Chapter 18
Teaching Individuals with Traumatic Stress

Trish Magyari

Applying a Trauma-Informed Framework to Teaching MBIs

This chapter (1) aids in the development of a "trauma-informed" competency in mindfulness teachers and therapists working with general population groups which may contain persons with traumatic stress symptoms and histories; and (2) offers additional guidelines for those teacher-therapists who are delivering dedicated trauma-focused mindfulness-based interventions (MBIs). The chapter includes a description of trauma-informed behavioral health intervention guidelines; applies those guidelines with practical suggestions from screening to follow-up; describes a trauma-informed method for beginning mindfulness meditations; offers specific guidelines for the body scan, mindfulness retreats, and additional adaptations for dedicated trauma-focused MBI groups. "Trauma-Informed Mindful Dialogue," (found in Part IV Chapter 24, D) applies many of these guidelines to inquiry following a mindfulness exercise.

Persons with trauma histories, trauma stress symptoms, or a diagnosis of post-traumatic stress disorder (PTSD) are likely to be in virtually all MBI groups. Many of the most common referral criteria include traumatic components such as chronic pain, anxiety, depression, traumatic illness, traumatic grief, and traumatic stress-related symptoms. Merriam-Webster's dictionary defines trauma simply as "*a very difficult or unpleasant experience that causes someone to have mental or emotional problems usually for a long time*." While not everyone who experiences trauma will be diagnosed with PTSD, many will exhibit some of the symptoms of traumatic stress, either acutely after the trauma or to a degree that may or may not meet the full criteria for a PTSD diagnosis.

Trauma survivors experience a number of challenges to developing mindfulness skills, especially regarding those practices that are still (as opposed to moving),

T. Magyari, M.S., L.C.P.C., N.C.C., R.Y.T.-200 (✉)
Mindfulness-based Professional Training Institute, UC San Diego Center for Mindfulness, 5060 Shoreham Place, Suite 330, San Diego, CA 92122-0980, USA
e-mail: trish@trishmagyari.com

W. Goodwin (ed.), *Forensic DNA Typing Protocols*, Methods in Molecular Biology 1420, DOI 10.1007/978-3-319-30100-6_18

eyes-closed practices with long expanses of silence. This limitation stems from the primary effect of trauma on the brain, namely, chronic and easily triggered fight/flight/freeze reactivity. There is also growing research evidence and clinical experience revealing that trauma survivors can master, benefit from, and experience transformative recovery through a trauma-informed, mindfulness-based approach (Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010; Folette, 2015; Williams et al., 2015); even more importantly, mindfulness is being recommended as an efficacious component of trauma recovery programs (SAMSHA, 2014; van der Kolk, 2014), including healing from the sequelae of adverse childhood events (ACEs) (Jackson Nakazawa, 2015). With these recent recommendations, it is likely that there will be an increase in referrals to MBIs or mindfulness-based therapists, often as an adjunct to individual trauma-focused therapy. The value of mindfulness training in general, and of MBIs in particular, is in the combination of learning to be present in *this moment* of one's life, along with very specific and concrete instructions on how to "be with" one's own experience in a way that is healing rather than retraumatizing, triggering, or otherwise self-injuring.

All MBI program components can be successfully taught to persons with trauma histories when using a trauma-informed approach. This approach to teaching the full MBI curriculum of mindfulness exercises allows for the greatest chance of mastery, healing, and success by anticipating and creating empowering solutions through skilled attention to the known challenges of working with traumatized populations. In general, what makes trauma-informed teaching successful is more in the "how" of it, rather than the "what" of it. This process is accomplished through four main "trauma-informed" teaching components with specific attention for evoking self-compassion as a resource woven throughout:

1. Offering anticipatory guidance both before and during the course regarding supports and resources for staying present, even while those recovering from trauma are participating fully in the curriculum. This includes the resource of the teacher and any resources the participant already has for staying present, grounded, and out of distress—such as techniques that calm the sympathetic nervous system.
2. Giving control to participants through options, choice, invitations, and seeking permission. Such as the choice for eyes open or eyes closed and normalizing, validating, and supporting choice and autonomy.
3. Working skillfully with trauma-related distress when it arises in class and during home practice through modeling nonjudgment, acceptance, and compassion.
4. Titrating periods of mindfulness meditation in order to stay within the therapeutic window, using resources and supports as well as modulating intensity.

General guidelines for trauma-informed behavioral interventions, of which mindfulness is one, include the following components: Preparing the client; Creating collaborative relationships; Creating safe environments; Supporting choice, control, and autonomy; Putting in place resources and supports for staying present; Monitoring and facilitating stability; and Managing trauma-related destabilization. (SAMSHA, 2014). Each of these trauma-informed components is operationalized and explained in this chapter, citing numerous practical applications to MBI cur-

riculum components. The last guideline, Managing Trauma-Related Destabilization, is also addressed in Chap. 37. Please keep in mind that many of these guidelines overlap, so that "Creating a Collaborative Relationship" is also a part of "Preparing the Client" and "Putting in Place Resources and Supports."

