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Introduction

We soldiers of the U.S. Army's First Cavalry Division are silhouetted from behind by a full moon. The year is 1971, and it is a typical hot, steamy, insect-infested jungle night. We are doing guard duty at an army encampment in Bien Hoa, South Vietnam. Armed with rifles, machine guns, and grenade launchers, we are positioned along a berm protecting our unit behind us. M18 Claymore mines, which explode in the direction of intruders, are laid in front of us and can be set off through hidden trip wires by anyone trying to sneak up on us. I am 22 years old, one of the elders in our unit, and college educated. Most are teenage high-school grads. Drafted into the army after graduating from college—and no longer protected by a student deferment—my sentiments are very much antiwar and anti-Vietnam involvement. Nevertheless, once in the army, I volunteer to go to Vietnam out of some misguided desire for adventure and to gain firsthand experience about war.

And then, at that instant in the still of that hot night, I hear something that sends fear to my core. I hear the unmistakable sound of someone crawling through the bush in front of us and toward our position. My heart is now racing unimaginably fast as I try to insert an ammunition clip into my M16 rifle. The full moon has lit us up from behind, making us easy targets. We are about to die.

We're trapped because we have been ordered to not fire our weapons without permission because of disturbing civilian casualties that have taken place. To fire so that we may protect ourselves and save our lives, we are required to call on a military field phone to headquarters and obtain permission.

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Alternative Therapies for PTSD: The Science of Mind–Body Treatments, by R. W. Motta

Whispering on a phone in the dead quiet of night would give away our position so that we would be even easier targets than we are now. I am desperately trying to insert that ammo clip into my rifle while keeping my head lowered, but I am shaking so badly that the action is almost impossible. I know and fear that a bullet from an enemy AK-47 assault rifle will, in the next millisecond, hit me straight in the head. I will die here. My intense rush of fear is soon accompanied by an overwhelming sadness and sense of disbelief:

> This is it. I'm going to die in this stinking jungle. Can this really be happening? I'm going to be delivered to my poor, poor mother in a green plastic body bag. What a waste of life, what a waste of a good education. How stupid, how wasteful, how sad! How could I let this happen to me by volunteering? Look what I've done.

Suddenly, gunfire erupts from somewhere. It is not clear. It is confusing. And then the night opens up with machine-gun fire, rocket-propelled grenades, grenade launchers, M16s, and AK-47 assault rifles. I am firing away with my M16 rifle, and then the clip is empty. I pick up a grenade launcher and start firing grenades in the direction where I heard the crawling. All hell has broken loose. A nightmare of unimaginable chaos takes hold. Total and utter confusion surrounds us. Rifle fire and explosions seem to be everywhere. And then, as often happens in these firefights, the shooting and the ear-splitting chaos slowly begins to subside, and we wait for the approaching dawn. We find nothing when the sun rises. There is no doubt that someone or something was out beyond our Claymores because they have been set off and exploded. We don't care. We are alive. We survived, and that is all that matters. We have survived one more day in what was euphemistically called the "Democratic People's Republic of South Vietnam." All I want is to go home, but I have gut-wrenching doubts that I ever will. I've aged years in one night.

The memories of this event and similar events are seared into my brain and will remain there until the day I die. The feeling of imminent death, of being trapped by our orders not to fire, and of the moon lighting us up for easy targeting is part of my being. It is part of who I am. I fear this kind of confinement, this life-threatening entrapment to this day. In that instant, on the verge of death, in that unbearably hot jungle environment, I was transformed from a naive antiwar activist into an animal. This newfound self, this animal, cared about only one thing: survival. This transformation is what posttraumatic stress disorder (PTSD) is really about, and it takes place regardless of whether the trauma involves war, rape, natural disaster, mugging, sexual abuse, the observation of horrific and deadly scenes, and many other overwhelming experiences. Fear and entrapment are critical elements of PTSD. PTSD transforms people in negative ways, and these transformations can last a long time, perhaps a lifetime.

As I write these words, I feel myself welling up with emotion. The memories of that night are as vivid to me today as they were more than 4 decades ago. These memories, these transformations of self, are why those with PTSD live

both in this world and in a world they once inhabited. They lead a double life. They often feel like imposters in this world of laws, justice, and predictability. Part of them inhabits another world, an insane world of fear and chaos. Traumatic experiences are overwhelming, impossible to grasp, and totally negating of any sense of fairness, reason, or constancy.

Despite the altering experience I just described, I was one of the supremely lucky ones. I take no credit for not coming home in a bag. It was just luck. I came home physically alive but emotionally dead. I suppressed the trauma of war, went to graduate school, and became a psychologist, researcher, and professor. The director of the doctoral program to which I had applied, Julia Vane, told me that my application material arrived soiled by mud, given that it was mailed from what we referred to as "the boonies." To this day, I continue to carry the guilt in knowing that more than 58,000 Americans just like me did not come home alive. They came home in body bags, and it was simply the roll of the dice that allowed me, a volunteer, to make it home and do something with my life and help others. My personal experiences with PTSD and my research and practice have provided guidance in understanding and treating traumatized adults and children. I now direct a university-based trauma clinic for children and families.

