The Importance of Mindfulness, Self-Compassion, and Yoga in Healing Trauma

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Abstract

Mindfulness meditation is a conscious and deliberate way of paying attention in a particular way, moment to moment. It is intentional cultivation of nonjudgmental moment-to-moment awareness. There are two parts to mindfulness, one is self-regulating attention in order to identify emotions while increasing endurance to be with the experience, and second is developing curiosity, openness, and acceptance towards experiences in the present moment. When healing trauma one has to become aware of how difficult emotions are experienced, and develop the curiosity of how current and past events and emotions affect one’s life schema. Experiencing a traumatic event can cause numerous consequences on one’s nervous system, emotions, reactions, physical and emotional well-being, and behaviors, often leading to anxiety, depression, addictions, inability to regulate emotions, poor impulse controls, risky behaviors, unhealthy life choices, and suicide. Often trauma survivors do not have clear diagnosis, which could be due to lack of memory, or awareness that they had experienced traumatic event(s), or that this event or cumulative traumatic events influence many aspects of individual’s life. These individuals may also lack the awareness that they need help, or what kind of help they need. When a trauma survivor becomes aware that life has become unmanageable, he or she can choose right actions, become compassionate towards self and others, and become empowered to make different choices, and feel safe to be with his or her experience. Through practice of mindfulness and yoga, trauma survivors can learn how to befriend their body. The purpose of this paper is to demonstrate how awareness, self-compassion and yoga practice can heal numerous trauma symptoms, and create a balanced life, emotionally and socially.
# MINDFULNESS IN HEALING TRAUMA

Abstract 2
Introduction 4
Foundations of Mindfulness Practice 8
- Principles of MBCT and DBT 11
- Principles of Mindful Self Compassion 13
- What is Compassion? 14
- What is Self Compassion? 15
- Principles of Yoga Therapy for Trauma and PTSD 18
Trauma on the Continuum 20
- Trauma History 22
- Trauma and Post Traumatic Stress Disorder or PTSD 27
- Complex Trauma 28
DSM-5 30
Adlerian Approach to Trauma and PTSD 34
Trauma Research, Causes, Effects, and Resiliency 36
- Research Results 37
- Discussion of Importance of Mindfulness in Healing of Trauma 42
- Importance of Mindful Self-Compassion 42
- The Importance of Self-Compassion in Therapy 43
- Importance Oxytocin and its effects on Stress 47
- Importance of Yoga on Trauma Healing 49
Adler and Mindfulness 53
Conclusion 55
References 58
The Importance of Mindfulness, Self-Compassion, and Yoga in Healing Trauma

The lack of availability of effective treatments for Complex Trauma and associated disorders in Canada is a critical mental health problem. Trauma, Complex Trauma, Post Traumatic Stress Disorder (PTSD), Acute Stress Disorder (ASD), Post Traumatic Stress Injury (PTSI), and Trauma- and stressor-related disorders (American Psychiatric Association, 2013) with associated conditions and symptoms have a long history of strong debilitating effects on Canadians (Brown, Campbell, Lehman, Grisham & Mancill, 2001), yet despite many advances in medicine, and mental health innovations, clinicians are still struggling to find effective treatments for trauma, often leaving those who suffer without proper care and support (Iveson, 2013).

Mindfulness based approaches, Mindfulness Based Cognitive Therapy (MBCT) (Teasdale, Segal, Williams, et al., 2000), Dialectical Behavior Therapy (DBT) (Linehan, 1993), Yoga with Trauma and PTSD sensitive approaches, such as Yoga Warriors (YW) (Stoller, Greuel, Cimini, Fowler, & Koomar, 2012) and Trauma-Sensitive Yoga (TYS) (Emerson et al., 2009), as well as Mindful Self-Compassion (MSC) (Germer & Neff, 2013), are evidence based modalities that are effective in reducing symptoms associated with trauma, such as anxiety and depression, improving affect regulation, reducing self-harming behaviors, and suicidal thoughts, as well as other ineffective coping strategies that trauma survivors develop over the course of their lives.

As mental health practitioners still hope to heal trauma and the disabling effects of trauma, the problem in Canada is that often, there is no effective treatment available through our universal health care system (National Defence and Canadian Forces Ombudsman, 2014). Issues related to mental health a huge and growing. According to
Mental Health Commission of Canada, one in five people in Canada experience mental health problems or illness, at a cost of $50 billion dollars per year (Canada, Mental Health Commission, 2012) and out of those, only one in three adults, and only one if four youth, seek or receive services or treatments, with a staggering number of suicides each year. Rates of suicide are growing, as over 4000 Canadians die from suicide each year (Statistics Canada, 2011).

Soldiers returning from war zones are frequently left without much support in terms of healing from trauma and PTSD, and are left to their own coping strategies, often resulting in worsening of symptoms, development of various addictions, and sometimes tragically ending with suicide. While government offers prayers and thoughts for them and their families, (Globe Staff and Canadian Press, 2013) what they actually need is treatment. There is a lack of available care offered in the outpatient clinics, with long waiting lists that are not weeks but sometimes months long. Other private centers treat addictions and trauma together, and for most of the centers in Ontario, except for one, a person who struggles with effects of trauma cannot access treatment unless he or she also has an addiction. Trauma survivors often develop substance abuse problems, which further worsens their condition and further increases the stigma associated with substance use and mental illness. Although about 75% of those who suffer from trauma do develop some form of addiction, often substance abuse, a small number, the remaining 25% do not (C. Pain, personal communication, July 13, 2013), and this population of remaining 25% of people with PTSD or complex trauma have even less chance of gaining access to inpatient care. People with trauma don’t always develop addiction, however, those who suffer from addictions most often have underlying causes of trauma
driving their addictions (Maté, 2010). Psychiatrists who specialize in trauma often provide assessments (C. Pain, personal communication, July 12, 2013) but rarely do they provide treatment. Psychiatrists who perform assessments typically send patients back to the community to their referring physician, with recommendation to look for their own treatment, which is quite costly, and has to be paid out of pocket by each individual.

Current standard, evidence based treatments for trauma often include Cognitive Behavior Therapy, Sensorimotor psychotherapy, body oriented types of psychotherapy such as relaxation techniques developed through practice of meditation and yoga, and pharmacotherapy (Centre for Addiction and Mental Health, 2009). Pharmacotherapy can be easily accessed, but it may only provide stabilization of symptoms. Pharmacotherapy has very little or no effectiveness on healing the underlying cause of symptom expression, such as the underlying trauma, and even less on purpose of the symptoms. While medication seems to not really correct the abnormality that is underlying the behaviors and emotions, pharmacotherapy “…helps to address some of the neurochemical problems associated with PTSD, thereby helping to modulate some of the embarrassing and upsetting behaviors and emotions” (van der Kolk, 2006, p. 5). Pharmacotherapy can inadvertently also lead to addictions and poly-substance use, further aggravating trauma and providing more chances of a traumatized patient getting re-traumatized or re-victimized.

Despite extensive research on trauma and related spectrum of disorders, clinicians are often failing to encourage those who need help to seek help (Fikretoglu, Brunet, Schmitz, Guay, & Pedlar, 2006), leaving individuals who suffer from post-traumatic stress disorder without effective care. We also appear to fail to provide treatment that
addresses and treats the underlying causes of trauma symptom expressions. Current trauma treatments often do suggest but do not primarily include or consider various non-traditional, yet very effective and easily accessible approaches, such as mindfulness-based meditation, yoga, or mindful self-compassion practices.

As a result of experiencing a prolonged activated state of the autonomic nervous system and the inability to discharge the autonomic nervous system by activating the parasympathetic nervous system (PNS), the nervous system of people who experienced trauma remain blocked from reaching homeostasis. This prolonged accumulation of stress response to various stimuli has disabling effects on body, mind, and overall physical and mental health and wellbeing. Research shows that prolonged exposure and extended states of activated sympathetic nervous system have clear and evident effects on the cardiovascular system, endocrine system, and nervous system, causing cascades of hormone releases, which all in turn have effects on functions of various organ systems, often resulting in expression of various physical illnesses (Luxenberg, Spinazzola, & van der Kolk, 2001).

Current therapies and treatments for trauma and associated disorders lack focus on the underlying dysregulation of the entire human organism and tend to focus on treating symptoms rather than a whole human and spiritual being, hence rarely succeeding to restore the individual’s wellbeing. The connection between mind and body is extremely important. According to Dr. Gabor Maté (2004), the author of the book *When the Body Says No*, emotional and physiological stress plays a powerful role in the onset of chronic illness. Dr. Gabor Maté found that there is commonality between people who lived highly stressful lives and their chronic medical and physiological conditions (Maté, 2004). It is
also evident that if someone who is experiencing psychological trauma associated symptoms will have difficulty functioning in life, and most probably in all three tasks of life, work, interpersonal relationships with society, and intimate relationships such as love relationships.

This paper will explore the history of the disorder, manifestations of the symptoms associated with trauma, physiology of trauma with the effects it has on the body, as well as the treatments available for healing trauma and PTSD. Specific focus will be given to the alternative treatment of trauma, which could be used as adjuncts to current therapy, such as mindfulness, meditation, yoga, and mindful self-compassion. Adjunctive approaches of therapy for trauma such as Yoga and Mindful Self-Compassion will be explored, specifically focusing on how these approaches can play a role in treatment of trauma and reduction of trauma symptom expression.

**Foundations of Mindfulness Practice**

Mindfulness is simply awareness. Mindfulness is most frequently quoted and described by Jon Kabat-Zin as a process of “… paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (Jon Kabat-Zinn, 1995, p. 4). The foundations of Mindfulness practice are based on Zen Buddhist teachings, which includes cultivating mind that is non-judgment, cultivating patience, trust, cultivating the beginners mind, acceptance of impermanence, non-striving, and non-attachment to things, non-attachment to people or ideas, and more simply, having the ability to let go.

Bishop et al. (2004) proposed that there are two parts to the definition of mindfulness. The first component includes self-regulating attention in order to remain present and able to identify emotions in the present moment. At the same time this
practice increases endurance for and capacity to be with the experience in the present moment. The second part of mindfulness includes developing curiosity, openness, and acceptance towards experiences, also in the present moment. Mindfulness meditation is a conscious discipline, which includes a particular way of paying attention movement to moment. It can be most simply described as the intentional cultivation of nonjudgmental moment-to-moment awareness (Kabat-Zinn, 1996).

