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THE SAN DIEGO PSYCHOLOGIST

The Official Newsletter of the San Diego Psychological Association

In this issue

President's Corner

by Annette Conway, Psy.D.

On October 2nd, 2017, Americans woke up to the horror of one of the worst mass shootings in U.S. history. This was, and continues to be a stark reminder of how often we have witnessed similar tragedies unfold in recent times. Among the many who experience vicarious trauma from such events are helping professionals, including (but not limited to) paramedics, police officers, physicians, nurses, lawyers, social workers, and psychologists who work with the victims and their loved ones. We often focus on our professional responsibilities by listening to our clients recall traumatic experiences, which in turn may affect our thoughts, feelings, and behaviors. Working with trauma survivors can shift our beliefs about the world as a meaningful and safe place. One way we can reduce the risk of vicarious traumatization is to ensure we are taking time for self-care. Avoiding isolation and connecting with professionals who understand the experience of working with trauma is helpful, as in maintain a healthy lifestyle consisting of exercise, healthy eating, meditation, yoga, spending time with loved ones, listening to music, taking time off from one's practice, and, so forth.

The 2017 SDPA Fall Conference entitled, ***Innovations in Trauma Treatment: What's Outside the Box?*** is another helpful resource in understanding trauma, helping those affected by trauma, and preventing trauma contagion. We have 19 distinguished speakers and 20 exhibitors, along with activities such as yoga, massage, live music, a book raffle table, exhibitor Bingo, and a casual networking buffet lunch. Dr. Bonnie Goldstein, a senior trainer of the Sensorimotor Psychotherapy Institute, and Dr. Constance Dalenberg, Distinguished Professor of Psychology at Alliant University, will be the Keynote Speakers. We welcome you and look forward to offering

you a stimulating agenda of continuing education, professional development and networking opportunities.

The Holiday Party/SDPA Awards Ceremony/Installation of the 2018 Board of Directors will be held on Sunday, December 10, 2017. The event is Free to all members and one guest, with the purpose of enhancing our professional and social networks. Giving the awards is a way SDPA can recognize and encourage excellence in the mental health field, as well as build better relationships with the community at large. The Awards that will be presented are as follows:

Distinguished Contribution to Psychology

Volunteer of the Year

Media Award

Legislative Award

Fellows Award

We would love to see you there.

In continuing with the theme of trauma and its treatment, our last issue of the year will address some of the pressing issues in our country right now. We would like to feature articles that talk about the role of mental health professionals in disaster relief efforts and helping fellow Americans cope with these uncertain political times. Thank you to those who have already contributed. We hope to hear from more of you, soon.

Editorial

by Gauri Savla, Ph.D.

"I became what I am today at the age of twelve, on a frigid overcast day in the winter of 1975. I remember the precise moment, crouching behind a crumbling mud wall, peeking into the alley near the frozen creek. That was a long time ago, but it's wrong what they say about the past, I've learned, about how you can bury it. Because the past claws its way out. Looking back now, I realize I have been peeking into that deserted alley for the last twenty-six years." (Khaled Hosseini, The Kite Runner)

Dear SDPA members and guest readers,

There have been times in our recent history that have been marked by a collective sense of great uncertainty, tumult, fear, and despair; this moment in history is no different. Whether it is the fallout from discriminatory public policies, prejudice toward minority and refugee populations, or the barrage of natural disasters in close succession, the lives of an overwhelming number of people are at stake. At the time of this writing, more than 65 million people (source: NPR) are displaced from their homes in Syria, Afghanistan, Lake Chad, Sudan, Myanmar, as well as various parts of the Americas due to Hurricanes Harvey, Irma, and Maria, the earthquake in Mexico, or the California wildfires.

As these global tragedies continue to unfold, millions of children and adults are facing personal horrors every day, sometimes in their own homes. As psychologists, most of us have, at some point in our careers, been sought out by individuals who are hoping to make sense of their traumatic experiences, whether due to childhood abuse or neglect, sexual assault, violence, automobile accidents, or death of a loved one. Regardless of whether the trauma was chronic or acute, it has the power to shape lives, often unconsciously, and underlies emotions, actions, life choices, and relationships. As we know, trauma is multifaceted, as is the response to it.

This issue of *The San Diego Psychologist* is published in conjunction with the 2017 Fall Conference of *The San Diego Psychological Association* entitled, "***Innovations in "Trauma Treatment: What's Outside the Box?"***. I am grateful to Mary Mulivhill, Ph.D., the SDPA CE Chair, and who personally reached out to some of our authors to encourage them to contribute to this issue.

The seven articles featured here are diverse, covering a range of topics: Dr. Goldstein (one of the keynote speakers at the Conference) has written about the use of play in group therapy with adolescents; Dr. Collins (SDPA board member) has eloquently described the role of trauma in couples therapy; Dr. Sterling has described her innovative mindfulness yoga course for patients with trauma; Dr. Trim has written a highly informative article on the treatment of trauma among eating disorder patients, a population that is currently underserved; Dr. Shibley's poignant essay on her own experience as a Dreamer highlights the trauma of having to navigate a hostile and broken immigration system; Dr. Kao has transcribed her interesting interview with Dr. Sidney Zisook, a psychiatrist at UCSD who studies Complicated Grief and its treatment. Finally, we have the honor of featuring Dr. Stevens' poem about coming together in the face of tragedy—his first-hand account of conducting therapy with the victims of Hurricane Irma will be published in the next issue of the Newsletter, coming out next month.

You may have noticed that we skipped the *Summer* issue of the Newsletter; we continue to struggle with poor response rates to our call for articles, and have sought to remedy that by reaching out directly to individuals in the SDPA community for articles. (We may be coming for you next!) Voluntary submissions, as always, will be gladly considered for publication. The last issue of the year will come out at the end of November, and continues in the theme of trauma with regard to current events. We are hoping to feature articles about our role as psychologists in disaster relief efforts, as well as in helping patients cope with the current political climate in our country. Please consider writing and making your voice heard!

Thank you for reading.

Mindfulness and Play in Group Therapy for Conflict-Resolution among Adolescents

by Bonnie Goldstein, Ph.D.

This article is a modified excerpt from the chapter, "Cultivating Curiosity, Confidence, and Self-Awareness through Mindful Group Therapy for Children and Adolescents," in Play and Creativity in Psychotherapy edited by Marks-Tarlow, Solomon, and Siegel (2017).