THE SEARCH FOR ALTERNATIVE METHODS FOR TREATING PTSD

After many years of practice, research, teaching, and supervision, I've come to the conclusion that despite our well-intended efforts, there are serious problems with our ability to treat PTSD. I don't pretend to have the answers to what the best ways are to treat this disorder. Nevertheless, I am aware of the limitations of our current methods and am equally aware of the need for alternatives to traditional modes of treatment. My experiences in Vietnam and my professional experiences have served to provide guidance and understanding in treating the disorder of PTSD. I hope to share some of those insights in this book on alternative and complementary treatments for PTSD.

Like many who suffer the effects of trauma, I did not realize I had PTSD when I came home, and I didn't even know what PTSD was. My view was that I was a survival machine trying to pass as a hardworking doctoral student. My nights were filled with dreams of war and sleeplessness. The Fourth of July, as you might imagine, was a real problem and left me dysfunctional into the next day.

I coped with my unrecognized PTSD primarily by the method most traumatized individuals use: avoidance. I tried to not allow thoughts of the war enter my mind, and I immersed myself in my studies and drank to deaden the pain that my body was aware of but my mind rejected. This avoidance continued for years. And then, unwittingly, I benefited from a form of graded exposure therapy: confronting the trauma in little steps—in my case, by teaching and

doing research on trauma disorders. I took up the alternative treatments advocated in this volume. Regular exercise, meditation, and yoga are among my tools. Yoga came last because I was not comfortable with the concept of uniting body and mind, and increasing the awareness of both. Lack of awareness and avoidance seemed to have served me well for many years. Unfortunately, avoidance is a short-term gain for a long-term loss strategy. In the short run, avoidance allows one to not deal with anxiety-provoking memories. In the long run, the memories and pain persist because the person has not dealt with them.

The thought of going for treatment at a Department of Veterans Affairs (VA) facility and being provided with cognitive behavior therapy (CBT), prolonged exposure therapy, and therapy groups was, and to some extent still is, too much to deal with. As a person who has experienced PTSD, I've chosen a gentler approach for myself, for my clients, and in our trauma clinic. These more tolerable approaches include some presented in this book as alternative therapies. They are primarily nonmedical alternatives to traditional psychotherapies. More directive and confronting approaches of traditional therapies most often lead to clients' becoming overwhelmed and fleeing therapy.

OVERVIEW OF THIS BOOK

I have selected the alternative approaches to the treatment of PTSD to include in this book because they meet three important criteria:

- They have been shown to ameliorate the symptoms of PTSD.
- They have amassed a degree of empirical support that allows them to not be considered the latest "fringe" method of treating problems.
- They do not place a heavy emphasis on reconfronting one's trauma experience in painful detail.

Although traditional therapies emphasizing the confronting again and processing of trauma experiences are considered gold standard treatments, they produce such a high level of avoidance among trauma sufferers that their utility is significantly compromised. Trauma therapists are often desperate to find effective approaches to treating PTSD that do not send their clients fleeing from therapy because of the extreme levels of anxiety that treatment often evokes. It is hoped that the approaches presented in this volume will become useful tools for clinicians and researchers in treating PTSD and in understanding the empirical bases of these methods.

Chapter Contents

Each chapter includes the following:

- overview of the intervention,
- description of the treatment process,

- case example,
- empirical research supporting the particular alternative intervention, and
- summary.

Chapter 1 attempts to give readers a succinct view of what PTSD is and how it often alters the self-view of the trauma sufferer. In addition, the critical role of avoidance, which is one of the diagnostic criteria of PTSD, is highlighted as a central factor that explains why trauma sufferers often stay away from traditional forms of psychotherapy. The anxiety that the traditional methods evoke often translates into quitting therapy. I review specific CBTs and address the need for alternative approaches.

Chapter 2 discusses eye-movement desensitization and reprocessing (EMDR). Although EMDR is now recognized as an empirically supported treatment for PTSD by many professional organizations, including the American Psychological Association, it continues to be viewed with suspicion and doubt perhaps because it does not fit into traditional learning theory explanations for why it works. Its methods and procedures bear few resemblances to traditional CBT treatment; as a result, the majority of therapists often reject EMDR, and academic and research communities especially shun it.

Chapter 3 covers yoga, which has become increasingly popular as a mode of intervention for those suffering from PTSD. It is likely that it is popular among trauma sufferers because yoga does not require anxiety-provoking recall and reprocessing of trauma experiences. PTSD often results in a separation of physical, emotional, and mental states, and yoga emphasizes and facilitates their integration. Trauma-sensitive yoga is a particular modification of yoga techniques that has been found useful in treating PTSD.

