

THE IMPACT OF SEXUAL VIOLENCE ON FEMALE STUDENT ATHLETES  
PERPETRATED BY MALE STUDENT ATHLETES AND APPICABLE THERAPEUTIC  
MODALITIES

by

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**TABLE OF CONTENTS**

	<b>Page</b>
Table of Contents.....	2
Abstract.....	4
Dedication.....	5
Chapter one: Introduction and Research Problem.....	6
Adolescent Vulnerabilities.....	8
Gender Disparatieis.....	10
Intercollegiate Sexual Violence.....	11
Rape Myth Acceptance .....	13
Impact of Sexual Violence on Females.....	15
Language and Violence.....	16
Sports Culture.....	20
Conclusion.....	22
Chapter two: Treatment Methods and Literature Review.....	24
Trauma-Focused CBT (TF-CBT) .....	27
Phase one: Coping skills in TF-CBT.....	29
Phase two: Trauma and narration reprocessing.....	32
Phase three: Closure .....	33
Trauma-Sensitive Yoga (TSY).....	34
Trauma-sensitive yoga versus regular yoga.....	35
Interoception.....	37
TSY and attachment theory.....	38
Role of the facilitator.....	39

Yoga forms utilized in sessions.....	41
TSY discussion.....	43
Chapter three: Therapeutic Effectiveness and Discussion.....	44
Trauma-Focused Cognitive Behavioural Therapy Effectiveness.....	44
Trauma-Sensitive Yoga Effectiveness.....	47
Discussion.....	53
References.....	58

### Abstract

Sexual violence against female intercollegiate athletes is a prevalent crisis evident in today's society (McCray, 2015). This capstone will focus on male intercollegiate athletes as the perpetrators of sexual violence against this population. Breiding (2014) illustrated in a United States focused study approximately 19.3% of the female population have been sexually abused during their lifetime. Although this finding is limited to the United States, it is still quite staggering. This statistic is only inclusive of females who have decided to report their sexual assaults (Breiding, 2014). Approximately 80% of the sexual assaults that occur within North American go unreported (Breiding, 2014; MacGregor, 2018). In an attempt to compliment the current research base, this capstone will concentrate on two therapeutic modalities that will support female intercollegiate athletes' recoveries. These types of therapies are Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Trauma-Sensitive Yoga (TSY) (Cohen, et al., 2012; Emerson, 2015). Subsequently, this capstone will also discuss the impact this form of trauma can impose on these individuals, alongside research to validate the therapies' effectiveness. The majority of the research conducted in this realm is quite recent and limited as result; due to this more studies, such as this capstone, are required to express the gravity of its impact on female intercollegiate athletes and different modalities that will support in their treatment (McCray, 2015).

**Dedication**

*It's not where you are in life, it's who you have by your side that matters*

*-Unknown*

To my friends, family, and husband:

Thank you for supporting me through thick & thin; always encouraging me to persist, succeed, and allowing me to be happy no matter the cost.

## **Chapter One: Introduction and Research Problem**

Sexual violence against female intercollegiate athletes is a prevalent crisis, and a reflection of present-day societal beliefs (McCray, 2015). This capstone will focus on male intercollegiate athletes as the perpetrators of sexual violence against this population. The majority of the research conducted is fairly recent and quite limited, and as a result more studies are required to express the gravity of its impact on female intercollegiate athletes (McCray, 2015). This research is especially relevant in today's society as it has begun to establish the impact and widespread prevalence of sexual harassment (McCray, 2015; Sawyer, Thompson, & Chicorelli, 2002; Forbes, Adams-Curtis, Pakalka, & White, 2006; McDermott, Kilmartin, McKelvey, & Kridel, 2015).

A United States based research study recognized that approximately 19.3% of women have been sexually abused during their lifetime (Breiding, 2014). This finding solely focuses on rape and only takes into consideration individuals that have chosen to report (Breiding, 2014). McDermott et al. (2015) also expressed that based on college sexual assault research published between 1950 and 2015, one third of college males involved in this research would be willing to force sexual violence on a female if they could be guaranteed they would not be caught (McDermott, et al., 2015). These statistics are significant and demonstrate that females as a population are vulnerable and susceptible to becoming subject to this form of violence (McDermott, et al., 2015). Unfortunately, approximately 80% or more of the sexual assaults that occur in Canada and the USA go unreported for various reasons that will be discussed throughout this capstone (Breiding, 2014; MacGregor, 2018). Researchers express that the lack of reporting by victims creates difficulty in better understanding this population, their experiences, and how to best support them during these critical times of need (MacGregor,

2018). This underreporting also creates obstacles in understanding what population the perpetrator may be part of; diminishing law enforcement's ability to profile this population (MacGregor, 2018).

These results emphasize the need for relevant research to support society's understanding of the impact these acts of sexual violence have on the victims and some therapeutic modalities that will facilitate their recovery. As mentioned, this capstone will focus primarily on the impact of sexual violence on intercollegiate female athletes perpetrated by male intercollegiate athletes. In order to successfully gauge a holistic viewpoint of the effect it has on this population, it is important to gain an understanding of the ramifications these dangerous and possibly life-threatening acts of sexual violence can have on the female gender as a whole.

Traumatic experiences, such as sexual violence, can often create unconscious physical symptoms (Levine, 2010). When humans are subject to triggers in their environment that relate back to their traumatic experience, it can generate the individual's nervous system to become dysregulated (Levine, 2010). Some of these unconscious physical symptoms may be sweating, racing heart, shaking, immobilization, fight, flight, freeze, tensing muscles, amongst many others (Levine, 2010). The intention of the therapeutic modalities discussed in this capstone are to support the client in better understanding these experiences when triggered and facilitate the creation of a mind-body connection. This will aid clients struggling through trauma, specifically sexual violence, and assist them in becoming aware of when they are triggered and attempt to process the emotions that accompany them as opposed to disconnecting and avoiding them (Levine, 2010).

### **Adolescent Vulnerabilities**

When most individuals graduate high school and continue on to attend post-secondary school, they are typically classified as adolescents (Ellsberg, Vyas, Madrid, Quintanilla, Zelaya, & Stockl, 2017). Adolescence, between the ages of 10 and 19, marks a critical point in a person's development from childhood to adulthood (Ellsberg, et al., 2017). During this time, there are countless significant social, economic, and biological experiences as well as demographic differences that present themselves and begin to establish a base for their future selves and endeavors (Ellsberg, et al., 2017). Due to the significance of this developmental stage, if these individuals experience a traumatic or violent event during this time, the impact can be detrimental to their development into a healthy and productive member of society; some of which include impulse control and future planning, discussed in more detail below (Ellsberg, et al., 2017).

One explanation as to why this stage of development is so imperative is due to significant neural maturation occurring during this time (Ellsberg, et al., 2017). Concurrent to these major developmental shifts, hormonal changes are also occurring in the limbic system that can have an impact on an adolescent's pleasure seeking, reward processing, emotional responding, and sleep regulation facets of their brain (Ellsberg, et al., 2017). They also experience difficulties in managing their inhibitions, planned problem solving, understanding and implementing flexible rule use, impulse control, and future orientation (Albert, Chein, & Steinberg, 2014). This can encourage the client to act or react in unexpected ways when compared to younger or older victims who experience similar trauma. For example, adults may have a greater ability to critically evaluate their behaviours prior to acting, whereas adolescents may struggle due to their

neurodevelopmental transition; potentially creating a more vulnerable population for sexual violence to occur within (Ellsberg, et al., 2017).

Simultaneously, there are substantial differences in the prefrontal cortex of the adolescent brain when compared to adults, such as decreased activity in this region which, as mentioned, can impact impulse control (Ellsberg, et al., 2017; Jaeger, 2013). This area is also responsible for executive decision making, organization, and future planning (Ellsberg, et al., 2017). These differences in the prefrontal cortex occur later in adolescence, which would coincide with an adolescent's transition from high school into college or university (Ellsberg, et al., 2017).

Other areas of change that are important to note during this stage of life are the understanding of gender roles, responsibilities, how relationships are viewed and engaged in, and the expectations that accompany being involved in a romantic relationship with a partner (Ellsberg, et al., 2017). Due to these changes in impulse control, future planning, executive decision making, as well as shifts in the formation of emotions, memory, and arousal, adolescence is a time of heightened risk for becoming a victim of sexual violence (Ellsberg, et al., 2017). It is also a time of elevated risk for becoming a perpetrator as these individuals may be subject to act on impulses and less likely to critically think about the consequences of their actions (Ellsberg, et al., 2017). Although this population may be at a higher risk due to the changes indicated above, many individuals in this population do not become perpetrators of sexual violence, and many do not become victims (Ellsberg, et al., 2017). The environment individuals are exposed to plays an essential role in determining who may or may not become a perpetrator, but this capstone will solely focus on male intercollegiate athletes as perpetrators and female intercollegiate athletes as victims (Ellsberg, et al., 2017).

