



Received: 04 December 2018
Accepted: 04 February 2019
First Published: 12 February 2019

*Corresponding author: Ephrat Havron, Department of Bibliotherapy, The David Yellin Academic College of Education, Jerusalem, Israel
E-mail: havron.havron@gmail.com

Reviewing editor:
Luca Cerniglia, Uninettuno university, Italy

Additional information is available at the end of the article

CLINICAL PSYCHOLOGY & NEUROPSYCHOLOGY | RESEARCH ARTICLE

Establishing the “area of need” through optimal responsiveness: Yoga/Psychotherapy for childhood sexual abuse survivors

Ephrat Havron^{1*} and Yael Itzhak-Edan²

Abstract: Childhood sexual abuse (CSA) causes severe harm to the self, halts its development and fractures it. Some of these harmful effects are caused by the interaction between the physical domain, where the abuse occurs, and the self; however, the physical is often neglected in the theoretical and clinical treatment of CSA. In this article we wish to introduce the Yoga/Psychotherapy treatment framework, a combined psychoanalytical/physical approach which, we will argue, constitutes what Bacal defined as an “optimal response” for women who were sexually abused in childhood. The article begins by introducing the concept of the “parental envelope,” coined by Israeli dance movement therapist Yona Shachar-Levy, to illuminate the body-self relationship. Then, drawing on the work of Rinat Rav-Hon’s idea of the “area of need”—a therapeutic space of selfobject responsiveness—we present two key components of the Yoga/Psychotherapy method which, we will argue, establish this therapeutic “area of need” as they constitute an “optimal response”: the regulating quality of the Yoga/Psychotherapy group setting; and the facilitators’ unique way of observing the participants. The group sessions, we will

ABOUT THE AUTHORS

Ephrat Havron (Ph.D.) is a Bibliotherapist and Psychotherapist, a graduate of the Psychoanalytic Israeli Society psychotherapy program. Her doctoral dissertation “Saying it differently: Bibliotherapy with adult survivors of incest” was written in Haifa University, Israel. She is a teacher at the David Yellin Academic College. Beside working as a psychotherapist, Ephrat Works with multidisciplinary staffs, teaching psychotherapy with trauma victims, and Bibliotherapy. Ephrat is a candidate at the “Human Spirit” psychoanalytic-Buddhist training program.

Yael Itzhak-Edan (Ph.D.) is a yoga teacher since 1998, as well as a trained group facilitator. She co-runs the Neve Sha’anana yoga center in Jerusalem. Before teaching yoga Yael taught at the Hebrew university while writing her doctoral thesis about conditions of perfecting the consciousness in the doctrine of Maimonides and Spinoza. Today Yael is focused on the therapeutic potential of yoga-training for trauma victims, especially sexual assault survivors, as well as working individually with survivors.

PUBLIC INTEREST STATEMENT

Childhood sexual abuse (CSA) causes severe harm to the self, halts its development and fractures it. Some of these harmful effects are caused by the interaction between the physical domain, where the abuse occurs, and the self; however, the physical is often neglected in its theoretical and clinical treatment. We wish to introduce the Yoga/Psychotherapy treatment framework, a combined psychoanalytical/physical approach which constitutes an “optimal response” for women who were sexually abused in childhood. The article introduces a specific concept of the body-self relationship. Then, drawing on Rav-Hon’s idea of the “area of need”—a therapeutic space of selfobject responsiveness—we present two key components of the Yoga/Psychotherapy method which constitute an “optimal response”: the regulating quality of the group setting; and the facilitators’ unique way of observing the participants. The group sessions, we suggest, provide an accurate therapeutic response which helps to mend the rifts in the self.

show, provide an accurate therapeutic response which helps to mend the rifts in the self.

Subjects: Gender Studies - Soc Sci; Feminist Psychology; Health Psychology; Multidisciplinary Psychology; General Psychology

Keywords: childhood sexual abuse; Yoga/Psychotherapy; body; area of need; optimal responsiveness; parental envelope; self psychology

1. “The body is the start of meaning” (Adonis)¹

Sexual abuse has a physical aspect. The initial sphere in which it occurs, although not the only one, is the survivor’s body. “I was a girl with no body”, writes Anna, one of the participants in our Yoga/Psychotherapy group for survivors of CSA which will be discussed in this article, thus emphasizing how much the body is harmed and in need for attention in the therapeutic encounter. However, in psychoanalytic writing about sexual abuse the body is not very present; sometimes the theory seems almost to forget that sexual abuse targets the body, and—moreover—its sexual parts. Some psychoanalytic theory has occasionally touched on the significance of physical experience in psychotherapy (e.g. Cates, 2011, 2014, 2018; Stern, 2010). Nevertheless, “Because psychoanalytic treatment tends to primarily focus on language, the body, and its intimate interdependence with the social world, remains in the background” (Cates, 2018, p. 261). When the body does appear, it does so in a mediated form, through the patient’s reports and in verbal descriptions that often remain at a great remove from the physical experience itself. Therefore, a major aspect of the abuse is left outside the therapeutic relationship, and outside transference. The body, in other words, remains neglected, excluded from psychodynamic observation, in a way that almost relives the invisibility of the survivor’s body when she/he was abused as a child.