Theoretical Considerations Regarding PTSD

The DSM-V (APA, 2013) places PTSD symptoms into four categories:

- Intrusion symptoms including triggers, flashbacks, and nightmares
- Avoidance, including dissociation, avoiding people/places/things as well as both emotional and memory numbing
- Arousal/reactivity where the fight or flight reactivity is overworking coupled with difficulty calming down
- Negative mood and cognition such as rumination over negative events

Mindfulness interventions are a good fit for addressing these symptom domains. Intrusion symptoms are addressed by teaching skills to stay present and work with intrusive memories and triggers like any other phenomenon—by teaching clients not to react to reflexive inner reactivity. Clients are coached to *move toward* what they are experiencing with a friendly attitude, even when they don't like their experience, thus decreasing avoidance symptoms. Arousal/reactivity symptoms decrease through the calming effect that mindfulness practices have on the nervous system, specifically by activating a parasympathetic response. Additionally, mindfulness of current surroundings can be used to notice the presence of safety when it is there. Negative mood and cognition are addressed by disrupting the downward spiral of depressive rumination and self-loathing by learning not to react, but instead simply to identify thoughts simply as just thoughts. Clients can also learn how to respond to self-critical thoughts in a kind way, creating a more positive relationship foundation with self. MBIs also involve training to identify and stay with positive experiences that are often overlooked or rejected in persons with negative mood states.

According to one theoretical framework, trauma potentially affects the domains of identity, relationship problems, and affects regulation (Briere & Rickards, 2007; Briere & Spinazzola, 2009). Each of these domains is described more fully below, including how MBIs address these domains:

1. Identity issues, including reduced access to self and being other-directed, are addressed through increasing inner-directed awareness and developing self-knowledge.
2. Relationship problems, including difficulty separating past from present in interpersonal relationships, are addressed by increasing the ability to identify and stay with present moment experiences, decreasing reflexive reactivity, and teaching specific mindful communication skills such as listening and speaking.
3. Affect Regulation, including a reduced ability to self-regulate moods, thoughts, and feelings, are addressed by increasing self-calming skills, increasing self-

compassion, and learning to respond vs. react, especially to inner reactivity and negative emotional, or cognitive states.

Research Considerations

A number of research studies have described the quantitative value of MBSR, MBCT, and other MBIs for persons with trauma histories on reducing PTSD symptomatology and are summarized in the book "Mindfulness-Oriented Interventions for Trauma Care" (Follette, et al. 2015). The following comments were collected through written questionnaires during one MBSR clinical trial for women with complex trauma from childhood sexual abuse. These comments illustrate MBIs' ability to address PTSD symptomatology and to have personal meaning for the participants (Magyari, 2015). Comments are disguised to preserve study participants' confidentiality without altering meaning:

Participant A's Words

WK4: "At last, I can let go of the shame and anger. Now I can stay with those thoughts without panicking or trying to avoid them."
WK8: "In this group, I've learned that I am not my crazy thoughts and it's OK to feel scared, sad, or angry. It doesn't mean that I am falling apart. The most important part was that (sic) learning not to bury my thoughts. That's at the core of my being able to forgive myself."

Participant B

WK4: "Before this class, I was stuck. This class is on growing and healing. It's really useful to learn not to be so judgmental of myself."
WK8: "To be in this moment, present, and not dwell on the past. I've learned that I have the strength and to heal myself and to be a friend to myself. It's like I've been awakened. I felt good to be reintroduced to myself."

Participant C

WK4: "This class has given me tool that will help me to handle my life better. The most useful tool for me is the body scan."
WK8: "In this group, I've been formally introduced to myself. I feel like I am finding myself after being lost for a very long time, and I am feeling more secure

about who I am during this period of my life. I am also more willing to reach out to people rather than withdraw from everyone. The body scan helped me to get in touch with the places where I hold all the pain in addition to all the normal aches and pains. I found myself again."

Participant C was again interviewed 2.75 years after the MBI course as part of a follow-up study. Some of the behavioral changes that she reports since the MBI course include:

- Recognizing how "stressed" she was in former job and finding a new, more fulfilling job that she's been in for the last 2.50 years.
- Stopping smoking after many previous failed attempts; now, smoke free for over 2.00 years.
- Getting married after a lengthy engagement. "Finally, felt safe enough"; feeling happy in marriage.
- Taking up running. She now runs a 5-mile race on a regular basis.

These reported behavior changes illustrate increased self-awareness, increased relationality, decreased reliance on an addictive substance for coping, and increased healthy behaviors. Such changes were echoed in other participants' follow-up reports.

Notable was the lack of distressing events during the silent, eyes-closed mindfulness meditations or laying down body scan or yoga routines, two activities often considered to be too emotionally challenging for those with complex trauma. The MBI had been delivered utilizing both the trauma-informed and trauma-focused guidelines in this chapter.

The most consistent feedback on the course was that participants liked and valued that they did not need to "tell their trauma story" to the group and that the MBSR curriculum focused on their lives now and moving forward.

Applying a Trauma-Informed Approach

The following guidelines come from (1) the clinical experience of leading MBI groups specifically for women with histories of childhood sexual trauma, who met full PTSD criteria at baseline; (2) facilitating over 60 additional MBI groups for a variety of traumatic stress, chronic pain, and/or chronic illness populations; (3) providing individual therapy for those with traumatic stress and PTSD using trauma-informed mindfulness-based and compassion-based approaches; (4) recommendations gleaned from participants during follow-up interviews; and (4) consultation and collaboration with other MBI teacher therapists working with traumatized populations using a trauma-informed approach.