## **Gender Disparities**

Although gender disparities have existed for centuries, these disparities increase significantly during adolescent development (Ellsberg, et al., 2017). On a global scale, males are provided more freedom, opportunities, and power, while females tend to experience a revocation of power, freedom, and opportunity (Ellsberg, et al., 2017; Sawyer, Thompson, & Chicorelli, 2002). There are also societal pressures consistently swaying individuals to fit themselves into a predetermined set of expectations, whether acting in such a way is natural or forced (Ellsberg, et al., 2017; Sawyer, Thompson, & Chicorelli, 2002). Males are commonly expected to be masculine, powerful, aggressive, and dominant, while females are encouraged to be chaste and submissive to their male counterparts (Ellsberg, et al., 2017; Sawyer, Thompson, & Chicorelli, 2002). The harm in falling prey to these societal norms and expectations is that it can lead to females becoming victims of male sexual violence (Ellsberg, et al., 2017; Sawyer, Thompson, & Chicorelli, 2002). This sexual violence may result in an array of negative side effects for the female victims such as Posttraumatic Stress Disorder (PTSD), unwanted teen pregnancy, difficulties in relationships, lowered academic performance, and potentially suicide or death (Ellsberg, et al., 2017; Sawyer, Thompson, & Chicorelli, 2002; García-Moreno, et al., 2013; McCray, 2015; McMahon, 2010).

Females experience a higher rate of sexual violence than males do, with adolescent females experiencing the highest rate of interpersonal sexual violence (Ellsberg, et al., 2017). It is important to note that many men have become victims of sexual violence and suffer as a result of this traumatic experience, but this research focuses on the far more common female victimization (Ellsberg, et al., 2017; Dartnall, & Jewkes, 2013; World Health Organization, 2012; Coker, Cook-Craig, Williams, Fisher, Clear, Garcia, & Hegge, 2011). One study noted that

sexual minority students, such as the LGBTQ+ population, also experience sexual violence, and gender differences within this population seemed to be insignificant regarding whether or not they experience sexual violence, indicating both genders experience similar types of interpersonal trauma within the LGBTQ+ community (Edwards, Sylaska, Barry, Moynihan, Banyard, Cohn, Walsh, & Ward, 2014). When females, specifically adolescents, are victimized, their perpetrators are more likely to be an individual they have some form relationship with, such as a family member, friend, or trusted member of their community (Ellsberg, et al., 2017). Approximately 45%-77% of perpetrators are a romantic or intimate partner (Ellsberg, et al., 2017; Dartnall, & Jewkes, 2013).

On a separate note, males are more likely to experience physical punishment at the hands of their caretakers, teachers, and peers and this can shape their expectations of others and the world around them, potentially convoluting their morals and sense of self (Ellsberg, et al., 2017). This could be explained by the idea that males have a higher tendency than females to engage in aggressive behaviours that are more likely to elicit this type of corporal punishment (Fréchette, Romano, 2015). It could also be partially due to sex-specific beliefs and expectations that society and parents may hold about this gender and their ability to handle this type of punishment (Fréchette, Romano, 2015).

### **Intercollegiate Sexual Violence**

Individuals in university are experiencing the latter end of their adolescence and are still undergoing many of the changes previously mentioned (Ellsberg, et al., 2017). The dark and grim fact is that college can be an unsafe place for females (Coker, et al., 2011). There are many occurrences on college campuses of individuals, especially females, experiencing sexual violence (Coker, et al., 2011). These assaults are often repeated and yet these victims are often

expected to attend college after their trauma at a cost to their physical and mental wellbeing (Coker, et al., 2011). The female intercollegiate population is considered to be an at-risk population for sexual violence, perpetrated by their male counterparts, many of whom will not be strangers (Ellsberg, et al., 2017). Although male college athletes account for less than 2% of the overall male population on campus, they represent 23% of the men accused of sexual assault, with more detail surrounding the potential cause of this outlined below (Sawyer, Thompson, & Chicorelli, 2002; MacGregor, 2018).

Being a male intercollegiate athlete comes with a very high expectation to perform in one's sport of choice, but also to become part of a team (McCray, 2015). Intercollegiate male athletes may be more easily influenced by their peer groups in an attempt to fit in and become part of the highly valued and esteemed group of student athletes (Flood, & Pease, 2009). When a group of these individuals come together and engage in male bonding activities, there is a high chance there will be alcohol or other substances involved (McCray, 2015; McMahan, 2010). Adding alcohol and other substances into an incredibly vulnerable group of individuals who are highly influenced by others could create a threatening and dangerous environment (McCray, 2015; Flood, & Pease, 2009; McMahan, 2010). Statistics indicate that this adolescent population typically commits crime in peer groups as compared to adults who often act alone (Albert, Chein, & Steinberg, 2014). Due to the intense social pressures these individuals are experiencing from their peers, they are more motivated to fit in than if they were not members of this elite group (McCray, 2015).

Some neural changes occurring in adolescence include an increase in gonadal hormones such as oxytocin within certain areas of the brain including subcortical regions and the limbic system (Albert, Chein, & Steinberg, 2014). An increase in oxytocin to these regions can impact

numerous areas such as the innate desire to engage in social bonding and become accepted (Albert, Chein, & Steinberg, 2014). When adolescents are in the presence of peers, they experience a reward-sensitive motivation that will increase the likelihood of them favouring short-term benefits of a potentially dangerous action, such as sexual violence, as opposed to valuing the longer-term reward that may be safer (Albert, Chein, & Steinberg, 2014).

As mentioned previously, while some men are experiencing opportunities for power, women are more likely to be subject to the idea of disempowerment, subsequently learning how to act in a submissive manner (Ellsberg, et al., 2017; Sawyer, Thompson, & Chicorelli, 2002). This, in turn can leave them more susceptible to becoming victimized by individuals they know (Ellsberg, et al., 2017; Sawyer, Thompson, & Chicorelli, 2002). Young women are expected to be pure, and if they are not they may be viewed by some individuals in society as sexual objects (Ellsberg, et al., 2017; Sawyer, Thompson, & Chicorelli, 2002). Although these gender norms might not be considered valid reasons for perpetration or victimization, they assist in creating an environment where those most vulnerable to becoming a victim and those most likely to perpetrate to thrive (Ellsberg, et al., 2017; Sawyer, Thompson, & Chicorelli, 2002).

### **Rape Myth Acceptance**

Rape myth acceptance plays a critical role in the likelihood of an act of sexual violence occurring (Sawyer, Thompson, & Chicorelli, 2002; McMahon, 2010). Rape myth acceptance refers to the idea that the aggressor is not at fault for his or her actions and the victim is to blame for their assault, which we understand is not the case (Sawyer, Thompson, & Chicorelli, 2002; McMahon, 2010). An individual who subscribes to the rape myth typically has an increased acceptance of dating violence and attitudes that reflect this belief such as sex role stereotyping and exploitative sexual relationships (Sawyer, Thompson, & Chicorelli, 2002; McMahon, 2010).

A perpetrator's inclination to commit sexual violence is closely associated with their level of rape myth acceptance (Sawyer, Thompson, & Chicorelli, 2002; McMahon, 2010). College male athletes have a higher tendency to subscribe to these beliefs than female college athletes do (Sawyer, Thompson, & Chicorelli, 2002). When compared to other college students, intercollegiate male athletes more frequently report the belief that females distort the truths in regard to the events of sexual violence, stating that females often incorrectly describe these events and that they never actually occurred (Sawyer, Thompson, & Chicorelli, 2002; McMahon, 2010). Some male intercollegiate athletes go so far as to indicate that "she asked for it" in cases where sexual violence had occurred (Sawyer, Thompson, & Chicorelli, 2002; McMahon, 2010). In other cases, the perpetrator even claims that the event never occurred, or that the female victim is providing a false statement which has a serious impact on female victims; if they are to report an incident of sexual violence there is a chance that law enforcement may not believe them or may not take action (Coates, & Wade, 2007). This leads to limited closure for the victim as well as an extensive and likely traumatic legal proceeding.

Rape myth acceptance was found to be higher among younger male college athletes than older male athletes, which coincides with the critical point in development for both males and females, increasing the vulnerability of the female victims while also increasing the likelihood of potential perpetration (Sawyer, Thompson, & Chicorelli, 2002). These beliefs are also more common among athletes in group sports as compared to individually focused sports (Sawyer, Thompson, & Chicorelli, 2002). This team environment reinforces traditional values that could normalize the idea of rape myth while encouraging sexual violence (Sawyer, Thompson, & Chicorelli, 2002). One potential reason for the increased rape-myth acceptance in males is the notion that society has been socialized to expect males to act in an athletically aggressive and

competitive manner (Sawyer, Thompson, & Chicorelli, 2002). This could in turn facilitate and encourage these individuals to act in this way as opposed to suffering the consequences of going against the grain (Sawyer, Thompson, & Chicorelli, 2002).

### **Impact of Sexual Violence on Females**

Research indicates that the act of sexual violence doesn't discriminate; all races, genders, and ages are subject to becoming a victim, with adolescent females experiencing the highest amount of risk (Dartnall, & Jewkes, 2013; World Health Organization, 2012). The impact of these assaults on some victims can be extreme, even life-threatening and potentially fatal (McCray, 2012). A very possible outcome of sexual violence is pregnancy, and for victims that are still in their adolescent years, this could have a tremendously significant impact on their development, social and interpersonal relationships, and their ability to complete their educational and athletic endeavours (García-Moreno, Pallitto, Devries, Stöckl, Watts, & Abrahams, 2013). Events such as sexual violence and teen pregnancy could have a critical impact on their physical and mental health as well (García-Moreno, et al., 2013; Ellsberg, M., et al., 2017). With pregnancy comes a plethora of other possible health risks such as stillbirth, miscarriage, intrauterine hemorrhage, nutritional deficiency, abdominal pain, and neurological disorders just to name a few, not to mention any physical or mental abuse the victim endured as a result of the traumatic assault (García-Moreno, et al., 2013). These physical maladies, alongside the mental impact the violence imposed on these individuals, could lead to other damaging mental illnesses such as post-partum depression or posttraumatic stress disorder (PTSD) (García-Moreno, et al., 2013; O'Hara, & McCabe, 2013). Other consequences of sexual violence include anxiety, depression, and phobias which can have a severe effect on the victims' day to day functioning and ability to be successful in their roles (World Health Organization, 2012).

