and threat. Mental trauma includes frightening thoughts and painful feelings” (National Institute of Mental Health [NIMH], n.d.). The criterion for a diagnosis of PTSD is that the person was exposed to a traumatic event which involved actual or perceived threatened death or injury, or threat to the physical integrity of self or others, and which can involve combat, natural disaster, or assault (Friedman, 2007). During the event, the individual experienced intense fear, helplessness, and/or horror. Later, he/she may experience intrusive thoughts, nightmares, and flashbacks that evoke emotional and psychological reactions perhaps months and/or years after the event. Many with PTSD may experience hypervigilance and hyperarousal during certain situations, which can cause them to take actions to create safety for themselves. Finally, the DSM IV states that the person must have experienced these symptoms for longer than a month, and may be dealing with social and/or occupational distress (American Psychiatric Association, 2000).

As a counselor at the Veterans Health Administration (VA), I heard many examples of these symptoms from clients, both in individual and group session settings. The majority of veterans report being uncomfortable with crowds and staying out of congested places such as stores or sporting events, and many have flashbacks and intrusive memories that can be triggered by a sight, smell, or sound. Most have had extensive training on weapons such as handguns and rifles, and they rely on this training to feel safe such as keeping a loaded weapon behind each door of their house. They can also feel the need to check the perimeter of their home multiple times a night to ensure the doors are locked and that no one is on their property. This can become a nightly routine with the perimeter extending further and further afield depending on their experience.

“We know that trauma has profound effects on the body and nervous system and that many symptoms of traumatized individuals are somatically driven” (Ogden, Minton, and Pain, 2000, p. xxviii). Many trauma survivors report coping with disregulated body experiences, and dealing with strong emotional and physical responses to situations or interpersonal contact. Many of these reactions cause distress to the trauma survivor, and their friends and family members. The veterans that I worked with discussed questioning their sanity, and feeling guilty about reactions to partners and children. A fair number reported multiple divorces, loss of long-term friendships, strained or nonexistent relationships with their children, and estrangement from parents and other family members. Trauma on its own can shift the individual’s perspective and make interactions between self and world more difficult, but military culture may also place its own communication barrier between the soldier and civilian society. The soldier learns a new way of speaking and reacting in the military, basically a language apart from civilians. Add trauma and the language shifts even more. Those that knew the person prior to his/her military service have no context for the person that the soldier has become.

Psychology Modalities and Trauma

There is a large body of literature that discusses military veterans, the stress of combat and potential for developing posttraumatic stress disorder (Dye & Roth, 1991; Gates et al., 2012; Marshall & Dobson, 1995; Ready et al., 2012; Sautter, Armelie, Glynn, and Wiet, 2011; Sherman, Zanotti, and Jones, 2005). Studies vary on the statistics of how many combat veterans will develop PTSD, ranging from 12-24% (Gates et al., 2012; Ready et al., 2012), with 40% of them suffering chronic PTSD symptoms ten plus years after onset (Sharpless & Barber, 2011). The overarching themes of the research are how the Veterans Health Administration (VA) serves military veterans, what types of therapies are offered, and recommendations about different therapies (Gates et al., 2012; Hunt & Rosenheck, 2011). There seem to be many articles on exposure therapies, specifically Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT), which are named most often (Karlin et al., 2010; Ready et al., 2012; Sharpless & Barber, 2011). The majority of the research also acknowledges the comorbidity of depression and anxiety with PTSD.

In addition to the evidence-based practices (EBP) that the VA offers to clients, there have been investigations of mindfulness practice, relaxation, and meditation (Perlman et al., 2010). One article discusses hope as a change mechanism, noting that veterans who report that hope has increased over the course of treatment for their depression and PTSD show a reduction in symptoms (Gilman, Schumm, & Chard, 2012). This research is correlated with the evidence-based practices of CPT and cognitive behavior therapy (CBT).

The evidence-based practices that the Veterans Health Administration has to offer can be categorized under the Western medical model of treatment. Body psychotherapy has not really been explored by the government and tends to be considered more unconventional. BP practitioners have had to provide their own research to prove the effectiveness of their therapies. The majority of body psychotherapy literature brings neuroscience into the discussion. This information seems to be missing from the articles written about trauma and the veteran population in the system of the Western medical model. Neuroscience is used to provide evidence that the body can be a repository of memories, holding trauma just like the mind does. These articles investigate the idea of a “bottom-up” approach to therapy, working with the body as a vehicle for healing, and comparing this to the “top-down” approaches that VA offers, which work with the mind and tend to ignore the body (Lopez, 2011; Madert, 2007; Ogden, 2003; Samardzic, 2012).