The body, the concrete sphere in which the abuse took place, is a significant part of the self. Almost all psychological approaches agree that there are preverbal layers in human development. The body is a source of memory, reaction, and learning and harbors within it physical responses related to emotions and their recollection (Ben Asher & Koren, 2002, p. 284). The subject’s world starts as an embodied experience, and primordial emotions are bodily forms of consciousness (Cates, 2014, 2018). Thus, the body-self relationship, the way we become “ourselves” through our skin, is formed from the beginning of life. As infants, we are initially enveloped in the parental body, which Israeli movement therapist and research Yona Shachar-Levy calls the “parental envelope.” This space always has physical, emotional, and mental dimensions. It is a relationship built on a given biological inequality—a small infant body encompassed by the larger parent, two body-soul systems, one is still emerging and dependent on others, the other is already relatively composed and coherent. The envelope relationship is based on the control of the infant’s bodily functions outside the infant’s body by the parent, with the support of the parent’s skin and spine (Shachar-Levy, 2005). This developmental stage of existence plays a crucial role in the construction of the self. The quality of the envelope naturally has a considerable impact on this self. The self, in other words, is (also) built through the body. After this early developmental phase, Shachar-Levy theorizes a later stage of relations between self and world that she calls “the open interpersonal space,” which coincides with separation and individuation, i.e., the psychological birth of the subject. This is the more common state of human relationships, in which two separate bodies face each other, and it is the basis of functioning in the social domain as the dominant system of human existence. The parental envelope does not disappear with the emergence of open interpersonal relations; rather, a bit like Melanie Klein’s positions, they coexist and a continuous movement between them takes place. When we engage in sexual relationships, as in other interactions involving both body and emotion, the envelope system emerges again along with its archetypes, which come to life even when we have already gained the possibility of an “interpersonal” system (Shachar-Levy, 2005).

The many kinds of damage to the self caused by CSA have been amply discussed, elaborating how the psychological catastrophe of abuse by someone close corrodes all aspects of the

survivor's identity, and severely disrupts the child's sense of self (Murthi, Servaty-Seib, & Elliott, 2006; Putnam, 2003). CSA harms "the development of physical and psychological self-integrity and self-regulatory processes (e.g. affect regulation and impulse control)" (Saha, Chungb & Thornec, 2011, p. 101.) Survivors also "tend to have low self-esteem, poor self-image and feelings of unworthiness" (ibid.). Such disruption of the positive sense of self results many times in a negative identity based on guilt, shame, self-hatred, and otherness (Crowley, 2000; Davis & Frawley, 1994; Herman, 1992). It creates a rift within the survivorized child's self and obstructs its development. The emergent self is "channeled" or "recruited" to respond to a deep and continuous incongruence between reality and the child's needs. However, the grave harm to the self stems not only from the destructive psychological rift, rather also because the sexual nature of the abuse involves the body. Since the physical is so closely linked to the self, sexual abuse attacks the envelope system itself: continuous CSA constitutes a hostile, non-empathetic, exploitative, incongruent, and persecuting envelope that creates a rift in the core of the self. Children who grow up through an encounter with this kind of envelope internalize it and develop a hostile attitude not only to their self but also towards their bodies.

Moreover, at times CSA "latches on" to an existing deficit that resulted from an initially deficient parental envelope. The abuser exploits this deficit, thus intensifying the harm, which fills the earlier parental lack in a distorted and destructive way. The abuse interferes with the body image as a source of self-nutrition and empathy, and in response to the abuse and to the absence of parental protection, fundamental suspicion, rejection, and dissociation define a core part of the self. Working over the years as a psychotherapist (EH) and a yoga teacher (YI), and during years of association with the Jerusalem Rape Crisis Center, we met survivors who shun contact, some hated their body, were not capable of being attentive to it, and wished to conceal, hurt, or punish it. We met women who engaged in intensive and harmful forms of athletic activity, some suffered from eating disorders, while others felt disgust at their body and found it hard to care for, including in a medical sense. Many suffered from multiple physical symptoms such as pain in various parts of the body, in some cases leading to hospitalization (Paras et al., 2009). A cruel cycle is formed, in which body and psyche, closely intertwined, continually hurt each other. It begins with sexual abuse of the body, which immediately damages the core of the self. The damage to the self manifests itself in physical symptoms (among others) and in the survivor's relationship with the body, leading to further psychological damage.

Through continuous dialogue with survivors, we came to know how complex the relationship with the body is, and gradually realized that the treatment offered to survivors should include a more extensive approach to bodily experience and to the emotional impacts of the abuse's physical dimension. In 2008 we started searching for accurate treatment options that eventually produced a therapeutic model for working with CSA survivors, the Yoga/Psychotherapy groups. Over time, the model has received validation from empirical studies done around the world attesting to yoga's therapeutic efficacy in improving post-trauma parameters among survivors of sexual abuse and their quality of life (e.g. Price et al., 2017; Rhodes, Spinazzola, & van der Kolk, 2016; West, Liang, & Spinazzola, 2017). These, combined with case studies of assisted yoga group therapy (Emerson, Sharma, Chaudhry, & Turner, 2009; Van der Kolk et al., 2014), have helped us hone our practical work and form the unique Yoga/Psychotherapy groups protocol.

