

AN INTEGRAL SOLUTION TO HEALING SEXUAL ABUSE TRAUMA

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ABSTRACT This article presents an Integral solution to the trauma and recovery of sexual abuse survivors. In doing so, it addresses the different areas of human experience for a multi-dimensional treatment and prevention approach to healing sexual abuse trauma. Current treatment models focus on the recovery of the perpetrator or the victim, with punishment and treatment of the perpetrator being addressed separately from the concerns of the abuse victim. The Integral framework approaches healing trauma through building a stronger self-identity and release of emotional trauma that is held in the body and mind through yoga therapy and additional practices, such as learning how to feel again, developing interior and exterior resources, building appropriate relationships and trust, and resolving the epidemic and stigma of abuse in society.

Key words: integral theory; PTSD; quadrants; sexual abuse; trauma

Sexual abuse trauma is a pervasive condition that affects millions of people across the United States. Hidden from the eyes of many, the effects of this form of trauma have historically been perpetuated through several forms of oppression: societal stigma, medical classification and diagnosis, the “false memory” controversy, the justice system, the media, the family system, and the victim’s own self-destructive actions. To heal the effects of sexual abuse trauma, which cross all socioeconomic classes, races, ethnicities, and genders, we need to take a deeper look at how we can address this epidemic on psychological, biological, sociocultural, and systemic levels. Healing on the individual level alone has not worked in stopping sexual abuse from continuing; today, the worldwide incidence of sexual abuse is one in four. This article will address the treatment of the effects of sexual abuse trauma, and preventing its occurrence through the use of an integral framework based on Integral Theory and Ken Wilber’s AQAL model. The application of the AQAL meta-framework effectively addresses the different areas (i.e., intentional/subjective, behavioral/objective, cultural/intersubjective, social/interobjective) for a multi-dimensional treatment and prevention approach to healing sexual abuse trauma.

Prevalence

Sexual abuse is a fact of life for many, yet goes largely unrecognized. The shocking statistic is that one in three girls and one in six boys are sexually abused before the age of 18 (Russell, 1988). Between 25% to 35% of women are victims of childhood sexual abuse, a staggering figure (Briere & Elliott, 2003; Finkelhor et al., 1990). According to the U.S. Department of Health and Human Services, there are over 60 million survivors of sexual abuse in the United States today, approximately 20% of the population. In a study done in 1997 by Dr. Dean Kilpatrick and Dr. Benjamin Saunders, of the

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22.3 million adolescents in the United States, 1.8 million had been victims of serious sexual assault. In a national random survey taken in 1990, 27% of the women and 16% of the men disclosed that they had been sexually abused as children; the median age for girls was 9.6 years and for boys was 9.9 years (Finkelhor et al., 1990).

Occurring in similar rates across all social classes, 68% of incest incidents take place in the victim's home (Russell, 1986). Of sexually abused girls, 53% are abused by their biological fathers, 15% by stepfathers, and 8.8% by uncles (Roesler, 1994). In cases of incest between siblings, 26% are between siblings of the same sex, 16% of cases are between brothers, and 10% are between sisters (Courtois, 1988). A slightly lower number, 4.9% of women, report an incestuous experience with an uncle before the age of 18 (Russell, 1986). Up to 90% of the abuse remains unreported to law enforcement, which keeps the perpetrators at large and continuing to re-offend (NAPSAC, 2008). The abuse usually occurs during a four-year time period, with 48% of incest perpetrators assaulting their victims 2 to 20 times, and 10% more than 20 times (Urquiza & Keating, 1990).

There is some variation found in the statistics of sexual trauma between the races, as well as genders. Although African-Americans are victimized in childhood at the same rate as Caucasian victims, they report being more severely abused, with greater use of force. African-American girls are more often abused by relatives other than their fathers; often the offender is an uncle (Russell et al., 1988).

Researchers estimate that males account for 25% to 35% of child sexual abuse victims (Finkelhor, 1994). Eighty-three percent of abused boys are under age 12; 26% are under age 6 (Urquiza & Keating, 1990). One study found that about one-third of boys are related to the men who molest them, with 8% of these boys sexually abused by fathers or stepfathers. Boys are reluctant to report sexual abuse in general, and even more reluctant to discuss sexual abuse by a family member (Urquiza & Capra, 1990).

Male survivors exhibit many of the same symptoms as females, but may also react in significantly different ways. Boys and men often tend to "act out" their trauma through aggressiveness and violence, while girls will "act in" their rage through self-destructive acts. Far more abused boys than girls will go on to sexually abuse others. One study of convicted sex offenders found that 38% provided confirmed evidence of being sexually abused as children, and another 17% provided probable evidence (Urquiza & Capra, 1990). Most men who abuse boys define their sexual orientation as heterosexual (Urquiza & Keating, 1990).

Ninety-nine percent of persons incarcerated for sexual assault or rape are men. About 35% were sexually assaulted or abused as children. Ninety-three percent of child sexual abusers are men (Crewdson, 1988). In a study of sexually abused girls by Roesler and Wind (1994), only 6.2% were abused by women.

In summary, sexual trauma in the U.S. is one of society's largest unresolved issues, driven underground by secrecy and shame. As the prevalence of child sexual abuse becomes more publicly known, more adult sexual abuse survivors, as well as abused children and adolescents, are getting the support they need in order to report. This increase in speaking out about childhood abuse attempts to hold abusers accountable and to increase treatment for the effects of trauma, but it is not enough. As this article will reveal, the effects of sexual abuse trauma suppress the development of the abuse victim

in many ways, and this is often transmitted intergenerationally, keeping millions from reaching their developmental potential. An assessment and treatment plan that includes all quadrants of human experience—from the intentional, behavioral, cultural, and social aspects at play in the proliferation of sexual abuse—is needed to address this issue effectively. In order to create such a plan, we need to first take a look at how sexual abuse trauma manifests. By understanding the effects of trauma on the body, mind, and relationships, from the internally felt symptoms to the externally observed behavior, we can better assess and diagnose the patterns and what may give rise to them.

The Acute Effects of Trauma on the Nervous System

To define the symptoms of trauma, it is necessary to understand the acute effects that it has on the nervous system. The autonomic nervous system (ANS) controls the internal organs, including the involuntary functions of breathing, heart rate, digestion and peristalsis, blood pressure and temperature regulation, sweat, and the secretion of hormones. The acute effects of trauma are seen in nervous system dysregulation, particularly the over-activation of the ANS's sympathetic branch (SNS) or parasympathetic branch (PNS). The SNS and the PNS act together in a relationship to maintain homeostasis in a reciprocal manner; when one is activated, the other is usually at rest. The SNS is activated in states of stress and emergencies that require us to “fight” or take “flight.” Signs of SNS arousal include increased heart rate and respiration, cold and pale skin, dilated pupils, and raised blood pressure. The PNS is activated in states of relaxation, allowing us to rest and digest. Signs of PNS arousal include decreased heart rate and respiration, warm and flushed skin, normally reactive pupils, and lowered blood pressure.

When the ANS experiences a traumatic event, the nervous system is overwhelmed, and becomes dysregulated. Sympathetic over-activation is demonstrated by hyperactivity, hypervigilance, mania, anxiety, panic, startle response, insomnia, and rage, while parasympathetic over-activation is expressed in the symptoms of depression, disconnection, disinterest, exhaustion, and numbness. When both the PNS and SNS are activated and overwhelmed simultaneously, the result is immobility, or the “freeze” response, which is likely to occur if death is imminent or the traumatic threat is prolonged. The freeze response is experienced as an altered state of reality, with a diminished awareness of fear and pain, where time slows down, in a form of dissociation. In this state, if harm or death occurs, the psychological and physical impact is not as great. The freeze response may temporarily increase the chance of biological survival, but over time the frozen or “bound energy” causes problems in the nervous system, and results in symptoms.

Dr. Peter Levine (2005) puts the symptoms of trauma in order of appearance:

- Hyperarousal (increased heart rate, sweating, difficulty breathing, cold sweats, tingling, and muscular tension)
- Constriction (breathing, muscle tone, and posture prepare for action, numbness, narrowing of perceptions)
- Dissociation and denial (endorphins are released, disconnection between body and painful emotions)
- Feelings of helplessness, immobility, and freezing (slows down the nervous system) (p. 18)

In the brain, the part that responds to traumatic threat is the limbic system, which is located between the brain stem (reptilian brain) and the neocortex. Known as the “midbrain” in the triune brain theory, the limbic system regulates survival behaviors and emotional expression, being primarily concerned with tasks of survival such as eating, sexual reproduction, and the instinctive survival defenses of fight and flight. It also plays a central role in memory processing. By releasing hormones that tell the body to prepare for defensive action, it activates the SNS, which prepares the body for fight or flight through increasing respiration and heart rate to provide more oxygen, and sending blood away from the skin and into the muscles for quick movement. The limbic system instinctively chooses the most appropriate defense based on whether there is enough strength, time, and space for flight, or adequate strength to defend. If freezing is chosen as the most adaptive defense, the limbic system will simultaneously release hormones to activate the PNS.

