Integrative Yoga Psychotherapy is Uniquely Placed Among Somatic Psychotherapies to Meet and Process the Psychological and Physiological Symptoms of Trauma. Discuss.

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It is estimated that between 70 and 90% of people will experience a traumatic event in their lifetimes (English et al., 2022 p.1; Schwartz 2020 p.19). Not all will develop symptoms. In fact only 5-10% of the population seeking help are diagnosed with PTSD (Yehuda et al. 2015, p.1) . Yet PTSD and complex trauma are thought to be under-diagnosed (Schwartz 2020, p.19). Moreover, trauma is increasingly thought to be present within people seeking help for other conditions - i.e. mental health or physical symptoms unrelated to trauma. With this growing awareness, trauma is increasingly considered through a transdiagnostic lens (Taylor 2020, p.1). For example, it may be present in eating disorder populations, or those seeking counselling or yoga therapy for a cancer diagnosis. Thus the treatment of the symptoms of trauma in order to yield better psychological and physical health is seemingly more needed than statistics suggest.

Effecting change in the traumatised client, however, is challenging. Traditional therapies such as talk therapy, T-CBT and exposure treatment have yielded limited results (English et al., 2022, p.1; van der Kolk et al., 2014, p.559). Somatic based therapies, which have emerged alongside recent gains in neurobiological understanding, have emerged as potentially more effective. This essay is concerned with examining current somatic approaches. I propose that Integrative Yoga Psychotherapy could be singular among somatic approaches in that it is uniquely comprehensive. IYP is able to meet the holistic biopsycho-spiritual need that trauma represents in a way that other modalities cannot. I propose that it is not only the body and psyche which want process, but that the spiritual dimension of trauma should be tended for the most satisfying evolution.

I will explore this hypothesis in firstly defining trauma - how complex and developmental trauma differ from PTSD. Paying particular heed to the psychological processes at play in fragmentation, and in order to fully illustrate the need for a bottom-up, top-down intervention, I will explicate the complex psychic and neurobiological processes which occur as a result of trauma. Next I will turn to the two most widely known somatic therapies which seek to address traumatic

experience - Peter Levine's Somatic Experiencing and Pat Ogden's Sensorimotor Psychotherapy, illuminating their processes and gauging the benefits and potential deficits.

Finally, I will focus on Integrative Yoga Psychotherapy and examine how this modality is equally if not more able to address the soma-psyche, but goes further in holding the potential for spiritual 'process' to take place.

The evidence base for each modality will be brought into focus, so that the fullest picture of 'what really works' can be drawn. Yoga and IYP are included in this critique and the limitations of IYP will also be brought to light.

In order not to forget the human at the heart of traumatic experience and in order to illustrate IYP as it meets a real client, I weave 'Ann's' story through the essay. Ann offers integrity to the discourse, where a focus on science, statistics and theory in the abstract risks obscuring real suffering. Illumination and alleviating human suffering are central to IYP's mission.

What is trauma?

Salient to any treatment protocol is the definition of what is being treated. When we as therapists meet a traumatised individual, whether with a diagnoses or not, in order to meet that individual with integrity, we must know what trauma means. It is one thing to find out about a condition such as diabetes or COPD with clear classifications and it is quite another to 'demarcate' what trauma is, bearing also in mind that trauma is transdiagnostic. For in trauma, the melding of the body mind experience is profound. In trauma an embodied presentation goes along with psychological presentation.

We may experience traumatic events, but trauma is not 'an objective event', rather it is a subjective experience (Senreich, et al., 2023, p.1). Judith Herman, (2015, p.24)
whose seminal treatise *Trauma and Recovery* helped progress our understanding of the subject, deeply explores the meaning, dynamics and forces at play in traumatic experience.
'Psychological trauma is an affiliation of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection,

and meaning'. She further elucidates the 'common denominators of trauma' - that of 'intense fear, helplessness, loss of control and fear of annihilation,' and that 'traumatic events usually involve threats to life or bodily integrity' (Herman, 2015, p.24). Peter Levine succinctly describes it as 'too much, too fast, too soon' (2020, p.4). Arielle Schwartz refers to Pat Ogden's definition in a PESI talk on Youtube (2025) as 'any threatening or overwhelming experience that we cannot integrate.' As subjective individuals our capacity to integrate traumatic experience varies enormously and may depend on our developmental environment and inherent levels of resilience and regulation.

But traumatic experience that 'cannot integrate' might lead to PTSD or Complex PTSD (Fisher, 2017, Schwartz 2020, van der Kolk, 2014). Non-integrated experience results in physiological and psychological sequelae. In the DSM-5 and ICD-11 we find the official and distilled list of presentations which ultimately might lead to a 'diagnosis' of PTSD. PTSD involves intrusion (re-experiencing and intrusive memories), avoidance (of anything connected with the event) and persistent mood, arousal and regulation difficulties as a result of exposure to extreme threat which lasts a significant period of time and affects one's quality of life (UK Trauma Council, n.d.).

Acute PTSD may result from a single shock trauma such as a natural disaster or witnessing a crash, but complexity of PTSD can occur where there is prolonged exposure to a variety of threats. This is the terrain of complex trauma and developmental trauma.

C-PTSD and developmental trauma overlap. Too, complex trauma and developmental trauma break through the circumscription of PTSD, though may feature acute PTSD episodes. Both involve time (repeated events, prolonged exposure) and both are relational (Herman, 2015, p.30). 'Complex PTSD occurs as a result of repeated or chronic exposure to extremely threatening events from which escape is impossible' (Schwartz, 2020, p.24). It might develop as a result of war, intimate partner violence, bullying or sexual abuse (Senreich et al., 2023, p.6). It can be quite unrelated to childhood development.

Attachment to primary caregivers, though, is the most 'significant factor in human development' (Senreich et al., 2020, p.6). Developmental trauma may occur if there is severe impairment in this most significant aspect of inter-human grounding and experience. In developmental trauma, children may be exposed to 'multiple types of abuse' for example 'physical

abuse, neglect, emotional distance, interpersonal suffering (Fisher, 2017, p.26). The implications of extreme adversity in childhood are profound and could lead to 'chronic dysregulation and dissociation' (Gladstone et al., 2023, Chapter 11 p.174), disease, somatisation and intra, interpersonal challenges.

The ICD distinguishes C-PTSD from PTSD, recognising it as a condition. The three elements which 'complicate' trauma are dysregulation, negative self-concept (usually associated with shame and guilt) and an inability to feel close to others (UK Trauma Council, n.d.). Thus in complex trauma, the already overwhelming physiological and psychological symptoms of hyper arousal, avoidance and intrusion become existentially critical.

Suffering is part of the human condition, yet some suffering surpasses what we might consider 'normal' or 'to be expected'. Trauma means hurt or wound (Senreich et al., 2023, p.5). As therapists involved in facilitating healing, the core wound of unworthiness and shame along with the positive regard and opening up of interpersonal possibilities are surely things we hold high in our awareness and as such, this essay is particularly mindful of complex and developmental trauma.