Clinical Challenges to Providing MBIs to Those with Traumatic-Stress Histories or Symptoms

The clinical challenges of teaching mindfulness/MBIs come primarily from the PTSD symptoms of *avoidance*, *reexperiencing, and reactivity*. Rather than seeing these challenges as limiting factors, described here are methods of addressing them that features one of the core mindfulness tenants of "responding" rather than "reacting" to a participant's emotional reactivity. When considering these challenges, it is important to evoke a sense of mastery of the MBI material so as not to perpetuate the cycle of failure so familiar to those with traumatic stress. Specific challenges experienced by survivors of traumatic stress include: (a) increased identification with, and attachment to, a negative story line and memories; (b) increased self-judgment and unworthiness, leading to thoughts of not doing it right, not being good enough, or that one is bad; (c) fear that PTSD symptoms will be triggered (i.e., worry, avoidance) if they become present to their own experiences; (d) feeling hopeless and a failure (i.e., self-doubt, unworthiness); (e) not practicing at home due to not feeling safe; (f) having a tendency to start with the most challenging practices rather than the easiest (Wilkins & Magyari, 2009). The trauma-informed approach responds to these clinical challenges while also maintaining the integrity of the MBI curriculum.

Trauma-Informed Guideline: Prepare the Client Through Screening for Trauma Symptoms or Events and Providing Anticipatory Guidance

Screening participants in advance for traumatic symptoms or events prior to the course, and offering all participants the option of one-on-one contact with the MBI teacher prior to or early on in the course is recommended. Specifically reaching out to those who answer positive to these screening questions can help build trust between the teacher and participant. The relationship with the MBI teacher can be a potent support to participants with traumatic stress.

General questions are helpful:

1. "What are your current stressors?" "Your sources of stress?" "Are there any past events that are still stressful for you?" If you limit screening to direct questions about trauma/PTSD, many trauma survivors minimize their own distress and might not mention it. In addition, if they don't have full-blown PTSD, they may say "no" to the question regarding PTSD.
2. "What are your current stress symptoms?"
3. "Do you have a history of trauma?"
4. "Who is helping you with any of the above?"

Flag for follow up anyone who (1) has a diagnosis of PTSD or describes PTSD symptoms—those who meet full criteria, and those who do not; (2) divulges a

trauma history or history of traumatic events, regardless of chronology; (3) becomes lost in a traumatic "story"; and (4) is having traumatic stress symptoms such as panic attacks, nightmares, flashbacks, and dissociation.

Appropriate Candidates for MBIs/Mindfulness Groups

MBIs are appropriate interventions for many healing from traumatic stress. However, attention to timing is important. Some clients are best served initially by having individual therapeutic work *prior* to entering a group situation, in particular: those in the immediate crisis phase of their trauma healing, those with ongoing physical safety concerns, and those who are not yet stable on any medications which may be indicated for co-occurring conditions. During this preliminary individual work, it is helpful to put in place basic tools for staying present. Potential MBI participants must be able to organize life on a practical level to attend regular weekly sessions. Participants are best served when MBI teachers aid in this discernment process regarding timing so as to ensure maximum chance of a successful outcome.

Contraindications for group MBIs include being actively suicidal, in an active addiction process, or actively psychotic (unless the MBI teacher/therapist has specialized mental health training to address these situations).

Trauma-Informed Guideline: Developing a Collaborative Relationship Prior to the MBI-Helpful Strategies Before the Class Begins

It can be helpful have opportunities for contact between teacher and participant prior to the MBI, whether in person at an orientation session, in an individual screening session, on the phone so that a trusted relationship might take place. In the words of Brach (2015) a first step in mindfulness-based therapeutic work with those with trauma histories is for the participant to be able to "take comfort in my presence—physically, emotionally, and energetically," a process that may take time. The relationship with the teacher is a valuable support and a resource for those entering into an MBI. Therefore, several points of preparation are helpful to ensure that the course begins smoothly for individual participants and for the group as a whole:

- Have a written registration form and review them as above.
- Touch base in person or on the phone traumatic stress histories or symptoms. Give the option to *all* participants to meet or talk by phone in advance of the first class date if at all feasible.
- In this interview/orientation, inform participants that there will not be a need to "retell" their trauma "story" within the MBI and but neither is it a taboo subject.

Give examples of what might be relevant—if memories or trauma symptoms resurface during meditation or if it relates to any of the practices in the class. Even within trauma-focused MBI classes, the focus is on the here and now—how the past trauma might be interfering with their lives, causing stress or illness—not on the retelling of the traumatic event story.

- In any welcome letter, invite participants to make "special requests" or "let you know of special needs." Control is key to healing trauma. A special request might be anything from wanting to sit in a certain place in the circle (near you, facing the door, near the door) to wanting to know in advance what is happening, to simply needing more reassurance that you know what to do if they get upset in class. Thank them for asking for what they need and be clear about what you can or cannot accommodate. Offer information or reassurance regarding your approach (based on the guidelines in this chapter); anticipatory guidance is often helpful for building trust and calming anxiety and/or reactivity.
- In your MBI class notebook or workbook, provide a listing of the general topics to be covered at each class session. Giving a reasonable amount of structure can help trauma survivors to heal and feel safe enough to trust the process and open to new experiences.
- Encourage participants to contact you if they find themselves in the "distress" zone between classes or find themselves struggling with themselves or the material. Very often, this distress is due to an increased awareness of self-critical cognitions.
- Trauma survivors with PTSDs will often ask in advance if they can just leave class if they need to. This fear is common, but it is a very rare occurrence. Explain that they are free to make their own choices, but you'd prefer that they let you know immediately if they feel distress during the class (see Chap. 37, "Dialogue"); get agreement in advance. Ask what symptoms would make them to want to leave. Normalize any that you can, for example, weeping in class. Weeping isn't disruptive per se and can often be a sign that someone is letting feelings flow instead of numbing or avoiding them.
- Put in place resources and supports for staying present (see below for further details). Even teaching one method for activating the parasympathetic, like taking slow, deep belly breaths when starting to feel activated, can be helpful.