The model, which takes place once a week and ideally encompasses 24 sessions, begins with 75 minutes of yoga practice followed by 75 minutes of group therapy in a mostly unstructured, dynamic approach, where participants are invited to talk about the experience of the encounter with the body or any other impressions or reactions. The group has two facilitators with experience in group work: a psychotherapist who specializes in treating CSA survivors, and a yoga teacher who is also proficient in working with sexual abuse. We found that this treatment, which begins by facing an experience contained in the body through its verbal conceptualization and working through, facilitates recovery processes in women who have been sexually abused in childhood. In this way, the body can be a source of knowledge, comfort and healing, as *Rachel*, a participant

in the group testifies: “I participated in a Yoga/Psychotherapy group for survivors of sexual assault [...] [This was] a day in which my clumsy body and I encounter each other anew—and I could meet that which has been engraved in my flesh [...] Because what I thought I had forgotten—the body knows. The body remembers. It is engrained in it very deeply and seeks release.”

2. Why yoga?

Kohut understood the role of the environment in development as critical, and saw the patient as the exclusive outcome of an environmental failure, because of which he/she is unable to articulate the nuclear self. CSA produces an environment so incongruent with the child’s needs that it blocks self-growth. As stated, the environmental failure is, among other things, physical: it is a breakdown of the parental envelope that, in turn, affects the flourishing of the self. For CSA survivors, contact is harmful, physical support very difficult, and the same physical and emotional interaction that is so essential for creating a clear and stable selfhood becomes potentially damaging: A type of hole or large scar is formed in the structure of the self. It becomes brittle and fragile, and complex life tasks might be experienced as complicated or even hazardous. The person feels a dissociated, sick sense of being mentally dead, lacking value for himself and others, redundant, insignificant, and invisible to the world (Hominer, 2004). Treatment seeks to restart the self, mend its rifts, and then facilitate its development by creating an environment tailored precisely as possible to the needs of the patient. In the triple junction of body, self and CSA, yoga is particularly well-suited to mending the damage that the self has suffered due to the conflict between its needs and the environment, in other words for finding the appropriate responsiveness crucial for reviving the development of the self. Two concepts can help understand how Yoga/Psychotherapy groups constitute a precisely adapted response for Y. and for other women who were subjected to sexual abuse in childhood. The first is the “area of need,” and the second is “optimal responsiveness.”

3. The area of need

Unlike mental materials such as desires or wishes, the **needs** of the self, belong to one’s very being, and the mere recognition of needs is at the center of psychotherapy, as argued by Rinat Rav-Hon (2017) who offers an important contribution to the conceptualization of the therapeutic presence, and to the means essential to the development of the self. Therapeutic presence adapted to the patient’s needs is embodied in the concept of the “area of need”: The area of need is in essence an area of being. Namely, it is a space that expands possibilities and allows existing formations to dissolve, so that that the self can enter a state of transformation. The expansion and realization of this potential depends on how the therapist joins this space. It is a therapeutic presence that differs from the deciphering or interpreting presence in its classical meaning, a presence that can be described as based on searching for a suitable way of meeting needs. This, assuming that the opposite of frustration is not gratification but rather the most suitable kind of encounter. This search requires the therapist’s willingness to seek and listen for that which is experienced as suitable by the patient (Rav-Hon, 2017). The attitude of the therapist is central and critical for establishing this space: Although there are two people in the room, the therapist and the patient, the presence of the therapist is what constitutes the patient’s selfhood (ibis., p. 44). Optimally, a space is formed that is between the realistic and the delusional, similar to the transitional space, and based on a delicate balance between the two (ibis., p. 49), which is the area of need. In practice, this means that at times the area discussed has an observing-interpretive quality, and at others a participating quality. However, even if the participating quality is evident and reciprocated by a concrete gesture—its value is always symbolic as well as practical.

4. Optimal responsiveness

The area of need is formed through the optimal responsiveness of the therapist to the patient’s needs. Bacal (1985, p. 215) claims that such optimal responsiveness is essential to the psychological survival of the self. To facilitate recovery, the needs met by optimal responsiveness must be provided by a selfobject, and verbal interpretations or verbal work are insufficient. Bacal refers to the blanket provided in therapy, to the thirsty patient given a glass of water, and to other needs of this kind that find an answer in the therapeutic context. The very expression of a desire or longing

unlocks a need that became hidden by a developmental failure, preventing the self from flourishing. What makes recovery possible is the therapist's careful search for the proper response, as though saying "This is what I understand that you need now, and I will find a way to meet this need in a way that you will experience as appropriate." In this way permission and consent are given, along, perhaps, with an invitation to melt the longing, the frozen need (Rav-Hon, 2017, p. 41). Through empathic attentiveness, the therapist learns to identify the patient's need; optimal responsiveness then says to the patient, "I understand." It is optimal responsiveness that manages to form, create, revive the area of need; this area is a therapeutic space in which the response of the selfobject—whether by acting or interpreting—allows the self to be restored.

We wish to claim that the Yoga/Psychotherapy setting establishes the area of need for survivors of CSA, because it is constructed as a setting of empathic attentiveness followed by optimal responsiveness. Two features transform Yoga/Psychotherapy into a domain that establishes the area of need: One is the inherently modulating quality of yoga and of the Yoga/Psychotherapy setting, as will be demonstrated, which constitute an empathic response and optimal responsiveness to the survivors. The second is the unique observation of the participants by the facilitators of the Yoga/Psychotherapy group, namely—how the therapists see the patients and how they understand what they see, which is another factor establishing the area of need.² All these "respond" to the fundamental needs of the survivors, and in this way the yoga as a discipline, the facilitators, and the psychotherapy session become an accurate selfobject, bearing an appropriate selfobject responsiveness.