The two other parts of the brain, the reptilian brain and the neocortex, are affected by trauma as well. The reptilian brain deals with subconscious processes, such as digestion, reproduction, circulation, breathing, and the execution of the “fight or flight” responses. As these responses are automatic, they are resistant to change, but are central to resolving trauma, as the reptilian brain responds to sensation and body memory, in comparison to the conscious thought processes mediated by the neocortex. The neocortex is responsible for higher cognitive functioning, such as language, decision making, planning, and speech. When there is a traumatic event, often what happens is the instinctual reptilian brain processes override the functioning of the neocortex, because trauma is stored in the limbic and reptilian brains, not in the neocortex. This is why youth have greater difficulty processing trauma consciously, due to a lack of connection yet to be developed within the neocortex. Trauma can also cause delayed development of the neocortex, which only enhances this problem, and can lead to significant problems with concentration and learning as well.

Bessel van der Kolk writes:

The current discoveries in the neurosciences about the automatic activation of hormonal secretions, emotional states, and physical reactions in response to sensory input have once again confronted psychology with a reality that was first emphatically articulated by Freud: most human actions and motivations are based on processes that are not under conscious control. The implications of these discoveries are particularly relevant for understanding and treating traumatized individuals. Realizing that they are prone to activate automatic trauma-related hormonal secretions and physical action patterns clarifies why they would tend to respond to certain triggers with irrational—that is, subcortically initiate—responses that are irrelevant and even harmful in the context of present demands. (as cited in Ogden et al., 2006, p. xx)

Van der Kolk continues by saying, “One of the most robust findings of the neuroimaging studies of traumatized people is that, under stress, the higher brain areas involved in ‘executive functioning’—planning for the future, anticipating the consequences of one’s actions, and inhibiting inappropriate responses—become less active” (as cited in Ogden et al., 2006, p. xxi). What this means is that there is a disruption in the way that the brain normally processes information. Rausch and colleagues found a “marked lateralization of activity in the right hemisphere, which is thought to be involved in evaluating the emotional significance of incoming information and in regulating autonomic and hormonal

responses to these incoming stimuli” (as cited in van der Kolk, 2007, p. 233). They also noticed that Broca’s area, the part of the left hemisphere responsible for translating personal experiences into language, “showed a significant decrease in oxygen utilization during exposure to traumatic reminders,” meaning that the person may be physiologically prevented from translating the experience into language (as cited in van der Kolk, 2007, p. 233). An EEG study by Martin Teicher and colleagues (as cited in van der Kolk, 2007, p. 228) shows loss of normal synchronization between the electrical activity of different cortical areas, particularly in the left hemisphere, in sexually abused children related to problems in language development and recalling historical information.

A similar effect can occur in which the neocortex overrides the signals from the midbrain and reptilian brain, in which the activation from the traumatic event is not discharged (Khouri, personal communication, December 7, 2007). In this case, we try to “out-think” the trauma, rather than release it, and keep it in the intellect rather than the midbrain and reptilian brain; this over intellectualization happens because our neocortex is so large. This can appear as an inability to understand the physical sensations and feelings that arise from the trauma. In their book, *Trauma and the Body: A Sensorimotor Approach to Psychotherapy* (2006), Pat Ogden and colleagues write,

After one or more confrontations with the futility of their emotions and automatic action patterns to restore safety and control, many traumatized children and adults seem to lose the capacity to utilize their emotions as guides for effective action. Their emotions may get activated, but they don’t recognize what they are feeling. This is called an inability to verbally identify the meaning of physical sensations and muscle activation, alexithymia. This inability to recognize what is going on inside—to correctly identify sensations, emotions, physical states—causes individuals to be out of touch with their needs and incapable of taking care of them, and often extends to having difficulty appreciating the emotional states and needs of those around them. (pp. xxi–xxii)

Post-Traumatic Stress Disorder

Trauma and post-traumatic stress disorder (PTSD) exist as a state of being that can occur at any stage of development, and are important to give us a deeper understanding of the effects of the trauma. PTSD is a relatively new diagnostic category in the history of psychology. It was first introduced in 1980, in the *Diagnostic and Statistical Manual of the American Psychological Association, Third Edition*. The current version of the American Psychological Association (APA) manual, *DSM-IV-TR*, states that PTSD develops in response to events that are threatening to life or bodily integrity, witnessing threatening or deadly events, and hearing of violence to or the unexpected or violent death of (or threat of death or injury to) family members or close associates. The victim’s response to the event must also “involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior)” (APA, 2000, p. 463). Events that qualify as traumatic include: combat, sexual and physical assault, being held hostage or imprisoned, terrorism, torture, natural and man-made disasters, accidents, and receiving a diagnosis of a life-threatening illness. PTSD can also develop in children who have experienced “developmentally inappropriate sexual experiences without threatened or actual violence or injury” (APA, 2000, p. 464). The *DSM-IV-TR* adds, “The disorder may be especially severe or long lasting when the stressor is of human design (e.g. torture, rape)” (APA, 2000, p. 464). Of the adult population of the United States, the lifetime prevalence of

PTSD is approximately 8% of the adult population (APA, 2000, p. 466), and PTSD is associated with increased rates of major depressive disorder, substance-related disorder, panic disorder, agoraphobia, obsessive-compulsive disorder, generalized anxiety disorder, social phobia, specific phobia, and bipolar disorder.

Symptoms

PTSD is classified as an anxiety disorder in the *DSM*. According to *The Handbook of Clinical Psychopharmacology for Therapists*,

Patients suffering from post-traumatic stress disorder (PTSD) and a related disorder, acute stress disorder, often do present with a host of anxiety symptoms; however, anxiety is but one aspect of PTSD. This syndrome also often includes symptoms of depression, transient psychosis, and dissociation. (Preston et al., 2006, p. 98)

The *DSM-IV-TR* criteria for PTSD include three main groups of post-traumatic symptoms, which are classified into three categories: acute (when the duration of symptoms is less than 3 months), chronic (when the symptoms last three months or longer) or with delayed onset (when at least six months have passed between the traumatic event and the onset of the symptoms) (APA, 2000, p. 465). The symptoms are intrusive/re-experiencing the event in varying sensory forms (e.g., flashbacks, nightmares), avoidance of reminders associated with the trauma/numbing, and chronic hyperarousal of the ANS (e.g., marked sleep difficulty, irritability and anger outbursts, difficulty with concentration, hypervigilance, exaggerated startle response). PTSD is present when these symptoms last more than one month and are combined with distress or impairment in social or occupational functioning (APA, 2000, p. 468). In studies by both Lars Weisaeth and Alexander McFarlane, it was found that “The emergence of an exaggerated startle response, hypervigilance, increased irritability, sleep disturbance, and disturbed memory and concentration is what differentiates the victims who go on to develop PTSD” (as cited in van der Kolk, 2007, p.172). The American Psychological Association (2000) adds:

PTSD can occur at any age, including childhood. In addition to typical PTSD symptoms, young children often present the following symptoms: generalized nightmares of monsters or of being threatened, the tendency to represent the trauma in repetitive play, belief in a foreshortened future, and stomachaches and headaches. (p. 466)

The *DSM-IV-TR* has only a small section of “Associated Features and Disorders” for PTSD that discusses symptoms in association with an interpersonal stressor, such as childhood physical or sexual abuse, or domestic battery, and there is no specified diagnostic category associated with these symptoms. These symptoms are listed as:

Impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness; shame, despair or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual’s previous personality characteristics. (APA, 2000, p. 465)

The Handbook of Clinical Psychopharmacology for Therapists (2006) adds to the symptoms of PTSD transient psychotic symptoms, avoidance, and associated features (major depression, panic attacks, substance abuse as an attempt to self-medicate to reduce anxiety or intrusive experiences) (Preston et al., 2006, p. 131).

The symptoms of the acute effects of trauma may be very similar to those of PTSD, both in the body and the behavior of the victim, as ANS hyperarousal may be present in each case. Symptoms of a lesser duration than one month may qualify under the diagnosis of acute stress disorder instead, which is similar to PTSD in symptomology, yet must develop within one month of exposure to an extreme traumatic stressor, be of a minimum of two day's duration, and a maximum of four weeks length. Acute stress disorder appears to be a good predictor of subsequent PTSD; the presence or absence of the diagnosis predicted PTSD at six months in 83% of cases in a study by Chris Brewin and colleagues (1999). It includes the criteria for PTSD but adds and emphasizes dissociative symptoms, such as derealization, depersonalization, and dissociative amnesia (inability to recall an important aspect of the trauma).

Similarly, Gina Ross, author of *Beyond the Trauma Vortex* (2003), states, "Dissociation is a key symptom of trauma. It has been shown to be the single most important predictor of PTSD" (p. 66). Van der Kolk and colleagues (2007) write, "In recent years, psychiatry has rediscovered that dissociative processes play a critical role in the development of trauma-related psychological problems (e.g. Briere & Conte, 1993; Spiegel & Cardena, 1991; Marmar et al., 1994b; Shalev, Peri, Caneti, & Schreiber, 1996)" (p. 306). Referring to studies by Gelinias and Noyes and colleagues, van der Kolk goes on to say, "A 'dissociation between observing ego and experiencing ego' (From, 1965) has often been described in traumatized individuals, such as incest survivors, traffic accident victims, and combat soldiers." This dissociative state is like the causal Witness state, but instead it is used as a defense mechanism, and is not integrated, or transcendental, but a dysfunctional attempt at transcendence that does not add to one's spiritual growth (Wilber, personal communication, July 1, 2008). One way that the Witness state can be integrated into the survivor's treatment plan is through the practice of meditation. This will be discussed in detail later in this article.