Group therapy harnesses the desire to connect, belong, and feel part of a community, as members' reflections about their interactions lead to insight and growth. This is especially true in young people who may not have had many opportunities to feel accepted and validated by others, which can reinforce mistaken beliefs about self and others. Young people who avoid others to avoid trauma, wind up isolating themselves from the even the relationships they need to heal and grow. Transformative moments begin with misreading another group member in the here and now, which may evoke feelings from past experiences and relationships. Capitalizing on such interchanges can lay the foundation for repair and resilience, social-emotional development and growth, and the cultivation of curiosity, creativity, and confidence.

Innovative and integrative group therapy comes about through co-creating a playful, safe, nurturing, growth-oriented therapeutic environment in which it becomes less shameful to show hidden parts of the self. Participants in group therapy can reassess their sense of self in relation to others, and gain reassurance as commonalities between members become evident, thus laying the foundation for shifts in experience. Observing changes in other group members can be helpful for those who cannot put into words their own thoughts, feelings and fears. Healing occurs as recognition, exploration, and resolution of trauma and developmental issues during the group experience are aided by an essential element of play, i.e., inviting curiosity. Mindfulness through playful queries such as "I'm curious" or "I wonder" offers a collaborative lens that welcomes wondrous and engaged curiosity, foundations in mindfulness practices, and fosters a deepening awareness of the present moment experience.

Creative and playful interventions to elicit mindfulness help to navigate complicated and contentious relationships, such as will be described in the case example of Danielle and Ian, two teen group members.

Danielle

As a young child, Danielle emigrated from the Middle East with her mother after a change in government regime resulted in their lives being threatened. That was the last time she saw her father, who remained behind. Danielle experienced even greater trauma following September 11, 2001, when both her first and last names were changed. In the ensuing months, her family and others in their community experienced an upsurge of hostility, rage, and racial profiling. These experiences led Danielle to become fearful of others and hesitant to engage with her peers, resulting in her feeling marginalized and rejected.

Danielle was referred to me for her depression by her school counselor, and we began intensive one-on-one therapy as she was beginning 12th grade. I suggested that group therapy could help her combat her sense of isolation as well as aid in developing awareness of the overarching impact of her traumatic experiences. Danielle was wary, but she agreed to give it a try.

After initial resistance that required "curbside therapy," i.e., meeting Danielle where she needed to be, we decided that she would enter the group with me, so she would not have to make conversation or face her peers alone. Danielle's body stance implicitly let all members know of her hesitancy; she entered the room with her head down, arms crossed, appearing defiant or avoidant. Her initial responses to group members were curt, often one-word answers to their questions. There was no eye contact. At the time, Danielle seemed unaware of her self-protective stance, which she later recognized as "body armor."

In a future meeting, group members were invited to share their experiences of one another. Addressing questions ranging from "What was your first impression of group?" to "What was your first impression of one another?" members developed insight and perspective, which led to more sensitivity toward each another. Danielle received feedback suggesting she shift her "body armor" so as to appear less alienating. A large, full-length mirror was brought out so Danielle could view herself in the stance we were discussing. Others also gazed in the mirror, supported by their peers, encouraged by the leaders, in what became a fun and interactive exercise providing much insight.

Danielle's "body armor" had led to her isolation from her peers, which was exacerbated by her avoiding school clubs and teams, eating lunch alone in the library, and dodging

opportunities to be with other students, lest they initiate conversation. In a social-feedback loop, her sense of isolation was maintained by her lack of insight into her avoidant behavior and the lack of tools to break out of this cycle.

As the group progressed, Danielle started to feel safer, both with people and with her own experiences, which slowly led to a sense of stability and confidence around others. She attained a better understanding of her body language and her own thoughts and feelings. This dyadic resonance went beyond simple mirroring to serve as the first step of a feedback loop that facilitated self-understanding. Danielle joined her peers in co-creating a safe environment by talking and listening, and supporting each other. Her intersubjective experience shifted, illustrating how the "group psychotherapy format offers an experiential immersion that fosters awareness and exploration of the ways we know and have a sense of the known within our subjective experience of being alive" (Goldstein & Siegel, in press, p. 260).

One group exercise focused on bringing members' attention to their body-based experiences (e.g., noticing feelings of curiosity about a new member) or becoming aware of aches in their stomach, legs, and feet (perhaps an urge to mobilize or run). For Danielle, the impulse to bolt could be identified with a tingling in her feet. She noticed her limbs would begin to move and wiggle, which she connected to her instinct to flee the room.

As our group sessions progressed, the members became keener interpreters of their inner body and mind signals, for a large part due to the relational component of the collaborative work. Over time, Danielle was encouraged to lead other members in brief breath-work exercises. Taking a turn leading the group in breath-work further deepened her self-confidence and inspired a growing curiosity about other's experiences. Learning to be more centered and finding equanimity through these self-calming exercises, which were introduced in a playful manner, Danielle and her fellow group members developed tools to mitigate feelings of shame, anxiety, fear, etc. Leading these exercises helped Danielle deepen her subjective experience and enhance her own integrative capacity, which prepared her for her conflict-ridden interactions with Ian.

Ian

Ian's ongoing interpersonal challenges and outbursts led his family to bring him to therapy so he could develop self-reflective skills and self-regulation strategies. In the months leading up to the 2016 presidential election, the issues of intolerance, separateness, inclusion, and belonging that were arising nationwide also arose within the therapeutic milieu. Ian, seemingly influenced by the political rhetoric, openly taunted his classmates, especially those whom he perceived as "different." He proclaimed that he would help "build that wall," arguing "some people don't belong here." Ian seemed to not understand the implications of his behavior, nor was he aware that it may have originated in his own experience of being a target of bullying.

(It was later revealed that Ian had been teased and called a "mutt" by peers because of his olive skin and mixed ancestry.)

Ian's attention-seeking behavior ranged from occasionally positive (bringing pumpkin cupcakes for his group mates) to frequently negative (using derogatory language, e.g., "dumb blonde" in reference to group members, or expressing oppositional or offensive opinions). One of his targets of aggressive behavior (shoving, pushing) and verbal taunts was Danielle. After the 2016 election results, he championed the president-elect and called his co-members with opposing political views, "dumb" and "idiots." He would yell "Make America Great Again" and "Build the Wall" in Danielle's direction to purposefully trigger her insecurities about her otherness.

