



SVRI Knowledge Exchange

Healing from
Sexual Violence:
Body-focused mental
health approaches



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Sverige

“I was looking for the key and I think I found it. I no longer feel the same weight, or the same emotion, the same guilt. I feel completely calm, relaxed, safe. There is something that happened, and now I can see it... Yes, I think the yoga has had a lot to do with my healing process, because if not, it wouldn’t have been possible for me to connect with myself or understand others, because I feel like everything was shut down, everything was deafened, because you’re so stuck in the pain...” CSA survivor “Juanita”¹



¹Fields, A., 2019, p. 151.



This Knowledge Exchange seeks to expand our understanding of effective interventions for managing ongoing trauma resulting from child sexual abuse (CSA) and sexual violence through the lifespan, highlighting innovative and increasingly evidence-based body-mind approaches that are showing great promise in the treatment of Post Traumatic Stress Disorder (PTSD) and other trauma induced symptoms, and exploring some basics about the neuro-biological underpinnings of body-focused interventions.

We examine complex trauma and various aspects of recovery and healing, followed by an exploration of body-focused approaches. The Knowledge Exchange is not intended to be a systematic review of therapeutic options in cases of trauma and PTSD (for a recent meta-analysis of psychological and pharmacological interventions for PTSD and comorbid health problems, see Coventry et al., 2020), nor is it a review of cognitive-behavioral approaches or talk therapy more generally.

Complex Trauma: The ongoing impacts of sexual violence

The impact of sexual violence on mental health can be profound, and often worsens over time (Cantón & Cortés, 2015; Rhodes, Spinazzola & van der Kolk, 2016). Child sex abuse, rape, intimate partner violence (IPV) and other forms of sexual violence can produce different mental health outcomes given the different ages, developmental stages and identities of the victims, the nature of the violence, and the widely varying contexts in which sexual violence occurs and its cumulative effects in people's lives. However, there are also many similarities in the way these experiences are processed neurologically and the psychological, physical and emotional symptoms they can produce (Herman, 1992; van der Kolk, 2002b).

Traumatic experiences impact everyone, but do not always develop into long-lasting, life-altering symptoms or problems. When they do, the diagnosis of PTSD provides the framework used by most psychologists worldwide for interpreting the clinical condition of millions of adult survivors of trauma, either alone or in conjunction most typically with diagnoses of depression and/or anxiety.

The PTSD diagnosis includes three primary symptom groups: re-experiencing the traumatic event (through unwanted remembering either as flashbacks or nightmares); behavioral and cognitive avoidance, and numbing (avoiding similar places or activities or sensations that set off memories of the event, or emotionally shutting down in order to evade feelings); and hyperarousal (the sensation of always being on alert and overreacting to sensory stimuli such as loud noises, as if back in the war zone again). It was expanded in 2013 to include negative changes in cognitions and mood, and dissociative responses (APA, 2013).



Unfortunately, the PTSD diagnosis fails to consider a person's history, prior mental health conditions, previous traumas, a range of psychosocial factors, and structural issues (such as systemic exclusions and marginalizations) that may exacerbate responses to traumatic events, leaving big gaps in comprehending why an individual responds in a specific way to a particular trauma. It also excludes numerous symptoms that commonly occur under specific trauma-inducing circumstances (Herman, 1992), particularly in cases of child sex abuse and other types of sexual violence. Moreover, PTSD is frequently applied as a one-size fits all diagnosis, ignoring sociocultural variations in the way that trauma is experienced and interpreted, and its consequent psychological impact (Bracken, et al., 1995; Summerfield, 2004, 2012).

By the early 1990s, psychologists and feminists began to raise questions about the PTSD diagnosis's limits in capturing the full nature of some traumatic experiences, which if more fully recognized could also enable more successful treatment and recovery (Freyd, 1996; Herman, 1992; van der Kolk, 1996). In 1992, Herman first formulated an alternative conception of trauma that identified a range of impacts which seemed to better typify the more "complex" psychological condition of survivors of chronic trauma. She named this Complex Trauma. Her subsequent proposal of a Complex-PTSD diagnosis would, over time, be complemented by other similar diagnostic alternatives that identify various problems and/or conditions that can arise, especially in cases of child sex abuse and other sexual violence.

