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HELPING TO HEAL THROUGH YOGA:
EXPLORING YOGA AS AN ADJUNCTIVE THERAPY TOOL FOR ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE

Sara Richeson

A Capstone Project submitted in partial fulfillment of the

requirements for the Master of Science Degree in

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College of Education

Counselor Education Department

CERTIFICATE OF APPROVAL

CAPSTONE PROJECT

Helping to Heal Through Yoga:

Exploring Yoga as an Adjunctive Therapy Tool for

Adult Survivors of Childhood Sexual Abuse

This is to certify that the Capstone Project of

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Has been approved by the faculty advisor and the CE 695 – Capstone Project

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Abstract

The purpose of this paper is to explore using yoga as an adjunctive therapy tool for adult childhood sexual abuse survivors suffering from the effects of trauma. This paper will present information related to complex trauma, childhood sexual abuse, posttraumatic stress disorder, traditional talk therapy, and Hatha yoga as a complementary intervention. There is a discussion on conventional talk therapy that examines Cognitive Behavioral Therapy, including theoretical components as well as implications for treating complex trauma survivors. The section on Hatha yoga will introduce the reader to the practice and clarify key elements and goals of yoga. Additionally, this paper will present current research on the efficacy of Hatha yoga for posttraumatic stress disorder as well as possible explanations as to how and why yoga is an effective intervention for complex trauma survivors. The section on Hatha yoga will also explore considerations for professional counselors interested in incorporating yoga-based strategies for trauma treatment. This paper provides compelling evidence that Hatha yoga is an effective adjunctive clinical intervention for adult survivors of childhood sexual abuse who are suffering from posttraumatic stress disorder.

Contents

Introduction ……………………………………………………………………………………1

Review of Literature ………………………………………………………………………...5

Trauma………………………………………………………………………………….5

Causes………………………………………………………………………..6

Symptoms……………………………………………………………………6

Childhood Sexual Abuse…………………………………………………………..7

Definition...……………………………………………………………………..7

Effects………………………………………………………………………..8

Posttraumatic Stress Disorder…………………………………………………………..9

Effects………………………………………………………………………..9

Cognitive Behavioral Therapy………………………………………………………...11

Theoretical Components……………………………………………………12

Considerations for Trauma Treatment………...……..…...…………………….……12

Hatha Yoga….…………………………………………………………………...14

Research……………………………………………………………………….16

Considerations for Therapists………………………………………………19

Conclusion..…………………………………………………………………………………...22

References ……………………………………………………………………………….24

Helping to Heal Through Yoga:
Exploring Yoga as an Adjunctive Therapy Tool for Adult Survivors of Childhood Sexual Abuse

Introduction

When it comes to the treatment of trauma, the field of psychotherapy has progressed in recognizing the critical connection between the mind and the body. While there has been growth in honoring a more holistic approach, psychotherapists have traditionally focused on the mind first with little consideration to the body. In recent years, however, there has been a shift in the profession to include the somatic experience, seeing the body as a vehicle towards change, recovery, and personal growth for individuals with a history of trauma. Exposure to trauma in our society is ubiquitous; over half of the general population reports experiencing at least one traumatic event during their lifetime (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

One of the most common disorders developed amongst trauma survivors is posttraumatic stress disorder (PTSD), with a lifetime prevalence of 10.4% for women and 5% for men (Kessler et al., 1995). Posttraumatic stress disorder can negatively impact an individual's health, emotional wellbeing, and overall quality of life (Emerson & Hopper, 2011). According to Kessler and colleagues (1995), approximately 70% of individuals diagnosed with PTSD are symptomatic for more than six months and may experience symptoms for years. While those who suffer from PTSD often respond to conventional psychotherapeutic treatments, estimates suggest that approximately 40% of individuals with PTSD experience chronic symptoms that are non-responsive to traditional treatment (Kessler et al., 1995).

Childhood sexual abuse (CSA) is one of the most common causes of complex trauma in our society. Complex trauma, according to Courtois and Ford (2009), is characterized by prolonged and cumulative trauma that is often experienced within the context of relationships or

environments. This is a particularly important population to focus on, especially considering the pervasiveness of CSA in the United States. Hall and Hall (2011) suggest that 28 to 33% of women and 12 to 18% of men have experienced sexual abuse during childhood. However, many CSA incidents go unreported, implying that the percentage of adults who experienced CSA might actually be higher (Hall & Hall, 2011).

