American Psychological Association

Spirituality in Clinical Practice

2326-4500/19/$12.00

2019, Vol. 6, No. 1, 27–43
http://dx.doi.org/10.1037/scp0000177

Trauma-Sensitive Yoga as an Adjunctive Mental Health Treatment for Survivors of Intimate Partner Violence: A Qualitative Examination

Viann N. Nguyen-Feng and Jamie Morrissette
University of Minnesota

Angela Lewis-Dmello, Hannah Michel, and Deena Anders
Domestic Abuse Project, Minneapolis, Minnesota and University of Minnesota

Chelsea Wagner and Cari Jo Clark
University of Minnesota

Yoga is a practice of uniting mind, body, and spirit that has been shown to improve mental health symptoms and is increasingly being used as adjunctive mental health treatment. Less well studied, however, is the impact of incorporating trauma-sensitive yoga into group psychotherapy for at-risk groups, such as survivors of intimate partner violence. Through the examination of care providers' (i.e., yoga instructors, group psychotherapists) viewpoints, the purpose of the present study was to assess, via qualitative interviews, the strengths, benefits, consequences, and challenges of integrating trauma-sensitive yoga into a psychotherapy program in a community setting for female survivors of intimate partner violence. This 12-week program consisted of 90 min of group psychotherapy followed by 30 min to 40 min of yoga taught by a registered yoga instructor. Nine interviews were conducted with 7 care providers following a structured questionnaire format. Interviews were recorded, transcribed, and then analyzed thematically. The results indicated that yoga as an adjunct treatment to group psychotherapy for survivors of intimate partner violence may have positive effects for both care providers and clients, exemplified by the identified common themes (e.g., spiritual healing, increased self-confidence, increased mind-body connection). Implementation of such a practice seems to be feasible within community settings with hindrances (e.g., initial client resistance) ultimately being worthwhile for the healing observed in the population served. The care providers reported experiencing more growth than distress in their work. An understanding of this dynamic might allow care providers to focus on these strength areas to increase well-being.

Keywords: yoga, trauma-sensitive yoga, care provider, qualitative interviews, intimate partner violence

This article was published Online First July 26, 2018.

Viann N. Nguyen-Feng, Department of Psychology, University of Minnesota; Jamie Morrissette, Department of Medicine, University of Minnesota; Angela Lewis-Dmello, Domestic Abuse Project, Minneapolis, Minnesota; School of Social Work, College of Education and Human Development, University of Minnesota; Hannah Michel, Domestic Abuse Project, Minneapolis, Minnesota; Deena Anders, Domestic Abuse Project, Minneapolis, Minnesota; School of Social Work, College of Education and Human Development, University of Minnesota; Chelsea Wagner, School of Social Work, College of Education and Human Development, University of Minnesota; Cari Jo Clark, Department of Medicine, University of Minnesota.

Jamie Morrissette is now at the Department of Medicine, University of Minnesota–Duluth. Chelsea Wagner is now at Tubman, Minneapolis, Minnesota. Cari Jo Clark is now at Emory University, School of Public Health, Atlanta, Georgia.

Correspondence concerning this article should be addressed to Viann N. Nguyen-Feng, Department of Psychology, University of Minnesota, 75 East River Parkway N218, Minneapolis, MN 55455. E-mail: viann@umn.edu

Yoga is a traditional practice of uniting mind, body, and spirit with various techniques, such as physical postures (*asanas*), breath work (*pranayama*), meditation, and chanting (for a review, see Cramer, Lauche, Langhorst, & Dobos, 2013). Integrating spiritual practices into psychotherapy is important as the field moves toward inclusivity and incorporating traditional forms of healing. Furthermore, yoga has been shown to improve a wide range of mental health symptoms and is increasingly being used as an adjunctive mental health treatment (e.g., van der Kolk et al., 2014). Less well studied, however, is the impact of incorporating yoga into group psychotherapy for at-risk groups, such as survivors of intimate partner violence.

Intimate partner violence has been associated with a host of poor mental health outcomes including posttraumatic stress disorder (PTSD), incident depression, and anxiety (e.g., Devries et al., 2014; Dillon, Hussain, Loxton, & Rahman, 2013) and warrants more treatment options. Group therapy is among the most frequently used modalities of mental health treatment, especially for lower-income clients due to it being more cost-effective than individual therapy (see, e.g., Morrison, 2001 for a review). As an adjunctive treatment, yoga may enhance the mental health benefit achieved through group psychotherapy by helping participants process trauma by engaging their bodies (e.g., Lin, Hu, Chang, Lin, & Tsauo, 2011), practicing self-care, and doing so in a safe space with mental health support that might not be available in a typical yoga class (Varambally & Gangadhar, 2016). Because regular practice outside of group is often not possible for survivors whose lives are frequently chaotic and unpredictable, the incorporation of yoga into group psychotherapy offers opportunities for spiritual healing that might not otherwise exist. However, the process of incorporating yoga is not without challenges and drawbacks and the view of the therapists involved in such an endeavor are almost absent from the literature.

The present study addresses these gaps by examining the strengths, benefits, consequences, and challenges of incorporating trauma-sensitive yoga (Emerson, Sharma, Chaudhry, & Turner, 2009) into group psychotherapy for female survivors of intimate partner violence as experienced by group psychotherapists and yoga instructors. This is one of the first studies to examine the process of incorporating trauma-sensitive yoga into a community mental health clinic and the first study to examine the perspectives of care providers in integrating this mind-body intervention into any setting.

Yoga for Survivors of Trauma

Yoga has been found to be effective in reducing distress and feasible to implement in samples with various types of trauma history. For instance, yoga and breathing techniques have been used with hurricane (Gerbarg & Brown, 2005) and tsunami (Telles, Naveen, & Dash, 2007) survivors to reduce stress and anxiety in an efficient and cost-effective manner. Yoga has also been found to reduce anxiety (Stoller, Greuel, Cimini, Fowler, & Koomar, 2012) and PTSD symptoms (Staples, Hamilton, & Uddo, 2013) among combat veterans. These beneficial results extend to traumatic life events, such as cancer; one sample of breast cancer patients undergoing an integrated yoga treatment program decreased levels of anxiety, depression, and stress (Banerjee et al., 2007), whereas another sample of breast cancer patients practicing yoga reported improved mood and less anxiety (Blank, Kittel, & Haberman, 2005).

These favorable results might be due to yoga's diverse, physiological benefits that assist practitioners to manage mental health disorders among survivors of trauma (Telles, Singh, & Balkrishna, 2012). For instance, Streeter, Gerbarg, Saper, Ciraulo, and Brown (2012) proposed that yoga reduces allostatic load and assists the practitioner to regain optimal homeostasis. Specifically, the cost (i.e., allostatic load) to the body in maintaining stability in conditions outside of homeostasis is theorized to decrease through the practice of yoga. As the benefits of yoga are diverse, the practice of yoga has become widespread; some women with a history of interpersonal violence report using yoga or other mind-body movement on their own as a self-care strategy for healing (Stenius & Veysey, 2005). Dale et al. (2011) found that yoga mitigates the negative impact of abuse on one's self-concept and ability to cope, with the greatest psychological benefits occurring when women incorporate yoga into various areas of their lives. These studies describe how yoga is able to help reduce distress and present

evidence to support the use of yoga as an adjunctive therapy for survivors of trauma.