Most [such] traumas occur in the context of interpersonal relationships, which involve boundary violations, loss of autonomous action, and loss of self regulation. When people lack sources of support and sustenance, such as is common with abused children, women trapped in domestic violence, and incarcerated men, they are likely to learn to respond to abuse and threat with mechanistic compliance or resigned submission. Particularly if the brutalization has been repetitive and unrelenting, they are vulnerable to continue to become physiologically dysregulated and go into states of extreme hypo- and hyperarousal, accompanied by physical immobilization. Often, these responses become habitual, and, as a result, many victims develop chronic problems initiating effective, independent action... (van der Kolk, 2006:7).

As outlined by Rhodes (2014), Complex Trauma is characterized as six interrelated areas:

1. Problems with regulating [emotions] and impulses. These include difficulty modulating emotional reactivity (e.g., explosive anger), and the subsequent maladaptive methods for coping with dysregulation, including for instance, self-injury and substance abuse.
2. Alterations in attention, memory, and consciousness, including amnesia, dissociative episodes, and depersonalization.
3. Self-perception problems such as shame, guilt, and self-blame.
4. Problems with relationships to others, including difficulties with trust and intimacy.
5. Problems with systems of meaning, including for example, loss of faith or a sense of hopelessness.
6. Somatoform symptoms, including pain or other bodily distress and bodily dysfunction... [including] physical problems related to chronic arousal of the autonomic nervous system (e.g., gastrointestinal problems, fatigue) (2014:9).

Another common response, with enormous implications for treatment, is the negative body image typically experienced by sexual violence survivors, who frequently feel disconnected from their bodies and may experience their body as "unsafe, damaged, uncomfortable, uncontrollable, or confusing as it has long been a place of pain, abuse, and maltreatment... Relating to the body in this way can lead to self-harming behaviors, such as substance abuse, eating disorders, and self-injury, as well as negative self-perceptions" (West, 2011:15).



Processes of recovery

Collective rituals have historically been practiced by diverse communities around the globe as a source of healing (Hinton & Kirmayer, 2013). Drawing on these traditions, one of the most effective intervention approaches used with survivors of different forms of sexual violence and other forms of sexual violence has been mutual-support group processes, which not only provide an understanding and supportive atmosphere for sharing experiences, but also create a sense of community and reduce the stigma and shame often associated with childhood abuse, rape and IPV. Promoted for more than half a century by feminists and others working with sexual violence survivors in all parts of the world, they provide an essential form of support for processes of recovery and healing (Bass & Davis, 1994; Rugama & Molina, 2017).

Although many have also benefited from the most common Western therapeutic approach—cognitive-behavioral therapy, or CBT—in both individual and group settings, research indicates that traditional psychotherapy is often not sufficient for eliminating automatic physiological and emotional responses (i.e., feelings of fear, terror or rage; panic attacks, heart palpitations and other anxiety symptoms; dissociation; emotional shutdown; body disconnect) when traumatic memories are triggered. Few studies with survivors have focused on the long-term effectiveness of such interventions, or how they impact the continuation or reemergence of symptoms over time. And although many studies have demonstrated CBT’s effectiveness in treating mental health problems in general and more specifically PTSD, including with victims of child sex abuse (for example, Capella et al., 2015), many such results are gleaned from comparisons with other cognitive-based therapies or no intervention at all (Wampold, et al., 2010).

As van der Kolk argues, talk therapy certainly “provides a deeper understanding of why [survivors] feel the way they do, but insight of this nature is unlikely to be capable of reconfiguring the overactive alarm systems of the brain” (2002b:7). In fact, numerous studies confirm that many adult survivors of abuse and sexual violence are not able to control these “overactive alarm systems”, and that they continue experiencing fallout for many years in the form of numerous life problems and ongoing symptoms, including severe depression, poor affect regulation, relationship problems, frequent revictimization, and substance abuse (Herman, 1992; Rhodes, 2014; Rhodes et al., 2016; West, Liang & Spinazzola, 2017).