There are a wide variety of individual and group therapeutic approaches to treating trauma. Historically, clinicians have treated trauma survivors with traditional talk therapy, which addresses the cognitive and emotional aspects of trauma (Emerson & Hopper, 2011; van der Kolk, 2014). More specifically, the literature suggests that Cognitive Behavioral Therapy (CBT) is one of the most commonly utilized evidence-based talk therapies for trauma treatment (Briere & Elliott, 2003; Emerson & Hopper, 2011; Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010; van der Kolk, 2014). Conventional talk therapies like CBT focus on telling the story of trauma; while many survivors may experience some relief by expressing their narrative and feelings, talk therapy does not address the memory of the trauma that is stored within the body (Emerson & Hopper, 2011; van der Kolk, 2006; van der Kolk, 2014). Furthermore, many survivors suffering from PTSD experience chronic somatic symptoms that do not diminish with traditional talk therapy alone.

According to Emerson and Hopper (2011), “trauma has a deep and long-lasting effect on the entire organism, from chemical and anatomical changes in the brain, to changes in our body’s physiological systems, to the subjective impact on the experience of the survivor” (p. 35). While verbally based psychotherapy may be helpful to trauma survivors and may play an important role in the healing process, clinicians are beginning to recognize that these cognitive-focused

treatment modalities might not be sufficient of their own accord (Emerson & Hopper, 2011; van der Kolk, 2006; van der Kolk, 2014).

There has been a recent surge of research efforts in the arena of non-traditional trauma treatment in the hopes of identifying complementary and alternative treatment modalities that effectively address complex trauma symptoms. More specifically, mindfulness- and movement-based interventions have increasingly been receiving attention, including: meditation, yoga, Mindfulness-Based Stress Reduction (MBSR), Mindfulness-Based Cognitive Therapy (MBCT), Dialectical Behavioral Therapy (DBT), Eye-Movement Desensitization Reprocessing (EMDR), theatre, and dance therapy (Courtois & Ford, 2009; Dick, Niles, Street, DiMartino, & Mitchell, 2014; Duros & Crowley, 2014; Emerson, Sharma, Chaudhry, & Turner, 2009; Emerson & Hopper, 2011; Forfylow, 2011; Shapiro, et al., 2007; van der Kolk, 2006, van der Kolk, 2014). While it is clear from this list that there are many valuable approaches to treating trauma, this paper will focus on yoga as a catalyst for change and healing in adult CSA survivors.

Yoga is an ancient mind-body practice that helps to calm the mind and the body; one could even call it “the original body-inclusive psychotherapy” (Duros & Crowley, 2014, p. 241). Hatha yoga, the most common form of yoga practiced in the United States, focuses on teaching people to utilize the body in order to foster physical, emotional, and spiritual health (Uebelacker et al., 2010). In other words, the ultimate goal is to help people create a balance between the mind, body, and spirit (Forfylow, 2011). Hatha yoga practices consist of three main components, including: breath control, physical postures, and meditation - all of which help people to calm down or regulate their emotions and physiology (Duros & Crowley, 2014; Emerson & Hopper, 2011; Forfylow, 2011; van der Kolk, 2014). According to trauma expert Bessel van der Kolk (2006; 2014), a critical aspect of trauma treatment is to help survivors

manage their somatic symptoms prior to engaging in or in conjunction with traditional talk therapy. Thus, considering that yoga practices involve the body, researchers have recently been investigating yoga as an effective adjunctive therapy option for PTSD survivors (Emerson & Hopper, 2011; Uebelacker et al., 2010; van der Kolk, 2006; van der Kolk, 2014).

Putting it all together, the purpose of this paper is to explore why and how yoga is a promising and effective adjunctive treatment intervention for adult CSA survivors suffering from PTSD. There is a review of the literature that discusses the following: complex trauma, CSA, PTSD, CBT, and some limitations of CBT specific to CSA survivors. Additionally, the discussion will explore yoga more in-depth and provide findings from current research on yoga as a complementary trauma treatment. This paper concludes with considerations for clinicians who are interested in incorporating Hatha yoga as a complementary treatment alternative for adult CSA survivors.

Review of Literature

In order to better understand why yoga is a promising adjunctive intervention for treating the cognitive, emotional, and physiological symptoms of PTSD amongst CSA survivors, it is important to have a thorough understanding of trauma, including causes and symptoms. This paper will focus on CSA as one specific cause of complex trauma; thus, it is critical to include definitions, symptoms, and disorders associated with CSA. Additionally, the research will focus on PTSD and explore CBT, which is the most widely used traditional talk therapy for trauma survivors. This discussion will include definitions of CBT as well as some limitations associated with talk therapy for CSA survivors. The remainder of the literature review will focus on yoga, including statistics, definitions, components of yoga practice, and a review of the recent research findings. This review will conclude with a discussion of considerations for mental health professionals interested in using yoga as an adjunctive treatment for complex trauma survivors.