Trauma-Informed Guideline: Preparing the Client Through Putting in Place Resources and Supports for Staying Present

The collaborative relationship with the teacher or therapist, and later, the group, is a valuable resource for the participant with traumatic stress. Other equally valuable resources include tips for grounding in the body (such as contact with the chair or soles of the feet on the ground) or mindful movement; orienting to time and place,

which may include opening the eyes temporarily if they are closed; calming the nervous system (through deep belly breaths or audible sighs), and self-soothing (through soothing touch or offering words of encouragement). These can be put in place prior to the MBI at an orientation, individual intake, or early in the first session. Handing out lists of these resources as a reminder for use during home practice can increase a sense of safety and help with emotional regulation when practicing both in session and outside of class.

Teacher/Therapist Characteristics

Teaching *dedicated* MBIs to those with PTSD requires an advanced level of mindfulness training, practice, and embodiment as well as a deep understanding of the traumatized psyche. It is possible to assist those in our mixed groups to a successful completion by using the trauma-informed approach described here. The most important characteristic for the MBI teacher is not reacting in an outer way to a participant's inner or outer reactivity. The teacher models the desired response to reactivity by nonjudgmentally naming the cognitive, physical, and emotional experiences that the client reports experiencing (see Dialogue). It is natural for the MBI participant to react in habituated ways to new experiences that may be frightening to them, which primarily stems from negative cognitive patterns being activated by sensory experiences. Participants may encounter predictable challenges (such as noticing that they can't "feel" parts of their body during the body scan or getting anxious when their mind is quiet) in the first few weeks of the MBI. Dropping out might be reactive, reinforcing a pattern of avoidant behavior toward challenging experiences. Most clients are able to work through temporary challenges brought on by mindfulness practice if they stay with the program and utilize their resources and supports for staying present without distress.

Instead of encouraging avoidance, the trauma-informed MBI teacher gently guides the participant through concrete inquiry with questions such as "what is happening right now in your body?" "What are your feelings?" "On a scale of 1–10, how intense is that feeling?" If the participant can't identify the feeling or says they don't know, ask "which of the four pure emotions comes closest to it—sad, angry, afraid/anxious, or happy/content?" "Where and how do you sense this in your body?" And "Can you be with them in a friendly way?" When negative cognitions arise, as they will, it is important to name them as thoughts and go back to staying with the sensory experiences. Other helpful characteristics include exuding confidence both in mindfulness as a modality and in the participant's potential for recovery and ability to learn mindfulness skills. A sense of humor for the way things are is also helpful. Above all, the teacher is a mindfulness practitioner and embodies the practices in class.

It can be invaluable for individual therapy to continue during the group MBI experience so that the material can be integrated with a known and trusted helper. Signing releases so that you can share the MBI approach and your observations with the individual therapist is recommended.

Incorporating Sensitivities to Trauma into Standard MBI and Other Mindfulness Interventions

Many of these suggestions stem from adhering to good teaching practices, from paying special attention to clarity, safety, trust, and boundaries, and from being aware of how to handle known and expected challenges.

1. **Trauma-informed guideline: Creating safe environments safety concerns**: Choose to hold your groups in a private space and cover any public windows during class time. Sit in a chair where you can watch the door; if a latecomer enters during the opening meditation, state this directly, i.e., "Sally is taking off her coat now and joining the circle." Confidentiality is particularly important; while the MBI teacher may know much about participants' trauma history, the level of sharing is left up to group members. Confidentiality guidelines are discussed/decided upon in the first session. MBI teacher insures group members' feeling of safety with a question such as, "Is there anything else you'd like to ask for to feel safe in this group?" Dim or turn lights off only with the explicit assent of all class participants. In early classes, it is preferable to have lights on, especially if the class is in the evening.
2. **Trauma-informed guideline: Supporting control and autonomy to participants through options and choices**: Language your instructions to invoke "invitations"; permission, emphasizing choice, and giving people time to go at their own pace. For example: "When you're ready, I invite you to open your eyes and rejoin the group." Helping participants to maintain a sense of control over the process of the intervention is empowering and helpful to recovery. Using declarative instructions like "Close your eyes" may raise up resistance, story, and distress; better to say, "You may have your eyes open or closed. If open, I invite you to rest them on the floor in front of you. If closing your eyes, let them gently close when you are ready." Areas of choice might be around eyes open/eyes closed; standing, sitting, or laying down for the body scan; having lights on for the meditations; choosing where in the body to be with the breath; to shift position when needed; to "opt out" or pass for an portion of the class, etc. Those with traumatic stress do not often advocate for their own needs, so explicitly giving options and supporting autonomous choice whenever possible, is helpful.
3. **Trauma-informed guideline: Monitoring and facilitating stability introducing mindfulness in a concrete fashion/titrating silent practice**: "Mindfulness" is often equated with a silent meditation on the breath. While persons with trauma histories/PTSD can benefit over time from extended silent periods of breath meditation, they often benefit from other, more concrete and guided mindfulness practices as a first introduction. I introduce participants to any mindfulness meditation using a grounding and orienting sequence:

   (a) Mindful movement, even a brief stand and stretch before any still, silent practice.

(b) Orienting to time and place: "I invite you to notice that you are here, now, in [this place] on [this day of the week, this date, this year]"; inviting to practice with eyes open or closed.
(c) Grounding in the support of the chair/cushion and floor, especially the soles of the feet (Pollak, Pedulla, & Siegel, 2014).
(d) Down-regulating with a few deep diaphragmatic breaths with long audible exhale to activate the parasympathetic nervous system (Hanson, 2009).
(e) Reminders to bring calming resources, especially self-kindness (Germer & Neff, 2015) into the practice when inner struggle is arising.