Non-judgment does not mean non-preference or condoning negative behaviors or situations, but it rather means not labeling anything as good or bad, just becoming aware of it. Non-judgment is a very important part of mindfulness practice, especially when it comes to the automatic thoughts, moods, and actions. Cultivating patience and staying present even when experiencing discomfort, without judging or rushing into a fixing mode is another vital component of mindfulness. Trusting is another component of mindfulness. Trusting is about respecting one’s own experience while trusting the process. Keeping an open mind, or the Beginner’s Mind is viewing the most familiar surroundings as if one is seeing it for the first time. The Zen Mind or Beginner mind allows one to adopt the view that each moment is unique, nothing is repeated, and nothing stays the same. Learning and accepting that impermanence is present at all times, as every moment is different from the next or the previous one, therefore, everything constantly changes and everything can always be different is vital to our wellbeing. Non-striving is another Buddhist concepts that mindfulness draws from, and it is an ability to give up expectations while not attaching to an outcome. Acceptance in context of mindfulness practice is related to acceptance of what is in the present moment, without judgment or without effort of trying to change it, avoid it, or distress about it,
while knowing that it is not permanent. Letting go is an action that requires no action; it is neither rejecting nor holding onto experiences, or thoughts, or emotions, whether they are pleasant or unpleasant, but rather, whatever occurs, letting it occur and pass. Recognizing thoughts as just thoughts while letting them pass, makes room for what happens next, and it cultivates awareness and ability to realize that one does not have to react on each thought that goes through our mind (Williams, Teasdale, Segal, & Kabat-Zinn, 2007).

In 1979, Jon Kabat-Zinn developed a successful mindfulness-based stress reduction (MBSR) program at the University of Massachusetts Medical Centre. By the 1995, Jon Kabat-Zinn developed The Center for Mindfulness in Medicine, Health Care, and Society. An offspring of the MBSR program, Mindfulness Based Cognitive Therapy (MBCT) was developed, which expanded on the MBSR philosophy, and it was developed by Williams, Segal and Teasdale, with the intention of treating depression and for prevention of depression relapse (Teasdale, Segal, Williams, et al., 2000).

Mindfulness is the ability to develop acute and sharp awareness of everything one does, which includes the ability to catch the mind when it wanders, and the ability to gently bring it back without making judgments or criticisms about it. Mindfulness is having the ability to be in the moment and to pay attention while keeping an open and nonjudgmental mind, remaining curious as if the event being observed is happening for the first time. In the book Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse, it is stated that: “… ultimate aim of the MBCT programme is to help individuals make a radical shift in their relationship to the thoughts, feelings and bodily sensations that contribute to a depressive relapse, and to do so
through changes in understanding at a deep level (Segal, Williams, & Teasdale, 2002, p. 65). Their main aim is to assist participants in learning to choose the most skillful way in which to respond to unpleasant thoughts, feelings or situations that arise, through learning how to “pay attention, on purpose, in each moment, and without judgment” (Segal, Teasdale, & Williams, 2002, p. 87).

MBCT teaches participants to adopt a different view on their daily life, their daily being and their daily doing. Many people are often problem orientated, focusing on how they want things to be, instead of being accepting with the way things are. Therefore, many often strive to fix things or situations by doing something, or by striving to get somewhere, towards a goal, while forgetting to just be in the present. Frequently much effort is invested in how to remove or escape painful thoughts, feelings, or body sensations, which eventually, and inevitably becomes taxing to the mind and body. People frequently try to do something in order to change feelings, or thoughts, either they try to numb them, push them away, or distract from them. However, that turns human beings into “human doings” as we constantly strive to do something about the way we are feeling. According to MBCT teachings, participants in mindfulness group need to intentionally place the attention on the present moment, and not in reference to the past or future. They need to develop a more accepting mind, including accepting that they are “good enough” as they are in the current moment, just like Adler would suggest, practicing being good enough.

This balance between the “human being” with the “human doing” is essential to the overall wellbeing of each individual. Similar to what Marsha Linehan identifies in her text titled *Cognitive Behavioral Treatment of Borderline Personality Disorder*:
Diagnosis and Treatment of Mental Disorders Series, (Linehan, 1993), the “wise mind”, is a balance or a state in which the balance between emotional mind and intellectual mind is activated. According to Linehan this state is an “inherent wisdom of patients” (1993, p. 33).

**Principles of MBCT and DBT**

The principles of Mindfulness Based Cognitive Therapy (MBCT) are in many ways similar to Dialectical Behavior Therapy (DBT), however, there are some major differences. MBCT is a structured group-based treatment program, which combines cognitive therapy with intensive training in mindfulness meditation. MBCT was designed to be delivered to patients in recovery from major depression, and it is more applicable for treating depression and preventing relapse of depression (Ma, & Teasdale, 2004).

While Dialectical Behavior Therapy (DBT) is also a structured treatment program combining mindfulness and Cognitive Behavior Therapy (CBT), DBT is also used as a tool for better affect regulation. DBT was originally developed and created by Marsha Linehan in order to treat suicidal patients. DBT later expanded and it has been used effectively in treating more severely affect-dysregulated patients, such as patients with Borderline Personality Disorders (Linehan, 1993). Therefore, DBT is more applicable and more effective in treating suicidal patients, patients who were diagnosed with Borderline Personality Disorders, and patients who struggle with various addictions. This population is more likely to have had suffered multiple traumatic events, and they most probably also suffer from complex trauma or post-traumatic stress disorder, as well as multiple addictions issues and self harming behaviors.
Principles of Mindful Self-Compassion

Mindful Self Compassion is a conscious and deliberate training and a form of self-discipline used in order to develop and learn how to cultivate mindfulness, or the awareness of thoughts and emotions, to learn how to cultivate and practice self-kindness, and to develop the awareness and connectedness to the greater humanity, instead of remaining isolated. Self-Compassion is a skill that clients can learn, so that when they are on their own, facing difficult emotions, they have the ability to soothe themselves. They learn the skill of comforting themselves, offering themselves kindness instead of self-criticism, while realizing that suffering is a natural part of being human, and in turn not over-identifying with their emotions but rather become aware of them. This process reduces psychopathology and improves psychological functioning (Germer & Neff, 2013) and emotional wellbeing. It is important to mention that self-compassion does not remove negative emotions, but rather it promotes embracing emotions experienced, which in turn shift the intensity of negative emotions making them become more bearable and tolerable.

The most important aspects of these ‘third wave’ of cognitive behavioral therapies, Mindfulness Based Cognitive Therapy (MBCT), (Segal, Williams & Teasdale, 2002), Dialectical Behavior Therapy (DBT) (Linehan, 1993), Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl & Wilson, 1999), Compassion Focused Therapy (CFT) (Gilbert, 2005, 2010) as well as Mindful Self Compassion (MSC) (Germer, 2009; Germer & Neff, 2013) is teaching clients to change their relationship to their emotions, by accepting emotional difficulties in a compassionate on nonjudgmental way. What all of these therapy approaches have in common is improving positive affect,
reducing negative affect, and improving overall well being by reducing emotional distress through cultivating a nonjudgmental mind, compassionate attitude, mindfulness, and loving kindness (MacBeth & Gumley, 2012).

**What is Compassion?**

Compassion is an emotion that we feel in response to others’ suffering with a strong wish and a desire to relieve others’ suffering. It is also a deep awareness of the suffering of oneself and other living beings, coupled with the wish and effort to alleviate it (Gilbert, 2005). Compassion and empathy are closely related. According to Halifax, (2012) empathy is the first step in the chain, which leads to the path of feelings of empathic concern and compassion. However, there is an important distinction between empathy and compassion, and that is: when one is feeling compassion, one is “feeling for” another person and feeling a strong wish to relieve their suffering, and when coupled with loving kindness, one is not feeling the same emotional load attached to the other person’s suffering. However, when one is feeling empathy, one is “feeling with” or “suffering with” the other person, vicariously sharing the same feelings as the other person. When one feels empathy, that person feels or understands the other person, but does not necessarily care to do something about it. When adding loving kindness to empathy, and a wish to alleviate that person’s suffering, we are experiencing compassion.

According to Daniel Batson (1987), there are two distinct emotions motivating individuals to help others and those are: Empathic Concern and Personal Distress.

*Empathic Concern* is focused on others, and it produces similar emotions when witnessing another person suffering (Baltson et al., 1987: Eisenberg, 2000) involving feelings such as sympathy, compassion, and tenderness. *Personal Distress* is focused on
oneself, and the motivation, or the intention behind it is to relieve another person’s suffering prompted by wanting to relieve one’s own uncomfortable feelings.

Depending on the motivation of the observer, actions taken may vary. If truly one is practicing compassion, the intention behind compassion is a “wish that all sentient beings may be free from suffering” according to Dalai Lama. Meditations on compassion and loving kindness originate from Buddhist traditions going back thousands of years. Feeling empathy and compassion alone does not help anyone if there is no action attached to it, like action of engaging in some form of helping. Metta meditation is a meditation of loving kindness and compassion, cultivation of loving kindness for self and other. “Metta is the ability to embrace all parts of ourselves, as well as all parts of the world. Practicing Metta illuminates our inner integrity because it relieves us of the need to deny different aspects of ourselves” (Salzberg, 1997, p. 22). Mindful self-compassion meditations often include forms or variations of Metta meditation.

What is Self-Compassion?