In her qualitative study with child sex abuse survivors, West (2011) also confirms the challenges that arise in traditional therapeutic settings. To begin with, the verbal recounting of traumatic memories can set off a range of uncomfortable sensations that makes it hard for many survivors to embrace the talk-therapy process.

[Difficulties] expressing traumatic experiences pose obvious challenges to engaging in talk therapy or healing through verbal narrative. Furthermore, poor interoceptive awareness and identifying internal sensations makes it difficult for a person to express her feelings, voice her needs, or gain through therapy relying on insight and understanding. A general distrust of others also creates a barrier to building a strong therapeutic alliance... As such, helping traumatized people to process and integrate their experiences through this type of treatment can be very difficult (West, 2011:18-19).

In addition, the Western psychological paradigm frequently approaches trauma as an individual pathology, largely ignoring the sociocultural contexts in which mental health problems arise and are addressed (Summerfield, 2004). As White and Marsella indicate (cited by Bracken et al., 1995), “the use of ‘talk



therapy’ aimed at altering individual behavior through the individual’s ‘insight’ into his or her own personality is firmly rooted in a conception of the person as a distinct and independent individual, capable of self-transformation in relative isolation from particular social contexts” (p. 4). In many collective cultures where healing after trauma is understood as a shared experience, individual talk therapy will not necessarily be effective.

New insights about the neural processing of trauma

The human brain tends to react similarly in almost any situation where survival is threatened. We have an automatic physiological response, in which the autonomic nervous system shuts down any unnecessary functions (hunger, for instance), and augments physical responses that enable fight or flight, thereby increasing our likelihood of surviving. Differences occur, however, following the initial trauma-producing experience. Trauma can generate diverse results, depending on the type of experience, its outcome, varying cultural interpretations, the forms of support available to the survivor, and the individual’s own degree of resilience.

In recent decades, psychiatrists, neuropsychologists and other scientific researchers have proposed that under certain trauma-inducing conditions (in particular those where escape or self-defense is impossible), experiences are processed differently due to the specific neurological circuitry that is activated (Frewin, 2016; Levine, 2016; Northoff, 2016; Rhodes et al., 2016; Teicher, 2016; van der Kolk, 2014). They argue that human instinct automatically triggers a series of neurological and hormonal processes (which are universal) when survival is threatened, which in turn affect the way that memories of such events are stored in the brain. Normally, the most developed part of the human brain, the prefrontal cortex, takes in information, compares it with previous experience, makes sense of what is happening and creates a narrative that is then incorporated into memory. This part of the brain is responsible for functions such as planning, anticipation, sense of time, and empathic understanding. When trauma occurs, the thalamus—which is located in the prefrontal cortex and van der Kolk (2013) refers to as the “cook” of the brain—completely shuts down, so an imprint of the experience is left behind in the brain, but without a corresponding story. Under some trauma-inducing circumstances, there is no explicit memory of the event itself, but instead feelings that are often confusing and beyond comprehension. For instance, it is not unusual for a woman who has just been raped to be unable to recount the story of what has happened, though she can remember the smell of the rapist (van der Kolk, 2016).

Because of the state of activation during trauma, the experience is recorded or stored in a more primitive part of the brain, the limbic area, whose functions include perceptions, emotions, categorization, and the relationship between the organism and its surroundings (there is a third and even more primitive or “reptilian” part of the brain—the brain stem—which is responsible for even more rudimentary functions, such as arousal, sleep, breathing, and chemical balance). By and large, the feelings referred to above are stored in memory as a series of separate sensations, rather than part of a coherent and accessible story (van der Kolk & Moore, 2013; van der Kolk 2016). Thus, accessing these non-narrative memories—through the body—can be the key to healing.