In the next section I will unfold the symptoms of traumatic response, unfold the neurobiology and neuropsychology in these traumas and introduce Ann's case study which will elucidate real life clinical presentation and lead to the primary focus of this dissertation, an exploration of which somatic therapies might be most helpful and why.

Neurobiology and Neuropsychology of Trauma

A traumatic response occurs where a person faces overwhelming threat and is mobilised to either fight the threat, flee the threat or freeze / fawn in the face of that threat to preserve life and bodily integrity. Whether that person actually is able to fight or flee is integral to the processing of the extreme stress response.

When under threat, the neuroendocrine, life preserving system becomes sympathetically aroused and floods the system with adrenaline, noradrenaline and cortisol to prepare it for action. It send sends glucose energy to the large muscle groups, it raises the heart rate and increases

blood pressure. Breathing becomes shallow for fast reactions, pupils dilate for vigilant perception (Schwartz, 2020, p.77).

A person with complex trauma may have experienced trauma repeatedly. Thus the body's response SNS, HPA-Axis within it, dorsal vagal, might think they're in danger all the time. The normative stress response, which sees the cortisol and adrenaline and noradrenaline return to normal levels and the body functions that go with it return to homeostasis, is impaired, resulting in chronic hyper or hypo-aroused states (Schwartz, 2020, p.78). Hyper arousal is associated with anxiety, hypo-arousal, where dissociation and non-response, non-stimulation is associated with depression, two co-morbidities of trauma (Ogden, 2015, p.565).

Traumatic experiences are often, particularly in developmental trauma, pre-verbal or detached from verbal narrative function. These experiences become 'implicit' memories. The emotional tone and sensory inputs, governed by the amygdala, keep the traumatic response encoded within the body' (Schwartz, 2020, pp.76-77). The memory is not necessarily explicit, 'seen', conspicuous or analysed, yet it is 'present' thrumming away in the substrata. The fear responses of the SNS and dorsal PNS - those fight, flight, freeze and fawn reactions felt then stowed away, trapped, without being 'processed' at the time are not only easily triggered, but potentially become drivers of personality and govern interpersonal relationships (Fisher, 2017, p.23).

Ann alludes to numerous violent spontaneous physical attacks and prolonged exposure to emotional abuse by both primary caregivers. As a child, she was not able to fight or flee. She froze. Later she developed the habit of hiding to avoid being seen by her parents. All of the arousal within her system, the high adrenaline, muscles bursting to move, fast heart rate and breathing, increased blood pressure, wide scared eyes 'went' nowhere. The traumatic experience was unresolved either by action or interpersonal repair. The intense and heightened life preserving reactions made a 'stamp' on her system and potentially became implicit memories - memories stored within her body.

Ann expressed that she feels all of her negativity, her symptomatic body, her high stress and her mental overwhelm are 'baked in' to her. Her metaphor imaginatively describes a quality of

crystallising or becoming immutable over time. It describes something which is other than what it could be. She speaks as if she is missing something.

Schwartz reminds us that '[i]t can be difficult for [trarumatised people] to differentiate between experiences that occurred in the past and what is happening in the present moment' (2020, p.78). The imperative of keeping safe skews the (functioning of) her nervous system and body and potentially effects her perception of the world. The 'alert to threat' or hypervigilence might presents in her very alert face and startle reflex. She defaults to interpreting threat or negative affect in others' faces. Threat is perceived where none actually exists.

Despite Ann's insomnia, her face is bright and awake with darting eyes. Now that our therapeutic relationship is established and very trusting, she startles less, but still finds it very difficult to fully 'let go' of the 'baked in' tension in her body. Her body and awareness generally defaults to perceived harsh judgment from others. She doesn't disclose all of her symptoms to doctors or nurses because they will think she is moaning. She notices the thought of returning to her childhood home, which she does once a year, instills fear. She wonders why she is still scared, even though the threat within the home has been gone for decades.

Over time, the chronic physiological symptoms experienced as a result of trauma, 'accumulate' and can potentially lead to serious illness. Health is psycho-neuro-immunologically compromised. The chronically 'disrupted body processes' can lead to 'chronic inflammation, heart disease digestive problems weight gain sleep problems, headaches, tension and pain, problems with memory focus anxiety' (Mayo Clinic, n.d.). In the 'Big Think' Dr. Vincent J. Felitti explains the two-fold ways trauma leads to health conditions. 'Numbing coping strategies like alcohol, using food, smoking themselves lead to disease.' Beyond these behaviours though, which can lead to disease, 'chronic major unrelieved stress on the workings of one's brain and nervous system can release pro inflammatory chemicals in a person's body' (Big Think, n.d.). Inflammation leads to illness and disease.

Ann has a serious auto-immune condition. Of course it is impossible to delieanate which symptoms are 'auto-immune' and which symptoms are 'trauma'. It is also speculation and outside the scope of practice to deduce or assume that her condition is aetiologically linked to her developmental trauma. Nevertheless, Ann struggles with myriad chronic somatisation. She is in

constant pain, has serious digestive issues, struggles with thermoregulation and sensori-processing, insomnia, headaches, nausea, dizziness, skin conditions and an array of undiagnosable, untreatable ‘symptoms’ which arise and disappear in constant flux. If inflammation is visible, it might look like a worried face which flushes red when any connection to her past, implicit or explicit, arises within her consciousness.

Developmental trauma overlaps with complex trauma but relates specifically to traumatic attachments. It can involve ‘multiple types of abuse’ (Fisher, 2017, p.26). Chronic attachment anxiety might occur where there is not only physical abuse, but potentially also emotional distance, neglect, interpersonal suffering, or a caregiver who is very sick or addicted to drugs or alcohol.

The term ‘complex’ is salient, because the schism which occurs in the psyche is non-linear, multivalent and involves processes which can be measured and explained by neurobiology but also those which cannot. The metaphorical term often used to describe the psychological fallout of trauma is ‘fragmentation’. The individual is split into many parts.

The structural dissociation model of fragmentation, developed and promulgated by Onno van der Hart (van der Hart et al. as cited in Fisher, 2017, pp.4, 24) explains what occurs within the brain structure particularly during development i.e. infancy and early childhood. The right hemisphere of the brain is immediately awake and alive and governs navigation of the world from the moment a child is born (and presumably in-utero). It is the emotional, feeling, instinctual, intuitive side of the cortex. It is part of our innate being and is non-verbal. The left hemisphere, while also innate, takes much more time to develop. Language, logic, evaluation, systemising, making sense of experiences and ‘interpretation through language’ is highly sophisticated. It is the domain of the left hemisphere and is not fully developed until adulthood.

The corpus collosum unites the two hemispheres and mediates emotion and reasoning and is not fully formed until the age of 12 (Fisher, 2017, p.23). Children who experience deeply insecure, avoidant, disorganised attachment may have poorly developed corpus callosum (Schwartz, 2020, p.80).

