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TRAUMA CENTER TRAUMA SENSITIVE YOGA (TCTSY) AND UTILIZATION OF PSYCHOTHERAPY

by

Helena Kriel

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctorate in Education.

Hamline University
St. Paul, Minnesota
December 2019

Dissertation Chair: Charlayne Myers
Reader: Evan Bodine
Reader: Jennifer West
“This encounter, the very heart of psychotherapy, is a caring, deeply human meeting between two people, one (generally, but not always, the patient) more troubled than the other. Therapists have a dual role, they must both observe and participate in the lives of their patients. As observer, one must be sufficiently objective to provide necessary rudimentary guidance to the patient. As participant, one enters into the life of the patient and is affected and sometimes changed by the encounter.” (Yalom, 2012, p. xxii)
ACKNOWLEDGEMENTS

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This research studied psychotherapists who practice Trauma Center Trauma Sensitive Yoga (TCTSY) as a treatment modality for Complex Post-Traumatic Stress Disorder (CPTSD), in addition to other treatment modalities, to explore the question: how do psychotherapists perceive that utilization of talk therapy changes when TCTSY is introduced into CPTSD treatment? Using survey and interview questions, psychotherapists were asked their perception of changes in how clients use therapy that may occur after the clients are introduced to TCTSY. Participants were also asked to note which changes in utilization were more or less likely to occur, and to discuss their perceptions of barriers to using TCTSY for clients and therapists. Participants reported that introduction to TCTSY is less likely to affect how much treatment is accessed, e.g., frequency of psychotherapy sessions, timeliness to sessions, or frequency of inpatient admission. Participants noted that TCTSY is more likely to affect the therapeutic alliance/relationship, how issues are explored in therapy, and which issues are explored. Participants commented on use of TCTSY with clients having a CPTSD diagnosis with or without behavioral comorbidities, and on use of TCTSY with clients who did not have a CPTSD diagnosis. Participants also commented on innovations in therapeutic use of TCTSY and on how learning TCTSY as a therapist affected how they practice.

**Keywords**: TCTSY, Trauma Center Trauma Sensitive Yoga
CHAPTER ONE

Background of Topic Interest and Intent

Introduction

Trauma Center Trauma-Sensitive Yoga (TCTSY) is a particular type of yoga designed to address Complex Post-Traumatic Stress Disorder (CPTSD) as an adjunctive treatment to psychotherapy (Emerson, 2015; Emerson & Hopper 2016). TCTSY is as of this writing a relatively nascent field with emergent research literature. Data has validated the efficacy of TCTSY quantitatively via a randomized controlled trial (van der Kolk et al., 2014). Studies have also explored the qualitative efficacy of TCTSY from the perspective of the student or client (Rhodes, 2014; 2015; West, 2011; West, Liang, & Spinazzola, 2016) and from the perspective of the yoga facilitator (Bodine, 2017). Limited data exists, however, on psychotherapists’ understanding of TCTSY’s role in treatment. Insights from psychotherapists may enhance the understanding of TCTSY’s impact in treatment, increase access and use by therapists, and improve rate of recovery from CPTSD (Herman, 2015). Thus, this qualitative study will address the research question: how do psychotherapists perceive that utilization of talk therapy changes when TCTSY is introduced into CPTSD treatment?

Writer’s Connection to Topic

I have taught yoga for over twenty years. For about half that time, yoga teaching was my primary profession. I ran a small independent yoga center in Minneapolis for allo-

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1 The Doctorate in Education at Hamline University, as of this writing, specifies that the first chapter of the dissertation give a description of personal interest and experience with the dissertation topic. Formatting germane to the program will be used throughout this work. This program-specific formatting includes, but is not limited to, repetition of research question at multiple locations in paper, explanation of terms and themes in chapter two, and inclusion of both research methods and research paradigm in Chapter 3.
most a decade, for which I was also the director of teacher training. In that capacity, I taught daily yoga classes, up to twenty-five a week, wrote curriculum including teacher training manuals, and managed training programs. During that time, I also travelled internationally with my contemplative awareness teacher Guru Dev Singh to continue my education (Dev Singh & Espinosa, 2015). I have taught general yoga for adults and children, as well as specialty programs for women, pregnancy, seniors, and cancer patients. In more recent years, my teaching has focused on somatic techniques to address pain management, emotional health, and psychological trauma.

I was introduced to TCTSY in 2016. David Emerson (2015), a yoga instructor who created TCTSY in tandem with a research team of psychotherapists and physicians (Emerson & Hopper, 2011), was teaching at the Minneapolis Yoga Conference that year. I was also teaching at the conference. Presenters were permitted to attend other presentations. I had a mild familiarity with Emerson’s (2015) work and decided to attend his session.

At the time of the conference, I was already interested in the intersection of yoga and psychological trauma treatment. My general interest in treatments for trauma began in 2009 because of my work in case management. My case management colleagues with behavioral backgrounds had taught me to screen for trauma when we encountered clients who were not improving as expected (Schnurr & Jankowski, 1999; D. Weeks, personal communication, April 12, 2012). I had read research on CPTSD and had a preliminary understanding of how psychological trauma can impair many areas of life and body systems (Sledjeski, Speisan, & Dierker, 2008; van der Kolk, 2009; 2014). I noted themes in

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2 Emerson had been a regular facilitator at Kripalu, a yoga research retreat center (kripalu.org). I had been onsite at Kripalu the same time as his programs in 2014-15 but had been attending other lectures.
the CPTSD literature about the importance of somatic therapies (Levine, 2010; Ogden, Minton, & Pain, 2006). I realized that high numbers both of my case management clients and my yoga students suffered the symptoms of CPTSD, and I began to be curious about how my two decades teaching yoga might have a role in CPTSD care.

Before the 2016 Minneapolis Yoga Conference, I assumed incorrectly that Emerson’s (2015) TCTSY work addressed Post-Traumatic Stress Disorder (PTSD) in military populations only. In his conference lecture, I realized that TCTSY had a unique and powerful application to CPTSD (Emerson & Hopper, 2011; van der Kolk, 2014) and was a ground-breaking clinical contribution to CPTSD treatment. I found TCTSY, and Emerson’s delivery of it, compassionate and innovative, practical and elegant, and founded soundly both in evidence-based research and a deep, applied knowledge of yoga and somatics. Soon after the conference, I enrolled in a nine-month certification program to become a facilitator of TCTSY (TSY, 2019). The training was directed by Emerson (2015) and Jennifer Turner, a lead TCTSY trainer and psychotherapist (TSY, 2019), and was based out of the Trauma Center in Brookline, MA, one of the development locations of TCTSY. During that training, I furthered a research interest in TCTSY and developed the topic of this dissertation with input from the program’s training team (TSY, 2019).

Understandings gained from TCTSY have significantly impacted how I teach yoga and how I approach case management, whether or not I am working with populations with known CPTSD. As will be discussed in Chapters 4 and 5, the participants in this study similarly reported not only that experience with TCTSY generated change for their clients, but also that TCTSY also changed how they themselves practice therapy. Since the research participants and I as the researcher have been influenced and developed by
TCTSY, our thoughts and feelings about TCTSY are part of the narrative of this study and likely affected its results. We are experienced with TCTSY, which can lend depth and credibility to the study. Yet because of this subject matter familiarity, and although research neutrality was maintained as much as possible, a perfect separation of personal opinion from data was not attainable. I wrote most of this paper in third person in an attempt to reduce bias in presenting information, but will occasionally revert to first person for purposes of transparency in sections of Chapters 3, 4, and 5, when discussing research context, assumptions, and bias.

**Intent of Research**

This study may contribute to the growing and established body of research on somatic options for treating CPTSD (e.g., Herman, 2015; Levine, 2010; Ogden, Minton, & Pain, 2006; van der Kolk, 2014). Somatic here indicates approaching treatment from the body, as differentiated from approaching treatment from the mind (Epstein & Gonzales, 2017). CPTSD indicates a disorder due to the effects of complex trauma; and complex trauma indicates longitudinal and relational trauma such as abuse within a partnership, family, or system such as a religious organization (Cloitre, 2016; Herman, 2015). CPTSD evidences the damage people can do to one another in relationships, and how that damage lingers in survivors’ bodies, behaviors, and minds (Herman, 2015; Ringel & Brandell, 2012; van der Kolk, 2014).

Since multiple approaches to treating CPTSD are often needed for each client (cf., guidelines of the International Society for Trauma Stress Studies [2019]) (Herman, 2015; O’Haire, Guerin, & Kirkham, 2015), studies exploring the interrelationship of CPTSD treatments may be of particular value. This study will explore one particular treatment
interrelationship: TCTSY and psychotherapy. Of the many possible permutations of treatment combinations, that of TCTSY and psychotherapy particularly merits study. TCTSY and psychotherapy further each other’s progress with the client by addressing both brain-to-body and body-to-brain pathways in the nervous system, which may have been affected by complex trauma (Emerson & Hopper, 2011; Emerson & Kelly, 2016; van der Kolk, 2014), within the context of a therapeutic relationship (Herman, 2015). The study may produce data to help CPTSD clinicians apply TCTSY practice with greater confidence, and to better understand dosing and titration when combining TCTSY and psychotherapy. Specific prescription of TCTSY in the arc of psychotherapy treatment may thus generate better client health outcomes.

This research may yield data to assist trauma researchers in future exploration. This study may give insight into the feasibility of studying TCTSY and psychotherapy in a broader population, target audience for this joint prescription, and learn about potential risks and benefits of combining these two therapies. The data presented here may also help identify potential outcome measures and correlations between measures that warrant inclusion in a larger study. To explain the parameters of this study, relevant terms will be defined later in this work, with the intention of rendering the research meaningful to a broader audience beyond clinicians actively treating CPTSD. Paths for future research will also be suggested based on these findings.

**Research Question and Conclusion**

In attempting to assess how psychotherapists perceive utilization of talk therapy changes when TCTSY is introduced into CPTSD treatment, this study will assess psychotherapists’ insights into how TCTSY can be combined with talk therapy and how TCTSY
changes clients’ use of therapy. To explain the importance of researching the experience of psychotherapists whose clients interact with Trauma Center Trauma Sensitive Yoga (TCTSY), the literature review in Chapter 2 details foundational research in trauma, yoga, and trauma-sensitive yoga. Chapter 2 and Appendix D include a review of key terms related to teaching yoga, diagnosing trauma, and historical and current treatments of trauma. Chapter 3 explains research methods and aims, and presents the study instruments. Chapter 4, a research analysis, leads to conclusions, discussion of research limitations, and applications for future research in Chapter 5. At the conclusion of Chapter 5, please find reference list and appendices of survey instruments, transcriptions, and related instruments.
CHAPTER TWO

Literature Review

Themes Explored in Literature Review

*Often, a body-oriented approach to the treatment of trauma yields quicker, more powerful results than cognitive therapy alone.* (R. Buczynski, Communication to National Institute for the Clinical Application of Behavioral Medicine [NICABM] Members, February 21, 2018)

This literature review reveals several themes related to Complex Post-Traumatic Stress Disorder (CPTSD): types of psychological trauma (e.g., van der Kolk, 2014); symptoms of trauma (e.g., Cloitre, 2016); types of trauma treatment (e.g., Herman, 2015); and importance of somatic therapies when addressing CPTSD (e.g., Levine, 2010; Ogden, Minton, & Payne, 2006). Themes related to yoga research include the definitions of yoga (e.g., Deslippe, 2012; Remski, 2018); establishment of yoga as a clinical intervention (e.g., Saper, 2017); development of trauma-informed yoga as a treatment path (e.g., Emerson & Hopper, 2011); and emergence of Trauma Center Trauma-Sensitive Yoga (TCTSY) as a clinical treatment (Emerson, 2015).³

**Research question.**

A growing and relatively long-standing body of research supports yoga, therapy, and yoga and therapy combined in the treatment of psychological trauma (e.g., Rhodes, 2014; Spinazzola et al., 2011; van der Kolk 2009; 2014). Researchers have shown relative efficacy of different types of therapy for treating CPTSD and Post-Traumatic Stress Disorder (PTSD) (Chapman, Gratz, & Tull, 2011; Foa, et al., 2018; Harned, Jackson,

³ Please note that the Hamline Doctorate of Education is a non-clinical program and degree. Terms will be explained for the education generalist in this chapter and further in Appendix D.
Comtois, & Linehan, 2010). Yoga has been studied as a mental health intervention for psychiatric disorders comorbid to PTSD (Brady et al., 2006; Campbell & Moore, 2004; Dale et al., 2011; Weintraub, 2004); explored as a combination therapy for psychiatric treatment (Emerson & Kelly, 2016; Nespor, 1984); researched as a direct intervention for PTSD (Jackson, 2014; Johnston, 2011; Telles et al., 2010) and combat stress (Stiller et al., 2012); and suggested as a tool for psychotherapists (Weintraub, 2012). TCTSY has emerged as a type of yoga particularly designed to affect the symptoms of CPTSD (Emerson, 2015). Data has detailed the successful introduction of TCTSY into CPTSD and PTSD treatment as an adjunctive therapy (Emerson & Hopper, 2015; Spinazzola, 2011; West, Liang, & Spinazzola, 2016).

Despite persuasive data on the efficacy of TCTSY from the perspective of the student or client (Rhodes, 2014; 2015; West, 2011; West, Liang, & Spinazzola, 2016) and yoga facilitator (Bodine, 2017), research reveals limited data on the perspective of the therapists on TCTSY as an adjunct treatment for CPTSD. As researchers investigate how TCTSY best fits into the arc of CPTSD treatment, direct input from treating clinicians may help refine both research and application of yoga for trauma (van der Kolk, 2014). Given this research gap, this study will explore: how do psychotherapists perceive that utilization of talk therapy changes when TCTSY is introduced into CPTSD treatment?

**Review of CPTSD and TCTSY Literature**

This literature review includes primarily peer-reviewed articles and reference books by experts in the field of psychological trauma and recovery. Some personal communication from trauma psychotherapists is included because many experts in trauma recovery are active in treatment rather than research. Several articles and interviews from
news periodicals are also included to provide current environmental context. When exploring epidemiology of trauma, this paper will also reference cultural artifacts.

**Diagnostic references and terms found in CPTSD literature.**

*Diagnostic references for psychological trauma.*


The *DSM-5*, produced by the American Psychiatric Association and currently in its fifth iteration, is used by United States clinicians, clinics, hospitals, and insurers to provide a common language for diagnosing and treating mental health (APPI, 2018). Although mental health conditions certainly can exist if not listed in the *DSM* (Herman, 1992), codification in the manual indicates a diagnosis has defined, recognizable, and treatable clinical parameters (APPI, 2018). Conditions noted in the *DSM-5* can be assigned diagnostic codes and are more likely to receive research funding, and thus United States-based research in psychology tends to center on conditions detailed in the *DSM-5* versus those that are excluded (cf., Spinazzola, Blaustein, & van der Kolk, 2005).

Another diagnosing body critical to the established definition of psychological trauma is the *International Statistical Classification of Diseases and Other Health Problems (ICD)* (Cloitre, 2016; WHO, 2018). The *ICD* (WHO, 2018), currently transitioning between its tenth and eleventh iterations, is a more global classification of diagnostic codes than the *DSM-5* on two levels: it functions internationally, and it includes both

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4 Appendix D contains additional terms relating to psychological trauma and therapy.
physical and mental health conditions (CDC, 2017; WHO, 2018). Where the ICD leads, subsequent editions of the DSM are likely to follow.

The ICD-11, presented in 2019 and slated to be fully implemented in 2022, will include a different type of trauma diagnosis: Complex PTSD (CPTSD) also known as developmental or relational trauma (Cloitre, 2016; Herman, 2015; cf., Irish, Kobayashi, & Delahanty, 2010). As is explained below, this diagnosis clarifies the needs and specifies the symptoms of a different (though sometimes overlapping) population from PTSD clients (Emerson & Hopper, 2011; 2016). The capacity to use this new CPTSD diagnosis code may help providers improve care and outcomes for clients with a history of traumatic relationships (cf., van der Kolk et al., 2014), versus PTSD clients’ history of one or more traumatic situations (Horowitz, Wilner, & Kaltreider, 1980; Sledjeski, Speisman, & Dierker, 2008). It may take time to see common use of CPTSD as a diagnosis by health organizations using ICD codes, since the ICD-10 may be used by clinicians and insurers for years after the ICD-11 is issued (WHO, 2018). The new diagnosis code can progress the treatment of trauma, however, even before the ICD-11 codes become standard use (Cloitre, 2016).

Diagnostic terms for psychological trauma.

Post-Traumatic Stress Disorder (PTSD).

The current DSM-5 psychological trauma diagnosis, PTSD, has been included in DSM editions since 1980 (Friedman, 2017). Clinicians were writing and lecturing about trauma, however, far earlier (Janet, 1889; 1907; also cf., Ringel & Brandell, 2012; van der Hart, Brown, & van der Kolk, 1989). The emergence of the 1980 diagnosis code does not indicate that psychological trauma did not exist in the 1970s and before, but simply that
the codified means of recognizing and treating psychological trauma in a clinical context were not yet formally established (cf., Luxenberg, Spinazzola, & van der Kolk, 2001; Tedeschi & Calhoun, 1996).

PTSD indicates that the individual has experienced a traumatic event and continues to experience symptoms related to that experience (APPI, 2018; Koren, Amon, & Klein, 2005). Clinically, PTSD is defined almost entirely by its symptoms and must involve the witnessing or experiencing of a traumatic event (Cloitre, 2016; Lauterbach, Vora, & Rakow, 2005). The Clinician Administered PTSD Scale (CAPS) is one of several diagnostic questionnaires that clinicians use to assess for PTSD, and the CAPS assessment may be given regarding the past week, past month, or worst month a client can recall (Tedeschi & Calhoun, 1996; Weathers, Keane, & Davidson, 2001). To receive a diagnosis of PTSD, the client answers questions to indicate experiencing one or more traumatic events, such as combat, assault, accident, or natural disaster (Blake, 1995; Weathers, Keane, and Davidson, 2001; USDVA, 2018). The CAPS then assesses the severity and frequency of symptoms in the aftermath of the traumatic event, including: re-experiencing or flashbacks, persistent avoidance of things, people, or situations that remind of the event, and persistent symptoms of increased nervous system arousal or reactivity (Cloitre, 2016; Horowitz, Wilner, & Kaltreider, 1980; Sledjeski, Speisman, & Dierker, 2008). Furthermore, in order to receive a diagnosis of PTSD, these changes must last more than a month after the event, and must produce a clinically significant, negative impact on the client's life (Lauterbach, Vora, & Rakow, 2005; USDVA, 2018). If a client's CAPS score is above a certain range, the client has PTSD; and if the CAPS score
drops, the diagnosis can be eliminated (Blake, 1995; Weathers, Keane, and Davidson, 2001; USDVA, 2018).

PTSD is most likely to be related to a single-incident trauma such as a car accident (Koren, Amon, & Klien, 2005; van der Kolk, 2014). It can also occur after a protracted but contextualized period in an environment with multiple traumas or extreme stressors, such as combat (Herman, 2015; Stoller, Gruel, Cimini, Fowler, & Koomar, 2012). PTSD is shown to respond to a number of therapies, including Eye Movement Desensitization and Reprocessing (EMDR) (van der Kolk et al., 2007), prolonged exposure (Foa et al., 2018), medication (van der Kolk, 2014), and experiential therapy (Levin, Latrobe, & van der Kolk, 1999). These therapies will be further detailed below.

_CPTSD and Complex Trauma._

Complex trauma unfolds longitudinally in relationships such as partnership or families, or in systems such as political or religious organizations (Herman, 2015; Irish, Kobayashi, & Delahanty, 2010). Complex trauma often occurs over the course of development and in domestic settings, and thus may also be referred to as developmental trauma or relational trauma (Cook et al., 2005; D’Andrea et al., 2012; Herman, 2015; Teicher, Anderson, & Polacari, 2002). The consequential disorder developed by some individuals who have experienced complex trauma is CPTSD (Cloitre, 2016). Clinically, CPTSD both presents distinctly and demands a separate treatment plan from PTSD: as the name implies, CPTSD presents with a more complex array of symptoms than does PTSD (Emerson, 2015; Herman, 1998; Levine, 2010).5

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5 Generally, CPTSD refers to the diagnosis, and complex trauma refers to the events one endured that provided a foundation for the diagnosis. Some providers, however, will use CPTSD and complex trauma as interchangeable terms when discussing the disorder or diagnosis (Emerson, 2015; Herman, 2015).
Complex trauma can include experiences of neglect, sexual abuse, physical abuse, verbal abuse, emotional abuse, or any combination of the above (Herman, 1992; Porges, 2013; van der Kolk 2014). CPTSD symptoms include the hypervigilance, avoidance, and intrusions common in PTSD (Cloitre, 2016; Horowitz, Wilner, & Kaltreider, 1980; Sledjeski, Speisman, & Dierker, 2008), as well as relational difficulties such as feeling detached or alone, a negative self-concept, pervasive feelings of guilt and shame, and challenges in emotional regulation beyond the autonomic nervous system's startle response, which may result in sensitivity or anger disproportional to situation (Cloitre, 2016; Hopper et al., 2018).

CPTSD emerged as a diagnostic category because clinicians recognized clients who had been traumatized but did not fit the diagnosis of or respond to the treatment for PTSD (Luxenberg, Spinazzola, & van der Kolk, 2001; Herman, 2015; van der Kolk et al., 2007). CPTSD, despite a prior lack of diagnosis code, has historically been clinically described and treated (Herman, 1992; Janet, 1907). In fact, clinicians have asserted for decades that relational-based trauma needs a separate diagnostic branch from PTSD (Herman, 1998).

Disorders of Extreme Stress, Not Otherwise Specified (DESNOS).

While differentiating the symptomatic aftereffects of complex trauma and prior to the formalization of CPTSD as a diagnosis, clinicians designated the Disorders of Extreme Stress, Not Otherwise Specified diagnosis (DESNOS) (Luxenberg, Spinazzola, & van der Kolk, 2001; van der Kolk et al., 2005). This diagnosis was used when PTSD did not fully describe the symptom presentation associated with CPTSD (Boscarino, 1997;

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6 More information on clinical neglect and its symptoms can be found in Appendix D.
It encompasses the ongoing deleterious effects following periods of extremely high stress that overwhelm one’s capacity to cope with and to digest an experience as it is happening (Buckley, Blanchard, & Neill, 2000; Ford & Kidd, 1998), as well as additional symptoms associated with CPTSD (Cloitre, 2016). DESNOS identifies affective changes including the possibility of self-harm behaviors, and may rely on data from brain scans that indicate changes in brain volume and activity post-trauma (APPI, 2018; Shin et al., 2001; 2004; Smith, 2005). DESNOS remains a valuable diagnostic concept, as clients may be experiencing symptoms demanding treatment in the aftermath of high stress or trauma, yet not fit the criteria for a PTSD or CPTSD diagnosis (Boscarino, 1997).

*Developmental Trauma Disorder (DTD).*

Pediatric considerations were included in the identification of the Developmental Trauma Disorder (DTD) diagnosis, another significant contribution to accurate trauma diagnostic classification (cf., Cloitre et al., 2009; Martindale et al., 2014). The emergence of DTD helped frame the impact of complex trauma on pediatric developmental phases, and thus identify symptoms in childhood versus adulthood (De Bellis, 2001). Since pediatric symptoms may present distinctly from those experienced by adults and may be further differentiated by the child’s age, understanding DTD can be critical in finding and treating symptoms stemming from complex trauma as early as possible (Cook et al., 2005; D’Andrea et al., 2012; Teicher, Anderson, & Polacari, 2002). For the purposes of this research, CPTSD will be used as the term to describe diagnosable aftereffects of complex trauma.

*CPTSD symptomatology.*
The symptoms of CPTSD can be far-reaching, painful, and compromising (Herman, 2015; Levine, 2010). CPTSD symptoms fall into several broad categories that will be expanded upon below: dissociation, negative cognition, hyper-vigilance, avoidance, intrusions, and emotional and physical lability (Cloitre, 2016; Herman, 2015; Ogden, Minton & Pain, 2006). Understanding CPTSD symptoms can help understand the potential role of yoga in treatment, providing justification for ongoing research into TCTSY (Spinazzola et al., 2011; van der Kolk, 2009; van der Kolk et al., 2014). TCTSY may have particular effect on certain CPTSD symptoms, elaborated upon below (Emerson, 2015).

**Neurological underpinnings.**

Changes in behavior, relationships, cognition, and physicality are common post-trauma, and many of these symptoms of CPTSD have an underlying neurological base (Herman, 2015; Nemeroff, 2004). The stresses of complex trauma can create neurological changes, visible in behavioral alterations, physical and emotional symptoms, and brain scans (Shin et al., 2004; Shin et al. 2001). Selective brain volume may decrease or increase post-trauma, as may areas of brain activity (Smith, 2005). For example, survivors may show decrease in blood flow to the medial pre-frontal cortex, which helps orient in time and space, order thoughts, and make logical conclusions (Shin et al., 2004).

**Afferent and efferent pathways.**

Understanding brain-body message pathways in the nervous system may help understand the effects of complex trauma on survivors (cf., Damasio & Damasio, 1989; van der Kolk, 2014). Post-traumatic neurological changes affect physical functioning through efferent nerve pathways from the brain to the body; and the body after trauma also com-
municates up to the brain by afferent pathways differently than it did pre-trauma (Levine, 2010; Ogden, Minton, & Pain, 2006; Porges, 2013, 2016; Westlund, 2014). Both afferent and efferent trauma responses were initially adaptive and survival oriented, yet may become maladaptive for the survivor if repeated over time in non-traumatic circumstances (Herman, 2015). Much of the pain of CPTSD is not necessarily the past events (said in no way to excuse what occurred) but rather the regenerating of traumatic responses (Levine, 2010; van der Kolk, 2014; van der Kolk et al., 2014). Even though the survivor cognitively may know that the danger of the past is over, nervous system and body are responding as though the trauma is happening now (Herman, 1998).

These efferent and afferent responses can be extremely frustrating for the survivor, impacting mental health, self-esteem, capacity to elicit support, and social functioning, thus significantly diminishing quality of life (Sledjeski, Spiesman, & Dierker, 2008; Roth et al., 1997). Yet the same pathways can be engaged in reparation (Emerson & Kelly, 2016; Hopper et al., 2018). A combination of treatment approaches such as talk therapy and TCTSY might engage efferent and afferent pathways in the nervous system to help develop new neural networks and new behavioral options for the client with CPTSD (van der Kolk, 2014).

*Hyper-vigilance: Insula and interoception.*

Of particular importance when studying somatic CPTSD interventions, survivors may have lessened activity in the insula, areas in the brain that process sensory information from the viscera (Craig, 2010; 2014). Interoception, the experience of this sensory information, can be expressed as noticing hunger, temperature, bladder fullness, stretching sensation from muscles, pain from a wound, balance in space, or pressure (Craig,
2010; 2014; Emerson, 2015). Interoception is a normal, ongoing aspect of self-regulation, helping the body maintain a relative degree of safety and comfort (Mehling et al., 2012), and can even include social factors such as drive for touch or physical proximity of others (Emerson, 2015). Capacity for interoception can be measured by brain scan and by self-report such as the Multidimensional Assessment of Interoceptive Awareness (MAIA) scale (Mehling et al., 2012).

In addition to processing interoceptive information, the insula also can impact capacity to understand relationship-building cues (Craig, 2010; 2014; Damasio & Damasio, 1989). When the insula or Broca’s area is under-active post-trauma, clients may also experience alexythemia (Craig 2010; 2014; Taylor, 1984; Tippett, 2017), an inability to put feelings or experience into words. This may also manifest as generalized aphasia, compromised ability to communicate linguistically and process information (Buckley, et al., 2000; van der Kolk, 2014). TCTSY may help regulate blood flow to the insula, potentially impacting the above symptoms (Emerson, 2015; Spinazzola et al., 2011; van der Kolk et al., 2014).

Interoception can be compromised in CPTSD because relational trauma survivors have a lived, physical experience of feeling chronically unsafe (Herman, 2015; Spinazzola et al., 2011). Often this danger existed in their own homes and may have started at a young age. In fact, many trauma survivors did not know a reality or a body prior to abuse, neglect, or violence (Rhodes, 2014; Spinazzola et al., 2015). During complex trauma, survivors may have needed to focus on exteroception over interoception, turning attention outwardly to navigate explosive situations (Herman, 2015; Naste, Price, & Karol, 2017). Survivors might recognize, for example, subtly different sounds when a parent enters
the house intoxicated versus sober, or might anticipate a pending angry reaction from an almost imperceptible muscle movement on a relative’s face (Nemeroff, 2004; van der Kolk 2014). They become “exteroceptive geniuses” (D. Emerson, personal communication, September 9, 2016), meaning they become expert in reading the environment and scanning for signs of instability at the cost of knowing their own internal environment (Naparstek, 2004).

Trauma survivors’ focus on exteroception and lessened capacity for interoception can leave them feeling confused about their own needs: therefore they can have difficulty making decisions for themselves or using internal cues to take effective action (Rhodes, 2014; 2015). This may display behaviorally with under- or over-eating (APPI, 2000; Emerson & Kelly 2016), isolation, forming damaging relationships, substance abuse, concerns of self-worth, neglecting the self (Herman, 2015), identifying and addressing physical needs (Muller, 2000; Taylor, 1984), self-injurious behaviors, and challenges with personal identity (West, Liang, & Spinazzola, 2016). Developing interoception in yoga practice or other therapeutic environments can help a complex trauma client more congruently fit action to personal need through improved ability for self-reference and increased self-understanding (Emerson, 2015; Spinnazola et al., 2016; van der Kolk et al., 2014).

*Negative cognition, intrusions, and self-perception.*

CPTSD alters the mechanisms of how survivors think, and changes how they think about themselves (Cloitre, 2016). The survivor’s experience of not having control over self or reactions during and after trauma may engender negative self-cognitions (Herman, 1998; 2015). Survivors may come to believe themselves not worthy of connecting to others or being treated well, and may see themselves as damaged, at cause, or even
separate from the human race (van der Kolk, 2014). This may occur by ingrained inference, or they may have been told clearly and repeatedly by the perpetrators (Herman, 2015). These beliefs magnify negative self-concept and make agency even more challenging (Clark et al., 2014; Hillis et al., 2001).

Memory of traumatic events also functions differently than other memory processes (Brewin et al., 2007). Traumatic memory differs both in how it is stored in the brain and in how it is replayed in intrusive states or flashbacks that feel like the original trauma is actually reoccurring (Cloitre, 2016; Damasio, 2000). Survivors may experience this reliving of trauma in multiple environments including those that are technically safe, and may become hyper-vigilant (i.e., on alert for perceived threat or a repeat of trauma) (van der Kolk et al., 2014). This alertness is understandable: the individual’s inner experience is attempting to protect from harm based on personal history (Cloitre, 2016; Herman, 1998; 2015).

These cognitive symptoms of CPTSD are not just thoughts, and their purview spans beyond the psychosomatic (Herman, 2015). The symptoms function to keep trauma living in the survivor (van der Kolk, 2014; West, 2011; West, Liang, & Spinazzola, 2016). TCTSY may assist with these symptoms by helping survivors sense information from the insula consciously. This sensory awareness can rebuild lost neurological networks, increase ability to track external environments accurately, and give survivors internal experiences more aligned with external, current reality (Emerson, 2015; Rhodes, 2015).

Dissociation.
Frequently for clients with CPTSD, “their bodies are the scene of the crime” (J. Turner, personal communication, February 18, 2017). To tolerate inescapable abuse or neglect, trauma survivors may detach from their physical selves (Emerson & Hopper, 2011). This detachment, initially a survival strategy, can become a symptom called dissociation (Herman, 2015). Dissociation indicates emotionally absenting or numbing oneself, usually with no conscious control, due to a trauma, stress, or trauma trigger (Cloitre, 2016; Herman, 1998). Dissociation means losing track of reality such as time, the present situation, or sensations by detachment or memory loss, rather than the loss of reality seen in psychosis (Cloitre et al., 2009; O’Haire, Guerin, & Kirkham, 2015). Dissociation can present with varying degrees of severity up to and including a full dissociative fugue similar to transient global amnesia but induced by flashback or trigger (Spinhoven et al., 2004; van der Kolk, 2014). For example, the dissociated survivor may be oriented in time and place but have difficulty experiencing sensations such as localizing skin contact, or may be fully unaware of surroundings at the present moment, or may be partially or entirely unable to recall recent situations for brief or lengthy periods (Emerson, 2015).

Dissociation is not inherently negative (N. Blume, personal communication, December, 2019; Emerson, 2015). Initially, dissociation may have crucial adaptive benefits for the trauma survivor (Porges, 2013). Dissociation resulting from active trauma may allow its tolerance (Cook et al., 2005; Herman, 2015; van der Kolk, 2014). Dissociation that occurs during trauma may also be life-saving, in that it may render the survivor less likely to engage with the environment at times when engagement might be dangerous (Emerson, 2015; Emerson & Hopper, 2011).
The challenge comes with unintentionally learned dissociation that persists and repeats long after the original trauma has passed (Cook et al., 2005). This patterned dissociation becomes a way of being, presenting during times when being more alert might be safer, healthier, and more rewarding for the trauma survivor (Cloitre et al., 2010). Dissociation can exacerbate common trauma comorbid diagnoses such as substance abuse and eating disorder (Brady et al., 2006; Boscarino, 1997; Collett et al., 2016; Lauterbach, Vora, & Rakow, 2005; Scime & Cook-Cottone, 2008). Dissociation can underlie self-injurious behaviors as well: if emotional pain becomes intolerable, inflicting an alternate pain can provide means of an escape or can allow one to feel briefly alive (Emerson & Kelly, 2016; Harnad et al., 2010).