To address the escalation of conflict in the group, I directed their attention to explore the meaning Ian ascribed to his comments. I also aimed to illustrate to Ian that he was recreating the type of interpersonal conflict that occurred frequently at his school. This required looking at the moment-to-moment experience transpiring within the group milieu.

One strategy of de-escalating conflict is the *"Power Pause."* The group knew that it was time to "down-regulate" when I stood up and indicated a stop sign with my hand, while whispering "*Power Pause."* This encouraged group members to examine their own thoughts and feelings and how they were experienced in their bodies: were they feeling more nervous, anxious, more awakened, or numb as the conflict within group escalated? Some observed with wide-eyed panic (perhaps a flight or freeze response, perhaps reminiscent of other conflicts in interpersonal relationships), while others reacted by matching anger, in ever-escalating verbal assault (fight response). By regulating the pace and flow of the group dialogue, group members felt assured of being safely guided through these interactions with support and reinforcement.

Over time, Ian benefitted considerably from supportive positive feedback; his appearance shifted from the confident/cocky bully-rebel, off-putting teen to a more vulnerable, accessible person. This change manifested physically. For example, as he shrugged, Ian's shoulders dropped forward, his eyes turned downcast. At these times he displayed a fleeting, palpable unease and sense of unworthiness. Often he found these feelings intolerable and would create a minor conflict or use his body provocatively, pushing boundaries or instigating interpersonal conflict to shift the moment or cause a distraction. Ian longed to be seen, recognized, honored, and respected, and these softer feelings were manifested over time in the group.

One way in which I led Danielle and Ian to address the conflict between them was through an interactive Sensorimotor Psychotherapy exercise that uses therapy balls. Danielle and Ian were asked to sit on two large therapy balls placed on opposite sides of the room. They could use gentle bouncing or soothing swaying movements, with feet pushing down on the ground. Gentle bouncing releases tension because it keeps one's feet firmly gripping the floor in order to balance, and the gentle movement can be calming.

Danielle and Ian were asked to select locations where they could gaze at one another, but at a distance they co-created. Once they found their positions, their conversation continued as they sat on the ball. Another brief hostile interchange was interwoven with playful giggling as one fell slightly off the ball and had to reestablish balance. Some wobbliness ensued, as each was encouraged to find a distance between them that felt correct. Danielle moved back until she was outside the room, at which point Ian said, "that's right…out…no more group for you". Our office doors are glass sliders, so Danielle's annoyance was visible as she sat on her ball without commenting on his incendiary words. Only after Danielle had moved far outside the group room did Ian indicate with his hands that she should stop (the glass "barrier" seemed to serve the function of offering safety).

At that juncture both Danielle and Ian were instructed to notice what they felt in their bodies. I asked body-oriented questions to encourage present moment awareness, including "What do you feel inside your body right now as you face one another?", "What is happening in your stomach now?" or "Do you feel the anger now that you mentioned feeling earlier?" Although Ian started to recognize that perhaps he had sent Danielle too far away, he seemed to have difficulty suggesting she come forward. He was encouraged to notice what happened when he invited her back into the room with only his eyes and his hand gestures. Peering through the glass, his hesitancy was palpable. As they cautiously and slowly continued the exercise, this time coming closer, Ian acquiesced that he had feelings of anxiety when beckoning her near. Danielle, however, came to a different realization. She said that she had become accustomed to lots of personal space through years of aloneness, and she was not so quick to move back into the group room. She noted that she could breathe more easily when there was plenty of space between her and Ian. She expressed that Ian continued to intermittently remind her of others who had taunted her, and said that she preferred to observe group from outside the glass, looking in.

Little headway was made with respect to their interpersonal conflict until we were able to bring their implicit experience of one another into the room, by examining the underlying process and feelings underlying the conflict. The slower pace allowed for curiosity about what was happening in the present moment, and opened space for members to share their thoughts and feelings, emotions and cognitions amidst the contentious and argumentative banter. As the exercise continued, I instructed Ian to ask Danielle to slowly move towards him, while he remained seated on the ball, until he felt that she was just the right distance from him. In the spirit of curiosity, he was encouraged to use his hands as guides, which he did, albeit reluctantly. After a few moments, the exercise shifted their experience of one another, dispelling the tension over Ian's comments. In time, Ian apologized for his abusive comments toward Danielle.

The support and respect Danielle garnered during her experiences in group therapy led to shifts in her sense of self in the world. This playful group experience encouraged Danielle to reach out to others at school. Her subsequent evident growth in confidence and willingness to risk being "seen" were clear manifestations of growth based on her group experience.

In this exercise, through the lens of curiosity and playfulness, the collaborative group experience offered connecting and redeeming opportunities that emerged as members shared with one another, as guided by the support of the group leaders. While the tension in the room continued, some members spoke out against Ian's political beliefs; others offered words of support to Danielle (a unique and gratifying experience for her). In this safe atmosphere, both members could take personal risks, revisit their challenging beliefs, and have an authentic learning experience.

Similar playful exercises are often useful during high-conflict moments in group, allowing for mindful self-awareness to develop, in the present moment, with opportunities for practice, reinforcement, and new cognizance. Please refer to the book chapter for details.

Conclusion

Working with adolescents in the group milieu creates new possibilities for interactions, self-understanding, and confident engagement with others. This is especially important in an environment where politics and prejudice have found their way into the lives of young people. Cohesive therapy groups can thrive when members are kept emotionally safe within the group despite the inevitable interpersonal conflict. The group can model acceptance by not ostracizing anyone or by not allowing a member to be exiled or "killed off." By prioritizing playful communication and movement exercises, group members can explore emerging internal conflicts, become more mindful of their moment-to-moment experience, and delve beneath the verbal content of presenting problems. All of this can lead to qualitative and quantitative healing and growth, as new neural pathways are created. Healing occurs when we understand how prejudices are mirrored in the body and how they prevent us from both feeling accepted and accepting others.

Relationship as a Developmental Trauma: Healing Directions in Therapy

by Linda Collins, Ph.D.

History taking with couples often reveals a childhood wherein the chronic relational experiences with one or both parents led to an environment that was emotionally unsafe, unpredictable, and unreliable. This developmental history might suggest an attachment disorder impacting future adult relationships. Is this condition also a form of developmental/relational trauma?