When a young child experiences fear or intense emotion, unable to process it with reason, it is especially felt in the right brain. A young child who experiences it again and again receives a ‘deeper impression’ or ‘crystallising’ of negative affect as Blaustein & Kinnburgh (2019, p.12) point

out: ‘For the infant and young child exposed to chaos, violence, or neglect, interpretation of sensory stimuli will become infused with danger. At this stage, given nonverbal processing, cues of potential danger will generalize and be solidified without language’. Thus the experience of trauma has a neuroanatomical model and neurobiological grounding.

But beyond the impaired development of the brain processes is an ongoing wave of psychological splitting which ‘has profound implications…’ ‘potentially laying the neurobiological groundwork for chronic (prolonged, lifelong) dysregulation and dissociation’ (Gladstone et al., 2023, p.173).

Fisher (2017, pp. 66,105-107) thoroughly explicates the complex nature of dissociative splitting, underpinned by the structural dissociation model, describing how the fragmentation of the self through trauma occurs. A child who is dependent on an adult for safety, security, love and attachment but does not receive that bonding or worse, is neglected or attacked endures a psychological dilemma. The child wants attachment, feels the proximity seeking need. But the frightening or frightened adult, themselves dysregulated, unreliable and threatening, ignites the deeper drive of preserving safety within the child’s system. Fight, flight and freeze responses rush within. Preserving life ‘happens’ by doing whatever is needed to stay safe near the caregiver - to be acceptable - and the intense fear responses ‘solidify’/ suppress into the non-verbal implicitly stored realm of consciousness, while the somatic marks and nervous system stamp remain active.

Further intensifying the irresolvable feelings within the child is the redoubled yearning for love and attachment in the time of danger. When one is hurt, one needs tenderness even more. Thus the wound from that desperate need for proximity where the attachment figure is dangerous is compounded and the split splits further.

The ‘visible’ side of the split self also survives, often very well, often thrives (Fisher, 2017, pp. 24). The visible is the ‘getting on with life part’. It is the way to be acceptable. A child will go to school, learn, make friends, continue to develop the functioning self which faces and meets the external world. They may move through the markers of life stages, finding satisfying work, start a family. Yet not thrive.

By the time the child is an adult, the prolonged years of arousal have become deeply ingrained. Blaustein & Kinnburgh (2019, p.18) describe the polarity, ‘Conversely, the increased

cognitive capacities of adulthood may allow the adult to “hold it together,” functioning in an apparently coherent way and competent in one or more contexts, while inwardly or in other contexts experiencing significant dysregulation or collapse’.

Ann is married, retired and with a grown son. She had a demanding job for many years and wonders why she can’t enjoy her retirement. She is very lonely in her marriage and is not able to communicate well with her husband and son. She looks back on her working life and wonders why she struggled so much, why she is struggling now. She reports being overwhelmed by constant anxiety and negative thoughts. She expects bad things to happen. She is quick to anger and harshly judges others. She is quick to perceive judgment and is afraid of what others think. Tears are close to the surface as well. She would like to ‘open her head and let out all the bad stuff’ - that it is dark there and she wants for light. She judges herself for ‘feeling too much’ and berates herself for not being able to enjoy life because she *should* feel blessed and lucky. She puts it down to her bad personality. ‘I am worthless,’ she says.

Emotional regulation, difficulty in relationships and negative self concept are listed in ICD-11 as the three symptoms which ‘complicate’ or characterise complex trauma. They are regulatory, ’interpersonal’ and intrapersonal deficits’ (Blaustein & Kinburgh, 2019, p.11).

Of the three, it could be said that negative self perception is the most pernicious as it is deeply entrenched and associated with ‘soul eating’ shame. Often there is shame or guilt around the traumatic experiences themselves (it was my fault or ‘why didn’t I do something?) - but more harmfully, it undermines the very basis of psychological well-being and self-love.

Thus in illustrating the neurobiological sequelae of trauma and its potential to seriously impact the physical health of the individual, the need for somatically attuned approaches is particularly key. Yet more complex and potentially deleterious to quality of life and health is the complex psychological impact - psychic splitting or fragmentation which can result from developmental trauma.

Understood in this light, it becomes clear that interventions which hope to heal these biological and psychological wounds should be present to their complexity and intervene with knowledge and sensitivity and, as I will argue, soul. Thankfully, our understanding of the affects of trauma on the traumatised individual is rapidly unfolding and newly informs interventions. ‘Twenty

five years of research has substantiated the relationship between Post Traumatic Stress Disorder and autonomic dysrgulation and unresolved physical responses' (Fisher, 2019, p.2).

Alongside advances in imaging technology and neuroscientific understanding, Bessel van der Kolk, Steven Porges, Peter Felitti et al. have shifted the paradigm in understanding the effects of trauma. That it is embodied. That through neurobiological and neuro-psycho-immunological processes, it leaves not just a psychic stamp, but a full bodied, sub-cortical, sub-conscious memory with the potential for causing long term mental and physical challenges. Progress in the psychology and neurobiology of attachment widens the scope of trauma and profoundly enriches understanding and with that, potential for healing. We know now, what happens to the body in the different forms of traumatic experience. Fisher's (2017, p.7) imperative to know which interventions to choose and why becomes more possible.

The evidence base for Cognitive Processing Therapy, Prolonged Exposure and T-CBT related interventions in the treatment of trauma is more established, but it is thought that cognitive approaches which do not incorporate or prioritise body awareness or interoception are not significantly effective (English et al., 2022, p.1; van der Kolk, 2014, p.231; van der Kolk et al., 2014, p.559). This points to a real need for changing this paradigm within the study of trauma treatment. Yet 'somatic interventions are seldom used in clinical medicine despite their important efficacy in treating war veterans and civilians diagnosed with PTSD', (Almeida et al., 2020, p.238). But the study of somatic interventions is on the rise. A 2019 systematic review reported that somatic interventions (which might include body awareness, yoga and mindfulness) were involved in 25-29% of studies into PTSD and we can assume that their involvement will continue to increase.

Considering bottom up approaches, infused with neurobiological understanding seem to offer more than traditional approaches, Somatic Experiencing and Sensorimotor Psychotherapy, each with their different strengths, present the two modalities with most potential to meet trauma. In the next section, I will explore their theoretical rationale and approach and protocol while holding IYP in awareness.

Somatic Experiencing (SE) and Sensorimotor Psychotherapy (SP)

Both SE and SP are somatosensory interventions for the treatment of trauma. In other words, they are particularly formulated for the treatment of trauma and they rely on the body as the primary mediator in healing. Senreich, et al.'s *Experiential Therapies for the Treatment of Trauma* juxtaposes these two modes (among others) and provides a clear basis for comparison (2023, chapters 6 and 11). Both are grounded in the neuroscience explicated in the above paragraphs. Before developing Somatic Experiencing, Peter Levine was a scientist at UC Berkley studying the nervous systems of animals. He went on to apply his observations to healing human trauma (2023, p.91). Pat Ogden incorporated advances in neurobiology into her new body based psychotherapy which emerged in tandem with attachment understanding (2023, p.173). Both hold to be true the stamp of implicit memory and that this inhibits the client, reduces psychological and physiological capacities. As will be explored, they name and approach implicit memory differently.

