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 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.
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 (Helfer, 2010), Spontaneous Healing Intrasytemic Process (SHIP) (Steenkamp et al., 2012), and Observed and Experiential Integration (OED) (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 EBP’s 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 timeframes 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 he 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

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’s neck, shoulders, and back tense 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 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.

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.

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.
BIOGRAPHY:
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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We welcome you to this exchange and to a celebration of the many methodological approaches and cultural stances in the understanding of human beings that Body Psychotherapy represents.

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