Although yoga has many benefits, typical yoga practice might be challenging or triggering for trauma survivors. For instance, certain yoga poses might remind survivors of their abuse and vulnerabilities associated with it. Additionally, the instructive language used by yoga teachers in a typical practice might trigger reminders of controlling verbal communication that might be present in violent relationships. To address this particular need, the Trauma Center at Justice Resource Center in Brookline, Massachusetts developed a form of yoga practice attuned to the specific needs of trauma survivors (Emerson et al., 2009). The principles of trauma-sensitive yoga encompass these five domains that require particular consideration: environment, exercises, teacher qualities, assists, and language.

Regarding the environment, trauma-sensitive yoga adapts the environment and teaching of yoga to create a safe, less vulnerable space for those who might be experiencing the effects of trauma within their minds and bodies. For instance, lighting is not too dark, external noises are minimized, privacy is maintained, and props are included. Exercises emphasize feeling over posture attainment with a focus on safety, gentleness, and nonjudgment. Teachers are directive yet allow the control of the student's body to be placed on the student. They also aim to embody a welcoming, light attitude. Hands-on adjustments from the yoga teacher are also eliminated, as they can be triggering for students and disrespectful of students' physical space. Regarding language, attention is given to the needs of this client population by removing suggestive, commanding, or triggering language and using invitatory language that maintains clarity and simplicity. Trauma-sensitive yoga also reinforces themes that emphasize experiencing the present moment, making choices, taking effective action, and creating rhythms (e.g., feeling into the flow of one's body movements). Emerson and Hopper (2011; Emerson, 2015) described the importance of trauma-sensitive yoga over typical forms of Westernized yoga found in yoga studios. Because these forms of Westernized yoga might focus on posture attainment (vs. the trauma-sensitive yoga foci of feelings, etc.), potentially triggering hands-on adjustments, and commanding language, then the environment is not the most conducive for those experiencing trauma within their bodies.

Work from other trauma therapy and somatic psychology researchers provide evidence for how these five trauma-sensitive yoga domains are important to consider in this practice. For instance, polyvagal theory (Porges, 2003) posits that the vagus nerve is important for nervous system regulation and contributes to social behavior. Most relatedly, the ventral vagal nerve promotes social engagement in that relating to an individual who feels safe (e.g., yoga instructor) relays messages of safety to the brain, which also positively activates other parts of one's body. Thus, it is highly important for the yoga teacher to foster a safe, gentle, and judgment-free environment. Trauma-sensitive yoga also aligns with the three-phase model of trauma recovery (Herman, 1992), which involves co-creating somatic resources and building safety within the body; processing and integrating memories, sensations, and experiences into the whole-body experience; and embodying new choices. Somatic techniques that involve awareness and movement in the body are also theorized to promote regulation (Ogden, Minton, & Pain, 2006). Additionally, these grounding techniques can help survivors stay within their window of tolerance (Siegel, 1999), which is their optimal arousal zone between hypoarousal (e.g., numbness, lack of energy) and hyperarousal (e.g., overwhelmed, panic). Thus, evidence for yoga as an intervention for survivors of trauma spans theories in different disciplines.

This specific form of trauma-sensitive yoga has been demonstrated to be efficacious for women with severe and chronic PTSD (Price et al., 2017) and in reducing PTSD symptoms among women who have experienced complex interpersonal violence (van der Kolk et al., 2014). Long-term follow up (Rhodes, Spinazzola, & van der Kolk, 2016) of participants 1.5 years later indicated that the frequency of continuing yoga practice significantly predicated greater decreases in PTSD and depression symptom severity as well as loss of PTSD diagnosis. A systematic review and quantitative synthesis of other forms of yoga as an intervention to reduce psychological symptoms following trauma, including trauma-sensitive yoga, indicated that between-groups effect sizes (yoga vs. comparison condition) were moderate to

large (*d*s = 0.40–1.06); however, more rigorous designs of future studies are needed to allow for more definitive conclusions (Nguyen-Feng, Clark, & Butler, 2018).

The present study used trauma-sensitive yoga as an adjunctive treatment for female survivors of intimate partner violence seeking group psychotherapy. The feasibility and safety of incorporating trauma-sensitive yoga into group psychotherapy for survivors of intimate partner violence has been demonstrated (Clark et al., 2014). Less well studied, however, are the impacts of integrating yoga into group psychotherapy from the care providers' (i.e., yoga instructors, group psychotherapists) perspective. This study adds to current literature by examining the care providers' personal growth, perspectives on client healing, and assessments of the practicality of trauma-sensitive yoga from a qualitative study embedded within the larger feasibility study. The authors have no formal affiliations or financial ties to The Trauma Center at Justice Resource Center or to endorsing trauma-sensitive yoga. The study did rely on the trauma-sensitive yoga curriculum developed at the Trauma Center, and David Emerson, Founder and Director of Yoga Services, provided consultation to adapt it to the group therapy environment and trained the study team, therapists, and instructors in trauma-sensitive yoga.

Care Providers' Perspectives

Because of the meaningful impact that care providers have on their clients, a strengths-based approach of assessing the positive growth through trauma work is warranted. Bell (2003) asserted that taking a strengths-based perspective helps identify strategies and resources to develop care providers' well-being and to prevent secondary traumatization symptoms, which have been defined as work-induced posttraumatic stress symptoms (e.g., intrusion or avoidance of clients' trauma stories). These strengths include a sense of competence about the care providers' coping style, maintaining motivation for their work, and resolving their own personal traumas. Cohen and Collens (2013) suggested that though the impact of trauma work might lead to short- or long-term distress, managing such distress via coping strategies might result in vicarious posttraumatic growth, or positive changes or perceived benefits following a crisis; however, provider growth only occurs in conjunction with client growth. As the literature and terminology shift, there might be more of an expanded, nonbinary view of the impact of trauma work (viz., positive and negative; Cohen & Collens, 2013) that has already been demonstrated for clients (e.g., co-occurrence of posttraumatic stress and posttraumatic growth; Brooks, Graham-Kevan, Lowe, & Robinson, 2017).

There are researchers who acknowledge both the negative and positive impacts that trauma work might have on care providers. In one study by Dane (2000), all child welfare workers in a sample reported feeling sadness but were also able to develop their own coping mechanisms. Ben-Porat and Itzhaky (2009) noted that though family violence therapists in their sample reported more negative changes in their spousal relations and worldviews than nonfamily violence therapists, family violence therapists also report several positive changes. These positive changes include self-reported development of assertiveness skills, control over anger, and constructive communications skills.

Naturally, care providers have particular feeling styles when working with clients (Holmqvist, 2001), meaning that care providers might have certain emotional reactions or countertransference feelings that arise during the therapy process. However, these feeling styles might also appear in the form of vicarious traumas, in which the care provider reexperiences the client's distress in a secondhand manner. This concept of vicarious traumatization has been thoroughly explored in the literature and demonstrated to be experienced by a number of helping professions, including physicians (Kadambi & Truscott, 2004), humanitarian aid workers (Shah, Garland, & Katz, 2007), criminal lawyers (Vrklevski & Franklin, 2008), qualitative researchers (Rager, 2005), and, most relevantly, psychotherapists (for a review, see, e.g., Cohen & Collens, 2013). The concept of secondary trauma is important, as it can have a negative impact on the therapeutic alliance and the client's psychological well-being if the care provider's reactions become apparent (Hesse, 2002); however, as mentioned earlier, a strengths-based approach might prevent and reduce vicarious traumatization symptoms. Not only are the care providers' perspectives important in evaluating their sense of growth, but they are also important in assessing the care providers' views of client outcomes.