Other predictors of trauma that Ross reveals in her book include the magnitude of exposure to the traumatic event, the age at the time of trauma, the experience of prior trauma, the environmental conditions existing at the time of trauma (e.g., poverty, conflict), the quality of social support during and after the event, and the amount of dissociation during the traumatic event (Ross, 2003, p. 28).

Biological Evidence

On a biological level, traumatic exposure can cause lasting alterations in the endocrine, autonomic, and central nervous systems. Rachel Yehuda discovered that the adrenal glands of those with PTSD do not release enough cortisol to halt the alarm reaction (Yehuda et al., 1990). Several studies, done by Bauer, Priebe and Graf, and Yehuda and colleagues (as cited in Rothschild, 2000, p. 9), have shown that individuals with PTSD have lower cortisol levels than control subjects, even those with other psychological problems like depression. Rothschild (2000) writes:

Once the traumatic incident is over and/or the fight or flight has been successful, the cortisol will halt the alarm reaction and the production of epinephrine/

norepinephrine, helping restore the body to homeostasis. This system is called the HPA axis. The reason it is important to trauma work is that in PTSD something goes wrong with it. (p. 9)

These studies suggest that cortisol may be a protective factor against developing PTSD. In addition to cortisol, marked increases have also been shown in the neurotransmitter glutamate, which may reach toxic levels and damage parts of the brain associated with affect regulation. This has been supported by both human and animal studies (Southwick et al., 1999; Heim et al., 2000; Heim & Nemeroff, 2002; Preston et al., 2006, p.134). Experimental treatments to decrease activity of noradrenergic cells in the locus coeruleus, by administering alpha-2 agonists, such as clonidine, have been promising (Preston et al., 2006, p.134). Fred Gallo writes in his book, *Energy Tapping for Trauma* (2007), “Also a low level of serotonin, an important neurotransmitter, is instrumental in exaggerated startle response (Depue & Spoont, 1986), suicide and aggression (Coccaro et al., 1989), and preoccupation with the traumatic event (van der Kolk & van der Hart, 1991)” (p. 21).

Van der Kolk (as cited in Ogden et al., 2006) says:

Various neuroimaging studies...have shown decreased activation of the medial prefrontal cortex in individuals with PTSD. This means that traumatized individuals as a rule have serious problems attending to their inner sensations and perceptions. When asked to focus on internal sensations, they tend to feel overwhelmed, or deny having any. (p. xxv)

These findings suggest that a chronic level of arousal dysregulates the emotions, both in terms of their action as a signal to take action, as well as being able to even experience them as emotions, and not as dangerous or threatening reminders that may lead to more arousal. “In PTSD, extreme feelings of anger and helplessness can be understood as the reliving of memories of the trauma; like other memories of the trauma, they become reminders to be avoided” (van der Kolk, 2007, p. 219).

Effects of Sexual Abuse Trauma in Childhood

Sexual abuse in childhood usually creates emotional and psychological problems that last into adulthood. Incest may cause even greater harm because of the betrayal and the complications of the close personal relationship. Studies by van der Kolk and Judith Herman (as cited in van der Kolk, 2007, p. 228) show “...intrafamilial abuse is increasingly recognized to produce complex posttraumatic syndromes (Cole & Putnam, 1992), which involve chronic dysregulation, destructive behavior against self and others, learning disabilities, dissociative problems, somatization, and distortions in concepts about self and others” (van der Kolk, 2007, p. 228). Van der Kolk and colleagues explain:

In a study of childhood antecedents of self-destructive behavior in psychiatric outpatients (van der Kolk et al., 1991), we found that the age at which their abuse and/or neglect had occurred played an important role in both the severity of their self-destructive behavior and the form it took: The earlier the abuse, the more self-directed the aggression. Abuse during early childhood and latency was strongly correlated with suicide attempts, self-mutilation, and other self-injurious behavior. In contrast, abuse in adolescence was significantly as-

sociated with anorexia nervosa and with increased risk taking... We concluded that childhood abuse contributes heavily to the initiation of self-destructive behavior, but that the lack of secure attachments maintains it. Those subjects who had sustained prolonged separations from their primary caregivers, and those who could not remember feeling special or loved by anyone as children, were least able to utilize interpersonal resources to control their self-destructive behavior during the course of the study. (p. 190)

Children who grow up being sexually abused in their own home face profound challenges in the developmental task of forming attachments to their caregivers, who may also be dangerous, negligent, or untrustworthy. Added to this task is the need to form a sense of self in relation to others, and develop a capacity for bodily self-regulation, even when the child's body may be at the service of someone else's needs. The child will also face the issues of developing initiative in an environment which demands they conform to the wishes of the abuser, and develop a capacity for intimacy despite corruption in their primary relationships (Herman, 1997, p. 101). Herman (1997) states, "All of the abused child's psychological adaptations serve the fundamental purpose of preserving her primary attachment to her parents in the face of daily evidence of their malice, helplessness, or indifference" (p. 102). To preserve this sense of attachment, the child will resort to psychological defenses, among them denial, rationalization, minimization, and dissociation. Herman (1997) explains one way that the child will accomplish this task:

By developing a contaminated, stigmatized identity, the child victim takes the evil of the abuser into herself and thereby preserves her primary attachments to her parents. Because the inner sense of badness preserves a relationship, it is not readily given up even after the abuse has stopped; rather, it becomes a stable part of the child's personality structure. (p.105)

By believing that they are bad, and the parents are good, the child can then remedy the situation by trying to be good themselves. This restores power to the child, who may then believe that they have the power to change the circumstances by being good. Herman (1997) says, "If she has driven her parents to mistreat her, then if only she tries hard enough, she may someday earn their forgiveness and finally win the protection and care she so desperately needs" (p.103).

Unfortunately, this kind of behavior can then be easily camouflaged to the unknowing observer as something to be rewarded, and this will further reinforce the child's desire to act this way. Herman (1997) continues, "This malignant sense of inner badness is often camouflaged by the abused child's persistent attempts to be good....She may become an empathic caretaker for her parents, an efficient housekeeper, an academic achiever, a model of social conformity" (p. 105). According to Herman, the development of dissociative defenses, a fragmented identity, and the pathological regulation of emotional states are the three major forms of adaptation that permit the child to survive in an environment of chronic abuse. They also allow the victim to preserve the appearance of normality, and disguise their symptoms of distress which is of importance to the abusive family (Herman, 1997, p. 110), yet are essential shadow issues that will need to be addressed in therapy. Duncan (2004) writes:

The difference between a family in which sexual abuse does not occur and a family in which it does occur is that underneath the layers of normalcy exists a

secret not to be revealed. In the outward behavior of the family in which sexual abuse occurs, the image of the family is maintained; underneath this facade is where the abuse occurs and where the beliefs form that sustain it. Somehow, the family members know when not to talk, not to hear, and not to see what is going on around them. This conspiracy of silence can sustain abusive behavior for years. (p. 57)

Recognizing the symptoms of trauma in children is essential for therapists to stop the cycle of abuse and provide adequate intervention before further damage is done to the child. Some of the symptoms are behavioral, such as a regression to earlier forms of behavior (e.g., thumb sucking, bedwetting, wanting the breast), withdrawal, excessive shyness, clinginess, emotional outbursts, aggression with other children, nightmares, phobias, and avoidant behavior. Children may also show compulsive repetition in their play, hyperactivity, controlling behavior, a tendency to startle easily, bed thrashing, or forgetfulness. School phobia is another way children show need for reassurance regarding safety. On a physical level, children may experience headaches, stomach aches, or diarrhea, all of which may have emotional components associated with them (Ross, 2003, p.162). Regarding sexual behavior in children, Duncan (2004) adds, “Normal child play does not include adult sexual acts or words. A child who exhibits adult behavior and knowledge, especially sexual knowledge, is repeating what has been shown to her or done to her” (p. 20).

If these symptoms are not detected, long-lasting changes to the reptilian brain and midbrain (which develop first in children and registers early traumatic experiences) can occur, leading to chemical changes and problems with the brain’s organization and functional capabilities (Ross, 2003, p.5). As Rothschild (2000) explains, a “predisposition to psychological disturbance, including PTSD, can be found in stressful events during early development: neglect, physical and sexual abuse, failure of the attachment bond, and individual traumatic incidents (hospitalization, death of a parent, car accident, etc)” (p. 24). In a study by Roger Pitman (as cited in van der Kolk, 2007, p. 184), it was found that people who develop PTSD secondary to child abuse had more profound physiological dysregulation in response to non-traumatic stimuli than did people who developed PTSD as adults. Another factor to consider is the impact that occurs to a child when exposed to the perpetrator’s belief system during the sexual abuse and to the family belief system prior to, throughout, and after the abuse. Without therapy, these beliefs are carried into adult life and will most likely set the stage for victimization by other people (Duncan, 2004, p.24). Other problems that can continue are the use of defensive strategies that helped them to survive as children (e.g, dissociation) as a way of dealing both with trauma-related intrusions and with other ongoing stressful life experiences (van der Kolk et al., 2007, p.305), among many other strategies that are related to how they dealt with the trauma of sexual abuse in childhood.