Self-compassion is compassion directed towards oneself. It is “...emotionally positive self- attitude that should protect against the negative consequences of self-judgment, isolation, and rumination (such as depression)” (Neff, 2003b). Furthermore, because of its non-judgmental nature, and its interconnected outlook, “…it should also counter the tendencies towards narcissism, self-centeredness, and downward social comparison that have been associated with attempts to maintain self-esteem (Neff, 2003b, p. 85), however, instead lead further to isolation and increase in anxiety. So, self-compassion appears to be the antidote to depression and isolation.
If compassion involves being touched by suffering of others, and opening one’s awareness to others’ pain without avoiding it or attempting to disconnect from it, while cultivating feelings of kindness towards others, and the desire to alleviate their suffering, then self-compassion means having the same desire for oneself (Neff, 2003b). This approach also requires cultivating a nonjudgmental viewpoint and understanding for those who did or do wrong, and towards ourselves when we think we fail or we did or are doing something wrong. In that way, others’ “… actions and behaviors are seen in the context of shared human fallibility” (Neff, 2003b, p. 87). In addition, self-compassion “involves offering nonjudgmental understanding to one’s pain, inadequacies and failures, so that one’s experience is seen as part of the larger human experience” (Neff, 2003b, p. 87). Self-compassion has three main components. These three main characteristics are: “… (a) self-kindness—being kind and understanding toward oneself in instances of pain or failure rather than being harshly self-critical, (b) common humanity—perceiving one’s experiences as part of the larger human experience rather than seeing them as separating and isolating, and (c) mindfulness—holding painful thoughts and feelings in balanced awareness rather than over-identifying with them” (Neff, 2003, p. 223). These three components if practiced, collectively contribute to the feeling state of balance and harmony.

Often people misinterpret self-compassion with self-pity (Neff, 2003); however, these two are very different from one another. When a person feels pity for others, individual feels remote and disconnected from those who are suffering, only relating on a self-centered egocentric level, thinking that he or she would not be in the same position, or would not experience this kind of suffering. Similarly when one feels self-pity, he or
she becomes self-absorbed in his or her own problems, forgetting that others also struggle. This “over-identification” and complete self-absorption with feelings of suffering, block access to other and different mental interpretations, or healthier emotional responses towards self and others. On the contrary, compassion and self-compassion allow one to feel connected to others, realizing that suffering is part of being human, and that all humans suffer (Germer, 2013).

Self-compassion also allows one to see the related experiences of self and others without this type of distortion or disconnection. Self-compassion also allows individuals to not “over-identify” with their emotions recognizing the broader human context of one’s experience and offering oneself kindness (Neff, 2003b). When one can step back from self, the individual can see the situation in a more objective way. Self-compassion requires discipline, the kind of discipline that consciously allows one to experience painful emotions without repressing or avoiding them, while being mindful of emotions, and balancing them in a compassionate objective way. When practicing mindfulness we become more balanced in the way we experience emotions, avoiding extreme over-identification or dissociation from painful emotions, seeing more clearly and accepting our mental and emotional states, accepting our own humanness. On the contrary, when individuals are not being mindful of painful thoughts and experiences, they are not accepting them, which creates increased level of anxiety, and increased levels of creating other coping strategies of avoiding feeling the experience that is presented.

This refusal of bringing difficult emotions to conscious awareness manifests as “…intense emotional resistance to the pain, so that one is caught up and swept away by one’s aversive reaction. This latter type of response typically involves narrowly focusing
and ruminating on one’s negative emotions (Neff, 2003). Negative emotions are typically attached to focus on self-worth, which is again a way of “over-identification”, and usually self-worth is attached to and contingent upon success. If one fails, self-worth decreases with each failure. This over-identification and competitive nature creates more isolation and further separates people from each other (Neff, 2003b). On the other hand, self-compassion is not contingent on success, therefore, if no self-criticism and harsh judgment is inflicted on oneself if failure occurs, there would not be feelings of isolation occurring. Self-criticism and rumination, as well as feelings of separation demonstrated in the past to be associated with depression. Fortunately, training in self-compassion and mindfulness can help teach individuals how to accept and tolerate their own painful thoughts and emotions, rather than trying to change them, which can be very helpful in preventing depression. Practice of self-compassion leads to achieving a more balanced emotional states which further moves individuals towards making better choices and consequently better outcomes (Germer, 2009).

**Principles of Yoga Therapy for Trauma and PTSD**

Yoga has been known for thousands of years to be a practice that unites or balances mind and body. This unity is achieved through various disciplined practices ranging from healthy balanced eating, meditative practices, physical activity, examination and careful choices of words and actions towards self and others, and through examining of other practices that are nurturing and caring of one’s mind and body. Yoga is practiced through various forms of behavioral, meditative, respiratory, and physical practices. The most important and necessary aspect of recovering from trauma and symptoms related to trauma, is learning various coping strategies which can calm the
anxious mind, and becoming more proficient in better self-regulation of emotions. When working on trauma through the body, the individual is teaching oneself how to promote states of relaxation by reducing stress inflicted on the body as a result of being in chronic stress response. Prolonged exposure to stress puts the body in constant fight, flight, or freeze mode, in which adrenaline is constantly being released, causing cascade of neurohormonal activation, resulting in increase in blood pressure, heart rate, and overall feelings of agitation and nervousness. Practices such as yoga and meditation activate conscious regulation of breath in order to reduce stress response, and activation of movement and body awareness, activating exercise, muscle tension and relaxation, inducing more balanced nervous system response (Centre for Addiction and Mental Health, 2009).

Recently there has been an increased amount of research devoting attention to yoga and meditation practices which include meditative and physical yoga practices and the effects of regular practice on mind and body and how these practices can reduce symptoms that trauma has on autonomic nervous system. According to Emerson (2009) “…Yoga practices, including meditation, relaxation, and physical postures, can reduce autonomic sympathetic activation, muscle tension, and blood pressure, improve neuroendocrine and hormonal activity, decrease physical symptoms and emotional distress, and increase quality of life” (Emerson et al., 2009, p. 124). Therefore, if Yoga can be used as an adjunctive therapy to improve behaviors, emotions, and physiological symptoms associated with PTSD and trauma, incorporating Yoga practices when treating those who suffer with trauma and PTSD, may be beneficial and vital to their recovery,
and these approaches may be the most inexpensive and easy to provide to a traumatized population.

**Trauma on the Continuum**

“When a man has learned within his heart what fear and trembling mean, he is safeguarded against any terror produced by outside influences” ~I Shing, Hexagram #51 (circa 2500 BC) (Levine, 2010).

Trauma, Post Traumatic Stress Disorder (PTSD), Complex Trauma, Acute Stress Disorder (ASD), Post Traumatic Injury (PTSI), Complex Trauma and Disorders of Extreme Stress (DESNOS) (Luxenberg, Spinazzola, & van der Kolk, 2001), and the latest, Trauma- and stressor-related disorders (American Psychiatric Association, 2013) are just a few latest names to describe or diagnose and give a name to a disorder for those individuals who suffered a traumatic event or multiple traumatic events and who have been emotionally affected by that event(s). Depending on the severity, intensity, chronicity, and complexity of the trauma one of the above diagnosis is assigned to those who suffered traumatic event(s).

The view of trauma and PTSD, as well as the diagnosis have been evolving, and taking various forms through time, and throughout our history. Trauma symptoms and various presentations, as well as trauma’s long lasting effects on the psyche have been known and identified for thousands of years; yet, clinicians are still struggling to find the best ways of healing trauma. The focus of traumatic experience originated from very prevalent, and still present various wars, and it evolved and expanded to include other types of physical abuse, sexual abuse, neglect, to vicarious trauma experienced by
observing others suffering such is in work related traumas seen presenting in health professionals and first responders.

Adler did not exactly talk about Trauma, but he did refer to shocking events in people’s lives, and the way those who suffered from shocking events later react to them in a similar way towards others, with anxiety, or depression (Strauch, 2001). In regards to other psychopathologies, Adler used to refer to them as symptoms being creatively used by the client in order to achieve person’s life style goals, consciously, or unconsciously. Strauch questions whether in PTSD Adlerian view is applicable, and whether one can come to conclusion that a person who suffers from PTSD uses symptoms in creating the life style, or whether other factors are influencing perception of that person while creating a view points which determine life style that individual later adapts (Strauch, 2001).

The Adlerian primary factor of resilience is social embeddedness (Ansbacher & Ansbacher, 1956, p. 127). When dealing with trauma, if a trauma sufferer has not developed strong feelings of social belonging, he/she would be more discouraged and for that person it will be more difficult to recover from the traumatic event. Therefore, Strauch (2001) recognizes the need of social support and Adlerian concepts of re-orienting being vital in healing trauma. It makes sense that this would be a reasonable approach to treating trauma, since the social support is vital not only for trauma recovery but for recovery from all types of human sufferings, because we cannot strive, survive, or recover on our own. Having social support and others to help restore safety during traumatic experience is vital and essential for healing. Apperception-schema, once understood by the individual can be re-oriented by help of a therapist; therefore,
someone’s lifestyle re-orientation can be another way of using Adlerian approaches to treating trauma (Ansbacher & Ansbacher, 1956, p. 333). Sometimes a person trapped in the neurosis caused by the past trauma can escape if someone, like a therapist, who is objective and holds “common sense” can see the patient’s “private sense” and can explain the patient to himself (p. 333). Although this is a vital component of trauma therapy, it is part of second stage of trauma therapy.

The first state in treating trauma is establishing and creating physical safety, emotional safety, and providing psychoeducation about symptoms, in order to understand and manage emotions. The client cannot process trauma if basic needs of safety are not established first. However, in the second stage of trauma therapy, the client can start to uncover, remember, grieve, and process traumatic memories. In this stage of cognitive behavioral therapy (CBT), psychodynamic and body oriented therapies can be used. The third stage of trauma therapy is reintegration, which includes reconnecting back into regular life, relationships, work, and spiritual aspects of life (Centre for Addiction and Mental Health, 2009).