The addition of new members or a third party such as a cotherapist can influence existing dynamics (Hamerdiner & Karlin, 2003). Unique to yoga group therapy, a yoga instructor, as the third person, is added to the therapist-client dynamic. Although adding a cotherapist is viewed as equally or more effective (Hendrix, Fournier, & Briggs, 2001), studies have not examined the consequences of adding a yoga instructor into the relationship. With the addition of a yoga instructor, the group therapist becomes an observer of the client-yoga instructor dynamic. The relationship between these two care providers is important as faulty separation (e.g., differentiation between provider approaches) or individuation (e.g., a coprovider's ability to appropriately develop) of care providers might impact the clients if they note any tensions (Friedman & Handel, 2002). Additionally, the triadic relationship in yoga/group therapy of the clients, group therapist(s), and yoga instructor displays an opportunity to assess differing viewpoints in addition to commonalities. Thus far, qualitative interviews have not been conducted on the aforementioned matters nor have any assessed the dynamics within yoga group therapy despite the growth in understanding the benefits of yoga for survivors of trauma.

Present Study

Through the examination of care providers' viewpoints, the purpose of this study is to assess the strengths, benefits, consequences, and challenges of integrating trauma-sensitive yoga into a psychotherapy program in a community setting for female survivors of intimate partner violence. The present qualitative study is a component of a larger study designed to assess the feasibility and safety of an integrated mental health intervention consisting of psychotherapy plus trauma-sensitive yoga. This study involved offering 30 min to 40 min of trauma-sensitive yoga by a certified yoga instructor (with a minimal professional qualification of Registered Yoga Teacher 200) trained in trauma-sensitive yoga at the end of weekly 12-week group psychotherapy sessions consisting of 5 to 9 participants. See Figure 1 for a layout of a typical group therapy session incorporating trauma-sensitive yoga. Groups were facilitated by Domestic Abuse Project, a community agency that provides advocacy and psychotherapeutic care to men, women, and children affected by intimate partner violence (Clark et al., 2014). The study was extended to two additional sites in the Twin Cities Metro, Alexandra House and Cornerstone. The present study used qualitative interviews with care providers (group therapists and yoga instructors) involved in the study to explore the following three aims:

Aim 1: Assess Personal Growth and Impacts From the Care Providers' Perspectives

As much of the literature focuses on negative outcomes (e.g., secondary or vicarious trauma), we attempt to examine the strengths and impact of trauma work on providers in the yoga group therapy context. We aim to explore the positive aspects of working with intimate partner violence survivors, such as increased self-knowledge, spiritual growth, enhanced support between therapists and instructors, and other learning points. Examining personal growth and impacts of yoga group therapy work is particularly important because yoga instructors do not typically focus on work with survivors of trauma, but they serve as care providers in this yoga group therapy context.

Aim 2: Assess Perspectives of Client Healing From the Care Providers' Perspectives

We aim to examine the diverse perspectives and commonalities of viewing client healing across training backgrounds, study roles, and other individual differences of the care providers. This is particularly valuable as Clark et al. (2014) focuses on examining the feasibility of incorporating trauma-sensitive yoga group therapy into a community setting instead of examining client outcomes. Additionally, because yoga is a more spiritual approach to healing than usual psychotherapy practices, it is important to assess the impact of trauma-sensitive yoga on client healing.

Aim 3: Assess Care Providers' Perspectives of Practicality in Implementing Yoga Group Therapy Programs in a Community Setting for Survivors of Intimate Partner Violence

We aim to examine strengths and obstacles (e.g., vicarious traumatization) in order to present guidance for community settings that might

Minutes 0 to 90:
Group psychotherapy processing led by therapist
Yoga instructor arrives 10 minutes prior to the end of group psychotherapy to set up, mentally and physically, in other half of partitioned room

Minutes 90 to 120 or 130
Chair practice
- Breath awareness and elongation
- Seated mountain form
- Head drop/flexion/head rolls
- Shoulder rolls with elbows on shoulders
- Breathing and moving (hands raise, hands open/close, sun breath)
- Twist
- Sun breath
- Seated cat and dog
- Leg raise
- Forward fold

Standing practice
- Mountain
- Standing sun breath
- Warrior I
- Warrior II
- Tree

Mat practice, seated
- Easy pose
- Torso circles
- Head to knee pose
- Sage twist
- Seated forward fold

Mat practice, prone
- Knees-to-belly
- Extension
- Knees side-to-side
- Bridge
- Knee-down twist
- Reclining leg stretch
- Knee-to-chest
- Prone figure four

Closing circle

Figure 1. Typical layout of group therapy session incorporating trauma-sensitive yoga (Emerson & Hopper, 2011).

want to implement yoga group therapy programs.

Method

Participants

Nine of 10 care providers (i.e., group therapists, yoga instructors) who took part in the yoga group therapy program at Domestic Abuse Project, Alexandra House, and Cornerstone were asked to participate in the present study. One care provider was not reachable due to out-of-date contact information. Otherwise, all group therapists ($n = 5$) and yoga instructors ($n = 2$) who were asked agreed to participate. On average, the group therapists were 34 years old (range = 23–52 years) with 9.5 years of experience (range = 1–27 years). The yoga instructors were 37 and 56 years old with 5 and 14 years of experience, respectively. Educational background of both the group therapists and yoga instructors ranged from bachelors-level to masters-level training. Of the group therapists, three primarily identified as licensed social workers, whereas the remaining two primarily identified as therapists, one who was a

licensed professional counselor/licensed drug and alcohol counselor and another in her last year of her masters of social work. All group therapists were involved with clinical work at their community mental health center, in some capacity, though three had dual roles as social workers. One group therapist also had a subspecialty in alcohol and drug counseling. One social worker also served as the program manager and clinical director at her site. All yoga teachers had Registered Yoga Teacher certificates through Yoga Alliance, qualifying them as certified yoga teachers. Additionally, they received trauma-sensitive yoga training through the Trauma Center at Justice Resource Center.

These care providers worked with various clients across the three sites, which all followed similar protocols. Regarding the group therapy with trauma-sensitive yoga sessions, the group therapists were charged with facilitating the psychotherapeutic processing portion of group. The psychotherapeutic processing portion of group followed a manual originally created in 2003 (with continual updates based on the literature) and follows women-centered care guidelines on working with survivors of intimate partner violence (e.g., World Health Organization, 2013). The 90-min psychotherapy session rotated among 17 different topics that follows typical psychoeducation in psychotherapy groups serving intimate partner violence survivors, which included definition, myths, and causes of violence; self-identity; shame; survival skills; self-care; progression of violence; protection planning; culture of origin; sexuality; anger; grief and loss; boundaries and communication; and healthy relationships. Group sessions involved psychoeducation on these topics as well as interpersonal processing. Though the focus of the present study is on trauma-sensitive yoga as adjunctive treatment, the manual for the psychotherapeutic processing portion of group is available by the study authors on request. The yoga instructors were charged with leading the trauma-sensitive yoga portion of group. Yoga instructors were not present during the processing portion of group, though group therapists were present for the yoga portion of group. Regarding compensation for participation in the interviews for the present study, group therapists were informed that they would not be directly compensated by the researchers, as all interviews took place during the participants' normal working hours. Yoga instructors received their usual hourly compensation in exchange for their participation. All received a gift card as a token of appreciation.

Clients were not direct participants in the present qualitative study. However, 40% of the clients who participated in the groups met criteria for PTSD (per the PTSD Checklist–Civilian Version; Weathers & Ford, 1996), 33% had clinically significant depressive symptoms (per the Patient Health Questionnaire-9; Kroenke, Spitzer, & Williams, 2001), 43% had clinically significant anxiety (per the State–Trait Anxiety Inventory; Spielberger, Gorsuch, & Lushene, 1970), and 33% had current chemical use. Regarding sociodemographic characteristics, 44% of clients identified as non-White and 82% had a high school level of education or higher. Nearly a fourth (23%) of clients were currently living with their abusive partner and 62% had experienced three or more prior traumas in addition to intimate partner violence. All clients signed confidentiality and informed-consent forms, and the Health Insurance Portability and Accountability Act was followed. Each time a new group member began, the confidentiality policy was reviewed as well as information regarding mandated reporting and informed consent.