The mind-body connection: Implications for treatment

Studies about the effects of different body-focused therapeutic techniques accelerated notably in the 1980s (Barratt, 2013), shedding light not only on the mechanisms involved in trauma processing, but also on more effective ways of coping with trauma-related symptoms.

Trauma study has yielded entirely new insights into the way extreme experiences may profoundly affect our memory, how our bodies as well as our minds respond to stress, our ability to regulate our emotions, and our relationships to other people... These discoveries, together with a range of new therapy approaches, are opening entirely new perspectives on how people who have been traumatized—whether by an individual in a private act of violence or by a disaster affecting an entire society—can be helped to overcome the tyranny of the past (van der Kolk, 2002b:10).

Dr. Peter Levine, a psychologist who has spent decades researching trauma’s mind-body connection, has proposed working on a much more physical level with trauma survivors to enable them to gain control over their lives. His therapeutic approach, called somatic experiencing, is aimed at helping people physically discharge unresolved traumatic experiences and create new narratives for traumatic experience. He refers, for example, to the fact that a person who has been sexually abused as a child can understand what has happened and how it has affected them, but still keeps reacting. To control the response, the body memory also needs to be attenuated. And this is not a cognitive process; it is somatic (2016).

Citing Alexander McFarland, van der Kolk states that exposure to trauma can impact the brain, leaving the body in a continuous state of alert, never able to calm. Being traumatized, whether due to exposure to war, torture or sexual violence, means people can find themselves out of sync with their own bodies and what is going on around them. It is “like living in a room with the lights turned out” (n.d., min. 12:50). Trauma can get locked in the body (Levine, 2005, 2016; Ogden, Minton & Pain, 2006; van der Kolk, 2002a, 2006, 2014), leaving many victims feeling immobilized and helpless. **Thus, treatment of trauma requires helping people to re-engage with their bodies, and reorganize their perceptions.** This is particularly true in cases of child sex abuse. When perpetrated by a person who is supposed to protect and take care of the child, the mind often cannot integrate what happened, and the associated feelings and sensations can become “frozen” in time (Levine, 2005, 2016; van der Kolk, 2014).

As mentioned, despite its documented usefulness in many therapeutic settings, the effectiveness of cognitive-based therapies in treating the long-lasting symptoms associated with trauma is not clear. In a recent APA publication on “practice guidelines,” Brown & Courtois (2019) critique the American Psychological Association’s failure to recognize a number of emerging and innovative approaches to treating trauma survivors, and its continuing reliance on CBT as the most effective approach in treating cases of posttraumatic stress disorder. Citing a recent systemic review by Metcalf et al. (2016), they note that:

The evidence for some treatments is in an emerging stage. In that review, techniques that are decidedly different from the recommended CBT treatments (including acupuncture, yoga, mantra-based meditation, and tapping energy psychology) as well as treatments from the somatosensory realm have received preliminary data supporting their efficacy. These findings strongly indicate that the need remains for more study of innovative methodologies that have emerged... (Brown & Courtois, 2019:135).



A range of techniques, focused on both the body and the mind, have sought new ways of accessing traumatic memories without provoking the painful re-experiencing often triggered by verbally recounting traumatic events, while reducing the terrifying feelings and sensations unleashed when traumatic events are revisited. Some of these innovative (and increasingly evidence-based) approaches are briefly summarized in the table below, although this is by no means a complete compilation.

Examples of body-mind approaches being used/studied with trauma survivors

TECHNIQUE	DESCRIPTION	AUTHORS/REFERENCE
Eye Movement Desensitization and Reprocessing (EMDR)	Client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus (usual therapist-directed lateral eye movements).	Shapiro, 1997.
Somatic Experiencing (SE)	Facilitates the completion of selfprotective motor responses and the release of thwarted survival energy bound in the body.	Levine, 2005.
Neurofeedback	A type of biofeedback that uses real-time displays of brain activity to teach self-regulation of brain function.	Gapan et al., 2016.
Sensory motor arousal regulation therapy	Emotional expression and meaning-making arise out of the somatic reorganization of habitual trauma-related responses.	Ogden, Pain & Fisher, 2006; Warner et al., 2014
Guided Methylenedioxyamphetamine (MDMA) therapy	Guided, intensive therapeutic sessions allowing patients to stay emotionally engaged without being overwhelmed while revisiting traumatic experiences. In the research phase.	Mithoefer et al., 2010; Thal & Lommen, 2018.
Yoga /Meditation / Breathing Exercises	Described in the following section.	See below.