1. Establishing the area of need through the modulation of yoga

CSA is a deadly blow to the survivor's ability to regulating itself. It is "a form of chronic trauma, in which the abusive other overstimulates and overwhelms the young child's ego capacities to the extent that it renders them essentially inoperative" (Davies & Frawley, 1994, p.54). The body meets a stimulus that it cannot bear; the nervous system and psyche are not built to cope with such events. The resulting overload leads, first and foremost, to dissociation in its various manifestations. Yoga/Psychotherapy is able to establish the area of need because its setting has a regulatory, modulating and containing effect, as does yoga itself as a discipline. Meetings have a fixed structure: they always open with a short meditation, continue with breathing exercise, followed by yoga practice (which is the core of the lesson), and end with a short regular relaxation pose. After this comes a short group meditation, the mats are put away, and chairs are brought in for a psychotherapy session. The very constancy reduces anxiety and has a modulating effect. In order to further reduce the participants' potential anxiety about the upcoming encounter with their bodies, we begin each session by explaining the day's topic—for instance "we will focus today on arms and hands." The yoga teacher sits in the same place each time, and the mats are likewise arranged in advance in the same order, although the participants choose each session where to practice. The instruction given during the practice itself aims to create a modulating environment: while the yoga teacher leads the class, the psychotherapist facilitator adapts herself to the participants' changing needs—remaining beside a participant who needs to observe her in order to practice, supporting another who needs the help of an attentive presence and so on. Both facilitators devote attention to adjusting the environment—bringing Kleenex, water, or adjusting the heating or air-conditioning. The constancy, the predictable setting, the repetition, and the structured attention all help to turn a potentially turbulent encounter with the abused body into an experience that is contained, constant, organized, predictable, and therefore regulated. The long-term planning of the sessions is also aimed to encourage a gradual, gentle acquaintance with various parts of the body and thus to help the process of modulation.

To demonstrate the process, we will draw in the following discussion mainly on the example of one participant, Tamar. One key aspect of our Yoga/Psychotherapy work is strengthening the arms, which participants are encouraged to do from early on in the process. The encounter with the body, in this case the hands and arms, was challenging for Tamar: it made her feel physical distress, and her responses to yoga practice were extreme in a way that seemed disproportionate.

“Downward-facing dog”—a yoga position in which the arms and hands bear much of the body’s weight—was at this stage an unobtainable dream for Tamar, not to mention a handstand, which seemed to her and to other participants a wild fantasy: “The thought of supporting myself on my hands... it’s a nightmare. Even putting my hands in position is terribly stressful for me. My hands are weak, they don’t support me. I will never ever be able to do a handstand.” In one of the sessions, Tamar stopped in the middle of the hand-strengthening practice and sat listlessly on her mat. It was a quiet, gentle despair, a kind of inner collapse. When we asked what was going on, she said that she didn’t know. The precise search for the answer of why she had stopped right now eventually let her formulate to herself in a whisper that the mat was too thin: “I’m not suitable for yoga conditions. It’s driving me crazy. The others are managing but not me... I’m different, I need a softer floor.” The encounter with her body took Tamar off balance, drove her and other participants “crazy.” What allowed them to cope with the distress caused by the encounter with their body was the therapeutic setting, which aims to accommodate, regulate and protect. The empathic attentiveness made possible the optimal response, which in this case was a practical gesture with a participatory quality: we brought Tamar another mat to add to her own thus “making the floor softer.” Grateful, Tamar rejoined the practice. Afterwards, a double mat awaited her every session, as though to remind her that we were engaged in a search, that we recognized that when she was feeling discomfort, her self was at risk, and that we would do our very best to make her comfortable.

The setting, which aims to accommodate, modulate and help us search for an optimal response, joins the yoga, which is the core of the work in Yoga/Psychotherapy groups. Even outside the therapeutic context, yoga is a regulatory discipline that provides, by its very nature, a way to manage overwhelming experiences. Questionnaire-based studies indicate that participation in yoga lessons intended for trauma survivors significantly reduced CPTSD symptoms (Rhodes et al., 2016) and, particularly, helped to regulate the physical and sensory aftereffects of trauma (Van der Kolk et al., 2014). Other studies indicate the positive effect of yoga on “purely” physical variables such as the autonomous nervous system, GABA levels (gamma-aminobutyric-acid, a substance that regulates activity in the nervous system), allostasis (the process of achieving stability through a physiological or behavioral change) as well as HRV (heart rate variability), an important measure of physical regulation (Streeter, Gerbarg, Saperc, Cirauloa, & Brown, 2012; Telles, Singh, Joshi, & Balkrishna, 2010). Interview-based studies (Rhodes, 2015) also indicate that yoga had a significantly positive effect on the quality of life of CSA survivors, in part thanks to their improved regulating ability. All this makes yoga, with its innate focus on regulating, an optimal response to the damage to the regulatory emotional and physical systems that stems from the abuse, as Anna wrote: *“I lived between feeling incredibly overwhelmed and feeling nothing. In yoga I learned how to help myself regulate the intensity of my feelings. When I focus on my hands or on my feet touching the floor, I’m not engaged in thought. I’m here. Present. Taking a rest from myself. When I can’t fall asleep, I breathe—and now I have a way of helping myself when things are hard. I’m learning that it is possible to expand the container within myself, whenever intensity and contents become too much. Yoga helps me regulate the difficult symptoms of the abuse, and in this way it has made me much less self-destructive.”* Yoga thus is the envelope—a framework and the substance itself—of the responses to participants’ needs in establishing the area of need, which is, as noted above, a space that expands possibilities and allows existing formations to dissolve, so that that the self can enter a state of transformation (Rav-Hon, 2017, p. 51).