**Trauma History**

Trauma history can be traced back to early 1900 B. C. when Egyptian physicians described psychological distress as a “hysterical reaction to trauma” which was described in people after having had experienced a traumatic event (Unknown, 2013, par. 1). Around 1000 B. C. an Egyptian combat soldier named Hori wrote about his feelings just before going into a battle: "You determine to go forward... Shuddering seizes you, the hair on your head stands on end, your soul lies in your hand" (Teflon, 2013, PTSD Within History, para. 1), which is clearly and very powerfully depicting symptoms of
PTSD. A 5th Century B.C. Spartan commander, was known to excuse soldiers from joining combat, and he made his decisions based on known previous proven bravery in soldiers, who later exhibited symptoms evident to be suffering from PTSD. Herodotus wrote of the Spartan commander Leonidas who had recognized that soldiers were affected psychologically by previous fights and spoke of them as they “…had no heart for the fight and were unwilling to take their share of the danger” (Teflon, 2013, PTSD Within History, para. 2), again, evidently describing how soldiers experienced avoidance of the stimuli, people and situation that remind them of previous traumatic event. In 1003 A.D. similarly, during the Anglo Saxon battle between the English and the Danes, one of the English commanders reportedly “…became so violently ill that he began to vomit and was not able to lead his men…” (Teflon, 2013, PTSD Within History, para. 5) portraying strong somatic expression of psychological trauma through the body. Samuel Pepys in 1666 illustrated similar PTSD symptoms experiencing in himself, while also noticing in others who survived Great Fire of London, classic PTSD symptoms such as insomnia and anxiety. In the diary of Samuel Pepys, six months after he had survived the Great Fire of London, he wrote "...it is strange to think how to this very day I cannot sleep a night without great terrors of the fire; and this very night could not sleep to almost two in the morning through great terrors of the fire..... a most horrid, malicious, blood fire... So great was our fear... It was enough to put us out of our wits" (Teflon, 2013, PTSD Within History, para. 6). This sharing of struggles with long lasting PTSD demonstrates how persistent and debilitating the symptoms could be, and the lack of awareness by the sufferers is still seen and not uncommon to this day.
Early diagnosis were being established gradually; in 1678 Swiss Physicians identified ‘Nostalgia’ a term used to define melancholia, persistent thinking of home, with sleep disturbances and insomnia, accompanied by loss of appetite, anxiety with cardiac palpitation, stupor, fever, and overall weakness. While at the same time German doctors used a term “heimweh” or “homesickness”, French doctors called it “maladie du pays” which also means feeling “homesick”, while Spanish used a term “estar roto”, which translates to “being broken” (Goodpaster, 2013). In the early 1700’s Dominique Jean Larrey describes the disorder as having three stages such as “heightened excitement and imagination.... period of fever and prominent gastrointestinal symptoms.... and frustration and depression” (Goodpaster, 2013, Early History, para. 2). In 1855 the Government Hospital for the Insane in Washington DC was established in order to treat those with mental illness and those who suffered from combat stress induced mental disturbances (Goodpaster, 2013). In 1860s after the Union Civil War thousands of veterans became hospitalized primarily with a diagnosis of “nostalgia”, depressed mood, with severe homesick feelings.

During the same period in late 1800s French scientist Briquet proposed that there was a connection between early childhood trauma and symptoms of “hysteria” later in life. These symptoms included somatic, emotional, and behavioral intense reactions, as well as dissociation. An American physician DaCosta, described classical PTSD symptoms in soldiers exposed to combat in American Civil War. The symptoms DaCosta described included increased arousal, irritability, and elevated heart rate. Da Costa proposed the term “disorderly action of the heart” (van der Kolk, McFarlane & Weisaeth, 1996, p. 48).
In 1866 The New York Times wrote about a new disorder called “railway spine” after a passenger reports surviving “...unbruised and his mind unconscious of any disorder beyond a general weakness and confusion...” (Slack, 2013, para. 4). During 1866 a British surgeon John Eric Erichsen wrote about psychological problems that were caused by severe injuries, further ascribing them to causes and “...warned against confusing theses symptoms with those of hysteria, a condition that he, and most of his contemporaries, claimed only occurred in women” (van der Kolk, McFarlane, & Weisaeth, 2007, p. 48). In 1887 a very innovative diagnosis came into being, “Railway and Other Injuries of the Nervous System" proposed the evidence of “unseen” injury, suggesting that injury to the spine and the brain caused “railway spine”, which is consistent with injury to the nervous system that can not be seen as a primarily a physical injury (Teflon, 2013).

During this period the conflict, or the dichotomy of the physical and emotional traumatic injury became more perplexing, the lack of physical evidence of the injury, and the lack of trust in mental disturbances by the health care professional, created further mistrust and shame of mental illness and suffering associated with it. In 1871 Jacob Mendez Da Costa published a study about the ‘irritable heart’ because soldiers who endured trauma had increased blood pressure and heart rate, evidently physical symptoms of PTSD (Goodpaster, 2013). It is understandable that for that time and for the lack of technology that is available today, the confusion about the connection between emotional trauma and the physiological effects on the body can be excused to a certain point, however, today with all the evidence of mind body connections, it is a lot more difficult to justify and ignore evidence of this strong connectedness. Today there are hundreds, if
not thousands of research studies demonstrating the strong correlation between mind and body, physiological effects, and the relationship of our mind on the cardiac and endocrine systems as well as other systems which are affected by neurohormonal imbalances, yet somehow, we still tend to neglect this evidence. The mind-body dualism is well addressed by Antonio Damasio in quite a few of his publications and books (Damasio, 2005). Finally, our brain and body do live in the same body, how could anyone think that our mind and body are not connected? Maybe a better question yet, is where does our mind reside?

In 1889, German neurologist Herman Oppenheim was one of the first doctors to propose the term "traumatic neuroses" suggesting that functional problems were related to the changes occurring in the nervous system, based on molecular imbalances, or what we know today as neurohormonal imbalances, which presented as symptoms of trauma in those who had experienced and suffered a traumatic event. He proposed that these subtle molecular changes in the nervous system expressed disturbances in the cardiovascular system, coming to the long and lasting terminology associating posttraumatic problems with terminology such as ‘cardiac neurosis’, ‘irritable heart’, ‘soldier’s heart’, ‘disorderly action of the heart’, and ‘neurocirculatory asthenia’ (van der Kolk, McFarlane, & Weisaeth, 2007, p. 48) which were common during World War I.

In 1904 Pierre Janet described subconscious memories being the cause of formation of mental schemes that influence how person interacts with those in his environment. He described that person is often not able to accurately form perception of current environment as a result of past trauma and past inability to respond to stress. “Janet proposed that when people experience "vehement emotions" the mind might not
be able to match what is going on with existing cognitive schemes. As a result, memories of the experience cannot be integrated into personal awareness. Instead, they are split off (dissociated) from conscious awareness and from voluntary control” (Teflon, 2013, Past Century & PTSD, para. 2). It appears that this was one of the first “…comprehensive formulation of the effects of trauma on the mind [that] was recorded. This was based on the notion that failure to integrate traumatic memories due to extreme emotional arousal results in the symptoms of what we today, call PTSD” (Teflon, 2013, Past Century & PTSD, para. 2). In 1905 ‘Battle shock’ was by that time regarded as a legitimate medical condition by the Russian Army (Goodpaster, 2013) because many soldiers experienced a dazed disoriented state, also referred to as “shell shock” (Bottome, 1939). In 1925 Pierre Janet, Freud’s contemporary proposed that when people had “vehement emotions”, “…their minds are not capable of integrating their frightening experiences with existing cognitive map”, therefore as long as the memories can not be integrated and translated they linger and cause the patient to experience fear of those memories, or they also tend to dissociate (Friedman, Keane & Resick, 2007, p. 38). In 1945 Moran described “…how, despite the acceptance of diagnosis of shell-shock, doctors found it extremely difficult to distinguish it from cowardice” (van der Kolk, McFarlane, & Weisaeth, 2007, p. 49) hence 11% of 200 British soldiers condemned to death for desertion were actually executed during WWII (p. 49). All of these symptoms described are consistent with our current PTSD diagnosis, and seems to add that it would take hundreds of years to talk about the same thing before it officially becomes a diagnosis, and to this day, sadly, PTSD diagnosis remains questionable and controversial in some instances.
Trauma and Post Traumatic Stress Disorder or PTSD

Post Traumatic Stress Disorder or PTSD, according to Chapman, Meyer, and Weaver (2006), in order to qualify for the diagnosis for PTSD, a person has to have an exposure to a serious traumatic event in which the person’s life or someone’s else’s life was threatened. This person must have experienced intense fear, helplessness, or horror. When this is experienced in childhood, the presentation is often seen as a disorganized or agitated behavior in the child who experienced trauma. The second criteria to qualify for diagnosis of PTSD is that the person has to have at least one of the following presentations, a) either a recurring distressing memories of the event, or b) recurring distressing dreams, or a c) recurring distress at cues that resemble traumatizing event, or d) intense psychological reaction at cues, or e) psychological distress and physiological reaction to cues resembling the event. The third symptom is exhibited by the persistent avoiding of stimuli associated with the event with numbing of the responsiveness, which is presented by at least three of the following ways, a) efforts to avoid related feelings or thoughts, b) efforts to avoid related activities, people, or places, c) inability to recall an important part of the event, d) experiencing feelings of detachment from other people, e) reduced participation in activities that are significant, f) having feelings as if the person’s life will somehow be cut short, g) and having a restricted range of emotions. The fourth criteria for diagnosis of PTSD is that the symptoms must be expressed for at least a month while causing significant impairment in daily functioning (Chapman, 2006, p. 50).

Complex Trauma

The field that studies trauma or the traumatic stress “…has adopted the term “Complex Trauma” to describe the experience of multiple and/or chronic and prolonged,
developmentally adverse traumatic events, most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence) and early-life onset. These exposures often occur within the child’s caregiving system and include physical, emotional, and educational neglect and child maltreatment beginning in early childhood” (van der Kolk, McFarlane, & Weisaeth, 2005, p. 402). Complex Post Traumatic Stress Disorder (C-PTSD) or Disorder of Extreme Stress Not Otherwise Specified (DESNOS) was not recognized in the DSM-IV as a diagnosis, but it was accepted as associated feature of PTSD (Luxenberg, Spinazzola, & van der Kolk, 2001).

The main differences between simple and complex trauma is that in simple PTSD there are changes occurring in three areas of functioning. Simple post-traumatic stress occurs typically as a result from a one-time traumatizing event, such as a sexual violence or a serious accident, and in order for the individual to meet criteria for diagnosis of PTSD, individual has have experienced an event in which the life, physical safety or physical integrity of the client was threatened or actually harmed, resulting in feelings of intense fear, helplessness or horror, and the individual is (I) continuing to re-experience the traumatic event after it is over, (II) is seeking to avoid reminders of the event, and (III) the individual is exhibiting signs of persistent arousal (American Psychiatric Association, 2000). However, in complex trauma changes occur in six domains of functioning. In order to determine whether an individual suffers from complex post-traumatic stress, individual has to experience changes in each of the six domains of functioning. The domains are: (I) changes in regulation of affect and impulses, (II) changes in attention or consciousness, (III) alterations in perception of self, (IV)
alterations in relations with others, (V) somatization, and (VI) alterations in systems of meaning (Centre for Addiction and Mental Health, 2009).