Patterns of dissociation permit trauma to live in the body for years or even decades after the original event (van der Kolk, 2009; 2014). Ongoing post-traumatic dissociation may mean that trauma survivors lose the capacity to be aware of, remember, and actively choose their lives (Herman, 2015). They may come to feel like bystanders or non-participants in their history and their present (Cloitre et al., 2010; Herman, 1992; 1998). A key component of TCTSY, learning to find and to tolerate one's own physical sensation, can not only increase interoception but also decrease learned dissociation (van der Kolk, 2014). This balance of more interoception and less dissociation may enhance overall safety and empowerment for the survivor (Emerson & Hopper, 2011; Rhodes, 2014).

The vagus nerve in dissociation.

People who have been hurt—not even metaphorically, but people who have been really hurt—find it difficult to create relationships, even though
on a cognitive level, it has a very, very high priority in their lives. It’s something they want. They desperately want it, but their bodies are saying no. (S. Porges, When the Body Guards Against Trauma, video post to NICABM members, May 17, 2018)

Particularly with trauma that involved captivity or entrapment, a specific type of dissociation can present similarly to a faint state (van der Kolk, 2014). To elicit the faint response, the unmylenated pathway of the vagus nerve, a cranial nerve connecting the brain to the body,7 produce responses in the nervous system akin to loss of consciousness or hibernation (Porges, 2013; 2016). This type of dissociation can present unique challenges to the survivor (Emerson, 2015).

Mammals including humans rely on social responses and connections to thrive (Egolf et al, 2004). Human socialization is communicated with gestures, vocal modulations, and facial expressions designed to connect, respond, elicit help, and bond (Herman, 2015). Reptilian expressions are often less facially varied, and reptiles display lowered responsiveness in certain conditions. Humans still possess a reptilian neurological aspect, expressed in part via the vagus nerve (Porges, 2013; 2016). The environment of complex trauma may under-develop social, mammalian-type responses while overdeveloping low affect, reptilian-type responses (Porges, 2013; 2016; van der Kolk, 2014).

A survivor of long-term childhood sexual abuse, for example, may have been dependent on the perpetrator for caregiving and basic needs, or or may have been trapped during abuse (D’Andrea et al, 2012). Shutting down may have helped the child survive the trauma yet may become a challenging part of later symptomatology (Damasio, 2000).

7 The vagus nerve has two bunches of nerve cells and aids in multiple afferent and efferent communications involving digestion, respiration, heart rate, motor and sensory function (Porges, 2013; 2016)
In adulthood, impairment to social bonding resulting from this vagal response leaves a survivor vulnerable to isolation and to physical and mental loss of well-being (Porges, 2016). With this CPTSD symptom, psychotherapy and TCTSY may pose a promising treatment option because of the redevelopment of safe relationships that include choice and agency (Herman, 2015), and the opportunity to practice initiating movement through times of vagal response activation (Emerson, 2015).

_Lability and reactivity: Fight, flight, freeze._

Porges (2013; 2016) reminds us that trauma symptoms may also vary by how the vagus nerve aids in the autonomic directive to fight, flee, or freeze in response to a stress trigger. These stress responses leave signature legacies in behavior and relationships (Herman, 2015). An over-conditioned fight response during childhood trauma may result in increased anger or hostility expressed verbally or physically later in life (Cloitre, 2016). Over-conditioned fear response may result in avoidance behaviors of people, places, and situations: a tendency with surprising levels of health risk including high rates of premature morbidity from suicide or non-suicidal health risk behaviors (van der Kolk, 2014). Highly conditioned freeze response, in which the individual is alert yet relatively immobile with muscle tone high and eyes wide, can result in difficulty speaking for one’s self in relationships, initiating action, and expressing preferences (Spinazzola et al., 2014; Yehuda, 2001; Wylie, 2004).

These changes in emotional response are conditioned not only behaviorally, but also neurologically via the vagus nerve and amygdaloid complex, which may become enlarged post-trauma (Cloitre, 2016). Even after traumatic circumstances have resolved, 

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8 The amygdaloid complex is a group of nuclei located in the mid-temporal lobe (Sah et al., 2003). Often in the treatment of CPTSD, the term amygdala is used to refer to this area (van der Kolk, 2014).
the survivor’s amygdala may respond to a trigger by creating an emotion stronger than warranted by the present circumstances (Sah, et al., 2003; Shin et al., 2004; Tippet, 2017). This emotional exaggeration can produce behavioral challenges for the survivor: exaggerated anger, fear, or shame can make healthy personal or professional connections difficult (Damasio, 2000; Gross, 2002; Herman, 1998). Fear or shame responses can increase avoidance and further limit sphere of tolerance (Cloitre, 2016). TCTSY can condition options for choice and control for the survivor dealing with these responses ( Emerson, 2015; Rhodes, 2014; 2015) and may increase capacity to tolerate discomfort with less lability ( Emerson & Hopper, 2011; van der Kolk, 2009).

Comorbidities.

Psychological trauma diagnoses carry high comorbidity rates, meaning that individuals with CPTSD and PTSD may be at risk for developing additional health problems affecting quality of life and longevity (Felicia et al., 1998; Horowitz, Wilmer, & Kaltreider, 1980; Kessler et al., 1995; 1997). After trauma, clients may be more likely to experience problems with physical function including, but not limited to, digestive disorders ( van der Kolk, 2014; Walker et al., 1995), rate of healing or of aging (Tyrka et al., 2010), changes in eyesight (Liebermann, 1995), reproductive function, immune response and autoimmune disorder (Haviland et al., 2010; Kawamura & Asukai, 2001), pain levels and chronic pain (Spinnhoven, 2004), and cardio-pulmonary function (Friedman & McEwen, 2004; Koren, Arron, & Klein, 2001; Rauch et al., 1996; Roth et al., 1997; Schnurr & Janowski, 1999; Yehuda, 2000; 2001). Behavioral post-trauma comorbidities may include but are not limited to attachment disorders (Ainsworth et al., 2015), depression, anxiety (Ginzburg, Erin-Dor, & Solomon, 2010), social anxiety, panic (Brady et al., 2006), self-
endangerment and inappropriate risk taking, abusive relationships, (Hillis et al., 2001), self-harm, eating disorder (APPI, 2000; Emerson & Kelly, 2015), addiction, and suicide (Herman, 2015; van der Kolk et al., 1996). These negative repercussions rarely improve spontaneously over time without treatment, often continue to worsen even years after onset, and may themselves be fatal (Barth et al., 2005; Boscarino, 1997; Kohen, Arron, & Klein, 2001).

Because of the extensive comorbidities and the persistence of symptoms post-onset, diagnosing CPTSD can be elusive (Herman, 2015). Clients with CPTSD who lack correct diagnosis may be on multiple medications for comorbid conditions without a plan to address the causal issue (Emerson & Hopper, 2011; van der Kolk, 2014). This potential for misdiagnosis lowers chance of successful recovery, and increases potential of adverse events from polypharmacy\(^9\) and medication interactions (Banks, 2002; Collett et al., 2016; Maher, Hanson, & Hajjar, 2014). Accurately diagnosed PTSD or CPTSD can be addressed with better outcomes from more precisely applied therapies, including TCTSY if appropriate (Emerson, & Hopper, 2015; West, Liang, & Spinazzola, 2016). Even if the survivor has not yet been correctly diagnosed, however, therapeutic yoga practice may ameliorate symptoms, potentially lessening risk and need for multiple medication therapies (Campbell & Moore, 2004; Saper et al., 2017; Weintraub, 2004; 2012).

**Treating CPTSD.**

*The big issue for traumatized people is that they don’t own themselves anymore.* (B van der Kolk, interview with K. Tippett, *On Being*, broadcast October 20, 2017)

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\(^9\) Polypharmacy indicates a regimen of multiple prescribed medications (Maher, Hanson, & Hajjar, 2014).
CPTSD as a diagnosis indicates the client is suffering because of relationship experience, and the nervous system is generating protective, yet compromising, means to avoid suffering (Hillis et al., 2001; Nemeroff, 2004). Either way, an active diagnosis of CPTSD means living with current limits that reference past experience (Herman, 2015). A trauma-informed clinician helps the client with CPTSD reduce painful symptoms and increase range of tolerance (Naparstek, 2004). The hope is that after successful treatment the client can lead a more fulfilling, rewarding life with an expanded range of choice and options in the present (Emerson, 2015; van der Kolk, 2009; 2014).

Trauma specialists generally agree on the above as a broad goal of treatment. How to arrive at these ends, however, is less universally agreed-upon. CPTSD is complex, layered and differentiated in presentation (Emerson & Hopper, 2011; van der Kolk et al., 1996). Furthermore, CPTSD recovery is recognized to progress linearly or cyclically in phases (Herman, 2015). Different treatments may be needed at different phases of recovery (Foa et al., 2009; Herman, 2015). Clients with CPTSD may experience a relief of symptoms from a therapeutic approach that includes one or more modalities such as TCTSY or other somatic therapy (Emerson & Kelly, 2016; Payne, Levine, & Crane-Godreau, 2015), experiential therapy such as animal-assisted intervention or equine therapy (Buck, Bean, & de Marco, 2017; Naste, Price, & Carol, 2017), psychotherapy (Chapman, Gratz, & Tull, 2011; Harnad et al., 2010), group therapy (Herman, 2015), medication (van der Kolk et al., 2007), inpatient therapy if indicated, narrative retelling, and other approaches (Cloitre et al., 2010; van der Kolk, 2014). CPTSD likely will take longer treatment times to resolve than related diagnoses such as PTSD; thus requiring
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patience from both the survivor and the treatment team, and the capacity to redirect therapy if needed (Clark et al., 2014; Hopper et al., 2018).

Research and empirical reports on CPTSD indicate the importance of including the body in successful treatment (Payne, Levine, & Crane-Godreau, 2015). A somatic component to treatment may be of particular value when the survivor wants to participate in therapy (is attending treatments and collaborating with provider) but is having physical reactions that impede treatment progression (Emerson, 2015). Somatic therapies often provide an essential first step in successful treatment by giving clients with CPTSD the ability to be in their bodies safely, tolerate heightened sensations, and minimize repeating trauma states (Emerson, 2015; Emerson & Hopper, 2011; Herman, 2015; Levine, 2010; Ogden, Minton, & Pain, 2006). Body-based therapies may include specific forms of yoga, body or breath work (Emerson & Kelly, 2016), physical awareness (Ogden, Minton & Pain, 2006), and other somatically experienced techniques (Levine, 2010; Rothschild, 2000).

Somatic modalities may also be critical in CPTSD treatment because the legacy of complex trauma may sporadically or generally impair the survivor’s capacity for language and reasoning (Porges, 2013; Taylor, 1985). If the body is not included in therapy, the survivor may not be able to overcome the dissonance between cognition and physical and emotional experience (Jackson, 2014; Payne, Levine, & Crane-Godreau, 2015). If the body is included in therapy, the survivor increases odds of overcoming symptoms and widening range of choice and tolerance (Bodine, 2017; Rhodes, 2014; van der Kolk et al., 2014; West, 2011; West, Liang, & Spinazzola, 2016).
As a further complication, survivors who were very young when their trauma began may not know any other physical reality than a traumatized one (Nemeroff, 2004; Rhodes 2014; Spinazzola et al., 2014). Somatic interventions give the opportunity to experience a way of being beyond a victim re-experiencing trauma (Hopper et al., 2018; Rothschild, 2000). An individual in Rhodes’ (2015) study of trauma survivors who engaged in trauma-informed yoga classes reported exactly this: “With yoga, I reclaimed my body... Or I claimed it, not reclaimed because I was so young [when the trauma happened]” (p. 250). No treatment can take away this subject’s history of complex trauma. Practicing yoga however, gave her a place to be in and with her body, non-referentially to prior abuse (Rhodes, 2014; 2015).

Although clinical research and practice over the last thirty years indicate that bringing the body into treatment of CPTSD can be especially reparative (Clark et al., 2014; Cloitre et al., 2010; Foa at al., 2009; Lauterbach, Vora, & Rakow, 2005; Spinazzola et al., 2011; van der Kolk, 1994; 1996), somatic interventions are not the only effective means of treatment (e.g., Libby, Pilver, & Desai, 2012; Roth et al., 2007). Psychotherapy can foster secure relationships and healthier cognitions for the survivor and is a core treatment for many survivors throughout treatment (Herman, 2015; van Dernoot Lipsky & Burk, 2009). Therapeutic discussion may help clients with CPTSD solve problems, build skills, experience safety, challenge barriers, change thinking, ameliorate symptoms, and improve capacity to trust (Emerson, 2015; Herman, 2015). Therapeutic discussion involves techniques and parameters indicated by theoretical frameworks, by diagnoses, and by symptoms that the client experiences (APPI, 2018).
A stable relationship between client and clinicians forms an essential part of the therapeutic benefit of talk therapy, especially for clients with CPTSD who may have limited or no experience with healthy connections to other people (Emerson & Kelly, 2016). Having a talk-oriented therapeutic relationship can provide an opportunity to name and give narrative to things that happened around and to the survivor (van der Kolk, 2014). The survivor may not have been able or allowed to verbalize traumatic experiences and may even have been told they were not happening (Herman, 1992; 1998). Speaking what is and was true for oneself can be critical in CPTSD recovery (N. Blume, personal communication, January 15, 2017).

Often, somatic specialists will recommend that survivors engaging in somatic therapy also concurrently work with a psychotherapist, for safety and best practice (Emerson, 2015; Emerson & Hopper, 2011). Talking with a psychotherapist can even increase body awareness by helping the survivor understand why the body is responding as it does (van der Kolk, 2014). This therapeutic relationship can lessen a client’s isolation and create relief. Group talk therapy may also help the client form community and lessen unhealthy seclusion (Herman, 2015).

Some treatments that a survivor may encounter within talk therapy may address cognition, neurology, and somatics (van der Kolk, 2014). Eye Movement Desensitization and Reprocessing (EMDR), for example, may reduce or eliminate autonomic neurological responses to trauma triggers and can thus significantly change the survivor’s physical reality (Fisher, 2014; Levin, Lazrobe & van der Kolk, 1999). In EMDR, a certified therapist guides the client through side-to-side movements of the eyes that help the two hemi-
spheres of the brain improve communication and potentially release trauma triggers (van der Kolk et al., 2007).

Additional interventions can further augment successful treatment. Medication can alleviate bio-physiological trauma responses such as escalated heart rate or chemical depression (van der Kolk et al., 2007). This intervention may give the survivor the chance to have alternative biochemical and thus behavioral experiences, which can build confidence and potentially elicit a neurological pathway alternative to the trigger response (Herman, 2015). Experiential therapy may offer the survivor an opportunity to have an embodied experience of confidence, collaboration, or empowerment that can translate into a new neural network (van der Kolk 1996; 2014). Experiential therapy often focuses less on talk and story and more on a therapeutic experience, which may be particularly helpful if a client is managing temporary cognitive impairment. These therapeutic experiences may involve working with people, animals, or both (Buck, Bean, & de Marco, 2017; O’Haire, Guerin, & Kirkham, 2015; Wylie, 2004).

Survivors can provide critical feedback about what works for CPTSD recovery (e.g., Rhodes, 2014; 2015; West, 2011; West, Liang, & Spinazzola, 2016). In early research on TCTSY, for example, researchers occasionally learned what did not work in a TCTSY class because of attrition and student comments on reasons for attrition (Emerson, 2015; Rhodes, 2014; West, 2011; West, Liang, & Spinazzola, 2016). Using this feedback, facilitators learned to make the environment more hospitable to recovery, offering more choices during class, creating stability with dress and habit, and avoiding destabilizing touch (Emerson, 2015; Rhodes 2014, 2015).

Challenges and considerations in treatment.
Since complex trauma unfolds in relationships and systems, the relationships and environments of CPTSD recovery are important clinical considerations (van der Kolk, 2014). Environments that mimic complex trauma or replicate its power dynamic do not generally help survivors recover (Remski, 2018), and hierarchical, dictatorial, overly prescriptive approaches tend not to create lasting improvement for CPTSD. When the client is not allowed to participate in choosing the course of recovery, its success rate drops (Herman, 2015; Emerson, 2015).

Many generally useful therapeutic techniques also may prove insufficient when applied to CPTSD. Although learning new cognitions can be helpful in the process of behavior change (APPI, 2018), for example, simply directing a client with CPTSD to stop reacting or feeling, to change thoughts or beliefs (e.g., Katie, 2008), or improve attention or level of gratitude (e.g., Frederickson, 2014) will not generally significantly reduce CPTSD symptoms (Herman, 2015). Exploring motivation and resistance to change can give important insight into behaviors (e.g., Miller & Rollnick, 2002), but CPTSD’s biophysiological responses are driven more by triggers from the amygdaloid complex than by logical thoughts from the medial pre-frontal cortex (Sah et al., 2003; Shin et al., 2004). Learning life-skills to manage triggers and emotions can help survivors navigate life more successfully (e.g., McKay, Wood, & Brantley, 2007), but may not resolve underlying neurological changes common after complex trauma that drive behavior and responses (Shin et al., 2001; Smith, 2005).

Most clients with CPTSD know when their reactions are not helping them, and this frustration can be a significant part of their pain and suffering (Grossman, et al., 2017). Thus behavior-change or affect-change approaches that center on positive psy-
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chology (e.g., Seligman, 2002; Seligman & Csikszentmihalyi, 2000), cognitive reframing (e.g., Katie, 2008), or even retraining the subconscious (e.g., Havens & Walters, 1989) may unintentionally increase shame and feelings of alienation in survivors (Herman, 2015). Similarly, cognitive mindfulness, though potentially therapeutic (Holzel et al., 2011), is not usually sufficient as a stand-alone CPTSD treatment, especially since clients with CPTSD may have trouble tolerating the physical stillness that is a core tenant of some mindful meditation approaches (Emerson & Kelly, 2016). Being present with external reality as it aligns with physiological reality, the arguable goal of CPTSD treatment (van der Kolk, 2014), is inescapably a physical experience rather than a mental abstraction. Again, survivors hold symptoms and means to recovery in their bodies (Ogden, Minton, & Pain, 2006; Tippett, 2017).

Another consideration is differentiating PTSD and CPTSD treatments: although PTSD and CPTSD can be related and concurrent, they are not identical disorders and therefore require different treatment protocols (Cloitre, 2016). Treatments such as EMDR may work remarkably quickly to resolve some PTSD symptoms but may not show such quick results for CPTSD due to the complex presentation of the disorder (although EMDR can have significant impact on the part of CPTSD being processed) (van der Kolk, 2014). Exposure therapy may have merit for PTSD treatment (Foa et al., 2018; Zayfert et al., 2005) but can be triggering for clients with CPTSD to the extent that some trials for exposure therapy and PTSD have excluded participants with CPTSD (N. Blume, personal communication, January 2018).

Yoga as clinical intervention.
When exploring the efficacy of yoga for CPTSD, it may be helpful to begin with a brief general history of yoga and of yoga as a somatic treatment. Ample empirical evidence aside, thirty years of evidence-based research have established the efficacy of yoga interventions (Evans et al., 2009; Nestor, 1985; van der Kolk 2007; Rhodes, 2015). Yoga shows merit as a therapeutic practice, depending on the study, as an adjunctive or at times primary means of treatment (Lavey et al., 2005; Saper et al., 2017; Spinazzola et al., 2011; 2016). Research shows yoga effective in reducing symptoms associated with back pain (Groessel, Wiengart, Aschbacher, Pada, & Baxi, 2008; Saper et al., 2017), chronic pain (Evans, Subramanian, & Sternlieb, 2008; Groessel, Weingart, Johnson, & Baxi, 2012), depression (Weintraub, 2004; 2012), major depressive disorder (Lacey, Sherman, Mueser, Osborne, Currier, & Wolfe, 2005), anxiety (Campbell & Moore, 2004; Weintraub, 2012), heart disease (Raub, 2002), combat stress (Stoller, Gruel, Cimini, Fowler, & Koomar, 2012), and addiction (Jackson, 2017). Research also indicates yoga interventions may result in biometric improvement that could improve perception of stress, thus influencing resilience (Evans, Tao, Sternlieb, & Zeltzer, 2009; Wheeler & Wilkin, 2007).

Several generations of research have also explored the combination of yoga and talk therapy (Nestor, 1985; Ware, 2007).

**Yoga: Classical definitions.**

Although yoga interventions may result in clinical benefits, specifically defining yoga presents a challenge that spans epochs and encompasses concerns of application and appropriation, both clinically and in practice (Barkataki, 2015; Bhakta, 2014; Deslippe, 2012; 2014; 2018 [May]). Yoga can be defined as union, and this has been interpreted as union with the divine, the self, or the breath, among other understandings (Iyengar, 2009;
Saraswati, 1996; Schiffman, 1996). The Vedas, a grouping of Indian philosophical Sanskrit texts set as hymns, provide information about yoga’s antecedents: the Rigveda, at c.1500 BCE the oldest of the Vedas, provides foundation for, or possibly evidence of the prior development of, yoga, while other of the Vedas could be viewed as foundational texts for Hinduism (Ferguson, 2017; Katz & Egenes, 2015). Multiple South Asian lineages subsequently describe early versions of yoga as including: foci on the hands and body, breathing techniques, ethics, devotion, service, self-healing, and physical habits regarding diet and cleansing behaviors (Ghandi & Wolff, 2017; Iyengar, 2009; Saeed, 2018)\(^\text{10}\). These principles predated the philosopher Patanjali (cf. the Upanishads [Katz & Egenes, 2015] and the Bhagavad Gita [Mitchell, 2002]), but were codified in Patanjali’s aphorisms on yoga in the second or third century CE. With these aphorisms, Patanjali divided yoga into eight limbs: breath, body postures, behavioral restraints, behavioral directives, wisdom, bliss, detachment, and concentration (Remski, 2012).

Patanjali’s compiled definition of yoga became known as Raj Yoga, or classical yoga, one of numerous iterations of these principles in South Asia (Rosen, 2014). Some yoga disciplines emphasized a particular of the eight branches, and some a combination (Schiffman, 1996). Most lineages directed a practice and experience of postures, including muscle holds or bhandas, and breath leading to an experience of meditation enacted both as spiritual pursuit and lifestyle (Saraswati, 1996). Within South Asia, yoga interact-

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\(^{10}\) There is possible evidence, via one interpretation of hieroglyphics, that yoga had older origins in Egypt as well (Ashby, 2005).
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ed with religion, politics, and mythology and was subject to variations by teacher, region, and time (Wildcroft, 2015).

Clinical teleology of yoga.

When exploring yoga in research, defining yoga often moves to the teleological: for research purposes, yoga is the particular practice being studied for its particular benefit. As an example, see the study on yoga and back pain from Saper (2017) and his colleagues, in which a specific yoga instrument was developed and delivered to participants in a manual. In Saper’s (2017) study, the yoga that was shown to ameliorate back pain was precisely limited to the selection of techniques presented in the manual. Similarly, in Rhodes’ (2014; 2015) studies on TCTSY, the yoga shown to benefit symptoms of CPTSD was specifically the style and techniques selected and refined by Emerson (2015) and his colleagues. These studies show that a clearly curated practice may have benefit for the condition, and yoga exercises consciously omitted from a study may be inappropriate for the condition (Emerson & Hopper, 2011; Emerson & Kelly, 2016; Saper, 2017).

11 These traditional yoga principles, or branches, generally accompanied yoga as it transferred cross-culturally to the United States, United Kingdom, and Europe throughout the twentieth century (Iyengar, 2007; Sir Arubindo, 2018; Yogananda, 1946). Yet Indian yoga forms were subject to changes in language or description almost as soon as a discipline became accessible to the public abroad (Deslippe, 2014; Jain, 2014). Even the more conservative yoga disciplines were subject to subtle alterations over time in a new country (Deslippe, 2012; Schiffman, 1996). The longer a yoga style’s international assimilation period, the greater the tendency to splinter and break with tradition (Deslippe, 2012; 2017). Sometimes this assimilation resulted in yoga traditions being collaged or entirely invented (Deslippe, 2012). As a result of these multiple alternations to definition and practice, contemporary yoga in the United States can be staggeringly diverse (Cook, 2007; Saeed, 2018). Currently in the United States, yoga teaching is open to individual re-definition, potentially assisting more student needs, and changing even more from its origins (Roberts, 2017). Though beyond the scope of this research, cultural appropriation is a concern for yoga teachers. This particularly applies to instructors who teach to trauma since appropriation via colonization contains inherent trauma dynamic (Arya Haas, 2011; Bharkataki, 2015; Bhakta, 2014; Ghandi & Wolff, 2017; Prashad, 2001). Instructors teaching to trauma may benefit from understanding legacies of abuse or power imbalance within yoga disciplines (Remski, 2018), including within practices that are trauma-informed (Kowlczyk, 2018).
**TCTSY as CPTSD intervention.**

TCTSY is a particular type of yoga developed by Emerson (2015) in conjunction with the Trauma Center in Brookline, MA. TCTSY is founded on over ten years of empirical and evidence-based research on yoga for PTSD and CPTSD (Emerson & Hopper, 2011; TSY, 2019; West, 2011; West, Liang, & Spinazzola, 2016), plus decades of research in neuroscience and attachment theory (Ainsworth et al., 2015; Spinazzola et al., 2011; van der Kolk 1994; 1996; 2006; 2009). TCTSY researchers worked with clients identified as having CPTSD, refining teaching approach based on qualitative feedback and quantitative data (Emerson, 2015; Emerson & Hopper 2011; Emerson & Kelly, 2016; Rhodes, 2014; 2015; Spinazzola et al., 2011; 2014; 2016; van der Kolk, 2009; 2014; West, 2011; West, Liang, & Spinazzola, 2016). The development of TCTSY included direct feedback from yoga students with CPTSD. Some of this feedback was reported by Rhodes (2014; 2015) and West (2011; West, Liang, & Spinazzola, 2016) in qualitative interviews. The specific, codified practice developed from this research became known as Trauma Center Trauma-Sensitive Yoga, or TCTSY, since it was initially developed out of the Trauma Center in Brookline, MA (Emerson, 2015; TSY, 2019). As indication of its research standards, TCTSY was listed as an Evidence-Based Practice (EBP) in the National Registry of Evidence-Based Practices and Programs (NREPP, 2016), a formal endorsement of TCTSY as a validated trauma treatment.

Trauma-informed and general types of yoga have been studied in other iterations as a treatment for PTSD (Johnston, 2011) and CPTSD (Dale et al., 2011; Dixon-Peters, 2007; Jackson, 2014; Price et al., 2017). A number of yoga systems are currently taught

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12 NREPP was governmentally disbanded in 2018. Please see the website samhsa.gov for information previously listed in NREPP.
or marketed as trauma-informed, or trauma treatments (cf., Weintraub, 2012). Numerous yoga approaches have been applied to the symptoms of complex trauma, some in practice (Jackson, 2014; Weintraub, 2012), and some in research environments (Dale, et al., 2011, Dixon-Peters, 2007; Groessel et al. 2012; Telles et al., 2010). This paper will not explore these systems in detail, neither to credit nor to discredit them. It may help providers to know, however, that multiple active yoga disciplines attempt to address trauma and may be effective options for clients.

TCTSY was created and refined as an adjunctive treatment for relational trauma (Emerson & Kelly, 2016; Rhodes, 2014; 2015; West, 2011; West, Liang, & Spinazzola, 2016). It is not indicated, nor was it created, as a sole treatment for CPTSD (Emerson, 2015; Emerson & Hopper 2011). TCTSY was chosen as the form of yoga for this study because of its established clinical efficacy and its intentional co-managed approach with psychotherapy (Emerson, 2015; Rhodes, 2014; Spinazzola et al., 2011; TSY, 2019).

TCTSY offers clients with CPTSD a safe context to experience information from their bodies that a history of complex trauma may have blocked (Emerson & Hopper, 2011; Rhodes, 2015). TCTSY facilitators work with principles of choice, invitation, agency, developing interoception, stable relationships, rhythm, non-attachment to outcome, and shared authentic experience (Emerson, 2015), which will be expanded upon below. Recovering skills such as being present with physical sensation and taking effective action in TCTSY can help clients with CPTSD increase safety and improve physical and emotional health (van der Kolk, 2014).

*Developing choice via invitation.*
Choice making, a component of the TCTSY pedagogical approach, can give the survivor practice with a basic lifeskill that complex trauma may have impeded (Emerson, 2015). Trauma inherently removes choice, on one level or on many (Herman, 1992, 1998). When choice has been removed in a threatening environment and relationships, the survivor can feel not only inexperienced with decision making but frightened by it, and relearning how to choose for oneself can be an important aspect of recovery (van der Kolk 1996, 2014).

Standard yoga practices may offer choice as a modification for injury, limited range of motion, or beginning students (Schiffman, 1996). Offering choices within the TSTCY yoga practice are more neutral in nature and are offered simply to give opportunity to practice choice (Emerson, 2015). The TCTSY facilitator does not stipulate whether an option is better or worse, harder or easier, but rather gives a non-qualified range of options from which to make a personal selection (Bodine, 2017).

The TCTSY facilitator offers these choices by careful invitational language (Emerson, 2015). In a standard yoga class, a teacher will often direct students, telling them where to place their bodies (Schiffman, 1996). In a TCTSY class, the facilitator will ask or invite the students to try different physical forms, and the students can make their own choices (Emerson & Hopper, 2011). Choice for the sake of choice can give survivors practice with making decisions for themselves, and managing their reactions to having the power to choose (Emerson, 2015).

Taking effective action and agency.

Related to choice making, TCTSY may also help rebuild capacity to take effective action (West, 2011; West, Liang, & Spinazzola, 2016). Capacity for agency, though
it may seem an act of individual will, is built socially in relationships: healthy early childhood experiences foster a child’s capacity for recognizing and meeting self needs (Ainsworth et al., 2015; Emerson 2015; Irish, Kobayashi, & Delahanty, 2010). A caregiver who responds reliably and effectively enough to a child enforces the child’s understanding of being worthy of care. The child also learns that actions on behalf of self can have a positive effect; in early life this might evidence as simply as crying for food and being fed (Ainsworth et al., 2015; Roth, et al., 1997).

In traumatic relationships, however, the child experiences the reverse of positive advocacy (Cloitre, 2016; Roth, et al., 1997). Acting as one's own advocate in a traumatic relationship can have consequences that range from ineffectual to lethal (Irish, Kobayashi, & Delahanty, 2010; van der Kolk, 2014). Often, survivors of complex trauma learn to stop taking action in their own interest, whether the trauma happened in infancy, childhood, or adulthood (Herman, 2015; Nemeroff, 2004).

Experiences of agency can be built in small steps in the TCTSY practice (Emerson & Hopper, 2011). The opportunity for agency is presented neutrally by inviting the survivor to notice possibilities to adjust experience (Bodine, 2017; Emerson, 2015). Like choice making, agency is fostered with verbal cues from the facilitator, since the CPTSD client may be unfamiliar and uncomfortable with taking action for the self and may need practice opportunities to develop this skill (Emerson & Hopper, 2011; West, 2011; West, Liang, & Spinazzola, 2016).

*Stable relationships: Rhythm and shared authentic experience.*

Complex trauma is at its essence relational (Herman, 2015). It occurs because of what people do to each other over time in the context of a relationship (Cloitre, 2016;
Emerson, 2015). Traumatic relationships are formed with power imbalances such as hiding information and erasure of truth, abandonment, physical, verbal, or sexual abuse, neglect, and coercion (Ainsworth et al., 2015; Herman, 2015). Rebuilding healthy relationships is a fundamental aspect of recovering from CPTSD (Emerson & Hopper, 2011). A supportive therapist-client relationship can become a pillar of trauma recovery (Emerson, 2015; van der Kolk, 2014), as can group therapy relationships (Herman, 2015). Similarly, the student-facilitator relationship in yoga class can provide a healthy alternative to trauma dynamics, or can consciously or unconsciously replicate trauma (Deslippe, 2012; Emerson, 2015; Remski, 2018).

The TCTSY pedagogical approach helps facilitators understand what to do and avoid doing (Rhodes, 2014; West, 2011; West, Liang, & Spinazzola, 2016) so that the student relationship centers on non-traumatic power sharing rather than traumatic power hoarding. The TCTSY facilitator intentionally creates a stable, predictable environment (Emerson & Hopper, 2011). TCTSY is often taught as a series with elements that repeat from class to class so that students can derive a sense of safety in knowing what to expect (Emerson, 2015). The TCTSY class is also structured so that facilitators can respond to students’ choices, which can enrich the therapeutic capacity of the relationship (Emerson & Kelly, 2016). When a facilitator makes adaptations based on student feedback, students learn that their decisions and reactions can positively impact their environment and well-being, which is the opposite of a trauma dynamic (D. Emerson, personal communication, February 20, 2019).