This sequence, which takes 1–2 minutes allows for temporary down-regulation and can also be helpful for those with not also traumatic stress, but also anxiety, ADHD, racing mind, or simply those arriving to class with sympathetic activation. Beginning in this way paves the way for an experience that is self-affirming rather than defeating. Speaking too softly or leaving long silences may encourage distress, getting lost in story, or spacing out.

Balance permissions/autonomy/control with structure and guidance. Beginners need concrete instructions for where to place their awareness while navigating silence on their own. Emotional reactivity is often found in the domain of emotions and thoughts, and traumatic experiences are often stored in the body. Therefore, providing a structured way of working with experiences in these domains can be helpful for evoking confidence and the ability to stay present, especially during meditations using bodily sensations, emotions, or thoughts as the anchor; open awareness (choiceless awareness) practices; and any meditation that involves long periods of silence. Neuroscience has a tenant, "if you can name it, you can tame it"; encouraging participants to name experiences while experiencing them is calming to the nervous system. Linehan (1993) developed a 3-step process as part of the mindfulness training in DBT that is particularly stabilizing: (1) observe: notice the experience; (2) describe: choose concrete, descriptive words to name it; and (3) participate: fully experience it.

Especially when you are leading challenging practices or exercises, be clear on the purpose of the exercise. Articulate the reason for the exercise/practice and how it fits into the curriculum.

4. **Addressing reactivity** ("I can't do this," "I'm not doing it right"). Listen carefully for these self-judgments, which are natural responses to beginning mindfulness practice that often cause a great deal of distress. Reframe these cognitions as examples of self-judgment that can be acknowledged and responded to appropriately: becoming aware, naming (i.e., "judging"), noticing how one experiences self-judging on a somatic level, and responding in a kind way to any reactivity that has already occurred following the self-judgment. Use brain science to depersonalize and normalize the "I'm not good enough" story of traumatized/stressed mind.
5. **Normalizing PTSD coping strategies and honoring their role in the past**: It is important to tell the participant "We aren't trying to 'get rid' of anything," especially in regard to past coping mechanisms. Participants may feel shame in regard to maladaptive coping such as avoidant behavior, an inability to control

reactivity to flashbacks or triggering experiences, perfectionism, or dissociation. For participants with childhood trauma histories and adult PTSD symptoms, it is helpful to explicitly state, perhaps in the initial meeting, that the "hurt little girl (or boy) was doing the best he/she could at the time," and is to be honored for keeping the participant alive until adulthood, and that now we are learning another way to respond to past traumas that will allow for a fuller way of living (Wilkins, 2014). Use motivational interviewing techniques to tie the MBI curriculum to participants' personal goals for reducing their trauma symptoms.

6. **Being explicit about how to maintain mindfulness that fosters healing** during class and at home should be done before any meditation practice. Teach participants how to differentiate between the constructive challenge of staying present with unpleasant experiences vs. the unproductive "staying with" once a participant has lost mindfulness and is living within a distressing experience or is in the "distress zone." Suggestions for using supports if participants find themselves in distress at home may include: stop meditation temporality, open eyes, stand, use senses to notice your surrounding, get water, take deep belly breaths, and/or do something self-soothing, along with naming the experience: "distress," "dissociating," "flashback," etc. When the ability to be mindful of present moment experience has returned, it is possible to rejoin the meditation. In later sessions on stress reactivity, discuss how to know whether one is entering the distress zone, seeing clearly the cognitions that take one there, and using present moment experiences to avoid, or exit the distress zone once in it. Give explicit words to track and note inner reactivity ("judging," "adding-on," "telling stories," "spinning"). Since participants are apt to swamp themselves with taking on too much in the beginning, it can be helpful to guide them to "Pick up the 5-lb weight, not the 50-lb weight" (Wilkins, personal communication, 2009); alternatively participants can be reminded "we're practicing meditation, not masochism" (Santanello, 2014). In practical terms, this means not doing extended silent practice without guidance from a CD or teacher until skills to constructively use the meditation are developed, generally after the first two or three weekly sessions.
7. **Balancing awareness and compassion**: Participants may develop focused attention and increased awareness early in the course. It is important to achieve balance in distressed individuals through the addition of compassion. Kindness and friendliness to one's own experience is woven throughout the MBI course from the beginning in implicit and explicit ways. A concrete and structured way to approach self-compassion that is well tolerated by those with traumatic stress is the loving-kindness meditation—especially offering the well wishes to those they love easily or who make them happy.
8. **Giving instructions on how to transcend the cycle of self-loathing** by responding instead of reacting to cognitive self-judgments. Since self-loathing and self-judging cognitive habits are generally very strong in this group, give explicit instructions for working with this habit in order to break the downward spiral that comes from then feeling bad about this habit, i.e., judging our judging as bad or wrong. If mindfulness is strong and there is no inner reaction stemming from "believing" these self-judgments, the participant may note, "judging," and keep

going. However, more often there *is* an inner reaction—some sense of feeling bad or wrong or defective stemming from the self-judgment. In this case, it is helpful for the participant to respond with self-kindness: self-soothing before continuing. Responding in this way sets up a new, more healing habit and sense of inner relationship to self. It can be helpful to check in with clients with trauma histories and ask them which method of self-soothing is working the best for them. If they don't know, exploring in a brief session can help ensure continued productive participation.