New horizons for adult survivors of sexual violence

Body-focused approaches that have been incorporated into therapeutic healing interventions have shown significant results in reducing trauma-related symptomology (Payne, Levine, & Crane-Godreau, 2015; Rhodes, Spinazzola, & van der Kolk, 2016; van der Kolk, 2014; van der Kolk et al., 2014).

Some of the more contemplative treatment approaches—principally yoga and meditation—are based to some degree on secular interpretations of Buddhist and Hindu philosophy, and the attainment of a higher level of “mindfulness,” which refers to a mental state attained through focusing on the present moment while simultaneously learning to recognize and accept feelings, thoughts and bodily sensations, whether these are agreeable or not. The main techniques involve breathing, meditation or yoga postures, or some combination of all, and are essentially geared toward an improved mind-body connection, focus and concentration, self-acceptance, and achieving greater tolerance of thoughts and feelings (Davis & Hayes, 2011).

Initial Western interest in yoga’s therapeutic potential stemmed from observations of yoga practitioners who were known to do remarkable things like dramatically slow their heart rates (Khalsa, 2016). This demonstrated an enormous control over the autonomic nervous system (which is involved in stress and emotional responses), as well as control over cortisol (released in response to stress) (Khalsa, 2016). More recently, scientists have explored the connection between such self-regulation and recovery from trauma, aided by new neuroimaging technology (MRIs). Some of the most cogent findings have been related to improved regulation of stress (Sharma, 2014), and over the past decade, research has explored the rationale for using body-mind approaches like yoga with those suffering from PTSD (Jindani, Turner & Khalsa, 2015; Menezes et al., 2015; Rhodes et al., 2016; Sharma, 2014; Streeter et al., 2012; Telles et al., 2012; van der Kolk, 2014). Today, yoga is practiced in a multitude of settings, including as a part of therapeutic processes, generally on a mat on the floor, but also—particularly when incorporated into therapeutic contexts—while sitting on a chair.

When yoga is part of a trauma healing process, it is aimed at learning to tolerate bodily feelings and sensations, achieving a greater connection with oneself, more awareness of what is happening on the inside, and learning to modulate activation (or the “triggering” of automatic and uncontrollable responses to reminders of a previous trauma) (Emerson & Hopper, 2011). Yoga helps people to deal with uncontrollable body responses that are often set off by sensory stimuli—images, smells, or other sensations—through learning to recognize emotions rather than avoid them. It engenders a greater sense of security or safety in the moment and helps integrate these emotional memories as positive sensations in the present (Jindani et al., 2015; Menezes, et al., 2015; Sharma, 2013; Streeter et al., 2012; van der Kolk, 2014, 2016, van der Kolk & Moore, 2013).

Yoga can support the processing of trauma by helping promote ease in the body, allowing a person to remain present in the here and now. The traumatized condition is stored in the sensory body; yoga helps to reprogram automatic physical reactions through meditative and focused practice. The person becomes aware of emotions and moods that were previously overwhelming and uncontrollable, and is gradually able to learn to manage such reflexive body responses (Clark et al., 2014; Emerson & Hopper, 2011; Khalsa, 2012, 2016; Menezes et al., 2015; Streeter, et al., 2012; Telles et al., 2013; van der Kolk, 2014, 2016; West, 2011). Combined quantitative/qualitative studies are demonstrating that yoga practice significantly reduces symptom severity among women with chronic PTSD and associated mental health problems stemming from prolonged or multiple trauma exposures, and that ongoing yoga practice has demonstrated effectiveness in maintaining long-term improvements (Price et al., 2017; Rhodes et al., 2016).