Many of the articles written about body psychotherapy (BP) and trauma are studies attempting to show the efficacy of different types of BP. These authors focus on specific courses of treatment such as Sensorimotor Psychotherapy (SP) (Langmuir et al., 2012; Ogden, 2003; Ogden & Kekuni, 2000), Bioenergetics (Helfaer, 2010), Spontaneous Healing Intrasytemic Process (SHIP) (Steenkamp et al., 2012), and Observed and Experiential Integration (OEI) (Bradshaw et al., 2011). These treatments discuss trauma at length and theorize about how trauma develops and how to treat it.

There is a small and growing body of work that talks about BP and veterans coming from U.S. government sanctioned studies. As is the trend with BP and trauma there are studies that discuss very specific types of treatments that fall under the BP umbrella. These studies look at healing touch, massage, craniosacral therapy, and biofeedback as vehicles for healing (Jain et al., 2012; Peniston, 1986; Price et al., 2007; Upledger et al., 2000). The majority of this literature also uses diagnostic instruments such as the Beck Depression Inventory (BDI-2), Beck Anxiety Inventory (BAI), and other PTSD measures to track the client’s progress or lack of progress toward relieving symptoms of PTSD.

Eye movement desensitization and reprocessing (EMDR) is a therapy that some consider to fall under the BP umbrella, and that the VA has embraced as evidence-based therapy. There have been multiple studies conducted that prove its efficacy in reducing symptoms of PTSD as well as depression, anxiety, anger, physical pain, and other somatic presentations (Rogers et al., 1999; Russell et al., 2007; Sharpless & Barber, 2011; Silver et al., 1995; Silver et al., 2008).

Along with the journal articles described above, BP with veterans is being explored in magazine articles, specifically *Somatic Psychotherapy Today: The USABP Magazine*. While not a peer-reviewed journal, it is a newly established magazine that produced an entire issue concentrating on how different aspects of BP could serve returning military veterans. The topics ranged from the role of early childhood trauma in combat psychology, to somatic experiencing and military mental health, to recognizing body sensations while treating combat veterans (Eichhorn, 2011; Hurley, 2011; Monell, 2011). These articles seemed to be the most current and all-purpose information about body psychotherapy’s usefulness with military veterans.

The VA has a culture of using therapies that have been studied and tested thoroughly, revisiting the evidence, and retesting the approach to verify its efficacy. Body psychotherapy has its own research/evidence-based review for its efficacy with trauma in general, but appears to be missing this sort of repetition. Just look at the meticulous framework the VA has set up for EBP. There is evidence that BP interventions can meet a trauma survivor’s presenting issues better than more traditional cognitive therapies (Eckberg, 2000; Ogden, 2003; Ogden et al., 2000; Totton, 2003). Is this as true with the veteran population as it is with civilian populations?

This has left me with many questions in regard to BP, U.S. veteran population and U.S. military culture, and EBPs provided by the VA. What would evidence-based body psychotherapy look like? How would it be structured, what are best practices related to using BP as a treatment modality at the VA? The VA tends to produce manuals and instructions on what is the best way to proceed with therapies offered to the veterans. How would BP navigate this communication trend that the VA has adopted? How can body psychotherapy use its own culture and work with the military culture present in the VA?

Case Study

The setting for this case study was the Veteran Administration Medical Center (VAMC) in Cheyenne, Wyoming which is part of the Veteran Health Administration (VA) system and is a government-run agency, employing many military veterans. Military culture is strongly woven into the policies, procedures, and approaches to healing those they serve. The veterans are

categorized as patients, utilizing a clinical Western medical model approach to this population.

In the military, expectations are outlined explicitly. If certain tasks are completed then promotions and commendations will follow. This formulaic approach is seen at the VA as well. If a certain therapeutic approach is used the expectation is that a certain result will happen. If one of the prescribed therapies is not successful then the provider goes back to the menu of approved approaches and tries another one from the list. These EBP options tend to include timetables for success, in the hope that the VA can motivate the providers to get clients in and out as quickly as possible.

The culture of the VA prefers therapies with a strong set of evidence to back up their effectiveness. In presenting this case study the hope is that a conversation will be started about evidence-based body psychotherapy as it relates to trauma in military veterans.

Client History

This case study covers ten weekly sessions. The client, Mr. J, is a 65-year-old, Caucasian male. He first served in the Army in the enlisted ranks, then became an officer a few years later. He is a Vietnam-era soldier, meaning that he served during the Vietnam conflict but did not serve overseas in a combat zone. He received his basic training in the late 1960's and served until 1978 when he requested and received a transfer to the inactive reserve with the rank of Captain.