It is evident that simple and complex PTSD are quite different. In complex post-traumatic stress disorder individuals have often experienced chronic and repeated abuse resulting in the individual losing the ability to trust others or feel safe. Typically an individual’s feelings of safety and trust are replaced by continuous expectation of harm and further betrayal, and feelings are filled with continuous expectation of harm, therefore remaining hypervigilant and always prepared to protect oneself. Complex PTSD is a result of childhood that was damaging and neglectful on ongoing basis, which lacked consistent and predictable parent attunement, hence complex PTSD is multidimensional and pervasive, therefore affecting human functioning on a lot more levels than simple PTSD does. The shorter the duration of trauma and the older the individuals were exposed to trauma more likely they would develop only core PTSD symptoms, however, the longer the traumatic exposure occurred and the greater the severity of trauma, compounded with less protection and younger age, the more complex the damage to the individual is evident. Research shows that trauma has the most impact if experienced during the first decade of life (van Der Kolk, McFarlane, & Weisaeth, 2007, p. 202).

**DSM-5**

Since trauma is very complex, and extends across many areas, DSM-5 (American Psychiatric Association, 2013) has dedicated a whole section, an entire chapter to Trauma- and stressor-related disorders to better delineate the complexity of trauma exposure and its effects, associated disorders, and to be able to come to a clearer
diagnosis. Hence, PTSD is no longer listed as one of the anxiety disorders but is under Trauma- and stressor-related disorders. Disorders associated with exposure to traumatic and stressful events are explicitly given unique diagnostic criteria. According to the DSM-5 (American Psychiatric Association, 2013) there is a new chapter given to the Trauma- and stressor-related disorders, these related disorders include: posttraumatic stress disorder (PTSD), acute stress disorder (ASD), reactive attachment disorder, disinhibited social engagement disorder, and adjustment disorders. This chapter and its placement reflects the close relationship between these diagnoses and disorders in the surrounding chapters, which are focused on anxiety disorders, obsessive-compulsive and related disorders, and dissociative disorders (American Psychiatric Association, 2013).

Experiencing a traumatic event produces psychological distress; however, the expression of symptoms will vary from person to person. In certain individuals’ symptoms they are expressed in the form of anxiety- or fear-based context, and for others the characteristics of clinical presentation will be evident as feeling unwell and unhappy (dysphoric), unable to experience pleasure (anhedonic), or by demonstrating anger, aggression, or dissociation. Because of the variations in presentation of symptoms trauma related disorders have been grouped into different categories of symptom expression, under trauma- and stressor-related disorders even though some symptoms overlap across different categories. In addition, reactive attachment disorder and disinhibited social engagement disorder both have the same etiology; the cause of development of these two disorders stems from childhood neglect, specifically, form absence of adequate care being given in childhood. The presentation of both disorders is different however; reactive attachment disorder is expressed through depressive and
withdrawn symptoms, more focused inward, while disinhibited social engagement is expressed by behaviors being externalized, more hence outward (American Psychiatric Association, 2013).

Post-traumatic stress disorder, according to new DSM-5 diagnostic criteria develops as a result of an individual being exposed to actual or threatened death, serious injury, sexual violence, or physical violence, which was experienced in one or more of the following: experiencing a direct of witnessed traumatic event, or by learning about the violent or accidental traumatic event that occurred to a close family member or close friend. The individual is experiencing repeated or extreme exposure to aversive details of the traumatic event such as in first responders who are collecting human remains or police officers repeatedly being exposed to details of child abuse. In addition, the individual is experiencing one or more of the following intrusion symptoms associated with the traumatic event: reoccurring and involuntary intrusive distressing memories about the event, repeated distressing dreams associated with the event, dissociative reactions such as flashbacks in which the individual feels or acts as if the traumatic event were recurring in the present moment, intense or prolonged psychological distress or marked psychological reaction if exposed to the cues that symbolize or resemble an aspect of the traumatic event, and persistent avoidance of stimuli associated with the traumatic event. The avoidance of the stimuli begins after the traumatic event occurred, and it includes one of both of following: avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event, and evident efforts to avoid external reminders such as people, places, conversations, activities, objects, or situations that arouse distressing memories, thoughts, or feelings.
about or closely associated with the traumatic event (American Psychiatric Association, 2013).

Additional symptoms of PTSD include negative alterations in cognitions and mood associated with the traumatic event, which begins or worsens after the traumatic event occurred, with two or more of the following: (I) Inability to remember an important aspect of the traumatic event, often as a result of dissociative amnesia, and not as a cause of head injury, alcohol, or drug consumption. Additional symptoms are (II) persistent and exaggerated negative beliefs or expectations about oneself, others, or the world, (III) persistent, distorted cognitions about the cause or consequences of the traumatic event that lead the individual to blame himself/herself or others, (IV) continuous negative emotional state, (V) markedly diminished interest or participation in significant activities, (VI) feelings of detachment or estrangement from others, (VII) and persistent inability to experience positive emotions such as happiness, satisfaction or loving feelings.

Additionally, individual experiences (I) marked alterations in arousal and reactivity associated with the traumatic event, which begins or worsens after the traumatic event, with two or more of the following symptoms: irritable behavior and angry outbursts which occur with little or no provocation, and are typically expressed as verbal or physical aggression toward people or objects, reckless or self-destructive behavior, hypervigilance, exaggerated startle response, problems with concentration, and sleep disturbance. Individual experiences (II) the disturbance for more than 1 month, (III) the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, (IV) the disturbance is not attributable to the
physiological effects of a substance such as alcohol or medication or another medical condition (American Psychiatric Association, 2013).

Some individuals experience dissociative symptoms, and in addition to an individual’s symptoms meeting the criteria for posttraumatic stress disorder, the individual, in response to the stressor, experiences persistent recurrent symptoms of either of the following: depersonalization, which is persistent or recurrent experiences of feeling detached from the body, and as if one were an outside observer of one’s mental processes, or when the body feels like as if one were in a dream; with a sense of unreality of self or body, or as if time were moving slowly. Derealization is another dissociative symptom in which the individual experiences persistent or recurrent experiences of unreality of surroundings, such as if the world around the individual is experienced as unreal, dreamlike, distant, or distorted. Notably, in this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance such as in blackouts during alcohol intoxication or during another substance ingestion (American Psychiatric Association, 2013).

**Adlerian Approach to Trauma and PTSD**

Alfred Adler, among classic psychoanalysts, in regards to cognitive aspect of functioning, Adler called “method of operation” a personality style and “self-perpetuated behavioral patterns closely approximate the core schemas invoked by modern cognitive therapists” (Friedman, Keane & Resick, 2007, p.38). The Adlerian approach recognized that a person who suffered trauma for some reason recreates traumatic events, consciously or subconsciously or, what we know as today, they are “re-enacting past traumas”. What Adler proposed for therapy is to have a safe therapeutic relationships
with the client and also to facilitate confrontation, resembling Socratic questioning, which is known today as cognitive restructuring practiced used by modern therapists today, or what is also knows as uncovering and reframing mistaken beliefs, which is what Adler practiced, and Adlerian therapists still practice today. The Adlerian approach is compatible with today’s trauma healing approaches, which focus first on stabilization, creating safety for the patient, and then cognitive therapy, reframing viewpoints and beliefs, integration of traumatic memories, followed by re-integration back into the world (Centre for Addiction and Mental Health, 2009).

In Alfred Adler’s biography written by Phyllis Bottome (1939), she wrote of Adler as a physician who worked during the war treating soldiers in overcrowded hospitals, and he observed and studied “shell shock”, recognizing it as an acute and unnecessary agony of young war victims (p. 111). Although Adler studied shell shock, he did not take time to note down in detail the effects of “shell shock”, he treated it, and recognized it, and defined symptoms of PTSD as “shell shock’s” effects (p.167). Finally, in 1952 DSM-I recognized ‘Gross stress reaction’ and first included symptoms of PTSD. Later, during the Vietnam War, in 1965, some changes were made, so that each military battalion was “provided with officers trained to treat psychological problems” (Goodpaster, 2013, para. 18). It appears that the main focus of PTSD was focus on combat stress, and diagnoses were separated according to types of trauma. Ironically, at that time, in 1980s the leading U.S. textbook in psychiatry claimed that “.... incest happened to fewer than one in a million women, and that its impact was not particularly damaging....” (van der Kolk, McFarlane & Weisaeth, 1996). Judith Herman in 1981 began documenting widespread sexual abuse of children and how prevalent and
devastating the effects of child sexual abuse were. This lead to Sarah Haley, who was a daughter of a World War II veteran with severe “combat neurosis”, and she was also an incest victim herself, to be one of the people who was most directly involved into acceptance of PTSD diagnostic category into third edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (van der kolk, McFarlane & Weisaeth, 1996). In 1987, however, DSM-III-R had dropped the requirement for the stressors to be outside the range of normal human experience, which led to the formation of National Center for PTSD within the department of Veterans Affairs in 1989, when the National Center for PTSD was established by the Congress to promote research and better education about PTSD (Goodpaster, 2013).

**Trauma Research, Causes, Effects, and Resiliency**

When measuring trauma, history, age, severity, and chronicity of trauma are factors attributing to PTSD development and or resilience. According to McHugo et al., (2005), age at the time of the traumatic event, severity, and chronicity are very important factors to consider, especially when considering gender differences in PTSD prevalence and co-morbidity, as some measures are “...content relevant to the stressors and traumatic experiences that are specific to, or more common for, women or men” (p.115). In addition, depending on gender, some traumatic experiences may not be reported at all, and it may take long time to diagnose someone with PTSD, while the experiences may also not be reposted equally as being traumatic in both genders (McHugo et al., 2005).