Where the facilitator is positioned may be as important as the words used. In a TCTSY class, the facilitator will attempt to equalize positional power by practicing with
the students rather than walking through the class directing as might happen in a typical studio class (Emerson, 2015). This shared, authentic experience of facilitator and students practicing together allows a relatively equal vulnerability between student and facilitator (Emerson, 2015). Practicing together can also foster unification and rhythm; a rhythm from which trauma survivors may feel disjoined (Herman, 2015). Feeling connected with other human beings can become a critical part of trauma recovery (van der Kolk, 2014).

Furthermore, the TCTSY facilitator generally staying on a mat may decrease the likelihood of dysregulating students who may be hyper-alert to changes in the environment (Cloitre, 2016; Herman, 2015; van der Kolk et al., 2014).

To equalize power further, TCTSY pedagogy excludes physical adjustments, which may be common in a typical yoga studio (Emerson, 2015). Adjustments may not be inherently traumatic (though they can be [Lucia, 2018; Remski, 2018]), but do not fit the power sharing of TCTSY (Emerson, 2015). Adjusting in yoga refers to the teacher giving a hands-on correction or assist, using hands, arms, and possibly also legs and feet to move the student’s body during practice (Schiffman, 1996). With such adjustments, the student receives the touch and does not choose when or how it happens (Emerson & Kelly, 2016). For a client with CPTSD, touch can be triggering, especially from an authority figure, as can lacking choice about receiving the touch (Herman, 2015). In a trauma-recovery environment where power dynamics are critical, the facilitator physically positioning the CPTSD client’s body into a form, however well intentioned, would not fit the recovery protocol (Emerson, 2015; Rhodes, 2014; West, Liang, & Spinazzola, 2016). TCTSY students are literally allowed space for their own physical experience, which may be another unfamiliar yet positive dynamic (Emerson, 2015).
Language, interoception, present-moment experience, and body.

TCTSY protocol also advises deliberate communication about physical sensation, which can help survivors orient to the interoceptive present moment rather than reliving past experience (Emerson & Hopper, 2011). The TCTSY facilitator guides students to notice if they feel sensation without qualifying the sensation, while the facilitator is simultaneously tracking internal sensation: this co-practicing and co-experiencing is an essential expression of shared authentic experience (Emerson, 2015; Emerson & Hopper, 2011). The facilitator’s neutral observations and invitations about sensation may allow the student to develop capacity for interoception without communicating that one sensation is preferred over the other (Emerson, 2015). Survivors may have an ingrained sense of being wrong, shameful, or a mistake (Herman, 2015). TCTSY’s neutral language offers an opportunity to experience internal sensation, which can be unfamiliar territory for survivors as they experience their current state without reference to an external wrong or right (Emerson, 2015). To enhance capacity for present-moment experience, metaphorical language is also avoided in TCTSY: since CPTSD clients may have a tendency toward dissociation, helping them to be with what is actually happening may be more useful than painting a non-real picture with language (Emerson & Hopper, 2011).

Trained to survive via exteroception, trauma survivors may be vigilantly paying attention to many layers in their environment (Cloitre, 2016). TCTSY thus also offers extensive repetition, which provides survivors multiple opportunities to filter the facilitator’s words through other perceptions and information competing for their attention (Herman, 2015). The TCTSY facilitator allows many ways to hear, try, sense, and
choose, all of which can contribute to trauma recovery (Emerson, 2015; Rhodes, 2014; Spinazzola et al., 2009).

In a TCTSY class, the facilitator also uses personal pronouns, most often you and your: the body becomes your body (Emerson & Kelly, 2016). After complex trauma, survivors may feel detached from or not belonging to their physical selves (Herman, 2015). Personal pronoun suggestions from the TCTSY facilitator can remind survivors of ownership of their bodies (Emerson, 2015).

*Non-attachment to outcome.*

Finally, non-attachment to outcome is a subtle but crucial point within TCTSY pedagogy. Naturally, as providers working with CPTSD, TCTSY facilitators are interested in amelioration of trauma symptoms (Emerson, 2015). Yet trauma potentially can, despite these good intentions, be replicated if providers force outcomes or treatments on survivors (Herman, 2015). Therefore, although TCTSY is a validated CPTSD recovery tool, its facilitators try to avoid prescribing timelines of recovery or predicting outcomes of treatment (Emerson & Hopper, 2011).

*TCTSY and psychotherapy.*

TCTSY was developed as an adjunctive treatment to psychotherapy because of the separate and distinct benefits of psychotherapy versus yoga and because of the critical therapist relationship in CPTSD recovery (Emerson & Hopper, 2011). The relationship that a trauma survivor has with a talk therapist, primarily mental and emotional, is different than the primarily somatic experience with a yoga facilitator (Emerson & Kelly, 2016). The survivor may derive particular benefit from having the opportunity to develop
both relationships (Emerson, 2015; TSY, 2019). Note that in some instances, the therapist may also be the yoga facilitator, if trained to offer both modalities (Bodine, 2017).

Ideally, the therapist consults with the yoga facilitator when introducing TCTSY into the treatment plan, if the client approves (Emerson, 2015; Herman, 2015). TCTSY trainings recommend that facilitators screen to ensure that students have an active, established relationship with a therapist (TSY, 2019). Recommended screening forms also include a query if the yoga facilitator may contact the therapist in case of an emergency (J. Turner, personal communication, February 18, 2017).

There is clinical justification for yoga facilitators involving the therapist in the treatment arc for students with CPTSD (Emerson, 2015; Weintraub, 2012). Therapists learn to assess different levels of risk, concerns, and clinical issues from those addressed in yoga training, and may have learned specific workflows and safety procedures for behavioral crisis (T. Swaggert, personal communication, December 3, 2015). There is clinical justification for therapists involving yoga facilitators in the treatment arc for clients with CPTSD as well (Spinazzola et al., 2011). Yoga facilitators work with the body and language of physicality, and may be more experienced than psychotherapists with subtleties of physical experience and how to approach physical change (Emerson & Kelly, 2016; Schiffman, 1996; Weintraub, 2012). If providers are empowered with explicit information about how various types of yoga function, they can make much more accurate, beneficial yoga prescriptions to their clients (Raub, 2002; Saper et al., 2017; Ware, 2007). The more information available on how types of yoga affect CPTSD specifically, the more therapists may be empowered to address CPTSD with yoga as an adjunctive thera-
py (Price at al., 2017; Rhodes, Spinazzola, & van der Kolk, 2016; van der Kolk et al., 2014).

**Conclusion and Summary**

As detailed above, numerous avenues of research, the experience of clinical experts, and direct reports from survivors show the merit of somatic interventions generally and TCTSY specifically in CPTSD treatment (e.g., Emerson, 2015; Rhodes, 2014; van der Kolk, 2014; West, 2011; West, Liang, & Spinazzola, 2016). The complexity of CPTSD is not only that the damage occurred repeatedly over time in relationships but also that multiple aspects of the client’s physicality may be affected (Sledjeski et al., 2008). CPTSD is shown to have an adverse and lingering effect on physical health, emotional health, and relationships (Herman, 2015). As the body and relationships are affected and compromised by CPTSD, the body and relationships can also be the means for recovery (van der Kolk, 2009; 2014).

Although no one modality could redress all the complexities of CPTSD, TCTSY offers a groundbreaking, remarkable solution of tolerated treatment and symptom relief (Rhodes, 2015; Spinazzola et al., 2011). TCTSY is also rich territory for ongoing research in multiple modality CPTSD treatment, since it was developed as an adjunctive therapy (Emerson, 2015). When using multiple modalities to remediate CPTSD symptoms, a clinically recommended approach (ISTSS, 2019), the perspective of all parties may help apply the interventions with greater accuracy. In the study of TCTSY and psychotherapy, data has been collected from clients with CPTSD (Rhodes, 2014; West, 2011; West, Liang, & Spinazzola, 2016) and from TCTSY facilitators (Bodine, 2017). It may be useful to add psychotherapist insights into client change with the data gathered.
here that addresses the research question: how do psychotherapists perceive that utilization of talk therapy changes when TCTSY is introduced into CPTSD treatment? The survey and interview in Chapter 3 explore how psychotherapists perceive the introduction of TCTSY changes utilization of therapy. Chapters 4 and 5 present research findings, limitations, and recommendations for future exploration.
CHAPTER THREE

Research Methods

Introduction and Research Question

With the dawn of Complex Post-Traumatic Stress Disorder (CPTSD) as a billable diagnostic code (Cloitre, 2016), now is an optimal time to research CPTSD treatments, especially as distinct paths to recovery from approaches centered on Post-Traumatic Stress Disorder (PTSD). Adequate and specific research may help guide best practice for general and trauma-specialist clinicians and thus improve outcomes for CPTSD, which has historically been so challenging to treat that it was once labeled treatment-resistant PTSD (Herman, 1992; 2015; van der Kolk, 2014). Quantitative research can indicate CPTSD treatment success rates by tracking data such as changes in cranial blood flow, improvements in assessment scores, and number of hospital admissions (Paley, 2000). Qualitative data, such as that contained here, can gather feedback from different stakeholders and participants in the CPTSD recovery process and thus also can inform treatment protocols by sharing experiential narratives, subjective and valuable insights, and expert opinions of best practices (cf., Remski, 2018; Sandeloski, 1993).

Qualitative data has been previously recorded on the experience of students practicing Trauma-Center Trauma Sensitive Yoga (TCTSY) (Rhodes, 2014; 2015; West, 2011; West, Liang, & Spinazzola, 2016), and on the experience of TCTSY facilitators (Bodine, 2017). Qualitative and quantitative data has also been validated regarding the general efficacy of TCTSY in alleviating and improving certain CPTSD symptoms (Em-erson & Kelly, 2016; van der Kolk, et al., 2014; West, Liang & Spinazzola, 2016). The survey and interview research of this study may help fill a specific gap by exploring the
research question: how do psychotherapists perceive that utilization of talk therapy changes when TCTSY is introduced into CPTSD treatment?

**Research Paradigm: The Qualitative Perspective**

Although clinical research often hinges on quantitative results (Page 2014; Skelly 2011), qualitative data is viable in the treatment of CPTSD because of the insights it yields from client or clinician (Rhodes, 2014; 2015) and because it can give voice to the survivor’s experience (Emerson, 2015; Herman, 2015). Qualitative data on CPTSD may detail the client’s personal experience and valuable perspective, or give insight into the treatment team’s challenges and successes that unfold inside or outside the research environment (McMillan & Schumacher, 2010). The qualitative data in this study was gathered via survey and semi-structured interview (McMillan & Schumacher, 2010). Please see Appendix E for survey and interview questions used in this research. The survey and interview templates of this study are original instruments, with precedents explained below.\(^\text{13}\)

Qualitative data “focuses on the ‘why’ rather than the ‘what’ of social phenomena and relies on the direct experiences of human beings as meaning-making agents in their everyday lives” (University of Utah, 2019, para. 1). Although the researcher attempts to maintain neutrality in qualitative research, the inherently subjective nature of the data requires a thorough explication of bias (McMillan & Schumacher, 2010). Disclosure of bias applies also in quantitative research, but numeric data may speak more for itself if transparently and ethically contextualized (Page, 2014; Skelly, 2011). Qualitative research,

\(^{13}\) To provide context for the research here, please note that the Doctorate in Education at Hamline University is as of this writing a non-clinical program, with research generally conducted in avenues of educational leadership.
conversely, is more a language of words than numbers, requiring flexibility on behalf of the researcher and perhaps even capacity for the researcher to become something of a research instrument. The story of qualitative data may become both deeper and less generalizable than a quantitative report (University of Utah, 2019).

**Research Design: Qualitative Descriptive**

The design of this research is qualitative descriptive. It fits the model defined in the research (Kim, Sefchik, & Bradway, 2016), presenting a study of a phenomenon in its natural state via data collection with semi-structured interview and survey for triangulation, and via content analysis (McMillan & Schumacher, 2010). The phenomenon or experience studied is that of psychotherapists treating CPTSD who have clients who have practiced TCTSY. Consistent with qualitative descriptive analysis, this approach contains elements of grounded theory and phenomenological design in a) the translation of participants’ themes into researcher’s language and b) an attempt to set aside preconceptions or theory developed *a priori* (Giorgi, 1997; Giorgi, 2012; Maxwell, 2005; McMillan & Schumacher, 2010). This study’s data was analyzed for themes that would enable theories and future avenues of research to emerge, rather than approaching the data with a pre-determined theory (McMillan & Schumacher, 2010). Since this data was collected via rating, scaling, and verbal or textual responses, analysis will explore both demographic trends and commonalities of language.

**Research Methods: Semi-structured Interview and Survey**

The original qualitative survey and semi-structured interview instruments presented here reference precedents in dissertation research on TCTSY and CPTSD (Bodine, 2017; Rhodes, 2014; West, 2011). This study includes:
1. Original Qualitative Survey (new instrument) of yes/no, multiple choice, scaling/rating, and brief written response prompts, sent via email and available on a TCTSY facilitator app, and submitted electronically.

2. Original Qualitative Semi-Structured Interviews (new instrument), a semi-structured brief interview, conducted telephonically and recorded, after the survey was closed.

Item one, the survey, gathered responses from trauma therapists who have experience with client use of TCTSY. A majority of these therapists were also TCTSY facilitators. The survey gathered demographic information from the participants to give context for the research, so that readers could understand participants’ background as therapists and the background of their clients. The survey then assessed the participants’ perception of what changes may occur in talk therapy when TCTSY is introduced into CPTSD treatment and what changes are less likely to occur. Item two, the interview, allowed participants the opportunity to share more detail on their experience introducing TCTSY into talk therapy for CPTSD. The interviews expanded the participant’s voice and, within a framework, gave the participant control of direction of discussion, which is central to research on CPTSD (Herman, 2015) and in accordance with qualitative descriptive design (Kim, Sefcik, & Bradway, 2016).

**Instrument refinement and implementation.**

Survey and interview were reviewed for validity by the Department of Institutional Research of the California Maritime University (CSUM) and by a lead TCTSY trainer, and revised after each review. The Hamline IRB granted permission to begin research on
July 22, 2019 (per document 2019-07-44ET). Potential participants were contacted via individual email outreach and on the Trauma Center Trauma Sensitive Yoga facilitator app, after IRB permission was secured.

A participation solicitation email was sent to trauma-specialist therapists with familiarity with TCTSY, from an international database at The Justice Resource Institute (JRI). The solicitation was also posted on the TCTSY facilitator app, also maintained by JRI. All outreached participants were asked if they wish to participate in survey and brief interview (or one versus the other). Survey participants were provided with the option to be interviewed at the conclusion on the survey as well. The survey was conducted by a survey program that protects identity of respondents, between July 22 and August 19, 2019.

The participation solicitation text was kept to a description of the study, to reduce bias that may have occurred by over-framing or steering responses. All potential participants, however, were given a contact at JRI to outreach if they had questions or concerns, my contact information as the primary researcher, and my dissertation chair’s contact information, if they had questions about the research before or after engaging. After completing a consent form, a separate electronic link and document, participants were offered a link to an online survey that protected identity (so once a participant began the online survey, we as researchers did not know the person’s name or contact information unless the participant chose to disclose it). At the conclusion of the survey, participants were again invited to outreach me if they wished to be interviewed.

14 For example, as will be described in Chapter 4, change in utilization of therapy could be interpreted in multiple ways, and participants were offered relative flexibility to indicate if or how they noticed change.
The number of survey and interview participants was determined by the number of responses received. Sixteen participants completed the research survey, and three participants consented to be interviewed. No minimum or maximum number of participants was set for either interview or survey. Participants’ consent was validated before beginning each instrument, and data confidentiality was and will be maintained to all extents possible (Hill, Thompson, & Williams, 1997). I was the interviewer for all three interview participants. Interviews took place on August 28 and 30, 2019, and transcriptions of the interviews may be found in Appendix F.

**Research Analysis: Content Analysis**

**Establishing triangulation and rigor.**

After gathering survey data and interview data, the interviews were transcribed, and the survey data was codified by the collection program used to gather the data (the survey program generates several automated reports to help preserve confidentiality and to organize the data). I shared the transcriptions and the survey reports with two research reviewers, one a lead trainer in TCTSY and one an independent case manager. To limit bias as much as possible, I did not pre-frame the data with remarks about trends I had noticed. Instead, I asked the reviewers to share with me what stood out to them as themes or observations.

I compared the reviewers’ responses to each other and to my own notes to develop a set of themes around which the data would be coded. The themes were chosen by elements we three found noteworthy, and by common words and topics in the data. The interview data was correlated comparatively to survey findings for triangulation, as well as coded for themes within the interview text itself (cf., Fink, 2009; Hsieh & Shannon,
Survey response themes were compared to interview response themes for commonalities. Some themes appeared in survey data primarily, some in interview data primarily, and some in both survey and interview data. This coding of free-form responses for textual themes and analysis of scaled questions to assess trends of responses is found in other research and research guidelines (cf., APA, 2010; McMillan & Schumacher, 2010; Maxwell, 2005; Miles & Huberman, 1994; Paley, 2000).

**Summative content analysis.**

In Chapter 4, information about participant demographics is presented, followed by themes from the data. Notes are given as to which themes were common in both survey and interview, and which themes predominantly appeared from survey or from interview. The analysis of this study is summative content analysis (Hsieh & Shannon, 2005): after coding as mentioned above, responses were interpreted for meaning (Saldana, 2016). Conclusions of the research were drawn *a posteriori* based on the results of the research (Neuendorf, 2002). This summative content analysis is from a qualitative descriptive perspective and contains trends of grounded theory (Kim, Sefcik, & Bradway, 2016): research conclusions were established based on the participants’ responses, the reviewers’ insights, and my interpretation as the researcher (Charmaz, 2014; Sandeloski, 1993; Strauss & Corbin, 1998). These conclusions are presented in Chapter 5.

**Research Justification: Previous Studies**

Generally researchers justify their approach by citing experts in their field who have established similar research criteria successfully (Estes et al., 2014; McMillan & Schumacher, 2010). Recent dissertation research in TCTSY by West (2011), Rhodes
(2014), and Bodine (2017) validated the use of qualitative interview and surveys to explore experiences of teaching and practicing TCTSY, as well as opening avenues for further research (Rhodes, 2015; Rhodes, van der Kolk, & Spinazzola, 2016; van der Kolk et al., 2014; West, Liang, & Spinazzola, 2016). Rhodes (2014, see Appendix B) and West (2011, see Appendix A) used qualitative interviews in dissertations to explore the value of TCTSY to trauma survivors (although Rhodes followed other courses of research as well in her 2014 work) (also cf., Rhodes 2015; West, Liang, & Spinazzola, 2016). In a 2017 dissertation, Bodine used qualitative interviewing to explore the lived experience of facilitating TCTSY (see Appendix C). These interviews gathered valuable data about benefits of TCTSY and TCTSY experience in the survivors’ and facilitators’ own words, which were sorted and coded for pattern analysis. Please note that these three dissertation guides are included as reference in the appendices (cf., Kim, Sefcik, & Bradway, 2016; McMillan & Schumacher, 2010). Similar qualitative methods were used to explore the following research question: how do psychotherapists perceive that utilization of talk therapy changes when TCTSY is introduced into CPTSD treatment? The original instruments used for this study are presented in Appendix E.

**Credibility and bias.**

I have twenty years’ experience teaching yoga, ten as a case manager, and three teaching TCTSY. That professional experience indicates some understanding of complex trauma and yoga, and may also have contributed bias to interpreting results. For example, I believe TCTSY can positively influence treatment outcomes for individuals with CPTSD, as I did at the beginning of the study. I work on a team with therapists and have developed a great appreciation for clinical consults with therapists. I thus may have un-
conscious bias toward valuing therapist opinion and feedback, which may have influenced neutrality when interviewing. One of the research reviewers, as a lead trainer of TCTSY, would have assumed expert familiarity with the modality, which could also add expertise and bias to interpretation.

Several assumptions were made at the beginning of this study, some of which were unconscious. I assumed, for example, that participation outreach would establish a population of therapists who were TCTSY facilitators, and a population of therapists who were not: my assumption may have been due to unfamiliarity with the JRI database. As will be explained in Chapter 4, almost all participants were also TCTSY facilitators. Participants’ high familiarity with TCTSY may also lend credibility and reduce neutrality regarding the findings. Chapter 5 explores bias and the limitations of this study in greater depth.

Summary

Since related data has been gathered from clients with CPTSD and from TCTSY facilitators (Bodine, 2017; Rhodes, 2014; West, 2011), this research adds responsive input from an essential part of the CPTSD treatment team, the psychotherapists, to assess the question: how do psychotherapists perceive that utilization of talk therapy changes when TCTSY is introduced into CPTSD treatment? Analysis of this study’s data is presented in Chapter 4. In keeping with the qualitative tradition, Chapter 5 presents avenues for future research and limitations of this research (McMillan & Schumacher, 2010).
CHAPTER FOUR
Research Results

Research Context

This study explored the research question: how do psychotherapists perceive that utilization of talk therapy changes when Trauma Center Trauma Sensitive Yoga (TCTSY) is introduced into Complex Post Traumatic Stress Disorder (CPTSD) treatment? Research findings will be presented below as demographic and thematic data. The demographic data explains who the participants are and whom, what, and how they treat. Thematic data clustered around topics of choice, non-attachment, shared authentic experience, provider education, client barriers, change of approach, positive change and improvement for clients, and vulnerability.

Some themes revealed in this data directly relate to the research question and some expand beyond it. The themes of positive change and improvement, choice, non-attachment, and shared authentic experience are TCTSY treatment precepts, and provided data most closely aligned with the research question. The remaining themes deepen understanding of the effects of TCTSY on both clients and therapists. The therapist participants shared personal, expert, and occasionally impassioned feedback about their experience with TCTSY. They discussed how practicing TCTSY shaped their clients’ treatment path, changed clients’ outcomes, and developed their own work as therapists.

Research sample size.

Before delving into the findings, it may be appropriate to frame this research based on the participant pool. To assure data saturation, enough participants must be sampled so that there is relative confidence in the research representing the population
studied (McMillan & Schumacher, 2010; Page, 2014; Skelly, 2011). As of the 2019-20 training year, there will be approximately 425 certified TCTSY facilitators, the majority of which are therapists (D. Emerson, personal communication, November 11, 2019). The number of psychotherapists who have attended continuing education 20- or 40-hour programs in TCTSY has not yet been tabulated by the training staff, but would increase the potential participant pool significantly (D. Emerson, personal communication, November 11, 2019).

Given the respondent rate of sixteen survey participants and three interview participants for this research, data saturation may not be strongly established here (McMillan & Schumacher, 2010), although findings may be transferable and relevant to TCTSY providers and trainers. This research might best be understood as a set of demographic and responsive qualitative survey data that supports the interview data as three interrelated, reflective, phenomenological case studies (McMillan & Schumacher, 2010; Page, 2014). In some instances, cross-correlation between questions in this study would not yield meaningful data again due to limited saturation (exceptions expanded upon below), and the effect of chance on outcomes should not be under-interpreted (Skelly, 2011). The primary recommendation at the completion of this research would be to adjust and then to replicate this study on a larger scale, perhaps with researchers outside the field of trauma studies to reduce bias, if there is interest in verifying data trends.

The significant insights from this study’s participants nonetheless offer new understandings in the exploration of TCTSY research. Their experience-based narratives and responses assist in investigating how TCTSY creates change. Their indispensable expert perspectives clarify how TCTSY is used in real-life contexts and present fresh ide-
as regarding the practical functionality of TCTSY in clinical practice and in the lives of their clients. Research findings will be detailed below, and Chapter 5 will describe research limitations and suggest avenues for further research in greater detail.

**Instruments and pilots.**

The research survey offered yes/no, multiple choice, and free text comment options; see Appendix E for full survey. The survey assessed participants’ professional background, client base, use of TCTSY, and perceptions on change in utilization of psychotherapy after the introduction of TCTSY. Before releasing the survey, a pilot version was assessed by the Department of Institutional Research at the California State University Maritime Academy (CSUM), a STEM-focused institution. The CSUM reviewers are familiar with survey analysis but unfamiliar with the topic so thus able to provide an unbiased assessment of question validity. The CSUM reviewers offered feedback on what level of data reliability the survey might yield. Survey questions were significantly revised after the pilot. As a second pilot, revised questions were then reviewed by a lead TCTSY trainer to ensure relevance for the clinical population. The survey was then sent to psychotherapists who have familiarity with TCTSY, after IRB clearance and via the email database and app described in the previous chapter. Sixteen participants completed the survey in the research period.

The interview instrument was designed as semi-structured, following the basic interview questions (Appendix E) and allowing for additional or adjusted questions based on participants’ responses. Interview questions were piloted similarly to the survey questions. They were first assessed by CSUM reviewers for data validity, and then once revised, reassessed by a TCTSY lead trainer for clinical validity. The revised interview in-
instrument was approved by the Hamline IRB and offered as an option for further participation to survey participants as described in the previous chapter.

Three participants consented to be interviewed and were able to schedule and complete a telephonic interview within the data collection period of August, 2019. I conducted the interviews on August 28 and 30, 2019 and recorded telephonically with consent given to record (transcriptions in Appendix F). Interview participants were asked open-ended questions, given free range of time to answer questions, and often offered opportunity to elaborate. They shared insights pertaining to the research question of change in utilization in therapy after the introduction of TCTSY. Their remarks also expanded into how TCTSY changed them as providers, their practical adaptations with clients, and their own lived experience with TCTSY.

Demographic information was primarily (but not exclusively) collected by the survey. Demographic information will be presented first in the below results. Thematic information was primarily (but not exclusively) collected by the interviews, and is presented at the conclusion of the demographic data. Source of responses, survey or interview, is identified throughout the below analysis.

The following themes were identified by assessing trends in the data, rather than being predetermined prior to research: change of approach, choice, client access, non-attachment, positive change and improvement for clients, provider education, shared authentic experience, and vulnerability. These themes, which are germane to and tangential to the original research question, are explored below. Notable remarks from survey and interview participants are also presented. As mentioned, themes were selected based on my observations and the observations of the two research reviewers. To establish the
themes shown below, I listened to and read the interviews multiple times, noted frequency of words and topics, selected quotations, chose themes, and then compared quotations to themes to refine. In my interpretation, two sub-themes, interoception/embodiment and relationship, were so closely linked with shared authentic experience in the participants’ descriptions that I created a single, merged category. Another reader may have chosen to separate them as independent themes, or may have chosen different themes.

**Research Findings: Demographics**

**Participant background.**

All sixteen survey participants were psychotherapists. All survey participants answered the survey questions about licensure, experience with Trauma Center Trauma-Sensitive Yoga (TCTSY) facilitating, geographical area of practice, and length of practice. Six were Licensed Clinical Social Workers (LCSW); two were Licensed Mental Health Counselors (LMHC); and the rest were other psychotherapy specialists. Twelve practiced in the United States, one in Australia, one in Germany, one in New Zealand, and one in the United Kingdom. Each survey participant reported working in a different primary city. States of practice in the United States included (one participant per state except where noted): California, Colorado, Delaware, Hawai’i, Illinois, Louisiana, Massachusetts (two participants), Minnesota, New York, Utah, and Wisconsin. Interview participants were all practicing psychotherapists from the United States and did not disclose specifics about their licensure or locations, although one mentioned working in a rural, Midwestern environment (Participant 2 [August 28, 2019]).

Survey participants had been practicing psychotherapy between two and twenty-one years, with a mean length of 9.06 years. Fifteen survey participants (approximately
94% percent) were TCTSY facilitators and one was not, indicating overall high literacy with TCTSY as a treatment method. Since fifteen of sixteen survey participants were TCTSY facilitators in addition to being licensed psychotherapists, almost all of the survey participants likely had joint roles, therapist and yoga facilitator. All interview participants were also TCTSY facilitators.

**Client background.**

All sixteen survey participants answered the client demographics questions regarding conditions treated in their practices, client age, and client exposure to TCTSY.

**Conditions treated.**

Survey participants were given the option to scale how frequently they treat seven different conditions. The conditions were selected because they are trauma diagnoses or frequent comorbidities (Herman, 2015). On this scale, survey participants listed most frequently treated conditions as Post-Traumatic Stress Disorder (PTSD) and Complex Post-Traumatic Stress Disorder (CPTSD) (Figure 1; Table 1). Ninety-three percent (93%) treated CPTSD frequently or very frequently. Eighty-eight percent (88%) reported treating PTSD frequently or very frequently. Following in decreasing order of frequently/very frequently treated were: depression, 73 percent; Generalized Anxiety Disorder (GAD), 69 percent; Developmental Trauma Disorder (DTD) 69 percent; Major Depressive Disorder (MDD) 50 percent; Borderline Personality Disorder (BPD) 31 percent; bipolar 12 percent.

---

15 When cited in-text, percentages discussed in this chapter are rounded to the nearest percentage point for ease of reading.

16 Note that all survey participants scaled all queried disorders except for depression, which was scaled by fifteen out of sixteen participants only.
When given the option to add an “other” response/s to the list of treated conditions, the following were noted, each with one mention: antisocial personality disorder, eating disorders (noted as frequently treated by the individual participant); grief, panic, stress, schizophrenia, and sensory processing disorder. Dissociative identity disorder (DID) was noted as an “other” response by two survey participants.

All interview participants noted treating clients with psychological trauma or history of complex trauma. Two interview participants also noted treating individuals with eating disorder (including anorexia and binge eating disorder). One interview participant noted treating obsessive-compulsive disorder (OCD); and one interview participant noted treating individuals with lower cognitive functioning.
Figure 1: Conditions treated by the sixteen survey participants. 1 (never or N/A) - 2 (rarely) - 3 (sometimes) - 4 (frequently) - 5 (very frequently)
Table 1: Conditions treated by the sixteen survey participants.

1 (never or N/A) - 2 (rarely) - 3 (sometimes) - 4 (frequently) - 5 (very frequently)

<table>
<thead>
<tr>
<th>Condition</th>
<th>1 (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>0.0%</td>
<td>0.0%</td>
<td>12.5%</td>
<td>50.0%</td>
<td>37.5%</td>
<td>16</td>
</tr>
<tr>
<td>CPTSD or complex trauma</td>
<td>0.0%</td>
<td>0.0%</td>
<td>6.3%</td>
<td>31.3%</td>
<td>62.5%</td>
<td>16</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>0.0%</td>
<td>0.0%</td>
<td>31.3%</td>
<td>31.3%</td>
<td>37.5%</td>
<td>16</td>
</tr>
<tr>
<td>Depression</td>
<td>0.0%</td>
<td>0.0%</td>
<td>26.7%</td>
<td>40.0%</td>
<td>33.3%</td>
<td>15</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>0.0%</td>
<td>12.5%</td>
<td>37.5%</td>
<td>37.5%</td>
<td>12.5%</td>
<td>16</td>
</tr>
<tr>
<td>Bipolar</td>
<td>18.8%</td>
<td>25.0%</td>
<td>43.8%</td>
<td>6.3%</td>
<td>6.3%</td>
<td>16</td>
</tr>
<tr>
<td>BPD</td>
<td>6.3%</td>
<td>6.3%</td>
<td>56.3%</td>
<td>12.5%</td>
<td>18.8%</td>
<td>16</td>
</tr>
<tr>
<td>Developmental trauma disorder</td>
<td>12.5%</td>
<td>6.3%</td>
<td>12.5%</td>
<td>25.0%</td>
<td>43.8%</td>
<td>16</td>
</tr>
</tbody>
</table>
Client age.

With regard to age of clients treated, participants could select one or more answers. Fifteen of the survey respondents reported treating adults. Ten participants treated adolescents, nine treated geriatric clients, and five treated pediatric clients (Figure 2, Table 2). Interview participants all noted treating adults, and one also noted treating adolescents.

Figure 2: Number of survey participants treating different age groups.

![Bar chart showing the number of survey participants treating different age groups.](chart)

Table 2: Number of survey participants treating different age groups.

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult (20-64) (1)</td>
<td>93.8%</td>
</tr>
<tr>
<td>Pediatric (0-12) (2)</td>
<td>31.3%</td>
</tr>
<tr>
<td>Adolescent (13-19) (3)</td>
<td>62.5%</td>
</tr>
<tr>
<td>Geriatric (65+) (4)</td>
<td>56.3%</td>
</tr>
<tr>
<td>Total Respondents: 16</td>
<td></td>
</tr>
</tbody>
</table>
**Diagnoses for clients who tried TCTSY.**

Six of the sixteen survey participants responded that all their clients who tried TCTSY had a diagnosis of CPTSD, whereas ten participants replied that not all clients who tried TCTSY had a CPTSD diagnosis (Figure 3.1). Participants reported that of their CPTSD clients treated with TCTSY, 94 percent had additional mental health diagnoses (Figure 3.2). When asked to identify the comorbidities of CPTSD clients who tried TCTSY, 15 survey participants gave one or more responses including: alcohol/substance abuse or dependence (6 mentions), antisocial personality disorder (1 mention), anxiety/generalized anxiety disorder/social anxiety (9), attention deficit hyperactivity disorder (1), bipolar disorder (4), borderline personality disorder (BPD) (3), complicated grief (1), depression/major depressive disorder (MDD) (10), DID (2), eating disorder (2), PTSD (1), schizophrenia/schizoaffective disorder (2). The three highest diagnoses mentioned here, anxiety, depression, and substance abuse, are common comorbidities with CPTSD (Cloitre et al., 2009; Roth et al., 1997; van der Kolk, 2014; Weathers, Keane, & Davidson, 2001).