Adolescents are already undergoing a critical transition from childhood to adulthood and are undertaking significantly more responsibility as they progress to post-secondary education. They typically have high expectations of what their future may hold and an incident such as this may set them back and deem them unfit to meet those expectations.

Sexual violence can also lead to suicidal ideation and attempts, which if successful, would be considered the most severe consequence (García-Moreno, et al., 2013). In some scenarios, the violence enacted upon the victims is so brutal that it can lead to homicide (McCray, 2015). There have been incidences portrayed in the media referring to male athletes that have committed such heinous acts during their frenzy of sexual violence that they have murdered their victim (McCray, 2015). One of these incidences occurred at the University of Virginia where the victim, a lacrosse player, was murdered by her ex-boyfriend, also a lacrosse player at the same university (McCray, 2015). These fatal sexual assaults are harsh reminders of the importance of research such as this to support victims through these crises and ensure the events do not escalate to this level (McCray, 2015).

### **Language and Violence**

Coates and Wade (2007) focus much of their research on violence and resistance, the conditions that enable personalized violence, actions taken by the perpetrators and language utilized when representing the actions that have occurred. Access to publication means and the media is typically unevenly distributed among the general public; with professionals, academics, celebrities, corporate leaders, government officials, and men, many of which incorporate intercollegiate male athletes, having more access than the remaining individuals in society (Coates, & Wade, 2007). These individuals have a greater ability to circulate their own particular views and opinions on a situation or experience and influence society when compared to

opposing points of views, such as that of the victim (Coates, & Wade, 2007). This is particularly impactful in situations where a female intercollegiate athlete is determined to express their traumatic experience to law enforcement/professors/other individuals in positions of power, especially when the perpetrator is a professional, a celebrity, male, and educated (Coates, & Wade, 2007). Society has a tendency to side with the individual in the position of power; in this instance the male intercollegiate athlete (Coates, & Wade, 2007). This leaves the female intercollegiate athlete vulnerable and subject to social ridicule, and it may deter other victims from sharing their experiences in order to avoid these incredibly traumatizing consequences (Coates, & Wade, 2007). The victims may be blamed, isolated, ostracized, and even bullied for expressing these bold realities that society may view as inaccurate accusations based solely on the perpetrator's level of power (Coates, & Wade, 2007).

The more strident the abuse of power is in the traumatic incident, such as in a situation of interpersonal sexual violence, the more adequately it is attempted to be justified or concealed by the perpetrator and their loyal followers (Coates, & Wade, 2007). These perpetrators who are in a position of power will frequently utilize language that intentionally manipulate the situation to entrap their victims, conceal violence that has occurred or is still occurring, and essentially avoid taking responsibility for their actions altogether (Coates, & Wade, 2007). These actions on the part of the perpetrator are intended to jeopardize the victim's safety and as a result, some sexual violence can occur for years, going unnoticed while the perpetrator maintains his status as an exemplary citizen (Coates, & Wade, 2007). This use of language is often how legal proceedings against violent perpetrators are built and can sway the outcome of a judge's ruling (Coates, & Wade, 2007). Once again, this can impact the outcome for female intercollegiate athletes that file legal actions against their perpetrators (Coates, & Wade, 2007).

Coates indicated that “[l]anguage is central to the law” (Coates, 1997, p. 281). It is a crucial aspect necessary in gathering information related to the incident at hand such as acquiring statements, asking questions, communicating arguments, and making judgements (Coates, 1997). The language utilized in legal proceedings are representations of the events that took place, but also encompass many versions of that situation (Coates, 1997). This is relevant in working with female intercollegiate athletes that have become victims of sexual violence as the language utilized when describing the event matter (Coates, 1997). If the event is described by the perpetrator in a position of power as “sexual intercourse” versus “rape” or “sexual assault”, each version will paint a very different picture in the community’s and law’s eyes (Coates, 1997). If these perpetrators are already in a position of power and have the support of their community around them, the inclusion of powers of discourse within the language negatively impacts the outcome for the female victim (Coates, 1997).

Coates and Wade (2007) discuss several different interactional and discursive views of violence and resistance that can impact the outcomes of these deliberate and violent acts (Coates, & Wade, 2007). The first aspect refers to the idea that violence is both social and unilateral (Coates, & Wade, 2007). In this statement, it is quite evident that violence occurs during an interaction between at least two individuals and is unilateral in that it involves one individual exercising their power and actions toward another individual, with no regard for their well-being and without choice on the part of the victim (Coates, & Wade, 2007). As mentioned earlier, violence is a deliberate act on the part of the perpetrator and they prepare for resistance from their victims (Coates, & Wade, 2007). The perpetrators take essential and vital steps in order to silence and repress the victims’ actions (Coates, & Wade, 2007). Coates and Wade (2007) also express that resistance is ubiquitous in that when an individual is subject to acts of violence, their

intuition is to resist (Coates, & Wade, 2007). Alternatively, acts of defiance could lead to additional violence or threat on a scale of mild to severe, deeming defiance the least likely method of resistance taken by victims (Coates, & Wade, 2007).

When it comes to social disclosure, misrepresentation is a pervasive demonstration of the imbalance of power and violence in society, and public displays can often be misleading and as a result, involuntary collusion with the perpetrator is a likely outcome (Coates, & Wade, 2007). Words and language can determine how concepts are understood and what power or meaning society assigns to the words (Coates, & Wade, 2007). Fitting words to deeds is another discursive view of violence that Coates and Wade refer to. The former refers to the idea that words are allocated to actions taken by the perpetrator and can determine how the perceptions are viewed and judged by society (Coates, & Wade, 2007). Lastly, Coates and Wade discuss that language is frequently used to conceal violence, minimize the victim's experiences, avoid taking responsibility on the part of the perpetrator, mask the victims' resistance to the act, and lastly blame and pathologize the victims (Coates, & Wade, 2007).

Some victims mention that language such as "abuse" can minimize their violent and terrifying experience as it lacks the explicit details and transparency that express what truly occurred and what the perpetrator is capable of (Coates, & Wade, 2007). Terms such as "learning from the past" insinuate that this experience is in the past and one must move on and grow from it, when this isn't the case for many victims; once again this type of language can minimize their experience (Coates, & Wade, 2007). There are also many words utilized in describing the perpetrator that tend to imply these behaviours were not a fault of their own; instead they were the result of "sexual urges" and "jealousy" (Coates, & Wade, 2007). Both examples exemplify the perpetrators' abilities to avoid taking responsibility for their actions in an attempts to remain

a model citizen while passing blame to their victim and minimizing the impact (Coates, & Wade, 2007).

### **Sports Culture**

As I have touched on above, the environments that male intercollegiate athletes are exposed play a critical role in determining why this population has a higher rate of sexual assault against female intercollegiate athletes than other populations (MacGregor, 2018). Research indicates that the disproportion of power between these two genders and populations is one explanation for their overrepresentation; but why (MacGregor, 2018)? In many organizations that exude power over others, such as male intercollegiate athletics, there is a culturally motivated version of masculinity that creates and perpetuates systemic subservience of females and other oppressed individuals (MacGregor, 2018). MacGregor (2018) expressed that violence is a consequence of collective privilege as opposed to an individual pathology that these male student athletes encompass (MacGregor, 2018). Violence is a result of inequality and there is an evident inequality between male and female intercollegiate athletes based solely on gender (MacGregor, 2018).

Athletes and fraternities are often compared to one another based on their values and belief systems (MacGregor, 2018). They share several qualities such as their gender uniformity, consistent group activities creating strong bonds and building relationships, valuing heteronormativity, patronizing those outside of their group, hypersexualizing women, peer pressure to conform to the norms of the group, vows of silence and secrecy, hazing rituals, and the eradication of an individual identity in order to conform to a group identity (MacGregor, 2018). Male intercollegiate athletes as well as males in fraternities have a tendency to believe that other men will endorse rape myths along with other hostile views toward women more so

than they would themselves (McDermott, et al., 2015). This thought can facilitate sexual violence as male intercollegiate athletes are craving the ability to be accepted as a team member, encouraging them to adhere to these the values and expectations of the collective while avoiding ridicule and isolation (McDermott, et al., 2015). Being part of such an elite organization and becoming a valued team member often requires that one complies to the rituals and values of the team, commonly endorsing the suppression of fear and weakness (MacGregor, 2018). When an individual doesn't comply with the team expectations, they may be subject to bullying and public shaming (MacGregor, 2018). This can become concerning when the team values do not align with an individuals' internal values, but this is a price many individuals pay to be part of elite organizations such as the world of athletics (MacGregor, 2018). These total institutions segregate male intercollegiate athletes and control the majority of their lives while they are part of the teams, and this isolation perpetuates the reinforcement of the collective values and rituals of the team (MacGregor, 2018).