Mr. J describes his upbringing as emotionally abusive and his parents as having had rigid expectations of him and his siblings. The family cultural norm was to rely on cognitive responses to situations and to suppress emotional expression. Intellect was valued highly in his family, and it was important to Mr. J that he be perceived as smart, hardworking, and extremely capable. The training he received in the military reinforced these same standards that were set for him in his family of origin. Additionally Mr. J has two college degrees, one in psychology and the other in electrical engineering. The one that he utilized most was the engineering degree which required a cognitive approach to most problems. This is how he tends to deal with issues to this day.

Mr. J has been in one form of therapy or another for fifteen years. He started with the VA system in the early 2000's and his therapists have utilized CBT, ACT, EMDR, meditation training, hypnosis, and 'body emotion desensitization' to help him resolve presenting issues. In addition to the emotionally abusive childhood with alcoholic parents, Mr. J was first responder to an accident that left his brother dead after being shot in the head. He was also a first responder during basic training when a mess hall exploded and he had to help render aid to wounded soldiers. When he was an officer, he once woke up in his bunk with a knife to his throat, and was able to talk the soldier down and get the knife away safely. On another occasion, he was held at gunpoint by a soldier who was on guard duty. The soldier was high on LSD and Mr. J talked his way out of that situation as well.

At the beginning of my internship at the Cheyenne VA I witnessed sessions facilitated by my supervisor before I starting facilitating my own. I watched my supervisor facilitate an EMDR session with Mr. J during the summer of 2012. As my supervisor and I debriefed the session later, we talked about a feeling in the room that we described as being cut off from our bodies. Mr. J has strong cognitive tendencies and can tend to ignore his body and physical responses. My supervisor agreed to let me work with Mr. J for a number of sessions using body psychotherapy interventions. The intent of these sessions was to see if BP could be used to help the client bring awareness to his body states and notice if there were sensations associated with the emotions he was working through.

Given the cognitive orientation at the VA, there was very little movement involved and my supervisor was the only person I had witnessed who tried to bring any body sensations or awareness to a session. I was curious to see what would happen with Mr. J if he got up and moved, redirecting his perspective away from cognitions and toward the body. My original intent was to do this for a few sessions and then have him sit with my supervisor for another EMDR session and see if anything shifted and if it did, what changed for him.

As we started to build a rapport and work together I saw an opportunity to have a more concentrated look at our sessions, document them, and turn them into a case study, having not seen individual case studies in the literature about veterans and body psychotherapy. I scheduled a meeting with Mr. J and my supervisor to discuss the possibility and we all agreed it would be interesting to see what the outcome might be. It was in the fall of 2012 that Mr. J and I started working with the understanding that the work was now for a case study. In reading about the military and talking with different veterans I had developed a better understanding of military culture and the military mindset. I was now curious to see if BP was a viable form of therapy for those who rely heavily on their cognitions and habitually suppress the messages their bodies try to send to them.

The setting for my sessions with Mr. J shifted over the course of the study. Each week we ended up in a different room or office around the mental health department. Sometimes it was a room where groups met and at other times we were in offices ranging in size from uncomfortably small to roomy. With each room came different furniture arrangements so that sitting and standing, video camera placement, and space to move differed from session to session. Our norm before the case study started was to sit facing each other and talk. I was titrating the idea of body states and sensations. I would notice hand gestures and other small body movements and I would also ask if he would describe sensations he noticed in his chest, back, and neck as he was talking about his different dilemmas and issues. My intent was to get him used to the idea of feeling into his body before we started any movements.

Mr. J tends to be hypervigilant, does not like surprises, and does not trust easily. It was important that I was explicit with everything that I was attempting and why I was suggesting different movements. Part of being open was giving the client copies of articles and papers I was reading relating to him and the case study. I believe that this helped to put him at ease as we started to go deeper into our work.

The Sessions

Our first session started in the same manner as our previous sessions, seated facing each other discussing what was present for him. Halfway through this session we stood up and started moving. The movements were small and I was very directive about what he should do. I asked him to hold his hands out in front of him, meeting my hands and pushing into me. We alternated from him pushing me away to me meeting his push with my own pressure. Mr. J reported that he felt a lessening of tension in his chest when he pushed me away and he had a fear response with tension and anxiety growing when I met his push.

Mr. J has stated in the past that it was dangerous for him to have emotional contact with his parents and that at an early age he learned to quickly hide his internal experiences. I was curious if these emotions were related to his tendency to feel safer by himself and the discomfort that came when I remained in contact with him. From what he reported, he had ample reminders that people are unsafe and that in some ways he is safer by himself. However, he also talked about being lonely and wanting companionship. He has had this struggle for many years; it is

very tender for him, and was brought up in multiple subsequent sessions.