Trauma

In the United States, over half of the general population reports having experienced at least one traumatic event once during their lifetime (Bonanno, 2008; U.S. Department of Justice, 2000). According to the American Psychiatric Association (2013), trauma tends to occur when individuals have been exposed to one or more events that threatened life or the physical integrity of self/others. In other words, there is one common thread to all traumatic experiences: they threaten an individual's physical, emotional, and/or psychological safety (Emerson & Hopper, 2011; van der Kolk, 2014). Another key component that helps to further define trauma for some is the experience or feeling of a somatic sense of helplessness – "the realization that no action can be taken to stave off the inevitable" (van der Kolk, 2006, p. 282). When a traumatic event occurs, there are times when our innate physiological processes fail to effectively respond to a

threat; thus, instead of engaging in a successful fight or flight response, some individuals become physically immobilized or frozen (Emerson & Hopper, 2011; van der Kolk, 2006; van der Kolk, 2014). Furthermore, trauma expert Bessel van der Kolk (2014) states that, "trauma, by definition, is unbearable and intolerable" (p. 1). This leads to the next section, which describes common causes and symptoms of trauma.

Causes. There are vast numbers of events and/or situations that could be perceived or experienced as a trauma. Some common causes of trauma include: child abuse; physical/emotional neglect and/or abuse; being a victim of a crime; the death of a close friend/family member; living through war, divorce, or interpersonal/community violence; and experiencing a natural disaster, medical trauma, automobile accident, sexual assault, and CSA (Emerson & Hopper, 2011; Ford & Courtois, 2009; Hall & Hall, 2011). The latter experience, CSA, is a complex cause of trauma that will be explored more in-depth in the second section of this project. While the causes of trauma are abundant, so are individual reactions to experiencing a traumatic event.

Symptoms. It is important to consider that everybody experiences and responds to trauma differently; some people may be able to adapt to the distressing event(s) while others may develop trauma-related impairments. These symptoms may occur immediately after trauma exposure or they may be delayed for months or years (Emerson & Hopper, 2011; Ford & Courtois, 2009). While the signs are varied and wide-ranging, some of the most common symptoms are: depression, anxiety, PTSD, fearfulness, sleep disturbances, somatic disturbances, chronic pain, anger, nightmares, feeling out of control, irritability, distractibility, inability to concentrate, and memory lapses (Emerson & Hopper, 2011; Ford & Courtois, 2009; van der Kolk, 2014). For many trauma survivors, these symptoms are persistent and overwhelming,

negatively impacting the individuals' lives and their abilities to cope (Emerson & Hopper, 2011; van der Kolk, 2014). This is particularly true in cases of complex trauma(s) from CSA, which will be explored in the next section.

Childhood Sexual Abuse

For the purposes of this paper, CSA is considered a cause of complex trauma with multilayered and unique aspects that differentiate it from other traumatic experiences. Courtois and Ford (2009) define complex trauma as "resulting from exposure to severe stressors that (1) are repetitive or prolonged, (2) involve harm or abandonment by caregivers or ostensibly responsible adults, and (3) occur at developmentally vulnerable times in a victim's life, such as early childhood or adolescence" (p. 13).

The impact of CSA is unique to each individual, just as is the type of abuse, duration of abuse, and circumstances surrounding the abuse. Research indicates that CSA causes significant and long-term damage and harm across the full range of functioning (Briere & Elliott, 2003; Dube, et al., 2005; Hall & Hall, 2011; Lev-Wiesel, 2008). For instance, CSA can negatively impact emotional health, behavior, cognitive functioning, achievement, physical health, interpersonal relationships, and social interactions (Briere & Elliott, 2003; Dube, et al., 2005; Hall & Hall, 2011; Lev-Wiesel, 2008). The upcoming section of this paper will explore this complex trauma more in-depth.

Definition. Defining CSA can be difficult because there are many different forms, levels of frequency, and circumstances associated with this complex trauma (Hall & Hall, 2011). The American Psychiatric Association DSM-5 (2013) defines CSA as "encompass[ing] any sexual act involving a child that is intended to provide sexual gratification to a parent, caregiver, or other individual who has responsibility for the child" (p. 718). Another definition is "sexual

abuse occurs whenever one person dominates and exploits another by means of sexual activity or aggression" (Feinauer, Hilton, & Callahan, 2003). Lastly, Hall and Hall (2011) describe CSA as "any sexual act, overt or covert, between a child and an adult (or older child, where the younger child's participation is obtained through seduction or coercion). Irrespective of how childhood sexual abuse is defined it generally has significant negative and pervasive psychological impact on its victims" (pp. 1-2).

Effects. CSA can be an overwhelming experience that negatively impacts the mind and body, both of which are closely intertwined (Emerson & Hopper, 2011; van der Kolk, 2014). Research indicates that some common trauma symptoms and disorders amongst CSA survivors are: depression; PTSD; guilt; shame; self-blame; eating disorders; somatic disturbance; emotional dysregulation; anxiety; dissociation; sexual difficulties; impaired capacity to initiate, navigate, and/or sustain relationships with others; low self-esteem; negative or distorted self-image; phobias; substance abuse and addiction issues; personality disorders; suicidal tendencies; chronic pain; self-harm; and damage to one's fundamental beliefs and systems of meaning (Briere & Elliott, 2003; Dube, et al., 2005; Feinauer, et al., 2003; Hall & Hall, 2011; Lev-Wiesel, 2008; Putnam, 2003; van der Kolk, 2014). This extensive list is a clear indication of the harmful, negative, and pervasive symptoms that are associated with CSA.