When asked what diagnoses clients treated with TCTSY had if not CPTSD, survey participants were allowed to respond with free text and could give multiple responses. Ten survey participants gave one or more responses. Five of these participants noted their non-CPTSD clients treated with TCTSY had a diagnosis of PTSD. One survey participant noted “other trauma or stressor related disorder” (July 22, 2019). Another participant noted that CPTSD “is not a formal diagnosis, therefore, they did not have it. However, 4/5 [80 percent] meet the suggested criteria” for CPTSD (August 3, 2019).
Thus, seven or 70 percent of these ten participants replied that non-CPTSD clients treated with TCTSY still had some diagnosis of trauma. Seven participants or 70 percent also reported that non-CPTSD clients treated with TCTSY had an anxiety diagnosis. Four participants or 40 percent reported that non-CPTSD clients treated with TCTSY had depression. Other responses (one participant each) included OCD, eating disorder, dissociative identity disorder (DID) (also possibly a trauma-related diagnosis [van der Kolk, 2014]), chronic pain, mood disorder, and adjustment disorder.
Figure 3.1: Client diagnosis CPTSD.

Did all of your clients who tried TCTSY have a CPTSD diagnosis?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>10</td>
</tr>
</tbody>
</table>

Skipped: 0  Answered: 16

Figure 3.2: Client diagnoses: CPTSD with comorbidities.

Did any of these clients have a mental health diagnosis in addition to CPTSD?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>1</td>
</tr>
</tbody>
</table>

Skipped: 0  Answered: 16
**Number of clients practicing TCTSY.**

When asked how many of their clients practiced TCTSY, survey participants were allowed to respond with free text. Survey participants’ interpretation of the question varied and included answers in percentages or whole numbers, and two responses with multiple sets of numbers. Of those who answered in percentage, replies were: 25-30 percent, 50 percent, 80-85 percent, and 95 percent. Of those who answered in whole numbers, replies were (one respondent per choice except where noted): 3 (two respondents), 4, 5 (four respondents), 10 (three respondents), 20 (two respondents), 24, 20-30, and 40. Three respondents replied with additional comments, explaining numbers connected to TCTSY introduction or group therapy participation. Data from this survey question, because of diversity of response type, is difficult to interpret meaningfully. Interview participants did not specify number of clients treated with TCTSY, though Participant 3 (August 30, 2019) noted beginning each session with an offer to practice TCTSY.

**Types of treatment.**

When asked what type of therapy they practice, survey participants could choose multiple options, and all sixteen participants responded (Figure 4, Table 3). Options were selected based on available treatments for CPTSD that might be offered in the context of talk therapy (McKay, Wood, & Brantley, 2007; Levin et al., 1999; Spinazzola et al., 2005; 2011; van der Kolk et al., 2007; 2014). Sixteen (all) of the survey participants responded that they practiced individual therapy. Additionally, nine practiced Eye Movement Desensitization and Reprocessing (EMDR), and eight practiced Cognitive Behavioral Therapy (CBT). Seven participants practiced group therapy, five practiced cou-
pies/family therapy, three practiced Dialectic Behavioral Therapy (DBT), and one participant practiced neurofeedback.

When given the option to note an “other” type of therapy practiced, two survey participants responded that they practice TCTSY, thus identifying TCTSY as a treatment modality. In the “other” category, one participant noted each of the following: somatic therapy, Internal Family Systems (IFS), Safe and Sound Protocol, Compassion Focused Therapy, Sand Tray, Acudetox, Mindfulness Based Cognitive Behavioral Therapy (MBCBT), MSC, sensorimotor psychotherapy, and Cognitive Processing Therapy (CPT). Interview participants (August 28-30, 2019) also noted pairing TCTSY with CBT, IFS, sensorimotor, and EMDR, and reported delivering TCTSY in individual and group therapy contexts.
Figure 4: Types of treatment practiced by the sixteen survey participants.

Table 3: Types of treatment practiced by the sixteen survey participants.

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual therapy (1)</td>
<td>100.0%</td>
</tr>
<tr>
<td>Group therapy (2)</td>
<td>43.8%</td>
</tr>
<tr>
<td>CBT (3)</td>
<td>50.0%</td>
</tr>
<tr>
<td>DBT (4)</td>
<td>18.8%</td>
</tr>
<tr>
<td>EMDR (5)</td>
<td>56.3%</td>
</tr>
<tr>
<td>Neurofeedback (6)</td>
<td>6.3%</td>
</tr>
<tr>
<td>Couples/family therapy (7)</td>
<td>31.3%</td>
</tr>
<tr>
<td>Other (please specify) (8)</td>
<td>37.5%</td>
</tr>
<tr>
<td>Total Respondents: 16</td>
<td></td>
</tr>
</tbody>
</table>

Themes of Research

Positive change and improvement for clients.

Survey participants were asked to rate frequency of changes that they noticed in clients who practiced TCTSY (Table 4), and all responded. This research attempted to assess the change in utilization of therapy after the introduction of TCTSY: this change could be interpreted as functional use or clinical improvement. Possible responses to this
question thus included functional utilization of therapy such as more frequently missing or being tardy for sessions, scheduling more sessions or being on time more often to session, and increase or decrease in inpatient admissions. This question also attempted to assess change in clinical use or expression, such as improvement or decompensation in affect, alternation in symptoms, improvement of sessions, hopefulness about the future, change in therapy relationship, change in issues discussed in therapy, and changes in how issues were explored. After rating these categories for frequency, survey participants were given a free text field to elaborate.

According to this scale, the introduction of TCTSY showed correlation with improvement and positive change in several domains. The following were noted frequently/very frequently in clients after experience with TCTSY: improvement of sessions (68 percent), hopefulness about the future (62 percent), and improvement in affect (75 percent). The introduction of TCTSY also correlated positively with the instigation of change. The following were noted frequently/very frequently after experience with TCTSY: relationship change with therapist (69 percent); change in issues discussed (57 percent); and change in how issues were explored (80 percent). Correlations with TCTSY and client positive change and improvement have similarly been observed in prior research (Emerson & Kelly, 2016; Rhodes, 2014; van der Kolk et al., 2014; West, 2011; West, Liang, & Spinazzola, 2016).

Timeliness, session frequency, inpatient admissions, and worsening of symptoms appeared to be minimally impacted by the introduction of TCTSY, per this survey. Missing more sessions, scheduling more sessions, increased tardiness, increase or decrease in inpatient admissions, and affect decompensation were all noted at zero percent frequent-
ly/very frequently occurring. Escalation of symptoms and increased timeliness were noted at 6 percent frequently/very frequently occurring.

Positive change and improvement following the introduction of TCTSY were the most significant theme of this assessment question. Interview participants also frequently commented on positive change and improvement. Interview participants will be noted below as Participant 1, Participant 2, and Participant 3.

Similar to survey participants, all interview participants noted positive change in sessions and therapeutic relationship after the introduction of TCTSY. When describing change in relationship after the introduction of TCTSY, interview participants’ language was strikingly alike. Participant 1 noted how TCTSY could “shift the relationship” (August 28, 2019), resulting in clients feeling more in control of outcomes. Participant 2 almost identically noted TCTSY’s capacity to “shift relationship” (August 28, 2019) between therapist and client, improving client progress. Participant 3 described how TCTSY “has shifted how the relationship has happened in therapy” (August 30, 2019), resulting in greater empowerment for clients. Since non-coercive therapeutic relationships are essential to successful CPTSD treatment (Herman, 2015), this is a notable commonality.

Related to the affect improvement noted by survey participants, interview participants observed improvement in symptoms after TCTSY. Participant 2 commented that TCTSY could “really make a difference in severe dissociative” symptoms (August 28, 2019). Participant 1 described TCTSY as “helping with [increasing] agency, helping with [decreasing] dissociation” (August 28, 2019). Participant 3 commented that TCTSY helped with a client “very numb to her emotions and…wanting to be able to feel” as well
as with clients who experienced “difficulty with expressing their own preferences” (August 30, 2019). All the above are symptoms commonly noted with CPTSD, as described in Chapter 2 (Nemeroff, 2004; Rhodes, 2014; 2015; Roth et al., 1997).

With regard to increased hopefulness observed by survey participants, Participant 1 noted TCTSY had a positive effect on clients stuck in past trauma. When introducing TCTSY to clients, she would describe “how trauma is often stuck in the body and that even if cognitively we can understand that that was then and this is now that a lot of times our body or other parts of ourselves are not completely time-oriented to the present around that... and that by doing a body-based intervention we can help people be able to live more in the present” (August 28, 2019). Recovery from complex trauma can include capacity to the present as it is happening, and ability to view the future with hope rather than resignation or dread (van der Kolk, 2014).

When assessing interview and survey data combined, additional themes emerged of choice, change in approach, non-attachment, shared authentic experience, provider education, client barriers to access, and vulnerability. In addition to interview transcription text, analysis included free text comments from nine survey participants about their observations after the introduction of TCTSY. These survey remarks will be integrated with interview feedback in the below sections. Positive change and improvement can be noted as ongoing trends throughout the remaining thematic exploration below.
Table 4: Changes noted by survey participants.

During the time your clients practiced TCTSY, did you note changes in any of the following? 1(never or N/A) - 2(rarely) - 3(sometimes) - 4(frequently) - 5(very frequently)

<table>
<thead>
<tr>
<th>Change in</th>
<th>1 (1)</th>
<th>2 (2)</th>
<th>3 (3)</th>
<th>4 (4)</th>
<th>5 (5)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in frequency of missing sessions</td>
<td>56.3%</td>
<td>31.3%</td>
<td>12.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>16</td>
</tr>
<tr>
<td>Increase in tardiness to sessions</td>
<td>62.5%</td>
<td>31.3%</td>
<td>6.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>16</td>
</tr>
<tr>
<td>Scheduling sessions more frequently</td>
<td>40.0%</td>
<td>33.3%</td>
<td>26.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>15</td>
</tr>
<tr>
<td>Increase in frequency of being on time to sessions</td>
<td>43.8%</td>
<td>25.0%</td>
<td>25.0%</td>
<td>0.0%</td>
<td>6.3%</td>
<td>16</td>
</tr>
<tr>
<td>Escalation of symptoms</td>
<td>31.3%</td>
<td>31.3%</td>
<td>31.3%</td>
<td>6.3%</td>
<td>0.0%</td>
<td>16</td>
</tr>
<tr>
<td>Improvement of sessions</td>
<td>0.0%</td>
<td>6.3%</td>
<td>25.0%</td>
<td>56.3%</td>
<td>12.5%</td>
<td>16</td>
</tr>
<tr>
<td>Hopefulness about the future</td>
<td>0.0%</td>
<td>6.3%</td>
<td>31.3%</td>
<td>62.5%</td>
<td>0.0%</td>
<td>16</td>
</tr>
<tr>
<td>Improvement in affect</td>
<td>0.0%</td>
<td>6.3%</td>
<td>18.8%</td>
<td>68.8%</td>
<td>6.3%</td>
<td>16</td>
</tr>
<tr>
<td>Decompensation in affect</td>
<td>37.5%</td>
<td>43.8%</td>
<td>18.8%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>16</td>
</tr>
<tr>
<td>Increase in inpatient admissions</td>
<td>87.5%</td>
<td>12.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>16</td>
</tr>
<tr>
<td>Decrease in inpatient admissions</td>
<td>66.7%</td>
<td>6.7%</td>
<td>26.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>15</td>
</tr>
<tr>
<td>Change in therapy relationship</td>
<td>0.0%</td>
<td>18.8%</td>
<td>12.5%</td>
<td>37.5%</td>
<td>31.3%</td>
<td>16</td>
</tr>
<tr>
<td>Change in issues discussed/explored in therapy</td>
<td>0.0%</td>
<td>0.0%</td>
<td>43.8%</td>
<td>37.5%</td>
<td>18.8%</td>
<td>16</td>
</tr>
<tr>
<td>Change in how issues were explored</td>
<td>0.0%</td>
<td>0.0%</td>
<td>20.0%</td>
<td>46.7%</td>
<td>33.3%</td>
<td>15</td>
</tr>
</tbody>
</table>

Choice.

As established in the literature review in Chapter 2, client choice is a critical component in the treatment of CPTSD (Herman, 2015) and is a key precept of TCTSY (Bodine, 2017; Emerson, 2015; Rhodes, 2014; West 2011; West, Liang, & Spinazzola, 2016). Choice as a precept of TCTSY has been highlighted in training materials since the inception of TCTSY (Emerson & Hopper, 2011; 2014), so choice is not emerging as a new theme in this research. Notably, however, all interview participants reflected on choice as a critical therapeutic benefit of TCTSY despite not being asked specifically about choice (or any other TCTSY principles) (Participants 1, 2, 3 [August 28-30, 2019]).
Participant 1 (August 28, 2019) reflected on the benefits of therapeutic choice that may, in the beginning of TCTSY treatment, need to be isolated to an experience within therapy. She described development of familiarity with choice in a TCTSY therapy group:

I actually do see [TCTSY group clients] having more of a sense of agency, even if only with me. Which I think is a nice place to start because sometimes the place where they are in their homes, it’s not safe to have a sense of agency...if they’re still in an abusive environment, and setting boundaries, sometimes that can invite more abuse.... I do hear a lot in my group about how great it feels to hear about that they have a choice (August 28, 2019).

Three survey participants similarly noted that TCTSY choice practice resulted in greater self-trust and trust of one’s decisions. Survey participants reported “an increase in a sense of agency frequently” (August 14, 2019); and noted clients building “a sense of self-trust and efficacy frequently” (August 16, 2019) after exposure to TCTSY. Per one survey participant, “many clients were able to be thoughtful about how they approached issues [after experiencing TCTSY]—and were able to access the ability to make more choices about if they wanted to explore an issue, memory, or trigger...which allows them to make different decisions” (August 2, 2019). This survey participant also remarked how TCTSY influenced clients’ “capacity to notice their own responses to things and track affect in the session which allows them to make different decisions” (August 2, 2019) in or out of session.
Participant 1 noted that although exposure to choice may be therapeutic for clients with CPTSD, having choice may be an unfamiliar concept. The initial client experience of choice may be frightening or overwhelming, so the therapist may need to titrate choice exposure as explained here:

...sometimes the word “choice” in and of itself is overwhelming...so sometimes I initially won’t use the word “choice”.... I’ll say, “You get to decide,” or “You’re in charge,” and then I start to weave the word “choice” in, especially with new students (August 28, 2019).

Per Participant 1, choice titration or dosage, i.e., how much choice to offer and how blatantly to describe therapeutic choice, may be a skill that therapists can develop as they work with TCTSY or use TCTSY precepts in other therapies.

Participant 3 described therapeutic choice for a client who had been practicing TCTSY periodically for 2 1/2 years:

...[W]ith this individual the TCTSY approach for therapy has been integral...the non-coercion, and honoring where power comes from, and her choice, and creating opportunity where she can...and acknowledging when she’s making a choice [and that] “no” is a choice... It’s been...significant growth for her (August 30, 2019).

Participant 3 reported this client was able to voice preferences regarding the option to practice TCTSY in session and in sessions that did not include TCTSY. She observed,

I really want to credit TCTSY 100 percent to the possibility of that ever happening in this relationship. Because of... her starting to make choices,
and her having a voice, and she’s been able to directly tell me that she
didn’t like something (August 30, 2019).

The therapist saw this as remarkable progress since the client could cross-contextually
self-identify needs and could discuss preferences with an authority figure in a collabora-
tive way, both potential challenges for individuals who have survived complex trauma
(Herman, 2015).

These choice experiences, though they may need to be contained within therapy
initially for safety reasons, may later expand to making decisions outside of therapy. Par-
ticipant 2 recalled how developing capacity to choose in TCTSY practice had significant
impact on a client’s life choices:

...[T]he insight that came out after three months of weekly TCTSY was,
“Wow I can make choices for myself and they can be good choices. I
don’t always make bad choices.” So actually from there, and this surprised
me, lead to the conclusion, “I should leave my abuser, because that would
be a good choice for me, and I can’t do that wrong”... [The client] credits
TCTSY as the turning point for her because of that focus on choice (Au-
gust 28, 2019).

In this instance, in addition to the therapist’s regard for TCTSY as a treatment
tool, the client reported that the introduction of TCTSY enabled her to move away from
abuse in a concrete manner. The client referenced TCTSY choice experiences to reach
the conclusion that she had the capacity to positively redirect her domestic situation, a
new understanding despite having discussed the possibility of leaving her abuser in nu-
merous prior talk-focused sessions. Participant 2 commented here that choice, specifical-
ly versus interoception, might be a key therapeutic tool in TCTSY for domestic violence/sexual abuse (DVSA) clients (August 28, 2019). And choice overall, as described by interview participants, can be developed as a practice and cultivated as an experience within TCTSY individual or group sessions with beneficial outcomes within and beyond therapy settings.

**Non-attachment.**

As reviewed in Chapter 2, attachment in therapy can refer to essential bonds formed with others, often influenced by early childhood experience (Ainsworth et al, 2015). TCTSY certainly can impact relationship-type attachment (Emerson, 2015; Rhodes et al, 2016), and TCTSY’s positive impact on therapeutic relationship is explored in the below section on shared authentic experience. As another meaning to the term attachment, therapists may explore a practice of non-attachment to outcomes, i.e. the yogic precept of aparigraha (Remski, 2012; Schiffman, 1996). This section will address the aparigraha type of non-attachment and TCTSY’s role in creating a safe, neutral treatment environment for clients that facilitates change and choice (Emerson, 2015; Rhodes, 2014; 2015; West, 2011; West, Liang, & Spinazzola, 2016).

Participants 1, 2, and 3 noted that when therapists approach treatment with as limited an agenda as possible, this neutrality may offer clients greater therapeutic opportunity to exercise agency. They found that TCTSY treatment environments may be viable arenas for both client and therapist to experience the benefits of non-attachment. They observed intersections between the precepts of non-attachment and choice (August 28-30, 2019).
Participant 2 (August 28, 2019) described the possibility of expressing non-attachment to adolescents in a TCTSY group more readily than in individual session where parents were present:

One adolescent in particular changed our relationship because she said, “Look, I have permission to sit there and sulk at you for an hour [in TCTSY group].” And I said, “Yes you do, if that’s what you need to do to feel in control and have choice, I care not if you sulk.” But if she does it in individual session, she’ll get yelled at by her mom. And so yoga has different rules. So I will say that really shifted our rapport and kind of did get her moving a little bit more just to feel like she could dig in and do the work she needed to... I don’t think it feels like real choice when it’s in individual therapy when her mother’s grilling her (August 28, 2019).

Therefore per Participant 2 (August 28, 2019), clients may be less likely to select and thus less likely to experience options (of behavior, technique, language) that engender negative response from an authority. Conversely, options approved by the authority may be selected even though they are not actually preferred by the client, a trend noted in the study of complex trauma (Herman, 2015; Roth et al, 1997). These limiting influences may be somewhat leveled within the relative non-attachment of a TCTSY treatment environment.

Participant 3 similarly noted that some clients, e.g., those managing CPTSD, may be extra-sensitive to authority figures, tracking and accommodating those in power (August 30, 2019). Participant 3 found the non-attachment environment of TCTSY a viable treatment option for such clients, allowing the opportunity to explore internal preferences
and even physical self-ownership via realizations such as, “[w]hose body is this, this is her body. And this is not just her brain, she actually has a body” (August 30, 2019). A survey participant similarly noted that client relationship with the self might shift post-TCTSY, enhancing self-understanding and allowing greater “access to personal history information” (August 3, 2019). For clients with CPTSD, awareness of inner preferences and sensations can be a significant marker of recovery, and being able to express these preferences collaboratively to a perceived authority (or to anyone) can indicate an even greater step (Herman, 2015).

Interview participants found non-attachment may thrive when therapists can avoid not only overt but even subtle steering in sessions, including steering toward any specific treatment. Participant 2 noted clients have opportunity for the above-mentioned “real choice” when the therapist expresses non-attachment by offering a variety of treatment options in session, rather than a more confining yes-no or binary selection (August 28, 2019). Participant 2 posts TCTSY literature in clinic settings so clients can take the lead in requesting TCTSY if they read about it and find it interesting. As a provider who travels between clinics, Participant 2 also carries a suitcase of treatment materials that clients can peruse and select or set aside, including yoga cards but also numerous other modalities (August 28, 2019). Participant 1 similarly offers a treatment “menu” to clients, presenting options and asking, “What would resonate most with you?” (August 28, 2019). Participant 3 begins each individual session by offering “option of breath, movement, relaxation, or mindfulness,” which may serve to level therapist preference for one modality over the other (August 30, 2019). These practical, functional adaptations to implementing
neutral non-attachment via choice show an artful understanding of how to deliver TCTSY’s benefits successfully.

Interestingly, therapist preference for or enthusiasm about a treatment model, including TCTSY, can dilute non-attachment (Emerson, 2015). Participants 2 and 3 (August 28-30, 2019) noted a subtle territory between offering TCTSY in a neutral way and steering to TCTSY in a (unintentionally) coercive way. Participant 3 described the importance of the therapist’s non-attachment being genuine rather than “just pretending” (August 30, 2019). She also discussed the therapist’s responsibility to “repair...an injury in safety and power and choice” if attention to the client’s preferences should slip, explaining how “my non-attachment is helpful...for [re-establishing client] safety” (August 30, 2019). As Participant 2 likewise explained, “I feel like with this [DVSA] population I have to be really careful because I don’t want to push things. Because they had enough coercion in their lives” (August 28, 2019). Participant 1 also noted the importance of continuing warm and open communication with clients who opted out of TCTSY, saying for example, “‘That’s totally ok [to decline TCTSY], is there any other way I could help you?’” (August 28, 2019). Despite the interview participants’ personal belief in the value of TCTSY, they developed a skill to walk the line between offering and pressuring, and attempted to maintain as much non-attachment as possible regarding clients’ preferred direction of therapeutic exploration (August 28-30, 2019).

Two survey participants noted that TCTSY helped develop a lower reactivity in clients that could be associated with the clients themselves developing internal non-attachment. Per one survey participant, TCTSY may help clients “notice more of their internal world without necessarily reacting to it right away” (August 16, 2019). Per an-
other survey participant, TCTSY practice may help clients with “noticing more sensations, emotions, etc., [and being] able to tolerate those feelings/sensations better” (August 2, 2019). Non-attachment in the therapeutic environment may help clients also to develop this precept as a tool.

**Shared authentic experience.**

Second to choice and slightly above non-attachment, the TCTSY precept of shared authentic experience was frequently mentioned by Participants 1, 2, and 3 (August 28-30, 2019). Shared authentic experience in the practice of TCTSY indicates that the facilitator is practicing with the client, while the facilitator is tracking as well as cueing interoception (Emerson, 2015; West, 2011; West, Liang, & Spinazzola, 2016). Interview participants reported their own sensations and realizations related to shared authentic experience, a self-observation fitting how this precept was clinically intended (Emerson, 2015): in practicing shared authentic experience, the TCTSY facilitator (who may be a therapist) is consciously noticing where sensation is or is not felt. It is important to distinguish, however, the “felt-sensing” (Participant 3 [August 30, 2019]) of shared authentic experience from the phenomenon of countertransference, the projected “irrational, often shameful, feelings a therapist experiences toward a patient that constitute a formidable obstacle in therapy” (Yalom, 2012, p. 284). Participants 1, 2, and 3, in contrast, reported that practicing shared authentic experience increased their ability to own their experience and thus to be more available, neutral, and present for their clients (August 28-30, 2019).

Interview participants described how shared authentic experience changed therapy sessions for both the client and the therapist, and described shared authentic experience as
clinically beneficial yet occasionally perplexing. Per Participant 2: “one of the things I most love about [TCTSY] and what can sometimes be a challenge is that shared authentic experience” (August 28, 2019). Interview participants described the greatest potential difficulty of shared authentic experience (which they also referred to as felt-sensing or embodiment [August 28-30, 2019]) as vulnerability for providers. Vulnerability as a topic will be expanded upon below.

Interview participants mentioned that providers with prior somatic education might accept TCTSY more readily than those unfamiliar with somatic therapy (August 28-30, 2019). Feeling one’s own sensations as a provider (via shared authentic experience) was noted as a significant potential hurdle for providers new to somatic treatments. Per Participant 2:

[C]ulturally, we’re conditioned that we don’t have to feel our bodies. And [as] professionals...we feel we have that luxury when we’re with a patient that it’s not about us, and if it is about us, we need to contain it... [o]r at least that was my training...”recognize your own stuff but then unless it’s a rare case where you could use it beneficially for the client, then you need to contain it. And deal with it later” (August 28, 2019).

Shared authentic experience might therefore introduce two simultaneous conflicts for the new TCTSY provider: the first, lack of experience with bodily sensation, and the second, an unwillingness to experience said sensation within session. Being challenged by sensation is a poignant parallel, since inhabiting the body can be such a significant hurdle for clients recovering from complex trauma (Emerson & Kelly, 2016; Herman, 2015; van der Kolk, 2014).
Interview participants noted that facilitators trained in other (non-psychotherapy) modalities, such as yoga teachers, may have a more natural understanding of shared authentic experience. Participant 2 described the training of the domestic violence advocates in her workplace, for example:

[TCTSY] principles are things they learned in advocacy training.... While I think with therapists sometimes I feel like we have more barriers to making this seem obvious. Or to making [TCTSY] seem, making it feel natural. Three years in and it still doesn’t always feel natural to me, as much as I do it. So I think it’s been interesting talking with folks in other professions and how for them [TCTSY] makes complete sense. This is what they’re already doing, I just happen to be doing movement with it (August 28, 2019).

The conceptual framework of prior professional training may influence level of resonance with shared authentic experience.

When therapists can tolerate shared authentic experience, interview participants noted a potential positive deepening in the therapeutic alliance during sessions. As mentioned earlier, all three interview participants described this as TCTSY shifting the therapist-client relationship: Participant 2 explained, “to have an authentic experience with an authority figure, to be in a relationship with me in a different way… I’ve actually seen that shift relationship” in therapy (August 28, 2019). Participant 3 noted that shared authentic experience “has shifted how relationship happens in therapy and in where power comes from in the relationship” (August 30, 2019).
Two survey participants also commented on improvement in therapeutic relationship with the introduction of TCTSY’s shared authentic experience. Per one survey participant, “the shift in relationship includes increased trust and comfort, ability to tolerate deeper exploration of thoughts and feelings” (August 1, 2019). Another survey participant described how the change in experience with the introduction of TCTSY increased clients’ comfort with the therapist: “just getting on the yoga mat and moving helps clients to open up and share” (August 1, 2019).

Interview participants 1, 2, and 3 remarked that clients found resonance and an opportunity for growth in shared authentic experience (August 28-30, 2019). As Participant 1 explained, “it definitely resonates with them...they definitely understand it. Because a lot of them will say, ‘Well I’ve had therapy for so long, and it’s mostly been talk therapy, and it hasn’t worked...[so TCTSY] makes sense to me then’” (August 28, 2019). Clients may be primed to experience the shared authentic experience of TCTSY if they have been “stuck in the processing and thinking and also feeling like they’re not making a lot of movement in therapy...[these] are the moments where, if it feels safe, starting to bring in embodiment ... may [bring] some depth to the work” (Participant 3 [August 30, 2019]). Participant 3 commented that such clients have often “understood the resource [of TCTSY], how exploring embodiment practices would be or could be a resource” (August 30, 2019). She also commented that TCTSY may help therapeutic growth to unfold more like a “discussion” between therapist and client, and less like a conventional model of the therapist giving “assignments” or homework (August 30, 2019), another enhancement and shift in relationship roles.
Given all its benefits for clients with CPTSD, shared authentic experience may be grounds for healing but may provoke fear for clients as well as therapists. Per Participant 1, a step-wise exposure might be helpful if fear is a barrier: “if someone is terrified of being in their body... if the word ‘body’ is upsetting to them, then maybe we do some other stabilization skills first” (August 28, 2019). When introducing shared authentic experience in the presence of fear and triggers, interview participants referred once again to the importance of giving choices to the client (August 28-30, 2019).

Shared authentic relationship may also lead to a subtle exploration of boundaries. Participant 2 explained how negotiating boundaries may require of the therapist both conceptual flexibility and time. She explained that in some psychotherapy education models, therapists are taught that:

[I]t is not ok to be in a shared authentic relationship because [clients] won’t respect you. Or it’s gonna blur boundaries, and especially with DVSA clients you do not need that boundary blur. And while I see that...I’m comfortable jumping between both [models] and having those conversations about boundaries. And I realize not everyone is or not every- one has the luxury of time to do it (August 28, 2019).

Also with regard to boundaries, Participant 3 recalled using the “felt-sensing” space of shared authentic experience to navigate sessions with a client who had given a “verbal ‘yes’” to practicing TCTSY, but seemed to be experiencing a “physiological ‘no’” (August 30, 2019). Participant 3 explained how shared authentic experience enhanced “a space between” therapist and client so that they could “co-wonder” about next steps (August 30, 2019), stabilizing the relationship so that power could be shared with-
out coercion. Since trauma survivors may have learned to override their own needs (Emerson, 2015; Herman, 2015), helping clients to understand their bodies’ “no” responses may be a useful therapeutic skill in CPTSD recovery. As a further complication, trauma survivors may genuinely want to move forward but may be experiencing a “physiological ‘no’” due to engrained trigger response (Participant 3 [August 30, 2019]; Porges, 2013; 2016). Two survey respondents similarly reported that TCTSY practice allowed exploration of “what the body might be saying” (August 1, 2019) with safety for the client’s “inner curiosity” (August 16, 2019) to be expressed. Shared authentic experience may provide an area to explore these complex concerns while reducing frustration and enhancing a collaborative approach.

**Change of approach.**

Although they were queried about TCTSY’s influence on their clients and did share perceptions on client change, interview participants also chose to comment extensively on TCTSY’s influence on themselves. When assessing change in utilization of therapy after the introduction of TCTSY, interview participants noted repeatedly that providers and clients were both likely to be affected. Prior research has explored TCTSY’s effect on facilitators directly (Bodine, 2017). The interview participants here independently (and extensively) volunteered information on how TCTSY affected themselves. Interview participants noted that learning TCTSY evolved how they practice psychotherapy (Participants 1, 2, 3 [August 28-30, 2019]). Participants noted that their approach to treatment is influenced by TCTSY even when not facilitating TCTSY with clients, i.e., Participant 2 who described introducing invitational language into EMDR sessions (August 28, 2019).
Participant 2 further elaborated, “[TCTSY] is the most beneficial training I’ve done because it has pervaded everything else,” and noted “following [TCTSY] principles with or without movement” in sessions (August 28, 2019). Similarly, per Participant 3, “the teachings of TCTSY have changed how I practice therapy wholly” (August 30, 2019). As a related response, one survey participant commented that “I use invitational language and choice making with all my clients—TCTSY has changed the way I talk to clients and has a very positive impact on my therapy practice” (August 1, 2019). Participant 1 (August 28, 2019) noted that TCTSY informs work in other modalities and is a primary tool to help clients who reach a stuck point in IFS or EMDR treatment, an interesting integration since TCTSY was designed as an adjunctive therapy (Spinazzola et al., 2011; van der Kolk et al., 2014).

As an additional change in utilization, interview participants reported setting aside practices from their original psychotherapy training that they experienced as coercive to clients, and making these changes because of what they experienced with TCTSY (Participants 2, 3 [August 28-30, 2019]). Participant 3 noted, “I feel like now with TCTSY I am able to not recreate patterns of harm in the therapeutic relationship that I was [originally] taught to do as best practice” (August 30, 2019” She further described how TCTSY changed both how she practices and how she views her practice due to “an understanding [in TCTSY] of that trapping and recreating patterns of harm that I didn’t see before” (August 30, 2019). Participant 2 (August 28, 2019) noted that particularly with clients being treated for domestic violence/sexual abuse (DVSA), moving away from practices that mimicked coercion could help recovery. This bears strong similarity to
Herman’s (2015) thesis on the importance of client control in CPTSD treatment, which strongly influenced the development of TCTSY as a modality (Emerson, 2015).

According to two survey participants, the change in approach for therapists after the introduction of TCTSY lead to a change in issues discussed in therapy. Per one survey participant, “we discussed somatic symptoms more and discussed what the body might be saying” (August 1, 2019). Per another survey participant, after the introduction of TCTSY, “clients [as well as therapists] learn a new language and start to connect with their emotions and their bodies” leading to “more addressing of symptoms and more tangible ways to approach treatment and coping” (July 22, 2019). Thus potentially, a new approach for therapists affects the content of therapy, and cascades to different treatment outcomes and learned tools for clients.

**Provider education.**

Participants 1 and 2 noted taking on an ambassador or educator role regarding TCTSY in their professional communities (August 28, 2019). Here, they illuminated again how TCTSY changed therapeutic experience for themselves as well as for their clients, a topic previous research has also explored (Bodine, 2017). In the process of provider outreach, Participants 1 and 2 noted that therapists experienced with somatic treatment modalities understood TCTSY more readily than therapists unfamiliar with somatic treatments, and suggested somatic-experienced therapists might have more acceptance of and interest in TCTSY. Participants 1 and 2 also mentioned that TCTSY’s base of evidence-based research helped establish its validity with therapists new to it. Participant 2 made a “one-page handout” condensing the research on TCTSY (e.g., Rhodes 2014, 2015; Rhodes et al., 2016; Spinazzola et al., 2011; West, 2011; West, Liang, & Spinazzo-
la, 2016) to present to providers, and reported the handout was a useful didactic tool especially for providers within the community’s “major medical system” (August 28, 2019).