Duncan, in her book, *Healing from the Trauma of Childhood Sexual Abuse* (2004), lists the specific problems in adulthood associated with childhood sexual abuse: addictions, anxiety, body image, chronic pain, depression, fearful thoughts and behaviors, memory, parenting, physical responses, relationships, revictimization of self or others, self-image, sexuality, sleep, and trust issues (pp. 97-103). This is a comprehensive list of the most prominent symptoms that those in treatment for sexual abuse confirm as occurring in their lives, yet not all victims will experience all of these problems.

Treatment

There are many techniques that have been explored to deal with sexual abuse trauma. Each method is effective to the extent that it can provide relief for the symptoms that it addresses, and with sexual abuse trauma, there are many symptoms to consider. As sexual abuse trauma affects lives on so many levels, I have chosen Ken Wilber's AQAL model and the Spiral Dynamics Integral (SDi) approach for their potential therapeutic means of recovery. To give readers a better understanding of Spiral Dynamics, I will first briefly outline the work of Clare Graves and Spiral Dynamic theory, a precursor to Don Beck's Spiral Dynamics Integral, which is referenced in Wilber's work.

Spiral Dynamics

The firsthand experience of sexual abuse can create a crisis in how one views the world. This crisis in perspective affects one's belief system and how one will then operate in life. When there is a threat that one may be attacked by a perpetrator, the fear of loss of security can lead to feelings of anger, anxiety, and a sense of being ungrounded. To the degree that this is a conscious process varies from person to person, and is dependent on the many life factors that make each person unique. One way to understand the different belief systems that can occur in trauma and address healing on different levels of society is through the work of Clare W. Graves and his Emergent Cyclical Levels of Existence Theory (ECLET). Graves believes that humans develop new biopsychosocial coping systems to solve existential problems and cope with their worlds. These coping systems are dependent on evolving human culture and individual development, and they are manifested at the individual, societal, and species levels. Graves theorized that tangible, emergent, self-assembling dynamic neuronal systems evolved in the human brain in response to evolving existential and social problems. This emergence of new biopsychosocial systems follows a hierarchy in several dimensions, with both progression and regression being possibilities in his model. Graves' theory influenced a number of theorists, including Chris Cowan, Don Beck, and Ken Wilber.

Beck and Cowan used Graves' theory as the basis for their book *Spiral Dynamics: Mastering Values, Leadership, and Change* (1996), which in turn has been referenced by integral theorist Ken Wilber. Spiral Dynamics was an elaboration of the biopsychosocial systems concept of Graves' original research. Beck updated and expanded Graves' concepts to appeal to a wider audience, introducing the concept of *value memes*. In Spiral Dynamics, the term *∞Meme* (short for values-attracting meta-memes) refers to a core value system. The *∞Meme* expresses itself through memes, which are patterns of thinking, habits, and cultural practices. These *∞Memes* fall into a series of eight levels, with two identified tiers. First-tier *∞Memes* or stages, of which there are six, are marked by the belief that their way of understanding the world is the only truly correct or valuable way. At second tier, the first integral impulses in consciousness come forth in two stages, marked by an understanding that all of the first-tier stages have a crucial, yet limited awareness of the world. The memes are not considered developmental stages, however, as they do not develop in order.

Each *∞Meme* emerged historically in response to satisfying the needs of existing life conditions and the consequent needs of new and more complex life conditions. Individuals and cultures do not fall neatly into any single *∞Meme*, as each reflects a mixture of the value patterns, which progress and regress over time dependent upon the circumstances surrounding the person and culture. However, one generally falls into a dominant *∞Meme*, named by Wilber *center of gravity*. In times of trauma and survival-based life conditions, previously submerged *∞Memes* often come to the surface as the

dominant meme. Given that the majority of the world's population, according to Wilber (2000b), is at the first-tier ethnocentric blue ν Meme, in this case we may see an increase in red ν Meme-oriented behavior, reflecting the egocentric self viewpoint (but could also reveal a lower ν Meme level, such as purple or beige, depending on the level of development prior to the trauma). How this is shown in the negative aspect is through rage and rebellion, high crime rates, and hedonistic behavior. As guilt is not yet developed at this level, but shame is, this is important to consider when devising an appropriate treatment plan. By approaching a solution from the level of the individuals and cultures, the respective treatment model will be much more effective. By imposing solutions or structures that are too far ahead of the curve, and thereby engaging inappropriate ν Memes, the result is often alienation and rebellion rather than transformation. In the case of trauma, if there is regression to the red ν Meme level, then operating from the blue ν Meme's value systems will be more useful in introducing change. This would include a strong focus on joining the collective and accepting and valuing participation in the group, finding purpose, bringing order by adhering to rules, law and moral codes of convention, and analyzing and strategizing on how to build a sense of security through traditional values and conformity. In a healthy manifestation of blue, qualities would include discipline, accountability, order and stability, and a movement toward transcendence in institutionalized systems, such as religion.

Eventually, when the culture evolves to a higher level of memetic development, interventions at the orange, green, and eventually yellow (second tier) levels could be introduced (reflecting rational/individualistic, relativistic/pluralistic, and integrative values, respectively) and allow for the development and expansion of the world-centric perspective. However, even these interventions can be detrimental, and allow for lower memetic values to arise if they work against the ν Memes below them. Care must be taken to send the appropriate message to the appropriate ν Meme for the best results, and this will vary between people, groups, cultures, and geographical locations.

Ken Wilber collaborated with Don Beck to update the Spiral Dynamics model and integrate his AQAL model, creating the new SDi model. One of the distinguishing characteristics of SDi is the use of Wilber's AQAL model (Fig. 2) into which it integrates Spiral Dynamics in the personal, organizational, and societal arenas.

Wilber points out in his recent book, *Integral Spirituality* (2007), how extreme postmodernism has contributed to an atmosphere in which pathological egocentric and ethnocentric orientations, the two developmental waves responsible for most acts of terror and abuse, are allowed and in some cases encouraged to flourish. He recommends a move from deconstructive postmodernism to a post-post-modern and Integral view, in which depth is honored. What this means is that any integral approach to change must account for what he calls *states* and *stages*. A state of consciousness is a temporary experience; a stage is an enduring capacity, which is lasting once attained. States are commonly known as waking (gross), dreaming (subtle), and deep sleep (causal), and also include others, such as meditative states (Witness and nondual), or altered states. They are exclusionary, and exist independently of one another. Stages are seen as milestones of development, measuring a particular line of development or intelligence, whether it be cognitive, emotional, moral, sexual, spiritual, or otherwise. Stages are inclusive, and develop in addition to each other. States are easily experienced, whereas stages take work to attain; however, increased contact to higher states of consciousness will, according to Wilber (2006, p.11), help one to develop through any of the stages of consciousness at a faster rate. He continues:

It is as if higher-states training acts as a lubricant on the spiral of development, helping you to disidentify with a lower stage so that the next higher stage can emerge, until you can stably remain at higher levels of awareness on an ongoing basis, whereupon a passing state has become a permanent trait. These higher-states training, such as meditation, are a part of any integral approach to transformation. (Wilber, 2006, p.11)