MacGregor (2018) illustrated that elite athletes are more likely to express sexual entitlement and power over women; ultimately exhibiting more sexually aggressive behaviour towards this population (MacGregor, 2018). This is concerning for female intercollegiate athletes as they are forced to be in close proximity to these individuals by the nature of their post-secondary education and athletics. MacGregor (2018) reviewed research on Australian rugby players and found that aggression on the field was viewed as encompassing a strong sex drive and this, mixed with their physical aggression, creates a potentially violent combination (MacGregor, 2018). MacGregor (2018) expressed that Australian rugby players are regarded as celebrities in their country, and therefore the majority of their behaviour off the field is tolerated (MacGregor, 2018). Society has a strong appetite to continue watching these players bring

success to their sport of choice and their hometowns (MacGregor, 2018). If these successful athletes are removed from teams due to sexual violence, then it is a possibility that the team may not achieve their victory (MacGregor, 2018). Excuses are also made for these individuals who perpetrate sexual violence, which can make it incredibly difficult to incriminate them and may instill feelings of hopelessness in the victim; encouraging them not to report the incidences (MacGregor, 2018). Many male intercollegiate athletes at the elite level are attending school on scholarships, and their success can lead to media coverage, financial success, and ultimately winning teams (MacGregor, 2018). This said, coaches and school administration have an obligation to create and maintain successful athletic teams and without these elite athletes they risk financial instability and negative press (MacGregor, 2018).

Coaches and other individuals of power may also project a level of power and authority over their athletes, frequently ostracizing them if they do not adhere to the expectations of the collective (MacGregor, 2018). They have an obligation to keep students and athletes safe but often prioritize the success of the athletes above all else due to the reasons listed above (MacGregor, 2018). This said, administrators have a role to play in preventing these situations from occurring, but they often have skewed priorities, risking the safety of many female intercollegiate athletes (MacGregor, 2018).

## **Conclusion**

Researchers must continue to take a deeper dive into why perpetrators commit these acts of sexual violence. They must continue to uncover what makes a victim most vulnerable while exploring preventative measures for victims, providing resources to affected individuals if the acts have been committed. The intention of this capstone will be to uncover and examine research surrounding types of treatments that can support female intercollegiate athletes that

have become victims of sexual violence. The first modality to be discussed will be Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) (Cohen, et al., 2012). Following TF-CBT will be a form of Somatic therapy, Trauma-Sensitive Yoga (TSY), that incorporates mindfulness-based strategies that support in creating a mind-body connection that will assist clients in reducing their negative symptoms such as stress and anxiety (Dutton, Bermudez, D., Matás, Majid, & Myers, 2013; Cohen, Mannarino, Deblinger, 2012). The final chapter will review literature that supports the effectiveness of these therapies and discuss limitations that could have skewed the researchers' findings.

## Chapter Two: Treatment Methods

As mentioned in chapter one, I will be exploring two forms of treatment that can be utilized to support female intercollegiate athletes struggling to work through trauma resulting from sexual violence. Female intercollegiate athletes who have experienced trauma frequently underreport their experiences for various reasons: Avoiding confronting the overwhelming material, previous interpersonal attachment related concerns that may have led to a distrust in therapists or other supportive figures in their lives, the concerns of language and sexual violence discussed in chapter one, or the idea that the victims may view these traumatic experiences as normal in their daily lives and are numb to their absurdities (Cohen, Mannarino, Kliethermes, & Murray, 2012). Although some of the treatments may not be tailored specifically to female intercollegiate athletes struggling through sexual violence or trauma, they can be beneficial for this population based on other societal and interpersonal aspects of the treatment that may resonate with this unique group of individuals (Cohen, et al., 2012).

In working with individuals struggling from traumatic experiences, there are several things to note that are of critical importance and are applicable in many forms of trauma-informed treatment. One aspect is that the therapist must be disinterested in the sense that they will not impose their privilege or power on their client to gratify any personal needs (Herman, 1992). The therapist must also be neutral and ensure they do not take sides in the clients' inner conflicts and are required to be mindful that the client is in charge of their own life and the decisions they make (Herman, 1992). Safety is at the foundation of transformation and the therapist must be patient and compassionate with their client to build a level of safety where the client is comfortable sharing their experience and journey (Herman, 1992; Webber, Mascari, Dubi, & Gentry, 2006). Patience is also essential in building safety with individuals suffering from

traumatic experiences as their journey to recovery can take a long and undetermined amount of time (Herman, 1992). Clinicians are intended to support their client in increasing emotional and behavioural stabilization, creating a shift from a constant state of unpredictable danger to a sense of dependable safety (Herman, 1992).

Once safety and stabilization are created within the therapeutic alliance, trauma memory processing can occur where the client begins to metabolize and process their experiences (Herman, 1992; Webber, et al., 2006). In this phase, the client begins to reconstruct their story and transform their traumatic memory (Herman, 1992; Webber, et al., 2006). It is in this phase where they begin to mourn their traumatic loss (Herman, 1992). The clinician is merely present to support the client through their journey by creating a safe space for them and bearing witness to their story (Herman, 1992; Webber, et al., 2006).

Lastly, once phase one and two have successfully been attained, a reconnection to the present and future state of the client can begin to take place (Herman, 1992; Webber, et al., 2006). In this phase the client can begin to redefine who they are and who they want to be (Herman, 1992; Webber, et al., 2006). The trauma they have experienced in the past does not define who they are, and they do have the choice in determining who that person is (Herman, 1992; Webber, et al., 2006).

One of the treatments I will be discussing is Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) (Cohen, et al., 2012). This form of Cognitive Behavioural Therapy (CBT), as indicated by the title, takes a CBT focused approach and tailors its methods towards supporting the population of individuals who have experienced traumatic events (Cohen, et al., 2012). TF-CBT is considered an Evidence Based Treatment (EBT), which is an intervention that incorporates the most recent and up to date research available that integrates clinical

proficiencies when it comes to client characteristics, cultures, values, and preferences (Dozois, 2013).

Much of the trauma that individuals experience, including sexual trauma, lives within the body (Rothschild, 2017). Research shows that our body often contains information that is valuable and imperative to the therapeutic process (Rothschild, 2017). Through the incorporation of EBTs, therapists work collectively with the client to gain access to that information (Rothschild, 2017; Emerson, 2015). In order to reach the information that is locked away by these victims of trauma, clients can utilize their bodies to retrieve it through their emotions (Rothschild, 2017). To successfully treat the whole individual, some therapists recommend incorporating somatic therapy into their client's treatment plan (Rothschild, 2017). The form of somatic therapy that a portion of my literature review will focus on is Trauma-Sensitive Yoga (TSY) (Rothschild, 2017; Emerson, 2015).

As a result of unconsciously holding on to their trauma within their physical body, these individuals frequently struggle to determine what is a true and current threat and what is a memory of the traumatic event, as triggers in their environment often bring their physical body back to the traumatic experience (Rothschild, 2017). This can trigger a state of hyperarousal or hypoarousal during situations that may not be life threatening, and this can create severe difficulties in daily functioning (Rothschild, 2017). Although many of these side effects of hyper or hypoarousal may be mental, many of them take a somatic form, which is why treating the whole individual and utilizing methods such as TSY is important to successful treatment (Rothschild, 2017; Emerson, 2015).

**Trauma-Focused CBT (TF-CBT).**

Trauma-Focused CBT (TF-CBT) takes an integrative and collaborative approach in working with clients fraught with traumatic experiences (Cohen, et al., 2012; Deblinger, Pollio, & Dorsey, 2016). Female intercollegiate athletes, and females in a more general capacity, have a tendency to value social support and collaborative approaches which would encourage the use of collaborative treatment methods (Steidinger, 2014). This social support is evident in the sporting world where females tend to favour partnership, teamwork, and comradery in order to achieve a common goal (Steidinger, 2014).

Much research has also identified social support as an integral factor in promoting a positive recovery for individuals overcoming injuries (Yang, et al., 2010). The social support these athletes receive after experiencing an injury could be a protective factor in reducing stress and negative mental consequences while improving and encouraging motivation during rehabilitation (Yang, Peek-Asa, Lowe, Heiden, Foster, 2010). This is where TF-CBT comes into play for female intercollegiate athletes struggling with traumatic experiences. This form of intervention incorporates loved ones (parents, guardians, and/or caregivers) into the treatment as a resource throughout the process and promotes a more positive and sustainable outcome post-treatment (Cohen, et al., 2012; Kirsh, Keller, Tutus, Goldbeck, 2018).

This following description of TF-CBT will provide an overview for clinicians regarding how to implement TF-CBT when working with female intercollegiate athletes struggling through traumatic experiences, in this case sexual violence. The literature provides practical strategies that support clinicians in utilizing this type of treatment with their clients (Cohen, et al., 2012; Deblinger, Pollio, & Dorsey, 2016). Before beginning the treatment, it is important to note that Cohen et al. (2012) promote excessive and continuous assessments of the clients on the part of

the clinician during pre-treatment sessions and throughout the entirety of the process. It is through this investigation that clinicians seek to explore information regarding the adolescent's past and current experiences as well as any relevant secondary misfortunes that may have occurred due to the trauma that could impact the healing process (Cohen, et al., 2012). Some of these secondary traumas that female intercollegiate athletes could encompass include rejection by their family, intrusive or painful medical procedures, or legal history/proceedings that could be considered traumatic, to name a few (Cohen, et al., 2012).