Dr. Bessel van der Kolk, identified a condition in 2005 that has been referred to as Developmental Trauma Disorder (DTD). This condition, not formally recognized in the DSM-5, is defined as living in general anxiety or non-stop terror before the age of three. This kind of trauma occurs prior to the frontal cortex coming on line and cannot be recalled as a discrete event. Van der Kolk identifies the symptoms of DTD as relational and chronic: the

inability to concentrate or regulate feelings, chronic anger, fear, and anxiety, self-loathing, aggression, and self-destructive behavior.

Van der Kolk (2005) identifies insecure attachment and attachment disorder as the cause of developmental trauma. Diagnosing DTD can only be made on the basis of the symptoms, since the defining experience of trauma occurs before it can be recalled. These symptoms are often somatic and not linked to event memories.

Another diagnosis that has been adopted by the traumatic stress field is Complex Trauma Disorder (Aideuis, 2007). Complex trauma (also not recognized formally in the DSM-5) is used to address "the multi-faceted nature of trauma experienced by children when violence, neglect and fear form the fabric of their early existence" (Aideuis, 2007). Seven domains of symptoms make-up this diagnosis, including insecure attachment issues, sensory processing issues, emotional regulation issues, alterations in states of consciousness, problems with behavioral control, cognitive difficulties, and problems related to self-concept.

The case example below illustrates the clinical presentation of relational experiences after the age of three that are remembered as emotionally unsafe and frightening. Both partners in the couple described below have trauma histories that include difficulties with experiencing emotional safety and the reliability of getting their needs met in their caregiving relationships. One of the partners has a history of other trauma, including early sexual abuse and witnessing the death of two friends, one by suicide.

Michael and Sherry (names changed for confidentiality) have two children, aged 4 and 6 years. Their son, 4, just started in a transitional kindergarten program. He has been diagnosed with ADHD, is very active, and has a hard time following directions and sitting. Sherry describes, with increasing irritation, that she has been trying to set up a meeting with her son's school to deal with his special needs, and that they have not responded.

Sherry continues focusing on her concerns in this couples therapy session about her son, listing the ways in which the school staff "doesn't care about his needs" and their lack of response to her emails. Sherry's voice begins to shift from irritation and anger to reflect her fear and hurt. Tears form in her eyes. Michael, in an attempt to diffuse the increasing emotion, offers an explanation that the school has a lot on their plate and may simply be delayed in getting back to them. Sherry is triggered by Michael's suggestion and reads his tone as a judgment about her concerns and reacts defensively. Michael begins to feel triggered by Sherry's defensive response, which he perceives as an attack. His efforts to help, he feels, have been rejected and misunderstood.

Both partners appear to be caught in a relationship interaction that felt reminiscent of chronic relational misattunements and emotionally unsafe relationships during their childhoods. During the intake, Michael revealed that he was sexually abused at 4 years of age by his brother's friend. His father was described as quick-tempered, as was his mother. Michael

began to get severe panic attacks at age 23 and has also been diagnosed with Attention Deficit Disorder. He has also struggled with depression most of his life.

Sherry describes growing up with a mother who was preoccupied with her own work life. Sherry felt perpetually blamed for not doing things the right way. She began using drugs in her adolescence, but has currently been sober for 16 years. She has struggled with depression, and in 2015 was diagnosed with rheumatoid arthritis and fibromyalgia.

The ways that the couple described above get "stuck" can be understood more clearly through the lens of the complex relational trauma that both partners experienced. Susan Johnson (2002) in her book, "Emotionally focused Couple Therapy with Trauma Survivors" points out the importance of beginning to work with couples as described above, by using past events and experiences to "validate the self protective stances partners are taking in the present relationship." Janina Fisher (2017) approaches the beginning of treatment by explaining the neurobiology of trauma and helping the couple to see their trauma as the villain rather than one another. Framing past trauma as their adversary has proven to be very helpful for Sherry and Michael; they could unite around this understanding rather than personalize the trauma-informed reactions.

Sue Johnson (2002) also suggests that therapy with trauma survivors may include the following stages of intervention. Stage 1 comprises stabilization where safety is established, and the couple understands how the effects of trauma and lack of security shape their responses to one another. Stage 2 is focused on restructuring the bond between partners, and Stage 3 is focused on a process of integration.

The case example above demonstrates how trauma history of one or both partners shapes and contributes to their relational problems. The emerging diagnoses of Developmental Trauma Disorder and Complex Trauma Disorder offer the clinician a way of understanding early trauma that does not fit into the more event-oriented trauma of the Post-traumatic Stress Disorder (PTSD) diagnosis.

Intervention models such as Johnson (2002) and Fisher (2017) reflect the need to alter the couple treatment approach based on an understanding of the trauma histories of one or both partners. Validating the defensive responses of both partners shaped by their trauma histories models compassion and understanding for both partners. Integrating a psycho-educational approach to understanding trauma and the dysregulation of the nervous system in response to trauma can help each partner to depersonalize some of the automatic and reactive responses received from their partners.

Mindfulness Yoga for Trauma: A New Approach to Trauma Treatment

by Dianne Sterling, Psy.D.

The concept of traumatic stress and PTSD is a relatively new one. Initially called "gross stress reaction" in the DSM after the Second World War to describe symptoms in veterans, it expanded to include other forms of trauma and labeled PTSD in the 1980 DSM-III. In the 1980s and 90s, PTSD symptoms were linked with the survival response of the nervous system, supporting the physiological underpinnings of the PTSD response.

Since then, prolonged exposure therapy and cognitive processing therapy (CPT) have been researched and heavily utilized for trauma treatment. Other approaches also emerged, such as EMDR. SSRIs and other antidepressants have been commonly prescribed as well. In the past 20 years, the understanding of trauma has expanded to include complex trauma, which involves chronic interpersonal trauma exposure, particularly during early development. Judy Herman, M.D. and Bessel van der Kolk, M.D. have been pioneers in expanding the understanding of traumatic stress to include trauma caused interpersonally.

Functional Magnetic Resonance Imaging (fMRI) research has greatly contributed to the understanding of the neurobiology of trauma, and the particular neurophysiological responses including the fight/flight/freeze reaction, sympathetic nervous system and neuroendocrine activation. fMRI studies of the phenomenon of triggering show that most activation occurs in the older and primitive structures of the mammalian and reptile brain.