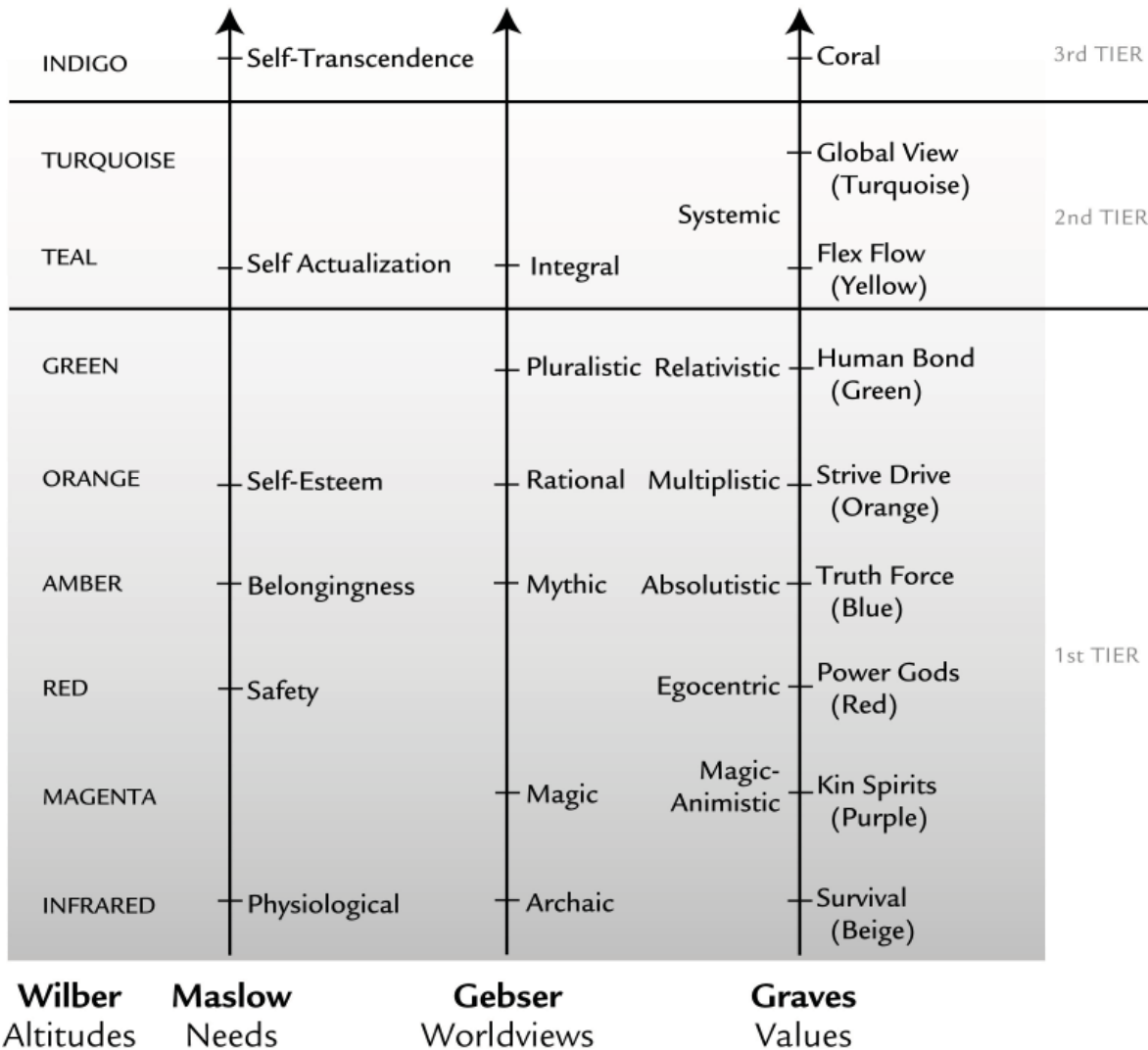


Figure 1. Cross reference of Wilber’s altitudes with Maslow’s hierarchy of needs, Gebser’s worldviews, and Graves’ values.

Ways of measuring these stages have been developed by several theorists, such as those of Suzanne Cook-Greuter and Jane Loevinger (ego development), Jean Piaget (cognitive development), Abraham Maslow (needs development), and Don Beck and Clare Graves (values development), to name a few. Within each stage conception theory, the stages can be thought of as vertical steps, ascended one at a time to a higher level, and states are horizontal stations of experience at each stage. The strength of the AQAL model is that it is the only model that addresses both vertical and horizontal development

simultaneously, which is where the other stage conception models fall short. Its ability to correlate the exterior development with the interior development of the individual and show how these are affected by cultural and social circumstances is an important contribution to the field of development studies. Figure 1 shows a cross reference of Beck's Spiral Dynamics Integral with Maslow's hierarchy of needs, Gebser's worldviews, and Graves' ECLET.

AQAL

In dealing with the psychology of trauma from sexual abuse with an AQAL framework, each of the quadrants is addressed by embracing body, mind, spirit, and shadow and their corresponding practices in self, culture, and nature. This approach embraces the idea that each perspective does not exist in a vacuum, but is interconnected with and affects each of the others. Wilber defines the degree of developmental unfolding of items such as complexity, consciousness, and the number of perspectives one can take as *altitude*, and this is measured in his AQAL model. Altitude colors measure similar degrees of development wherever you see the same color. For example, red will always be a version of egocentric, self-protective, magical-power regardless of the quadrant you are working with, and on what line of development within each quadrant. Thus, subsequent references to altitude should be taken as an indication of the Meme level. Lines are like intelligences, such as cognition, morals, musical talent, and needs (Wilber, 2000a), and in each person these lines will differ in development to some extent. By looking at each quadrant in detail to see where the strengths and weaknesses lie in

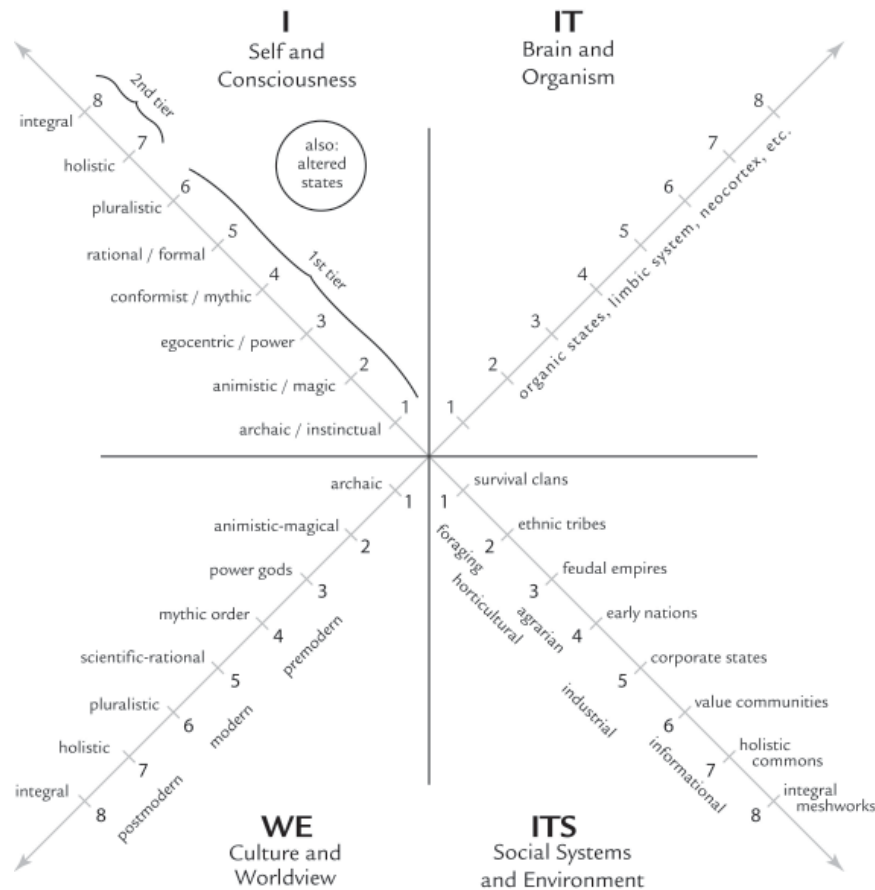


Figure 2. The four quadrants of Integral Theory (AQAL).

each of the lines of development, practices can be suggested in each of the quadrants to remedy any problems in an adaptive way, keeping in mind the center of gravity or altitude at any one point in time, and facilitating healing on multiple levels simultaneously, with each level assisting each other.

One of the advantages of the AQAL framework is that it is scalable (to fit each person's lifestyle) and modular (from which one can choose which practices they would like to work on), and can therefore be tailored to fit people at different levels of development, with different centers of gravity. The goal is to balance whatever is present to the best degree possible, and reduce suffering. On the horizontal level, this may mean accepting the self and finding integration and harmony so the client may become as healthy and functional as they can at their current level of development; on a vertical level, this would mean increasing their capacity with a practice such as yoga or meditation to grow to higher or deeper levels of development. By cross-training in both dimensions, their total capacities develop faster than by participating in one or two practices alone. How the client is functioning will determine what the emphasis for the therapy will be in each of the quadrants, and how a practice will be approached. No matter what the practice is, a dedicated daily practice is recommended to produce a lasting transformation.

An interesting point to note is that the cognitive line of development is necessary (but not sufficient) for all the other lines of intelligence to develop, and establishes at what level one's perspective is (i.e., egocentric, ethnocentric, worldcentric) through which the states are experienced. What this means in terms of the effect of trauma is that if the cognitive line is in the early stages of development when the abuse occurs, it could paralyze the victim's development at that stage, thus affecting their world view and ability to develop in other lines, allowing for further victimization. This is seen with victims of childhood sexual abuse experiencing multiple adverse childhood experiences (ACE), including childhood abuse, neglect, alcoholism, drug and alcohol abuse, depression, suicide attempts, and unintended pregnancies more frequently than those who have not experienced this abuse, with the likelihood of experiencing each category of ACE increasing 2- to 3.4-fold for women and 1.6- to 2.5-fold for men (Dong et al., 2003, pp. 625-639).

Next is a look at each of the quadrants in detail (Fig. 2), as they pertain to healing trauma in the victim of sexual abuse. Overall, the treatments will not be tailored specifically to any altitude or level of development (although they will be noted as such where applicable), as there tends to be overlap between the different pathologies and treatments, and the appropriate treatment plan will need to be determined for each individual.