Different forms of trauma can impact many realms of female intercollegiate athletes' lives in different ways from biology, self-image, cognition and perception, academic or athletic functioning as well as typical posttraumatic stress disorder (PTSD) symptoms among many others (Cohen, et al., 2012). Gathering information is a collaborative process between the therapist and the adolescent in conjunction with their caregivers and school resources, while also maintaining a trusting relationship with the client who could be mistrustful of this approach due to their traumatic history (Cohen, et al., 2012). During this assessment stage of treatment, many different standardized tools are utilized to support the clinician in gaining an in depth understanding of where the client is at, what support they require, and an assessment of their exposure to trauma, PTSD, and complex trauma outcomes (Cohen, et al., 2012). Two of these assessment tools include the Traumatic Events Screening Inventory for Children and the UCLA PTSD Reaction Index, and the Trauma Symptom Checklist for Children (Cohen, et al., 2012).

Trauma-Focused CBT is a three-pronged phase-based approach that incorporates 1. an initial stabilization stage that supports the client in acquiring coping skills, 2. a trauma processing phase that supports the client in understanding their personal traumatic experiences, and lastly 3. an integration phase that promotes mergence and generalization of safety and trust into their

daily lives (Cohen, et al., 2012). Typical therapeutic sessions would dedicate 1/3 of their time to each phase, but due to the difficulty clients suffering from trauma may have in establishing a strong and trusting relationship with their therapist, clinicians may spend approximately half of their time working on the coping and skills building phase (Cohen, et al., 2012). It may take up to 25 sessions with clients, sometimes close to 30 sessions, in order to observe true transformation (Cohen, et al., 2012).

As is the case in most forms of therapeutic treatment, developing and sustaining the therapeutic relationship is central in facilitating change in these female intercollegiate athletes suffering from sexual violence (Cohen, et al., 2012). Clients may view many relationships as potentially threatening and therefore require gradual exposure to positive relational influences in order to gain practice, and hopefully mastery, in creating and maintaining healthy relationships (Cohen, et al., 2012). Early on in sessions, the therapist will expose the client to the idea of these safe and predictable relationships (Cohen, et al., 2012). This can be difficult in some situations with caregivers where the parental figures may have also experienced their own forms of trauma in their lifetimes; this is where distress tolerance is critical for the therapist to maintain with both the adolescent and the caregiver (Cohen, et al., 2012). This distress tolerance can be defined as one's ability to self-regulate when they are triggered by negative experiences that may be reminders of their traumatic history (Cohen, et al., 2012). The practical strategies that clinicians can incorporate into their practices to best support the client are described below in the phase-based approach (Cohen, et al., 2012).

### **Phase 1: Coping skills in TF-CBT.**

In the initial stage, known as the Coping Skills Phase, therapists work with their clients to build a warm, trusting, and respectful relationship (Cohen, et al., 2012). This strong therapeutic

bond will be the framework on which the treatment can begin. By modeling a safe, predictable, fair, and consistent rapport with specific boundaries, the client will begin to learn and understand what a positive relationship with others can look and feel like (Cohen, et al., 2012). The therapist will work with the client to provide them with skills that will support them in self-regulating when they are feeling activated and anxious (Cohen, et al., 2012). During this phase, it is important for the facilitator to understand and validate that although the client's previous coping skills may have had negative consequences, such as excessive drinking or drug misuse, they have supported the client in surviving thus far, therefore they have served a purpose (Cohen, et al., 2012). It is possible that the client has been criticized in the past for utilizing many of these coping skills but, eliminating them from their daily lives can create a sense of fear in the client; this is another reason why building a trusting and reliable therapeutic relationship early on is critical (Cohen, et al., 2012).

Some coping skills that can be tapped into are relaxation-based skills to decrease the client's heart rate and relax their muscle tension (Cohen, et al., 2012). These techniques can vary in form and practice. For example, visualization and mindfulness activities can be practiced during sessions to create behaviour shifts and encourage the client to tap into them during times of duress (Cohen, et al., 2012). As trust can be a constant struggle for these female intercollegiate athletes violated by sexual violence, the client may frequently test the reliability, commitment, and authenticity of their therapist to determine whether they truly care about the their wellbeing (Cohen, et al., 2012). Some of these adolescent females may be in a constant state of true or imagined fear, but regardless of reality, the client may justly believe their lives are in danger when triggered (Cohen, et al., 2012). A real or imagined state of fear can create similar side

effects and therefore, need to be addressed immediately as well as continuously reviewed throughout the sessions (Cohen, et al., 2012).

Suicidality, self-harm, and substance misuse are some safety concerns that the therapist must be aware of on an ongoing basis (Cohen, et al., 2012). Developing a sense of safety between the client and therapist will depend on the therapist's ability to create a sense of security that will facilitate the construction of a secure attachment, or a stable behavioural and emotional relation to their therapist (Cohen, et al., 2012; Belfiore, & Pietrowsky, 2017). To ensure that secure attachments are maintained outside of sessions, caregivers or loved ones are incorporated into the treatment plan (Cohen, et al., 2012; Yasinski, Hayes, Ready, Cummings, Berman, McCauley, Ready, Berman, Webb, & Deblinger, 2016; Kirsh, et al., 2018).

The therapist and client will work together to determine safe and trusting adults in their greater community that can support in times of need that will provide a non-judgmental space for the client to express their feelings and emotions (Cohen, et al., 2012; Yasinski, et al., 2016; Kirsh, et al., 2018). To facilitate in creating such an environment for the client, the caregivers of the client will receive every aspect of TF-CBT in tandem with parenting sessions to support them in learning how to provide the best care possible for their adolescent (Cohen, et al., 2012; Yasinski, et al., 2016; Kirsh, et al., 2018). If the client is motivated to learn and implement new coping skills and their caregivers are not equipped with the skills to support their adolescent through the process, the implications could impede their success and development, and the client could regress (Cohen, et al., 2012; Yasinski, et al., 2016; Kirsh, et al., 2018).

Some female intercollegiate athletes may not have the opportunity to share their experiences with a parent as they may be separated by choice, death, distance, or other reasons. In these instances, it is beneficial to determine a secondary adult that the adolescent feels

comfortable and safe with that can support them through their recovery (Cohen, et al., 2012; Yasinski, et al., 2016). In the context of female intercollegiate athletes, this could be a coach, trainer, professor, or school counsellor (Tamminen & Holt, 2012). Coaches, trainers, professors, and school counsellors have the ability to influence and mentor their student athletes while providing another level of support as they are working towards building a trusting relationship based on achieving mutual goals (Tamminen & Holt, 2012; Martens, 2012).

Within phase one, the therapist works with the client to provide psychoeducation surrounding trauma and the impact that it can have on their lives (Cohen, et al., 2012). The therapist will then aim to identify specific trauma themes that are evident throughout their sessions that will provide both the client and therapist with insight into what the traumatic experience means to the client (Cohen, et al., 2012). These themes often come to fruition naturally during session or they can be facilitated by Socratic dialogue and questioning (Cohen, et al., 2012).

### **Phase 2: Trauma narration and processing.**

Female intercollegiate athletes struggling through interpersonal sexual violence may have difficulty discussing and dissecting their past (Cohen, et al., 2012). Therapists in this phase will work with their clients to process their experiences by sharing them in a narrative to enhance their ability to self-regulate and decrease activation; bringing clients into their window of tolerance (Cohen, et al., 2012). This narrative will focus on the themes collaboratively determined by both the therapist and client as opposed to being dictated by the incidences themselves (Cohen, et al., 2012). The themes will encompass the client's feelings, behaviours, thoughts, and perceptions regarding their traumatic experience (Cohen, et al., 2012). Together, they will create a life narrative that typically begins at birth and sequentially continues on and

incorporates the traumatic experience(s) and themes that accompany them including the thoughts, feelings, and sensations that are felt (Cohen, et al., 2012). The client can then utilize an outlet, such as story writing or rapping, where they can express their stories in the form of a metaphor to support in processing their trauma (Cohen, et al., 2012). The words written down are not nearly as important as the experience of processing the information (Cohen, et al., 2012). This narrative is then shared with their caregiver or another trustworthy adult to allow them to understand and support their progress outside of therapy (Cohen, et al., 2012; Yasinski, et al., 2016). The trusted adult must be motivated to support the client from a person-centered perspective; if they are not open and trusting, then sharing such a vulnerable aspect of the clients' lives could be potentially damaging and the client may begin to shut down (Cohen, et al., 2012; Yasinski, et al., 2016). If the client decides not to share their narrative, this decision should be respected (Cohen, et al., 2012).