Crucially, both SE and SP are 'phase oriented' modalities. This means that trauma can only be 'approached' once client safety and nervous system regulation are well established. Co-regulation or nervous system attunement between client and therapist is foundational to all work in both systems. The window of tolerance, the 'optimal state of arousal' - the measure by which we understand what is emotionally and physically tolerable to our system in any given moment, is key to both therapeutic approaches. Both also deploy resourcing coupled with 'curious' mindful body awareness as the processing of traumatic embodiment progresses.

Clearly, there are overlaps in how both modalities guide the human toward traumatic process. These shared techniques and shared neurobiological basis evince the value of a somatic 'nervous system' approach to healing.

Integrative Yoga Psychotherapy is aligned with SE and SP in the aforementioned ways. Though not specifically developed to heal trauma and though it sets out to receive the human holistically and transdiagnostically, IYP shares terrain. The following alignments are outlined in the IYP Model (The Minded Institute, 2023). IYP is grounded in the neuroscience and the neurobiology of development. It is somatosensory, is phase oriented - establishing client safety and ANS regulation in the client as a priority - and relies on co-regulation, resourcing, grounding and the window of tolerance to help in this process. While IYP integrates cognitive as well as body based

therapeutic approaches, i.e. whether the therapist is in a CFT mode or IFS, or Rogerian, these underpinnings are there.

IYP also deviates from SE and SP in several ways. Importantly, Somatic Experiencing is a copyrighted protocol-based, systematised intervention. In addition to the aforementioned techniques, an SE therapist is trained in SIBAM. SIBAM stands for Sensation, Image, Behaviour, Affect and Meaning and is a way for therapist and client to follow internal world, moment by moment and as a 'container' for the 'entire phenomenological gestalt of the patient's experience' (Dann et al., 2023, p.95).

Jordan Dann (2023) further outlines the 9 therapeutic elements at play within an SE session. In addition to co-regulating and establishing safety, sensation is explored, pendulation - the observation of our most innate sense of expansion and contraction and wherein resourcing and the window of tolerance might be felt— is guided, which then supports titration - a drop by drop return to traumatic memory. Crucially, the body is always the source of exploring. Language such as 'how does your body let you know that…' is used. Close observation of the client and therapists own system (resonance) may signal that a shift is taking place and a feeling of empowerment is being restored. Uncoupling occurs where fear remains 'immobilised' - attached to the new feeling of empowerment. Bound energy is a Reichian concept utilised in somatic experiencing - the 'stuck' incompleted action is gently guided to 'discharge' and therefore 'complete' - finally restoring the nervous system to relaxed alertness. Lastly, re-orienting to the present takes place, where the client is hopefully better primed for social engagement.

In comparing IYP to other somatic interventions and promulgating it as an equally valid if not more beneficial intervention for trauma, it is necessary to understand the validity of the modality in comparison. Is there an evidence base for SE?

There are a number of studies and clinical trials involving SE. A Google search yields a wide range of articles in support of its theoretical basis as well as individual trials (Almeida, Brom, Kuhfuß, Leitch, Payne, et al.) A scoping literature review and a systematic review of evidence all point to the relevance of this modality in the treatment of trauma (Kuhfuß et al., 2021), stating, 'there is a 'high interest in clinical practice and a growing number of empirical studies'.

The systematic review of somatic interventions for PTSD found that a randomised control outcome study for SE effected a 44% positive outcome. In a RCT, SE had a significant effect on PTSD symptom reduction compared to the control group. Finally, case study evidence (not controlled), not 'robust' points to a 90% positive effect on trauma symptoms. (Almeida et al., 2020, p.241). A scoping literature review found that SE helped alleviate symptoms of PTSD both immediately and a year later. It found that the use of touch and resourcing were most consistently identified as key methods in the success of treatment Kuhfuß et al., 2021, 4.4.1). However it is that the studies did not relate to complex PTSD. Both reviews found that more robust research is needed to establish a scientific basis for treatment. Moreover, the scoping review found that SE is often combined with other modalities and this combination may account for the positive effect (Kuhfuß et al., 2021).

It could be argued that a limitation of SE, especially when compared to other somatic modalities and IYP is in its leanness, that it is too narrow in its scope to 'completely' meet trauma. SE is not psychotherapy and while the SIBAM scaffold is useful, SE cannot address the wider and deeper implications of trauma, such as the crisis of self-perception.

Where SE has a very focused approach to healing the implicit memory of trauma, one might say, 'efficient' and directive, SP is broader. Crucially, while SP encompasses trauma of any source, it is also founded on attachment theory. SP is therefore able to meet the client in greater depth. The trauma of SP is one of complexity and often developmental in source. It is also founded on neuroscience and prioritises the body. It addresses the real possibility of dissociation within traumatised clients and gears its approach with this in mind, offering specific methods for each 'experiment' for the dissociative.

Also a phase-oriented modality, Pat Ogden's (2015) SP seeks to establish safety and ANS regulation in clients before heading toward what it terms the 'procedural memory' (the right brain) of embodied trauma (pp. 25, 565). Through the five building blocks of present moment awareness (gross body, body sensation, 5 senses, awareness of emotions and thoughts) (p.138), the window of tolerance is gently and gradually widened for greater scope in emotional tolerance and hence holistic processing. Psychoeducation is very present in the approach (p.13). Experiments and worksheets slowly open the client up to self awareness and knowledge - empowering them in their

own healing. The experiments develop felt linkages between body movement, memory, mood and body state and offer ways to shift and create new experiences. In other words, they facilitate neuroplasticity. For example a client may be invited to notice what shape their body makes when thinking of a negative memory, the associated body sensation, emotion and thought process. They may be invited to make an opposing shape and observe the reaction in their mind, body, breath and emotion. It is 'mindful' and intentional change.

Another distinguishing feature of SP, not found in SE is its acknowledgment of the negative core beliefs and interpersonal challenges and emotions associated with complex trauma (pp. 607-630). Sensorimotor Psychotherapy weaves in awareness of disrupted self perception, demonstrating through experience how a collapsed slumped body can correlate to childhood notions of unworthiness. In the phase oriented approach, through which sound resourcing is established and the the window of tolerance gradually expanded, the client may eventually face and process painful emotions and negative beliefs cognitively. A true bottom-up, top-down process, the 'top' i.e. pfc higher cortical processing site is the 'last' area of pain and trauma to be touched. The prefrontal cortex is also involved in a more direct way and earlier on in asking the client to link language to the felt sense (pp.201-223). The painful negative self perception is acknowledged and integrated with the thoughtful and slow approach of somatic based regulation and new patterning.