More specifically, there is strong evidence indicating that PTSD is one of the most common psychological disorders amongst CSA adult survivors (Breslau, Davis, Peterson, & Schultz, 2000; Lev-Wiesel, 2008; Putnam, 2003; van der Kolk, 2014). This is not surprising considering that this trauma is complex in nature, but it also occurs during key developmental periods. The subsequent section will further explore this disorder along with the effects that PTSD has on survivors.

Posttraumatic Stress Disorder

As indicated above, many adult CSA survivors display symptoms of PTSD as well as experience many other devastating effects. According to the American Psychiatric Association's DSM-5 (APA, 2013), PTSD survivors may experience some of the following symptoms, which are associated with the traumatic event: (a) recurrent, uncontrollable, and intrusive memories, nightmares, flashbacks, psychological distress, and physiological reactions, (b) persistent efforts to avoid or avoidance of distressing memories, thoughts, and feelings as well as external reminders, (c) negatively altered cognitions and mood including fragmented memories, negative beliefs/expectations of oneself, self blame, guilt, fear, horror, shame, isolation, and inability to experience positive emotions, (d) significant changes in arousal and reactivity including irritable behavior, angry outburst, self-destructive behavior, hyper-vigilance, exaggerated startle response, concentration problems, and sleep disturbances, and (e) dissociation symptoms such as depersonalization or de-realization.

Effects. In his book *The Body Keeps the Score*, van der Kolk (2014) asserts that traumatic experiences like CSA can alter a survivor's physiology, brain structure, and functioning; this can then lead to vast numbers of other psychological and social impairments. For instance, when there is a perceived threat, our bodies automatically go into fight, flight, or freeze response, causing an increase in heart rate, respiration rate, stress hormones, and vigilance (van der Kolk, 2014). This response results in reduced activity in the prefrontal cortex of the brain and increased activity in the limbic system; this chronic stress is toxic to the brain (van der Kolk, 2014). Lastly, these neurobiological changes can influence a survivor's psychosocial world, often resulting in difficulties with being present, paying attention, taking effective action,

verbal expressions, and relationships (van der Kolk, 2014). Moreover, according to van der Kolk (2006), CSA survivors suffering from PTSD "seem to lose their way in the world" (p. 280).

While recent research and literature have well documented the numerous effects of trauma, this paper will focus on the subjective, sensory, and visceral experiences of trauma survivors. A body remembers and holds on to traumatic memories and emotional pain (Emerson & Hopper, 2011; van der Kolk, 2014). While this is evolutionary and adaptive, it can have detrimental effects causing increased levels of discomfort and distress (Emerson & Hopper, 2011).

Moreover, as indicated earlier, experiencing a traumatic event can often cause our natural fight/flight defenses to be aborted. For instance, children who are sexually abused are often unable to do anything to stop the assault, causing their self-protective systems to progressively disintegrate or break down (van der Kolk, 2006; van der Kolk, 2014). According to van der Kolk (2006; 2014), individuals with PTSD often experience inappropriate fight/flight reactions to minor events and an inability to regain a sense of personal safety or physiological relaxation. "While the mind usually shuts down during a traumatizing experience, the bodily sensations associated with immobilization and helplessness carry the memories of having absolutely no control over the outcome of your life: the fate of trauma survivors is lived out in the heartbreak and gut-wrenching sensations" (van der Kolk, as cited in Emerson & Hopper, 2011, p. xix). In essence, traumatized individuals often feel as though they are unsafe in their own bodies and as if their own bodies are the threat or enemy (Emerson & Hopper, 2011; van der Kolk, 2014).

Thus, it seems as though one of the most difficult aspects for complex trauma survivors is to manage the triggers and/or sensations that reside deep within their own bodies (Emerson & Hopper, 2011; van der Kolk, 2014). While the trauma occurred in the past, the body continues to

react as if there is still presently an imminent danger; it is almost as if the body keeps getting hijacked into experiencing intolerable sensations and emotions (Emerson & Hopper, 2011; van der Kolk, 2006; van der Kolk, 2014). Bessel van der Kolk (2006; 2014) asserts that individuals suffering from PTSD often become skilled at bracing against and/or ignoring their inner sensations and feelings.