Participant 1 described a sample conversation with therapists less open to trying TCTSY, in which she also referred to sources noted in Chapter 2 for support:

I would say with people who tend to be more talk therapists [only], they tend to be more skeptical [about TCTSY]. Maybe not as open to needing anything more than talking. With them, I don’t want to step on any toes or make it sound like I know more than them, because I don’t, we just have different areas... that we’re skilled in. So I tend of kind of plant seeds, “Oh, have you ever read The Body Keeps the Score [van der Kolk, 2014], have you ever read Pat Ogden’s [2006] book about the body and trauma, have you read Peter Levine [2010],” and I just start conversations (August 28, 2019).

Participant 3 recalled similarly subtle provider-to-provider conversations about TCTSY, remembering “encouraging [other providers] to participate, to get some training in TCTSY and start practicing it...to build up some sense of comfort in doing this themselves” (August 30, 2019). Participant 1 also described the importance of suggesting rather than forcibly educating when broaching the topic of TCTSY. She discussed how describing TCTSY as an adjunctive treatment rather than a replacement treatment may help therapists gain comfort and feel less threatened by the new modality (August 28, 2019). Her description of TCTSY fits how the modality was developed and intended (Emerson, 2015).
Participant 2, positioned within a clinical training system, is able to provide not only provider education but also provider experience: “we’re a teaching institution so we’re encouraged to have...graduate students or PA students...sit in with our patients” (August 28, 2019). Participant 2 navigates this opportunity skillfully by inviting trainee providers to participate in TCTSY group class. Clients already enrolled in the class are informed that new students will be attending, and then trainees may then simply experience TCTSY as part of the group without existing clients feeling scrutinized. The graduate students may subsequently process their TCTSY experience with the TCTSY facilitator or with their clinical supervisors. Participant 2 also noted that even offering “five minute demos” of TCTSY can be enough to garner “buy in” from colleagues (August 28, 2019). Since somatic work for trauma is more experiential than cognitive (Levine, 2010; Ogden, Minton, & Payne, 2006), these trial sessions may prove especially effective as promotions and learning experiences.

Interview participants reported attempting to engage other providers in TCTSY education because of their clients’ positive improvement with TCTSY and their own belief in its efficacy as a treatment method (August 28-30, 2019). Survey participants mentioned similarly transformative experiences with TCTSY, including witnessing clients who “credited TCTSY” (August 1, 2019) with their greatest improvements in therapy. As another survey participant described, “TCTSY literally was the turning point in therapy and has made an incredible difference” (August 3, 2019). After seeing these groundbreaking shifts, participants’ high regard for TCTSY and desire to share it with other providers can be both contextualized and understood.
When analyzing the importance of provider training in furthering TCTSY, continuing education for existing TCTSY providers may also impact the discipline. Participant 1 noted that “being really active in the TCTSY community and problem-solving together” (August 28, 2019) in peer education groups enhances her skills as a TCTSY provider. Peer support groups may also help the larger TCTSY discipline evolve by discussing new practice approaches and studying off-label practice adaptations. Even within the limited context of these interviews, noteworthy TCTSY adaptations and sub-populations were mentioned, such as Participant 2’s work with bariatric surgery populations, lower cognitive function populations, and adolescent-adult mixed groups (August 28, 2019), and Participant 3’s work with body image groups and obsessive-compulsive disorder (OCD) populations (August 30, 2019).

**Client access: Barriers and solutions.**

When asked to comment on barriers that could prevent clients from participating in TCTSY and accessing its potential therapeutic change, interview participants discussed challenges related to culture, finances, and symptoms. As noted in chapter 2, symptoms of CPTSD can include fearful avoidance (Cloitre, 2016) to the extent that models of trauma treatment may include specialized outreach for clients who are phobic of people or afraid to leave their homes (Wiggall & Boccellari, 2017). Participant 1 (August 28, 2019) described a potentially related phenomenon: after expressing enthusiasm for joining a TCTSY group during an initial telephone screening, clients may fail to attend their first scheduled session. “Just showing up for class can be really scary...[and] getting from the phone call to class was really hard” (August 28, 2019) for some individuals with CPTSD. Participant 2 likewise noted the importance of considering client tolerance re-
Regarding “can you be in a room with other people” (August 28, 2019) at all, and especially if those other people also have a history of complex trauma.

Participants 1 and 2 noted these issues could be addressed by refining the screening process for TCTSY groups. They suggested adjustments such as offering access to the therapist between screening and first class; offering TCTSY individually before or in lieu of group work; or careful curating of TCTSY group members (sorting groups by types of trauma/disorder, gender, or other relevant concerns) (August 28, 2019). Interview Participant 2, for example, detailed using TCTSY for a mixed group that included:

..a mix of bariatric patients pre-surgery and folks whose coping strategy was starving themselves. And that was a place when I really wished I had two separate sections, because it was hard for those folks to be in a room with each other and not get into some scary cognitive stuff (August 28, 2019).

Thus if blending clients into the same group creates unnecessary and unproductive triggers, differentiated groups might be recommended.

Interview participants also noted clients’ cultural beliefs regarding or experiences with yoga could affect access to TCTSY (Participants 1, 2, 3 [August 28-30, 2019]). Interview participants noted that regional factors may play a role in clients’ comfort with the concept of yoga. For example, Participant 2 noted perceptual limitations regarding yoga in her “Midwest” and “rural” community of practice (August 28, 2019). “They hear the word ‘yoga’ [and] sometimes they freak out about that,” explained Participant 1 (August 28, 2019). Participant 2 explained a possible solution: “...if a client has a problem with the word ‘yoga’, I say we can certainly call it something else” (August 28, 2019).
Given that yoga communities may be a locus of traumatic events (as discussed in Chapter 2 [Deslippe, 2012; Remski, 2018]), Participant 2 also added, “...if I know they have a history of trauma with yoga, I offer, ‘Would you like to try some mindful movement?’” (August 28, 2019). Semantic changes, as suggested by the interview participants, may be helpful when exploring a new and potentially triggering topic with a client. Interview participants used both cultural and clinical competence to select practice terms in the introduction of TCTSY.

Even when clients accept the terminology of yoga, interview participants remarked that clients may be unsure of the validity of a somatic practice. Per Participant 1, “sometimes they have this feeling that it’s not the real work” (August 28, 2019) of therapy and may be concerned that a somatic practice will detract from limited time with the therapist. Participant 1 remarked that this can be addressed by familiarizing clients with the benefits of TCTSY, as referenced earlier:

I talk a lot with clients about how trauma is often stuck in the body and that even if cognitively we can understand that that was then and this is now... a lot of times our body or other parts of ourselves are not completely time-oriented to the present... and that by doing a body-based intervention we can help people be able to live more in the present (August 28, 2019).

Per Participant 1, for clients uncertain about the benefit of a somatic practice, the solution may be discussion and education.

For other clients, somatic therapy in general may trigger additional symptoms and defenses. Participants 2 and 3 (August 28-30, 2019) explained that clients whose coping
skills include dissociation may find somatic practices not only conceptually foreign but also experientially overwhelming, at least initially. TCTSY, however, was generally associated with clients’ symptoms improving, per four survey participants. One survey participant noted “decrease in dissociative symptoms” for clients, and increased “ability to breathe and self-regulate” post-TCTSY (August 1, 2019). Similarly, another survey participant scaled clients pre- and post-TCTSY and reported improved scores on the Multidimensional Assessment of Interoceptive Awareness (MAIA), Patient Health Questionnaire (PHQ) (a depression scale), and Generalized Anxiety Disorder (GAD) assessments (August 1, 2019). Other survey participants described how TCTSY enhanced “…body awareness...self-compassion...awareness of their nervous system and patterns of regulation” (August 16, 2019), and facilitated “connection to body offering greater grounding” (August 3, 2019).

Interview Participant 1 also noted that TCTSY can be a tolerable initial somatic practice since it is “gentler, if they’re willing to try it” than some somatic modalities (August 28, 2019). Participant 2 observed that TCTSY lends itself readily to titration so can become “a beautiful bridge” to other sensorimotor therapies (August 28, 2019). Participant 3 (August 30, 2019) again referred to the importance of choice, describing how she offers clients TCTSY at the beginning of each session so that they may opt to practice only when ready.

Participants 1, 2, and 3 noted the above strategies of education, choice, titration, screening, and language when helping their existing or engaged clients access TCTSY (August 28-30, 201). When treating trauma, separate strategies may be required to reach populations who could benefit from treatment but are not yet engaged with providers.
For clients not yet engaged, therapists may improve access through partnership with established community organizations. Participant 2 described how local YMCA/YWCA chapters became a primary referral source:

[T]he Y as a whole is looking at what are barriers to fitness for folks, and they’re starting to get cognizant that trauma can make a lot of being in a gym really hard.... So nationally they’re looking for other ways they can be more relevant in their communities. So they have been some of my biggest supporters…(August 28, 2019).

Community organizations working to help clients overcome barriers in other areas such as fitness may already have an understanding of the limitations of trauma, and may even have existing outreach models that therapists can leverage via partnership.

Community organizations can also ease TCTSY access challenges related to cost, which can be a substantial barrier for clients. Participant 1 (August 28, 2019) further noted that when TCTSY services can be billed to insurance, clients with coverage may more easily avail themselves of TCTSY. Insurance claims are not a universal solution, however, since not all clients have insurance coverage or may have high deductibles and copays that inhibit access to covered services (Participant 1 [August 28, 2019]).

Vulnerability.

Although the treatment of complex trauma certainly can be vulnerable for clients, interview participants noted that TCTSY can also be a vulnerable experience for providers. They reported that this provider vulnerability could present a barrier to using TCTSY as a therapeutic tool (Participants 1, 2, 3 [August 28-30, 2019]), and could stem from several sources. First, when introducing TCTSY, providers might experience discomfort
about unknown treatment outcomes. Participant 3 noted “fear” that clinical professionals might have around offering a modality like TCTSY, wondering “is it going to be too much. Whatever that too much is” (August 30, 2019). Participant 2 (August 28, 2019) noted similarly that providers might be concerned about TCTSY opening up unknown issues for clients.

This is not an entirely unfounded concern, since per one survey participant, clients may “have a panic or dissociative episode” (July 22, 2019) during TCTSY practice. Yet the TCTSY context even during escalation resulted in a positive “addressing of symptoms and more tangible ways to approach treatment and coping” (July 22, 2019), and per another survey respondent in “making treatment more targeted, meaningful, and understandable for the client” (August 3, 2019).

Participant 2 also noted that clients may have flashbacks during TCTSY practice or could be triggered by the presence of other group members. Some triggers could be reduced by screening and group selection. As mentioned for example, Participant 2’s post-bariatric clients and anorexic clients did not fare well in the same group, although both populations benefited from TCTSY (August 28, 2019). Participant 2 also reported that TCTSY or talk therapy could be used to process flashbacks that may have occurred in TCTSY practice, and added that some clients simply wished to mention when these experiences happened during practice without requesting further processing (August 28, 2019). Conversely, TCTSY could be added to a talk session, with a client’s permission, to help process a trigger encountered in talk therapy (Participant 3 [August 30, 2019]). Such strategies could be shared with providers concerned with vulnerability regarding client experiences in TCTSY practice.
Another vulnerability might stem from providers questioning how to validate TCTSY. Participant 2 commented on the vulnerability of providers using TCTSY because “it is just not measurable” in the way Cognitive Behavioral Therapy (CBT) may be:

I come from a CBT-based organization. So [TCTSY] just doesn’t sit with the general culture. I think there’s been some concerns from other providers about liability or risk or just insurance of, how will I contain any problems [clients] might have if anything comes up. Or what problems are [providers] going to get because of what [TCTSY] is going to bring up, or are they ready as clinicians to hold whatever might come up as a result of [TCTSY] (August 28, 2019).

For this vulnerability of the unknown, providers may need additional resources to manage both measuring and understanding the outcomes of TCTSY. Research showing yoga’s measurable outcomes may be helpful to introduce at this point, as well as a discussion of the decades of evidence-based research on yoga (Nespor, 1985; Raub, 2002; Saper et al., 2017; Spinazzola et al., 2011). As one survey participant mentioned, the MAIA, GAD, and PHQ scales are readily available to therapists and may help validate TCTSY’s efficacy and results on a case-by-case basis (August 1, 2019). As described above, provider support groups for TCTSY may also be of service for sharing best practices among clinicians.

All three interview participants (August 28-30, 2019) noted that within TCTSY, shared authentic experience can be especially vulnerable for providers because it may be directly contrary to how they were trained. Participant 2 noted therapists may be “afraid” of TCTSY and experience “fear” particularly when it comes to practicing being embod-
ied themselves: “I think folks are fearful because [TCTSY is] so not CBT... it makes us vulnerable as providers in some ways because we have to be willing to be there in it with [the clients]” (August 28, 2019). And co-experiencing with clients, again, may be unfamiliar territory. Participant 2 further explained that

[S]ome other therapy modalities allow us to keep that outside, or that barrier, that distance... [S]ome of my psychologist colleagues... how they were taught is, “you need to keep that distance and it’s not ok to get closer or to be on an equal footing with [clients] at any point.”...I wonder too if discipline of therapy...makes a difference, or their training, or their interests, and just comfort level with vulnerability and that authenticity (August 28, 2019),

which is central to TCTSY’s shared authentic relationship. This co-experiencing presents a fundamental change in utilization of therapy for both client and therapist, and may require ongoing adjustment in understanding and practice from the therapist as well as from the client.

Participant 3 reported that the vulnerability of TCTSY practice may allow—and perhaps require—relational risks on behalf of the client and therapist that potentially deepen therapeutic alliance (August 30, 2019). Participant 2 reminded that the experiences of TCTSY can also be a marked shift and challenging expansion both for client and therapist: “I think the first time we experience embodiment...to ask someone to be vulnerable and to have that shared authentic experience at the same time, when both of those are big asks...is intimidating” (August 28, 2019). Participant 2 noted that titration of the TCTSY experience may be as important to the therapist as it is to the client especially
initially, and also referenced the importance of peer support to process new ideas and sensations (August 28, 2019).

**Summary**

The research question for this study was: how do psychotherapists perceive that utilization of talk therapy changes when TCTSY is introduced into CPTSD treatment? Data yielded from the study addressed the question and expanded to several domains beyond the question. Although this study was initially focused on assessing changes in client use of therapy, data revealed changes for both client and therapist after the introduction of TCTSY. Overall themes of the research data encompassed choice, non-attachment, shared authentic experience, positive change and improvement for clients, change in approach for therapists, provider education, client access, and vulnerability.

Survey and interview participants reported that TCTSY correlated with improvement in their clients’ symptoms, capacity to explore different concerns, and capacity to explore concerns differently. Participants associated the introduction of TCTSY with beneficial change in client-therapist relationship. Survey and interview data showed that TCTSY is being used with its target population of CPTSD clients and that TCTSY has relevance with multiple other populations.

Survey data indicated that clients’ experience with TCTSY largely did not affect quantity of mental health services accessed: TCTSY did not significantly change how often clients attended psychotherapy nor did it affect the frequency of their inpatient stays. The introduction of TCTSY was also not correlated with decompensation in client affect nor with a worsening of symptoms.
Interview and survey data revealed therapists’ perception of the importance of choice, therapeutic alliance via shared authentic experience, non-coercion, and non-attachment in the treatment of CPTSD. Interview and survey participants shared their assessment of how TCTSY positively impacts and develops these domains. Participants shared how TCTSY may have a broad impact on therapist practice, influencing how therapists talk to clients, work with clients, and conceive of their role in therapy. Participant responses also underscored challenges therapists and clients may have with TCTSY. In assessing data themes, opportunities to expand TCTSY provider education and provider support were revealed.

Participants’ overall responses encouraged reflection not only on the application of TCTSY in trauma therapy but also on the relationships that contain the therapy. Participants explained how a situational change (e.g., the introduction of TCTSY into therapy) will affect everyone in the situation (e.g., both clients and therapists) (Ogden, 1994). The next chapter explores conclusions pertaining to the research that address and expand beyond the original research question. Options for future studies and instrument refinement, limitations, and bias are also detailed in Chapter 5.
CHAPTER FIVE

Conclusion

Utility of Study

This study presented survey and interview instruments that may be replicated, edited, and expanded (McMillan & Schumacher, 2010), to address the research question: how do psychotherapists perceive that utilization of talk therapy changes when TCTSY is introduced into CPTSD treatment? The study participants were psychotherapists trained in Trauma Center Trauma-Sensitive Yoga (TCTSY), who have introduced TCTSY to their clients. The data revealed trends related to symptom improvement following the introduction of TCTSY and positive change in therapeutic relationship and treatment outcomes during and after experience with TCTSY, with additional themes of choice, non-attachment, change in approach, client access, provider education, and vulnerability. These trends and themes could be studied on a larger scale for verification and further exploration.

Participants’ responses to the survey and interview in this research may help prescribe TCTSY more accurately to clients with Complex Post-Traumatic Stress Disorder (CPTSD) and with other diagnoses. This study may enhance understanding of practical in-session use of TCTSY that may help introduce TCTSY more precisely into treatment. Adaptations of practice and professional challenges reported here may further TCTSY training development. In the sections below, researcher bias, research limitations, and suggestions for future research will be described, with conclusions and insights of research appearing throughout the chapter and in the chapter summary.

Considerations of Bias
I am certified in TCTSY, as are 94 percent of the survey participants and 100 percent of the interview participants. One of the research reviewers is a TCTSY lead trainer. There is no significant conflict of financial interest regarding the author or dissertation advisor and the subject matter studied.

All interview participants discussed managing their bias toward (or against) treatment methods including TCTSY (August 28-30, 2019), such as Participant 2’s comment that “I really don’t drink the Kool-Aid on models often but [TCTSY] really has something, I really believe in that” (August 28, 2019). Participants reflected also on other implicit bias such as Participant 1’s view of male clients’ comfort with yoga (August 28, 2019). Any of our preferences, opinions, or other biases may have impacted the study’s results.

I feel fortunate to have received and reviewed the feedback, reflections, and insights of the expert clinicians in this study. The richness of their understandings shared here owes no small part to their professional experience with TCTSY and their expertise as somatic therapists. Yet although research neutrality was maintained to the fullest extent possible, bias in favor of the studied treatment modality should be considered when reviewing this study, given participants’ and researchers’ familiarity with and regard for the modality studied (Skelly, 2011).

In addition to the above presuppositions and the biases explained in Chapter 3, I discovered I held additional assumptions regarding this study. Many of these presumptions were revealed as research progressed. Perhaps most significantly, I thought the survey and interview data would be more closely tied to the research question, and to each other, than the results showed.
The research instruments, although piloted extensively on individuals inside and outside the TCTSY community, were shown to be imperfect in unanticipated ways after data review: this is a critical finding in and of itself (and is discussed further below).

Most demographic questions netted clear data, for example, but some did not and could be revised (see below section on question revision). As explained in Chapters 3 and 4, many responses were given in this study that shed light on the research question, triangulation between survey and interview data was established, and valuable responses also were shared that expanded beyond the research question. I assumed that there would be even more connections between the survey data and the interview data, however, and between both sets of data and the research question.

Looking back, I realize that the instruments reviewers were checking that the questions could net usable data (in terms of qualitative content, accurate demographic numbers, or both), which overall the reviewers accomplished very successfully. I did not ask them, however, to consider interrelationship of survey and interview questions when making instrument revision suggestions. And although I explained the purpose of the study to the reviewers, I did not ask specifically for reviewers to look at connection of research question to instrument questions. Sometimes when managing the intricacies of research, it is difficult always to keep in mind the big picture. I would suggest if these instruments are used again, future researchers decide how closely they want to keep explorations to the exact research question presented here, and make modifications accordingly.

I also discovered some finer-point presumptions after reviewing data. For example, I had assumed TCTSY would have a larger impact than it did on the practical func-
tioning of therapy (e.g., how many sessions were attended, number of inpatient admissions, client timeliness). Actually, the practical functioning of therapy after the introduction of TCTSY was minimally or not at all affected, as reported in this study. And although I knew about the importance of the therapeutic alliance (Herman, 2015), I assumed that most of the changes that therapists reported would be about their clients. As discussed in Chapter 4, therapists reported that both sides of the relationship were affected, including changes to themselves and their practice. As a non-therapist, my limited understanding of the two-way functioning of the therapeutic alliance (Ogden, 1994; Yalom, 2012) may have driven these assumptions.

Not being a therapist myself may have resulted in other suppositions. For example, I was surprised (and impressed) that Eye Movement Desensitization and Reprocessing (EMDR) was used more than Cognitive Behavioral Therapy (CBT) as a general treatment modality as reported by participants, 56 percent to 50 percent respectively. I also did not expect neurofeedback’s relatively low use, a reported rate of only 6 percent. A practicing therapist, especially one who regularly attends therapist trauma conferences (versus those I attend for yoga teachers, yoga researchers, and/or trauma generalists), might have entered into this research with a clearer understanding of current CPTSD treatment modality predominance (APA, 2019).

Furthermore, I did not anticipate that the embodiment of TCTSY’s shared authentic experience would be as challenging for therapists as the interview participants reported it can be (August 28-30, 2019). As a yoga teacher, I found co-experiencing sensation in the TCTSY context similar to previous embodied practices I had studied and taught, such as Sat Nam Rasayan (Dev Singh & Espinosa, 2005). Foundational somatic experi-
ences rehearsed over decades made TCTSY’s shared authentic experience more readily adoptable and natural for me, similar to the experience of advocacy training referenced by Participant 2 (August 28, 2019). As all interview participants noted (August 28-30, 2019), prior experience with somatic modalities may indicate that a facilitator has an easier time adopting TCTSY.

The participants’ challenges with somatic embodiment and shared authentic experience caused me to reflect on my history with somatic practices. I have been practicing yoga for nearly two-thirds of my life, so yoga has an ingrained naturalness for me now. But that ease was earned, not inherent. When I first came to yoga class, I thought more than felt, and I felt emotions more than sensations. Co-experiencing physical sensations in a room with other yoga students was awkward and uncomfortable, and it took years for this discomfort to dissipate. I felt similarly out of place in my own body ten years later when I first studied somatic awareness (via Sat Nam Rasayan [Dev Singh & Espinosa, 2005]). Over hours, days, and years of practice, shared embodied experience gradually became a normal way of being with myself and others. Remembering my own long, slow somatic acclimation gave me a more empathetic understanding of dosing and titrating shared authentic experience for new students and new providers.

The participants’ generous sharing of their own vulnerability around shared authentic experience also caused me to reflect on my biases around the TCTSY co-provider relationship of yoga facilitator and therapist. I realized I held assumptions about how the two providers related. My first assumption, as previously mentioned, was simply that the implementation of TCTSY would involve two providers. This study showed, at least with this population, the prevalent likelihood that one provider would act both as yoga facilita-
tor and talk therapist, both for full-length classes and moments of TCTSY inserted into session\textsuperscript{17}. Benefits and limitations of one person assuming both TCTSY provider roles would be material for another study.

What I discovered in this research, however, was an assumptive bias about provider-to-provider influence. For the ten years I have worked in case management, I have been profoundly and positively affected by my therapist colleagues. Incorporating tools learned from therapists into my work (though I could not take the place of a therapist) has helped me connect with clients more respectfully, listen more authentically, and be of greater service. Even exposure to something as simple as the therapeutic open-ended questions of Motivational Interviewing (Miller & Rollnick, 2002) improved how I communicate in many arenas\textsuperscript{18}. Before beginning this research, I was eagerly anticipating learning even more from the therapist perspective, and the participants in this study met and exceeded that hope with the innovations and insights they shared. I did not realize, however, how much and how positively somatic awareness from my field could influence how therapists practice therapy. Future TCTSY trainings and peer support might explore maximizing the benefits of this provider-to-provider influence.

Finally, I anticipated that the data of this study would provide a clearer view of TCTSY’s effects on CPTSD. My assumption here may be due to my lack of familiarity

\textsuperscript{17} Most experience mentioned by Interview Participants 1, 2, and 3 described the participant as both the yoga facilitator and the therapist. This trend was also supported by the survey in which fifteen out of sixteen participants were therapists and TCTSY facilitators. Participants 1 and 2, however, referred to having some clients in TCTSY group class who were treated by referring therapists. In those instances, the participants would have served as yoga facilitators only.

\textsuperscript{18} I was originally taught as a yoga teacher to “poke, provoke, confront, and elevate your students to excellence” (Bhajan, 1995, p.1). The receptive, open-ended communication of Motivational Interviewing (Miller & Rollnick, 2002) and the non-coercive interactions of TCTSY (Emerson, 2015) provided practical and philosophical counterpoints. Similar to the participants in this study, I found TCTSY’s approach a significant departure from how I was taught to teach, and one that realigned my perception of student-teacher interactions.
with provider diagnostic and billing codes: I know generally which disorders are currently billable, but I do not diagnose nor assign diagnostic codes in my work. The data here reflects TCTSY’s impact on CPTSD but does not provide a clear view of a CPTSD population in isolation. This is possibly influenced by CPTSD’s position as a nascent billable diagnosis code, particularly in the United States. Diagnosis coding as a limitation for this study is expanded upon below.

Limitations of Research

**Population size: Factors influencing participation.**

As discussed in Chapters 3 and 4, although the findings of this study may show transferability, the number of respondents for this study may be too small to establish data saturation (Page, 2014; Skelly, 2011). Numerous factors may have limited potential participants’ willingness or capacity to engage. Data was collected in the summer, which may have been a higher likelihood for vacation time in some areas or for individuals connected to a United States school schedule. The TCTSY app, one of the solicitation loci, is (currently) not highly used, as of 2019 showing one or fewer posts per month. No incentives were offered for participation. Some potential participants may have gone through TCTSY training with me, which could have positively or adversely affected participation depending on individual opinion. Participants’ confidence in the confidentiality of data they shared could have affected participation, especially with regard to an interview in which opinions were shared in depth. The time required to schedule and complete an in-

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19 I was also surprised, given the international base of facilitators for TCTSY (TSY, 2019), that most of this study’s participants were from the United States: a stronger familiarity with the TCTSY facilitator database may have leveled this assumption.
terview could have been a limiting factor for some participants, and may help explain why more participants responded to the survey than the interview.

**Cross-tabulation and interrelationship.**

With a larger pool of participants than was studied here, cross-tabulation of results might yield interrelationships within the data not discoverable here due to limited participants. This might be accomplished with the original questions or by adding questions. Length of practicing therapy or prior work with somatic therapies, for example, could be correlated with perceived success rates in using TCTSY. Frequency of modality use (such as CBT, EMDR, etc.) could be correlated with perceived success rates of TCTSY.

Participants were asked in this study which conditions they treated most frequently, and which diagnoses their TCTSY clients had. To expand on that data, future participants could be invited to note more specifically which diagnosis categories were more and less likely to be treated with TCTSY, which could allow cross-tabulation of responses about treated populations. Other correlations between questions could be explored at future researchers’ discretion.

**Diagnostic limitations.**

Historical limitations of diagnostic criteria affect current research and treatment (Emerson, 2015; Herman, 2015), and probably limited the scope of this research. As mentioned in Chapter 2, CPTSD is a newer diagnosis code than Post-Traumatic Stress Disorder (PTSD) (APPI, 2018; Cloitre, 2016), and therefore more validated research exists on PTSD (Lauterbach, Vora, & Rakow, 2005; Horowitz, Wilner, & Kaltreider, 1980;
Sledjeski, Speisman, & Dierker, 2008; van der Kolk, 2014), though of course the condition of CPTSD has long preceded the diagnosis code (Herman, 1998; Janet, 1907).

For an example of the differentiation between condition and diagnosis, when asked to assess which *conditions* they treat most frequently, participants in this study listed CPTSD (93 percent), PTSD (88 percent), depression (73 percent), and anxiety (69 percent), followed by other conditions. Participants mentioned treating additional trauma-related conditions throughout the survey and interview, as explained in Chapter 4. Given that this survey was distributed to therapists familiar with trauma-informed yoga, it is not unexpected that participants frequently treated trauma-related conditions. Participants’ frequent mention of trauma conditions may indicate that TCTSY is reaching its target population of individuals with CPTSD (Emerson, 2015).

Yet when asked about *diagnoses* of their clients who tried TCTSY, study participants reflected a complicated picture in which CPTSD did not appear to dominate. Their responses may indicate question revision is in order in the survey instrument. Or, their responses may simply show the difference between CPTSD as a condition (that participants reported treating more frequently than any other) and CPTSD as a diagnosis (that participants may still be limited in how they can assign in the United States). This trend could be followed in a larger and longer study. Probing for CPTSD clients’ barriers to accessing TCTSY would be suggested if the trend continued over the long-term.

**Quantitative studies.**

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20 Cost as barrier to TCTSY access may particularly merit further study as mentioned in Chapter 4.

21 A barriers study related to TCTSY access may also be generally indicated regardless of diagnosis. Interview participants enhanced understanding of client barriers to trying TCTSY (August 28-30, 2019), and future participants could be invited to comment on strategies that help pre-engaged clients or clients already engaged in therapy to access TCTSY. Further logistical factors to improve access, such as the childcare offered by the YMCA described by Participant 2 (August 28, 2019), could be identified.
The research here is qualitative descriptive, providing valuable details on subjective experience, expert best practices, and narrative data on lived experience, as presented in Chapter 4. Qualitative research has firmly established validity regarding TCTSY, at the dissertation level (Bodine, 2017; Rhodes, 2014; West, 2011) and beyond (Rhodes, 2015; West, Liang & Spinazzola, 2016). Yet quantitative data such as the randomized controlled trial on TCTSY (van der Kolk et al., 2014) is a validated clinical research standard and would lend numerical backing to the qualitative trends reported here regarding therapist perception of client change post-TCTSY (McMillan & Schumacher, 2010; Page, 2014; Skelly, 2011). A quantitative study with this material might involve a group of CPTSD psychotherapy clients who received TCTSY and a group who received a different yoga protocol, somatic therapy, or education. The TCTSY and somatic therapy could be facilitated by providers other than the therapist participants, so that the therapists could reduce bias (Skelly, 2011). The therapists could then scale client improvement using clinical assessments (such as the MAIA, GAD, or PHQ) and other benchmarks. Ethically, the researchers would offer the clients access to both forms of treatment post-study (cf., Reverby, 2000).

**Comparative studies.**

If less limited by funding and time than this study, interaction of treatment methods for CPTSD could be studied over time, including and beyond the interaction of TCTSY and psychotherapy. This may be particularly relevant in the study of CPTSD, since the disorder may benefit from multiple treatment modalities (Emerson, 2015; Herman, 2015; Nespor, 1985) and its research may benefit from longitudinal studies (Rhodes et al., 2016). Multiple treatment dyads could be explored and compared for efficacy, such
as Cognitive Behavior Therapy (CBT) plus Eye Movement Deprogramming and Reprocessing (EMDR); EMDR plus TCTSY; TCTSY plus CBT, and so on. Treatment triads could also be researched longitudinally. Using Herman’s (2015) stages of recovery as a guide, CPTSD mono-therapy, dyad therapy, and triad therapy over the course of recovery could be assessed for relative efficacy.

In this study, participants were asked if they practiced the following therapies: individual, group, couples/family, Dialectic Behavioral Therapy (DBT), Cognitive Behavior Therapy (CBT), Eye Movement Deprogramming and Reprocessing (EMDR), neurofeedback, and other (free text). Highest rated were individual, EMDR, CBT, and group. This may corroborate that TCTSY could be paired with the most commonly selected therapies and could be delivered to individuals or groups. Another avenue for future research would be to study psychotherapists who practice TCTSY against a control group who do not, to assess treatment modalities used between the groups.

It is possible that somatic or neurological approaches to psychotherapy, such as Eye Movement Deprogramming and Reprocessing (EMDR) and neurofeedback, might be practiced with more frequency among therapists who practice TCTSY. Conversely, cognitive or behavioral approaches to treatment, such as Dialectic Behavioral Therapy (DBT), Cognitive Behavior Therapy (CBT), might be practiced with more frequency among therapists who do not practice TCTSY. Correlating frequency of other treatment methods with frequency of TCTSY as a treatment approach could help identify popula-

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22 Notably, CBT, at 50 percent, was less frequently practiced by survey participants than EMDR, at 56 percent. This could be a trend to track in a larger population study and has been a focus of prior research on trauma treatments (van der Kolk et al., 2007). Modalities’ frequency of use in general may merit tracking in a longitudinal study: data might then indicate therapies’ growing or diminishing popularity as treatments for trauma.
tions of therapists more likely to be interested in studying TCTSY, or therapists who would have a client pool more likely to benefit from TCTSY.

**Instrument Changes**

Several changes to the instruments presented here could be considered if this study is replicated. Some changes are simply structural to help net cleaner data. Other modifications are recommended to assess more deeply for trends and themes that emerged in this research.

**Question revisions, additions, and expansions.**

**Number of clients and TCTSY.**

The survey question, “How many of your clients have tried Trauma Center Trauma-Sensitive Yoga (TCTSY)? [free text answer]” generated such different responses that its data could not be successfully analyzed. Future researchers could determine whether data here is preferred in percentages or whole numbers. They could then rewrite the question to offer multiple choice or range answers, and give the option to comment in free text at the end of the question.