I Quadrant

For the "I" quadrant, which focuses on the interior of the individual from the first-person intentional subjective perspective, there are several practices that can help treat trauma on the level of the self and consciousness, and address the symptoms that have appeared in the body, mind, and spirit, as this is the quadrant where most of the focus of healing sexual abuse has traditionally been. I have used Wilber's full spectrum model of psychological development to look at how trauma can affect development in the "I" quadrant. Wilber (1986) explains:

I have...attempted to develop an overall or spectrum model of psychology, one that is developmental, structural, hierarchical, and systems-oriented, and

that draws equally on Eastern and Western schools. Vis-à-vis psychopathology the conclusion I reached was that the spectrum of consciousness is also a spectrum of (possible) pathology. If consciousness develops through a series of stages, then a developmental “lesion” at a particular stage would manifest itself as a particular type of psychopathology, and an understanding of the developmental nature of consciousness—its structures, stages, and dynamics—would prove indispensable to both diagnosis and treatment. (p. 66)

Using Wilber’s model, we find that childhood sexual abuse typically fixates victims at what is known as self-stage or fulcrum 2 (F-2), “phantasm-emotional,” where the infant’s identity becomes associated with the emotional-feeling body, or fulcrum 3 (F-3), “representational-mind.” F-2 begins at around age one and lasts until around age three where the conceptual mind begins to develop, and the child eventually differentiates from the emotional body and conceptual mind between the ages of three and six years old, which is F-3. If there is a trauma at either of these two fulcrums, the mind may fail to differentiate from bodily feelings, or not integrate, or repress bodily feelings (Wilber, 2000a, p. 93). A fixation at F-2 will lead to a difficulty in differentiating the self from others, resulting in narcissism or other borderline disorders. At F-3, depending on whether one differentiates or not, a fixation will lead to a repression of the emotional self or a fusion with it (Wilber, 2000a, p. 94). Fulcrum 4 (F-4), or “rule/role mind,” develops between ages seven through twelve, and the self begins to take on the role of others, shifting from egocentric to sociocentric. A trauma at this level leads to a “script pathology,” where the self learns faulty scripts and stories about itself (Wilber, 2000a, p. 96).

Tools to work with these fixations include structure building to develop the self’s boundaries and increase ego strength, so that it may complete the process of separation and individuation necessary for differentiation for F-2 (practiced in object-relations therapy, self psychology, and psychoanalytic ego psychology). In his book *A Secure Base*, John Bowlby (1988) explains that the adults children have significant relationships with are their working models to help them regulate initial traumatic relationships. These relationships are then internalized, providing the child their basic level of differentiation. This explains how lower levels of differentiation can be transmitted intergenerationally. F-2 therapies apply to magenta altitude. Uncovering and connecting with repressed feelings and integrating these into the psyche is prescribed for F-3 (as practiced in Jungian therapy, classic psychoanalysis, and Gendlin’s focusing, among others), and these tools apply to red altitude. F-4 tools include cognitive therapies to help the self replace faulty ideas about the self with healthier scripts (Wilber, 2000a, pp. 94-96) and are useful to treat those at amber altitude.

Individual psychotherapy is very helpful for trauma. Wilber suggests that typical individual therapy tends to involve strengthening boundaries (F-2), contacting and befriending shadow feelings (F-3), and cognitive rescripting (F-4), but that bringing awareness to the facets of experience that were previously distorted or repressed in itself can be curative (Wilber, 2000a, pp. 98-99). These therapies can also be useful in working with the perpetrator, particularly when focused on structure-building, such as with Kohut’s self psychology methods of optimal frustration and transmuted internalizations (Kohut, 1984, pp. 98-99). Interventions such as art therapy can be useful with children or those who have experienced trauma on a pre-verbal level (“sensorimotor” fulcrum, or F-1). Cognitive-behavioral therapy has been particularly successful in the treatment of sexual abuse trauma. Practices such as thought stopping, thought redirection, and identification of catastrophic thoughts, along with challenging distorted or unproductive beliefs, opinions, attitudes and assumptions in the style of Aaron

Beck's cognitive therapy, are helpful to alleviate the symptoms of PTSD.

Another therapy that is useful in dealing with the negative thoughts associated with sexual abuse trauma is rational emotive behavioral therapy (REBT). REBT focuses strongly on cognition, and also considers the importance of the body, or behavior, which includes fulcrums 2 and 3. As the experience of sexual abuse is often long held within the body, affecting both thoughts and feelings, a release of trauma on both levels makes a good match for childhood sexual abuse survivors.

As mentioned as a tool for working with F-3, another useful technique of psychotherapy is working with the shadow, which comes from the psychodynamic approach of psychology. The *shadow*, as first named by psychologist Carl Jung, manifests as parts of our unconscious that we are not truthful about, and hide from consciousness. These parts show up as symptoms, neurosis, and pain because they are being suppressed, and are looking for a way out. By facing suffering and the shadow as friend, we both engage and release it, thereby finding the way in to the Self. In the Integral self system, there are three selves identified. The *proximate* self is the self we are aware of, the *distal* self is the object in my awareness that I embrace as me, but is not where I am presently (i.e., me as a child), not where I am now, and the *antecedent* self is the Witness, God, spirit, however one may understand it; and there is the shadow, or disowned parts of the complete self. Shadow material can be explored on a transverbal level through dream work, which places one in touch with the messages from the unconscious to resolve problems on the conscious level (or state).

Psychotherapy can help bring awareness to the interior state of being, the Witness state, and the formation of a healthy ego in the process of development from the prepersonal to personal stages, prerational to rational stages of development, that may have been arrested due to the experience of trauma. A strong ego has control over libidinal attachment, bringing awareness without attachment, through the development of a strong Witness. The Witness state is experienced as a disidentification with all objects, a pure witnessing with impartiality. A strong ego is also able to stay integrated at higher levels of activation, such as when recalling traumatic experiences during therapy, and in other stressful situations that may occur for them. Psychotherapy is used to develop this state, and through witnessing attachment to the libido, or other symptoms of the shadow that have manifested, and making it an object, it then has no control over one's life. The practice of observing oneself objectively allows a new sense of freedom to the mind that separates one from their thoughts and feelings, and liberates one from their usual ways of suffering. With practice, the potential exists to develop long-term personality traits from these experienced Witness states. Research by Baer and colleagues (2006) suggests that these traits include the capacity to suspend judgments, to act in awareness of our moment-to-moment experience, to achieve emotional equilibrium or equanimity, to describe our internal world with language, and to have a burgeoning sense of self-observation (Siegel, personal communication, August 31, 2007).

Although psychotherapy is aware of early stages of development, it is generally not undertaken to achieve the activation of wider states of consciousness. This is more the domain of spirituality, which utilizes techniques in the relative plane (personal to transpersonal) to transcend the ego, and is applicable to higher level Memes (such as orange and green). In contrast, most therapy just tries to help the ego and can bring one more deeply into the situation and looking at it from different perspectives, stopping short of transcending it; whereas meditation transcends the ego and brings a greater awareness of a situation. In studies at Harvard, MIT, and Yale (Lazar et al., 2005), it has been found in brain

scans that the cortex, which is associated with attention and sensory processing, is thicker in meditators than non-meditators, which shows a distinct link between the “I” and “It” quadrants. According to Sara Lazar, the Harvard psychologist who led these studies, “Our data suggest that meditation practice can promote cortical plasticity in adults in areas important for cognitive and emotional processing and well-being” (as cited in Solan, 2007, p. 14). Dan Siegel, co-director of the Mindful Awareness Research Center at UCLA and author of *Developing Mind: Toward a Neurobiology of Interpersonal Experience* (1999), says regarding studies on mindfulness training:

The finding revealed that even after only eight weeks of mindfulness training, the brain tended to shift its frontal activity to the left hemisphere, suggesting that a person is ready to move toward events in life—even those that are uncomfortable and unpleasant—rather than moving away from them. These research findings revealed neural correlates of psychological resilience developed with mindfulness training. Here we could see that how we focus our attention could actually change the firing in our brains, leading to changes in the connections among neurons that make up the actual structure of the brain. You’ve read that right: the mind (the flow of energy and information we direct by the focus of our attention) can change both the activity and then the structure of the brain.

When we put all of this together, we find that how we focus our attention—how we learn to be mindful—in our relationships with others (interpersonal well-being) and within ourselves (mindful awareness practice) can actually promote the growth of areas of the brain connected to the core of well-being. (Siegel, personal communication, 2007)

Regardless of the type of therapy that is undertaken, the common factors of acceptance, awareness, and non-attachment are more important to the effectiveness of therapy than the type. Perhaps the most intriguing aspect of the Lower-Left quadrant is what Ken Wilber calls “the magic of we” (Wilber, 2007)—the heart of the therapeutic alliance in psychotherapy—which lies in the “I” quadrant. This is summarized by clinicians and clients forging a shared experience of “we” in the therapeutic setting, and using the therapeutic relationship to address relational difficulties, especially those to do with trust, communication, boundaries, and identity. Support, especially in a nurturing environment such as therapy, increases resiliency to the effects of trauma. Support and feelings of safety can be fostered by mirroring youth and their emotions, which helps put words to their feelings. Just being seen and heard for the first time by a supportive adult such as a therapist can be transformative for them. Mirroring also increases their sense of self-awareness. People who suffer from trauma are likely to have alexythymia, which means that they are unable to express their feelings. When an adult offers words or images that can help build their feeling and sensation vocabulary, this helps to build new connections in the brain, along with a relationship to their inner world. This can be tremendously healing for them.