The next three sessions worked with Mr. J's back and the *Five Fundamental Actions*. This movement sequence was created by Susan Aposhyan (2004) and has five different motions: yield, push, reach, grasp, and pull. Each of these motions has a corresponding meaning associated with it. The yield can be related to becoming grounded and connecting one's feet to the earth. In the push, a person is creating boundaries, learning to say "no". With the reach, there is exploration and desire, a curiosity to see what is out there. When grasping we think of making connections with new objects, people, and concepts. Finally, the pull is bringing new things into the person's life.

From what I have seen in the past, Mr. J likes to do things correctly, as quickly as possible. In working with his mistrust of most people and situations, I surmised that it would be better to demonstrate the actions first before walking him through the exercise. I did this with my hands, arms and upper body. I chose this expression of the *five fundamental actions* because it was easy to do standing or sitting and was the least dangerous way of moving for my client. There was a teacher/student feel to this but I felt it was important to help Mr. J settle into the exercise and work our way toward not having tutorials in future sessions.

As he was going through the sequence by himself I noticed that the reach was almost non-existent. After three times through the actions we talked about it and I found a prop for him to reach toward. He was able to find reach but when we talked about it again, he skipped over discussing it and talked about grasp and the meaning of it. I had to bring it up again for him to talk about it, but even then it was quick and he was off again on another topic.

When things were bothering the client his neck, shoulders, and back tensed pretty visibly. He described it and I have observed it as an involuntary response. He did this, and then noticed it had happened. As I was asking what it would be like if I were to walk around him and go to his back, he jumped back away from me about six inches, and said that he did not like the idea at all. At this point I felt that I did not want to cause him more distress and asked him if he wanted to go forward with the experiment or if he would rather we just talk about what it would be like. He said he wanted to go through the actual motions. I walked around his back, telling him what I was doing the entire time I was walking.

The exercise was repeated a few times during the session and he told me it got easier to withstand with each rotation. Toward the end I was not talking as much and just moved around him. As a final experiment I stood with my back to his and we talked a little in that position. With each suggested movement on my part, walking around to his back or standing behind him, he reported a shiver that went down his spine and stayed there for the entire time that I was behind him. It would linger there for a while even when I had moved to face him again.

He related the two attacks he had managed to endure successfully to his sensitivity to having his back exposed to others. Mr. J's hypervigilance tends to manifest with him keeping his back to a wall in public. He stations himself in the corner of a restaurant or other venues, keeps an eye on the exits, and can see all of the action going on in the space. Having anyone at his back causes a fair amount of tension and his physical response is to try to get his back covered as quickly as possible.

The fourth session put the *five fundamental actions* together with his back. I asked Mr. J to go through the actions with his back this time instead of his hands and arms. I also told him that I would not show him what to do and he was going to have to figure out how to accomplish the task given to him. He was hesitant at first and had to practice the motions with his hands as in the previous sessions. He wanted to remember them before he tried the new way of doing the actions, which he did with his back and shoulders. He noticed the muscles in his chest had loosened and that he was clasping his hands together when he was going through the

grasping motion. He reported a tension in his back as he was grasping and his stomach muscles tightening when he went to pull.

The fifth session was more verbal than the previous meetings. It was almost like Mr. J was self-regulating his experience to bring it to a more cognitive level. I felt that he was titrating the last few sessions and preparing for the next set of sessions and where we would go from there. There was a lot of verbal interaction and bringing it back to body sensation. He was able to name some body states, and he seemed to be more in tune with what was going on and was noticing things that he had not noticed in the past. He started naming his own movements and becoming curious about them as he did them.

The next set of sessions hit a couple of tender themes for the client. Mr. J's tendency was to change subjects quickly when he started feeling emotional about a topic. He was discussing his desire for a partner, someone to confide in and be a part of his life. As he was describing his past marriage and another relationship that was unsatisfying, he changed topics. This happened multiple times in session. I let him go with it for a while and then asked if he noticed what was going on. We went palm to palm again and I asked him to push on my hands any time he felt the urge to change the subject. This helped keep him on topic and we were able to work with the subject for longer periods of time. At the beginning of the exercise my arms were straight but by the end of our discussion my arms were completely bent. I wanted to stay in contact with Mr. J and not get pushed away so I stood my ground and let my arms fold more and more as he talked. I felt the client's tension between wanting to change the subject and his need to talk about his feelings. He was able to use me to motor through the topic and stay with the discomfort and vulnerability he was experiencing.