At this point it is worth turning to the emerging science of interoception to further reinforce why bottom up approaches may yield better results in the gentle process of healing trauma. Interoception refers to what is felt inside the body. Awareness of sensations of movement either organic or energetic, light or temperature, signals like fullness or hunger, noticing numbness or high activity in a particular internal location are all examples of interoception.

Chen et al., (2021) describes the sub to high cortical process in interoception. Interception 'ignites' the nucleus solitary tracts within the brainstem first, then the ventromedial (underside) of the thalamus communicates the signal to the posterior insular cortex where integration with somato-motor information occurs, then on to the anterior insular cortex which communicates emotion. Lastly it may link with higher cortical functioning bringing sensation into 'conscious awareness' (p.5) . The PFC 'may be involved in linking between interoceptive and emotional or

cognitive states for further integration and interpretation.' (p.21). In other words it may be involved in 'affect tolerance'.

It is a pathway that, if you will, metaphorically mimics our evolutionary biology - dorsal vagal emerged first, followed by the sympathetic system and finally the ventral vagal - which opened up inter-human social engagement (Porges as cited in Schwartz, 2020, p.71). The thinking brain is the last area to go 'online' (when conditions are right). That we as humans seem to want safety, then gentle 'mindful' exploration of body sensation on the way to cognitive process makes more sense. The evidence thus far seems to support this deduction. Interventions where cognitive approaches are used to treat trauma have attrition and incompletion rates (Dietrich et al., 2024, p.2;, van der Kolk et al., 2014, p. 559).

Bessel van der Kolk et al. (2014) plainly states the problem. 'Becoming flooded or dissociating interfered with the resolution of traumatic memories.' Too, this leads to discontinuation of treatment and potentially worsening symptoms (p.559).

It is in the 'making sense of' knowingly, cognitively integrating the body sensation and emotion with language that may distinguish SP from SE. SP is concerned with the mental processing of trauma and goes beyond the safe and cared for discharge of traumatic muscle memory. SE is limited in this way.

Sensorimotor Psychotherapy is clearly more aligned with Integrative Yoga Psychotherapy in that it is a 'fuller' psychotherapy. Whereas SE, SP and IYP are all grounded in neuroscience, SP also, like IYP is grounded attachment theory. Too, its scope is wider in that it can meet issues such as interpersonal difficulties, disrupted self perception and the shame and guilt associated with complex trauma.

Unfortunately, the efficacy evidence base for SP is yet to be established. 'At present SP lacks the research base to be regarded as an evidence-based treatment' (Gladstone et al., 2023, p.185). Searches yield only three studies into its efficacy. The first pilot study showed 'preliminary evidence of the effectiveness of SP in reducing trauma-related symptoms' (Langmuir, as cited in Gladstone et al., 2023, p.185). Another study refers to statistically significantly positive results in reducing PTSD symptoms as well as depression and demonstrated 'overall improvement'. In the only RCT to date, similar improvements in regulation (soothing) receptivity and reduction in anxiety

(presumably associated) along with improvements in body awareness were shown, however the hypothesised reduction in dissociation was not demonstrated (Classen, et al., 2020, p.10). All studies related to group therapy and were limited in various ways. However it is encouraging that two of the three studies addressed complex trauma as opposed to PTSD alone and that all three were 'encouraging' and offered 'preliminary evidence' and 'proved beneficial' .

This discussion has defined trauma and distinguished complex trauma from PTSD, explicated the neuro-bio-psycho processes at play with a case study illustration and has explored two 'new' body-based modalities which are increasingly being used in the treatment of trauma with references to how Integrative Yoga Psychotherapy might enter into the field of effective interventions.

The evidence for SE and SP, though promising, is insufficient to confirm efficacy. Other approaches which align with and or amalgamate aspects of neuroscientifically informed, body based modalities include Janina Fisher's Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation manual, Susan McConnell's Somatic Internal Family Systems Therapy, (and the supplemental trauma workbook) and Arielle Schwartz's Complex PTSD Treatment Manual.

In some ways, these three approaches, which overlap with each other and integrate polyvagal theory, wider neurobiology of trauma with mindfulness and interoceptive / somatic practices and parts work might be even more useful touchstones of 'comparison' with IYP for trauma. However, they are not declarative, distinctly defined therapeutic modalities and have not been involved in scientific study.

All are 'bottom up / top down' and each enfolds body awareness, mindfulness and somatic practices. However, with the exception of Arielle Schwartz's limited inclusion of yoga, none incorporates yoga as a means of healing. As we will soon see, this is important. Moreover, while each addresses the deepest of existential wounds in negative self concept and shame and further, may allude to or incorporate notions of 'self' and spirit, none is declaratively spiritual in foundation.

Why does this matter? How might IYP offer a more innovative, comprehensive and reliable framework for healing trauma given that it involves yoga and is spiritual? The answer lies in both science and the immeasurable. In the next section, I will assert that yoga is salient to trauma

treatment because it has a secure evidence base. I will explore how this modality's underpinning in yoga and yoga therapy, means that it is able to meet the whole presentation of embodied trauma in a way that other therapies cannot. I will address the implications of spirituality within the field of trauma, the traumatised individual and trauma treatment. Considering that it can meet the whole embodied presentation of the client, that it can address the psychological wounds of negative self concept and that it touches the spiritual nature of trauma, Integrative Yoga Psychotherapy may have the potential to meet the traumatised client in a uniquely comprehensive way. Equally, it may have certain deficits and drawbacks which could mitigate its effectiveness and relevance and these too, will be explored.

Integrative Yoga Psychotherapy - a 'comprehensive' trauma intervention

In his paradigm shifting book, *The Body Keeps the Score* (2014), Bessel van der Kolk promoted yoga as helpful in the healing of trauma, stating that it has proved 'so successful in helping [survivors] calm down and get in touch with their dissociated bodies' (van der Kolk 2014, p.86).

Before his work infused the field of research and 'yoked' yoga with polyvagal theory, yoga was already keenly studied in a wide range of inquiry. Since then the study of yoga as a healing mechanism in trauma has surged. Countless studies and trials have been conducted. Reviews and meta analysis of the literature and knowledge base, testifying to the very active nature of scientific inquiry, abound. (Cramer et al., 2018; Macy, et al., 2018; Nguyễn Feng et al., 2020; Ong et al., 2023; Riley & Park, 2015; Taylor et al., 2020; Telles et al., 2015). Though yoga (and particularly trauma sensitive yoga) continues to be thought of as an effective and evidence based, valued tool in processing trauma, the clear unconditional confirmation is elusive.

In studies and trials, it is varyingly described as, 'effective' and 'advantageous and reducing PTSD symptoms' (Taylor et al., 2020 ,p.1), beneficial (Ong et al., 2023), and as having 'potential to be significantly beneficial' (Nguyen-Feng et al. 2020, p.9). Studies showed yoga 'significantly improved' symptoms of PTSD and associated depression and anxiety (Dietrich et al., 2024, p.1), and 'significantly improved PTSD symptomology' as well as other positive outcomes. However all reviews call for much more robust and rigorously controlled research. Many studies have pointed

to its efficacy, yet the overall quality of that evidence is ‘low’ owing to inconsistencies in data gathering, potential for bias and lack of control. Nevertheless, yoga is widely considered to be an effective adjunct to treating trauma and the research is ‘encouraging’ (Gaffney et al, 2023, p.1).