Recent developments in trauma treatment include strategies that expand beyond verbally based psychotherapy to approaches that integrate the body into the therapy. Enhanced mind/body approaches to trauma treatment such as Sensorimotor psychotherapy and Somatic Experiencing address implicit memory that evokes trauma-related hypo or hyper-arousal. Van der Kolk and colleagues have investigated other bodily-based and holistic ways to heal trauma, including meditation, yoga, and neurofeedback, among others. This research demonstrates that trauma resides in the body and underscores the need for comprehensive treatment that includes the physiological symptoms of trauma. In his recent book "The Body Keeps the Score," van der Kolk explains how symptoms of trauma are adaptive and survival-based, and tend to get wired in the nervous system and "encoded in the viscera." Traumatic residue in the body may result in symptoms that are often physical in nature, such as triggering, startling, chronic nervous system over-arousal, and anxiety. Research suggests that the threat system in the brain becomes altered with intense or repeated trauma, including a persistent reactive autonomic nervous system and sensitized endocrine system. Trauma survivors also frequently employ numbing and dissociation, leaving them feeling unsafe and disconnected from their bodies.

"The body keeps the score. If the memory of trauma is encoded in the viscera, in heartbreaking and gut-wrenching emotions, in autoimmune disorders and skeletal/neuromuscular problems, and if mind/brain/viscera communication is the royal road to

emotion regulation, this demands a radical shift in our therapeutic assumptions." (van der Kolk, The Body Keeps the Score, p. 86)

In psychotherapy practice, we frequently encounter patients with trauma. As psychologists, we have many tools to address emotional pain and traumatic memory, but often do not target the somatic symptoms of trauma directly where they live in the body. As someone who has studied and treated trauma for 30 years and followed the work of Drs. van der Kolk, Herman, and others, I have been intrigued the mind/body approach to treatment. However, despite having been a long-term meditator, mindfulness teacher, and yoga practitioner, I found it challenging to implement these approaches in my traditional psychotherapy practice. I have utilized mindfulness tools and tracking the sensations in the body as a source of information to differentiate thoughts, feelings, and body experiences, as well as explaining ways to invoke the relaxation response. Yet, I remained convinced that there was a wider range of somatic interventions that could further help my trauma patients.

Over the years, I have referred patients to MBSR classes (Mindfulness Based Stress Reduction), local meditation classes, and yoga classes. Unfortunately, my trauma patients did not always benefit from them; some reported that breath meditation created anxiety with the focus on the bodily experience of breathing. Others found that certain yoga poses as well as certain actions of the yoga teachers created discomfort, nervous system reactivity, and sometimes brought on an overwhelming sense of vulnerability.

In his work at the Trauma Center in Boston, Dr. van der Kolk had similar experiences when he began researching yoga as a therapeutic modality. In fact, he had a 50% drop out rate in his initial yoga research because of the discomfort it aroused in trauma survivors. This led to the development of Trauma-sensitive yoga with David Emerson, a yoga teacher, so survivors could benefit from the therapeutic aspects of yoga practice without the "side effects" of a traditionally led yoga class. Patients at the Trauma Center were referred to yoga classes on site in addition to their therapy visits.

The principles of Trauma-Sensitive Yoga include not using certain poses that evoke a sense of vulnerability, no adjustments by the teacher, never walking behind students in class, no "commands" or instructions to push endurance, and avoiding certain props. The goal was to create a safe environment that fostered choice and control while allowing survivors to safely connect to their bodies, breathing with movement and quieting the overactive nervous system. David Emerson has documented this refined approach in several publications, and also offers online and in-person training.

Armed with my knowledge of the mind/body research on trauma and available somatic interventions, I developed a carefully choreographed six-week course (currently named Mindfulness Yoga for Trauma) that could be adjunctive to psychotherapy. This course combines didactic information about the science behind the neurobiology of trauma and

related topics, with teaching mindfulness and somatic practices, such as Trauma-Sensitive Yoga.

Science and research can drive acceptance and understanding, creating more motivation to use and try mindfulness and yoga practices. Learning and understanding the mechanisms of trauma and what can be done to alleviate symptoms empowers the participant to take charge of their own healing at their own pace. It also has the possibility to "de-shame," since gaining understanding that the symptoms of traumatic stress are not cognitive, but survival-oriented and originate in more primitive brain structures in our brain. In other words, you cannot "out-think" it; it is an automatic survival mechanism.

The Mindfulness Yoga for Trauma course emphasizes tools for calming, grounding and self-regulation, and no expectation of self-disclosure. It is made clear that it is not a therapy group, but a safe space to learn with the implicit knowledge that everyone present has a trauma history. This course has been taught three times over the course of the last year.

Each of the six weeks is focused on a different topic, and comprises an hour of presentation and an hour of mindfulness training and trauma-sensitive yoga practice. Some topics are didactic only, such as the neurobiology of trauma, polyvagal theory, and how trauma resides in the body. Other topics covered are commonly employed strategies in trauma treatment, such as how to use grounding both cognitively and physically to anchor and establish safety, physical and emotional self-regulation, self-compassion, and post-traumatic growth and resilience. Each topic is followed by a mindfulness exercise or training. The exercises are geared toward observation of sensations without judgment and tracking sensation and emotion to interrupt automatic reactions. This cultivates self-awareness and makes space for self-observation, noticing and befriending what is experienced to reduce the stress response. For those who have disconnected or dissociated, it allows safe reconnection. For those who are physically reactive with triggering and hyper-arousal, it promotes pausing and noticing what is being experienced and eventually interrupting the stress response. Directing attention to the present moment has been proven to increase ability to gain perspective and regulate responses. Resources such as books and webcasts are provided in the handouts.

The second hour of each class is a guided yoga session of slow, gentle poses and breathing using the principles of trauma-sensitive yoga. Participants are encouraged to practice mindful awareness while practicing yoga, and to go at a pace that is right for them. They are also encouraged to use grounding if anything becomes triggering and uncomfortable.

At the end of the course, participants are are asked to complete a confidential feedback form. The following are some abbreviated comments that we have received over the last year:

- "I liked the lectures, it made understandable why the yoga and movement helped"
- "When I feel triggered I have been able to use the tools to overcome it, thank you!"
- "Grounding helped a lot"
- "I appreciated not being asked to share or talk about personal trauma"

- "I wanted to let you know that I made the connection of my response to a homeless person. In my sadness, I was able to pause and connect to a former experience in my life when I had to stay in a safe shelter for a month. I allowed my feelings to arise with self compassion, took a breath, grounded, and was able to feel peace and not shame. I've learned a lot"
- "I appreciated not being asked to share or talk about personal trauma" "Someday a body-centered mindfulness treatment will be prescribed for most people who suffer serious trauma, like physical therapy after an injury. We will look back and wonder how it was possible to recover without addressing the pain that resides beyond the mind's reach"

The overall goal of Mindfulness for Trauma is to equip participants with tools and information, heightening perceptivity in the mind/body connection and how trauma impacts functioning. Participants learn to comfortably practice mindfulness and yoga exercises on their own without being triggered or having to look for appropriate yoga classes or courses like MBSR, or MSC (Mindful Self Compassion). This increases understanding, self-awareness and increased capacity to pause, observe and reduce reactivity as well as promotes self-compassion, becoming more present without fear and, of course, reducing symptoms.