We Quadrant

The “We” quadrant reflects our culture and worldview, from the second-person intersubjective perspective, the interior of the collective. It can be understood as a combination of many “I” perspectives,

taken together, which includes the values and semiotics that create a culture. One of the most important things to acknowledge in the “We” quadrant with respects to sexual abuse is that victims have been oppressed, shamed, and silenced by perpetrators, and thus have been prevented from speaking out in public about their plight, for fear of retaliation on the personal and social levels. By keeping silent, this oppression has continued on for many years, almost unchecked, in all socioeconomic classes and races. To bring an end to this epidemic, child abuse must be addressed not only on an individual level, but on the familial and cultural levels, all levels of “We.” What happens to the child affects the family, often resulting in separation and divorce, which in turn affects the society, and the beliefs that are perpetuated in each culture. Parents need to establish a dialogue with their children as to what is acceptable and right in terms of behavior towards the opposite sex, to help them to understand and learn appropriate sexual values.

By re-establishing appropriate boundaries within interpersonal and sexual relationships, a sense of personal control and equalization of the balance of power in relationships can be attained. Other ways of empowering those who have suffered sexual abuse in improving their lives and relationships with others include increasing their communication skills in therapy, sharing their stories and learning to express themselves to develop confidence, putting an end to the silence that has defined the lives of many victims. This work can be done in individual and family therapy, and supplemented by attending a support group for victims of sexual abuse. Confronting one’s perpetrator can also be a very powerful way of releasing the anger and rage that has often been held for many years. By learning how to turn this anger and rage against the perpetrator and society around, new beliefs and attitudes about how women can develop, and instill a change from mistrust in others to trust. This requires sufficient ego strength however, but once achieved, being able to use their voice to defend themselves and control their own power, and break the cycle of abuse by speaking out, will only strengthen their new beliefs that they are worthy individuals. This new perspective of self can lead to increased cognitive development, which will enable further memetic development to occur as well, from surviving to thriving. This change will enable healthier relationships, family life, and eventually greater morals and values in society. It is important that abuse survivors play a role in the development of understanding of the effects of sexual abuse on their lives and the lives of their families, so that healing can be addressed on multiple levels. Social policy, prevention ahead of cure, advocacy, education, empowerment, collaboration, attention to diversity, action-orientation approaches are helpful to address this problem at the “We” level, and in the context that the abuse occurs.

From a Spiral Dynamics integral perspective, encouraging development from an egocentric or ethnocentric standpoint to a worldcentric perspective can help the victim of abuse learn to forgive themselves, others, and move on in their lives. The ability to take perspectives is a good way to measure and understand the development of cognition. As some children are quite young when they experience abuse, even as early as between the ages of three and five years old, they can become fixated at the level of egocentric development, being able to take on a first-person perspective or sense of “I”-ness, which resonates with the red ν Meme. This is shown by the inability to put oneself in another’s shoes; there is a sense of me versus everyone else. If they are a little bit older when the abuse occurs, at around age seven, they have likely developed to the ethnocentric stage or blue ν Meme, where they are able to take the perspective of other, the second-person perspective, and understand the concept of “we.” In adolescence, an evolution to the orange ν Meme usually occurs, where the child can take the third-person, worldcentric perspective. This allows the child to think objectively about interactions from an external, hypothetical perspective. One needs at least this level of development to move

forward and understand how systems work at a rational, modern level. It is still a first-tier level of consciousness, focused on the self and self-consciousness, unlike the second tier level of development in which one becomes aware of oneself, and can then participate fully in their own evolution by seeing integral patterns within the different systems in life.

Some effective ways to treat trauma on a cultural level are to make educational information available to the media about the effects of trauma, PTSD, and ways to comfort children who have experienced the effects of sexual abuse, as well as places that individuals and families dealing with abuse can get help. This kind of learning is valuable as it has the possibility to reach a large number of people at a relatively low cost, provided the information is presented in a way that would be understood by the greatest number of people, from an intellectual and value-based standpoint. As the majority of the population is at a first-tier level of development, with 70% thought to be in the blue and orange ^vMemes, the approach needs to be tailored to these levels of understanding so that it can reach the greatest number of people. Having this information available in multiple languages would also increase the number of people it will reach. Distributing this information to children in schools, churches, community centers, and other organizations that cater to family life would also be helpful in spreading the message. The idea is to normalize the situation as a common problem that people can get help for, whether they are the victim of abuse or the perpetrator. Removing the stigma from both roles in the relationship is important for people to feel they can act to get help without repercussions. This requires a very sensitive approach to how the message is delivered, but is important to prevent backlash against both victims and perpetrators. Conflict can be restricted by respecting and expecting that change can happen, and allowing those involved to take responsibility for their actions and get help.

Keeping in touch with family and friends, and connecting with people provides social support and strengthens resilience to the effects of trauma. Some people find comfort in connecting with a higher power, whether through organized religion or a spiritual practice, whether individually or in the community, which is a healthy amber altitude solution. Assisting others in a time of need, such as doing volunteer work with a community organization serving abuse survivors, can be empowering as well as working for social change through rape law reform and involvement in marches such as “Reclaim the Night,” although this overlaps with the “Its” quadrant, which will be addressed next.

Its Quadrant

For the “Its” quadrant, which is our social systems and environment from a third-person interobjective perspective, the exterior of the collective, we need to look at how we can transform the experience of sexual abuse trauma through society. This involves healing the polarization of beliefs against victims, and against perpetrators of abuse, and leading to tolerance of our differences in beliefs in this healing process, all “We” quadrant issues, but manifested in our social systems and institutions. To do this, we need to focus our treatment in a way that erases the “us versus them” mentality of those who have been traumatized, and ways in which blaming the victim has caused endless cycles of re-victimization in the process.

One way that this has been addressed is through legal reforms. Legal reforms inspired by the feminist movement have helped those affected by sexual violence to seek justice in court, and some support services have encouraged more victims to speak out and confront their abusers. Things are not always that simple, however; in trying to protect those that are vulnerable to

sexual abuse, women have often been ostracized and ridiculed in identifying their perpetrators. Carol Gilligan, psychologist, researcher, and author of *In a Different Voice: Psychological Theory and Women's Development* (1982), believes that a double standard exists for women in society, in preventing harm to both herself and others by speaking out about sexual abuse:

While society may affirm publicly the woman's right to choose for herself, the exercise of such choice brings her privately into conflict with the conventions of femininity, particularly the moral equation of goodness and self-sacrifice. Although the independent assertion in judgment and action is considered to be the hallmark of adulthood, it is rather in their care and concern for others that women have both judged themselves and been judged. (Duncan, 2004, p. 152)

Only recently, after a lengthy "false memory" debate, have adult survivors who recall their abuse after a period of amnesia been granted the opportunity to testify in court, which has helped to expand the reach of the law to a greater degree. The Jacob Wetterling Act, which the U.S. Congress passed in 1994, requires all states to establish registries of sexual offenders who victimized children. Congress then amended the Jacob Wetterling Act and passed Megan's Law in 1996, allowing state and local law enforcement agencies to make available to the public information such as names, offense committed, and the location of convicted sex offenders, including publishing their pictures on the Internet (Duncan, 2004, pp. 146-147). These laws are important steps in increasing the exposure of known sexual predators, but lobbying for stricter laws, longer reporting periods, and enforcement of these laws to prevent sexual abuse is imperative if we are to see change in this area. Informing judges, lawyers, and social workers in the family system of the possibilities for trauma treatment when they deliver their rulings would be another good intervention to consider as well (Ross, 2003, p.183).

Another way to approach social systems change is by bringing the stories of abuse to the collective, to share and awaken people to the understanding of the trauma that is perpetuated for both victim and abuser in an endless cycle if it remains unchecked. Restorative justice can take different forms, but what is common between them is that the victims can share the impact of the abuse upon their lives, and hold the perpetrator accountable for their actions. The perpetrator is then given the opportunity to tell the story of why they committed the abuse and how it has affected their lives, and usually provides a restitution to the victim for their wrongdoing. Judith Herman (1997) says"

Recovery requires remembrance and mourning. It has become clear that in newly democratized countries in Latin America, Eastern Europe, and Africa, that restoring a sense of social community requires a public forum where victims can speak their truth and their suffering can be formally acknowledged. In addition, establishing any lasting peace required an organized effort to hold individual perpetrators accountable for their crimes. At the very least, those responsible for the worst atrocities must be brought before the law. (p. 242)

The sharing of stories and education also occurs on a daily basis through our entertainment media. According to Gina Ross (2003), some ways that the entertainment media can encourage healing and prevent the occurrence of trauma in our societal systems include: showing the consequences of violent acts to the perpetrators, avoid showing violence that leaves the viewer in an aroused state or

violence that is uninterrupted and not subjected to critical commentary, tell stories with a healing message, show how people have successfully recovered from tragedies, and promote stories that encourage connections between people and their communities (pp. 143-145).

By educating children and the community about sexual abuse, reporting, and hotline numbers to call through the media, schools, and community programs, there is a greater likelihood that children will reach out for help and perpetrators will be caught. Organizations such as NAPSAC (National Association to Prevent Sexual Abuse of Children) have helped by creating national advisory councils, producing television programs (e.g., “Broken Trusts, Broken Childhoods”), and working to create large-scale public service announcement campaigns, education within schools, and the training of front-line child protection professionals (e.g., educators, early education providers, clergy, health care, legal, and judicial professionals) about child abuse. Other important areas to address are testing children for psychological trauma at a young age so that they will not be misdiagnosed as having learning disabilities, providing school courses on developing resiliency to trauma and emotional intelligence training, and training school counselors and psychologists in detecting the psychological effects of trauma and how to treat it (Ross, 2003, p. 183). Safeguards against false accusations also must be considered.