It is worth re-iterating, however, that comparatively, top down approaches have high ‘incomplete response’ rates and lack ‘meaningful improvements’ (van der Kolk et al., p. 559). They may be ‘too distressing’ and lead to high attrition rates, ‘non response' and overall ‘treatment resistance’ (Dietrich et al., 2024, p.2).

The regulating effects of breath control, mindfulness and non-judgemental body awareness in yogic movement are posited as reasons for increased tolerance of the body and internal world and for increased self-compassion, however the ‘mechanism’ for ‘why yoga works’ is hard to pin down. Recent qualitative research found that stabilisation, self authenticity, equanimity and community were primary ‘healing agents’ to a group of trauma survivors (Gaffney et al 2023, p. 1). Trauma sensitive yoga goes further in compassionately tending to the traumatised individual in that it is sensitive to appropriate practices, shapes and language and gently moves the client toward self-agency. This is akin to the zone of proximal development as taught in IYP.

In a recent salient study into the effectiveness of one-to-one TCTSY for trauma, yoga was found to significantly improve ‘anxiety, depression, post-traumatic stress symptoms, attention regulation, self-regulation, and body listening’ (Dietrich et al., 2024 p.1). One highly relevant outcome of the study was the future direction of care which asked whether TCTSY combined with psychotherapy would be of even more value. The authors called for further research comparing siloed ‘treatments’ of TCTSY and psychotherapy alone with the ‘synergistic’ combination of the two (Dietrich et al., 2024, p.10). This is highly relevant and underscores the timely nature of Integrative Yoga Psychotherapy entering into the world of body mind healing.

Integrative Yoga Psychotherapy is singular in its capacity to hold body and mind in one synergistic therapy. Further, its spiritual underpinnings and ability to ‘hold’ the spiritual inflection of trauma distinguishes IYP even more expressly.

As IYP therapists are highly experienced yoga teachers and rigorously trained yoga therapists, they are able to enfold the evidence based yogic practices known to help process trauma. Other modalities including SE and SP do not benefit from this type of experience in their

facilitators, nor are they positioned to address the body. They are not able to meet the co-morbidities of body nor meet trauma transdiagnostically across a spectrum of somatisation.

Not only are the skills and tools for regulating the nervous system part of the IYP skill portfolio, but much deeper understanding of neurobiology and the effects of yoga are within the IYP's knowledge base. This is relevant and important because trauma, particularly complex trauma is likely to come with embodied dis-ease (Felitti, Schwartz).

Ann suffers from an auto-immune disease which compromises the myelination of her nervous system. I understand that poor myelination effects regulatory control as well as causing any number of other symptomatic expressions in her physiology. I use my knowledge of vagus nerve practices to improve or maintain vagal connectivity. I know that in yoga, the Broca's area 'comes online'. Ann does not struggle with alexythymia, she is highly descriptive and connected to her sensation, but notices that movement ignites observation of her sensations. I know that GABA is low in PTSD and her condition (Huang et al., 2023, p.1; Droby et al., 2020). In practising and observing movement, with short holds, she may benefit from increased GABA, nitric oxide for efficient oxygenation and elevated BDNF which is involved in neurogenesis. Throughout a practice - if it is what she expresses she needs that day - she moves from sympathetic arousal to the parasympathetic state, which again aids the whole 'growth' system, particularly in lowering the stress response and therefore dampening the inflammation field, providing an environment for the slower moving organs to renew.

Poor mental health in trauma may lead to dis-ease and somatisation - 'physical symptoms which have no medical explanation' (Waldinger et al., 2006, p.129). In an innovative study synthesising current knowledge on childhood trauma and somatisation, Waldinger et al. established a link between insecure attachment and somatisation. The attachment deficit mediated adult somatisation, in women (not in men). Between '30%-60% of patients in primary care settings complain of symptoms that have no medical basis'. Somatisation linked to adverse childhood experience creates a confused and unsatisfactory experience for both patient and professionals in primary care and comprises a significant component of patients seeking care. Given its understanding of both somatisation and attachment patterning, it is surely apposite to highlight IYP as a very fit prevention and intervention.

Ann usually starts each session with an update of her frustrations in seeking medical care. She is beset by a spectrum of symptoms without cause. Professionals are rarely able to help and the accounts are infused with her intense emotional response to the interpersonal exchanges with receptionists, doctors, nurses and increasingly - technology. Of course her auto-immune condition may well account for the symptoms, but trauma is transdiagnostic and I hold this quietly in mind. We discuss that her condition may be the cause, that adverse childhood experience can also lead to unknown symptoms. We may discuss attachment theory and occasionally, we may discuss why slower exhalations are helpful while we practice. If the field suggests it is relevant, I may further share neurobiology or neuropsychology. Psycho-education is explicitly named as part of the therapeutic approach in many trauma healing modalities including SE, SP (2015, p.13) and the others named above. Judith Herman (1998) illuminates why: 'The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections' (p.146) The recovery must involve empowerment. Fisher further clarifies, helps to equalise the inherent power differential by "making public" the knowledge base that will be used in the therapy, empowering clients to become educated consumers in their own treatments' (2017, p.10).

IYP, too, believes that empowering the client with psycho-education in any context is a key part of healing. While it would be unhelpful to overload a client or make formal the imparting of salient information, a natural sharing environment, where the therapist is attuned to the client and to the relational 'alchemical' field may suggest that psycho-education is very pertinent in that moment and will 'land well'. Additionally, psycho-education and empowerment comes along quite naturally with home practices. Moreover, it should be a part of the therapist's awareness of the zone of proximal development.

We have seen that IYP includes the factors which help other somatic therapies to succeed and we have seen how IYP goes beyond - how the integrative yoga psychotherapist is uniquely skilled in meeting the whole presentation of the traumatised client.

Though IYP may be considered a somatic therapy, it is also, importantly, person-centred and humanistic. At this junction, we begin to step away from neuro-psycho-science, and statistical

evidence and turn toward the theoretical, the spiritual and that which is less measurable and exact in the process of healing.

Threading through the theoretical model and hopefully through the therapeutic encounter, are the Rogerian core qualities of empathy, congruence and unconditional positive regard. Other modalities may not incorporate these at ground level, though the mirroring and relational sensitivity and highly cultivated client observation in SE and SP suggest that they are, even if not named. Nevertheless, '[N]ew clinicians may find it challenging to remain attuned to their clients while implementing the method [SP] without proper training in broader psychotherapeutic processes' (Gladstone et al., 2024, p.185). As an experienced yoga therapist, and trained IYP, I am alert to attunement and I know that the brain chemistry changes when it feels that alchemy in talking to another person. Thus it can be said that IYP is secure in this crucial tenet of successful therapy.