### **Phase 3: Closure.**

Phase three focuses on consolidation of the treatment, closure, and reintegrating the client back into their community, utilizing their caregiver or trusting adult as a resource (Cohen, et al., 2012; Yasinski, et al., 2016; Kirsh, et al., 2018). This process could take longer than anticipated as the client may require more practice to test out what they have learned (Cohen, et al., 2012). The intention of this is to allow time for the client to comprehend that they have the ability to successfully apply these new skills while reducing or replacing their previous and potentially destructive coping behaviours (Cohen, et al., 2012). Applying a grief-focused approach may also be relevant for some individuals that have experienced trauma as they may be struggling through grief or loss (Cohen, et al., 2012). For a female intercollegiate athlete, a type of loss could be loss of friends and social network, an inability to focus on school work, or a failure to perform in

their sport of choice. It could also be the loss of an interpersonal relationship as a result of being victimized by a partner, or an inability to effectively participate in a current romantic relationship. Although TF-CBT is a phase-based approach, many of these phases will not occur in a linear fashion and may overlap or backtrack (Cohen, et al., 2012). This level set is critical to avoid experiencing a sense of deflation or discouragement when the process may seem to take steps backwards or remain stagnant (Cohen, et al., 2012).

### **Trauma-sensitive yoga (TSY).**

Yoga can be defined as “a combination of physical forms, focused breathing, and purposeful attention or mindfulness” (Emerson, 2015, p. xiv). The intention of incorporating Trauma-Sensitive Yoga (TSY) into treatment is to facilitate utilizing the body in a purposeful manner to promote awareness of the mind-body connection (Emerson, 2015). Payne et al. (2015) indicated that trauma causes a long-term dysregulation of the nervous system, and therefore resources that support the mind-body connection are necessary in treatment. This establishment of a mind-body connection will coincide with the implementation of productive self-regulation skills to support in addressing any trauma that is held in parts of the clients’ body (Emerson, 2015).

Forms of yoga have shown to be effective in reducing distress in individuals who are suffering from traumatic experiences (Nguyen-Feng, Morrissette, Lewis-Dmello, Michael, & Anders, 2018). Nguyen et al. (2018) stated that a mixture of TSY and mindfulness-based practices are best paired with other forms of therapy, such as group psychotherapy, to clients in talking through their somatic experiences. TSY can be facilitated in a one on one setting or a group setting (Nguyen-Feng, et al., 2018). As is the case for TF-CBT, TSY can take a collaborative or group approach to their methods (Cohen, et al., 2012; Nguyen-Feng, et al.,

2018). Again, this collaborative and community-based approach to treatment may resonate with female intercollegiate athletes when compared to their male counterparts as they tend to rely on others for support more frequently during difficult times (Steidinger, 2014).

Different forms of yoga can also provide physical health benefits for athletes that may be appealing to this population (Polsgrove, Eggleston, & Lockyer, 2016). One benefit is the improvement athletes might experience in their flexibility, which can enhance athletic performance as an added advantage (Polsgrove, et al., 2016). Balance is another critical feature of being a successful athlete and some forms of yoga can improve this aspect of their skillset as well (Polsgrove, et al., 2016). This said, although TSY may initially be intended to support this population through their traumatic experiences, the added benefit of performance enhancement and collaboration may be attractive (Polsgrove, et al., 2016).

#### **Trauma-sensitive yoga versus regular yoga.**

There are many aspects of trauma-sensitive yoga that differentiate it from regular yoga (Emerson, 2015). In regular yoga, many instructors do just that, instruct yogis or participants to move into a certain posture or pose, for a specified amount of time (Emerson, 2015). In TSY, every movement is an invitation for the participant to engage in a certain form when they so choose (Emerson, 2015). The facilitator in a TSY session will also create a shared, authentic experience between themselves and the participant; this will be discussed further in the “Role of the facilitator section” below (Emerson, 2015).

There is, in some cases, a sense of unhealthy comparison in regular yoga classes among participants (Emerson, 2015). Female intercollegiate athletes working through sexual violence may already experience a sense of dissociation and severe discomfort within their own bodies, and this comparison could trigger them into a state of activation (Emerson, 2015). In TSY the

facilitators alter their vocabulary, labelling physical movements as “forms” as opposed to “poses” to eliminate the sense that one is posing for someone else (Emerson, 2015). Some victims of sexual violence have literally been expected to pose for their abusers, and the language used in a traditional session could become quite triggering (Emerson, 2015). It is also a reminder to the participants that the TSY practice is for the benefit of the individual engaging in the practice and not others around them (Emerson, 2015). The forms these individuals are invited to take part in are less about the external expression and more about the internal experience and sensations (Emerson, 2015).

As mentioned above, the language utilized in TSY must always come from a place of invitation as opposed to instructing or requesting (Emerson, 2015). Many female intercollegiate athletes suffering through the effects of sexual violence may experience a loss of control over their bodies and instructing them what to do could create a negative atmosphere, a sense that their practice may be right or wrong, or a loss of control (Emerson, 2015). In TSY, there is no right or wrong, there is only what feels right and comfortable for the participants (Emerson, 2015). If facilitators “invite” these female athletes to take a certain form when they are ready, they empower the participants to take back their sense of choice and control over their own bodies (Emerson, 2015).

Regular yoga classes incorporate breath work by prescribing how and when to engage in certain forms of breath (Emerson, 2015). TSY utilizes forms of breathwork as well, but this treatment empowers participants by merely reminding them to breathe and not suggesting how to breathe (Emerson, 2015). Suggesting how one should be breathing creates an environment of comparability and an assumption that one way of breathing is better than another, removing the clients’ power of choice and control (Emerson, 2015). Instead, TSY invites participants to

engage in forms of breathing when and if they feel comfortable doing so (Emerson, 2015).

Mindfulness, or purposeful directed attention toward another entity, is an additional aspect that is incorporated into both forms of yoga, but TSY focuses more heavily on the experience of the body (Emerson, 2015). Whenever a facilitator invites a participant to direct their attention anywhere, it is always towards the sensations they are experiencing within their body and not the external conditions or cognitive thoughts (Emerson, 2015).

### **Interoception.**

Trauma-sensitive yoga relies heavily on the experience of “interoception” (Emerson, 2015). Interoception is arguably one of the most critical terms and experiences an individual is subject to in regard to TSY (Emerson, 2015). Interoception can be defined as “an attentional praxis that center[s] on our ability to feel the activity of our interior self, that is, the self-contained within our skin” (Emerson, 2015, p. 22). The intention of interoception is to redirect clients’ attention from cognitive or emotional experiences to their internal visceral and musculoskeletal sensations (Payne, Levine, & Crane-Godreau, 2015). To experience interoception is to feel the sensations occurring within oneself, such as the heart beating, the stomach grumbling, or the muscles stretching (Emerson, 2015; Payne, Levine, & Crane-Godreau, 2015). It is an intra-organismic awareness of what is occurring within the boundaries of one’s own skin (Emerson, 2015; Payne, Levine, & Crane-Godreau, 2015). In TSY, participants are invited to merely notice these sensations they have struggled to acknowledge or notice in the past without judging their experience (Emerson, 2015). Female intercollegiate athletes that have suffered from sexual violence often struggle to experience interoception (Emerson, 2015; Khalsa, Rudrauf, Feinstein, Tranel, 2009). One reason behind this thought is that there has shown to be lowered brain activation than others not suffering from trauma in the thalamus, the

medial prefrontal cortex, and the anterior cingulate gyrus; all of which support the interoceptive pathways (Emerson, 2015; Khalsa, Rudrauf, Feinstein, Tranel, 2009).

Much of the work conducted in TSY comes full circle to the language utilized by the facilitator and the many benefits the words spoken can have on the participant (Emerson, 2015). One of the most essential words in reference to facilitating interoception is “notice” (Emerson, 2015). For example, the facilitator may invite the participant to open both arms out to the side, asking them to notice the sensations they are experiencing during this movement such as an opening in their chest without judgement (Emerson, 2015). The facilitator must be intentional with the sensation they are inviting the participant to notice (Emerson, 2015). If the facilitator is not intentional with their request, the participant may become overwhelmed by sensations and not know where to focus their attention, causing anxiety (Emerson, 2015). This movement can be continued by inviting the client to lift one arm at a time and notice the difference (Emerson, 2015). Many varieties of this technique can be applied in a session to continue the incorporation and employment of interoception (Emerson, 2015). The intention is to bring the clients’ awareness back to their body in the here and now, recognizing they are safe, and they have survived this experience (Emerson, 2015).

### **TSY and attachment theory.**

Attachment theory aims to understand an individuals’ behaviour in their adult years as being directly related to the experiences they have had in their early life relationships, mainly infancy and childhood (Emerson, 2015). If the infant or child does not experience a sense of secure attachment during these critical periods of development, it could critically impact their development and future functioning (Emerson, 2015). As discussed in chapter one, female intercollegiate athletes are considered to fall into a population undergoing critical development,

which only reinforces the idea that sexual trauma during this point in their development can have serious effects (Ellsberg, et al., 2017). This element is important to note as TSY treatment occurs in the context of many relationships such as the facilitator/therapist/clinician and the student/patient/client/participant (Emerson, 2015). Aspects of attachment theory must be incorporated into the application of TSY as this population may have experienced ruptures in their interpersonal relationships as well as how they view healthy relationships (Emerson, 2015). Relationships with others can be both the cause of interpersonal trauma and an element that supports healing, which creates cognitive dissonance and difficulty in processing for adolescents that may initially be hesitant to build a therapeutic bond with the facilitator or therapist who is present to support in their recovery (Emerson, 2015). TSY provides an opportunity for participants to experience healthy relationships with their therapist/clinician/facilitator and apply those skills into their daily lives, supporting their progress towards healthier relationships outside of treatment (Emerson, 2015).