Managing PTSD Symptoms Through Food (or no Food): Trauma, PTSD, and Eating Disorders

by Julie Trim, Ph.D.

Individuals with an eating disorder (ED) who report a history of trauma, or indeed, meet full criteria for post-traumatic stress disorder (PTSD), pose several challenges to the practitioner wishing to deliver evidence-based treatment. ED practitioners may have expertise in eating disorders, but few have strong training or experience with PTSD and associated comorbidities. Working with this subgroup requires specialized training in PTSD assessment and treatment. Diagnosing PTSD can be difficult in ED individuals because ED symptoms can "mask" or suppress PTSD symptoms, and PTSD symptoms can overlap with other psychiatric disorders such as major depressive disorder.

When an ED patient has PTSD, there are certain areas of sensitivity or conflict that arise in ED treatment and present additional barriers to success. The experience of a traumatic event can cause significant shifts in survivors' views of the world, self, and others. Disruptions in one's sense of safety, trust, power/control, intimacy, and self-esteem have been shown to be particularly salient in trauma survivors. Anecdotally, it is often these areas that pose additional challenges to treatment for the patient and the clinician alike.
For example:

- Safety: In order to preserve a sense of safety, a person who experienced trauma may tell themselves that the trauma occurred due their body size or weight, and that being at a higher or lower weight will keep them safe from future traumas. ("If I hadn't looked a certain way, I wouldn't have been raped."). In fact, these types of self-blaming beliefs maintain or perpetuate PTSD.

- Trust: It is generally difficult for ED individuals to trust their treatment providers with regard to food, weight, and exercise recommendations. With an ED–PTSD patient, there are often additional barriers to trust given that interpersonal traumas (e.g., abuse or assault) often lead to a general distrust of others.

- Power/control: ED–PTSD patients often report feeling "in control" if they are able to make choices about their food and weight, and treatment typically involves letting go and allowing others (e.g., a dietitian) to influence these decisions. For ED–PTSD patients, this seems to trigger a strong pull to regain control and may lead these patients to "dig their heels in" and refuse to follow their team's recommendations. Power/control issues may also emerge in intensive ED treatment settings, which are highly structured and supervised. The rules of the treatment center may lead ED–PTSD patients to feel extremely safe (i.e., one of the only safe places they have) or could be perceived as an unnecessary restriction of their rights, power, and control.

All of these sensitivities (i.e., safety, trust, and power/control) make sense given the patient's history. However, they can lead to a "bumpy road" in treatment and, in some cases, may result in dropout or premature termination from treatment.

ED-PTSD individuals can present with a range of diagnoses and behaviors. With respect to ED behaviors, binging and purging are typically more prominent than food restriction in this subpopulation. Researchers have speculated that overeating or binging becomes a self-soothing strategy for a traumatized individual, as these behaviors decrease emotional arousal and "numb" or suppress unpleasant feelings and memories. Purging serves a similar function, and can occur as a way to counteract an episode of binge eating. Outside of their ED diagnosis, ED patients with PTSD individuals tend to have significantly more comorbidities than those without PTSD; these include substance use disorders, mood disorders, impulse control disorders, and borderline personality disorder (BPD).

Formulating a treatment plan for a patient with an ED and PTSD is not easy, to say the least. ED practitioners are faced with complex questions: When to start PTSD treatment? What type of PTSD treatment to use? When to pause or stop PTSD treatment (if a problem arises)? Although research on the types of trauma experienced by individuals with EDs, comorbidity rates, and so forth is abundant, clear guidelines for treating ED-PTSD patients are lacking. ED clinicians are generally aware that trauma-related symptoms often represent a major obstacle to ED recovery, and yet clinicians are often fearful that starting PTSD treatment will trigger increased ED behaviors as well as other worrisome behaviors like self-harm, substance abuse, and suicidality. In a recent study by Kathryn Trottier, Ph.D. and colleagues, ED clinicians cited several barriers to providing PTSD treatment to their patients, including: (1) uncertainty about how to integrate trauma work with ED treatment, (2) lack of training in trauma-focused treatment, (3) institutional financial constraints, (4) not an institutional priority, (5) belief that trauma-focused treatment is a "long-term" endeavor, (6) preference for

individualized treatment, (7) perceived readiness of the patient for trauma-focused work, and (8) concerns about psychiatric decompensation. Approximately half of participating clinicians anticipated at least four of these barriers, and 12% anticipated all eight.

Decisions about the treatment plan are fairly arbitrary given the limited research in this area. Possibly the least arbitrary—although still complex—is determining when the patient is ready for PTSD treatment. In some cases, other problems should be addressed prior to starting PTSD treatment (e.g., danger to self/others, safety concerns, and psychological conditions that interfere with the patient's ability to receive or benefit from PTSD treatment), but PTSD treatment can be started as soon as these issues are resolved (Resick et al., 2014). Tim Brewerton, M.D., a prolific researcher in this area, argued that PTSD treatment should not begin until (1) the patient indicates a readiness to begin trauma work, (2) the patient is adequately nourished and able to process information emotionally and cognitively, (3) the patient's eating disorder symptoms are relatively under control, and (4) the patient has demonstrated an adequate level of distress tolerance.

Due to its clear structure in addressing multiple behaviors and treatment targets, Dialectical Behavior Therapy (DBT; Linehan, 1993) lends itself well to treatment with these patients. The DBT hierarchy monitors patient safety, minimizes behaviors that undermine or interfere with therapy, and provides a framework or "road map" for treatment. Melanie Harned, Ph.D., has developed a protocol for integrating Prolonged Exposure (PE; one of the four evidence-based treatments for PTSD) with DBT. The DBT PE protocol may not only enhance treatment effectiveness but also allow ED practitioners to feel less trepidatious delivering PTSD treatment to their patients. Furthermore, because many PTSD patients would like to be free of PTSD symptoms, making PTSD treatment contingent on elimination of higher treatment targets (i.e., life-threatening behavior and therapy-interfering behavior) can be a highly effective strategy for both reducing the severity of PTSD and meeting higher treatment targets.