9. **Emphasis on naming the "habits of the mind"**: From the first session, the teacher discusses the therapeutic value of getting to know the habits of the mind. Cognitive neuroscience is helpful in this regard; participants may be able to understand the concept of "neural grooves" and the value of noticing and naming cognitive habits as just that—habits or "grooves" that may or may not be relevant to the present moment. I challenge participants to notice and acknowledge their most common mental habits—planning, worry, analyzing, judging, spinning stories, fantasizing, or "spacing out."

Adaptations to Standard MBIs: Applying a Trauma-Focused Approach

Running trauma-focused MBIs—that is, groups in which all members have traumatic stress symptoms or full PTSD—requires considerable skill and trauma training beyond that required to run a trauma-informed MBI. It is recommended that those teaching trauma-sensitive or trauma-focused groups and adaptations have mental health licenses or qualifications, and work in consort with other mental health professionals who may be working with the client. Those offering Trauma-focused MBIs for specific populations will want to incorporate all of the proceeding trauma-informed guidelines in addition to the following additional considerations. These additional considerations are directly related to monitoring and facilitating stability—within each individual member, as well as the group as a whole.

1. **Increase contact before, during, and after the course or extending the length of the MBI**: A trauma-focused group often has additional intensity simply from the fact that everyone in the group has been affected by trauma and a higher degree of emotional destabilization may be present in the group. Spending time upfront creating a collaborative relationship through having an individual session with every participant, as well having an orientation session where participants can meet each other and ask questions before the MBI begins, builds the resource of the teacher and the group to draw on prior to the MBI. Additionally, building in time for beforehand to put in place resources and supports and tapering off rather than having an abrupt ending, is helpful. As an example, the 8-week MBSR course could be extended to 14 weeks, to allow for an intro week 1, a "pre" session putting in place resources and support such as touch points, soles

of the feet, soothing touch in week 2, the 8-week intervention in weeks 3–10; and then 2 additional sessions to integrate, 2 weeks apart in weeks 12 and 14. Extending integration time through monthly dedicated grad classes for up to 12 months is ideal. If not possible, suggest having integrated sessions with a trusted therapist, or joining an ongoing mindfulness practice group to integrate and stabilize.

2. **Predictable class structure**: Participants benefit from having a reliable structure to the class, which can be deliberately, but slowly, made more flexible as needed as the group progresses. I use the following structure within each class: (a) formal meditations learned in the preceding class (to evoke a sense of confidence or orientation within the 8-week structure); (b) inquiry check-in to encourage naming of raw experiences rather than "storytelling" and identify participants in distress; (c) dyad sharing regarding at-home practices, using a mindful listening/speaking format to stay present to one's own experience; (d) inquiry; (e) new material; (f) check-in; (g) review of pertinent notebook pages; (h) assignment of at-home practices; (i) ritualized ending involving holding hands while standing in a circle, emphasizing connection to self (body/breath), group members, and the earth.
3. **Increased processing time**: While there may not be time to do a full inquiry after every meditation, it is possible to check-in with everyone through brief inquiry methods. After every meditation, include at least a go-around mindful inquiry: "one or two words of your current experience: physical, emotional, or mental," with attention paid to the degree of presence. This provides additional opportunity to process experiences and identify participants having trauma-related distress. (See Dialogue, Chap. 24, for how to work with distress once identified).

   Making time in the curriculum for participants to express their experience of being in a dedicated group where everyone shares this history, perhaps in the second or third meeting is helpful. Participants may find the shared history comforting on one hand, and destabilizing on another, as the reality of their history is reinforced by their inclusion in this group. Allowing for noticing, naming, and expressing their experience, and the additional vulnerability this might stir up, is helpful. The teacher normalizes and validates any experiences, including ambivalence for being part of the group.
4. **Additional practice for staying in contact with the self during dyads**: Dyads are helpful to practice mindful listening and mindful speaking on a weekly basis as well as to process at-home experiences. Even with mindfulness in place, participants can be pulled out of themselves through the process of relating to others. Participants can thence practice coming back to themselves through the "three breaths break" between dyad questions While participants stay with their experience of three breath cycles, the teacher reinforces the idea that they are moving from "outer" to "inner," from "doing" to "being," and invites participants to notice what this movement feels like; cue to the support of the chair and the floor, for additional grounding.
5. **Positive psychology enhancements**: Class material is taught in a manner designed to emphasize the positive psychology tenets of mastery, cultivating gratitude, acknowledging one's efforts, savoring positive experiences, connec-

tion, noticing what works, coping effectiveness training, and honoring one's own inner wisdom. It is important to encourage acknowledging one's experience first, only then applying positive psychology. Otherwise "being positive" can engender resistance. Instead, invite curiosity. Rather than saying, "be grateful to yourself for completing the course" (which can sound like a demand ask) say, "notice if there is anything you feel grateful for towards yourself, whether you appreciate anything, and how you might like to express that towards yourself."

6. **Retreats**: If the MBI includes a retreat, offer it in a trauma-informed and trauma-focused manner. See retreat section, below, for specific recommendations.

Example of Trauma-Informed Practice: The Body Scan

Spending unstructured silent time focusing on bodily sensations (or lack of sensations) may stir up uncomfortable sensations, "story," and potentially be retraumatizing, especially if the participant doesn't feel safe in the practice. On the other hand, increasing one's ability to "be with" physical experiences is very helpful for healing from trauma, so much so that some trauma therapists feel this is a critical component of the healing process (van der Kolk, 2014). In addition, some MBI participants feel the body scan to have been the most helpful mindfulness practice for them in their trauma recovery, as noted earlier. The trauma-informed approach relies on giving participants preparatory suggestions for practice, either in a session before the course or in the first class, so there is a better chance of having an affirming experience. The following guidelines are useful in helping participants feel safe, in control, and able to participate to whatever degree they are choosing to participate during the body scan by applying many of the trauma-informed guidelines already delineated. Most may only be necessary during the first or second sessions, while participants are becoming familiar with the space, the process, and the experience.