Another relationship that must be restored is the participant's relationship to the self (Emerson, 2015). Individuals that have been traumatized live in a body with which they have an unreliable and unpredictable relationship with (Emerson, 2015). In working with female intercollegiate athletes struggling with the aftermath of sexual violence, these clients experience fractures to their relationships with themselves and this must be reestablished in order to continue the healing process (Emerson, 2015).

### **Role of the facilitator.**

The facilitator must work to create a safe, warm, and inviting environment that will encourage the participant to be open to their interoceptive experience and connection to the self (Emerson, 2015). To aid this experience, the facilitator will create a shared authentic experience

with the participant (Emerson, 2015). This means that unlike many regular yoga classes, the facilitator is an active participant in these sessions, engaging in a yoga session alongside their client/participant (Emerson, 2015). This creates a level of trust, demonstrating that the facilitator would not invite the client to engage in an activity that they themselves would not participate in; strengthening the positive therapeutic relationship (Emerson, 2015).

As humans, we often fall prey to unconsciously favouring our own opinions and biases (Emerson, 2015). This being said, therapists/facilitators/clinicians are in a very unique position of authority and could potentially impose those biases on a very vulnerable population; in this case, female intercollegiate athletes (Emerson, 2015). This means that facilitators must engage in frequent self-reflection to acknowledge these biases and face them head on to avoid any imposition, allowing the participants to have their own personalized TSY experience that will support their recovery (Emerson, 2015).

It is also imperative that the facilitator not coerce the participant during these sessions (Emerson, 2015). The facilitator must be mindful they are not forcing the participant to engage in a movement or form the facilitator believes will benefit the participant (Emerson, 2015). Instead, the facilitator is expected to provide the participant with options and choices, allowing the participant to determine which forms are best suited to them (Emerson, 2015). If a facilitator does pressure the participant to engage in a certain form, it could rupture the therapeutic relationship and create an even larger inability for the client to establish healthy relationships outside of the sessions (Emerson, 2015). This action may also shift the intention of the process towards external expectations as opposed to an internal experience (Emerson, 2015).

**Yoga forms utilized in sessions.**

Although there is a large variety of yoga forms that can be utilized in a TSY session, I will list only a few below, along with their benefits and how instructors can engage the client (Emerson, 2015; van der kolk, Stone, West, Rhodes, Emerson, Suvak, & Spinazzola, 2014). Starting in a seated position is the ideal method to initiate the incorporation of TSY into therapy as this supports meeting the client where they are at physically and mentally (Emerson, 2015). It is a less invasive and vulnerable position for some, although not all, and therefore is a great starting point (Emerson, 2015). It is important to note that facilitators and therapists must tailor these forms to their clients as they may not know which forms will trigger a client. For example, sitting in a seat across from a facilitator may not be ideal for some individuals if this is a position where they have experienced trauma in the past (Emerson, 2015). Facilitators must remind participants' that they have the power to decline any offer or invitation throughout the session, empowering them to take control of their own body and experience (Emerson, 2015).

Seated mountain form is a position by which the participant is sitting in their chair with a straight back, knees hip distance apart, back is lifted from the back of the seat, and hands are on their knees (Emerson, 2015). The facilitator could approach this form by inviting the participant to sit up in a comfortable position, inviting them to bring their feet to the floor with their ankles under their knees at hip's distance apart (Emerson, 2015). This invitation allows the participant to decline the offer if it either triggers them or if they experience physical discomfort; this will be the case for all the remaining forms listed below (Emerson, 2015). Without offering an invitation to participate in each form, the facilitator removes the perception of choice in the session, potentially discouraging a client and eliminating the sense of empowerment they are working to create (Emerson, 2015). When it comes to the interoceptive experience of this form, the

participant may begin to sense their body lengthening and their chest opening up, promoting smooth breathing (Emerson, 2015). The facilitator can also invite the participant to sense the experience of grounding their feet firmly on the ground and sensing the feeling of be present in the here and now (Emerson, 2015).

A gentle spinal twist is another form that can be applied in the seated position (Emerson, 2015). The participant will be seated in a position much like the seated mountain form and invited to turn the upper half of their body, first to one side and then to the other (Emerson, 2015). The facilitator may say “if you like, feel free to experiment with turning the upper half of your body from one side to the other, maybe experiencing a stretch up one side, and after a few breaths, feel free to switch to the other side at your own pace” (Emerson, 2015). This also encourages the power of choice and encouraging them to choose which action to take and when (Emerson, 2015). This form can also promote calming and steady breathing (Emerson, 2015).

Facilitators can experiment with standing positions as well if both the client and facilitator are comfortable with this decision (Emerson, 2015). At no point should the facilitator coerce the participant to do so, but instead, they can provide it as an option if they wish to attempt it (Emerson, 2015). The standing form I will discuss is called back and shoulder stretch, variation one. The client is invited to stand behind their chair with both hands on the back of the chair (Emerson, 2015). They are then invited, if they so choose, to take a few steps back, slightly bending forward at the hip (Emerson, 2015). In this position, the facilitator may invite them to be aware of the sensations they are experiencing, such as noticing the muscles that support them in a standing position and sensing a slight stretch down their back (Emerson, 2015). They could remind the client that these muscles working to support them in standing are the same ones

supporting their entire body, both physically and mentally, bringing their awareness back to the strength they have in the here and now (Emerson, 2015).

**TSY discussion.**

This type of therapy can be complex while still providing many benefits, both from a mental and physical perspective (Polsgrove, Eggleston, & Lockyer, 2016; Nguyen-Feng, et al., 2018). Some of the physical benefits such as enhanced athletic performance of some forms of yoga could appeal to female athletes seeking treatment for interpersonal trauma (Polsgrove, Eggleston, & Lockyer, 2016). The role of the facilitator is paramount to the success of this type of treatment (Emerson, 2015). The language they utilize must empower the participant and allow them to experience a sense of choice (Emerson, 2015). Many female intercollegiate athletes who have become victims of interpersonal sexual violence have experienced a loss of control over their body and, subsequently, may have lost their sense of self. Because of this, reestablishing a sense empowerment, choice, and empathy are critical to the success of this treatment (Emerson, 2015). Due to the dissociation from their body that some victims may experience as a result of their trauma, the facilitator and participant must work together to bridge the connection of body and mind through interoceptive awareness (Emerson, 2015).

### **Chapter Three: Therapeutic Effectiveness and Discussion**

The below sections will review literature that supports the effectiveness of both TF-CBT and TSY as adequate treatment options for female intercollegiate athletes struggling with the aftermath of sexual violence. Some sections review meta-analyses while others address the outcomes of randomized-controlled trials. Chapter three will conclude with limitations to these literature reviews and research findings, as well as a final discussion of the capstone.

#### **Trauma-Focused Cognitive Behavioural Therapy Effectiveness**

A study was conducted by Yasinski et al. (2016) to determine the impact that having a caregiver accompany their youth or adolescent into Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) sessions has on the effectiveness and prognosis of trauma symptoms (Yasinski, et al., 2016). As mentioned, the inclusion of a caregiver during this recovery process can be critical to the effectiveness of this treatment and reduced PTSD symptoms (Yasinski, et al., 2016). If a parent is not a viable option, other well-respected and trusted adults in the youth or adolescents' life can support them throughout their recovery (Cohen, et al., 2012; Yasinski, et al., 2016). In the case of female intercollegiate athletes, this could include coaches, professors, school counsellors, friends' parents, trainers, captains, and many more. The adult selected must be committed to the program and support the adolescent and youth for the duration of the program and support their ability to maintain and sustain the changes accomplished (Cohen, et al., 2012; Yasinski, et al., 2016).

Yasinski et al., (2016) found that the ability of the client's caregiver to emotionally process the information being provided during the trauma narrative phase was predictive of the adolescent reducing their inclination to internalize or externalize their symptoms. In contrast, if the caregiver blamed their adolescent or avoided the situation during the trauma narrative phase,

this was found to worsen the adolescents' proclivity to internalize or externalize their trauma symptoms (Yasinki, et al., 2016). This avoidance and adolescent blaming during phase two can also lead the adolescent to overgeneralize, which is predictive of worse outcomes (Yasinki, et al., 2016). Caregiver avoidance during the initial stabilization and skills building phase was also a predictor of worsening the externalization of trauma symptoms (Yasinki, et al., 2016).

These findings are crucial in articulating the impact that caregivers have on their adolescent, especially during the skill building and trauma narrative phases (Yasinki, et al., 2016). Not only is their positive support predictive of favourable outcomes, but they also have the ability to worsen their adolescents' trauma symptoms if they are not respectful, compassionate, and empathetic (Yasinki, et al., 2016). TF-CBT, as mentioned, can be an effective form of therapy in working with adolescents struggling with these experiences when conducted in a specific environment, alongside a supportive caregiver (Yasinki, et al., 2016).

Jensen et al. (2014) conducted a study to evaluate the effectiveness of TF-CBT in a community setting when compared to therapy as usual (TAU) (Jensen, Holt, Ormhaug, Egeland, Granly, Hoaas, Hukkelberg, Indregard, Stormyren, & Wentzel-Larsen, 2014). This study examined 156 youth who have experienced any form of trauma (Jensen, et al., 2014). The participants were randomly assigned to either the TF-CBT group or the TAU group (Jensen, et al., 2014). This specific study is one of few that incorporates individuals struggling from a variety of traumas with a multitude of psychological symptoms (Jensen, et al., 2014).