Materials

A structured interview questionnaire created by the coauthors was used (see Figure 2). The questionnaire consisted of four parts: (1) background, (2) yoga, (3) clients and group, and (4) future directions. The first part (background) asked about what types of yoga and other holistic health techniques the care provider had used in their social work or yoga practice prior to or outside of the study. The second part (yoga) evaluated how the care providers perceived the yoga portion of group therapy, its differences from their usual practice, and its impact on events. The third part (clients and group) assessed perceptions of the therapeutic alliance between the client and the yoga instructor as well as perceptions of client healing. Last, the fourth part (future directions) probed for changes, desired changes, and ideas to carry into future implementations of the study.

Background

1. Prior to or outside of the study, what types of yoga and other holistic health healing techniques have you used in your social work / yoga practice?
    a. How have you used these techniques?
    b. What training have you received in these techniques, if any?

Yoga

2. Please walk us through a night of the yoga portion of group from its start to its conclusion?
    a. Specifically, what did you notice or what stood out to you?
3. Group therapist: What impact did the yoga portion of group have on your ability to achieve group therapy related goals?
   Yoga instructor: What was different about your experience leading yoga after the psychological and educational portions of group compared to your typical group client experience?

Clients and group

4. Group therapist: How did the clients react to yoga in therapy? Did this change over time?
   Yoga instructor: How did the clients react to you and the yoga? Did this change over time?
5. What changes have you seen in clients in relation to the yoga in group?

Fut ure directions

6. How has incorporating yoga / trauma -sensitive yoga through the study changed your therapy / yoga practice approach?
7. What would you change about the process of integrating yoga into group therapy? What was successful?
8. If you plan to continue to use yoga or other holistic practices / work with domestic violence survivors, what resources or support would be helpful?
9. What have you learned from the study that you will take with you and use in the future?

Figure 2. Structured interview questionnaire.

Additionally, open-answer questions on facilitator forms were included in the coding. The care providers submitted a short, weekly facilitator form following the yoga group therapy sessions that were conducted as part of the (Clark et al., 2014) protocol. These forms asked the group therapists to list major or unique group events, client-reported symptom or presentation changes, client contact during the week (if any), and whether/how the research protocol was discussed. In addition to the above, the yoga instructors were asked to list deviations from the Trauma Center at Justice Resource Center trauma-sensitive yoga protocol (if any) and client-reported issues or discomfort.

Procedure

This study was completed with approval from the Institutional Review Board at the University of Minnesota and all participants completed informed consent. With the exception of one group therapist, all care providers were interviewed once within the 3 months immediately following the yoga group therapy program at Domestic Abuse Project. To examine care provider perspectives at various stages of the program (i.e., during, after), one group therapist provided consent to be interviewed three times over the course of one year, with the last interview occurring during the summer following the yoga group therapy program. Thus, nine total interviews with seven different care providers were conducted. Two trained, graduate-level research assistants who also have Registered Yoga Teacher 200 certifications conducted the interviews, which were each approximately 60 min in length. Interviews were recorded, transcribed verbatim by a professional transcrip-

tion service, and then analyzed thematically. Per suggested guidance from Knox and Burkard (2009), the interviewers received in-depth training, which included conducting interview role plays, reviewing prior transcripts, and holding debriefing sessions all under doctoral-level supervision. A trained undergraduate research assistant noted any environmental cues or hand gestures not otherwise captured by the audio for the interviews conducted in the summer following the yoga group therapy program ($n = 7$).

Coding categories were generated and refined following the data-driven approach described by Boyatzis (1998). Boyatzis described thematic qualitative analysis, in which a goal is to delineate the themes and patterns of qualitative data. According to this process, researchers look for themes in a flexible, not rigid manner. In a data-driven, inductive approach, data are coded without attempting to fit them into a preexisting coding framework or researcher preconceptions. This approach seemed appropriate given the exploratory nature of the research aims. For a review of Boyatzis' thematic approach, see Braun and Clarke (2006).

Following the thematic analysis plan, all interviews were coded synchronously by discussion and verbal mutual agreement of two research assistants. Because of the synchronous coding procedure, interrater reliability was not explicitly calculated, as consensus was required for each step. Consensus was reached via verbal agreement, in which the research assistants discussed the assignment of themes in person at every step, which ensured a concordant foundation and understanding of the data from the initial step and familiarization of the data. Because both research assistants were trained together by the doctoral-level principal investigators prior to the synchronous coding process, discussions were conducted professionally following communication guidelines discussed in the trainings. Discrepancies were discussed between the two research assistants and with the principal investigator, if needed. The principal investigator provided oversight and verified the accuracy of coding and themes through asynchronous (i.e., at a different time) review of the coded transcripts. Any discrepancies in coding between the principal investigator and the research assistants were resolved through discussion. A copy of the coding data dictionary that defines indicator, exclusion, and differential criteria is available from the authors upon request.

Results

Preliminary Analyses

The verbatim, transcribed interviews were coded with Atlas.ti v. 7 qualitative data analysis software. The data were then analyzed thematically using Atlas.ti v. 7. Each interview was examined individually rather than collated by interviewee due to potential changes in interviewee perspectives over time. Frequency and cross-tabulation tables of codes were created along with co-occurrence tables, which included calculation of the Co-occurrence Index (C-index; Contreras, 2011) that reflects the degree of common (i.e., overlapping) utterances (i.e., quotations direct from transcripts). These common utterances were measured from a range of 0 to 1 with 1 representing maximum overlap. The C-index is used to describe associations between concepts, which can explain the intensity, meaning, and role of the two factors under study. Two factors are considered to co-occur if they are in some way associated with each other in the transcripts. That is, the coded quotations are within, enclosing, or overlapping with each other. C-index values were calculated using the Co-occurrence Explorer Tool in Atlas.ti v. 7.

Codes were given various levels, given the repeated revision of themes in thematic analysis. First-level coding identified and labeled the data in the initial code generation, whereas second-level codes provided more detail on the patterns within the data. First-level codes were used to delineate the higher order concepts (i.e., broader themes) prior to delving into the patterned themes. These codes are listed primarily in order of the structured interview questions: *prior* (e.g., holistic healing techniques, trainings, and experiences prior to the study), *event* (e.g., walk through night of yoga, what stood out), *goal—therapy* (e.g., impact on group therapy goals), *goal—yoga* (e.g., impact on trauma-sensitive yoga goals), *diffs* (e.g., differences between typical practice and study), *pos* (e.g., positive reactions, feelings, stories, differentia-

tions.), *neg* (e.g., negative reactions, feelings, stories, differentiations), *reaction* (e.g., client feelings toward *x*), *change—client* (e.g., how client changed), *change—therapist* (e.g., how therapist changed), *change—instructor* (e.g., how yoga instructor changed), *change* (e.g., what one would change about the study), *keep* (e.g., what one would keep about the study or what was successful), *resource* (e.g., helpful resources), *learned—therapist* (e.g., new information gained by therapist), *learned—client* (e.g., new information gained by client), *learned—instructor* (e.g., new information gained by instructor), *benefit* (e.g., potential mental or physical effects), *instructor* (e.g., aspects of yoga instructors), *change—study* (e.g., changes in protocol made throughout the study).