Relational depth is an expectation in Integrative Yoga Psychotherapy and in fact the therapeutic relationship is deemed and acknowledged to be the most important factor of all in healing or 'successful' therapy. The container or therapeutic frame, one in which safety, trust and the core qualities are present, provides an environment in which corrective relational experiences take place - emotions and interpersonal interplays which were previously 'not allowed'. The client hopefully evolves psychologically in this context. Clearly, this phenomenon is hugely important in complex trauma, where inter-personal and intra-personal deficits are the norm. Somatic therapies which sit too much in bottom up experience, may unwittingly miss the importance of this unfolding.

The IYP Model is also grounded in attachment theory (2023, p.5). Whereas SP foregrounds attachment and Fisher and Schwartz also incorporate it, SE does not seemingly prioritise attachment.

As an IYP, practised in the core qualities, wise to the phenomenon of the relational field and aware of the influence of attachment style, I am able to hold the following:

Together, Ann and I have arrived at a practice which touches the feeling of breath in her solar plexus. Her breath is 'frozen' there and she struggles to ever feel her abdomen move in breathing. Ann's insecure-avoidant or disorganised attachment style has potentially shaped her closed body. Her chest is collapsed, her shoulders round up and in as if shielding this vulnerable part of her. She has a pronounced kyphosis and by her own admission says she likes to feel

hidden and as a child and teen, she would hide and ‘disappear’ whenever she could. She used to harshly judge herself in her shape, but now she is moving toward curiosity and is making connections between her ‘frozen breath’ and her past. She witnesses how it has shaped her and is less judgmental and increasingly in touch with the child who suffered. Over the course of many months we have built a trusting and empathic therapeutic relationship. During our gentle breath inquiry, in which we explore what her breath feels like in the diaphragm - what information might be arising in this area - she is silent while she goes within and eventually says, ‘It feels like a child who stops themselves crying’. Ann is able to cry a little at this point and with the use of therapeutic touch, my hand on her feet, I then guide her in RAIN (recognise, acknowledge, inquire, nurture) practice to help or at least begin process the emotional pain of the wounded child.

In this process, I am aware of the life stages of my client and also of the loosely corresponding chakra energies which are at play and which need movement. Too, I’m aware of the interplay of the panchamaya koshas, which inform the continuum of assessment in yoga therapy. Clearly, other modalities mentioned in this essay do not reach this level of psycho-spiritual process and theory. SE, SP and others all value and rely on mindfulness and tracking body sensation. Fisher says, ‘Mindfulness skills must be explicitly taught’ (2017, p.10). Ogden (2015 p.41) uses relational mindfulness (witnessing the client’s moment by moment presentation) and relies on intentional directed mindfulness as part of her phased psychotherapy while Schwartz (2020) devotes a chapter to cultivating mindfulness (chapter 5). Levine traces his body tracking methods to Gendlin’s Focusing (1997, p.67). It is said that SE touches the transcendent and his modality more than the others is linked to the spiritual. Interestingly, his method has been likened to Goenka vipassana, (Freese, 2023) suggesting that, along with the brain changes which take place in mindfulness and meditation, interoception itself can be spiritual.

However, no other therapy is declaratively ‘spiritual’, yogic or Buddhist in origin. It is this aspect of IYP which differentiates it above and beyond all other current somatic modalities which hope to heal trauma.

In the next section, I will explore how spirituality is salient to healing trauma and that this unique underpinning, particularly when yoked to established psychotherapeutic theory as it is in IYP, distinguishes IYP from other somatic therapies.

In Trauma, Meaning and Spirituality, Crystal Park, et al. (2016) posit that there is a 'reciprocal interplay' between trauma and spirituality (p.13). It is easy to comprehend why such interplay is present. Firstly, and most readily accessible, is the 'fact' that having a spiritual or religious life aids trauma resilience. Those with faith or religion are less likely to suffer from PTSD symptoms at least in military contexts (Richardson et al 2022, pp. 332, 334, 339) (Sharma et al., 2017, p.1).

However this discussion is concerned with those who are symptomatic, who have, for whatever reason, less resilience. It is therefore more of a concern to explore trauma and spirituality in relation to meaning making and bring the unique capacities of IYP in relation to this into focus.

Spirituality has been defined as 'the search for the sacred'. Where sacred can mean god, it might also - importantly - mean 'other aspects of life that are perceived to be manifestations of the divine or imbued with divine like qualities, such as transcendence, immanence, boundlessness and ultimacy'. Religion, by contrast, 'houses' the potential for spirituality - it is found in established organisations (Pargament via Park et al. 2015 pp.7-8).

How is IYP spiritual? It is a biopsychosocio-spiritual modality. At the risk of being too incisive - it is founded upon and girded by the spiritual and philosophical traditions of yoga and Buddhism and, quite simply, it declares itself to be so in its foundational principles, naming 'spirituality' above biological and psychological (though all inter meld) (The Minded Institute, 2023, p.4). In the following paragraphs, and using The Minded Institute's IYP Model, (2023) I will highlight in turn the spiritual framework and methods which infuse psychotherapeutic process, the spiritual 'container' and finally, the IYP view of the Self.

As we have seen, IYP deploys neurobiochemical understanding, attachment theory and (many) other theories such as Erikson's life stages and Clarkson's relationship model to inform its therapeutic approach. However, it is the yogic and Buddhist lenses that in many multi-tonal ways inflect the model with the 'sacred'. It has been said that imagination is the new word for soul. The energetic and philosophical lenses of the yogic body mind are highly imaginative and metaphorical. There is no science to prove the chakras, koshas or other tenets of yoga philosophy such as the existence of samskaras. And this is potentially what lends yoga its power, at least in a spiritual context.

The sacred is something which is infused by the divine, both transcendent and immanent (Pargament via Park et al. 2015 pp.7-8). The unseen, unmeasurable fields of the chakras and koshas are not earthbound or material. In that sense they are ‘boundless’ and soulful. In the panchamaya kosha model five intermingling sheaths, ranging from the gross to the subtle, from the physical to the spiritual, are said to make up the holistic human being. These sheaths obscure the sacred Self within. The seven chakras also range in subtlety and reach from ‘base level’ to the highest spiritual sense. Both are used in IYP to assess clients and to inform the therapy. Practices such as movement, become more meaningful when movement is playful, flowing and linked to the creative, childed svadhisthana chakra - more meaningful still, when a client had a restricted, stressful, uncreative childhood.

The chakra model as it loosely links to Erikson’s life stages and as a lens for life development is richly instructive and offers practices which help awaken a sense of presence and peace which go beyond mere ANS regulation. Science confirms what happens to the body in regulation. Qualitative research affirms the feelings generated by mindfulness, meditation, breath work. When these practices are personalised and linked to something meaningful such as the inability to feel safe or lack of childhood play or to feel love, they become potentially more potent. Particularly where trauma has blunted a clients creativity and many other aspects of their expression, - these methods offer a new, elevated ‘non-earthly’ way to experience themselves.