**Client age.**

Survey participants were asked also about client age. Most participants treated at least two different age ranges, and overall, pediatric, adolescent, adult and geriatric groups were being treated. Participants were not asked, however, which age groups they treated with TCTSY specifically. Participants may have developed best practices here that could be shared with other facilitators. Interview Participant 2 (August 28, 2019), for example, noted that adolescents may respond positively to the permission to opt out of group TCTSY activities, which they may not be free to choose in individual talk therapy.
when supervised by a parent and subjected to a parental agenda. Participant 2 also reported extremely successful innovations in blending ages within a single treatment group. Since early-life trauma can create substantial later-life complications and since untreated trauma persists symptomatically, as discussed in Chapter 2 (Hillis et al., 2001; Irish, Kobayashi, & Delahanty, 2010), understanding how to use TCTSY with different age ranges may help future clinicians create more efficient outcomes. Questions could be added about which age groups at which frequency are introduced to TCTSY, frequency of age groups that adopt the practice, and perceived benefits of TCTSY for different age groups.

**Diagnoses questions.**

Researchers may wish to broaden questions about diagnosis in this study, at least until CPTSD becomes a more established billable diagnosis in the United States. Asking whether clients had a trauma diagnosis (not just a CPTSD diagnosis), and if so, which type of trauma diagnosis might generate a fuller picture of TCTSY clients affected by trauma. Alternately or additionally, researchers could ask survey participants how many of their clients who tried TCTSY had a history of complex trauma. Also, since survey participants reported that 94 percent of CPTSD clients treated with TCTSY had additional mental health diagnoses, researchers could ask about rates of diagnosis pairings. Given the high rates of comorbidities with PTSD and CPTSD discussed in Chapter 2 (Haviland et al., 2010; Hillis et al., 2001; Sledjeski, Speisman, & Dierker, 2008), this may be useful data to understand.

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23 This suggests that only a limited number of clients who try TCTSY in therapy are being treated for CPTSD only. This trend correlates with previous data about the tendency of CPTSD to occur with behavioral comorbidities (cf., Brady et al., 2006; van der Kolk, 2014) and again with the recent establishment of CPTSD as a diagnosis code (necessitating other diagnoses for billing treatment) (Cloitre, 2016).
Facilitate or refer.

Ninety-four percent of survey participants and all interview participants were TCTSY facilitators, indicating a meaningful, and probably positively biased, understanding of the modality. As explained in Chapter 4, interview participants provided TCTSY to their clients themselves, sometimes in group therapy and sometimes interwoven in individual therapy. If this study is repeated, future researchers may wish to assess if survey participants refer clients to other providers for TCTSY, or if they provide TCTSY themselves, in addition to assessing for facilitator certification. It might but should not be assumed that if a therapist is a TCTSY facilitator, the therapist will also be the client’s TCTSY facilitator. If this instrument is used in future research, it may also be useful to understand if non-TCTSY facilitators had extensive training in TCTSY other than a full facilitator training, for example a 20- or 40-hour continuing education program.

Exploring TCTSY precepts.

Larger interview themes that emerged from this data could also be translated into additional questions. For instance, interview participants observed benefits of some TCTSY precepts more frequently than other precepts. Interview participants were more likely to discuss the precepts of choice, non-attachment, and shared authentic experience, over precepts such as repetition and rhythm (cf., Emerson & Hopper, 2011; Emerson 2015). Survey and interview participants could be queried as to which TCTSY precepts they rely upon the most. This could be accomplished with a frequency question to survey participants followed by a free text field, and with an open invitation to comment for interview participants. This type of assessment may help understand when TCTSY precepts
may be of particular value. It may also clarify if training gaps or opportunities exist regarding underrepresented precepts.

**Additional Studies and Surveys**

**Therapist change.**

Some data trends found in this research might better be explored by creating new studies or surveys, rather than by amending the existing instruments. Perhaps the most significant of these in terms of amount of data gathered here was TCTSY’s effect on therapists. Although this research intended to explore changes clients experienced when exposed to TCTSY, surprising interview themes emerged with regard to TCTSY’s impact on the therapist facilitators. These themes could be parlayed into expanded instrument questions. Or, data shared here was rich and extensive enough potentially to warrant a separate study on therapist change, referencing Bodine’s (2017) work on TCTSY facilitator experience.

Interview participants (August 28-30, 2019), and some survey participants, noted that TCTSY has influenced and significantly changed their overall approach to practicing therapy. Future researchers could more specifically assess overall impact of TCTSY on clinical practice and on the therapist side of the therapeutic relationship. Survey participants could be asked to scale the extent to which TCTSY has affected different domains of practice. Interview participants could be asked about how TCTSY has changed their approach to treatment, and how this has created different outcomes for their clients.

**Provider education and engagement.**

Provider education emerged as a theme from the interview data. This might merit a separate study to explore training and outreach gaps, especially if the TCTSY organiza-
tion were considering training revisions. Since interview participants noted that provider’s prior education may influence their willingness to try TCTSY, future researchers could more specifically assess how to introduce TCTSY to providers unfamiliar with somatic modalities. Findings might lead to training refinements or to the creation of a bridging training for non-somatic providers. Interviews in this research also revealed how strongly some TCTSY facilitators advocate for the modality in their professional communities, which may be an untapped resource worth studying. Assessing how facilitators introduce TCTSY to colleagues could help produce focused outreach or advertising materials.

If studying a refinement of provider engagement, length of practice could be considered as well. For example, in this study, average length of practice was 9.06 years, possibly indicating that TCTSY can be introduced successfully at various points in therapists’ career arc. Since TCTSY is a relatively new modality (Emerson & Hopper, 2011; Spinazzola et al., 2011), it may be assumed that the longer-practicing participants in this study were introduced to TCTSY mid-career or later. It may be useful to have more information about how therapists adopt TCTSY at different points in their career, to enhance engagement, training, and peer-supervision enrichment.

*Provider vulnerability.*

Interview participants (August 28-30, 2019) observed that working with TCTSY can be a vulnerable experience for therapists. This concern was noted extensively enough to merit further study consideration in several avenues. Vulnerability was reported with regard to assessing benefits of TCTSY (i.e., providers might be unsure how to validate TCTSY’s impact on clients). A study could be considered to develop an additional so-
matic therapy assessment tool for therapists, or to assess best practices in using existing assessments with TCTSY clients (such as the MAIA, GAD, or PHQ).

Vulnerability was also disclosed around addressing client symptoms arising as a result of practicing TCTSY in therapy (i.e., providers might not trust their ability to manage issues a client has during or after TCTSY). Here, TCTSY therapist facilitators could be assessed pre- and post-certification to understand concerns regarding competence and to ascertain if these concerns are resolved by their training. If facilitator training is not addressing competence concerns, training could be amended or peer support groups could attempt to close training gaps. If the concerns are being met adequately by training or peer support, the issue might be better addressed in pre-training outreach or advertising.

The most significant vulnerability noted by interview participants, however, was the practice of shared authentic experience. This could be another trend to survey pre- and post-certification, especially comparing TCTSY therapist facilitators and TCTSY yoga teacher facilitators. It is possible that among TCTSY facilitators, the yoga teachers may show less concern around shared authentic experience than therapists, given their professional experience with student-teacher concurrent somatic experience. If this supposition were supported by survey findings, the TCTSY training community could leverage yoga teacher expertise by creating joint-background peer support groups to help therapists develop comfort with shared authentic experience.

New Populations

Populations and protocols.

Interview and survey participants noted using TCTSY for its target population of CPTSD. They also noted using TCTSY for other populations. A recommendation at the
Conclusion of this research is to explore population use for therapist TCTSY facilitators 1-5 years post-certification. Researchers could assess both for ongoing fidelity of methods (which is already a part of continuing education for TCTSY [TSY, 2019]) and also for the emergence of adapted uses and protocols. In this survey and interview data, TCTSY’s relevance was noted in populations with obsessive-compulsive disorder (OCD), anxiety, depression, lower cognitive function, body dysmorphia, eating disorder, and numerous other diagnoses. Many of these sub-populations may warrant study regarding TCTSY and symptom improvement.

TCTSY has already been identified as an adjunctive treatment for clients with a history of trauma who are experiencing eating disorder (Emerson & Kelly, 2016), and this sub-population bears individual mention here. Interview Participants 2 (August 28, 2019) and 3 (August 30, 2019) both described using TCTSY in the treatment of eating disorder for group or individual clients. Survey participants also mentioned working with eating disorder populations. It is possible that a TCTSY protocol specific to disordered eating could be developed, since resonance with the general TCTSY practice already has been established for this population.

**Blended groups.**

This research indicated that blended treatment groups may present treatment challenges as mentioned in the prior chapter. Yet judiciously selected TCTSY mixed-participant groups were associated with clinical benefit in this research and may merit further study. Participant 2, as mentioned, noted surprising successes when integrating adolescents into an adult and geriatric TCTSY group:
I opened one of my groups to adolescents and adults. Which has been lovely. I expected protest on both sides, and I didn’t get it. The adults have told me they love seeing teens getting help early... and the teens have said this is the motivation for them, they don’t want to be in treatment when they’re in their 70s (August 28, 2019).

As presented in Chapter 2, research repeatedly shows the impact childhood trauma may have on later life (Nemeroff, 2004; Teicher, Andersen, & Polcari, 2002; Tyrka et al., 2010), so this type of treatment group may be a valuable phenomenon to study.

Participant 2 also noted that “lower cognitive” clients may fare exceptionally well when introduced into a TCTSY group with cognitively normal students (August 28, 2019). The simplicity of the TCTSY activity and the opportunity to belong in community created a safe and connective environment for all the participants. Further research might explore how this type of blended group derives success from a treatment base of TCTSY (versus traditional talk therapy or other approach). Researchers could also query participants about their experience with blended groups of any type, to learn from their successes, challenges, and strategies, including when they advise separating groups.

Summary

This study attempted to address the research question: how do psychotherapists perceive that utilization of talk therapy changes when TCTSY is introduced into CPTSD treatment? Throughout survey and interview data, the psychotherapist participants noted they perceive that TCTSY is associated with improvement and positive change, similar to themes notes in prior research of different stakeholder groups (Bodine, 2017; Rhodes,
Participants reported their client’s symptoms ameliorated after exposure to TCTSY, as sessions became more productive and diverse in content. Participants reported how the experiences of neutrality and free choice built into TCTSY helped clients change abusive and limiting life circumstances. They described how TCTSY helped therapists shift relationship to provide a more productive recovery environment for clients.

TCTSY did not appear to affect structural elements of sessions (timeliness, number of sessions attended) strongly, but had a notable effect on the progress and path of therapy. This data also revealed rich territory for future research in several areas that could be studied in greater depth than was possible in this context, i.e., frequency of use of TCTSY precepts, TCTSY’s interaction with other modalities, enhancements to provider outreach and education, diagnoses treated with TCTSY, and post-treatment changes based on diagnosis.

This study asked therapists to share their perceptions of how therapy changes after the introduction of TCTSY. Although it was attempted to approach the data without assumption, a bias still existed toward assuming change in utilization would reflect clients’ experience primarily if not exclusively, and assuming that providers are not changed by the experience of therapy while their clients change. The participants of this survey, in sharing how TCTSY developed both sides of the therapeutic relationship, present an invitation to re-conceptualize not only the tools of therapy for trauma but the structure of the therapy. They offer a view of trauma therapy based on an actual shared experience, contained within safe boundaries and appropriate roles for client and provider. They reflected
on the potential for this embodied authenticity to foster growth, beneficial discomfort, a reconceiving the self, and new options for all involved.

Participants described how TCTSY enhanced stability, safety, and sensitivity in the client-therapist relationship, through the embodiment of shared authentic experience and the space of non-coercion and non-attachment. As with any change in relationship, both parties were affected by the introduction of TCTSY: participants illuminated the limitations and inaccuracies of a one-sided view of clinical tools as shaping clients without touching practitioners. TCTSY’s shared embodiment, according to this study’s participants, often proved as transformative for the therapist as for the client. Participants reported how practicing TCTSY can leave therapists feeling more vulnerable while it enables them to connect both more deeply and more neutrally with clients. Participants reflected on the complexities of therapists integrating the awareness of shared authentic experience into their practice and the stretch of clients integrating that awareness into being. They described how TCTSY evolved their view of clients, themselves as therapists, relationships, communication, and power, not only when they were practicing TCTSY but cross-contextually.

To work in the field of trauma recovery is to work within a live system in the process of expanding, and to know one’s work may influence and be influenced by that expansion. Innovations shared by this study’s participants may help future therapists, trainers, and researchers develop TCTSY and deliver care more effectively to clients with CPTSD. Participants’ generous willingness to share their knowledge and experience may improve outcomes for people suffering from the effects of complex trauma and other disorders. In their compassionate non-attachment to outcome, participants revealed a deep
philosophical alignment with the conceptual framework of TCTSY and showed a practical capacity to deliver TCTSY ethically and effectively to their clients. Learning from and building on these participants’ insights may improve the accuracy of trauma treatment and gain back time and quality of life for trauma survivors.
APPENDIX A

Jennifer West's Interview Guide

(excerpted directly from dissertation [2011, p. 245])

When some people look back at certain traumatic experiences they realize there were long lasting effects. Many people describe things like you have described which are often very difficult to deal with. Sometimes people also report that dealing with such a powerful life event has caused them to learn things that have changed them in more helpful ways. Now, this doesn’t ignore or minimize the very difficult and disruptive effects. Instead, you or other people may recognize changes in addition to the struggles.

1. Please think about yourself before this study, and tell me about ways that dealing with the [TRAUMA EXPERIENCE] had long-standing effects on you, both things that were potentially disruptive or potentially useful?
   a. Emotions and feelings
   b. Thoughts about yourself
   c. Outlook on life/future
   d. The way you relate to your body
   e. Relationships
   f. Spirit
   g. Other?

2. Please tell me about your experience in yoga – both positive and negative? What stands out?

3. Has your participation in the program changed the way you think about the trauma? The role it has in your life? The way you actively participate in life?
4. Considering the areas discussed in the first question, did you notice any changes in yourself throughout your participation? Positive and/or negative?

5. Is there any particular aspect of the program that stands out to you?
   a. Postures, focused breathing, meditation
   b. Community (e.g., of trauma survivors)
   c. Teacher-guided practice and self-guided practice at home
   d. Being a part of a study/filling out questionnaires
   e. Other

6. Have you continued engaging in similar activities since? If so, what and how often?

7. Is there anything that could change in the program to have made your experience better?

8. Is there anything I have not asked you that you think would be important for me to know?
APPENDIX B

Alison Rhodes' Qualitative Interview Guide
(excerpted directly from dissertation [2014, pp. 187-189])

Interviewer: In the final part of this interview, we would like to get a sense of where things are at for you now in relation to the impact of your trauma experiences and the potential role of yoga in your healing process. There are no right or wrong answers here; our goal is really to understand how, if at all, yoga has impacted your experiences of healing from trauma.

1. Please describe how your experience of yoga or your practice of yoga has changed over time? (if participant stopped practicing after intervention ended, ask: How did your experience of yoga change during your time in the intervention? Can you describe any lingering effects or continuing changes?)

2. Please describe any influence the yoga intervention (and/or your ongoing yoga practice) has had for you within the context of your experiences of healing from trauma—either positive or negative.

   a. follow-up: can you describe that experience (or experiences) further? What was that like for you? If ideas are very abstract: Can you provide an example of when that happened?

3. Please describe any influence of your yoga practice on your experience of trauma symptoms day to day or the way you manage your trauma symptoms in your day to day life.

   Interviewer: The next set of questions are designed to ask you more specifically about several aspects of your life where your experiences of yoga may or may not have
had an impact. Although you may have touched on some of these issues in relation to the previous questions, we hope this can be a space to elaborate further, and try to make sure we are covering everything.

4. Please reflect for a moment on your experiences over time of being connected or disconnected from your body, the way you have felt or feel now about your body, and any influences your yoga practice may have had on this dimension of your life. Please describe how your yoga experiences have shaped your relationship with your body or your experiences in your body. What stands out about these experiences in relation to your healing process?

   a. follow-ups: can you describe that experience further? Are there additional experiences you have had where yoga has influenced your experiences of your body? Has this changed over time?

5. Can you describe a time when your yoga practice influenced the way you feel, express, tolerate, or have control over your emotions? What was that (or those) experience(s) like for you? What stands out about the experience(s) in relation to your healing? follow-ups: can you describe that experience further? Are there additional experiences you have had where yoga has influenced your experience of your emotions? Has this changed over time?

6. When you reflect on your experiences of yourself as a person, and the influence of the yoga intervention (and/or your practice of yoga) has had on your notion of who you are or your sense of self, please describe these experiences. What does this (participants’ answers) mean for you in terms of your healing?
a. if participant struggles with this question, might try reframing as: Has your “relationship with yourself”—for instance, how you view yourself, what you see as your strengths or limitations—changed at all in the context of your yoga experiences? Please describe these experiences, and what they mean for you in terms of your healing.

7. Can you describe any experiences where your yoga practice influenced your relationships with others, or your feelings of being connected to or disconnected from others? Please describe how your yoga experiences have impacted this dimension of your life. What do these experiences mean for you in terms of your healing?

8. Has your practice of yoga influenced your ability to make meaning from the struggles you have faced related to your trauma history? If so, please describe this experience further.

9. Has your practice of yoga influenced your priorities or outlook more generally in any way? If so, please describe this impact. What does this mean for you in terms of your healing? (if participant doesn’t understand question might say: for instance, has it influenced your sense of what is possible, your sense of hope for the future, or your sense of optimism/pessimism, etc.)

10. Has your yoga practice impacted your spirituality, your sense of meaning in life, or your sense of feeling connected to something greater than yourself? If so, please describe that experience. What does that experience mean to you in terms of your healing?

11. Are (were) there particular components of a yoga practice that you felt were more helpful than others to the changes you mentioned above—for instance, breathing exercises, meditation, the physical postures or certain specific postures, the group class
format, the teaching style, or was it everything together? (If participant mentions specific aspects ask her to elaborate).

**If the participant did not attribute positive/negative changes to yoga but continues to practice nevertheless, interviewer should inquire: Given that you have not seen changes in the areas we’ve discussed above, why do you continue to practice yoga?**

participant has not practiced yoga post-intervention, interviewer should inquire: Can you tell me more about your experiences within the yoga intervention and/or factors in your life outside of the intervention that led you to not continue to practice yoga?

12. Is there anything I have not asked you that you think would be important for me to know? Any areas of difficulty or sources of strength that we haven’t talked about? Anything you’d like to ask?

13. Have there been any significant life changes since we last saw you that may account for some of these changes we’ve discussed? For example, in addition to yoga, can changes be attributed to: other mind or body practices, life stressors, positive life events, change in therapy or medication regimen, etc.?
APPENDIX C

Evan Bodine’s Interview Questions to Teachers

(expected directly from dissertation [2017, pp. 188-189])

1. I know you have taught yoga and trauma-sensitive yoga. In your experience as a teacher, what differences have you noticed?
   a. Describe any shifts you have felt from teaching yoga to teaching trauma-sensitive yoga.
   b. What have been your thoughts associated with teaching trauma-sensitive yoga?
   c. What have been your feelings associated with teaching trauma-sensitive yoga?
   d. What have been your behaviors associated with teaching trauma-sensitive yoga?

2. How, if at all, does your professional training that is related to mental health impact teaching trauma-sensitive yoga?

3. How, if at all, does your personal trauma history impact teaching trauma-sensitive yoga?

4. What, if any, negative effects have occurred in your life since you began teaching trauma-sensitive yoga?
   a. Have you experienced vicarious traumatic symptoms or burn out? If so, describe this experience of them.
   b. What have been your subsequent thoughts associated with these experiences?
   c. What have been your subsequent feelings associated with these experiences?
   d. What have been your subsequent behaviors associated with these experiences?
   e. If at all, have these effects shifted over time?
f. How, if at all, has your self-care routine changed as a result of teaching TSY?

5. What, if any, positive effects have occurred in your life since you began teaching trauma-sensitive yoga?
   a. Have you experienced vicarious growth with clients on their journey? If so, describe this experience of them.
   b. What have been your subsequent thoughts associated with these experiences?
   c. What have been your subsequent feelings associated with these experiences?
   d. What have been your subsequent behaviors associated with these experiences?
   e. If at all, have these effects shifted over time?

6. What, if anything, do you do to prepare for working with clients?
   a. What, if anything, do you typically feel while you are teaching trauma-sensitive yoga?
   b. What, if anything, do you typically do for yourself after teaching trauma-sensitive yoga?

7. What, if anything, does teaching trauma-sensitive yoga mean to you?

8. How, if at all, has teaching trauma-sensitive yoga impacted you personally?
   a. How, if at all, has your personal yoga practice been impacted? If so, please describe how.
   b. How, if at all, has your non-yoga profession been impacted? If so, please describe how.
APPENDIX D

Additional Terms

Since this research is conducted within an educational leadership degree program, this appendix will define terms for the non-clinician.

Clinical

For these research purposes, clinical indicates pertaining to a health care clinic or clinicians. Clinical can also refer to research involving patients or clients (APPI, 2018).

Somatic

In the context of this research, somatic refers to the body, in particular the body as distinct from the mind (APPI, 2018).

Talk Therapy

In the context of this paper, talk therapy indicates psychotherapy centering on discussion between client and clinician (APPI, 2018). Talk therapy for Cognitive Post-traumatic Stress Disorder (CPTSD) recovery may include Cognitive Behavior Therapy and other modalities (defined below) (APPI, 2018; van der Kolk, 2015).

Cognitive Behavioral Therapy (CBT)

In CBT (APPI, 2018), the therapist helps the client explore thoughts (cognitions) that may influence or drive actions (behaviors). A benefit of CBT can be learning to recognize when a thought or assumptions is inaccurate or unhelpful, due to distortions in cognitions, and how to explore more adaptive cognitions (Nespor, 1985). CBT may also involve learning to choose or respond differently to one’s thoughts (D. Weeks, personal communication, May 2017; Katie, 2008).

Dialectic Behavioral Therapy (DBT)
DBT may be administered in individual therapy but is especially common as short-term, targeted group therapy administered jointly with individual psychotherapy (McKay, Wood, & Brantley, 2007). DBT helps clients prone to intense, unbalanced emotional reactions (such as those experienced by some clients with CPTSD [Herman, 2015]) to learn new skills and cognitions, while providing support and collaboration (Chapman et al., 2010; Harnard et al., 2011). DBT has been found helpful in the treatment of self-harm behaviors, suicidal ideation, and borderline personality disorder (APPI, 2018), all of which can have an underlying driver of unresolved CPTSD (Herman, 2015).

**Eye Movement Desensitization and Reprocessing (EMDR)**

EMDR has become a frontline means of treatment for Post-Traumatic Stress Disorder PTSD (van der Kolk, 2014). EMDR may help to reduce the distress of memories or triggers (van der Kolk et al., 2007). In EMDR treatment, the client is asked to recall aspects of a traumatizing or triggering experience, while engaging in bilateral activity such as moving eyes side to side, hearing tones through headphones in alternating ears, or holding tappers that pulse alternately hand to hand (N. Blume, personal communication, April 22, 2018; van der Kolk, 2014).

**Exposure Therapy**

Exposure therapy involves therapeutically exposing the client to the situation that triggers symptoms (Foa et al., 2018). The goal of therapy is to desensitize the client gradually to the emotional trigger so that the window of tolerance widens and symptoms decrease, and the client is able to tolerate the stimulus. Exposure therapy is empirically validated for anxiety disorders and some phobia disorders (APPI, 2018). Regarding exposure therapy’s relevance to PTSD and CPTSD, data shows positive results for those re-
maintaining in therapy but high attrition rates and risks of re-traumatizing for participants with CPTSD (N. Blume, personal communication, March 22, 2019; Foa et al., 2018; Scott & Strandling, 1997; Zayfert et al., 2005).

**Group Therapy**

Group therapy is therapy administered to groups, and may be focused on talk therapy or other therapeutic activity (APPI, 2018). Therapy groups may be assembled based on shared educational purpose such as learning DBT skills (Chapman et al., 2010) or shared life experience such as grief or complex trauma (D. Deers, personal communication, January 2018). Benefits of therapy groups may include normalizing shared experience, learning from peers, peer support, and community, all of which have relevance for treating CPTSD (Herman, 2015).

**Experiential Therapy**

Experiential therapy involves engaging in directed, specific activities for therapeutic benefit and under therapist supervision (APPI, 2018). Versus therapy focused on dialogue and discussion, experiential therapy (as its name suggests) focuses on active experiences undertaken by the client (Buck, Bean, & de Marco, 2017; Naste et al., 2017). Examples may include drama or art therapy (van der Kolk, 2014) or animal therapy (O’Haire, Guerin, & Kirkham, 2015; Phenow, 2016; Smith et al., 2016).

Experiential therapy using Animal-Assisted Interventions (AAI) may help clients, including those with CPTSD, to improve social, cognitive, or physical functioning (Smith et al., 2016). Types of AAI include activities, education, and Animal-Assisted Therapy (AAT). Horses and dogs are common animals for AAI (O’Haire, Guerin, & Kirkham, 2015; Phenow, 2016). Some AAT relies on the theory of biophilia: since humans evolved
codependent with animals, people may also have evolved capacity to rely on animals to communicate dangers in the environment (Wilson, 1984). Interacting with an animal at rest or at play may improve relaxation and capacity to form relationships, which can be helpful for clients with history of complex trauma (Herman, 2015). Caring for animals can also help CPTSD recovery due to an increased understanding of one’s own value and one’s inter-reliance with other beings, both of which can be concerns for clients with CPTSD (Lynch, 2013; van der Kolk, 2014). Equine therapy deserves particular mention in AAI for trauma. Since their survival depends on avoiding predation, horses have evolved extraordinary capacity to sense threat, avoid threat, and use social strategies to elude predators (Lynch, 2013). Clients with CPTSD who experience hyper-vigilance may feel a particular accord for the horses’ sensory abilities, reactions, and herd bonds (Buck, Bean, & de Marco, 2017; Naste et al., 2017), as they learn from horses’ simultaneous somatic, grounded steadiness (H. Jeffries, personal communication, September 21, 2019).

**Clinical Neglect**

Clinical neglect indicates that a caregiver has failed to fulfill needs of a dependent to the extent that the dependent has ongoing, measurable negative outcomes (Spinnazola et al., 2011). With CPTSD, the survivor may have history of abuse, neglect, or both (Herman, 2015; Spinazzola et al., 2016). Neglect cases can be more insidious to identify and more difficult to treat, even within the known challenges of CPTSD treatment (N. Blume personal communication, April 25, 2018). Neglect generates a neurological paradox. Instead of abuse’s message, i.e., “you don’t deserve to exit,” neglect communicates, “you don’t exist.” Internalizing this message results in an almost impossibly unresolvable
conflict of identity, similar to the Zen no-self crisis (Brown, 2009) but devoid of underlying sense of value or belonging (van der Kolk, 2014).

Neurologically, the vagus nerve may attempt to resolve the paradox of neglect by inducing states of dissociation or shut down (Porges, 2013; 2016). Heart-rate variability may reveal how the nervous system and cardiopulmonary system also carry the legacy of neglect24 (Telles et al., 2010; Tippet, 2017; Wheeler & Wilkins, 2007). Addictions may also occur here as a form of escape, and to numb any part of the pain of CPTSD (Brady et al., 2006; Boscarino, 1997; Collett et al., 2016; Jackson, 2017; Lauterbach, Vora, & Rakow, 2005; Scime & Cook-Cottone, 2008). Neglect survivors may also try to resolve the paradox cognitively through an existential crisis (Herman, 2015). Survivors may not believe they belong in society, may believe mortality is imminent without clinical evidence, or may even perceive themselves as inhuman in a metaphoric or literal way (van der Kolk, 2014).

Since caregivers regarded the child as essentially non-existent, the survivor of neglect may adopt a means of playing dead as a way of life (Brooks, 2006). As Emerson (2015) points out, this is not much of a life. Clinical evidence can be found in overpopulated orphanages offering basic care but where staff-to-baby ratio is too low for crying infants to receive caregiver attention (Brooks, 2016). The infants learn to stop crying when distressed or in pain, overriding a natural, hardwired, adaptive response to communicate need for assistance (Brooks, 2016). Subsequent recovery is challenging indeed, since the learned, defensive shut-down response can occur anytime during treatment.

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24 Normal heart-rate variability, or HRV, indicates heart rate returning to normal after a stress or startle response. In CPTSD or PTSD, heart rate may not return to normal at expected rates after an external stress has been resolved, indicating ongoing biochemical and physical cost to the survivor (van der Kolk, 2014).
complicating accessing information from the survivor and potentially clouding diagnosis (N. Blume, personal communication, June 15, 2018). TCTSY may offer benefit here with its principle of advocacy, encouraging the survivor to identify individual need or preference and to take action to address personal needs (Emerson, 2015; Emerson & Hopper, 2011; West, 2011; West, Liang, & Spinazzola, 2016).25

**Traumatic Brain Injury (TBI)**

The scope of this study pertains to traumas that are considered mental health disorders, though they may include substantial physical symptoms and risks (Herman, 2015). Traumatic Brain Injury (TBI) is not considered a mental health disorder, though it may result in significant and even lethal emotional health complications. A TBI results from physical trauma to the head (Gomez-Pinilla & Kostnkova, 2008). A TBI may be diagnosed following physical abuse or assault, an accident or fall, sports injury, combat, or other injury. A TBI may be mild, moderate, or severe, and is categorized by the length

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25 PTSD and CPTSD, like any condition affected by epidemiological factors, exist in relationship with population conditions and demographics (Sledjeski, Speisan, & Dierker, 2008). Early childhood trauma versus later trauma may result in greater likelihood of subsequent diagnosis of CPTSD (Ford & Kidd, 1998; Grossman et al., 2017), and earlier and multiple instances of trauma have strong population-based correlations. The importance of attending to childhood trauma is an obvious moral imperative, critical because of likelihood of severe later effects on physical symptoms, behavioral symptoms, relationships, capacity for life success, and early death (Cloitre et al., 2009; 2010; Cook et al., 2005; Irish, Kobayashi, & Delahanty, 2010; Nemeroff, 2004; Tyrka et al., 2010), and also because patterns of early trauma connect to larger patterns of social injustice (ProInspire, 2018). With Pediatric Abuse as a medical sub-specialty per the American Medical Association since 2009, physician experts can be trained to screen for relational trauma earlier, and assist other clinicians in recognizing abuse indicators earlier (Swenson, Derauf, & Lucken, 2015; Hudson et al., 2011; Martindale et al., 2014). Adequate training may also help address cultural patterns of trauma connected to trends of inequity: although trauma can affect anyone at any time of life, CPTSD in the United States disproportionately affects women, people of color, population diasporas, those who identify other than cisgender, and those living in poverty (Epstein & Gonzales, 2017), and exposure to trauma increases likelihood of subsequent trauma (Herman, 2015). To treat trauma optimally, providers consider cultural appropriateness for multiple populations; access to care, resources, and diagnoses; inclusion versus bias within training materials; the importance of voice and contribution from traumatized individuals and groups; and equity of access to provider training (ProInspire, 2018).
of time it takes to recover, how much recovery is possible, and the extent of physical, neurological, and cognitive symptoms that emerge because of the event (Chapman, Gratz, & Tull, 2011; Hoge & Castro, 2014). TBI bears mention here because of its potential overlap with PTSD and CPTSD, which adds complexity to treatment. Some clients with PTSD or CPTSD may have a history TBI, and some may not (van der Kolk, 2014).

**Post-Traumatic Growth**


Clients with CPTSD may suffer losses of vitality, time, health, and options that may not be recovered, enduring damage that may extend into future generations (Herman, 2015; van der Kolk, 2014). Although these losses and the suffering underlying them cannot be justified, clients with CPTSD may also prove astonishingly resilient, showing positive growth after trauma (Tedeschi & Calhoun, 1996; 2009). Post-traumatic growth has become a research trend, drawing on studies on post-traumatic stress and exploring survivors’ progress in treatment (Linley, 2003; Linley & Joseph, 2004; Naparstek, 2004).

Given the varied human responses of learning, adaptation, and creativity indicating neuroplasticity (Doidge, 2007), some responses to trauma over time may include new skill building and growth in understanding and capacity (Shakespeare-Finch & Enders, 2008; Zoellner & Maercker, 2006).

Post-traumatic growth is not the same as recovering from trauma. After trauma, growth and recovery may occur independently, sequentially, or concurrently (Tedeschi & Calhoun, 1996; 2009). Per the post-traumatic-growth model, recovery would indicate reduction in symptoms, while growth would indicate enhanced skills, capacity to relate, or
positively adaptive viewpoints (Linley & Joseph, 2004). Post-traumatic growth may vary by person, and can include gratitude, realistic understanding of human limits, compassion, empathy, resilience, previously unknown strengths, spiritual connectedness, and desire to help and to connect to others (Shakespeare-Finch & Enders, 2008; West, 2011; West, Liang, & Spinazzola, 2016).
APPENDIX E

Instruments Used in This Research

Survey Questions

1. Please briefly describe your licensure/training (e.g., LPC, LFSW, etc.).

2. Are you also a TCTSY facilitator? Y/N

3. How many years have you been practicing as a psychotherapist?

4. What conditions do you treat? 1(never) - 2(rarely) - 3(sometimes) -
4(frequently) - 5(very frequently).

   1. PTSD
   2. CPTSD or complex trauma
   3. Generalized anxiety disorder
   4. Depression
   5. Major depressive disorder
   6. Bipolar
   7. BPD
   8. Developmental trauma disorder
   9. Other (please list):

5. What age clients do you serve? Select all that apply.

   1. Adult (20-65)
   2. Pediatric (0-12)
   3. Adolescent (13-19)
   4. Geriatric (65+)

6. Which types of therapy do you practice? Select all that apply:
1. Individual therapy
2. Group therapy
3. CBT
4. DBT
5. EMDR
6. Neurofeedback
7. Couples/family therapy
8. Other (please specify):

7. Please list the nation and city/ies where you practice. If in the United States, please include state.

8. How many of your clients have tried Trauma Center Trauma-Sensitive Yoga (TCTSY)?

9. Did all of these clients have a CPTSD diagnosis? If no, which diagnoses did they have?

10. Did any of these clients have a mental health diagnosis in addition to CPTSD? If yes, which diagnoses did they have in addition to CPTSD?