Descriptive analyses demonstrated that the care providers came from a variety of mind-body training backgrounds prior to participating in the yoga group therapy program. These included having studied or therapeutically used visualization techniques ($n = 5$), rituals (e.g., closing circle, marking the moment), massage, meditation ($n = 3$), mind–body techniques abroad, ayurverdic medicine, eye movement desensitization and reprocessing therapy (EMDR), mindfulness techniques, art therapy, and sexuality exploration ($n = 2$). Care providers also had prior training in each of these techniques: Acting, voice, aromatherapy, hospice work, nutrition work, and reiki ($n = 1$). Especially notable among the therapists was widespread prior experience with mind and body work either through personal practice or through their work (e.g., visualization techniques, rituals, massage, meditation, EMDR).

Aim 1: Assess personal growth and impact from the care providers' perspectives. The examination of personal growth and impact provides information on yoga group therapy's effects for the two care provider roles (i.e., group therapist and yoga instructor). The common themes described by the instructors related to awareness of the impact of trauma, the importance of encouraging choices among the women, an increase in self-confidence, and present moment awareness. The yoga instructors stated that they gained increased knowledge in using invitational language (e.g., emphasizing choice instead of using usual instructional commands) that subsequently created visible changes in their teaching style, which was also observed by the group therapists. The yoga instructors (individuals who typically do not work specifically with trauma survivors) began to be attuned to the impact of trauma in how others understand their own bodies, which is illustrated in the following quote: "And now . . . I have an awareness that not everybody can [be present] so easily because of their stories and their life experiences." By examining the co-occurrence of utterances, the yoga instructors' change in their sense of security within the group environment was also correlated with changes in empowerment, support, and further knowledge of spiritual healing (C-index $\sim$ 1). Changes in all three of these components were also related to the instructors' sense of being included as more of an insider within the group dynamic (C-index $\sim$ .33).

Similar to the yoga instructors, the group therapists also reported changes in self-confidence levels ($n = 3$) and changes in their language ($n = 2$), with the latter consisting of understanding the different connotations of "yoga" (e.g., aside from an "elitist," physical appearance-focused frame of mind, as stated by one therapist when describing clients' initial perceptions of yoga) in addition to learning invitational language. Differentially, and despite not being the target population for the yoga group therapy, all of the group therapists described changes in their own attunement into their bodies as well as a strengthened awareness and knowledge of the mind–body connection. Particularly, utterances in which the therapist described herself as feeling like a participant of the yoga group rather than merely an observer were related to learning and a gain in knowledge (C-index $\sim$ 1). This awareness of the mind-body connection's strength is well illustrated in this quote by one group therapist who participated during the yoga group therapy sessions.

> When you're breathing, when you're moving, when you open yourself up to that new experience, there's something—I do believe that there's something that is there. There's energy, there's mystery, there's connection, solidarity. It's power . . . it adds another dimension to the healing in group. I see it, I feel it—I do not know what the words exactly are, and I'm sure there are words that could describe it more. There's something vulnerable about it too, there's that connection in our vulnerability that can be pretty powerful.

By examining the co-occurrence of utterances, the therapists' strengthened connection with themselves was related to a strengthened connection to their body (C-index ~ .4) and to awareness in the present moment (C-index ~ .5). One therapist said, "it (taking part in the trauma-sensitive yoga group therapy program) makes me better as a therapist."

A common event that stood out to both yoga instructors and most therapists ($n = 4$) relating to the yoga group therapy was the transition period between the end of group and the start of the yoga exercises. The two yoga instructors mentioned this experience in five utterances. Particularly, the yoga instructors felt as though they were outsiders entering the group dynamic, which three therapists also similarly described the yoga instructors as such. Therapists noted that building trust ($n = 2$) and support ($n = 3$) with the yoga instructor stood out to them during the yoga group therapy period. However, this feeling of being an outsider appeared to have changed over time, as illustrated by a quote from one yoga instructor:

> It took a little while after a few weeks for me to feel like I was kind of integrated into the group because it was really like I came in, we just did yoga and I left. I was not even sure, like, should I know their names? Should there be just total anonymity, like I'm just here to teach yoga and then I leave; I'm not really part of the group. But over time it became clear that . . . I was like a healing energy that could benefit these women and their relationships would benefit me.

Aim 2: Assess client healing from the care providers' perspectives. One therapist described the purpose of the yoga: "[The clients] come [here] for specific support around the abuse . . . [We] just give a little window into the wisdom of their bodies and what a resource that is, if they could just tap into . . . You've got all this other—I mean, our trauma lives in our body, we know that, so if we're all [in our head], we're missing huge wisdom and huge healing potential and huge resource that each person has." Both care provider roles (group therapist, yoga instructor) noted benefits of trauma-sensitive yoga on the body ($n = 5$), breath ($n = 4$), and self-awareness ($n = 4$, all therapists), and emphasis on choices ($n = 3$). Utterances in which the care provider spoke of empowerment co-occurred with utterances in which the care provider mentioned the benefits of invitational language (C-index ~ .5). Two therapists described initial lack of openness from the clients to the yoga practice itself. However, this appeared to change over time and was balanced by the many benefits that the care providers noted, such as by the following therapist:

> Throughout the time there I noticed women feeling more comfortable taking choices for themselves, doing different things. I think in the beginning they were more following [the yoga instructor's] instructions to the T, but toward the end became more comfortable making choices for themselves. So some women would do the exercises a bit differently, or some women would choose to be in their seat for most of the time and then during the session then the next week would be backup or back on their mat or whatever . . . They were making different choices for themselves, doing different things, feeling comfortable to do that. Then seeing [one client who was used to] sitting in the corner, sitting in the front row—she was sitting in the front row in the middle and doing almost all the poses and having the support of the other women as well. So that was definitely one thing, pretty major difference, I would say.

Adding onto the aforementioned perceived benefits of trauma-sensitive yoga, the care providers described visible changes in the client's body ($n = 5$) and self-awareness ($n = 4$; therapists only), sense of calmness ($n = 4$), knowledge and appreciation of their sense of choices ($n = 6$), and sense of safety ($n = 4$ over eight utterances). This mind-body connection is important because, as one therapist stated, "When we experience traumatic experiences we lose the use of language. We often don't have word to describe what we're experiencing or what happened." That highlights the utility of mind-body work; however, only the instructors (over four utterances) tended to mention applicability of the yoga into the client's daily life, citing examples in which clients spoke of their application of the yoga.

Additionally, the yoga instructors (over five utterances) were more likely to describe how the clients softened their reactions to the yoga to be less inhibited though both care provider roles spoke of the increased openness to participating. Utterances regarding softened reactions co-occurred with those describing a change in the instructor feeling like an insider of the group (C-index ~ .17), viewing the clients to have moved away from self-judgment (C-index ~ .17), and viewing the clients to have applied more yoga into their daily lives (C-index ~ .13). The therapists particularly noted changes

in client-to-client support (all therapists over 11 utterances) and emotional responses to the yoga ($n = 2$). Another event that stood out primarily to the therapists ($n = 2$) was the self-judgment that clients potentially had not only while participating in the yoga, but even in choosing to take food if it was offered (C-index $\sim$ .5), though changes were noted over time. Additionally, the therapists ($n = 3$) tended to note a sense of calmness over the group at the end of the yoga practice, specifically in comparison with the milieu during group processing. Both the therapists and the yoga instructors noted a strengthened connection to the body among the clients, which might have been associated with triggers that some clients experienced in the yoga session.

> As the weeks went by, there was more and more of just like everyone looking forward to the yoga, enjoying the yoga. But it was still hard, like there were still times where you could tell that certain clients did not want to do the yoga because it was just going to bring up feeling, and they didn't want to have that happening. In one instance a woman left the room. So it was like people warmed up more and became more comfortable but it was never like the yoga became really easy for everybody. Even up until the last session there were still some triggers happening . . .