Rav-Hon’s metaphorical transformation (also) becomes literal in Yoga/Psychotherapy, as participants begin to realize their physical potential and discover their body’s ability to change and adjust. Thus, in addition to adding a mat, whenever we felt that the encounter with the memory of her abuse was causing Tamar deep anguish, or every time leaning on her hands made her feel that she was “going crazy,” we suggested that she do an upright pose instead, one that in particular she experienced as comforting and calming. This alternate pose, with its soothing effect, let Tamar continue the practice with less inner torment. The comforting, regulating effect of the context as

a whole enabled Tamar to keep practicing despite her difficulties—a new experience different from her usual reaction of helplessness which led her to “forget about it.”

2. Observation by a selfobject that constitutes the area of need

We have seen above that yoga in general, and the Yoga/Psychotherapy group setting in particular, has a modulating effect that turns a potentially unsettling encounter with the body into a therapeutic and restorative one. A second parameter that makes Yoga/Psychotherapy therapeutic and precisely adapted to the needs of CSA survivors is the observation or, to be exact, the varied observations of the abused body that occur within this treatment. A child begins its life as a virtual form of being, i.e., it exists as a reality within the mother’s experiential area. This assumption is based on the idea that an entity comes into being because it is seen (Rav-Hon, 2017 p. 40). One of the sources of harm to the self of CSA survivors is that they should have been seen, but were not. Not only is the survivor not really “seen” by the abuser, but, moreover, this often exacerbates a lack that was already there, when the abuse occurs in a parental environment that was oblivious or insufficiently attuned to the needs of the child. The abuse, in other words, happens many times in the context of a flawed parental envelope, so that the self of a child who was sexually abused is doubly invisible, lacking both the initial mirroring and the observing gaze of his or her surroundings when the abuse occurred.

The self of a CSA survivor is perforated, brittle, not only because its invisibility did not allow it to “become”; frequently, it is further ruptured by the dissociative response characteristic of trauma. The dissociation occurs in order to protect the psyche from the catastrophe it experiences, causing CSA to be “an event without a witness” (Laub, 1992, 89–96), parts of it absent from one’s consciousness. Being able to “put together” the story of the abuse into a cohesive narrative with a beginning, middle, and end, is an important, even crucial, factor in processing the trauma. The lack of such a story, the lack of knowledge and of memory, transform the story of the abuse into an isolated island of wordless terror. Nevertheless, even as dissociation keeps the story of the abuse from being verbally formulated, that story—as noted by Rachels’ words in the beginning of the paper—is always present and preserved in the body, which retains it as a physical memory: “The need to forget painful feelings coexists with an urgency to remember what the body already knows” (Cates, 2014, p. 36). Knowledge can become a story when it is heard and seen. What the survivor needs, as we’ve noted, is mirroring in its most complex and varied demonstration. The facilitators of the Yoga/Psychotherapy group provide that gaze. They witness the body, including the physical manifestations of trauma, and can tell the story together with the participant, sometimes for the first time—a story that begins, for instance, with weak hands. The facilitators’ gaze is not a silent one, but a “narrative observation” by a selfobject, whose very existence is that which constitutes the story. This allows the epistemological-dissociative fracture of meaning to be healed. Survivors of CSA need a selfobject to see the testimony given by their bodies, to “translate” it into a meaningful narrative, and to integrate this story into the broader one of their life.

For example, Tamar’s difficulty in training her hands, described above, did not translate into new insight during the group psychotherapy in the second part. We, the therapists, who saw her sitting with her arms folded, struggling or avoiding positions that involved her hands, were the ones to see what’s going on and put it into words: “It seems like you don’t want to do this, it feels like your hands are disloyal to you.” According to Rav-Hon’s model, through empathic attentiveness we learned to identify Tamar’s needs, and the optimal response included interpreting her distress while also suggesting practical solutions (e.g., an upright pose suggested as an alternative by the yoga teacher, which the second facilitator sometimes practiced with Tamar while the rest of the group were doing their regular poses). Later, we had a group discussion of the resonance of hands: the participants spoke of very weak hands unstable and untrustworthy as support, or unable to carry out their wishes: “If I want something, I don’t think I will get it, because I can’t make it happen. My hands have no power to act”, commented a participant. Contributors to the discussion directly tied the inability to act to their inability to prevent their abuse and subsequent feelings of guilt. Hands were also repeatedly associated with the injurious hands of the abuser, or else with

the inert hands of the mother. The participants repeatedly encountered hands and arms that symbolized inadequacy, neglect, dissociation, or aggression.

Slowly, in the course of several sessions, the group and facilitators came up with an interpretation which Tamar could relate to (even if not to own yet), a story about missing maternal hands, the need to be “my own hands, to hold myself,” the harmful hands of the abuser, and the recreation of this experience in the lives of the participants when they, too, became parents and were fearful of holding, hugging, and loving their children. After several additional sessions, in which we continued to practice strengthening the arms and talked about the process, the story developed, and hopeful ideas began to emerge as well: their hands and arms, the participants noted, were still trying, even succeeding in carrying the weight of their bodies in various poses. As therapy went on, the hands could suddenly also symbolize the possibility of pregnancy, of motherhood that was healthy and healing, of a rediscovered softness. Prompted by the interpretive gaze of the facilitators and taken up by the group, weak, passive or aching hands became a meaningful, even hopeful story. The optimal response established the area of need, a therapeutic zone where our response, together with that of the group itself, restored the self. The facilitators’ observation of the practice, as a selfobject which saw the story told by the body allowed this story to emerge on the way to recovery.