The spiritual therapeutic frame of IYP might also extend to the environment, or container in which the therapeutic encounter takes place. By lighting a candle and incense if the client welcome it, the tone of the space changes to something beyond the mundane and suggests a permission to connect with higher meaning making as well as suggesting that the client’s experience is important. ‘[R]esearch findings and clinical experiences have demonstrated the importance of individuals’ spiritual lives in the process of making meaning of and recovering from traumatic experiences (Park et al 2015, p. 5). Levine describes the relationship between trauma processing and spirituality as ‘intrinsic and wedded’ (Levine 2010 as cited in Dann et al., 2023 p. 92).

Thus attending to the spiritual is needed in trauma intervention. SP claims no connection to the spiritual aspects of trauma, though the process of unfolding new connections might be implicitly ‘spiritual’. SE on the other hand, holds spiritual potential within its frame. What happens in trauma

recovery may mimic mystical and mediative experiences, the release of new vitality may feel ‘transcendent’. He refers to cultivating ‘qualities of the spirit’ and that connection to others and something beyond oneself may be part of this. (Dann et al., 2023, p.92). However, he makes no reference to the inner ‘self’ as most psychotherapies do and which is a primary feature of yoga.

Complex trauma disrupts inter and intra personal fluidity and integration, resulting in deeply damaging self perception and sequelae of struggles related to this such as inability to connect with others. Trauma may obscure the ability to ‘perceiv[e] good in the world’ and lead to an understandable need to seek meaning from the experience. A sense of self as unworthy and bad is a serious impediment to a sense of wholeness, spiritual or otherwise.

From a yogic perspective as well as from a traditional psychological perspective, the sense of union with the self is integral to wholeness and healing and is ground zero of moving toward ‘connectedness’. Self is the healing principle.

The IYP theoretical model sees suffering as a manifestation of dis-connectedness (The Minded Institute, 2023, p.3). It is salient here to refer to Herman’s defining characteristic of trauma as one of ‘disconnection from others’ (1998, p.145). Thus the treatment of trauma should hold this awareness of self at its heart and seek to create a pathway to realisation so that the client can deeply connect with sense of self, potentially cultivate a higher meaning of ‘Self’ and move the intrinsic spirit outward toward others and ultimately towards ‘oneness’. Yet in complex trauma, the hidden ‘exiled’ unworthy self must not be overlooked, rather held as the key to unlocking potential within the client.

IYP offers both yoga and Buddhist practices and philosophies to facilitate this potentiality. The IYP Model (2023) asks that we as therapists offer whichever method or practice is most suited to the client (not our preference). With all of the above in mind, I navigate Ann’s complex presentation.

Ann grew up with strict religion which was unfriendly to her in many ways. She still finds comfort in her connection to it. She is, however, benefitting from mindfulness and Buddhist compassion practices. Though she has struggled by putting others before her, she chose five ACT value cards which focused on help and compassion for others. These are her values. To work with all of the above, I guide Ann in metta meditation. She is warm and safe and has heavy blankets on

her legs. At the end of the meditation, in which we offer loving kindness to ourselves and then to others, she is quiet, and without opening her eyes says, ‘when I do this, my mind goes back to how bad I was, that I must be a bad person.’

Ann longs to be content. Contentment is elusive as long as her perception of herself, which is intrinsically ‘baked in’ to her body, remains ‘I am bad’. Glimpses of contentment occur during therapy and continue to increase as we move somatically through her story. The lightly held spiritual dimension in the container, the imaginative methods, the attention to Self as healing principle and key to feelings of ‘connectedness’ all allow Ann to meet her experience spiritually. Meaning making goes beyond merely ‘functioning better’. IYP gently engenders the spiritual in its biopsycho-spiritual approach.

Somatic Experiencing could offer Ann processing possibility but I would assert it does not hold a secure enough approach to reaching ‘self’. Equally it is not able to address the somatisation presentations of complex trauma. SP experiments are very useful and are slowly unfolding new patterns in Ann’s bodymind to real positive effect. SP also offers a pathway to address negative self beliefs and constructs. However self (nor Self) is not directly named and might prevent a fuller experience of connectedness. Too, it does not highlight the spiritual aspects ‘intrinsic’ to trauma.

Fisher’s and Schwartz’s integrative models and McConnell’s IFS potentially, may be more tuned to notions of self and soma, but they do not necessarily hold the notion of self as spiritual, nor hold the spiritual dimension of trauma in other ways. IYP encourages the therapist to weave in methods particular to the client’s need. I could continue to work with shame and help shift Ann’s symptom’s of trauma by integrating IFS parts work or Integrative Eye Movement Therapy. However she is already making ‘moves’ to evolve the physical, mental and spiritual aspects of her negative self concept. Recently in tracking body sensation in movement and yogic shapes, she said her solar plexus felt like a ‘tight jacket’. She felt through the inner sensation and shape, ‘taking off the jacket’ to wide armed, fuller, breath. She stood tall and broad and said it was like being seen in the sun.

IYP is able to hold and address all aspects of trauma, both in a named trauma presentation and trasdiagnostically. It is able to compassionately move with a client’s experience of trauma neurobiologically, psychologically and spiritually. It has the potential to be the most effective of all

modalities, yet it too has limitations. The integrative nature of IYP is both a benefit and in this context, potentially a drawback. Both SE and SP offer outlined, phased, sequential approaches to treatment. SE offers a lean protocol. IYP, as a broad church, does not offer a scripted method. In fact, the wide range of options available to the IYP therapist may be overwhelming. The yogic concept of wholeness may 'spiritually bypass' or minimise the true nature of fragmentation within complex trauma and lead to unrealistic assumptions about yoga's power to heal.

The other factor which could paradoxically inhibit true effectiveness is in the concept of 'yoga'. Yoga has been shown to help alleviate trauma suffering. Yet many people unused to yoga may remain averse or sceptical. Aversions to perceived esoterica and spirituality may limit its ability to move into the mainstream of interventions. Yet increasingly, the biopsycho-spiritual model of wellbeing is being promulgated by organisations concerned with human health, such as the WHO (Saad et al., 2017). Therefore, I conclude this discussion on a hopeful note, that with unfolding understanding of the body's role in trauma and our evolving understanding of what makes us holistically well, spiritual-biopsycho models, grounded in science and sound theoretical methods and evidence based, will be received more readily.

IYP is concerned with healing and believes that 'bridging body and mind disturbances' is 'fundamental for truly working in the wheelhouse of alleviating suffering, developing well-being, and reaching one's potential'. Most psychotherapies 'cannot jointly address' the body-mind in this way (The Minded Institute, 2023, p.5). Contained within the spiritual framework of yoga, IYP becomes distinctive and comprehensive. Considered in its biopsycho-spiritual totality, it emerges as singularly placed among therapies, especially somatic therapies, in the field of trauma intervention.

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