As mentioned earlier in this review, the American Psychiatric Association's DSM-5 (2013) clarifies symptoms associated with PTSD, two of which are intrusive and avoidance symptoms. Often, traumatic memories intrude a survivor's consciousness, causing emotional and/or physiological distress (Emerson & Hopper, 2011; van der Kolk, 2006; van der Kolk, 2014). In order to escape from this distress, survivors often display avoidance symptoms, the most extreme form of which is dissociation (Emerson & Hopper, 2011; van der Kolk, 2006; van der Kolk, 2014). Dissociation is characterized by de-realization (i.e. perceiving one's world or environment as not real) and/or depersonalization (i.e. perceiving one's self as not whole, connected, or real) (APA, 2013). In essence, it is a mental, emotional, and physiological escape. However, this coping mechanism becomes problematic because it creates a complete disconnection from our emotions, body, and thoughts (Emerson & Hopper, 2011).

Considering the numerous effects outlined above, it is evident that CSA survivors who suffer from PTSD could benefit from professional help. This leads us to the next section, which examines traditional trauma psychotherapy, specifically CBT.

Conventional Talk Therapy – Cognitive Behavioral Therapy

While many different treatment modalities have been used to treat CSA survivors, the most traditional intervention is talk therapy. This approach is a cognitive intervention that focuses on the survivors' thoughts, feelings, and emotions (Emerson & Hopper, 2011; van der

Kolk, 2006; van der Kolk, 2014). More specifically, the literature suggests that CBT is the most effective evidence-based trauma treatment intervention (Cook, Schnurr, & Foa, 2004; Emerson & Hopper, 2011; Möller & Steel, 2002; van der Kolk, 2014). As its name implies, the foundation of this theory is based on two effective forms of psychotherapy: cognitive therapy and behavior therapy. CBT primarily involves working with clients to explore their emotions, thoughts, and behaviors (Hall & Hall, 2011). Like most other traditional psychotherapies, the main focus is on trying to construct a healthy cognition that helps to explain one's feelings (van der Kolk, 2014). The upcoming sections will further define CBT, outline some key theoretical components, and discuss considerations for trauma treatment.

Theoretical components. Some common attributes of traditional 'talk' CBT are (a) collaborative relationship between the client and the therapist, (b) the belief that psychological distress is a result of maladaptive thinking and behaving, (c) the goal of replacing thoughts with more adaptive ones, thus creating positive changes in both affect and behavior patterns, and (d) a time-limited and psycho-educational form of treatment that focuses on a client's specific problems (Hall & Hall, 2011; Linden & Zehner, 2007).

In other words, cognitive-behavioral therapeutic work starts with trauma survivors telling what happened in the past and then identifying irrational thought patterns and/or dysfunctional behaviors. Next, clients try to rewrite or replace those dysfunctional thoughts with more logical or positive thoughts. The idea is that this, in turn, will lead to positive changes in mood and behaviors, thus resulting in a reduction of PTSD symptoms. "Telling the story is important; without stories, memory becomes frozen; and without memory you cannot imagine how things can be different" (van der Kolk, 2014, p. 219).

Considerations for Trauma Treatment . Nonetheless, "telling a story about the event does not guarantee that the traumatic memories will be laid to rest" (van der Kolk, 2014, p. 219). As previously indicated, CSA can be traumatizing on multiple levels; it can lead to long term psychological damage and physiological harm as well. While CBT can be helpful in reorganizing and/or rewriting dysfunctional thought patterns, it does not help CSA survivors with any physical or bodily issues (Emerson & Hopper, 2011; van der Kolk, 2014). Conventional talk psychotherapies like CBT do not pay sufficient attention to the physical side effects of traumatic events (van der Kolk, 2014). Moreover, CBT does not address "the emotional states that are imprinted in the state of the body's chemical profile, the state of one's viscera, and the contraction of the striated muscles of the face, throat, trunk, and limbs. Yet, that is the level on which the trauma continues to be played out – in the theater of the body" (van der Kolk, as cited in Emerson & Hopper, 2011, p. xxiv). Furthermore, individuals suffering from PTSD have a tendency to associate their current physical sensations and emotions with their experiences from the past; this, in turn, impacts how they react to present day events (van der Kolk, 2006; van der Kolk, 2014). Therefore, while CBT appears to be effective in addressing the cognitive issues and problems that plague CSA survivors, it seems to be missing one critical piece of the puzzle: the physical body.

Another potential problem with talk therapy treatment modalities is that CSA survivors may resist talking about their history simply because it is too traumatic. In some cases, describing or 'reliving' the sexual abuse may actually do more harm than good because it can trigger trauma-related physical sensations and emotions such as helplessness, fear, and shame (Emerson & Hopper, 2011; van der Kolk, 2006; van der Kolk, 2014). Not only could this be detrimental to the counseling process, but it could also create a vicious cycle, causing the

traumatized individual to feel and to act as though they are being traumatized all over again (van der Kolk, 2006; van der Kolk, 2014). Moreover, some survivors may not have the words for their feelings, which is a phenomenon known as alexithymia (van der Kolk, 2014). Many adult CSA survivors are unable to describe what they are feeling because they are unable to discern the physical sensations that are occurring inside of their bodies (van der Kolk, 2006; van der Kolk, 2014).