Furthermore, according to the study from Mexico on childhood trauma and the relationship trauma has on physical health later in adulthood, in 2009, Baker, Norris, Jones, and Murphy, found that prevalence of childhood trauma was as high as 35%. Men
generally reported more childhood trauma than women, however, there was an exception; women reported more sexual violence and exposure than men did. When taking into account total physical health, men who suffered childhood sexual violence, had more overall physical symptoms than women, however, when measuring depression and the relationship between childhood sexual violence and physical health symptoms, for men and women the symptoms were equally distributed (Baker et al., 2009). These studies also show relationship of psychological and emotional trauma experiences in relationship to the physical illnesses and physiological expression of trauma later on, the effect of emotional suffering taking a toll on the body.

According to Baker et al. (2009), in women only “…PTSD mediated the relationship between childhood sexual violence and total, muscular-skeletal, and gastrointestinal and urinary symptoms. PTSD also mediated the relationship between hazards/accidents in childhood and total, muscular-skeletal, cardiopulmonary, and nose-throat symptoms” (p. 255). Interestingly, this study had proposed that health professionals need to widen their awareness to the prevalence of childhood trauma in Mexican children, therefore, improve screening practices, and identify trauma early, based on physical symptoms presentation, in order to improve health outcomes for trauma survivors (p. 257).

In 2002, in a study by Jankowski, Leitenberg, Henning, and Coffey, with nine hundred and seventy four women participants, the study results show that women who have been sexually abused in childhood were twice as much at risk of being sexually assaulted in adulthood, and that women with two or more traumas were three times more likely to be sexually re-victimized in adulthood. When they examined relationship
between parental care, there was no correlation with parental care and being re-victimized (p. 235). Therefore, even if parental care is adequate, it did not show to be enough to buffer for the trauma exposure, nor did it show to prevent re-victimization. More traumatic events, greater the severity, more likely it is that these women would also develop physical symptoms as adults, either as a result of purely physical exposure to violence, or as a result of mind-body connection, which is finally getting attention in the last decade.

**Research Results**

Finally that the Trauma and PTSD symptoms have been accepted and established, now the treatments and healing trauma modalities will continue to evolve probably for long time. Current traditional recommended treatments for healing trauma and PTSD mostly focus on pharmacotherapy, or behavior changes, and they are oriented and focused mainly on managing symptoms and regulating emotions. One very interesting way of exploring trauma and its effects is by looking into the relationship that trauma plays within mind and body, especially when it comes to trauma and trauma processing. According to extensive research and brilliant work of Peter Levine (2008), trauma processing and healing can occur even if one does not remember the traumatic event. Levine’s approach to healing trauma is through body, and “body memory” of the trauma. His theory is that when people can access “body memories”, they can start to discharge the instinctive survival energy that they did not have a chance to discharge at the time of the event. Levine believes that because “…trauma happens primarily on an instinctual level, the memories we have of overwhelming events are stored as fragmentary experiences in our bodies, not in the rational parts of our brains” (Levine, 2008, p. 31).
His explanation is that when we encounter a traumatic event, trauma gets stuck in our body, because we cannot do what our natural instinct would have us do, which is “fight”, “flight”, or “freeze”, and later discharge the energy, or “shake it off”, like wild animals do. We unfortunately, after entering the “freeze” mode, have a hard time returning to normal, after being in this state for a prolonged period of time.

Levine strongly believes that the primary reason for developing PTSD is our inability of returning to balanced state after using the “immobility response” (Levine, 2008, p. 29). Peter Levine has done extensive research on healing trauma, and his approach is to understand that trauma is primarily physiological, that it happens initially to the body and instinct and then it spreads to mind and spirit. Therefore, if we can access trauma through body, move out of our immobility, release the frozen energy and frozen state, and discharge energy necessary to restore to normal functioning, we could heal trauma (Levine, 2008, p. 30).

Dr. Bessel van der Kolk, who is a psychiatrist and a founder of the Trauma Center in Brookline, Massachusetts, has done extensive research on trauma and how to heal trauma. His concern and focus in is not on what is the root cause of trauma but rather, his focus is more on how to restore well being, and release the tension, fear, constant hyper-arousal, and feelings of helplessness which is what most of the trauma patients experience. Since trauma stays “frozen” in our body, relationship to our body is vital in order to restore and regulate our nervous system. In addition various cognitive and behaviour changing therapies, Eye Movement Desensitization and Reprocessing (EMDR) and Somatic Experiencing (SE), Sensorymotor psychotherapy (Ogden, Minton, & Pain, 2006) and Yoga, have proven to have positive effects on healing trauma. David Emerson
in collaboration with Dr. Bessel van der Kolk (Emerson et al., 2009) has studied effects of Yoga on PTSD symptoms. In an initial pilot study (Emerson, et al., 2009) comparing eight weeks of DBT to eight weeks of Yoga, participants in Yoga group showed improvements in all dimensions of PTSD “... an increase in positive affect and decrease in negative affect, and an increase in their physical vitality and body attunement.

Compared to participants who received DBT, Yoga participants reported a greater reduction in frequency of all PTSD symptoms and severity of hyper-arousal symptoms, as well as greater gains in vitality and body attunement” (Emerson et al. 2009, p. 125).

Due to the small sample size of the pilot study, there was no statistical significance, however, Yoga did appear to have positive influence on affect regulation, and improvement in decrease of hyperarousal.

Stoller et al. (2012) study found that sensory-enhanced hatha yoga was effective in reducing anxiety in participants with combat stress. The Yoga Warriors International™ program is a specifically tailored yoga for first responders, and was developed to alleviate symptoms of combat stress and post-traumatic stress disorder (PTSD) and increase the resilience. Lucy Cimini (2012) developed the program after studying combat veterans and she is teaching yoga to populations who are working in high stress environments such as soldiers, police officers, as well as firemen, paramedics and other first responders. The effects of yoga in her study showed improvement of critical task performers working in high stress environments, including affected caregivers and family members (Stoller, 2012).

It would only make sense that learning how to relate to the body instead of numbing and dissociating, or vacating the body when inconvenient, depending of
situations encountered, it would be reasonable to expect that developing change to the relationship one has to his/her body, would create awareness and familiarity to the body’s needs, responses, and hopefully with time one can developing feeling of safety while still remaining in the body.

Yoga practice, mindfulness, and breathing restore and reset the physiology of the nervous system that is in a constant hypervigilant state, such as in those who suffered from various types of trauma. Yoga offers an experience of change in mental state, reducing hyper arousal state, inducing feeling of relaxation, and bringing the feelings of being “normal” again. Therefore, a somatic approach such as Yoga practice can rewire the brain, and change the response to stressors by creating more balance between sympathetic and parasympathetic nervous systems.

Emerson (2011) teaches that by learning how to regulate our own body, our movements, and our nervous system we can release past trauma from our body and reset our system to more restored and balanced state. Benefits of practicing mindfulness and yoga are that we learn to develop a flexible mind-set, and we learn how to more calmly approach difficulties that arise in our every day life. Through Yoga practice we learn to return to relaxed state more quickly, becoming better able to manage our emotions, and responses to stressful stimuli, becoming more proficient in a new language: mind-body relational language. Yoga brings awareness to the body, therefore sharpening the focus on our sensations, and body needs, improving our response to our body needs, which makes our ability to take care of ourselves more efficient and responsive. Through Yoga we cultivate self-acceptance, we learn to reduce judgment, and negative thinking, and we become aware that we have some control over our body and our emotions.
Discussion of the Importance of Mindfulness in Healing of Trauma

Most frequently, trauma survivors are not even aware of their body, because often, and based on their past experiences, being in the body did not feel safe, so they learned how to leave their body, and they learned a plethora of clever and innovative coping strategies on how and when to leave the body. Often those strategies served a purpose when faced with danger, however, when they become habits of second nature, trauma survivors use these survival skills developed even when not in danger. Becoming aware of trauma response coping strategies being used, but no longer useful, is the first step towards healing. Then befriending oneself with kindness and compassion would be the next step towards healing. In order to heal we must nurture ourselves with compassion and loving kindness. Finally, one needs to befriend his or her body in order to heal, learn to inhabit the body, and learn that it is safe to be in the body at the present moment. Becoming familiar with one’s body takes time and practice, and this is where Yoga comes into play. Yoga practice that is sensitive to trauma survivors is designed to invite participants to explore choices, feel their body, and become empowered that being in the body is safe, eventually leaving old unhealthy coping mechanisms behind.

Therefore, practicing mindfulness, self-compassion, and Yoga, can be great benefits in healing numerous debilitating trauma symptoms.

Importance of Mindful Self-Compassion

Self-compassion is a practice in which the individual learns to form a healthy way of relating to self by treating oneself in a positive and kind manner, by cultivating a kind, nurturing and self-soothing way of talking to oneself. Similar to mindfulness, self-compassion creates healthy relation towards oneself recognizing difficult emotions and
accepting them instead of pushing them away or rather than self-indulging in them, while recognizing that difficult emotions are experienced by everyone. This recognition is responsible for promoting feelings of interconnectedness, social embeddedness and common humanity. The feeling of social interest, recognizing and feeling that we are not separate or unique in our suffering, promotes a feeling of connection rather than isolation from others. By meditating, individuals learn how to calm the nervous system, and how to tolerate difficult emotions.

If we look at compassion in evolutionary terms, as MacBeth (2012) describes it, having the threat-based system which is responsible for detecting danger and activating survival mechanism is very useful, but the threat system is also closely related to negative emotions such as anger, fear and shame, while the positive affect systems are related to motivation and reward drive system, and to the soothing system. Therefore it is social connectedness, or the social feeling (Ansbacher & Ansbacher, 1956) mentality that comes into play when individuals have the intention and motivation to alleviate distress in others. When these feelings are activated, such as sympathy, non-judgment, co-operation and caring, individuals form bonds, therefore, “…compassion is understood as an evolved motivational system designed to regulate negative affect through attuning to the feelings of self and others, and expressing and communicating feelings of warmth and safeness…” (MacBeth, 2012, p. 4).