From the perspective of the infant, the selfobject is experienced as part of itself, like one of its body parts, and thus provides a response that is adapted to its needs (Rav-Hon, 2017, p. 40). The selfobject identifies these needs, understands them, and meets them in a suitable way. Even more than traditional psychotherapy, Yoga/Psychotherapy invites the therapists to be a part of the survivor’s body, as they are indeed sometimes experienced that way during the yoga practice. When Tamar couldn’t handle downward-facing dog, the teacher asked her permission to support her physically in order to reduce the burden on her hands, and for a moment, they became one body. The facilitator’s observation of the participant is not detached, but intimate and connected. This allows the damaged parental envelope to be mended almost concretely, in the form of an alternative parental envelope created by a selfobject who is part of the survivor’s body. The repair happens almost from “within.” The encounter with the participant’s body—observing it “from inside”, seeing it from within through physical contact—generates physical transference. The physical dimension of the relationship, the very close observation that it allows for, and the intimate story that emerges create layers of nonverbal communication through body language that passes from patient to therapist and back (Horesh, in Rosenthal, 2012).

Helping Tamar by detecting her physical or psychological pain, and responding to it, let therapist and patient take part in a shared physical experience, and physical transference occurs, paving the way for a very important, sometimes unique and unrepeatable possibility of telling the story of the abuse, giving witness to it. The facilitators experience the physical transference relations, which gives them the means to correct the grave fractures inflicted on the parental envelope by the abuse and beyond it, since, as noted, the encounter in the Yoga/Psychotherapy by its nature recreates the dyadic body language and the primary mental states that exist in the envelope space. The physical transference takes participants back to the parental envelope and thus offers an opportunity to mend it, while formulating the story that the body knows.

A final key component of the Yoga/Psychotherapy groups involves the unique implications of the setting—a normative yoga practice room within which therapy takes place. Although the participants are all survivors of CSA, in this case they are also women who meet for a weekly yoga lesson. The facilitators never forget that they are facing a group of abuse survivors, but at the same time the class is a “regular” yoga practice session, offering an alternative way to perceive the participants, one that does not rest exclusively on their abuse. For healing and recovery to take place, the abuse must be recognized, its story must be told and its damage recognized. At the same time, however, recovery also requires that the women are not defined only by their abuse. The Yoga/Psychotherapy setting maintains this duality throughout. The participant in the group is a yoga

student, she does not need to be defined by what happened to her. Assuming that “things become because they are seen,” being seen this way establishes health, normativity, life. For example, in one of the sessions Zoe found it hard to lie on her stomach to stretch and even to see other participants in this position. In the discussion after the practice, she related that this position brings back a strong memory of her abuse, creating a visual flashback; she asked not to be instructed anymore to “lie on your stomach,” since hearing these words was insufferable for her, causing her to experience an unregulated physical and emotional response—shortness of breath, dissociation, and crying. We hesitated whether to avoid the pose entirely, or leave out parts of it; in the end, we felt that even though some poses trigger flashbacks, they should not be avoided. The difficult memories they bring up would need to be processed, but we would at the same time look at the participants as yoga practitioners and encourage them to think of themselves the same way. Not abandoning the yoga protocol, and seeing the participants as yogis, was a therapeutic statement that lying on the stomach could ideally be reframed as tied to health and normativity, not only to traumatic memory. At its best, Yoga/Psychotherapy gives participants the gift of yoga itself—an experience that, though it brings them into contact with their trauma, transcends it.

The different ways in which the facilitators view and respond to the participants meet the needs of the self. “*I felt that she [the yoga teacher] saw what I couldn’t say, and see.*”, writes Anna. From the virtual existence grows the core self, through a presence that is adapted to the needs of the emergent self. At heart, this is a presence that **sees** and thus makes present, and a presence that can be relied upon as a reliable source of reassurance and confidence (Rav-Hon, 2017, p. 40, my emphasis). All these together eventually allow the self to be revitalized and grow, and this process in turn enables the participant herself to turn a different kind of gaze on herself—a gaze that interprets, understands, carries meaning, regulates and sometimes even allows her to experience self-love.

3. “Wow! I did a handstand!”—concluding comments

After many weeks of hand-strengthening practice, about eight classes before the group was to end its sessions, we suggested that the participants attempt a handstand—an upside-down pose that, for those who have never done it, might be deeply unsettling: it is stimulating, destabilizing, and can therefore make those who practice it feel out of control and experience a sense of regression, even more challenging for CSA survivors. Moreover, attempting a handstand usually requires the intimate physical support of the yoga teacher. During the previous sessions, Tamar could not imagine doing a handstand successfully, and just the thought of it made her anxious. The weakness of her hands, her fear of leaning on others and receiving help, the anticipated failure and feeling that she is always different and never “like the others”, and the terror of losing control—all these were discussed in the group psychotherapy, but Tamar remained afraid of the handstand, though she very much wanted to experience the pose.³ As noted before, the basic premise of the Yoga/Psychotherapy groups is that meeting the participant’s need will make it possible to restart the core self, the self that once, before the abuse, was healthy and intact. On that day, meeting her need meant including in the yoga lesson a shoulder-stand pose (which Tamar had perceived as comforting throughout the sessions), in order to help her in a difficult moment.