Chapter 4 presents mindfulness meditation as a discipline that trains individuals to focus on the here and now, and reduce ever present mind wandering. This training is particularly important for PTSD sufferers, whose minds are frequently drawn to painful recollections and images of their distressing experiences. Specific meditation techniques that enhance perceptions of control and tranquility include the mountain meditation, lake meditation, and the loving-kindness meditation. Overall, training in mindfulness improves one's control over distressing and intrusive thoughts as it enhances the ability to focus on the present and to produce tranquil states of mind.

Chapter 5 highlights recent findings on the unexpected value of physical exercise in reducing PTSD and accompanying anxiety and depression. Although it is unclear why exercise, and particularly aerobic exercise, is of value in reducing PTSD, research suggests that physical and mental states are inseparable and, as a result, physical exercise, by necessity, enhances emotional well-being. The chapter presents research showing PTSD reductions through exercise for children, adolescents, and adults.

The utility of natural environments and the presence of animals are addressed in Chapter 6, especially in regard to their utility in helping veterans and other traumatized groups with the management of their PTSD. Interacting with animals helps to develop a capacity to connect emotionally, and being in

the presence of natural environments reduces the high anxiety and distress levels of those with PTSD. Dogs in particular have been specifically trained to ameliorate specific PTSD symptoms and are certified for that purpose.

Chapter 7 covers the use of acupuncture in treating PTSD. Evidence of the value of acupuncture in reducing pain is substantial, and the World Health Organization has endorsed acupuncture as a valid pain intervention. The chapter reviews recent studies demonstrating the use of acupuncture in reducing PTSD. Western medicine has no generally accepted explanation for the effectiveness of acupuncture, but Eastern medicine attributes its beneficial impact to the unblocking of the bodily and spiritual energy, qi (pronounced *chee*). Western researchers appear to be at a loss as to why acupuncture alleviates both psychological and physical distress, and yet it does.

Chapter 8 covers a relatively new alternative therapy for PTSD: EFT, or emotional freedom techniques. Rather than using needles as in acupuncture, EFT involves a body-tapping sequence that the trauma sufferer or client performs while making statements of self-acceptance and self-affirmation. The chapter details the mechanics of how EFT is done and also presents the empirical evidence, including meta-analyses, that support its efficacy in treating PTSD. Despite supportive evidence, EFT, much like EMDR, has encountered resistance from traditionally trained clinicians and researchers.

Chapter 9 reviews the use of 3,4-methylenedioxymethamphetamine (MDMA), which goes by the street name "Ecstasy," in treating PTSD. The effectiveness of MDMA for ameliorating trauma-related disorders is so compelling that the U.S. Food and Drug Administration has fast-tracked it for approval. Its primary impact is that it promotes feelings of empathy and compassion, and it allows PTSD sufferers to confront their traumas without undue anxiety. Given the large number of treatment-resistant cases of PTSD seen at VA medical centers, this labor-intensive treatment could actually prove itself economically viable in contrast to existing, often unproductive psychotherapeutic treatments that go on for years.

Chapter 10 provides a summary of strengths and weakness of all the alternative therapies for PTSD covered in this book. It also touches on other emerging therapies that have not yet garnered strong empirical support.

The Appendix provides readers with written, video, and other Internet resources that they may find useful for treatment planning and research. Given the ever-increasing numbers of people who suffer the cruel psychological impact of trauma and PTSD, the field is clearly in need of treatments such as those covered in this book.

Key Considerations for Alternative PTSD Treatments

Despite the value of these alternative approaches to therapy, which are sometimes referred to as CAM (complementary and alternative medicine) approaches, I don't believe one ever completely overcomes the impact of trauma just as one never really overcomes the impact of grief. Grief involves the

loss of a loved one; trauma, the loss of the self. It is hoped that the approaches presented in this volume are helpful to those who are in the position to treat traumatized individuals and will serve as a vehicle through which those who have been traumatized can find a little peace.

CLOSING THOUGHTS

A telling occurrence is worthy of mention point. I recently bowed to the pressures of my wife and visited our local VA hospital after 47 years of having avoided the VA at all costs. Just driving there created so much anxiety that I was *dissociating*, that is, temporarily losing awareness of where I was going or why.

A psychiatrist interviewed me. It is difficult to put into words how troubling this interview was because intense emotions were the dominant theme during this meeting. I became highly upset when asked questions like, "Did you see dead bodies?" "Did you see dismembered or mutilated bodies?" "Did you shoot anyone?" "Did you feel you were going to die?" "Do you feel guilty that you came home and others did not?" "Describe your nightmares." To say this meeting was troubling is the height of understatement. I couldn't have fled that "mental health" office fast enough. The aversion I felt toward this directive, confronting style of interview bordered on extreme revulsion and energized the urge to escape as quickly as possible.

This traditional confronting approach, which is used in many therapies, creates such a level of aversion that most traumatized combatants, including me, stay as far away from the VA as possible. Alternative approaches to dealing with PTSD are clearly needed.