11. During the time your clients practiced TCTSY, did you note changes in any of the following? N/A - 1(never) - 2(rarely) - 3(sometimes) - 4(frequently) - 5(very frequently).

   1. Frequency of missing sessions
   2. Frequency of tardiness to appointments
   3. Scheduling sessions more frequently
   4. Frequency of being on time to appointment
5. Willingness to discuss challenging topics
6. Escalation of symptoms
7. Improvement of sessions
8. Hopefulness about the future
9. Improvement in affect
10. Decompensation in affect
11. Increase in inpatient admissions
12. Decrease in inpatient admissions
13. Change in therapy relationship
14. Change in issues explored/discussed in therapy
15. Changes in how issues were explored
16. Other/Please expand:

**Interview Questions**

1. How did you negotiate or introduce the idea of TCTSY into therapy? How did those conversations go?

2. What would help therapists refer to TCTSY for CPTSD more effectively?

3. What might prevent therapists from referring to TCTSY for CPTSD?

4. What might prevent clients from participating in TCTSY for CPTSD?

5. Describe a situation when you were treating a client with CPTSD who was participating in therapy but encountered a roadblock in therapy. In your opinion, would the introduction of TCTSY have changed the client’s experience at that point? Please briefly elaborate, whether your answer is “yes” or “no”.
6. Describe a situation when you would be most likely to recommend TCTSY to a client.

7. Describe a situation when you would be unlikely to suggest TCTSY to a client.

8. Would you like to share additional comments or feedback about TCTSY and utilization of therapy?
APPENDIX F

Interview Transcriptions

Transcription of Participant 1 Interview, August 28, 2019

Interviewer: I am now recording, and I just wanted to ask your permission if it’s ok to record today.

Participant 1: Yes that’s fine.

I: Thank you. And just so you know you can skip any questions and you can stop the interview at any time.

P1: Ok, ok, sounds good.

I: Ok great, any questions for me before we get started?

P1: No, un-unh!

I: Ok well I’ll just dive in with my first question which is, how did you negotiate or introduce the idea of TCTSY into therapy?

P1: Um so I talk a lot with clients about how trauma is often stuck in the body and that even if cognitively we can understand that that was then and this is now that a lot of times our body or other parts of ourselves are not completely time-oriented to the present around that... and that by doing a body-based intervention we can help people be able to live more in the present. And then if they’re interested in that, I talk a little it more about what TCTSY offers about like helping with agency, helping with dissociation, things like that.

I: Great, thank you. How do those conversations go, or is there not usually a way they typically go?
P1: Um they tend to go pretty well and people are like, “Oh my god that makes so much sense,” more often than not.

I: So it sounds like they have a real resonance with the work right away.

P1: Yup it definitely resonates with them. Yup they definitely understand it. Because a lot of them will say, “Well I’ve had therapy for so long, and it’s mostly been talk therapy, and it hasn’t worked.” And I’m like “Yeah!” And they’re like, “That makes sense to me then.” So yeah. Yeah, talk therapy alone I should say.

I: Right, right. What do you think would help therapists refer to TCTSY for CPTSD more effectively?

P1: What would help therapists ...would you say that again? I didn’t understand the question.

I: Thinking about if therapists might want to use TCTSY for people with a history of complex trauma, what would help therapists refer to TCTSY more easily?

P1: Oh you mean if they’re not a facilitator.

I: Yeah.

P1: You know, I know that in times of insurance and evidence-based treatments, I do find that when I talk to therapists about the research, that helps. I also find it helpful that I direct, that I choose my audience. I both offer TCTSY in my individual therapy but then I also offer a group. So I did the half day presentation [on TCTSY to trauma professionals], I’m also EMDR certified, to my regional [EMDR] meeting. I did the 1/2 day presentation to a group of trauma therapists who already understand the body stuff, so that really helped. I think they were an easy population to start with because I get a lot of my referrals from those people because they understand the importance of adding a body-based
component. I would say with people who tend to be more talk therapists [only], they tend to be more skeptical. Maybe not as open to needing anything more than talking. With them, I don’t want to step on any toes or make it sound like I know more than them because I don’t, we just have different areas maybe that we’re skilled in. So I tend of kind of plant seeds, “Oh, have you ever read ‘The Body Keeps the Score’, have you ever read Pat Ogden’s book about the body in trauma, have you read Peter Levine,” and I just start conversations.

I: Mmm hmm.

P1: Because if I come on too strong, “I offer this for trauma, here’s why, here’s the research”, they get almost defensive, like they don’t know. They feel like what I’m doing is going to threaten what they’re doing rather than be an adjunctive treatment. So with those types of therapists I tend to go more slowly and see if they’re open to conversations about how trauma’s in the body, and if they’re not really open to that, I just like I said kind of plant some seeds. If they’ve already read some of those books, then we start to talk about it and I can say, “Hey, there’s something cool that I offer, I don’t know if you’re interested, but it’s just body-based therapy.” And then I tell them about TCTSY and the research of how it works and all that kind of stuff. But like I said therapists who are not really open to it, haven’t really read any of the books, aren’t really super interested in how the body needs to be included in treatment, the bottom up approach, I just kind of then plant little seeds here and there. If that makes sense.

I: Great. Yeah it sure does. Yeah and you brought up something, my next question is about barriers, therapist barriers. You brought up something that makes so much sense, of just not being familiar with body-based interventions.
P1: Absolutely, or thinking that they’re just...what’s the word I’m looking for, coo-coo, or not coo-coo, but some kind of made up crap. [Laughs]

I: That totally makes sense [laughs].

P1: Yeah

I: Anything else in your mind that might prevent therapists from referring to TCTSY?

P1: Um...I think they want to make sure that, if I’m going to offer TCTSY especially individually but even the group...I think they feel less threatened if I offer it in the group because it’s group therapy there’s no way it’s going to interfere with what they’re offering. Um whereas I think if it’s individual, it’s really important that they understand that I would just be doing this [TCTSY]. So that they don’t feel like their work is threatened, or that I’m going to mess up what they’re doing, or give different messages, right?

I: Right.

P1: That’s one thing. I think sometimes therapists as a population can be sensitive about you know our clients liking someone else more than us. So sometimes I see that as a barrier. Um so yeah. I’m trying to think of what else. I know cost can sometimes be a factor, and because I bill insurance for [TCTSY], I know that can sometimes help, because their clients don’t always have a lot of money. But let’s say they have a high deductible and high copay then [the therapists] often don’t refer. But also time, I think. If the therapist knows the client is overwhelmed with the timing of things, that might be something, just time, like schedule. And then sometimes they’re hesitant. But I think they’re just taking care of their clients’ needs around that. I’m trying to think of other reasons. So many other reasons why therapists don’t refer. I think it’s lack of knowledge really, or lack of understanding about body-based therapies or lack of belief that they work.
I: Those are really insightful answers, thinking about collaboration and the proprietary sense that we have with some of our clients, that’s great. Thank you.

P1: Right yeah.

I: Any barriers that you can think of that would prevent clients from participating in TCTSY?

P1: So I’ve seen several, some are in my group and some are in individual. In individual, even though we’ve talked about how it can help and why and the research and I help them touch in with how they feel after... when we do that, some of them are like, “We do that [TCTSY for] ten minutes, and then we don’t get to the real work of therapy”. And I talk to them about how this is part of the real work of therapy. It’s just a different kind of a result that they see and it’s not as immediate. But I think sometimes they have this feeling that it’s not the real work so then they’re hesitant to always do [TCTSY] in our individual sessions. If they’re already my individual client. Now if they’re someone else’s client that I’m seeing just for [TCTSY], I’m finding barriers around scheduling and time and monetary resources to pay their copays. So there are some with the individuals. What I see in group, I will do the intake interview, about 30 minutes. I’ve started talking to them about, “Hey one of the things I’ve noticed is that people will be really excited after the phone call, this sounds great, they can hardly wait, they’re really on board. And then sometimes that next step, just showing up for class can be really scary.” Because I’ve seen that as a huge barrier. So I’m kind of telling you how I’ve addressed it. So I just say, “If anything comes up for you, feel free to call me or send me a text or an email and let me know if you want to talk more. Let me know if there’s something I can do to make it more accessible for you.” The way I found that out is that a lot of my students...what was
happening is I would give them a heads up, being really transparent, “Hey it looks like we may have some new students start, so you may see some new faces next week.” And then [the new students] never come and they’re like, “Didn’t you say we were having new students?” And I’m like, “Yeah, this seems to happen.” You know, people get excited in the phone call. So we’ve had these conversations, and they said “Well I’ll tell you, just getting from the phone call to class was really hard.” It’s scary because you know you’re going to be in a room full of trauma survivors, so that’s really vulnerable. And adding something to your schedule is hard, and really dedicating the time when you’re already really scared. Another thought I’ve had about that is can I get them in for an individual session where we do [TCTSY], so at least they’re familiar with me. And I have not done this yet, it’s just some brainstorming I’ve done, that if I could do individual TCTSY first and then invite them to the group...I don’t know, it’s just some things I’m thinking of. But I notice that there’s a huge barrier there.

I: That’s so practical.

P1: Yeah and then for sure financial and time. I’ve only ever had one client where I did the intake interview, and she didn’t really I don’t think disclose just how disregulated she was and how dissociative as a result then. So then when she came to class it was overwhelming, and she didn’t come back. But she said it was just too much. I said “That’s totally ok, is there any other way I can help you” “No, I’m just going to stay with my individual therapist.” And I was like, “OK”. So I know like since then I’ve really been mindful of screening well, even more than I was. I already was to begin with but screening even more.
I: Boy those are some really clear, practical steps that therapists could use, thank you for sharing that.

P1: Of course!

I: Do you have an example of a time when you were treating a client with complex trauma history who was participating in therapy but encountered a road block...

P1: Oh yeah all the time [both laugh]

I: And then you can either think back to a time before you knew TCTSY or a time when you used TCTSY...how would that have changed the situation?

P1: So I actually...I’ll give a maybe more direct answer in a moment...I actually sought out TCTSY for the sole purpose of, I was trained in EMDR and what I was finding is that a lot of my clients with complex trauma could not tolerate it. Some of it could have been I was a new EMDR provider, it was a couple years in. And some of it I think is it is a pretty intense protocol, EMDR is, it’s a lot. Even though we do a lot of prep work, it still sometimes is too much. So I thought, I had read David Emerson’s first book, not realizing it was David Emerson’s book, because I’m a yoga teacher. I thought, how could I incorporate, I’m always interested in how could I use yoga for therapy, it’s why I became a yoga teacher. And then I saw his second book. I had searched on how you can use yoga for trauma in therapy and I came across his book and read his book and was like “oh yeah, I’m getting trained”. So I emailed him that week and was registered. So I mean... and I have found that how I found TCTSY useful, is maybe it’s not the only trauma-based protocol I do, but it’s often the first. Because... I find it to be for most people gentler. If they’re willing to try it. Some people just don’t want to do it. They hear the word “yoga” so sometimes they freak out about that, and I try to explain a little more about
that. But I find that [TCTSY] kind of helps them get more connected with some sense of self so that maybe they can tolerate better EMDR. Or, when I use IFS, internal family systems, if they didn’t have a very good sense of self energy or self with a capital S, then the TCTSY helps create that. And so I use it that way a lot. And even since, let’s say a client wasn’t super interested in, I kind of offer a menu of options and see what resonates more with them. And one of those is TCTSY and I also talk about IFS and EMDR. And I just kind of talk about pros and cons of each and what I see valuable and what I see could help them specifically. And then I say, “What would resonate most with you?” And let’s say they choose like IFS or EMDR first. But we’re having, like with IFS let’s say, they are not able to get self-energy in their system to be able to really do it. Then I kind of say, “Hey let’s back up for a moment, and see if we can...so I know that you initially said [TCTSY] is the way you want to go. But I wonder if it would make sense for you to try TCTSY for a bit because I’ve noticed that if we do that first, or as part of it, then sometimes the IFS goes more smoothly because you’re able to connect with that self-energy.” So that’s how I’ll do that with IFS because I see that a lot with complex trauma, and again that could be because that’s pretty new with IFS, I’ve only done my level 1 training. But with EMDR, I’m actually pretty careful with EMDR nowadays. I really do a ton of resourcing. And if they don’t want to do TCTSY as part of it, that’s ok. So [getting stuck] happens less with EMDR, but sometimes I’ll say the same thing, “So let’s back up a little bit. What I’ve noticed is that we’re getting stuck, you’re repeating a lot, your memories are getting stuck and even when we do cognitive interweave the memories are still stuck. So what if we tried [TCTSY]?” So whenever I see those other processing types get stuck, even if it’s something they initially weren’t open to, I kind of talk about
why maybe [TCTSY] wouldn’t be a bad choice to consider now. But again I always talk about choice with treatment in general, ever since I did my TCTSY training, I’m much more offering kind of options that they have. You know? I don’t know if I answered your question.

I: Oh you did!

P1: That’s what I’m seeing. Yeah.

I: Really helpful and again so practical and clear. I think in a way you’ve answered the next question but I’m just going to ask to see if there’s anything that comes to mind. Are there any situations where you’d be less or more likely to suggest TCTSY to a client?

P1: Yeah so like I said I do more of a menu and I think if a client has a problem with the word “yoga”, I say we can certainly call it something else. Or if I know they have a history of trauma with yoga, I offer, “Would you like to try some mindful movement?” So that’s one way I kind of talk about it. I think I will say I’m a little...I think this is maybe some of my own implicit bias showing up...but I’m a little more hesitant to offer [TCTSY] with men because they seem less open to it. I mean if they are a man who seems like they could do it, I will, but yeah then...and then I think if someone is terrified of being in their body, like if the word “body” is upsetting to them, then maybe we do some other stabilization skills first.

I: Great, thank you.

P1: Yeah. That’s what I can come up with right now.

I: Yeah, that’s great. Last question that I have is would you like to share any additional comments or feedback about TCTSY and utilization of therapy?
P1: Like I said I think it helps really well to get people more present, and I actually do see them having more of a sense of agency, even if only with me. Which I think is a nice place to start because sometimes the place where they are in their homes, it’s not safe to have a sense of agency. Right? Like if they’re still in an abusive environment, and setting boundaries, sometimes that can invite more abuse. So I think that’s impressive. I do hear a lot in my group about how great it feels to hear about that they have a choice. I also hear that sometimes the word “choice” in and of itself is overwhelming to them. So sometimes I initially won’t use the word “choice” when we first start. Maybe the first two movements we do, I’ll say, “You get to decide” or “You’re in charge” and then I start to weave the word “choice” in, especially with new students. Or if I know someone in class has a hard time with that word, I did have an individual client who had trouble with that word, so we kind of build up to that. I am excited and impressed with how [TCTSY] does help people seem to be able to shift the relationship with their body even if it’s just a little bit at first. I think that’s exciting.

I: Yes

P1: I have had challenges keeping my class full, my group full just because of some of the things I’ve talked with you before, so that’s certainly frustrating. And I will say something that has made [TCTSY] less easy is now that the current administration got rid of NREPP, it’s a little harder to talk about it. I mean it’s evidence based, but people misuse science all the time, so that means a little less now, because they got rid of NREPP and because I can’t point to the website. So I found that to be unfortunately a barrier sometimes. That’s been upsetting to me because I’m displeased already with things that are happening with the administration, so then that’s one more thing. Yeah, but I’m trying to
think of other things. Mostly really positive, yeah. I have noticed like I said, some people get overwhelmed with it, so then I’m really careful. So I think that’s all I’d really say.

I: Well I have learned a lot about how to deal with barriers and make it more accessible just talking to you, so I’m going to be really excited to get this transcribed and commit more of your ideas to memory!

P1: Thanks, I’m excited to see your results! Yeah. It’ll be fun. And I will tell you a lot of what I offer and some of the ways I address the barriers has come though being really active in the TCSY community and problem-solving together. I did the peer supervision thing for one year, just continuing to participate and learn I think. And then just really being open to client feedback, just like Dave was, I think he did a nice job mirroring that for us. When if we can really listen when clients are having a hard time or when they’re really enjoying it, “What is that about for you, would you help me understand that, if you’re willing? Right? No pressure, it’s not your job to teach us, but we really want to help make this accessible for you and for others. So do you have any thoughts on that?” And most of the time people do. Sometimes they’re like, “Ummm...[hesitantly],” and I’m like, “You won’t be in trouble if you share it!” And they’re like “I’m just not ready in my personal stuff”. And I’m like, “That’s ok, you’re not a bad person for not sharing.” But almost always what I’ve learned is just listening to clients and then like I said, connecting with community. So these aren’t all my ideas. Some of them came from other people and some of them were brainstormed in my supervision with Dave and some of them came from those brain stormings if that makes sense. So I just like to give credit where it’s due.

I: Yeah! And you’re leveraging the community which is seems like one of the precepts of TCTSY, kind of making the power more even and learning from one another.
P1: Yeah, totally, totally. I’ve been a little less connected to it in the last six months. My mom died abruptly six months ago...

I: Oh I’m sorry.

P1: So I’ve been a bit overwhelmed with just functioning on a basic level, going to work and seeing clients. So I haven’t been as involved in the last six months. But I definitely plan to get back to it once I’m a little a more stable.

I: Yeah, yeah. Well that makes so much sense and I’m so sorry for your loss.

P1: Thank you I appreciate that. I appreciate that.

I: And I also so appreciate the time and the insights that you shared. Thank you so much for taking the time.

P1: Of course! Thank you for asking and if you have any follow up questions that you think of, you’re free to just let me know.

I: I sure will. And I’m going to stop the recording.

**Transcription of Participant 2 Interview, August 28, 2019**

Interviewer: I am just starting my recording here so I just wanted to check with you that it’s still ok with you to record this interview today. Is it all right to record it?

Participant 2: Sure that’s great.

I: Ok thank you for you that and just know that if there’s any question that you want to skip or if you want to stop at any point, that’s perfectly fine.

P2: Sounds good!

I: Ok. So let’s just start with the first question here. How did you negotiate or introduce the idea of TCTSY into therapy with your clients?
P2: Sure, so I lead two group TCTSY classes and so I have the flyers just up in my office and in our waiting room and a couple other more visible places. So sometimes it will come out of client questioning of, “Ok that looks interesting but I don’t want to commit to a group”. The other way, I have four offices so I sort of joke that I have a traveling suitcase. Literally it’s a suitcase of supplies, and among those I’ve kept yoga cards. So sometimes I’ve had clients that will pull it out that way as a resource. And now that they have the specific TCTSY [cards] I’m really excited, that makes that it even easier. And then with some clients, depending, maybe you get this too, some read my bio really carefully, or some seek me out because I do body-based work. I’m also trained in sensory motor, so I do a lot with that. So sometimes it will just come up with folks in the intake, of what can you offer me that’s different from anyone else, or what can I expect to get out of treatment, or what approaches or whatever. So usually I bring up TCTSY as one possibility, group or individual at that point.

I: That’s great, some it sounds like it’s almost like passive advertising although of course you’re not advertising, but you’re just putting the information out there and seeing who asks about it.

P2: Right, and with some clients I will directly bring it up as, “Here’s something I’m noticing and here’s why I think...” just directly approach it that way. But I’ve found, I’m trying to think, I can’t give you exact numbers, but I would say the majority of my case load I’ve done some form of TCTSY with either individual or group at some point. It’s just such a lovely resource and a just beautiful addition to what we’re doing. And I’m not sure Dave at all would appreciate me saying this but frankly there’s a lot of parallels with sensory motor. And so frankly with some folks I’ll use it as an introduction to sensory
motor, so I’ve given you this, I think of TCTSY as a prescribed experiment that they can choose to engage, and then I might take it a step further with sensory motor, “do you want to design an experiment. Here’s what I’ve offered you and here’s what we’ve chosen as a list together, do you feel ready to make up your own.”

I: Oh that’s fascinating.

P2: Again I don’t think Dave would appreciate me saying that, so I fully say that off label. I think there’s research to be done of how this can be a beautiful bridge to other somatic approaches.

I: Agreed.

P2: But I know...I have found models, I love Dave and all, I really do, but I think when you spend so much of your time investing in a model, there’s something to be said about fidelity. And so I want to honor, I recognize they’re separate, and this is how I’m using it and finding it super effective.

I: Oh that’s so interesting. Well there’s...I think it’s always worth exploring how the modalities are actually used when the rubber meets the road.

P2: Right because it’s so different in theory and in reality. And I will say, I love this [TCTSY], I wish I could do more of it because it’s just been such a beautiful gift for individual and group.

I: That’s great to hear. When you think about how other therapists might access TCTSY, do you have any thoughts about therapists could refer to TCTSY more effectively?

P2: I yeah I think I don’t know in your region but here there’s a lot of “everyone thinks all yoga or all so called trauma informed yoga is the same and what we offer is not necessarily different,” so I think some clarity on this is an evidence-based modality. The focus
is...I work almost exclusively with domestic violence and sexual abuse across the lifespan and so for one I have my colleagues refer or frankly anyone regionally we talk about how this focuses on choice while other models, other yoga classes are less likely to do that.

I: Great.

P2: Because for that population in particular that is such a key, key focus of our work. And I think honestly I’ve found just the more folks, if I can give little five minute demos or let them come and sit in on the classes, that’s been a really helpful for referrals for folks to experience what it feels like to be in a class. And to experience what it’s like with my voice versus with Dave or Jen, because my own voice is going to be a little different.

I: That’s really smart to do that.

P2: Well it’s ...in some of my work settings, I’m in a major medical system and I’ve been fighting an uphill battle because this is part of our work and our program. And frankly I didn’t get much buy in until people saw what it was and until I summarized the data in one page. And I think just even that one page hand out of “ok yes there’s all this beautiful literature, here’s what you might be likely to read in it.”

I: That’s really so usable that you would distill it for people and also pull out that one point about choice.

P2: Well in referrals to knowing most of my referrals are going to be DVSA related. I think if I was opening it more to other forms of trauma, I might focus more on some of the other points. But for the specific referrals I tend to get...I was thinking about that too just are there other points where you might want to highlight some of the other benefits of this? At least here interoception doesn’t seem to get much buy in as some of those other points. But I’m in the Midwest in a very rural area and so even the word “yoga” still has a
little bit of push back. So I don’t know. I’m going to transition, I’m home, hang out a
second while there might be a loss of connection. Are you still there?
I: Yes.
P2: All right beautiful. Yeah I’m not sure what else I can say about that question. I’ll also
just say about targeting approaches, I’ve found a lot of buy in and referrals from Reiki
teachers and from our integrative medicine team who seem to be more open to “this
doesn’t all have to look the same”. And the other referral source that’s actually been phe-
nomenal is our local Y.
I: Really!
P2: Yeah, which is surprising. As I learn more, the Y as a whole is looking at what are
barriers to fitness for folks, and they’re starting to get cognizant that trauma can make a
lot of being in a gym really hard...
I: Yes.
P2: So nationally they’re looking for other ways they can be more relevant in their com-
munities. So they have been some of my biggest supporters eventually. I teach over there
one day a week...
I: Really!
P2: Yeah, which has been phenomenal because it’s still therapy, and I say, you know, I
am a licensed therapist who also does this. But um, yes, anyway. So I don’t know if that
helps but I think just being curious...I’ve found other clinicians were more likely to refer
once they were hearing about it from patients who found out about it at the Y.
I: Isn’t that interesting!
P2: Right?

I: So leveraging community organizations that are not necessarily about trauma services directly.

P2: Correct. And I guess I’m not sure what else that might be other than some of these holistic approaches that I think are inherently more aligned with this. I thought going to other yoga studios would be, I did not at least here, I haven’t gotten as much support from them as I’d hoped. But the ones through the Y, I’m amazed, it’s been such a big supporter.

I: That is great to know especially because you’re talking about being in a rural community.

P2: Right, so that is a big... And frankly I think having childcare just makes any service more accessible.

I: That’s right. I think you’ve answered the next question but I’ll just ask it in case you have any other thoughts. What might prevent therapists from referring clients to TCTSY to help with CPTSD?

P2: Yeah I think it’s lack of knowledge of what [TCTSY] is. Which is exciting that it is new and cutting edge, well newish. At least in my context, and I guess I don’t want to speak to all, but here there’s been a lot of skepticism when I come from a CBT-based organizations. So it just doesn’t sit with the general culture. I think there’s been some concerns from other providers about liability or risk or just insurance of how will I contain any problems [clients] might have if anything comes up. Or what problems are [providers] going to get because of what [TCTSY] is going to bring up or are they ready as clinicians to hold whatever might come up as a result of this.
I: And how would you suggest addressing those barriers, of the lack of knowledge?

P2: For me that one page handout has really been ... part of it’s timing, part of it’s been, I mean I’ve been doing this three years now and for the first time I have a pretty steady stream of referrals.

I: Ok, so it can be time as well...

P2: And I think opening the group, participants know this that folks might come in and out. But they don’t know if it’s another participant or if it’s a colleague or who it is necessarily, and as long as they’re engaging that’s been a...frankly it’s so weird, because we’re a teaching institution so we’re encouraged to have you know graduate students or PA students or whatever it may be sit in with our patients, and that to me feels really invasive. But [graduate students sitting in on TCTSY group] to me has been a beautiful compromise because they can be there and learn without it feeling like it’s taking away from anyone. And I also reached out to our local graduate programs in anything mental health related.

I: Oh wow that’s wonderful.

P2: Yeah I really don’t drink the Kool-Aid on models often but this one really has something, I really believe in that. That’s helped too I think is grad students. Because I stumbled into this by accident, honestly I was stumbling for a master’s topic. And something, I don’t remember I think it was a blog post about trauma, referenced this as an up and coming. And my advisors were supportive, just fully said, “This is new to us, you’re kinda breaking ground, you’re not going to be able to rely on us for that academic knowledge.” So part of me is just really hoping it’s time, and a better research body, and just I think we have to advocate for ourselves in this. I’ve found that for the sensory mo-
tor community too. I’m guessing it’s similar with other body-first approaches. Just I think folks are fearful because it’s so not CBT and not measurable and I think it makes us vulnerable as providers in some ways because we have to be willing to be there in it with [the clients].

I: Yes.

P2: And I’m not... I think some other therapy modalities allow us to keep that outside, or that barrier, that distance. And I’ve talked to some of my psychologist colleagues, who actually that’s how they were taught is “you need to keep that distance and it’s not ok to get closer or to be on an equal footing with [clients] at any point”. So I think part of it and I don’t know if it’s just these particular psychologists but I wonder too if discipline of therapy if that makes a difference, or their training, or their interests, and just comfort level with vulnerability and that authenticity...which one of the things I most love about [TCTSY] and what can sometimes be a challenge is that shared authentic experience.

I: So you’re talking about getting TCTSY to therapists during their educational process, such a good idea.

P2: Yeah.

I: What about the shared authentic experience is most challenging for providers?

P2: I think it’s culturally, we’re conditioned that we don’t have to feel our bodies. And professionals, I think especially we feel we have that luxury when we’re with a patient that it’s not about us, and if it is about us, we need to contain it real quick and then deal with it later. Or at least that was my training was “recognize your own stuff but then unless it’s a rare case where you could use it beneficially for the client, then you need to contain it. And deal with it later.” I think the first time we experience embodiment or ex-
perience it in that way it...to ask someone to be vulnerable and to have that shared authentic experience at the same time, when both of those are big asks for a lot of is, I think is intimidating. I’m not sure how to better titrate that for folks other than I tried to get grad students in because then I can process with them after. And they have their supervisors and a bunch of supports built in.

I: I like what you’re saying about titration and processing, they might be two pieces to help people go forward with that shared authentic experience.

P2: Well and I think also just accepting, “what would happen if you tried this shift, what’s the fear behind it.” I took... state laws are weird, so I ended up having a psychologist as a supervisor when I was doing my training hours who clinically could not be more my opposite. Which is fine, it turned out to be, because we were both open, a beautiful, beautiful thing. But I mean she talked about it is not ok to be in a shared authentic relationship because they won’t respect you. Or it’s gonna blur boundaries and especially with DVSA clients you do not need that boundary blur. And while I see that I guess I’m comfortable jumping between both and having those conversations about boundaries.

And I realize not everyone is or not everyone has the luxury of time to do it. And the other thing, I sort of modified our TCTSY a little bit in the sense of, and this is based on patient request, that they want 10 minutes at the end just to name anything they’re noticing. So we don’t process anything past, it’s just present moment, “I notice this”. And that also gives me a chance for that direct feedback if they want to give it, or folks can leave. Like this last few minutes is completely, like “there’s a separation with general movement, we’ve done our containment, I will be in the room for 10 minutes, here’s open discussion if you want it”. But I feel like even that offering at least for me has allowed that to “okay,
we’ve had this and now if you need me as your therapist under a very limited thing, here’s what we can do.”

I: That’s great.

P2: Yeah, and that was totally based on their feedback. They just said it feels really awkward to just leave. And they didn’t want to be waiting in line to see me basically.

I: So kind of leaving it open rather than just “come up one by one if you have questions.”

P2: Right, and I’ll say too, “If you need a one-to-one hang out you can call me or whatever, but if you feel like you’d like some group support, if you think others might have this question or concern or noticing....” And sometimes folks don’t have anything to say and that’s fine. But, and I actually talked with Jen about that too, I’m curious if folks who aren’t therapists could do that, because it’s not really processing. Or if it starts to get processing, we don’t have time really do much. So I can say, “Great, note it for your individual therapist.”

I: Yeah I mean if it’s really talking about somatic experience, that could probably be done by any facilitator...

P2: Right and I’ve found [therapy content] doesn’t really come up with that question either, of just, “What are you noticing from practice?” I mean some of them might say, “I had a flashback,” or, “I had a memory that I hadn’t thought about in a long time”. But then, “Ok so what do we do with that, is there, what do you need to resource or contain or ground or whatever it may be. Or it is even just that you need to be heard that you had that [experience] and that’s awful.”

I: Well that’s kind of an innovation in how it’s being used, that’s great to hear.
P2: Yeah, I found it helpful, I don’t want to tell other people how to practice but that seems to...and when I’ve mentioned that to other colleagues, to go back to your original question, that’s been kind of a nice bridge of what makes it therapy in their eyes. If there’s still a discussion and a processing-like experience.

I: Oh yeah so it’s like a transitional use, potentially, for some therapists

P2: Right and so if that gives them...and frankly when I’ve had grad students, or practicum students, who they can’t lead the TCTSY itself, they can open that question. So that’s something any entry level therapist can work with. And I’ve checked, and that still fits within because it’s not—I’m not saying that part [the post-class discussion] is TCTSY. It’s just, “You’ve had an experience, here’s a discussion time if you want it.”

I: Great. Ok moving to a different look at barriers. Are there any barriers that you’ve noticed for clients to participate in TCTSY other than what you’ve already mentioned?

P2: Yeah, so there’s been a couple...some of it, it seems to depend of referral source. But there was one period where I had a mix of bariatric patients pre-surgery and folks whose coping strategy was starving themselves. And that was a place when I really wished I had two separate sections, because it was hard for those folks to be in a room with each other and not get into some scary cognitive stuff.

I: Yes I imagine.

P2: Even though they could all benefit [from TCTSY], that was a barrier I did not expect I guess. And I’ve had a similar issue with gender but I solved that of, one group is female-identifying and the other is open. I think it’s kind of similar barriers frankly as for therapists of being asked to be in body is a really big ask. So I usually emphasize, that’s not my first selling point, you know. It’s, “Do you want, can you tolerate being in a room
with other people who can also say at least to me for the intake paperwork that they’ve experienced trauma at some point? Can you be in a room with other people?” That’s a big ask for a lot of our folks. We can resolve that with the individual but I guess in terms of bringing TCTSY to a small group, I will also say frankly of me being thin and white and female has been a trigger or an obstacle for some of my folks. And my being queer has been an obstacle for others for different reasons. I’m not sure of a way around that other than just recognizing that there are levels of privilege that can make it hard. That’s true for any modality but I think it’s more apparent in this one.

I: You’re talking about structural elements that could be apparent in a lot of forms of therapy, but since this is body-based, they might come up a little bit faster.

P2: Yeah and I think it’s a little bit more obvious. And I think individual it’s a little easier to titrate that. But to be asked, “Here’s yet another setting where you are physically different” is a big ask.

I: That’s really true, that can be such a big part of someone’s pathology or part of the pain of their condition. Boy these are such great insights, I just have a few more questions...looking for your thoughts, when you were treating a client with a history of complex trauma who was participating in therapy but encountered a road block, would TCTY have changed the client’s experience at that point? Or maybe you introduced TCTSY and there was a change. What are your thoughts about that?