To our knowledge, the Eating Disorders Center at UC San Diego is the only program in the country that provides evidence-based PTSD treatment for ED patients in a partial hospitalization program (PHP) or intensive outpatient program (IOP). In our Adult Program, patients can choose between Prolonged Exposure (PE) and another evidence-based PTSD treatment, Cognitive Processing Therapy (CPT). Post-treatment follow-up of patients who have participated in UC San Diego's ED+PTSD program have shown positive outcomes.

"No soy DACA, ni soy de allá"
I am not from Here nor There

by Mariela Shibley, Psy.D.

The tile is a play of words based on a song written by the late Argentinian composer, Facundo Cabral, "No soy de aquí, ni soy de allá."

When I was 13 years old, my parents decided to leave my country of birth, Argentina, and drag me along with them to the United States. With the passing of time, I learned English and slowly adapted to the American culture, but I always held on to my Argentine roots. Not being able to adjust my immigration status for years, I lived in the shadows – paying thousands of dollars in non-resident tuition so I could attend community college and altering my social security card so that I could get a job. Most of my friends did not know that I was undocumented because of the shame and fear I felt. When I was finally able to return to Argentina years later, I was treated like a visitor. It was then when the title of one of Facundo Cabral's songs began to play over in my head: "No soy de acá, ni soy de allá," which translates to "I am not from here, nor there." This dichotomy has been the core of my experience as an immigrant, and how many immigrants feel as well.

The United States has become home for many individuals who were brought to the country as young children with their families. Many were brought when they were infants and have never gone back to their native country, making the United States the only country they have ever known and the place they call home. These children grow up speaking English as their first – and sometimes only – language, and since they are undocumented and thus unable to travel internationally, they have never left the United States. Many of these children do not find out about their immigration status until they graduate high school, when they attempt to obtain a driver's license or to enroll in college. Imagine the shock, the confusion, and the frustration these young people feel. They did not choose to come to this country and be uprooted from their native land. And they certainly did not decide to be subjected to all the obstacles they face as a result of being undocumented. Suddenly, these young people realize that they and their families are different from other American families. Due to the negative stigma associated with being undocumented, these young kids tend to keep their undocumented status a secret from their peers. They suffer in silence, feeling alienated from their American friends and sometimes distanced or resentful toward their parents, who brought them here in the first place.

Efforts to fix this problem date back to August of 2001, when congress failed to pass a bipartisan act called the DREAM Act (Development, Relief, and Education for Alien Minors), a bill that would provide conditional permanent residency to certain young immigrants who meet specific requirements. In June of 2012, President Barack Obama signed an executive order to curb the deportation of certain young undocumented immigrants. This policy, known as the Deferred Action for Childhood Arrivals (DACA), allows certain undocumented immigrants who entered the United States as minors to obtain a renewable work permit and

may prevent their deportation. They are able to apply for a driver's license, join the military, and in some U.S. states they can attend universities and qualify for in-state tuition. DACA was a compromise for the DREAM Act. Although it is not in and of itself a path to citizenship, it allows these undocumented individuals to build a future for themselves and to contribute to society. Almost 800,000 Dreamers between the ages of 16 and 36 are currently able to attend college and graduate school, to work, and to pay taxes because of this program. They do not have to live in fear of being deported for not having legal immigration status. Their U.S. citizen relatives do not have to fear being separated from those they love most and their families being torn apart.

This past September 5, the new administration announced that it will rescind the DACA program. For those currently in the program, their permits to work and attend college will begin expiring in March of 2018 – unless Congress passes legislation allowing a new channel for temporary or permanent legal immigration status. Trapped in a broken immigration system, intelligent and hard-working youth must confront an uncertain future because of the barriers to continuing their education, working, or joining the military. These 800,000 young people, who once felt a sense of hope and who have been contributing to this country's growth, are now faced with having to go back to the shadows. They fear being deported from the country they call home – the only country they know – to a foreign land. As President Obama (2017) said in a beautiful Facebook post: "These Dreamers are Americans in their hearts, in their minds, in every single way but one: on paper."

Immigrating to a new country entails numerous losses: the loss of one's familiar surroundings, their loved ones, possibly language, and even culinary customs, amongst others. The extent to which a person is able to accept such losses determines one's ability to adapt to the new host culture (Volcan, 1993). For example, a person who was forced to leave their familiar surroundings and who does not want to rescind their customs and way of life will have a much harder time adapting to the new environment and culture, especially if it is very different from what they are accustomed to. This is also mitigated by age (older individuals tend to struggle more than young children) and whether the relocation will open doors to a more prosperous future.

Individuals whose departure is involuntary are more prone to experience culture shock – a general feeling of disorientation due to a sudden introduction to an unfamiliar culture, environment, and way of life (Garza-Guerrero, 1974). This unleashes a stressful, anxiety-laden process whereby one struggles to adapt to the changes while grieving the losses inherent in the transition. The combination of mourning such profound personal losses and a forceful introduction to a new environment challenges the stability of a person's psyche (Akhtar, 1995).

One can only imagine the negative effects that being removed from the United States, the only country many of these young Dreamers know, will have on them. It's true, these people who were brought to this country are not from here, but they are also not from there. Regardless of

what Congress decides to do about these 800,000 Dreamers, damage has been done by highlighting the fact that they do not belong. And believe me, it hurts.

Note: * Dreamers are those who would qualify for benefits under the DREAM Act, even though such act has not been made into law. They are immigrants who were brought to the United States as children (prior to age 16), who have been residing in this country continuously since 2007, and who were younger than 31 years of age by June of 2012.

Sidney Zisook, M.D.: An Innovator in the Treatment of Grief and Suicide Prevention

interview *by* Erika Kao, Ph.D.

I had the pleasure of interviewing Sidney Zisook, MD at his office at University of California, San Diego (UCSD). Filled with natural light and cozily decorated, his office is an inspiring environment for research on therapeutic mental health interventions.