Create a Safe Space Where You Are in Control of the Room

Please refer to the basic logistics discussed/outlined previously in the chapter, regarding the teacher's location in the room, and the room's lighting (see also Chapter 1, Stewardship).

Let Participants Know They Are in Control of Their Experiences

- Invite them to choose whether to sit or lie down. Normalize either choice.
- It is alright for them to take a break and simply rejoin the scan when ready; there is no point in getting overwhelmed on the first try.

- If they can't locate particular parts of the body, simply note "can't locate," or "no sensation," and rejoin the scan at the next body part. Normalize physical numbing.
- If they become swamped by distress and lose mindful awareness (see below), they should let you know immediately.

Give Participants Tools for Self-Soothing, as Necessary

- Let them know, if they are heading toward distress, that they can open their eyes and take deep abdominal breaths, or place a hand on their heart, and focus on being in the room or practice behavioral compassion—standing up, getting a drink of water; then rejoin the scan when ready.

Guidance and Assurance Through the Body Scan Practice

- If some are sitting and others are lying down, finish with a very brief "downward" scan, always ending with feet. This practice is most grounding for those sitting up.
- Invite them, as beginners, to "see what we are experiencing today," invoking curiosity.
- Give everyday metaphors that garner interest, such as walking through a museum whose exhibit changes everyday often—"some things you might like, others you might not, but we can honor and respect them all."
- "Normalize imperfection": validate physical numbness, validate lack of sensation or inability to locate a part; acknowledge the validity of historical developmental dissociation or avoidance or bodily numbing (Wilkins, 2014).
- Avoid dissociative visualizations in the midst of the scan.
- Scan the room occasionally yourself to check whether anyone is experiencing signs of distress, knowing that those who have dissociated may *not* exhibit any outward signs.

Inquire About Participants' Experience After the Body Scan

Inquiry regarding participant experiences can be especially helpful after the body scan, either through dyads, a brief "go-round" or full group inquiry. Brief go-rounds—hearing 1 or two words about "right now" from each participant can be especially helpful for trauma-focused groups where participants have experienced physical or sexual trauma. Not only does naming experience help to calm the nervous system but it also helps participants to recall the resource of the group and

teacher. Assess for signs of dissociation and check in before end of class to see if anyone "hasn't come back yet" (see Dialogue). When responding to inquiry, it is helpful to validate what participants *can* feel and model acceptance of the what can't yet be sensed in the body.

Body Scan Recordings and Instruction for Practicing at Home

Recording two lengths of the body scan provides choice and a point of entry for more participants: a 20 minutes brief body scan focused on finding and sensing relatively large swaths of the body, with many concrete cues and very little silence (1–2 breath cycles per pause); and a 40 minutes body scan including cues to smaller and more subtle sensations (i.e., individual toes or fingers,) with longer silence (up to 3–4 breath cycles per pause). Encourage starting with the shorter scan, and moving to longer scan only if shorter one does not provoke distress. Emphasize making wise choices, including stopping in the middle if "too much."

Ask participants to discover "Where in your body you can rest your awareness most comfortably? It doesn't have to be a comfortable sensation, but it might be. Ie. in your hands or feet for instance [name examples of areas that might be neutral]. Once you've found that place, you can use it as a 'home base' to come back to whenever you want during the body scan or during any of the silent meditation practices if you get lost or need a break from the practice" [this puts in place a powerful resource for them].

Cueing to resources: Opening eyes, stretching your body, offering self-soothing touch or words; taking deep belly breaths." Rejoin the scan when you're ready.

Especially in trauma-focused groups, participants may benefit from additional external support at home, such the picture of a supportive person, pet or spiritual figure; or an object that reminds them of support and/or inner strength. They may wish to do the body scan having it near-by, holding it, or putting it on their chest by their heart.

Cue to down-regulating resources: Suggest exercising, doing some mindful movement, or taking three deep belly breaths before the body scan can be helpful for calming the nervous system.

Mindfulness Retreats: Trauma-Informed and Trauma-Focused

Trauma-Informed Retreats

Trauma-Informed Silent Retreat Days: Retreats offer the opportunity to reap the benefits of extended periods of mindfulness meditation and their completion are often a point of pride and accomplishment. For many in an MBI, this is their first silent retreat and the newness may be anxiety provoking; a new location or

additional people attending may be a source of anxiety. The following are helpful trauma-informed considerations: Providing anticipatory guidance regarding any new element such as additional people attending.

Bracketing the day with a structured opening and closing sequence, which includes brief sharing. During the opening sit, include grounding elements and a reminder of resources (including self-soothing and the group itself); follow with dyad sharing around present moment experience and setting an "intention" for the day (a mindful quality); brief "go-round" sharing 1–2 words of "right now" and one's intention; teacher reinforces that all intentions are now in the room as a resource.

Providing a brief orientation, defining silence as a "companionable silence"; silence doesn't mean you can't sneeze or cough or laugh, if those arise naturally; state that questions about "what we are doing" are welcome at any time. State directly when entering silent period. Doing yoga as the first formal practice after entering the silence can help down-regulate. Gathering before unstructured time (ex. meal time), to sense resource of the group and orient briefly to activities during this time; offer to talk with anyone during meal break "if they're in distress"—just knowing someone is available is often all that is needed to increase safety. Cuing to their chosen intention and reminding of resources before any meditation with extended silence.