Particularly, utterances describing the clients' reactions to their body awareness highly co-occurred with descriptions of the client's change of self-awareness (C-index $\sim$ 1).

Furthermore, the changes in the clients' knowledge of their choices were associated with utterances regarding the client's change in trust (C-index $\sim$ .44), empowerment (C-index $\sim$ .13), and self-judgment (C-index $\sim$ .13). The client's change in willingness to share with others in the group was also associated with strengthened empowerment and openness to the yoga (C-index $\sim$ .20). One therapist described it as follows: "Self-confidence of the women increased a lot . . . that was new for some of them and then especially for the women with the severe PTSD symptoms feeling more calm in her body and able to feel her body . . . it was powerful."

Aim 3: Assess care providers' perspectives of practicality in implementing yoga group therapy programs in a community setting for survivors of intimate partner violence. The care providers noted the many aforementioned strengths and benefits in implementing yoga group therapy in this community setting, though a few care providers listed the following resources as potentially helpful in the future: Additional readings on trauma-sensitive yoga and the mind-body connection, quieter and more open space to conduct the yoga group therapy, and additional training on trauma-sensitive yoga. All care providers noted the yoga group therapy as meeting both yoga and group therapy goals, though the time (a 30-min yoga session after 90-min group processing) was an important consideration. The timing of the yoga was described by both care provider roles as a positive and a negative, with the pros including ending the sessions on a calm note and the cons involving the early ending of the group processing sessions and the transitional period. A seamless transition from group therapy to yoga was difficult. Some group process time was lost to accommodate the yoga, which was a constant challenge for the therapists, as process time is essential to healing. On the other hand, process time can be difficult to keep in check, so the need to transition to yoga often provided needed containment. Greater client preparation, however, would have enhanced the client's ability to make therapeutic gains through yoga and more seamlessly bridge the two healing modalities.

> The topic (intimate partner violence) was tough for them to talk about, processing got really deep, transition was hard to the yoga piece and then they would shut it off. A lot of them said, "I felt I was supposed to turn off whatever was happening for me and do the yoga, rather than whatever was happening for me, experience it while I was using my body." I thought that was interesting and I think maybe that was a failure on our part to communicate but [we] were also trying to let it be their own thing, they needed to do what they needed to do. We didn't want to dictate what was happening.

More frequently than the material resources listed in the preceding text was an emphasis on emotional resources. All of the therapists noted the importance of having space to share their experiences of the group session with the yoga instructor, especially during the transition period between group processing and yoga. All of the care providers noted the importance of emotional support. The piece of emotional support was particularly important for the yoga instructors, who typically do not work with survivors of trauma, as well illustrated by the following quote from one instructor:

> I emailed [the program coordinator] after one of those nights that I cried all the way home because I was like, "Ah, so intense. How do we hold some of this?" So having the ability to check in like that, even e-mail, was great, and enough. So it's not like we would need in-person meetings. But definitely having those open channels to check in.

Though emotional support was provided as part of the research protocol, as was training on secondary trauma, there was initially little consideration of the emotional needs of the yoga instructors as they were not directly involved in the psychotherapy portion of the session. However, the intensity of the emotional experiences was palpable and remained a feature of the yoga portion of the session. Emotional support for yoga instructors is an important programmatic component for community agencies implementing yoga group therapy for survivors to minimize the potential for harm, especially if the yoga instructors have little prior experience working with trauma survivors.

Additionally, not all clients who participated in the integrated sessions embraced the yoga due to personal or religious reasons. Although these clients were among a very small minority, there is the risk that clients do not feel empowered to refuse because it is a part of the group therapy environment. Despite constant emphasis on choice, honoring oneself, and self-care, one client in a study-affiliated group expressed this sentiment, but only on the last day of therapy. Therefore, consideration is needed to ensure that psychotherapy group participants are open to spiritual mind/body practice and have ample opportunity to opt into comparable nonintegrative health groups.

Finally, incorporating yoga into group psychotherapy entailed shortening the traditional therapy portion to accommodate the yoga. Although this accommodation was viewed on balance as a bonus given its complementarity to group therapy goals and its potentially synergistic impact, it did lengthen the session, which occurred in the evenings. The study was able to provide food, childcare, and rooms spacious enough for the yoga to occur. Not having these resources might make the incorporation of yoga into resource-constrained, community-based therapy environments more challenging.

Discussion

This study provides a unique perspective on examining the impact of yoga as an adjunct mental health treatment for survivors of intimate partner violence, specifically by interviewing the care providers instead of the client base. To the authors' knowledge, this is one of the first studies to examine the process of incorporating trauma-sensitive yoga into a community mental health clinic. Additionally, it is the first study to qualitatively examine the perspectives of care providers, including both group therapists and yoga instructors, in integrating the trauma-sensitive yoga protocol into any setting. Particularly given this unique mind-body intervention, this study expands the literature on work with trauma survivors by focusing on the care providers' perspective with a strengths-based focus, which deserves further examination rather than negative outcomes only. By examining this perspective, we are able to assess their personal growth and impact of trauma work on care providers, which has been traditionally understudied as research tends to focus on clients. The approach in the present study also uniquely examines perspectives of client healing from the care provider's point of view rather than relying on self-report client measures. By taking a qualitative interviewing approach, more information could be gathered than in a typical survey. By employing inductive thematic qualitative analysis to examine exploratory aims, there was inherent flexibility in the qualitative approach; thus, the a priori qualitative analysis procedure was able to be adequately followed. Nonetheless, the study is not without its limitations.

First, the sample size was limited in that the data gathered were based off nine interviews among seven care providers. Though comparable to other qualitative studies, this sample size was small compared with quantitative studies and involved combining two different types of care providers, that is, group therapists and yoga instructors. However, this represented all but one of the care providers involved in the study across three different sites. Second, client interviews were not gathered nor were clients blinded to the treatment intents of trauma-sensitive yoga. The study did monitor participant experience quantitatively and found that participants on the

whole perceived personal benefit from their participation (see Clark et al., 2014); yet, a more in-depth qualitative examination of healing from clients' perspective would provide additional data with which to triangulate findings from the care providers' views. However, the reliance on interview and weekly monitoring data from both therapists and yoga instructors does provide some degree of triangulation lending credence to the findings presented. Third, though the study was intended to be more strengths-based to fill a gap in the literature, a more balanced examination of strengths and challenges might be beneficial in deeply understanding the work experiences of these care providers. Fourth, there are general and specific ethical considerations. In general, because of the literature on trauma-sensitive yoga is in its infancy, it is unknown whether this is the best approach for survivors of intimate partner violence. Additionally, adding a yoga instructor to the treatment can impact issues of confidentiality and privacy, as yoga instructors tend to have less training on these issues than license mental health providers. However, these yoga instructors could not ethically be replaced by mental health providers with yoga training; yoga instructors are more experts in their field, have completed at least 200 hours of training and certification, and have a wide breadth of yoga that allow them to teach clients appropriate modifications and mind-body practices. Lastly, the care providers interviewed in the study present a potential selection bias because they cannot serve as independent, blind evaluators of trauma-sensitive yoga due to their involvement with the study. Though the purpose of the present study was to examine this unique perspective and though these care providers do provide the most first-hand experience in evaluating the impacts of trauma-sensitive yoga, there are inherent limitations in interviewing care provider perspectives only. Specifically, clients were not interviewed to assess their perspectives and experiences in a novel intervention of trauma-sensitive yoga as an adjunctive mental health treatment. Future studies would benefit from more measurement considerations and qualitative interviews with both care providers as well as clients. Additionally, having third-party assessors of therapist change (e.g., clinic supervisor) might be beneficial in evaluating therapist well-being in administering such an intervention. With these measurement considerations, personal and spiritual growth could be more objectively measured.