The Importance of Self-Compassion in Therapy

In mindfulness-based approaches to therapy, such as in mindfulness based cognitive therapy (MBCT) and mindfulness based-stress reduction (MBSR) self-compassion has been found to be the key mechanism of effectiveness when it comes to
predicting improvement in psychiatric symptoms and interpersonal relationships. (Germer & Neff, 2013). Participants in the Mindful Self-Compassion (MSC) program created by Germer and Neff (2013) demonstrated in their research a “…significant increase in self-compassion, mindfulness, compassion for others, and life satisfaction and a decrease in depression, anxiety, stress, and emotional avoidance. All gains in outcomes were maintained at 6 months and 1-year follow-up. In fact, life satisfaction actually increased significantly at the 1-year follow-up, demonstrating that continued self-compassion practice enhances one’s quality of life over time” (Germer & Neff, 2013, p. 859). Self-compassion practices do not suggest to push negative emotions away, but rather to embrace them. By accepting negative emotions as they arise, with kindness and curious attitude, individuals develop resiliency to tolerate their own emotions on a daily basis. Just by the process of not wrestling with negative emotions on a daily basis, but rather embracing them, significant reduction in stress is observed, and the negative emotions naturally change, and positive emotions are generated by the ability to withstand negative ones (Germer & Neff, 2013).

Individuals practicing self-compassion exercises develop emotional resiliency. It is suggested that self-compassion “…deactivates the threat system (associated with feelings of insecure attachment, defensiveness, and autonomic arousal) and activates the caregiving system (associated with feelings of secure attachment, safety, and the oxytocin-opiate system)” (Germer & Neff, 2013, p. 3). Therefore, individuals practicing self-compassion exercises can reduce activation of stress hormone release such as adrenaline, vasopressor, and cortisol, while improving heart-rate variability.
According to Bessel van der Kolk and his research done on neurophysiology and PTSD (2006), heart rate variability (HRV) “…provides the best available means of measuring the interaction of sympathetic and parasympathetic tone, that is, of brainstem regulatory integrity” (van der Kolk, 2006, p. 285). According to van der Kolk, low HRV has been associated with depression and anxiety, coronary vascular disease, and increased mortality, while high HRV is associated with positive emotions and resistance to stress. His research demonstrated that there was a fundamental dysregulation of arousal modulation at the level of brain stem in PTSD patients, showing that PTSD patients had increased baseline autonomic arousal and lower resting heart rate compared to normal controls, suggesting that they had increased sympathetic and decrease parasympathetic tone (van der Kolk, 2006). Furthermore, there was a strong inverse relationship between heart rate and HRV in individuals with PTSD, while a substantial proportion of PTSD patients did not have an elevated basal heart rate (van der Kolk, 2006). It appeared that “…in order to come to terms with the past it may be essential to learn to regulate one’s physiological arousal” (van der Kolk, 2006, p. 285).

Mindful Self-Compassion practice developed by Germer and Neff is practiced in a small group setting. Typically, groups are not very large, under 25 participants with one or two teachers, out of which at least one is a mental health professional. Teachers in typical MSC groups model compassion and self-compassion, they also encourage participants to support each other through being kind and respectful to each other, and they also model creating a safe and compassionate environment in the group. The safe and compassionate environment is necessary in order to promote development of inner resources while exploring the ability to remain with difficult emotions that may arise.
MINDFULNESS IN HEALING TRAUMA

(Germer & Neff, 2013). Typically, there are 8 sessions over an 8-week period and each session explores different aspects of development of a compassionate nature towards self and others. For example, in the first session, individuals discover mindful self-compassion by being introduced to the program, and to each other. Participants are introduced to contemplative exercises in which they notice how they relate and treat others and self during difficult times in their lives. Participants are thought how to practice “Self-Compassion Break” which is a short exercise in which each individual repeats the following, or similar phrases whenever they encounter difficult emotions, or experience emotional distress: “This is a moment of suffering” (mindfulness), “Suffering is a part of life” (common humanity), and “May I be kind to myself” (self-kindness) (Germer & Neff, 2013). These phrases promote breaking the cycle of rumination and engagement with negative thoughts and emotions, they promote the feeling of being more connected to others and less isolated, and they promote self-soothing and self-compassion. Participants are also encouraged to self-soothen by placing their hand on their body, approximately where their heart is, and feeling the warmth of their hand on their chest while they are also encouraged to ask themselves what do they need, which helps identifying needs.

In the second session participants learn theory and practice of mindfulness, relationship of mind and body, and they learn how to anchor their attention by focusing on their breath or an object, like a stone, focusing on being in the here and now. In the third session participants are introduced to loving kindness meditations, which involve repeating phrases such as “May I be safe” or “May I be kind to myself” while focusing on attention. This can be done in sitting meditation or any time throughout the individual’s
day. In the fourth session group participants are taught how to find their compassionate voice, and how to identify their self-critical voice. They learn how to use an encouraging voice for themselves, the same as they would use when encouraging a good friend. Participants also get a four-hour retreat, which is often in silence, used to slow down, walk mindfully, enjoy the environment, eat mindfully and learn how to scan their own body using body awareness meditation. In the fifth session participants learn to explore core values, while in the sixth session participants learn how to manage difficult emotions, and how to become more aware how their emotions affect their own body sensations. Individuals are taught how to soften, allow, and soothe themselves through physical, mental and emotional compassion during difficult times. The seventh session teaches participants how to transform painful relationships with others or with self. “Participants learn to use compassion phrases for the pain they have endured in difficult relationships, and also to breathe compassion in for themselves and out for others with whom they wish to reconnect” (Germer & Neff, 2013, p.10). Lastly in eight session participants learn how to embrace their life, and more fully become aware of their negativity bias, while appreciating good things in life, which enable them to enjoy life more fully.

Meditating, relaxing, and creating feelings of gratitude, calmness, and positive emotions have positive effects on our nervous system, causing cascades of neurohormonal release, opposite of fight or flight effect, but rather deactivating the nervous system activation and calming the mind and body.

**Importance of Oxytocin and its Effects on Stress**

During the Metta meditation suggested in Germer’s mindful self-compassion (Germer & Neff, 2013) individuals are instructed to place one hand over the other on
their chest, right over the heart, and they are instructed to feel the warmth of their hand on their heart while repeating in their mind phrases composed of offering themselves loving kindness and wishes of wellbeing. During this process, individuals can activate their own release of oxytocin. Oxytocin is the hormone widely known as the one responsible in stimulating labour and milk ejection. However, oxytocin has many other healing properties as well. In the research study on oxytocin, (Kubzansky, Mendes, Appleton, Block, & Adler, 2012) showed that oxytocin helps regulate positive social behaviour. When given to research participants in men, studies have found that “… exogenously administered oxytocin reduced fear-related activation in the amygdala, reduced cortisol levels and distress in response to social stress, increased prosocial behaviors, and modulated social memory” (Kubzansky, Mendes, Appleton, Block, & Adler, 2012, p. 4).

“Social interest” or “Gemeinschaftsgfühl” is one of Adler’s key concepts. Community feeling that Adler talks about is very much related to responding well in a social context, being useful is having a prosocial behavior, having empathy and concern for others rather than being focused on oneself. Adler may have not known about oxytocin release at the time, however, his key concepts are still the main and most responsible concepts for wellbeing and healing for isolation, depression and traumatic symptoms. “Humans are fundamentally social creatures who are ‘motivated’ to be with others” according to Gordon, Martin, Feldman, and Leckman (2011). In their review, role of oxytocin was examined, and how it relates to social motivation. Oxytocin is synthesized in the brain, and body, such as heart, thymus, GI tract and reproductive organs. The oxytocin receptor “… expression is also sensitive to changes in the external environment and the internal somatic world. The OT system functions as an important
element within a complex, developmentally sensitive biobehavioral system” (Gordon et al., 2011, p. 471). Although there are other elements related to oxytocin interplay, such as sensory inputs, the hypothalamic-pituitary-gonadal axis, and the hypothalamic-pituitary-adrenal stress response axis, responsible for activating stress response, and are also affected, it still remains unclear the exact effects of this interplay on complex human biobehavioral system, and human interactions in social patterns. However, what is evident, is that oxytocin produces “anti-stress” like effect by decreasing blood pressure, decreasing cortisol level, decreasing anxiety, and promoting healing (Gouin, Carter, Pournajafi-Nazarloo, Glaser, Malarkey, Loving, Stowell, Kiecolt-Glaser, 2010).

**Importance of Yoga on Trauma Healing**

Since the mind and body connection plays an integral role in trauma it would be wise to assume that healing trauma needs to come from both aspects, from the mind and from the body. Bessel van der Kolk started researching methods how to create regulation of the core arousal in the brain while feeling safe in the body for trauma-sensitive people. According to van der Kolk, Yoga showed to get “…people to safely feel their physical sensations and to develop a quiet practice of stillness” (Integral Yoga Magazine, 2009, p. 12). In trauma survivors, individuals are not necessarily attached to some awful story of what happened to them in their past, but trauma that is the “…residue of imprints left behind in people’s sensory and hormonal systems (Integral Yoga Magazine, 2009, pp.12-13) and that is what is affecting individuals when they are experiencing sensations in their bodies. Hence, most of them do need some body oriented trauma work in order to heal and feel safe in their body again. Because intense emotions cause increase activation of the brain areas responsible for survival, at the same time areas in the brain responsible
for feeling of being fully present are less active, resulting in people with PTSD to feel that they have lost their way in the world. “Their bodies continue to live in an internal environment of the trauma. We all are biologically and neurologically programmed to deal with emergencies, but time stops in people who suffer from PTSD. That makes it hard to take pleasure in the present because the body keeps replaying the past” (Integral Yoga Magazine, 2009, p. 13). Dr. van der Kolk suggest that individuals who practice Yoga, over time, develop feeling of their body being strong and comfortable bringing them into present rather than remaining stuck in the past. He suggests that through Yoga practice, individuals with PTSD can learn how to tolerate feelings and sensations while increasing capacity for interoception and awareness, which will help them modulate arousal.