Yet another implication of using CBT with traumatized individuals is related to bodily dissociation, which was touched on in an earlier section of this paper. Often times, CSA survivors tend to develop a negative body image or they have a complete disconnect with their bodies (van der Kolk, 2006). According to van der Kolk (2006; 2014), many adult CSA survivors believe that their bodies somehow betrayed them or they view their physical bodies as damaged or dead. While survivors might be able to talk about their feelings and emotions or identify them as illogical, CBT may not effectively help survivors learn how to accept, befriend, or inhabit their physical bodies.

Clearly, a major gap exists in conventional counseling for CSA survivors who want to try to heal from their trauma. From the evidence provided thus far, it seems as though many symptoms resulting from CSA involve the body, yet traditional psychotherapies like CBT do not treat the subjective or visceral experiences. This leads to the next section of this paper: what can mental health professionals do to help CSA survivors heal some of their physiological damage? The literature indicates that yoga is a promising and effective adjunctive intervention for treating the physiological symptoms associated with CSA survivors suffering from PTSD.

Hatha Yoga

For thousands of years, yoga has existed as an ancient practice that can help calm the

mind and body. The Sanskrit word yoga means to yoke or to unite, which reflects its purpose of joining the mind, body, and spirit (Emerson and Hopper, 2011; Forfylow, 2011; Uebelacker, et al., 2010). While the practice of yoga originated in India, it made its way to the United States during the latter part of the last century (Uebelacker, et al., 2010). Since that time, yoga has permeated our popular culture. It is estimated that over 15 million Americans practice some form of yoga (Emerson & Hopper, 2011; van der Kolk, et al., 2014). In fact, yoga is a multi-billion dollar business; Americans spend over $5 billion each year on yoga classes and yoga-related products (Emerson & Hopper, 2011).

Hatha yoga is the most well-known and commonly practiced form of yoga in the United States (Duros & Crowley, 2014; Forfylow, 2011; Meyer, et al., 2012; Uebelacker, et al., 2010). Hatha yoga practice includes breath control (pranayama), physical postures (asanas), and meditation (dhyana) (Duros & Crowley, 2014; Forfylow, 2011; Meyer, et al., 2012; Uebelacker, et al., 2010). “In [Hatha] yoga, the focus of attention is on sensory experiences of breathing and physical sensations” (van der Kolk, et al., 2014, p. e2). According to Meyer and colleagues (2012), the main emphasis in Hatha yoga is on the physical yoga poses, which are performed intentionally and slowly in combination with breathing exercises; the ultimate goal is to promote relaxation, present-moment awareness, and coordination between the mind and the body.

Body-oriented therapies like Hatha yoga can help individuals get in better touch with their physical states by teaching them to feel and experience their breath, physical sensations, sensory perceptions, muscles, and bodily movement (Emerson & Hopper, 2011; van der Kolk, 2006; van der Kolk, 2014). Interventions like Hatha yoga have been called a ‘bottom up’ approach because they are based on somatic experience as a way to enter an individual’s innermost experiences and thoughts (Emerson & Hopper, 2011; van der Kolk, 2006, van der

Kolk, 2014). Moreover, van der Kolk (2006; 2014) asserts that one important goal of movement-based trauma therapy is to help survivors address and manage problems with dissociation, affect regulation, and estranged relationships with themselves. In other words, yoga focuses on helping survivors connect with themselves on a somatic level first and then addressing their thoughts, emotions, and behaviors second.

Furthermore, engaging in yoga practice may offer trauma survivors some additional, practical benefits. For instance, as compared with psychotherapy and/or medications, practicing yoga can be a cost savings. Moreover, there is almost no required equipment and yoga can be practiced just about anywhere. If trauma survivors suffering from PTSD are concerned about taking medications and/or about medication side effects, yoga is a good natural alternative therapy. Finally, yoga practice can be adapted to an individual's mood as well as their physical ability (Emerson & Hopper, 2011; Meyer, et al., 2012). However, with this being said, it is important to note that prior to starting a yoga practice, it is advisable for participants to consult a medical professional regarding any health questions, concerns, and/or medical conditions.

Clearly, as indicated by the above paragraphs, Hatha yoga is both accessible and beneficial on numerous levels. This leads to the next section, which will investigate and summarize recent research on Hatha yoga practice.