Research Implications

Because research on trauma-sensitive yoga as adjunctive mental health treatment is in the nascent stages, the care providers' perspectives on feasibility and acceptability of the intervention might provide a first step toward proof of concept. Future research would benefit from furthering evidence on trauma-sensitive yoga in more objective manners. This study also has general implications for researchers who work with care providers of trauma survivors, particularly in how future research might measure outcomes with these care providers. The study takes a strengths-based perspective in examining care providers' personal growth from working with this at-risk population, which expands the understanding of the impact of this type of work. This strengths-based perspective is seen from the assessment of positive growth through trauma work rather than focusing on unbeneficial impacts. The results suggest that care providers experience noticeable personal and spiritual growth when working with survivors of trauma in this setting, in which the growth appeared to occur as a function of belonging (i.e., not feeling like an outsider) within a group. That is, increases in empowerment, support, and knowledge of spiritual healing was related to more belongingness. Contrary to research that focuses on the negative impact of trauma work, the care providers in this sample viewed understanding how trauma impacted the clients as a positive form of awareness. Additionally, the care providers experienced increases in self-confidence from their work. Perhaps specifically to the practice of trauma-sensitive yoga in this setting, the care providers also grew in their understanding of the importance of encouraging choices among survivors as well as present moment awareness for themselves. Participation in trauma-sensitive yoga strengthened the trauma workers themselves potentially by providing

opportunities for growth, which might increase well-being (Bell, 2003).

Though the care providers acknowledge these benefits, this is not withstanding the challenges and distressing situations that were presented to the care providers. These situations allowed opportunities for growth by identifying and utilizing new strengths, such as the one yoga instructor who sought support from the research team after crying on the way home following a session. By understanding these challenges, care providers such as this yoga instructor might expand on their abilities to understand their own reactions and to serve this client population. The interviews helped reveal additional consideration of these potential triggers, though the training that the instructors received was intentional to ensure that they had an understanding of trauma and secondary trauma with the client population.

Clinical Implications

This study also has clinical implications for group psychotherapists and other care providers (e.g., yoga instructors) who might work with survivors of trauma. The findings suggest that care providers view the implementation of spiritual mind-body techniques to be beneficial to clients. Specifically, the care providers stated that the clients appeared to be empowered, experience positive changes in their body, and become more aware of their breath and mind-body connections as a pathway to healing from the trauma within their bodies. The effectiveness of yoga among this at-risk population is consistent with literature that demonstrates the effectiveness of yoga for those with noninterpersonal trauma histories (e.g., Telles et al., 2007) and those with other forms of interpersonal trauma (e.g., combat; Stoller et al., 2012). The areas of growth that the care providers observed in the clients were similar to the areas of growth experienced by the care providers (e.g., self-awareness, awareness of choices, confidence), demonstrating how therapeutic growth can be mirrored across the client-therapist dynamic. Alternatively, this points to the salient areas of growth observed by the care providers.

Finally, despite the seeming complexity of implementing such an intervention in community-based populations and adjusting typical group psychotherapy structures within such settings, the care providers reported overall high practicality and feasibility, although careful consideration of the potential challenges and unique circumstances of community-based settings is warranted. The present study gave insight into clients' perspectives in what could be adjusted for future iterations of the intervention (e.g., providing closure from the psychotherapeutic portion of group rather than quickly transitioning to the yoga portion), which could be taken into account when administering trauma-sensitive yoga in community-based settings. For further resources and information regarding trauma-sensitive yoga and its tenets, http://www.traumasensitiveyoga.com/resources.html provides an overview of resources.

Conclusion

This study demonstrates that care providers view trauma-sensitive yoga as an adjunct treatment to group psychotherapy for survivors of intimate partner violence as having positive impacts for both care providers and clients. Additionally, the implementation of such a spiritual mind-body practice seems to be practical within community settings with hindrances being worthwhile for the healing observed in the population served. Care providers, particularly those who work with at-risk populations like trauma survivors, experience more growth than distress in their work in this context; the use of a strengths-based approach specifically assessed the positive impacts of trauma work, in which an understanding of such might allow care providers to focus on these strength areas to increase well-being.

References

Banerjee, B., Vadiraj, H. S., Ram, A., Rao, R., Jayapal, M., Gopinath, K. S., . . . Prakash Hande, M. (2007). Effects of an integrated yoga program in modulating psychological stress and radiation-induced genotoxic stress in breast cancer patients undergoing radiotherapy. *Integrative Cancer Therapies, 6,* 242–250. http://dx.doi.org/10.1177/1534735407306214

Bell, H. (2003). Strengths and secondary trauma in family violence work. *Social Work, 48,* 513–522. http://dx.doi.org/10.1093/sw/48.4.513

Ben-Porat, A., & Itzhaky, H. (2009). Implications of treating family violence for the therapist: Secondary traumatization, vicarious traumatization, and growth. *Journal of Family Violence, 24,* 507–515. http://dx.doi.org/10.1007/s10896-009-9249-0

Blank, S. E., Kittel, J., & Haberman, M. R. (2005). Active practice of Iyengar yoga as an intervention for breast cancer survivors. *International Journal of Yoga Therapy, 15,* 51–59.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: SAGE.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77–101. http://dx.doi.org/10.1191/1478088706qp063oa

Brooks, M., Graham-Kevan, N., Lowe, M., & Robinson, S. (2017). Rumination, event centrality, and perceived control as predictors of post-traumatic growth and distress: The Cognitive Growth and Stress model. *British Journal of Clinical Psychology, 56,* 286–302. http://dx.doi.org/10.1111/bjc.12138

Clark, C. J., Lewis-Dmello, A., Anders, D., Parsons, A., Nguyen-Feng, V., Henn, L., & Emerson, D. (2014). Trauma-sensitive yoga as an adjunct mental health treatment in group therapy for survivors of domestic violence: A feasibility study. *Complementary Therapies in Clinical Practice, 20,* 152–158. http://dx.doi.org/10.1016/j.ctcp.2014.04.003

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: A meta-synthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5,* 570–580. http://dx.doi.org/10.1037/a0030388

Contreras, R. B. (2011). Examining the context in qualitative analysis: The role of the co-occurrence tool in Atlas.ti. *Atlas.ti Newsletter, 2011,* 5–6.

Cramer, H., Lauche, R., Langhorst, J., & Dobos, G. (2013). Yoga for depression: A systematic review and meta-analysis. *Depression and Anxiety, 30,* 1068–1083. http://dx.doi.org/10.1002/da.22166

Dale, L. P., Carroll, L. E., Galen, G. C., Schein, R., Bliss, A., Mattison, A. M., & Neace, W. P. (2011). Yoga practice may buffer the deleterious effects of abuse on women's self-concept and dysfunctional coping. *Journal of Aggression, Maltreatment & Trauma, 20,* 90–102. http://dx.doi.org/10.1080/10926771.2011.538005

Dane, B. (2000). Child welfare workers. *Journal of Social Work Education, 36,* 27–38. http://dx.doi.org/10.1080/10437797.2000.10778987

Devries, K. M., Child, J. C., Bacchus, L. J., Mak, J., Falder, G., Graham, K., . . . Heise, L. (2014). Intimate partner violence victimization and alcohol consumption in women: A systematic review and meta-analysis. *Addiction, 109,* 379–391. http://dx.doi.org/10.1111/add.12393

Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and physical health and intimate partner violence against women: A review of the literature. *International Journal of Family Medicine, 2013,* 1–15. http://dx.doi.org/10.1155/2013/313909

Emerson, D. (2015). *Trauma-sensitive yoga in therapy: Bringing the body into treatment*. New York, NY: Norton and Company.