P2: Yeah I think I can speak to both. I think...so one patient ‘s story, we did hit kind of a stuck and she was open to [TCTSY], which kind of surprised me. And the insight that came out after three months of weekly TCTSY was, “Wow I can make choices for myself and they can be good choices. I don’t always make bad choices.” So actually from there,
and this surprised me, lead to the conclusion, “I should leave my abuser, because that would be a good choice for me, and I can’t do that wrong.” And this is after months of individual work where I was kind of dancing around, “Are you really ever going to get better if you are in abuse 24-7.” But she credits TCTSY as the turning point for her because of that focus on choice. I have a couple other clients who...I hesitate to bring things up, I prefer that it come up more naturally whether they pull it out of my suitcase or they see it on the wall, but I think they would really benefit from the grounding and the community [of TCTSY group] and just...I think body integration is the next step. And I feel like with this population I have to be really careful because I don’t want to push things. Because they had enough coercion in their lives.

I: Yes right, right.

P2: But I think for a lot of folks, with any of these principles, right, to have an authentic experience with an authority figure, to be in a relationship with me in a different way, I think... and I’ve actually seen that shift relationship. I had an adolescent client, and that was another surprise to me, I opened one of my groups to adolescents and adults. Which has been lovely. I expected protest on both sides, and I didn’t get it. The adults have told me they love seeing teens getting help early.

I: Oh...that’s nice!

P2: Right and the teens have said this is the motivation for them, they don’t want to be in treatment when they’re in their 70s. One adolescent in particular changed our relationship because she said, “Look, I have permission to sit there and sulk at you for an hour”. And I said, “Yes you do, if that’s what you need to do to feel in control and have choice, I care not if you sulk.” But if she does it in individual session, she’ll get yelled at by her mom.
And so yoga has different rules. So I will say that really shifted our rapport and kind of did get her moving a little bit more just to feel like she could dig in and do the work she needed to.

I: And you gave her a real choice.

P2: Right and I don’t think it feels like real choice when it’s in individual therapy when her mother’s grilling her and everything. As much as I can beg parents, “Please just let me do what I need to do”, that’s not going to happen with every parent, and I get that. But there’s nothing to grill about with yoga. We move for 45 minutes. The end.

I: Yeah. Those are great examples. Anything else to share before I move to the next question?

P2: I don’t know how many case examples you need...I’m just thinking of another patient where this really made a different in severe dissociative, really good dissociative skills.

Part of it for her was not feeling connected to her body at all or not seeing parts of her body. And there was...I’ll never forget this one session of yoga where I said something like, “You might choose to look at your feet.” And she had this epiphany that “I have feet and they’re mine and they got me out of things” And I think that’s something I couldn’t have pulled off in an individual session.

I: That is so interesting that that was the chain of events.... just looking at your feet lead to that realization.

P2: Right and just that permission so she saw her feet for the first time. Because for her, body parts come in and out of awareness, she can’t always see herself in a mirror. Really extraordinary dissociative skills with what she’s survived. This took weeks of group but there came a point when she could look at her feet and see that they were hers. So yeah a
beautiful modality, I think it does make a lot of big differences. I wish we could get more folks trained and on board.

I: Well you’re doing that! Any situations when you would be more or less likely to recommend TCTSY to a client?

P2: Let’s start with less, because I think that’s easier, and I think that I’ve mostly covered that one. I think that with groups at least based on my current population I might hesitate if I don’t think folks are going to feel like they fit, or that they’re too different. With individuals, if they’ve been in the unit, I tend to wait at least a month before I bring this up as a possibility just because it can be so activating and I want to make sure they’ve built a month with at least some stability or at least enough to live independently. With folks who have just flat out told me, “I’m never doing body stuff” because they know that tends to be my theoretical leanings, I won’t push it or I wouldn’t actively recommend it if they’ve given me a hard no. I take that as no until they tell me otherwise especially because I have so many other...I mean, [descriptions of TCTSY are] in their face, they could bring it up if they wanted”. I’m trying to think otherwise, I mean...I don’t think so, because I have folks with MS and with chronic pain and in wheelchairs, and with low cognitive functioning, and this just seems to be one of the few modalities that’s beautifully accessible for those needs. Because there’s always still something they can do. And even my low cognitive folks, actually this is usually one of the first groups I’d recommend for a lower cognitive. Because they don’t necessarily have to understand what I’m saying, they can look around and still feel like there’s a sense of that belonging. And then they can start to get group support in a way where the material is more accessible. I found I tend to refer, and maybe this is just my gut right now or my current case load but I’ve
been referring more and more adolescents because of that choice piece and because of their skepticism with therapy and their barriers to it. They’ve told me [TCTSY] doesn’t feel like therapy.

I: So interesting, certain groups....

P2: Right yeah, which has just been a lovely, I can get so much more buy in if we start with [TCTSY] and then move to individual work.

I: Makes so much sense...

P2: Yeah.

I: Go ahead I’m sorry

P2: No I think that’s all I got. What was your next question?

I: This is actually the last question, and I will just mention if any thoughts come up after we wrap up today, we can certainly have a follow up phone call or you can feel free to send me anything. The last question is just do you have any additional comments or feedback about TCTSY and utilization of therapy that you’d like to share.

P2: I think I’ve said a lot. Now that I’m thinking of, it’s just it’s nice in that it offers so much flexibility. I have some folks with individual [sessions] who start and end with this, or if they start to get disregulated, that will be on the list of things we can try, if they’re tugging toward the edge of a window. Even if it’s not a full practice per say but just two or three forms that they can just lead or pick ones that I know they like, and I’ll just go by default to those. I’m trying to think what else. I think it’s just making it more accessible and I think really selling it more and distinguishing ourselves from all the other...I think there’s a place for this to be in the community and I’m all for that. But I think also there’s a place for this for those of us that are licensed therapists to bring [TCTSY] in to the
room. And I think probably I said this earlier but I find it a really nice bridge to more direct somatic work because it can be titrated a little more easily and because it’s a little more familiar. And maybe this is my weakness as a facilitator but I tend to give more or less the same [TCTSY] sequences, same spiels, [so clients] get familiar with the languaging, and so I think that element of predictability builds safety.

I: Yes.

P2: And once that’s established, we can start to think about, “would it be feasible to try being in your body. Or paying attention to your body for more than a hot second.” And if we’ve already started to build that, “Ok can you tolerate interoception for just a moment, and then I’m gonna offer you something else”. And I’ve found it frankly a beautiful bridge to mindfulness and more in depth, because I’ve found a lot of the breathing work, and the “can you pay attention”, even the progressive muscle relaxation is really hard for my sexual trauma folks.

I: Right.

P2: So [TCTSY] can be a nice introduction to that. Especially knowing they can make choices. And once they feel confident with choice, ok “skip clutching or squeezing your glutes if that feels like too much. Stop, don’t do it, that’s ok, you can.” And I think that permission to say no or to make adjustments really gets solidified by TCTSY work.

I: It’s so experiential... it’s like you’re introducing the ideas but then you give them the experience of it.

P2: Right and I think especially in a group setting that seem to feel more...well, not for everyone. But I feel like if I do mindfulness one on one, or breathing one on one, that can
feel really awkward because of the relationship. But in a group setting when there’s, especially when I can get a more mixed group of folks who’ve done [TCTSY] for a while...I do drop in style approach at this point, that’s been really nice, if they can see other folks are doing other things and that can give permission.

I: You really know your community and you’re just doing so much innovative work with finding the right modalities that fit to help your community. That’s remarkable.

P2: Thanks. Really...I don’t know, I really believe in this stuff. I haven’t found any other, and that makes me question my field sometimes, but I haven’t found any other trauma modality that feels so right. And I’ve been trained, I do TSCBT and EMDR and sensory motor and the list grows but this, maybe it’s that shared authenticity [in TCTSY] and just all that “you really do have choice.” And I think some of these other modalities, as much as I love them and still use them I think they sometimes can feel more coercive even if that’s not our intent. And I don’t think there’s anything...I think Dave et al. have done a beautiful job of taking out as much of the coercion as they can.

I: That’s right.

P2: And it’s been interesting, as I’ve done this, I’ve realized this has changed the way I practice EMDR. In that my training at least, they didn’t train us to use invitational language, you just “go with that, stay with that” or whatever. I’ve started throwing on the invitational language, and I’ve felt a shift in it. I don’t know if patients have but to me it just feels better. To give them that choice: “If you want to stay with that sensation, go for it.”

I: Wow so it’s kind of pervading other aspects of your work.
P2: Yeah and I think, I have a weird department, there’s 4 therapists and 5 advocates under one umbrella. And so I’ve been teaching [the advocates] about this because they’re one of my prime referral sources and half my team. All of these principles are things they learned in advocacy training. Which I thought was really interesting of just ...to them it made complete sense, from that lens. While I think with therapists sometimes I feel like we have more barriers to making this seem obvious. Or to making [TCTSY] seem, making it feel natural. Three years in and it still doesn’t always feel natural to me as much as I do it. So I think it’s been interesting talking with folks in other professions and how for them [TCTSY] makes complete sense. This is what they’re already doing, I just happen to be doing movement with it.

I: That’s really cool.

P2: So I’d be curious about that. I don’t know. It seems like training for DV advocates really varies but at least the 5 that I work with, it seems like, they said that this is in their code of ethics.

I: So interesting.

P2: Right so I think this is...if nothing else, in some ways this is the most beneficial training I’ve done because it has pervaded everything else and by following those principles with or without movement. As much as I can.

I: Yeah. Wow well thank you, I’m going to have a lot to think over after hearing your insights, I really appreciate it!

P2: And I’ve love to read your stuff, I’m curious what other ...sometimes I feel as little isolated in this work as much as I appreciate the [TCTSY] app. If that makes sense. I’m glad folks are doing this research. I’d love to see more communities of therapists doing
TCTSY. Which it sounds like you’re building. Can I ask more about your dissertation, what you’re looking at?

I: You certainly can. I’m going to stop the recording.

**Transcription of Participant 3 Interview, August 30, 2019**

Participant 3: Glad we could make this time!

Interviewer: Yes, me too, thanks so much for being willing to be interviewed.

P3: Yes of course, it’s very important to me.

I: I’m just going to ask, I’m now recording the call, just want to be sure that I have your consent to do that.

P3: Yes absolutely.

I: And just so you know you can choose to skip any questions and please feel free to stop the interview at any time.

P3: Perfect.

I: All right. So first question for you, how did you negotiate or introduce the idea of TCTSY into therapy?

P3: So when I started the training... oh gosh it could have been around the time I started or even before I started it...I started to invite the option to begin with a [TCTSY] practice, each session, with all of my clients. And so I described [TCTSY] as movement, as an option, I would give an option of breath, movement, relaxation or mindfulness. So that was one way that before we even talked about TCTSY as an intervention, it was an option that would show up through movement if they chose movement. I would always do it as a TCTSY format. Yoga, you know in that way. And so that is just a part of my practice is that people may be introduced to that experience in that way. And then from there if there
were things that were specific towards embodiment, trauma, or trauma symptoms, then I may introduce it more directly as an intervention that has a purpose and this is something we could explore even more directly. Whether it was in a group, I ran a group, if they wanted to participate in a group, or if we were here in our individual work together, a little bit more fully. Does that make sense?

I: It sure does, that’s very helpful. I’ll ask a follow up question, how did those conversations go with your clients?

P3: That’s a very open question, I mean I could say...I mean my first response is I think they would go well. I think some people would be very curious and interested. I think some people understood the resource, how exploring embodiment practices would be or could be a resource. There are also some who would feel timid, and I think pretty nervous and afraid. And unsure. And some who continued to choose not to do [TCTSY] even though the offer stands and comes up from time to time as a resource. And I’m thinking of one person in particular. Intellectually, I would say can wrap her head around [TCTSY] being useful and it making sense. And in an embodied way, has not cultivated a readiness to explore it whether it’s in the group that I offer or here [in individual session]. These ranges I would say, you know.

I: That makes so much sense, and it sounds like you create an environment where your clients are free to choose any option.

P3: All the time. To me, I have felt that the teachings of TCTSY have changed how I practice therapy wholly. Not just the, if you would think of the movement piece. The non-coercion is very significant and options, very significant. And honoring power is a very significant piece.
I: Well that’s very helpful. Would you like to say anything else about that? Does anything else come to mind as to how TCTSY has changed how you practice?

P3: Yeah I would say that that beginning piece of offering individuals an option if they would like to choose a practice today or not, and my non-attachment to that and being able to model that, that unspoken modeling in the relationship when we’re together. “It’s up to you if you’d like to or not, you know, you’re welcome to or not”. That a lot happens I think in our relationship when a person either chooses something or doesn’t choose something that day. I think there’s a lot of attachment work that’s happening as we’re just exploring in that first five to seven minutes of practice whether or not they’d like to do something. And for me I think that has shifted how relationship happens in therapy and in where power comes from. In the relationship. And for me that feels very TCTSY, and I’ve felt it be incredibly useful. Does that make sense I hope?

I: It does very much and also very helpful. To switch gears a little bit, from your experience with TCTSY do you have any ideas of what would help therapists refer to TCTSY for CPTSD more effectively?

P3: Just so I can rename it, to see if I’m getting this right. Refer to it, meaning like, in moments, if they’re in a session with someone and they’re witnessing something or kind of coming across something and they’re just wondering, “huh, I wonder if TCTSY would be a good match here for this person” and how they refer to that.

I: Yeah. It also could be a clinical referral.

P3: Ah, referral out to someone who is doing [TCTSY], is that what you mean?

I: Either way actually.
P3: Yeah. Yeah, so let me think about when...I’m so sorry, I don’t know if you can hear it, there’s someone doing yard work outside of my office [laughs]

I: Oh that is no problem!

P3: So if you hear that, that’s what’s happening, and I can’t actually escape it unfortunately. I would say when that [option to refer to TCTSY] shows up, I would say there are, when there are moments, particularly when I have clients who are sort of stuck in the processing and thinking, and they’re struggling with linking their body with their brain. So sort of stuck in the processing and thinking and also feeling like they’re not making a lot of movement in therapy, as if things are not happening, they’re not going. And there’s sort of a stall. Those are moments where if it feels safe starting to bring embodiment, to start to increase some connection between brain and body and maybe some depth in the work. Other moments are difficulty with experiencing being in their body and wanting to be able to start to explore that. In a place that may have sort of a safe enough environment to do that. That may even be client-lead or it could be a wonder coming from the therapist. You know, they notice that and if they want to name that and sort of wonder, if that’s a goal that the individual has that hasn’t been named yet. That I’ve had someone come to me who she was, she expressly said that she felt like she kept reaching a wall and that she was very numb to her emotions and she was wanting to be able to feel. And felt [TCTSY] was very helpful. That was in one of my groups. And I might be able to come up with others if you want, if I sat with this for a little longer but those would be the first ideas that I kind of come up with.

I: Yeah that’s fantastic, and if you do have other ideas after we wrap up today, we can always have follow up phone conversations. And you actually answered my next ques-
tion which was, if you had a client who was participating in therapy but encountered a roadblock, how would TCTSY have changed the client’s experience. And you just answered that beautifully, thank you for that. Do you see any roadblocks either for therapists or for clients to participating in TCTSY or using it? You mentioned one client who was kind of intellectualizing. Any other road blocks on either side, client or therapist?
P3: Yes. So this client I’m referring to right now, I think she can give me a mental “yes” to TCTSY but there hasn’t been something that’s happened to a physiological “yes”, a physiological permission to start to explore this. And so this is where I’m sitting with this particular client, because she’s got a mental “yes” but we haven’t been able to access the physiological “yes” together in some way. And so I don’t have an answer to that yet, but that is something I’m sitting with, and may collectively sit with her and wonder about that...if there really is this mental divide or if she wants to explore this. So naming that with her, saying that might be happening. And it seems to make sense to you, I don’t have to name what that means, right, like that makes sense to you when I say that?
I: Yes, I think that’s really a powerful insight that there could be a mental “yes” and a physiological “no.”
P3: Yes. Right.
I: And how do you navigate that.
P3: Right. And I think TCTSY is perfect for that. The foundation of it, right, and what we’re devoted to here. Yeah so that was one thing. Another thing I would say is the clinician probably feeling comfortable in introducing [TCTSY] and sort of talking about it and maybe even exploring embodiment practices. You know. I don’t have that [issue]...but I have heard this from others in my community. And I’ve been kind of encour-
aging them to participate, to get some training in TCTSY and start practicing it you know so that they can maybe start to build up some sense of comfort in doing this themselves, and maybe how do we start doing this with clients and feel safe enough. You know. Through practice together. Yeah. And I wonder too, is like the fear of what will come up and if there’s something that’s maybe too much if we start to go down this road, is it going to be too much. Whatever the too much is.

I: Really good point. Really good point. So the therapist would need to have some comfort with, “Hey if I open this up, do I feel like I can keep the client safe with whatever direction we might go.”

P3: Right, yeah. And maybe for the client too, like a shared... whether it’s at the same time, a client may too be afraid, “what am I going to find out in there, what’s it going to be like.” When I talk with individuals about the group, because I have a, I mean often-times when I get to talking about TCTSY with my clients in my individual practice, we’re already experimented with some movement. They’ve often chosen it at least once. So I’m able to refer back. It’s like, “You’ve kind of done this already, this is the kind of movement we do. You know. There’s a way that you’ve maybe just chosen it and kind of liked it.” So there’s somewhere in there of like, “Oh, maybe it’s not as scary as I thought it would be”. But with others who are entering in to the group to be able to talk about, being able to honor that sometimes things do come up, and sometimes things really things aren’t...there isn’t always as much as what one might think. We don’t always know exactly. But sometimes it could just be like noticing my big toe and feeling that and sometimes it might be something else, like noticing and feeling into that. Yeah so I guess for me when I think about clinicians, their own comfort level of going in and kind of
wondering into their bodies and being able to access noticing might create more of a sense of, “oh ok, this is what’s it’s like to go in”. And maybe sometimes it can be something [significant] and maybe sometimes it’s just a noticing. And it’s a neutral noticing. All the varieties of what you might notice in there might give them a sense of safety and grounding and going into ...so that collectively they can have something like that to kind of explore from together. Make sense?

I: Great. It does, and in a way it sounds like you’re talking about shared authentic experience too.

P3: Right. Right.

I: You said, just to double back, you said for the client who maybe had a mental or verbal “yes” but physiological “no”, you were saying TCTSY was really perfect for her. Can you say a little bit more about how it would be a good fit for that situation?

P3: Yeah. So I think there’s two ways I think about it. One is if I...the approach to even just inviting this into awareness with this individual. If I was even to talk about that, “you know we talk about [TCTSY], and it seems like in your head you’re saying yes, but maybe I notice there might be something else there. Like maybe in the space between us or maybe even how you’re feeling in your body there might not be a yes there.” Just to even... just even in that way, talking about that, to me that feels...that curiosity, that wondering, that languaging, that not giving an answer to something. That feels a little kind of TCTSY. Like, “I’m not going to tell you what that is. I’m not going to psychobabble anything. I’m just going to kind of hold some space, and can we wonder at this together.” Because I really don’t have the answer exactly of what’s going on. And because how could I know exactly what’s going on inside [someone else]. And the intention may be to
hold space, and can we co-wonder together. And I might be wrong, and we might want to close it right there. And my non-attachment is helpful in all that for safety and wondering. So that’s just in the verbal part of wondering about this. But in the physiological part too, that if there was that unconscious mapping and tracking that’s happening all the time, of what’s happening in our relationship. When I ask her each time if she wants to do some sort of practice with her body, and I practice non-attachment to whatever she’s choosing, that may be giving some permission for her to make choice and for her to notice and be ready when she’s ready. And that when we do start to go into that noticing that, it’s all the attachment piece that’s in there, that safety in relationship and choice, and I think that’s huge. Whose body is this, this is her body. And this is not just her brain, she actually has a body. And we’re just going to name it, there might be a brain response and there might be a body response and wonder about it. I don’t know. Is that clear enough for you?

I: Yeah, that’s fantastic because it’s really getting into a lot of the [TCTSY] core principles in a very specific way, so we get to see how things like that shared power and asking permission and invitation, how all of would those play out. And that’s great.

P3: And I would say the non-attachment to me so key and that as the clinician do I actually embody that in felt-sense way or am I just pretending? I don’t mean that, because it sounds really judgy but like you know, “I want to be non-attached but [laughs]...I’m not really that unattached.” And how can I really check myself on that you know?

I: Yes, and that’s authenticity too, feeling out, “I want to be non-attached, but maybe sometimes I’m going to be a little bit attached.”
P3: Right, and then if that does happen, and that is a felt sensing that happens in the room, how do we repair that? Because that really in an injury in safety and power and choice. And whose life is this anyway, and what are we doing here, and who’s responsible for what. You know? So for me, this has helped me sort of track how in an embodied way the things that we’re doing together...and the space in between at all times, and the choices that we’re making and where it comes from. The movement, the growth, and yeah. I don’t know if that makes sense when I say that.

I: Yeah this is really helpful. And just if you would like to, do you have any comments on the repair that you talked about, how that would occur, repairing the relationship?

P3: Yeah totally, totally! There’s...with certain individuals my guess is that their tracking meter is higher. On me. Like what’s my facial expression... that [with those individuals] I might sort of name things when I’m off, or ...this just happened today, so this is wonderful, and it doesn’t happen all the time, but it happened today, like an hour and a half ago [laughs]...

I: [laughs] I love it.

P3: Isn’t that great? Oh you know... So I came in, and I did the thing, “would you like to practice or would you not like to practice.” And she chooses no, which is a choice, which is a big deal. And this is an individual that honestly if I were to really break down... with this individual the TCTSY approach for therapy has been integral, integral with movement I would say, and the non-coercion, and honoring where power comes from, and her choice and creating opportunity where she can...and acknowledging when she’s making a choice which, no is a choice. You know. It’s been a big piece for allowing for movement and seeing I think actually significant growth for her. And so here we’ve been doing this
together for about 2 1/2 years. So I came in [today] and did the thing, “would you like to practice, would you not like to practice”. And I had kind of a stressful phone call right before she came in, and so my mind was like a little on something that I found out about, someone was sick, so my life stuff, it happens. So I think there’s a way where my mind was still tracking that thing, in some capacity, even though I was trying to orient to her and here and now. And then I was like, “oh, I forgot my coffee, can I get my coffee?” So I got my coffee, and I sat down, and I was like, “Would you like to practice... I said that before! Woah! Wow. I’m so sorry, I was really ...I was not with you. I think I need to pause for a moment, I think I need to breathe for a minute. I think I need...” you know. So there’s a way that I was being really authentic and maybe a little vulnerable in saying, “I think I need to breathe for a minute” and so I did a little breathing practice. I invited her to join me, she already said she didn’t want to...but there was a way that I was going to, I had to, right? To be able to be with her. And that was real. And it was maybe 3-4 breaths. Not a huge amount of time. I don’t think it was a major boundary violation of taking too much time. But it allowed me to then arrive, you know, even more, like in an embodied way. I was back, I was there. And then I just acknowledged it, you know. I was like, “I’m sorry, I kind of had a lot of plates spining I think. And now I put those aside, and I’m here with you now more. And I apologize for that”. And so to me I think that would be...I just sort of named the miss. And kind of did it on my own. In a very short way. And I’d have to think about if there’s been any other ones that I saw it, that I did a thing...I know with this client in particular there’s been moments where I’ve kind of seen it, I’ve guessed it, and I’ve wondered. And I’ve also been able to name when she started to tell me what she likes and what she doesn’t like, which is so huge with this individual. And I
really want to credit TCTSY 100% to the possibility of that ever happening in this relationship. Because of the things of her starting to make choices, and her having a voice, and she’s been able to directly tell me that she didn’t like something.

I: Wow! Wow.

P3: Yeah! That means a lot to you too, that’s huge, with this client, it’s huge. With some other people, not so huge. With her it’s very significant. It’s very significant. Yeah.

I: So I again, I don’t want to get into prescribing for the future but it sounds like that might be someplace where TCTSY could be helpful. Because I’m sure a lot of therapists encounter clients who have difficulty with expressing their own preferences.

P3: Yes!

I: Do you have other situations that come to mind of situations where you would be likely or less likely to suggest TCTSY? It sounds like you do at the beginning every session, but more in the flow of the session or group?

P3: I missed that last part.

I: So I know you would start just about every session with an invitation [for TCTSY]...are there places during a session or group where you would be more or less likely to suggest it again?

P3: Oh yes, right! Yes. So if someone declined, and other times, they seemed to be kind of sitting there like, “Ummm [hesitantly]”, I might say, “If you’re feeling ‘no’ right now, we could always explore this again later.” Sometimes that happens in the middle of a session or toward the end of a session, that we might explore a practice somewhere in the middle or the end. So if there’s that sense of a person who’s like, “oh I don’t know,” I might throw it out there like, “There’s more than just this one option, there’s another
time, it doesn’t have to be only in this time that we explore [TCTSY].” So that’s one way. And then maybe in a session...so to be clear, too, the groups that I offer, I do offer body image groups, and when I’m doing that, there’s sort of a time that we’re doing the movement, so [TCTSY] is a part of it. So we may do sort of talking, educational practice in some sort of way, and then we do an experiencing and movement. And it’s sort of a set time, and people know that they’re coming and we’re doing this. The other group that I offer is TCTSY. And we really just do that. I don’t do any other blending psychotherapy or traditional psychotherapy and TCTSY [groups], except for the body image group. And we don’t really process the movement after, it’s actually the ending. And so there’s a closing and a going. So for that. But in a [individual] session, where might I wonder about [introducing TCTSY]? I mean...there are moments where...this is a good question. It all depends on the person. Sometimes very much so if there is some not feeling in their bodies, kind of getting in their head, wondering if we’d want to explore some movement and see what comes up, that’s a possibility. And if somebody’s already expressed that as a goal. Another maybe specifically a feeling of ungrounded, definitely could come to the body as a resource, you know moving away from a sensation and towards like a neutral sensation, “can you notice,” something like that. Or if being in stillness kind of...like to explore something different, if you’d like to explore into some movement, if you’re feeling kind of still or stuck a little bit physiologically. You know, always can notice and pause again. But that titrating, being able to do that. Yeah. Those are coming to my mind so far.

I: Yeah, those are great examples and very clear. I have reached the end of the questions that I have. So at this point what we just ask is do you have any additional comments or
feedback that you’d like to share about TCTSY and utilization of therapy? And that could be now and/or a follow up call or email.

P3: Ok. I think I already said that [TCTSY] has changed my practice and how I practice wholly. If I didn’t say that, I want to say that again. I’ve found that if we were thinking of the whole practice and incorporating the, I don’t know if we would call them tenants, but the core aspects of TCTSY, I’ve incorporated them with certain individuals and their specific needs that I’ve noticed that we’re able to make movement. Or I say “we” in a relational way, as well as “they”, are able to make so much more movement, than I could have with traditional, I would say maybe western medical model, teachings, therapy. And just to name, there’s three different sort of...I have a focus with eating disorders, anxiety disorders, sometimes a certain amount of OCD, and the trauma. There’s varying thoughts about these different populations and getting sort of getting stuck and entrenched in certain things. That I feel like now with TCTSY I am able to not recreate patterns of harm in the therapeutic relationship that I was [originally] taught to do as best practice. And so I am so grateful that I think that there’s like an understanding [in TCTSY] of that trapping and recreating patterns of harm that I didn’t see before. And yeah, really grateful for that. And thinking, yeah about especially eating disorders and trauma patterns and how they can co-occur. Yeah. And that understanding that movement can be so minute but so big. Seemingly so small and simple but so profound and deep. When it happens like this. And there aren’t these little check box things that are necessarily being [marked] according to like “did you do this”, but it’s more sustainable, it’s deeper, it’s richer, it’s... you know. Yeah. More personal. So that for example that thing of like, she, this one client I mentioned earlier, she actually said she didn’t like something that I was doing. Now she’d
probably bristle at that because it’s really hard for her to like even to conceptualize that still. But that was the action that happened. She wanted something different, and it felt like I was doing something that wasn’t ok and it wasn’t really helpful or useful for her. And whoa, so huge, that was a big shift, and as there’s been these little moments, she’s become more independent, and they keep building on each other. She keeps, it keeps building, without us every directly going to those behavioral changes and saying “these are your tasks”...they’re happening.

I: That’s really cool

P3: Yeah! We’re not doing that sort of, “ok, here’s your assignment!” You know. There are discussions around things like that, but it’s different. It’s a different quality to our discussions.

I: Yeah. And the work itself is so different, and it sounds like it’s creating a different relationship for you with your clients.

P3: Yes! And so for her a relationship with herself and hopefully more and more over time herself and the world and outside. Yeah.

I: Well this is very, very powerful information and I’m extremely grateful that you shared it. And really if any other thoughts or examples come to mind that you’d like to share, please feel free to reach out. Would love to get more feedback from you if there’s more that comes to mind.

P3: Great! Absolutely! If it’s ok, would you mind sending me your questions because there was one where I was like, I feel like I have more thoughts on it, but I can’t remember what the question was. Just in case something comes up.
I: Oh I will certainly do that. I’d love to do that, and you may see them a little differently because it’s a semi-structured interview and we sort of go off what you’re saying. But sometimes reading the original brings up more thoughts too. So yeah, I will send those off to you today, and I’m going to stop the recording now.
REFERENCES


Brooks, J. (2016). *The girl behind the door: A father’s quest to understand his daughter’s*


Clark, C. J., Lewis-Dmello, A., Anders, D., Parsons, A., Nguyen-Feng, V., Henn, L., &
DOI: [http://doi.org/10.1016/j.ctcp.2014.04.003](http://doi.org/10.1016/j.ctcp.2014.04.003)


DOI: [https://doi.org/10.1176/appi.ajp.2010.09081247](https://doi.org/10.1176/appi.ajp.2010.09081247)


Retrieved January 4, 2018 from

[https://www.yogajournal.com/practice/not-all-yoga-is-created-equal](https://www.yogajournal.com/practice/not-all-yoga-is-created-equal)


DOI: https://doi.org/10.1007/s40801-015-0055-0


DOI: https://doi.org/10.1016/B978-0-444-53491-0.00009-2


De Bellis, M.D. (2001). Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment,

Google Scholar.


(Eds.), Mindfulness-oriented interventions for trauma: Integrating Contemplative practices. New York: Guilford.


DOI: 10.5032/jae.2014.05078.


Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V....


Friedman, M. (2017). PTSD History and Overview. From US Department of Veterans
DOI: http://psycnet.apa.org/doi/10.1037/10723-000


DOI: 10.1016/j.surneu.2008.05.023


Herman, J.L. (2015). *Trauma and recovery: The aftermath of violence--from domestic abuse to political terror*. New York: Basic Books.


DOI: 894–9867/9220700—0377506


DOI10.1177/0011000097254001


DOI:10.1001/jama.2014.6670


Retrieved May 9, 2018 from
http://religiondispatches.org/claiming-yoga-for-india/


https://repository.library.northeastern.edu/files/neu:964/fulltext.pdf


DOI: https://doi.org/10.1017/S1121189X00008575


Levin, P., Lazrovec, S., & van der Kolk, B.A. (1999). What psychological testing and
neuroimaging tell us about the treatment of posttraumatic stress disorder by eye movement desensitization and reprocessing. *Journal of Anxiety Disorders, 13*, pp. 159-172. DOI: https://doi.org/10.1016/S0887-6185(98)00045-0


Directions in Psychiatry, 21(25), pp. 373-392.


DOI: http://doi.org/10.1517/14740338.2013.827660

Martindale, J., Swenson, A., Coffman, J., Newton, A. W., Lindberg, D. M., Bretl, D., ...


Public Library of Science, 7(11), e48230.


complementary medicine, 23(4), pp. 300—309. Retrieved from:

ProInspire. (2018). Awake to work to work: Building a race equity culture. Retrieved May 9, 2018 from
https://static1.squarespace.com/static/56b910cc660b971d5f98a75ae22562fa7ff76a49e9/1524764255184/ProInspire-Equity-in-Center-publication.pdf.

Raub, J.A. (2002). Psychophysiologic effects of hatha yoga on musculoskeletal and cardiopulmonary function: A literature review. The Journal of Alternative and Complementary Medicine, 8(6), pp. 797-812. DOI:
https://doi.org/10.1089/10755530260511810


https://thewalrus.ca/yogas-culture-of-sexual-abuse-nine-women-tell-their-stories/


Rhodes, A.M. (2015). Claiming peaceful embodiment through yoga in the aftermath of

Retrieved from:


Rosen, R. (2014). Who was Patanjali?: Learn what we know about Patanjali, the sage who wrote the Yoga Sutra. *Yoga Journal*(April 14, 2014). Retrieved May 9, 2018 from https://www.yogajournal.com/yoga-101/who-was-patanjali

field trial for posttraumatic stress disorder. *Journal of Traumatic Stress, 10*, pp. 539–555. DOI: https://doi.org/10.1023/A:1024837617768


DOI: 10.1016/S0006-3223(01)01215-X


DOI: https://doi.org/10.1098/rsbl.2015.0907


DOI: https://doi.org/10.2190/YDK2-C66W-CL6L-N5TK.


mind, body, and society (pp. 214-241). New York: Guilford.