Research. In recent years, researchers have been studying yoga in order to determine whether or not it is an effective therapeutic tool for treating psychological and physiological issues. Yoga practices have been shown to be an effective adjunctive intervention for treating medical concerns, including: asthma, heart disease, hypertension, diabetes, respiratory conditions, chronic pain, arthritis, muscle tension, and insomnia (Emerson, et al., 2009; Forfylow, 2011; Uebelacker, et al., 2010; van der Kolk, et al., 2014). Moreover, yoga practices

are an effective complementary therapy treatment for mental health concerns/disorders, including: depression, anxiety, addiction, excessive rumination, and acute stress reactions (Emerson, et al., 2009; Forfylow, 2011; Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010; Kinser, Bourguignon, Whaley, Hauenstein, & Taylor, 2013; Meyer, et al., 2012; Uebelacker, et al., 2010; van der Kolk, 2006; van der Kolk, et al., 2014). These positive and promising findings - combined with what is known about trauma, PTSD, and conventional trauma treatment - may act as the catalyst for researchers to investigate whether or not yoga is an effective adjunctive treatment intervention for traumatized individuals suffering from PTSD.

Since 2003, the Trauma Center Yoga Program at the Justice Resource Institute in Brookline, Massachusetts, has been offering yoga as a complementary trauma treatment for individuals suffering from PTSD. During this time, van der Kolk and colleagues have launched numerous pilot studies to evaluate the efficacy of yoga as a treatment intervention for PTSD. There were several goals behind these small-scale investigations, including: to determine the feasibility of having trauma survivors participate in yoga practice; to measure heart rate variability (HRV); and to compare the effects of group yoga classes to group psychotherapy.

Before discussing the findings of this study, it is important to define and further explain some of the aforementioned goals and terms. First and foremost, a critical component was to determine whether or not individuals suffering from PTSD would be able to participate in yoga practices considering some of the unique challenges faced by survivors. As discussed in earlier sections of this paper, many adult CSA survivors may feel disconnected from their bodies or feel as though their body is the enemy (Emerson & Hopper, 2011; van der Kolk, 2014). Therefore, considering that yoga is largely a body-based practice, it was important for researchers to determine the feasibility of this intervention.

Secondly, it is important to clarify what HRV is and why it is an important marker for trauma survivors. HRV refers to the interval between one's heartbeats, and it can be measured by monitoring the degree to which one's heart rate corresponds to breathing (Duros & Crowley, 2014). This is a significant measure because good HRV is an indication of increased capacity for self-regulation (Duros & Crowley, 2014). Self-regulation is defined as the ability to restore a state of calmness or self-control to one's thoughts, emotions, and body when triggered or distressed (Emerson & Hopper, 2011). Thus, an individual with good HRV is well balanced and has reasonable control over his/her emotions and impulses, whereas an individual with poor HRV is unbalanced and unable to regulate his/her emotions and impulses. Traumatized individuals often experience chronic high levels of frequent agitation and extreme difficulties with affect regulation; this causes trauma survivors to either overreact or underreact to perceived stressors (Duros & Crowley, 2014; van der Kolk, 2006; van der Kolk, 2014).

Returning to the pilot studies, the results indicated that Hatha yoga is a feasible and beneficial adjunctive treatment for trauma survivors. In one of the initial investigations, researchers found that participants who practiced Hatha yoga significantly changed HRV over eight sessions of Hatha yoga as compared to those who did not practice Hatha yoga (van der Kolk, 2006). Moreover, the yoga participants subjectively reported improvements in PTSD symptomatology (van der Kolk, 2006). In another pilot study, subjects were randomly assigned to either eight sessions of a Hatha yoga class or a DBT group. Self-report inventories were utilized to assess changes in PTSD symptoms, positive and negative affect, and body awareness (van der Kolk, 2006; Emerson, et al., 2009). After eight weeks, the participants who practiced Hatha yoga reported improvements in PTSD symptoms, including: increased positive affect, decreased negative affect, decreased frequency of intrusions, reduced severity of hyperarousal

symptoms, and increased physical vitality and body attunement (Emerson, et al., 2009; van der Kolk, 2006). Due to small sample sizes, however, the results of these pilot studies did not reach statistical significance. Nonetheless, the positive outcomes are important and noteworthy; practicing Hatha yoga appears to have numerous benefits for some individuals suffering from PTSD.

Considering the promising initial findings summarized above, van der Kolk and colleagues (2014) conducted a larger, randomized, controlled trial, which examined the efficacy of Hatha yoga as an adjunctive treatment for PTSD. The participants (64 women with chronic, treatment-resistant PTSD) were randomly assigned to either Hatha yoga or supportive women's health education, each as a weekly 1-hour class for 10 weeks. The primary outcome measure was the Clinician Administered PTSD Scale (CAPS). At the end of they study, 16 of 31 participants (52%) in the Hatha yoga group no longer met criteria for PTSD compared to 6 of 29 (21%) in the control group (van der Kolk, et al., 2014). Additionally, the research results indicated that the physical and meditative components of yoga were key variables in reducing PTSD symptoms (van der Kolk, et al., 2014).