Emerson, D., & Hopper, E. (2011). *Overcoming trauma through yoga: Reclaiming your body*. Berkeley, CA: North Atlantic Books.

Emerson, D., Sharma, R., Chaudhry, S., & Turner, J. (2009). Trauma-sensitive yoga: Principles, practice, and research. *International Journal of Yoga Therapy, 19,* 123–128.

Friedman, R., & Handel, O. (2002). Facilitating individuation processes in supervision groups comprised of co-therapists conducting group therapy with bereaved parents. *Group, 26,* 95–105. http://dx.doi.org/10.1023/A:1015478829720

Gerbarg, P. L., & Brown, R. P. (2005). Yoga: A breath of relief for Hurricane Katrina refugees. *Current Psychiatry, 4,* 55–67.

Hamerdiner, S., & Karlin, B. (2003). Therapy using interpreters: Questions on the use of interpreters in therapeutic setting for monolingual therapists. *Journal of the American Deafness and Rehabilitation Association, 36,* 1–13.

Hendrix, C. C., Fournier, D. G., & Briggs, K. (2001). Impact of co-therapy teams on client outcomes and therapist training in marriage and family therapy. *Contemporary Family Therapy, 23,* 63–82. http://dx.doi.org/10.1023/A:1007824216363

Herman, J. (1992). *Trauma and recovery*. New York, NY: Basic Books.

Hesse, A. R. (2002). Secondary trauma: How working with trauma survivors affects therapists. *Clinical Social Work Journal, 30,* 293–309. http://dx.doi.org/10.1023/A:1016049632545

Holmqvist, R. (2001). Patterns of consistency and deviation in therapists' countertransference feelings. *The Journal of Psychotherapy Practice and Research, 10,* 104–116.

Kadambi, M. A., & Truscott, D. (2004). Vicarious trauma among therapists working with sexual violence, cancer, and general practice. *Canadian Journal of Counselling, 38,* 260–276.

Knox, S., & Burkard, A. W. (2009). Qualitative research interviews. *Psychotherapy Research, 19,* 566–575. http://dx.doi.org/10.1080/10503300802702105

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16,* 606–613. http://dx.doi.org/10.1046/j.1525-1497.2001.016009606.x

Lin, K.-Y., Hu, Y.-T., Chang, K.-J., Lin, H.-F., & Tsauo, J.-Y. (2011). Effects of yoga on psychological health, quality of life, and physical health of patients with cancer: A meta-analysis. *Evidence-Based Complementary and Alternative Medicine, 2011,* 659876. http://dx.doi.org/10.1155/2011/659876

Morrison, N. (2001). Group cognitive therapy: Treatment of choice or sub-optimal option? *Behavioural and Cognitive Psychotherapy, 29,* 311–332. http://dx.doi.org/10.1017/S1352465801003058

Nguyen-Feng, V. N., Clark, C. J., & Butler, M. E. (2018). Yoga as an intervention for psychological symptoms following trauma: A systematic review and quantitative synthesis. *Psychological Services*. Advance online publication. http://dx.doi.org/10.1037/ser0000191

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. New York, NY: Norton.

Porges, S. W. (2003). The polyvagal theory: Phylogenetic contributions to social behavior. *Physiology & Behavior, 79,* 503–513. http://dx.doi.org/10.1016/S0031-9384(03)00156-2

Price, M., Spinazzola, J., Musicaro, R., Turner, J., Suvak, M., Emerson, D., & van der Kolk, B. (2017). Effectiveness of an extended yoga treatment for women with chronic posttraumatic stress disorder. *Journal of Alternative and Complementary Medicine, 23,* 300–309. http://dx.doi.org/10.1089/acm.2015.0266

Rager, K. B. (2005). Compassion stress and the qualitative researcher. *Qualitative Health Research, 15,* 423–430. http://dx.doi.org/10.1177/1049732304272038

Rhodes, A., Spinazzola, J., & van der Kolk, B. (2016). Yoga for adult women with chronic PTSD: A long-term follow-up study. *Journal of Alternative and Complementary Medicine, 22,* 189–196. http://dx.doi.org/10.1089/acm.2014.0407

Shah, S. A., Garland, E., & Katz, C. (2007). Secondary traumatic stress: Prevalence in humanitarian aid workers in India. *Traumatology, 13,* 59–70. http://dx.doi.org/10.1177/1534765607299910

Siegel, D. J. (1999). *The developing mind: How relationships and the body interact to shape who we are*. New York, NY: Guilford Press.

Spielberger, C. D., Gorsuch, R. L., & Lushene, R. E. (1970). *State–Trait Anxiety Inventory*. Menlo Park, CA: Consulting Psychologists Press.

Staples, J. K., Hamilton, M. F., & Uddo, M. (2013). A yoga program for the symptoms of posttraumatic stress disorder in veterans. *Military Medicine, 178,* 854–860. http://dx.doi.org/10.7205/MILMED-D-12-00536

Stenius, V. M. K., & Veysey, B. M. (2005). "It's the little things": Women, trauma, and strategies for healing. *Journal of Interpersonal Violence, 20,* 1155–1174. http://dx.doi.org/10.1177/0886260505278533

Stoller, C. C., Greuel, J. H., Cimini, L. S., Fowler, M. S., & Koomar, J. A. (2012). Effects of sensory-enhanced yoga on symptoms of combat stress in deployed military personnel. *The American Journal of Occupational Therapy, 66,* 59–68. http://dx.doi.org/10.5014/ajot.2012.001230

Streeter, C. C., Gerbarg, P. L., Saper, R. B., Ciraulo, D. A., & Brown, R. P. (2012). Effects of yoga on the autonomic nervous system, gamma-aminobutyric-acid, and allostasis in epilepsy, depression, and post-traumatic stress disorder. *Medical Hypotheses, 78,* 571–579. http://dx.doi.org/10.1016/j.mehy.2012.01.021

Telles, S., Naveen, K. V., & Dash, M. (2007). Yoga reduces symptoms of distress in tsunami survivors in the Andaman Islands. *Evidence-Based Complementary and Alternative Medicine, 4,* 503–509. http://dx.doi.org/10.1093/ecam/nem069

Telles, S., Singh, N., & Balkrishna, A. (2012). Managing mental health disorders resulting from trauma through yoga: A review. *Depression Research and Treatment, 2012,* 1–9. http://dx.doi.org/10.1155/2012/401513

van der Kolk, B. A., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. *The Journal of Clinical Psychiatry, 75,* e559–e565. http://dx.doi.org/10.4088/JCP.13m08561

Varambally, S., & Gangadhar, B. N. (2016). Current status of yoga in mental health services. *International Review of Psychiatry, 28,* 233–235. http://dx.doi.org/10.3109/09540261.2016.1159950

Vrklevski, L. P., & Franklin, J. (2008). Vicarious trauma: The impact on solicitors of exposure to traumatic material. *Traumatology, 14,* 106–118. http://dx.doi.org/10.1177/1534765607309961

Weathers, F., & Ford, J. (1996). Psychometric review of PTSD checklist (PCL-C, PCL-S, PCLM, PCL-PR). In B. H. Stamm (Ed.), *Measurement of stress, trauma, and adaptation* (pp. 250–251). Lutherville, MD: Sidran Press.

World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, Switzerland: Author.

Received October 1, 2017
Revision received May 18, 2018
Accepted May 23, 2018 ■