During this series of case study sessions we touched upon two of the traumas that happened to him in the military. These were when he woke up to a knife at his throat and when he had an M-16 pointed at his chest by a soldier on guard duty. He tells the story of each of these events and reports a choking feeling in his throat while he talks about what had happened. He tries to make light of the situation and tells them in a "funny" manner. I maintain two ways of thinking about these events: At first I thought he was choking down anger at himself and self-judgment about the situations. He was able to talk his way out of both situations and walk away unhurt — but I wonder if there was something else he wished he would have done that he did not do.

In the last two sessions we hit upon both of these events again. He mentioned the choking feeling in his throat and as we went further into the topic he mentioned there was another event he has never told anyone about. He said a lot of times he used the knife and gun events to talk about this other incident. I am curious if the choking sensation is about what he does not say, not allowing himself to tell anyone about what happened during this other trauma.

Evaluation of the Sessions

At the end of our first session he had noted that he liked standing and since then we started every session standing so it became rare for us to sit at all during any of our time together. Although neither of us made it an explicit rule, at the beginning of each session he would take up a standing position in the room as we started our work. Starting in this position seemed to help Mr. J notice his body more, and he is quicker now to notice his sensations and motions. As our sessions progressed over time, he would start to notice what his body was doing before I could ask or get curious about his posture or gestures that were manifesting at that moment.

One of the biggest themes that came up implicitly and explicitly was trust. Could he trust me, our work together, and how I might act and interact with him, as we deepened our therapeutic

relationship? It was a slow process with as much transparency as I could provide, to earn his trust. I also noticed that the more I disclosed about myself and my process, the stronger our rapport was. For him to trust we had to build a strong relationship of give and take. Bringing body movement into a session was a slow and careful process. First, we had to work with sensation and description before movement. There was still some shyness about movement: it was easier for him to ask for and receive a prescribed movement than to execute a spontaneous movement.

Family of origin coupled with military culture taught Mr. J that the safest place to be in his body is in his brain. Intelligence, logic, and persuasion were tools that he had used with great success for decades. He dealt with alcohol dependency in the past and I believe it was a tool to help him suppress his mind and body when his old coping strategies were not working well anymore. In seeking help for his dependency he started therapy and has been working with therapists ever since.

There were times during the my work with him that I would assign homework to Mr. J. When we were working with his back and the shiver response I asked if he could go with someone he trusted to a restaurant and sit with his back to the crowd. He chose his son, a martial arts black belt, to watch his back as he completed this assignment. He reported that he was able to do it and notice the shiver in his back and the impulse to grow eyes in the back of his head.

I also asked him to sign up for a tai chi class (a slow meditative physical exercise designed for balance and health) to see what it was like to move in front of others. Mr. J is close with his elder son, the martial artist, and admires his practice, the forms that they do and how his son talks about the benefits of this practice. When we talked about it, he was uncertain if he wanted to try it. He talked about a senior's golf class that he had signed up for and gone to previously. He noticed that a lot of the participants knew each other and he did not, so he chose not to go back.

In the tasks Mr. J undertakes he likes to be seen as minimally competent and prefers to be good at things. The tai chi class was something that he had never done before. Not only would he be moving in front of others, he was not trained or practiced in the activity before stepping into the class. He attended multiple classes and brought the movements into the sessions with me. He also became aware of body sensations while practicing these forms, describing different feelings with his in breath and out breath and how they corresponded to the different movements.

Throughout our time together I watched Mr. J get close to a tender emotion and then use his body to quiet his emotions and move into cognition. Now there is awareness around this tendency and he can name it after it happens. He is conscious of tension in his body, and how he holds it in his back, shoulders, and neck. He has also developed ways to relax and release this tension after he realizes it is there. There is still a tendency to change the subject when he is feeling emotional and this is something that can be brought up again in therapy and worked with.

The BP interventions that were brought into therapy have seemed to help the client bring awareness to his body, his emotions, and many of the different habits he has acquired over the years to quiet the feelings and sensations that he did not want to, or could not deal with. Mr. J can fall into depression and self-isolate as a way to cope with his lowered physical and emotional states. He reported that he felt his depression come back to a certain extent in the last month of our work. He had tried to wean himself off of antidepressants at the beginning of the study and was feeling the effects of this.

His doctor prescribed another anti-depressant. Mr. J has reported that even though he felt the urge to self-isolate again, he was going out and attending his classes, finding time to play golf, and picked up playing basketball again. He stated that he felt better after doing these activities and this helped him to stay active. He also traveled back to his hometown, a place he had avoided for many years. Mr. J then took time to travel around parts of the country to test out a desire to get out more.