Trauma-informed yoga and the positive outcomes of a body-focused intervention

Although the practice of yoga offers benefits in almost any context, yoga teachers and practitioners have been working with psychologists and trauma experts to design programs that respond more to the specific needs of trauma survivors, and particularly survivors of sexual violence. One such program is Trauma Sensitive Yoga, an empirically supported, adjunctive clinical treatment for complex trauma or chronic, treatment-resistant PTSD, developed at the Trauma Center in Brookline, Massachusetts, USA (Trauma Center, n.d.). Its goal is to guide the process of gradually befriending a body that has been the source of pain and alienation, often for many years. Its theoretical foundations include Trauma Theory and Hatha Yoga, using a combination of yoga postures, meditation and breathing exercises. Practicing yoga in this manner offers “a way to make peace with your body, to learn through experience that your body can be effective again, and to reclaim your body as your own” (Emerson & Hopper, 2011:5).

Clark et al. (2014) researched the effectiveness of using Trauma Sensitive Yoga as an adjunct treatment in group therapy for domestic violence survivors. They were trying to determine whether “incorporating trauma-sensitive yoga into group therapy for female victims of partner violence improves symptoms of anxiety, depression, and posttraumatic stress disorder (PTSD) beyond that achieved with group therapy alone” (p. 2). All of the participants reported that the yoga practiced one time weekly following group therapy sessions was personally meaningful, with one woman noting, “I didn’t have to leave the meeting with anxiety... I was able to leave it on the mat” (p. 8).

A trauma-informed yoga practice can exert numerous therapeutic effects on stress responses, including reductions in anxiety, depression, and anger, as well as increases in pain tolerance, self-esteem, energy levels, ability to relax, and the ability to cope with stressful situations. In general, such mind-body practices have also been found to be a viable intervention for improving the constellations of PTSD symptoms such as intrusive memories, avoidance, and increased emotional arousal (Fields, 2019; Kim et al., 2013; Menezes, Pereira & Bizarro, 2012; Prathkanti et al., 2017). They have shown important correlations with improvements in physical symptoms associated with trauma, such as gastrointestinal problems and headaches/migraines (Fields, 2019; Rhodes, 2014).

In addition to reductions in clinical symptoms, a range of positive growth outcomes among sexual violence survivors practicing trauma-informed yoga have been documented, including better regulation of emotional arousal “by raising awareness of internal states, [increasing the] ability to experience emotions safely in the present moment, and [promoting] a sense of safety and comfort within one’s body,” leading to benefits such as “self acceptance, personal presence, and deeper connections to others, as well as... feelings of gratitude, self-compassion, and personal empowerment” (West, 2011:218). For example, a pilot study in Uganda assessing a yoga-based program for trauma healing with adolescent girls who had experienced human trafficking (HaRT Yoga) not only found decreases in depressive symptoms among participants, but also positive improvements in overall emotional health (Namy et al., 2020).

A lingering question, one that challenges some of the most basic assumptions of Western psychology (in particular, its heavy reliance on individual psychotherapy), is whether yoga offers a viable “stand-alone” path to trauma recovery. Even those who recognize the central role that the body plays in trauma healing generally insist that trauma-informed yoga should be understood as an adjunct to or component of psychotherapy (Rhodes, 2014; West, 2011). Some research points to other possibilities, other ways of conceptualizing yoga and therapeutic support, which recognize that the body can be the principal route



toward healing, without the need to explicitly work “cognitively” in the psychotherapeutic sense of the word (Fields, 2019; Prathikanti et al., 2017). Clearly, this does not mean that someone can just walk into any yoga studio and expect automatic healing. But it does mean that specially designed, culturally-situated trauma-informed yoga with back-up mental health support could offer a framework for recovery that does not necessarily require ongoing psychotherapy.