Dr. Zisook is an accomplished researcher and Professor of Psychiatry at UCSD, and a kind, interesting, and warm person. His interest in Grief and its manifestations have roots in both his personal and professional life; he first began thinking about Grief as a teenager, when he encountered it first-hand after losing a close friend. His professional interest in Grief began when his mentors at Massachusetts General Hospital, where he was a resident, and at Harvard Medical School, where he was a fellow were studying Grief as a model for resilience or psychopathology. Today, Dr. Zisook is considered to be a leading authority in the field of Grief research.

What is "Complicated Grief" (also known as prolonged grief, or, in the DSM-5 as "persistent complex bereavement disorder") and how does it matter to you as a clinician?

"There is no formula for how to grieve or a definition for 'normal' or ordinary grief. Everyone grieves in their own way: Grief may be different for different losses, and shifts over time. Yet, there are some commonalities, including intense emotionality (e.g., pangs of yearning, longing, sorrow, anxiety, guilt, anger and shame Interspersed with positive emotions), cognitions (e.g., a sense of disbelief, frequent insistent thoughts and memories of the person who died, difficulty concentrating on other things) and behaviors (e.g., proximity seeking and/or avoiding reminders of the loss). Many of these features overlap with symptoms of depression and, especially after a very violent, sudden, unanticipated or traumatic loss, such as after suicide, accidents or homicide, features that overlap with posttraumatic stress are common. Nevertheless, for most bereaved individuals, intense emotionality subsides, thoughts and memories recede into the background, the sense of disbelief lessens, and wellbeing is restored. Although the loss will never be erased, healing occurs over time and the individual is able to get on with this or her life. However, sometimes this progression gets derailed and intense grief persists, often accompanied by strong negative feelings such as unrelenting guilt, blame, and

loneliness, avoidance of, or preoccupation with, reminders of the deceased, feeling disconnected to the past, present and future, and a sense of meaningless and despair. This condition, the failure to adapt to the loss, is what we call 'Complicated Grief.'

Those suffering from Complicated Grief may have self destructive tendencies; they appear unable to move forward, and are at higher risk for suicide. In the DSM-5 complicated grief is identified as Persistent Complex Bereavement Disorder (PCMD), a condition for further study. It appears in the section of Trauma-and Stressor-Related Disorders. Complicated Grief (or PCBD) differs from Posttraumatic Stress Disorder (PTSD) in that the trigger is loss rather than threat. Correspondingly, primary emotions are yearning and sadness rather than anxiety and fear. Intrusive thoughts and images are focused on the person rather than the event, and these thoughts and memories are not frightening. At times, they may even be pleasurable.

In the absence of treatment, Complicated Grief may persist indefinitely and is associated with substantial ongoing emotional pain and psychological and medical morbidity. The good news is that there are several emerging, evidence-based therapies for Complicated Grief. The form of therapy with the most evidence, simply called Complicated Grief Psychotherapy (CGT) has now been found effective in three large, randomized trials. CGT is a form of cognitive behavioral therapy that also draws upon exposure therapies, interpersonal therapy, motivational interviewing and gestalt therapy. Each of the 16 manualized sessions focuses on both loss and restoration."

A recently completed NIMH-funded randomized controlled study of CGT lead by Dr. M. Katherine Shear (Columbia University) with Drs. Charles Reynolds (University of Pittsburg), Naomi Simon (Harvard), and Sidney Zisook (UCSD) also explored the role of antidepressant medications for symptoms of Complicated Grief. That study did not find medications particularly effective, either alone or in combination with CGT, but it did confirm the robust effectiveness of CGT. At the initiation of treatment, participants had been profoundly impaired, often for several years. Comorbid depression and PTSD were common and 43% of the bereaved participants expressed suicidal thoughts at the start of treatment. Despite the severity and chronicity of symptoms, an impressive 83% of the treatment group responded to CGT. There were corresponding improvements in function, depressive and anxious features, and suicidality. Indeed, none of the participants who received CGT were suicidal at the end of treatment. In addition, the subset of participants who had suffered from losses that were particularly violent and traumatic, such as after suicide, accidents and homicide, did equally well with CGT as those whose loved ones died from nonviolent, natural causes of death. Few clinicians are familiar with this innovative and highly effective treatment, and thus may not well equipped to optimally help their clients with Complicated Grief.

Dr. Zisook also shared important work he has done in suicide prevention. He is involved in a project to reduce suicide amongst physicians and other healthcare providers. Healthcare providers, including physicians, nurses, and pharmacists are at elevated risk for suicide (there is

anecdotal data that psychologists, too are risk for suicide, but there are no studies yet). Female physicians are at especially at high risk. In light of these sobering occupational risks, Dr. Zisook and his team at UCSD have launched a proactive educational, support and outreach program aimed at destigmatizing mental health treatment, and preventing burnout and suicide.

At the SDPA 2017 Fall Conference, Dr. Zisook, Alana Iglewicz, M.D., and Danielle Glorioso, L.C.S.W. of the UCSD Complicated Grief Study Team will talk about this ground breaking treatment for Complicated Grief at the SDPA Fall Conference taking place on October 28th, 2017.

The Fall Conference of the San Diego Psychological Association
Saturday, October 28th, 2017
Please go to https://www.sdpsych.org to register.

Please see next page for Dr. Steven's poem

A Storm Can Change the Balance

by Mark W. Stevens, Ph.D.

We may differ on who should be President
and how we worship God, or if we even should
We may disagree on whether the color of our skin
determines if we are inherently bad or good

We may struggle with one's choice of sexual identity
make our decisions based upon one's gender
and argue how the world came into existence
or how nature or mankind might end her

We may stand divided on a multitude of issues
fire our weapons, pound our fists, point our fingers,
but lest we learn how to talk, and to actually listen
the poison of hatred will linger

We can no longer be silent,
while hatred continues its mission to kill
Can't look the other way and pretend it's not happening
as we slowly forget how to feel

Suddenly, in a heart beat, all of this pales
Harvey, Irma, and Maria have struck and insist upon a change of perspective
I've seen first hand, devastation so immense
there's simply no room for continued invective

Destruction, indescribable
Needs of the afflicted, immeasurably greater
Things that divide us are finally irrelevant
We must drop them now and help others, and this, sooner not later

If you need a good reason to change your perspective
before another life's lost, harmful word uttered, or a missile is sent
Remember so many depend upon our choices for survival
regardless of differences, as do all the world's innocent

The fate of our children hangs in the balance of all our personal choices
For violence to ever end and hatred finally cease
these must be informed by our love and compassion
Only then can we hope to find peace