Conclusion

Military culture and training can stay with a person even after leaving the service and can be brought into his/her civilian life. It can lead to problems down the road when the individual is confused by the messages the body is giving. Why is there pain in this part of the body? Why does my heart go a million miles an hour when I interact with other people? Why am I angry after I talk with most people? Why can they set me off with a look?

In our sessions together Mr. J made connections and found new information in the movements that he was working with. It became a tool to express a need while still discussing an emotional topic, and he was eventually able to talk about what was distressing him without changing the topic. It was tough for him to say the topic was tender and it was easier to show it by pushing into me and monitoring the need to express it.

The challenges in our sessions together were that both the client and I tend to be cognitive people and it was easy for me to let the session become about the talking. I had to be mindful about bringing in body psychotherapy interventions and utilizing them at the appropriate time while not becoming overbearing with them. Mr. J needs to trust those he works with and this trust comes slowly and is easily lost. Movement and sensation needed to be titrated slowly over time so that he did not feel like I was bulldozing over him in the sessions.

There was some countertransference that I was aware of as we worked together. Again, being a cognitive person myself I found it easy and understandable when he was telling a story. There are traits that he carries that remind me of my father and my husband (both engineers). There were times when I would feel like I totally understood where he was coming from or would get annoyed with him because he would remind me of them. I would have to check these and make sure the next question came from a place of curiosity instead of interpretation. I would go back to description when I had these feelings and go with what was in the room.

I believe that he was trying to be the "good" client on many occasions. There were times when I was curious whether he did what I asked because he was being the good client and I was in a position of authority or if it was where we needed to go. I checked this out with him and he suggested that both were probably true.

The study that I undertook was with one individual who had already had many years of therapy. He had come to me with some awareness of his body sensations, where he held his stress, and how his body held tension. He had been dealing with depression off and on for years, and it waxed and waned in our time together. Before we started Mr. J stated that his tendency was to self-isolate during down times and though he was still working with the symptoms, he reported that he has not given in to the urge to hide in his house like in the past. Overall he stated that he feels better and is pleased with the trajectory of our sessions together. I have seen a person who had previously been unaware of certain movement tags and habits name the motions as he did them. These brought him information and he was able to realize and name emotions and feelings that he had been unaware of before.

Many of the veterans who seek help at the Veterans Health Administration find themselves working with the evidence-based psychotherapy offered. These have been shown to be effective ways of treating PTSD and corresponding symptoms up to a point. The work with Mr. J demonstrates that body psychotherapy may be another way to help veterans cope with the traumas they have endured and help to instill a new way of thinking about the body and emotions. If approached properly the body's messages can become insights into why a veteran responds a certain way to situations, and not just something that needs to be ignored so that s/he can keep going.