This will help establish safe communities for ourselves and our children, and hopefully will bring the necessary social services and mandated therapy to the families who have suffered abuse, as well as the perpetrators and their families. The more we are of the mindset that individuals alone are responsible for their health, the less social systems and funding are in place for this kind of support. Mandatory trauma treatment for perpetrators after serving their mandated prison sentence, making them responsible for restitution if possible, and giving them the chance to engage in work that can give them skills they can use once paroled are other useful suggestions for bringing about change (Ross, 2003, p.183).

The APA public education campaign network has allowed for continuity in school personnel working with children on the after-effects of trauma. Working together with teachers and groups helps to extend psychological help to students and their families. APA’s continuing education and state associations, agencies and psychology departments need to put together offerings on anxiety management, and increase the training for clinicians and doctoral students, as well as provide special ongoing training in abuse trauma for all psychologists, medical doctors, and nurses. There is a lot of opportunity for growth in each of these areas, including increased governmental research funding in techniques to heal trauma, and insurance companies extending benefits for trauma treatment to those who need it.

It Quadrant

Finally, the “It” perspective, the exterior of the individual from a third-person objective perspective, is addressed. This quadrant looks at the physical organism, including the brain, and the behavior of the organism that can be observed. Clients suffering from trauma often present with symptoms of heightened arousal and chronic anxiety, which is a biological process that occurs in the body. Trauma is first experienced in and through the body. To be able to feel comfort in the body again, a treatment that will work with releasing the trauma that is frozen in the body needs to be employed. Bessel van der Kolk (as cited in Wills, 2007) says, “The memory of the trauma is imprinted on the human organism. I do not think you can overcome it unless you learn to have a friendly relationship with

your body” (p. 41). A study he conducted that was published in the *Annals of the New York Academy of Sciences* found that a group of female patients who completed eight Hatha yoga classes showed significantly more improvement in symptoms, including the frequency of intrusive thoughts and the severity of jangled nerves, than a similar group that had eight sessions of group therapy. The study also reported that yoga can improve heart rate variability, a key indicator of a person’s ability to calm themselves.

There are multiple benefits of practicing yoga; from being grounded and present, to gaining awareness of one’s body and strength, and feeling calm and in control of one’s thoughts. Richard Miller, a California-based clinical psychologist, yoga teacher, and cofounder of the International Association of Yoga Therapy, is currently using the practice of *Yoga Nidra*, which he calls *Integrative Restoration*, or *iRest*, in two studies with active-duty soldiers with PTSD from their experiences in the Afghanistan and Iraq war zones, at the Walter Reed Army Medical Center in Washington, D.C. The Sanskrit word *nidra* means sleep; Yoga Nidra is also known as *yogic sleep*, where one learns to use breath and attention to progressively relax each part of the body. It is an ancient transformative meditative practice that leads to psychological, physical, and spiritual healing through integrating the various splits that are present in the body, mind, and senses and restoring a sense of oneness with all.

iRest works through the embodiment of pure awareness, and the release of negative body sensations, emotions, and beliefs and stress that give rise to self-destructive patterns. It is a non-religious practice consisting of a series of 30- to 40-minute sessions where participants are guided through a sequence that includes body sense training, breath and energy awareness, and systematic desensitization and disidentification to neutralize negative body sensations and stress, negative feelings and emotions, and negative beliefs, images, and memories. It also includes the experience of joy and well-being, freedom from the sense of separation generated by the senses, mind, and ego, and the ability to experience equanimity with the realization that everything in life is constantly changing.

Results have shown that soldiers are able to sleep better, with less insomnia, and feel less anxiety, depression, and fear. Participants of the recently conducted Walter Reed Feasibility Study also reported improved interpersonal relations and an increased sense of control of their lives, being paradoxically more comfortable with situations they could not control. The feasibility study concluded that iRest is a feasible and acceptable treatment approach and may be beneficial to soldiers who are experiencing significant PTSD symptoms (Center of Timeless Being, n.d.).

How this is related to the biology of the person suffering from sexual abuse trauma is that Yoga Nidra induces a lateral phase shift in the brain. According to Miller (2006), “It produces actual physical changes in the frontal lobes, amygdala, and hippocampus, among other structures in the body.” His work with Yoga Nidra is relevant to those suffering PTSD from sexual abuse, and points to how sexual abuse victims can also use Yoga Nidra techniques to bring relief from their symptoms. Interventions to address sensory complaints, such as tension, pressure, aches, chronic pain, and fatigue are solutions that are useful as therapeutic adjuncts in the “It” quadrant. Yoga asana (postures) can be either active or passive. Active postures are used to increase blood flow and reduce tension in stressed areas and to improve overall immunity, whereas passive postures are more calming and balancing. As yoga induces the relaxation response, it releases muscular and nervous tension, massages the musculoskeletal system, improves body awareness, lowers blood pressure, reduces heart rate, helps the digestive system and assimilation of nutrients, improves respiratory function, and stimulates the

immune system and flow of lymphatic fluid. Relaxation techniques, including progressive muscle relaxation, belly-breathing, grounding in the body, and sensory-based experiencing techniques such as somatic-experiencing and bodywork or massage, can all be used to address trauma as the client is ready. Additionally, each of these techniques can shift the mental state and state of consciousness through taking action with the body.

As yoga is a mind-body discipline, the practice of yoga affects the development of the “I” quadrant as well, affecting the emotional, subtle, and causal bodies, and acting as a cross-quadrant discipline. Amy Weintraub is the author of *Yoga for Depression*, the founder and director of the LifeForce Yoga Healing Institute, and a senior Kripalu Yoga teacher who has studied extensively with Miller. Weintraub offers trainings to psychotherapists in ways that they can integrate yoga into their work with clients. She says that “the first step toward transformation is to accept where you are now, without judgement” (Weintraub, 2003, p. 211). Accepting those things about oneself that one wishes to change helps the student practice compassion toward themselves. Often during a practice, tears will flow, without the student even knowing why. This is often a release, a layer of tension peeling away. Weintraub (2003) says that this practice will:

...bring the emotional body back into balance. As we learn to witness the rise and fall of the emotions, particularly when we are holding postures for an extended period of time, we are developing a kind of desensitization, so that we can see the events in our lives without the original feelings of confusion and terror attached. (p. 212)

In yoga, this is sometimes called the *Witness consciousness*, and is a higher sense of awareness which allows for a deeper sense of insight into the past. With the safe container of good therapy, the emotions associated with bodily tensions will release, and it will become possible to talk about and release them, and eventually, learn not only to accept but to love oneself, and eventually, others. The Kripalu approach to self-discovery uses techniques aimed at developing one’s Witness consciousness during long holdings of postures, which allow repressed feelings and thoughts to become conscious. Developing this sense of self-awareness and being present allows the mind the freedom from feeling overwhelmed by and attached to these feelings. Pushing past these feelings and keeping the Witness allows for moments of insight, a connection with the body that provides wisdom beyond that available through the mind alone. These insights can provide a greater understanding and belief in the self, a sense of release of emotional and energetic tension in the mind and body, and develop resiliency, strength, and confidence by meeting one’s own needs instead of giving these away to someone else.

Other options to try that involve both the “I” and “It” quadrants (i.e., the interior and exterior of the individual) include combining alternative medicine or pharmaceutical interventions with psychotherapeutic work. However, drug therapy does nothing to treat the source of anxiety and traumatic stress, which is why drugs must not be used alone, but as an adjunct to psychotherapy. Treatment may also be necessary for alcohol and/or drug addiction that may be used as a method of coping with the symptoms of anxiety and depression. This may include a dependence on prescriptive psychotropic medications, both of which may keep the client in a state unable to engage in the necessary work in therapy. This must be approached with care, focusing on the roots of anxiety through therapies such as cognitive behavioral therapy, and avoiding delving too deeply into insight-oriented therapy until the client is stabilized and at least at amber altitude. With more research into this field, we will likely

find more precise drug and therapeutic solutions to relieve sexual abuse trauma. This will hopefully help to expand the definition of PTSD in the *DSM-IV-TR*, as well as its causes and symptoms, and lead to more specific pharmacological options for the different symptoms over time.

Conclusion

Integrating the four quadrants into a treatment plan for our clients is possible, and for the treatment of trauma, can start with the I, and We and It quadrants, and move on to the Its as the client is ready. The more quadrants that are embraced simultaneously, the more rapid will be the transformation, as development in each of the quadrants assists development in the others. There are many time-tested options and choices for each individual to choose from to make a complete practice, at whatever level of development or perspective they are at. The key is to have each quadrant work in tandem with the others, not independently. This is something that has been lacking in the current treatment models that focus on the recovery of the perpetrator or the victim.

I look forward to continuing research in this field, as I believe that many benefits from each of the quadrants can be realized through the judicious application of Integral Theory as a treatment model in the recovery of sexual abuse trauma. My hope is that this article will bring awareness to new ways of resolving this epidemic, thereby increasing the level of development of many affected by sexual abuse trauma, and hopefully bringing us one step closer to a world without childhood sexual abuse.

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