The attempt to grasp and articulate the exact therapeutic process, must take into consideration that in the Yoga/Psychotherapy groups, like all psychoanalytic interventions, as VanDerHeide (2010) remarks, we are dealing with a nonlinear occurrence which “dispels the illusion of certainty from our notions of therapeutic action, thereby averting the foreclosure of ongoing process that a sense of certainty can engender” (p. 49). So, with some modesty as to testifying to the exact etiology of the moment, it seems that identifying Tamar’s need and responding to it positively, enabled her to remember during this exercise that as a child she had often enjoyed this pose, with her legs up on the wall. A conversation developed within the group about the fear of encountering once again the tragic moments in which the enjoyable becomes dangerous, and the great effort not to feel this collapse of good into bad all over again. As a result, Tamar was able to express accurately—for the first time—her fear of losing control and precautions she takes against it, including by avoiding the

handstand pose. Her observation of her body, together with an appropriate selfobject responsiveness which included seeing her, followed by mirroring as well as a physical gesture (adding a mat), led to the telling of a coherent story of avoidance that had previously been untold. The narrative that emerged became part of our months-long effort to find the proper way of meeting Tamar's needs, of seeing her difficulties as she encountered her body and her history and responding to them optimally so as to create the area of need. In addition, we, the facilitators, recognized Tamar's health, her potential and ability to do whatever she chose and to be a part of a group, not merely a victim or survivor, a person not defined mostly by the abuse but by her potentials, unrealized-but-possible futures as a human being in the world. Together, all these made Tamar eventually realize her wish to try a handstand.

The handstand pose is always a very powerful experience, and for Tamar it was a dramatic moment, after which she burst into laughter mixed with tears, saying repeatedly: "Wow! I did a handstand!"—a response so live, exciting and authentic that was joined by participants and facilitators as we all laughed together with great relief. In the psychotherapy session following, Tamar spoke about her feeling of power, capability, and trust in her hands, and of the connection she felt to her body. She described how happy she felt that she had been able to cope with the anxiety involved in losing control, but also, no less than that, in relying on the physical help of the yoga teacher and the psychological support of the psychotherapist and of the group.

Ben-Zur comments: When you are upside-down, the unexpected can happen: A small act of magic that challenges balance; an impossible reality, a complete escape from reality. In a fraction of a second, everything is turned on its head; you see differently; everything is reversed. A complete change. A reversal of the rules. Nothing can touch me, hurt me, cause me pain. I left the game when it became hazardous for my soul. I enacted new laws of gravity, a new perspective, internal and safe (Ben Zur, 2018, n.p.). In many respects, this description poignantly captures the way in which Yoga/Psychotherapy dissolves existing formations and invites transformation. The primordial fault in the parental envelope, which pulls the body and the self down and restricts them, is "turned on its head." Through contact with the body, mediated by a selfobject, Yoga/Psychotherapy invites the self to restart, soften and expand. As Tamar said, "Now that I did a handstand, I can do anything. I won. I'm returning my self to myself."

Funding

The authors received no direct funding for this research.

itself in Yoga/Psychotherapy classes, where participants are free to choose which poses to avoid.

Author details

Ephrat Havron¹

E-mail: havron.havron@gmail.com

Yael Itzhak-Edan²

E-mail: office@vijjanayoga.com

¹ Department of Bibliotherapy, The David Yellin Academic College of Education, Jerusalem, Israel.

² The Neve Sha'anana Yoga Center, Jerusalem, Israel.

Citation information

Cite this article as: Establishing the "area of need" through optimal responsiveness: Yoga/Psychotherapy for childhood sexual abuse survivors, Ephrat Havron & Yael Itzhak-Edan, *Cogent Psychology* (2019), 6: 1580917.

Notes

1. Reuven Snir (trans.), Yet to be published.
2. The two components are of course interrelated and the observation by the facilitators is both part of the setting and a regulatory factor. But for purposes of the discussion they will be presented separately, less integratively than the actual occurrence of the emotional processes.
3. Tamar wanted to do a handstand, but it must be noted that the handstand is not a goal in and of

References

- Bacal, H. A. (1985). Optimal responsiveness and the therapeutic process. *Progress in Self Psychology*, 1, 202–227.
- Ben Asher, S., & Koren, B. (2002). The body of the movement therapist as a tool for receiving indications of early abuse. *Sihot*, 15(3), 283–287. [Hebrew].
- Ben Zur, M. (2018). On transference in psychoanalytic treatment of loss and bereavement. Thoughts and associative ruminations following David Grossman's book 'A Horse Walks Into a Bar', and into three therapy vignettes. A Lecture introduced in the Israel Psychoanalytic Society, June 12, 2018.
- Cates, L. B. (2011). Nonverbal affective phenomena revisited. *International Journal of Psychoanalytic Self Psychology*, 6, 510–530. doi:10.1080/15551024.2011.606641
- Cates, L. B. (2014). Insidious emotional trauma: The body remembers. *International Journal of Psychoanalytic Self Psychology*, 9, 35–53. doi:10.1080/15551024.2014.857751
- Cates, L. B. (2018). Silencing of sadness: Finding the story in the body. *Psychoanalysis, Self and Context*, 13(3), 259–271. doi:10.1080/24720038.2018.1462047