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Diana Houghton Whiting has worked with trauma survivors of domestic violence, sexual assault, and combat veterans. She received her Master's in Somatic Counseling with a specialization in Body Psychotherapy from Naropa University in May 2013. She completed her internship at the VA Medical Center in Cheyenne, Wyoming April 2013. Diana has received EMDR level 2 training and was a victim's rights advocate at a Northern Colorado shelter for three years. Diana uses cognitive and behavioral therapies in conjunction with body psychotherapy interventions and specializes in trauma recovery and PTSD treatment. She is a member of the United States Association of Body Psychotherapy and American Counseling Association.
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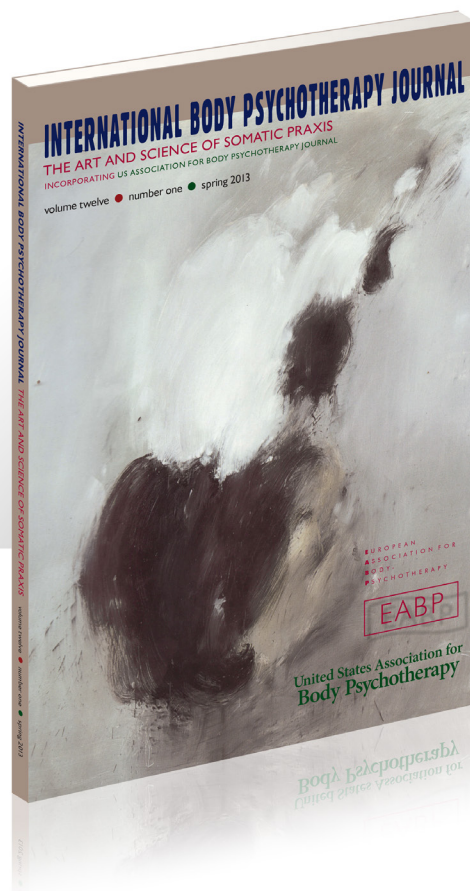
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REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Aposhyan, S. (2004). *Body-mind psychotherapy: Principles, techniques, and practical applications*. New York, NY: W.W. Norton & Company, Inc.
- Bradshaw, R., Cook, A., & McDonald, M. (2011). Observed & experiential integration (OEI): Discovery and development of a new set of trauma therapy techniques. *Journal of Psychotherapy Integration*, 21(2), 104-171. doi: 10.1037/a0023966
- Dye, E., & Roth, S. (1991). Psychotherapy with Vietnam veterans and rape and incest survivors. *Psychotherapy*, 28(1), 103-120.
- Eckberg, M. (2000). *Victims of Cruelty: somatic psychotherapy in the treatment of posttraumatic stress disorder*. Retrieved from <http://search.proquest.com/docview/42420993?accountid=28179>
- Eichhorn, N. (2011). Somatic experiencing and military mental health: An interview with Peter Levine, PhD. *Somatic Psychotherapy Today: The USABP Magazine*, 1(2), 12-14.
- Friedman, M. J. (2007). PTSD *History and Overview*. Retrieved from <http://www.ptsd.va.gov/professional/pages/ptsd-overview.asp>
- Gates, M., Holowka, D., Vasterling, J., Keane, T., Marx, B., & Rosen, R. (2012). Posttraumatic stress disorder in veterans and military personnel: Epidemiology, screening, and case recognition. *Psychological Services*, 9(4), 361-382. doi: 10.1037/a0027649
- Gilman, R., Schumm, J., & Chard, K. (2012). Hope as a change mechanism in the treatment of posttraumatic stress disorder. *Psychological Trauma: Research, Practice, and Policy*, 4(3), 270-277. doi: 10.1037/a0024252
- Halvorson, A. (2010). *Understanding the military: The institution, the culture, and the people*. Retrieved from http://partnersforrecovery.samhsa.gov/docs/military_white_paper_final.pdf
- Helfaer, P. (2010). Positive development for persons with traumatic spectrum disorders. *The USA Body Psychotherapy Journal*, 9(2), 26-36.
- Hunt, M., & Rosenheck, R. (2011). Psychotherapy in mental health clinics of the department of veterans affairs. *Journal of Clinical Psychology*, 67(6), 561-573. doi: 10.1002/jclp.20788
- Hurley, E. (2011). Recognizing body sensation while treating combat veterans. *Somatic Psychotherapy Today: The USABP Magazine*, 1(2), 15-16.
- Jain, S., McMahon, G., Hasen, P., Kozub, M., Porter, V., King, R., & Guarneri, E. (2012, September). Healing touch with guided imagery for PTSD in returning active duty military: A randomized controlled trial. *Military Medicine*, 171(9), 1015-1021.
- Karlin, B., Ruzek, J., Chard, K., Eftekhari, A., Monson, C., Hembree, E., Foa, E. (2010, December). Dissemination of evidence-based psychological treatments for posttraumatic stress disorder in the veteran health administration. *Journal of Traumatic Stress*, 23(6), 663-673. doi: 10.1002/jts.20588
- Langmuir, J., Kirsh, S., & Classen, C. (2012). A pilot study of body-oriented group psychotherapy: Adapting sensorimotor psychotherapy for the group treatment of trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(2), 214-220. doi: 10.1037/a0025588
- Lopez, G. (2011). Why verbal psychotherapy is not enough to treat posttraumatic stress disorder: A biosystemic approach to stress debriefing. *Body, Movement and Dance in Psychotherapy*, 6(2), 129-143. doi: 10.1080/17432979.2011.583060
- Madert, K. (2007). Behandlung traumatisierter mit körperpsychotherapie. *Analytische Psychologie*, 38(105), 336-359.
- Marshall, R., & Dobson, M. (1995). A general model for the treatment of posttraumatic stress disorder in war veterans. *Psychotherapy*, 32(3), 389-396. Retrieved from
- Monell, T. (2011). The role of early childhood trauma in combat psychology. *Somatic Psychotherapy Today: The USABP magazine*, 1(2), 10-11.
- National Institute of Mental Health [NIMH]. (n.d.). Helping children and adolescents cope with violence and disasters: *What parents can do*. Retrieved from *Helping children and adolescents cope with violence and disasters: What parents can do*. (n.d.). Retrieved from <http://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-violence-and-disasters-parents/index.shtml>
- Ogden, P. (2003). *Building somatic resources: The theory and practice of sensorimotor psychotherapy in the treatment of trauma* (Doctoral dissertation, Union Institute and University). Retrieved from <http://wwwlib.umi.com/dissertation/fulcit/3081058>
- Ogden, P., Minton, K., & Pain, C. (2000, October). Sensorimotor psychotherapy: One method for processing traumatic memory. *Traumatology*, 6(3), 149-173. doi: 10.1177/153476560000600302
- Pavlovic, R. (2009). [Review of the book Trauma and the body: a sensorimotor approach to psychotherapy, by P. Ogden, K. Minton, & C. Pain]. *British Journal of Guidance & Counseling*, 514-516.
- Peniston, E. (1986). EMG biofeedback-assisted desensitization treatment for Vietnam combat veterans posttraumatic stress disorder. *Clinical Biofeedback and Health*, 9(1), 35-41.
- Perlman, L., Cohen, J., Altieri, M., Brennan, J., Brown, S., Boss Mainka, J., & Diroff, C. (2010). A multidimensional wellness group therapy program for veterans with comorbid psychiatric and medical conditions. *Professional Psychology: Research and Practice*, 41(2), 120-127. doi: 10.1037/a0018800
- Price, C., McBride, B., Hyerle, L., & Kivlahan, D. (2007). Mindful awareness in body-oriented therapy for female veterans with post-traumatic stress disorder taking prescription analgesics for chronic pain: A feasibility study. *Alternative Therapy Health Medicine*, 13(6), 32-40.
- Ready, D., Sylvers, P., Worley, V., Butt, J., Mascaro, N., & Bradley, B. (2012). The impact of group-based exposure therapy on the PTSD and depression of 30 combat veterans.