In a study about the mind-body relationship in healing from trauma conducted in Nicaragua in 2017, adult female survivors of CSA who took part in a trauma-informed yoga program underwent dramatic, life-altering changes that included notable reductions in physical, psychological and emotional symptoms, and positive growth in the form of greater tolerance of sensations, reconnection with their bodies, increased self-acceptance/self-awareness, and improved intimate relationships (Fields, 2019).

The outcome of the yoga practice that seemed to resonate most strongly with the women was their sense of reconnection with their bodies, on many levels... The alienation they had experienced from their bodies as adolescents and young women (at times as severe as feeling “severed from their bodies”) had given rise to numerous physical and psychological symptoms; thus, connecting again, beginning to accept and love their bodies, was a central component of their healing and positive growth processes. At the simplest level, this meant a new sense of control over their bodies, such as the ability to do new and sometimes challenging things... Eventually (and most importantly), this connection led to a greater sense of control over their emotions and feelings. As they all stated in one form or another, the body was the key. Feeling, accepting and loving their bodies opened the door to so much self-discovery, enabling them to feel parts of themselves that had been shut down for so long (Fields, 2019: 166).

Working with the body to assist trauma recovery, whether through yoga or other forms, is a new field that requires ongoing innovation and experimentation, albeit within a solid research-supported framework. Existing trauma-informed, body-focused models offer an excellent starting point; however, different contexts can benefit from different mindsets and perhaps distinct “ways of doing,” rather than rigidly reproducing programs that have demonstrated effectiveness.

Psychologists working with survivors of CSA and other forms of sexual violence are encouraged to consider the importance of incorporating the body into therapeutic processes, and working in a more holistic body-mind connected manner to help survivors break the devastating cycle of trauma-induced pain. This is an especially important issue in resource challenged non-Western settings.

As noted by “Ana,” a young Nicaraguan woman who for many years had lost all memory of her childhood abuse,

Like I said, I now have memories but I no longer try to avoid them all the time... And I definitely think it’s been positive, giving me the ability to see that my body speaks. Yoga has allowed me this opening, to listen and explore the abuse that was hidden away, and to be able to heal (Fields, 2019:151).



Summary thoughts

Emerging theories and research on the human brain's processing and memory of traumatic experiences suggest that such experiences are nuanced by cultural context and social conditions, which mediate the way trauma is interpreted, its psychological impact, and processes of recovery. (Bracken, et al., 1995; Marsella, 2010; Marsella & Yamada, 2007; Tummala-Narra, 2007). Not all human beings respond in the same way to traumatic events, and exposure to sexual violence does not lead automatically to posttraumatic stress requiring psychological attention. Similarly, not all victims/survivors of trauma respond by “working through” their experiences as suggested by the Western model of psychotherapy (Summerfield, 2004), and a growing body of evidence points to the importance of engaging the body in trauma healing interventions.

As Brown and Courtois affirm,

Clinicians need to attend to what our clients are telling us about what does and does not work for them. We need to follow the innovators. We must take culture, context, and our clients' intersectional identities into account in understanding the meaning of their trauma and their idioms of distress rather than attempt to squeeze people, particularly those from marginalized groups, into a one-size-fits-all paradigm. (2019:136)

Trauma treatment requires ongoing innovation in program development and in research, which includes recognizing the limitations of existing interventions that do not address the somatic component of trauma responses and strengthening them so that they do. Future research must look beyond an intervention's ability to reduce PTSD symptoms, and also assess outcomes related to:

- A broader range of emotional, psychological and physical difficulties that stem from trauma resulting from sexual abuse and violence;
- The embodied nature of trauma-associated symptoms, and engagement of the body to access these (and heal);
- The sociocultural contexts in which mental health problems develop, including poverty, marginalization, inequity, violence and intergenerational factors, and their relationship to processes of recovery;
- Positive growth (i.e., self-acceptance/self-knowledge, improved relationships, and better emotional regulation) and the improved quality of life that can result from healing and recovery processes;
- The way in which healing modalities can best be delivered, such that trauma informed principles of agency, autonomy, and choice remain at the center.

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