- Crowley, S. (2000). *The search for autonomous intimacy: Sexual abuse and young women's identity development*. New York, NY: Peter Lang.
- Davis, J. M., & Frawley, M. G. (1994). *Treating the adult survivor of childhood sexual abuse*. New York, NY: Basic 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.
- Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.
- Hominer, D. (2004). From interpretation to being [Lecture given at the Psychological Service of Tel Aviv University]. Retrieved from <http://www.selfpsychology.org.il/139057/דפנה-הומינר-מפירוש-להווייה> [Hebrew]
- Laub, D. (1992). An event without a witness: Truth, testimony, and survival. In S. Felman & D. Laub (Eds.), *Testimony: Crises of witnessing in literature, psychoanalysis, and history* (pp. 75–92). New York, NY: Routledge.
- Murthi, M., Servaty-Seib, H. L., & Elliott, A. N. (2006). Childhood sexual abuse and multiple dimensions of self-concept. *Journal of Interpersonal Violence*, 21, 982–999. doi:10.1177/0886260506290288
- Paras, M. L., Murad, M. H., Chen, L. P., Goranson, E. N., Sattler, A. L., Colbenson, K. M., ... Zirakzadeh, A. (2009). Sexual abuse and lifetime diagnosis of somatic disorders: A systematic review and meta-analysis. *JAMA*, 302(5), 550–561. doi:10.1001/jama.2009.1091
- 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(4), 300–309. doi:10.1089/acm.2015.0266
- Putnam, F. W. (2003). Ten years research update review: Child sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 269–278. doi:10.1097/00004583-200303000-00006
- Rav-Hon, R. (2017). The participation of the analyst in the area of need. In I. Gavrieli-Rehavi, R. Kela, & K. Goldberg (Eds.), *Writings: Psychology of the self - The Israeli contribution* (pp. 37–54). Jerusalem: Carmel. [Hebrew].
- 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(3), 189–196. doi:10.1089/acm.2014.0407
- Rhodes, A. M. (2015). Claiming peaceful embodiment through yoga in the aftermath of trauma. *Complementary Therapies in Clinical Practice*, 21, 247–256. doi:10.1016/j.ctcp.2015.09.004
- Rosenthal, L. (2012). “The body I understand”: Following a study evening on the physical aspects of the therapist in psychoanalysis (online version). *Hebrew Psychology*. Retrieved from <https://www.hebpsy.net/articles.asp?id=2736> [Hebrew] doi:10.1094/PDIS-11-11-0999-PDN
- Sahaa, S., Chungb, M. C., & Thornec, L. (2011). A narrative exploration of the sense of self of women recovering from childhood sexual abuse. *Counselling Psychology Quarterly*, 24(2), 101–113. doi:10.1080/09515070.2011.586414
- Shachar-Levy, Y. (2005). Basic typology of the language of emotive movement. *Sihot*, 19(3), 237–246. [Hebrew].
- Stern, D. B. (2010). *Partners in thought: Working with unformulated experience, dissociation, and enactment*. New York, NY: Routledge.
- Streetera, C. C., Gerbargb, P. L., Saperc, R. B., Cirauloa, D. A., & Brown, R. P. (2012). Medical hypotheses effects of yoga on the autonomic nervous system, gamma-aminobutyric-acid, and allostasis in epilepsy, depression, and post-traumatic stress disorder panel. *Medical Hypotheses*, 78(5), 571–579. doi:10.1016/j.mehy.2012.01.021
- Telles, S., Singh, N., Joshi, M., & Balkrishna, A. (2010). Post traumatic stress symptoms and heart rate variability in Bihar flood survivors following yoga: A randomized controlled study. *BMC Psychiatry*. doi:10.1186/1471-244X-10-18
- 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. *Journal of Clinical Psychiatry*, 75(6), 559–565. doi:10.4088/JCP.13m08561
- VanDerHeide, N. (2010). Reflections on Mirroring. *International Journal of Psychoanalytic Self Psychology*, 6(1), 46–49. doi:10.1080/15551024.2011.529868
- West, J., Liang, B., & Spinazzola, J. (2017). Trauma sensitive yoga as a complementary treatment for post-traumatic stress disorder: A qualitative descriptive analysis. *International Journal of Stress Management*, 24(2), 173–195. doi:10.1037/str0000040



© 2019 The Author(s). This open access article is distributed under a Creative Commons Attribution (CC-BY) 4.0 license.

You are free to:

Share — copy and redistribute the material in any medium or format.

Adapt — remix, transform, and build upon the material for any purpose, even commercially.

The licensor cannot revoke these freedoms as long as you follow the license terms.

Under the following terms:

Attribution — You must give appropriate credit, provide a link to the license, and indicate if changes were made.

You may do so in any reasonable manner, but not in any way that suggests the licensor endorses you or your use.

No additional restrictions

You may not apply legal terms or technological measures that legally restrict others from doing anything the license permits.



Cogent Psychology (ISSN: 2331-1908) is published by Cogent OA, part of Taylor & Francis Group.

Publishing with Cogent OA ensures:

- Immediate, universal access to your article on publication
- High visibility and discoverability via the Cogent OA website as well as Taylor & Francis Online
- Download and citation statistics for your article
- Rapid online publication
- Input from, and dialog with, expert editors and editorial boards
- Retention of full copyright of your article
- Guaranteed legacy preservation of your article
- Discounts and waivers for authors in developing regions

Submit your manuscript to a Cogent OA journal at www.CogentOA.com