- Psychological Trauma: Theory, Research, Practice, and Policy*, 4(1), 84-93. doi: 10.1037/a0021997
- Rogers, S., Silver, S., Goss, J., Obenchain, J., Willis, A., & Whitney, R. (1999, January-April). A single session, group study of exposure and eye movement desensitization and reprocessing in treating posttraumatic stress disorder among Vietnam war veterans: Preliminary data. *Journal of Anxiety Disorders*, 13(1-2), 119-130. doi: 10.1016/S0887-6185(98)00043-7
- Russell, M., Silver, S., Rogers, S., & Darnell, J. (2007, February). Responding to an identified need: A joint department of defense/departments of veterans affairs training program in eye movement desensitization and reprocessing (EMDR) for clinicians providing trauma services. *International Journal of Stress Management*, 14(1), 61-71. doi: 10.1037/1072-5245.14.1.61
- Samardzic, D. (2012). Trauma and the body: The somatic experience in psychotherapy. *Dissertations Abstracts International: Section B. Sciences and Engineering*, 73(2-B), 1265.
- Sautter, F., Armelie, A., Glynn, S., & Wielt, D. (2011). The development of couple-based threatment for PTSD in returning veterans. *Professional Psychology: Research and Practice*, 42(1), 63-69. doi: 10.1037/a0022323
- Sharpless, B., & Barber, J. (2011). A clinician's guide to PTSD treatments for returning veterans. *Professional Psychology: Research and Practice*, 1, 8-15. doi: 10.1037/a0022351
- Sherman, M., Zannotti, D., & Jones, D. (2005). Key elements in couples therapy with veterans with combat-related posttraumatic stress disorder. *Professional Psychology: Research and Practice*, 36(6), 626-633. doi: 10.1037/0735-7028.36.6.626
- Silver, S., Brooks, A., & Obenchain, J. (1995, April). Treatment of Vietnam war veterans with PTSD: A comparison of eye movement desensitization and reprocessing, biofeedback, and relaxation training. *Journal of Traumatic Stress*, 8(2), 337-342. doi: 10.1007/BF02109568
- Silver, S., Rogers, S., & Russell, M. (2008). Eye movement desensitization and reprocessing (EMDR) in the treatment of war veterans. *Journal of Clinical Psychology: In Session*, 64(8), 947-957. doi: 10.1002/jclp.20510
- Steenkamp, J., Jaco van der Walt, M., Schoeman-Steenkamp, E., & Strydom, I. (2012). Introducing SHIP as a psychotherapeutic model to access the body memory of traumatized clients: Depathologising expressions of trauma. *South Africa Journal of Psychology*, 42(2), 202-213.
- Totton, N. (2003). *Body Psychotherapy: An introduction*. Philadelphia, PA: Open University Press.
- Upledger, J., Kaplan, B., Bourne, R., & Zonderman, R. (2000). The effects of Upledger craniosacral therapy on post-traumatic stress disorder symptomatology in Vietnam combat veterans. *Subtle Energies and Energy Medicine*, 11(2), 123-143.
- Volkin, M. (2007). *The boot camp survival guide*. Retrieved from <http://images.military.com/Recruiting/BootCampSurvivalGuide.pdf>



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