Trauma-sensitive Yoga has been offered since 2003 at the Trauma Center Yoga Program at the Justice Resource Institute in Brookline Massachusetts, and it has been offering Yoga to a variety of trauma survivors, such as war veterans, survivors of sexual assault, at-risk youth, as well as survivors of chronic childhood abuse and neglect (Emerson, Sharma, Chaudhry & Turner, 2009). Trauma-Sensitive Yoga was specifically designed for those who have experienced trauma and still struggle with symptoms of trauma or PTSD. This type of Yoga allows practitioners to feel their body in a safe environment, without having physical adjustments by the instructor, and allows individuals to experience activation of the nervous system, experiencing and tolerating difficulties while realizing that those will not last forever. Trauma Center conducted a pilot study to examine the impact of its Yoga program on PTSD symptoms. The participants were 16 women aged of 25 to 55, randomized into either eight weeks of
Yoga or Dialectical Behavior Therapy (DBT), and after eight weeks, Yoga participants demonstrated improvements in all dimensions of PTSD, “…an increase in positive affect and decrease in negative affect, and an increase in their physical vitality and body attunement. Compared to the DBT participants, Yoga participants reported a greater reduction in frequency of all PTSD symptoms and severity of hyperarousal symptoms, as well as greater gains in vitality and body attunement” (Emerson, Sharma, Chaudhry & Turner, 2009, pp. 124-125). Even though there was no statistical significance in this study due to the small sample size (n=16), Yoga did show improvement in affect regulation and decrease in hyperarousal (Emerson, Sharma, Chaudhry & Turner, 2009, p. 125).

Trauma-Sensitive Yoga has some characteristics that are different from typical Yoga-studio class. There are five aspects that require consideration when teaching Yoga to trauma survivors, and those are environment, types of exercises, teacher qualities, assists, which are limited to verbal cues, and language. Environment for trauma survivors is important; it needs to be safe and it needs to feel safe. Exercises are modified so that they can be suitable and not triggering for various populations. The teacher dresses conservatively to minimize distraction, and is modelling a welcoming attitude. The teacher does not move around a lot, which makes it more predictable for students, and overall teacher is gentle, non-judgmental and uses invitational language rather than commands. Instructions are slow; however, the focus is on feeling the body rather than using imagery, which can cause participants to dissociate (Emerson, Sharma, Chaudhry & Turner, 2009, p. 126). Another very unique and important aspect and approach to teaching trauma-sensitive yoga is using language that encourages choices, while giving
various options to each stretch and choices are encouraged. Participants, over time, become familiar with their body, they tend to feel safe in their body, and they also learn how to make choices for themselves rather than accepting whatever they are told to do. All of these aspects, in addition to relaxation, mental and emotional endurance building, physical strength building, contribute to better affect regulation, attending to the needs, and feeling of empowerment and overall wellbeing.

Another style of Yoga was developed specifically for military, and was studied in combat stress in deployed military personnel, to assess whether sensory-enhanced hatha yoga had effects on anxiety in military personnel. Seventy military personnel who were deployed to Iraq participated in a randomized controlled trial in which thirty-five received yoga and 35 did not receive any form of yoga, and “…treatment participants showed significantly greater improvement than control participants on 16 of 18 mental health and quality-of-life factors” (Stoller, Greuel, Cimini, Fowler, & Koomar, 2012). Unfortunately, traditional mental health care may be insufficient to address these problems, because studies have shown that talk therapies alone have limited success in treating PTSD (Ogden, Minton, & Pain, 2006; van der Kolk, 2006) and can even increase dysregulation (Ogden et al., 2006). Imaging studies have shown that Broca’s area, a major language center of the brain, can become deactivated in response to traumatic reminders, a finding that may explain why PTSD survivors are often at a loss for words to discuss their trauma (Shin, Whalen, Pitman, Bush, Macklin, Lasko, Orr, McInerney, & Rauch, 2001).

Yoga Warriors was created by Luci Cimini and like Trauma-Sensitive Yoga, was modified to be useful and therapeutic for combat stress and PTSD related to first
responders, police officers, and military personnel. There are modifications used for these yoga classes, but the basic premise behind Yoga Warriors training, is activation and deactivation of the sympathetic nervous system arousal. Exercises vary from powerful and strenuous to resting positions, almost mimicking CNS sympathetic arousal, or the fight or flight response, and then the instructions follow rest position, mimicking resetting the nervous system arousal activating parasympathetic activation. This appears to train nervous system how to get activated and also how to turn off, which often those who suffer from PTSD do not know how to achieve, especially after being in a prolonged chronic arousal state. Activating and deactivating the sympathetic nervous system, relaxation using breathing techniques and physical exercise in itself is quite beneficial for depression and anxiety. The data from (Stoller, Greuel, Cimini, Fowler, & Koomar, 2012) study yielded evidence that “…the sensory-enhanced hatha yoga program helped to significantly reduce both state and trait anxiety, as determined by comparing the treatment group with the control group” (p. 63).

**Adler and Mindfulness**

We must connect our thought with a continuous active adaptation to the demands of the outer world if we are to understand the direction and movement of life. We must think that this is a question of something primordial, or something that was inherent in primeval life. It has always been the matter of overcoming of the existence of the individual, and the human race, always a matter of establishing favorable relationship between the individual and the outer world. This coercion to carry out a better adaptation can never end. (Ansbacher & Ansbacher, 1956, p. 106)
In this paragraph there are all facets of the Mindful Self-Compassion process included. Connecting our thoughts is becoming aware of our thoughts and connecting them to our feelings and actions, and relationship to our life and what we do in life and how we live. Examining our thoughts, traumas and origins of our thoughts and beliefs, and examining them at a greater level, how those thoughts and our actions affect us in relationship to common humanity, like Adler said “the human race” would be the next step. The importance of social interests, or contributing to others in society, feeling connected to others and realizing that we are not alone in our suffering is a vital component of Buddhism, Mindful Self-Compassion, and Adlerian Psychology in order to reconnect to society, intimate relationships and in order to thrive in life. Those concepts are vital in healing trauma as well. And, lastly, just like in Mindful Self-Compassion, practice is focused on acceptance of emotions, acceptance of self, while striving to improve and be useful to others, in Buddhism, meditation practices are focused on practicing and being with oneself, as a life long process, while Adler said, that “this coercion to carry out a better adaptation can never end” (Ansbacher & Ansbacher, 1956, p. 106). This practice of acceptance of self and constant striving to improve self and relationships to others is a life long work and vital to our survival and wellbeing.

Compassion, and self-compassion are innate to all human beings and can also be very well observed in animals as well. Most of us have the ability to put ourselves in another person’s shoes and try to feel, to a certain extent, how the other person feels. It is vital to our interconnectedness to be able to understand and feel what others feel, so that we can be useful and try to alleviate their suffering. Buddhist Metta meditation, meditation on universal love, teaches universal loving kindness, and one of the common
MINDFULNESS IN HEALING TRAUMA

phrases is wishing all beings well, repeating: “May all be well and secure, May all beings be happy!” According to Buddharakkhita (1995) “…analysis of the behavior-pattern and traits commended by the Metta Sutta for meaningful interaction, both with reference to persons individually and to society as a whole, provides ample insight into the great implications of the sutta for mental health” (Buddharakkhita, 1995, Ethics of Metta, para 6).

What Adler calls a social feeling refers back to compassion. Adler believed social interest to be innate and although it is not inborn, it is “…an innate potentiality that has to be consciously developed” (Ansbacher & Ansbacher, 1956, p.134). Just like compassion, although it may be innate, it becomes forgotten or distorted as part of life events, especially if individual is affected by traumatic life events. Nevertheless, when an individual feels safe and secure, each person can consciously work on developing compassion, or social feeling, towards others and self. According to Adler and Individual Psychology “…empathy and understanding are facts of social feeling, a harmony with the universe” and this type of identification can be trained (Ansbacher & Ansbacher, 1956, p.136). According to Adler, one “…must sense that not only the comforts of life belong to one, but also the discomforts. One must feel at home on this earth with all its advantages and disadvantages” (Ansbacher & Ansbacher, 1956, p. 136). Similarly to Buddhist philosophy, it is vital to understand and accept the inevitability of human suffering, and accepting all emotions as part of life, as part of being human, not in comparison to others, but seeing how similar we are to each other, in our home, interconnected, and impermanent.

Understanding our common humanity, and feeling connected, supported by each
other is vital to our healing and survival. Trauma survivors can heal only once they feel safe, once they process their memories, thoughts and emotions, and finally reintegrate themselves back into society, contributing to social interest, and feeling useful as a part of social context.

**Conclusion**

In conclusion, the most important information to impart is that trauma is a very individual experience and it is affecting every culture. Trauma effects will depend on variations of predisposing factors, such as resilience, support, intimate connection between family members, society, and environment. Trauma effects and its presentation will depend on duration of the traumatic event experienced, intensity of trauma, physical, emotional, and psychological nature, or combination of all aspects, culture, historical and political condition of that time, and very much it will be dependent on the age and gender of the person experiencing trauma. The healing will also be dependent on immediacy and availability of support, openness and trust of sharing the experience and the quality and the duration of support.

The stigma of experiencing fear, or associated “weakness”, sadness, and the paralysis of the fright, have to come to light and the surface of this world, so that those who were frightened once don’t have to experience fear of sharing the terror that they experienced, and once again be perceived as weak or unable to handle what had happened to them. Trauma also has to be released through the body through various forms of Yoga, meditation, awareness, sensory-motor and somatic experiencing. Therapists have to be open minded and encouraging, and provide a safe and non-judgmental environment for those who experienced trauma, so that trauma survivors are able to share, learn, and
heal from what happened. Trauma survivors can restore their health and functioning, feel safe again while aware and vigilant in a healthy way, in order to not get exposed to situations where they could possibly get re-traumatized or their safety could be compromised. At the same time the hope is that those people could have lives worth living with ability of trusting others again. Definitely more research needs to be done on different aspects and continuum of trauma and trauma effects in order to be able to better understand and treat Trauma- and stressor-related disorders.

Finally, controlling breath, and breathing in a more relaxed focused manner, we have the only chance at controlling our autonomic nervous system, which normally works without our conscious input or control. By consciously slowing down our breath we can activate the parasympathetic nervous system, which is responsible for relaxation and the shift from the sympathetic nervous system response, which is responsible for arousal and stress response. If we can manage our activation of relaxation by slowing down the breath consciously, all we need is the awareness to know when we need to do it, otherwise breathing is an affordable and inexpensive technique that we can work with to start. Activation of parasympathetic nervous system causes the heart rate to slow down, which causes blood pressure to slow down, activating hormones responsible for relaxation, producing feeling of safety and wellbeing. Prolonged practice or various modalities that promote relaxation, feelings of safety, connectedness, and wellbeing, will have long lasting and therapeutic effects on healing trauma in the body and in the mind.
References