Ending with structured closing, including opportunity for verbal sharing. Trauma-informed inquiry questions include: "what was most helpful?," "what was most pleasant?," and "what would you most like to remember?" Offer to "be around for a few minutes" if anyone wants to talk and check-in directly those who expressed verbal or non-verbal cues of distress. Sexual trauma can take the form of rape, incest, assault, or other sexual violations.

Trauma-Sensitive and Trauma-Focused Retreats

The considerations in the previous section on trauma-informed silent retreat days (ex. structured beginning, etc.) can be tremendously useful for trauma-focused retreats; trauma-focused groups may also benefit from additional stabilizing adaptations, such as:

Shortening the hours of the silent retreat, to perhaps half-day.
Starting with brief mindful movement before the 30-minutes structured opening described earlier.
Shortening the unstructured time after the meal.
Adding additional "check-ins" with participants, especially right before and after the unstructured meal period, and after any still silent practices.
Reinforcing a shared experience of the mindful eating by sharing potluck or provided food. Standing together experiencing sights and smells of the food prior to eating.

Delaying the retreat until later in the series, especially if there are more than eight sessions; ensure there is at least one more session after the retreat for integration. Having the retreat follow directly after one of the regular weekly sessions, if the class is during the day and the venue is available.

This has the advantage of grounding in the "known" of the class structure, venue, and course participants, and the stress-relieving aspect of the mindfulness practice in the class first before the retreat.

Conclusion

This chapter has reviewed guidelines for applying a trauma-informed approach to teaching MBI's as well as additional suggestions for teacher-therapists who may be offering trauma-focused MBIs. There are a variety of clinical challenges for this population. Those with traumatic stress symptoms and histories benefit from mindfulness interventions, including trauma-informed titrated instruction, thoughtful adaptations, and helpful collaboration between the referring therapist and mindfulness provider. With attention to these factors, MBIs and other mindfulness approaches may allow persons to free themselves from the sequelae of past traumatic life events, and to move forward with renewed mental health, increased resilience, and enhanced coping strategies with which to meet future life events.

Acknowledgement With deep gratitude to all of the men and women who have entrusted their sufferings to our care, and whose lives are blossoming moment by moment. *May they be well. May they be safe. May they be happy and free*.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Brach, T. (2015). Healing traumatic fear: The wings of mindfulness and love. In V. Follette, J. Briere, D. Rozelle, et al. (Eds.), *Mindfulness-oriented approaches to trauma care* (p. 32). New York, NY: Guilford Press.

Briere, J., & Spinazzola, J. (2009). Assessment of the sequelae of complex trauma: Evidence-based measures. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide [e-book]* (pp. 104–123). New York, NY: Guilford Press.

Briere, J., & Rickards, S. (2007). Self-awareness, affect regulation, and relatedness: Differential sequels of childhood versus adult victimization experiences. *Journal of Nervous and Mental Disease, 195*(6): 497–503.

Follette, V. M., Briere, J., Rozelle, D., Hopper, J. W., & Rome, D.I. (eds.) (2015). *Mindfulness-oriented interventions for trauma*. New York, NY: Guilford Press.

Germer, C. K., & Neff, K. D. (2015). Cultivating self-compassion in trauma survivors. In V. Follette, J. Briere, D. Rozelle, J. Hopper, & D. Rome (Eds.), *Mindfulness-oriented interventions for trauma* (pp. 43–58). New York, NY: Guilford Press.

Hanson, R. (2009). *Buddha's brain: The practical neuroscience of happiness, love and wisdom* (p. 81). Oakland, CA: New Harbinger Press.

Jackson Nakazawa, D. (2015). *Childhood disrupted: How your biography becomes your biology and how you can heal* (pp. 161–160). New York, NY: Atria Books.

Kimbrough, E., Magyari, T., Langenberg, C., Chesney, M., & Berman, B. (2010). Mindfulness intervention for child abuse survivors. *Journal of Clinical Psychiatry, 66*(1), 17–33.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Press.

Magyari, T. (2015). Teaching MBIs and mindfulness to women with complex trauma. In V. Follette, J. Briere, D. Rozelle, J. Hopper, & D. Rome (Eds.), *Mindfulness-oriented interventions for trauma* (pp. 140–156). New York, NY: Guilford Press. Retrieved from http://www.merriam-webster.com/dictionary/trauma.

Pollak, S., Pedulla, T., & Siegel, R. (2014). *Sitting together: Essential skills for mindfulness-based psychotherapy*. New York, NY: Guilford Press.

Santanello, A. Personal communication, October 2014.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *Trauma-informed care in behavioral health services* (Treatment improvement protocol (TIP), Vol. 57). Rockville, MD: Author. HHS Publication No. (SMA) 14-4816.

van der Kolk, B. (2014). *The body keeps the score*. New York, NY: Penguin.

Wilkins, C. (2014). Mindfulness, women, and childhood abuse—Turning toward what's difficult. *Social Work Today, 14*(2), 10.

Wilkins, C., & Magyari, T. (2009). *Shelter in the storm: Teaching mindfulness for those with PTSD*. Paper presented at the annual meeting presentation: Mindfulness in medicine, health care and society, University of Massachusetts Medical School, Worcester, MA.

Williams, G., Mark, J., Fennell, M., Barnhofer, T., Crane, R., & Silverton, S. (2015). *Mindfulness and the transformation of despair: Working with people at risk of suicide*. New York, NY: Guilford Press.