These findings suggest that participating in a yoga program can significantly reduce PTSD symptoms for trauma survivors. The researchers assert that most conventional PTSD interventions are based on the cognitive model and largely ignore key trauma symptoms, such as loss of body awareness, alexithymia, and loss of affect regulation (van der Kolk, et al., 2014). Moreover, according to van der Kolk and colleagues (2014), "Body awareness is a necessary aspect of effective emotion regulation. Learning to notice, tolerate, and manage somatic experience may substantially promote emotion regulation. Yoga can serve as a widely available and relatively economical adjunct to the treatment of PTSD" (p. e2).

Clearly, these research efforts are just the tip of the iceberg; it is essential that mental health professionals continue to encourage and conduct more rigorous research in order to provide further evidence of the efficacy of yoga as an adjunctive therapy for CSA survivors suffering from PTSD. In addition to the need for more evidence-based research, there are also important considerations for therapists who desire to use yoga as a complementary treatment.

Considerations for Therapists. From the information presented in this paper, it appears that using Hatha yoga as a complementary intervention is an effective tool in trauma treatment. However, there are various aspects that therapists must be aware of and take into consideration. First, it is critical that clinicians have proper training and expertise when incorporating yoga interventions with traumatized clients. Given that Hatha yoga involves both the mind and the body, this technique has the potential to be powerfully evocative for some clients, especially traumatized individuals suffering from PTSD (Duros & Crowley, 2014). Secondly, it is important for therapists to learn how and why yoga is effective before suggesting this technique to clients. As with any therapy, it is essential that clinicians understand how to effectively incorporate yoga into their practice. Emerson and Hopper (2011) have identified at least five aspects of Hatha yoga that may require special consideration in order to make this body-based therapy accessible to trauma survivors, including: environment, exercises, poses, teacher qualities, physical assists, and language. A fourth and final consideration involves clinician/client communication; therapists must communicate clearly and regularly with clients about therapy goals, rationale, and safety elements surrounding Hatha yoga. Furthermore, it is imperative that therapists routinely check in with their clients about their experience(s) with yoga as a therapeutic technique.

The following questions are examples of some important issues for therapists to consider: Is it best practice to incorporate yoga practices into the individual client session or refer clients out to a group yoga class? If referring clients out, what yoga instructors and/or classes are appropriate for CSA survivors? How might a CSA survivor suffering from PTSD feel about participating in a group yoga class? What if a client is triggered during a yoga practice? Which yoga poses are the most appropriate and/or effective for trauma survivors? For what length of time does a survivor need to practice yoga each day and/or week in order to experience an improvement in PTSD symptoms? What if a client is not physically able to engage in certain yoga poses? What if a client has pre-existing health conditions? Is it best practice to engage in yoga practices simultaneously with the client? These are just a few questions but it is clear that there are numerous aspects and questions that need to be taken into consideration prior to utilizing Hatha yoga as a trauma treatment option for CSA survivors suffering from PTSD.

Conclusion

From the information presented in this paper, it appears that Hatha yoga is an effective adjunctive treatment option for adult CSA survivors suffering from PTSD. Traditional talk-therapy trauma treatments, like CBT, focus on the story and the mind, which are important in the healing process. However, CBT neglects some critical pieces of the puzzle: namely, the physical and visceral effects of complex trauma(s) like CSA. As stated numerous times throughout this paper, trauma negatively affects one's mind and body; therefore, it seems logical that in order for trauma treatment to be effective, it needs to address the entire organism for healing to take place.

One adult CSA survivor who practiced yoga as part of her therapy described her experience: "Yoga is about looking inward, instead of outward, and listening to my body. A lot of my survival has been geared around never doing those things…I have been refusing to listen to my body, which is such an important part of who I am…in the yoga class, I was able to move my body and be in my body" (as cited in van der Kolk, et al., 2014, p. e6). Another trauma survivor made the following comment about yoga therapy: "I slowly learned to just have my feelings, without being hijacked by them. I am more present in the moment. I am more tolerant of physical touch" (as cited in van der Kolk, et al., 2014, p. e6). These client statements are powerful testaments to the healing potential of Hatha yoga in the realm of trauma treatment.

While there are important issues that therapists need to consider prior to implementing Hatha yoga as a therapeutic tool, yoga is a practice that can be modified to meet the unique physical and emotional needs of a traumatized individual. Through yoga, CSA survivors suffering from PTSD can begin to learn how to be present in and interact with their own bodies in a way that works best for them. Practicing yoga can help to cultivate an adult CSA survivor's capacity for self-awareness and self-regulation. Moreover, yoga can help to empower CSA

survivors in their healing journey by creating an internal sense of safety and personal control. Through yoga's breath, movement, and meditative practices, adult CSA survivors suffering from PTSD can begin to befriend and inhabit their bodies, which are important parts of the healing journey.

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