This research discovered that the incorporation of TF-CBT, as opposed to merely TAU, significantly reduced PTSD symptoms (Jensen, et al., 2014). Additionally, Jensen et al. (2014) found that TF-CBT also reduced depressive and anxious symptoms while improving the clients' general mental-health and functioning (Jensen, et al., 2014). This is especially important to note

as PTSD often co-occurs with other disorders, and treatment options for depression do not typically outperform TAU, although that was not the case for this study (Jensen, et al., 2014). The source of this reduction in depressive symptoms was not identified but may be a result of the reduction in the PTSD symptoms as the adolescents may be experiencing hope regarding their future and recovery (Jensen, et al., 2014). Participants in this study also experienced a decrease in externalizing behaviours, social and interpersonal problems, hyperactivity and concentration problems, and an increased ability to emotionally regulate in comparison to the TAU group (Jensen, et al., 2014). Based on this research it is evident that teaching adolescents' skills and techniques they can utilize to regulate their emotions and correct their maladaptive coping behaviours is fundamental in achieving successful and effective treatment in TF-CBT (Jensen, et al., 2014).

At the time this study was conducted, it was the first randomized study conducted outside of the United States where TF-CBT was initially created (Jensen, et al., 2014). The fact that this study was conducted in Norway and was able to produce similar effective outcomes to this type of therapy indicates it is culturally inclusive and potentially effective on a global scale (Jensen, et al., 2014). Jensen et al. (2014) mentioned that the program did not require significant adaptation when being implemented in Norway as opposed to the United States, once again expressing TF-CBT's flexible and culturally competent nature (Jensen, et al., 2014).

One limitation of this study is that the researchers did not attempt to determine which aspects of TF-CBT were particularly effective in reducing these negative PTSD symptoms in order to reproduce them in future treatment modalities (Jensen, et al., 2014). Another limitation was the discrepancy of psychologist training between the TF-CBT and TAU groups (Jensen, et al., 2014). The TF-CBT group encompassed more psychologists with postgraduate training when

compared to the TAU group (Jensen, et al., 2014). There was also significantly more supervision for the psychologists in the TF-CBT group than the TAU group (Jensen, et al., 2014). This being said, the psychologists working with the TF-CBT groups were new to this type of therapy which is why they required additional supervision and training (Jensen, et al., 2014). The lack of supervision and discrepancy in training on the part of the psychologists between the two groups could have impacted the quality of therapy in the TAU group (Jensen, et al., 2014). Lastly, there were significantly more females than males in the study and therefore more research is required to determine the effectiveness in working with that population and could have skewed the results (Jensen, et al., 2014).

### **Trauma-Sensitive Yoga Effectiveness**

In 2014, Bessel van der Kolk recognized that more than one third of the 10 million females suffering through traumatic, sexually violent experiences in the United States developed some form of PTSD (van der Kolk, et al., 2014). van der Kolk also suggested that a supplementary treatment was required to address the somatic aspects of the disorder (van der Kolk, et al., 2014). Issues involving impulse regulation in individuals struggling with PTSD have stimulated the requirement for such a supplementary treatment (van der Kolk, et al., 2014). The next step in van der Kolk et al.'s (2014) research was to determine the effectiveness of such a treatment.

The team studied 64 women, with an age range from 18-58, that were experiencing PTSD related symptoms and had yet to experience progress in their prior treatments (van der Kolk, et al., 2014). These individuals were enlisted via radio, newspaper, and website advertisements (van der Kolk, et al., 2014). Their trauma history was obtained through a self-report survey and to qualify for this, the participants must have reported at least three years of PTSD specific

treatment that was self-identified as ineffective (van der Kolk, et al., 2014). Each individual taking part in the study were randomly selected to join either a trauma-informed yoga class or the control group consisting of a women's health education class, both with a duration of one hour each, one time per week, for ten weeks (van der Kolk, et al., 2014). It is important to note that some researchers utilize the term Trauma-Sensitive Yoga (TSY) while others use Trauma-Informed Yoga (TIY) and it may differ depending on how they view this type of therapy or the root of the issue. For the purpose of this capstone, TSY and TIY are interchangeable and indicate similar treatment.

The trauma-informed yoga sessions focused heavily on forms of hatha yoga such as breathing, postures, and meditation (van der Kolk, et al., 2014). The yoga facilitators had master's and doctoral-level degrees in psychology with consistent supervision from the investigators (van der Kolk, et al., 2014). The facilitators relied heavily on invitational language when requesting that clients engage in self-inquiry about bodily sensations (van der Kolk, et al., 2014). Some of these phrases included "when you are ready" and "if you like" as a gentle reminder that the clients do have control over their bodies and the actions they take (van der Kolk, et al., 2014). As previously mentioned, individuals struggling to overcome traumatic experiences may develop a sense that they don't have control over their body, as someone else may have taken that away from them (Emerson, 2015). They may also experience a sense of dissociation from their body, and trauma-sensitive yoga is intended to bridge that gap and create a mind-body awareness and connection (Emerson, 2015). The participants remained in certain forms they felt comfortable and safe in for however long they chose and were invited to become aware of the sensations felt during these forms (van der Kolk, et al., 2014).

The women's health education condition consisted of active participation and mental support and while providing education surrounding several different areas of women's health (van der Kolk, et al., 2014). Some of these discussions included available medical services, issues surrounding health and medical professionals, normalizing the experience these individuals are going through, medical terminology regarding the body, and how to engage in self-care activities (van der Kolk, et al., 2014). These resources were shared with the participants via workbooks, games, charts, recordings, and group discussions (van der Kolk, et al., 2014).

The results of this ten-week randomized controlled trial (RCT) indicated that the inclusion of trauma-informed yoga when compared to supportive therapy significantly decreased PTSD symptoms in clients (van der Kolk, et al., 2014). Although the control group did have success in reducing depressive symptoms, this positive change was not sustained to the same degree as the trauma-informed yoga (van der Kolk, et al., 2014). This proposes that the interoceptive and physical aspects of yoga rather than solely the social aspects of the treatment groups were critical in generating positive results (van der Kolk, et al., 2014).

In 2017, Hilton et al. conducted a meta-analysis review of RCTs to determine the effectiveness of meditation as a therapy in working with individuals suffering from PTSD and related symptoms. Meditation has been identified as an important aspect of trauma-sensitive yoga as it is a technique utilized in order to facilitate the mind-body connection (Hilton, Maher, Colaiaco, Apaydin, Sorbero, Booth, Shanman, & Hempel, 2017). The goal of meditation is to train the mind through regulating attention and/or emotional affect to bodily functions, symptoms, as well as physical and mental states of being (Hilton, et al., 2017). Meditation relies heavily on breathing techniques and physical postures that promote and emphasize focused attention to emotional and physical stimuli and responses (Hilton, et al., 2017). One of the

studies Hilton et al. (2017) examined found that although meditation does show evidence for being an effective therapeutic technique, much of the research fails to establish true efficacy of the effectiveness of meditation (Hilton, et al., 2017). More research is required to determine its effectiveness when partnered with adjunctive evidence-based therapies (Hilton, et al., 2017).

Hilton et al. (2017) discussed that in a recent review of the effectiveness of meditation in treating mindfulness, it was discovered that 11 of the 12 studies reported significant improvement in PTSD symptoms (Hilton, et al., 2017). That said, this review also stated that the strength of the evidence found was quite weak as the quality of the methodological techniques utilized were poor. There was a similar finding in another study Hilton et al. (2017) discussed in that 12 of the 16 studies they reviewed observed positive effects in treating PTSD symptoms with meditative techniques. The strength of these findings were questionable as there was limited variation in the quality and design of the study (Hilton, et al., 2017). In a much smaller analysis of nine studies, it was recognized that meditation did improve the symptoms associated with PTSD, but similarly the quality of methodologies utilized varied among the studies reviewed (Hilton, et al., 2017).

This meta-analysis identified 1,365 citations Hilton et al. (2017) found to be clinically relevant in answering their research question: How effective is meditation as a therapeutic modality in treating PTSD symptoms. After a thorough examination of the identified citations, 70 were potentially applicable (Hilton, et al., 2017). Many were removed for numerous reasons such as type of publication, lack of reporting on primary data, participants not meeting PTSD diagnostic criteria, some were not considered RCTs, or they failed to provide an eligible outcome (Hilton, et al., 2017). After a systematic review of the literature, Hilton et al. (2017) expressed that when meditation was offered as an adjunctive form of treatment on top of the participants'

TAU, PTSD symptoms were significantly decreased in comparison to TAU, meditation alone, education, or present-centered therapy. This was found to be consistent among all sources of trauma (Hilton, et al., 2017).

Although these findings are promising, there were some limitations of this study that are important to note (Hilton, et al., 2017). The authors of this study did not reach out to any of the researchers and the information provided is based solely on published data (Hilton, et al., 2017). The researchers only included studies that were published in English due to the cost of translation, therefore the perspectives may have a westernized bias (Hilton, et al., 2017). They excluded conference abstracts and dissertations as they were searching for scholarly reviewed resources and these exclusions did not contain enough information to evaluate the quality of the studies (Hilton, et al., 2017).

Sciarrino et al. (2017) were interested in expanding this research on the effectiveness of forms of yoga in treating individuals suffering from PTSD symptoms. They expressed that current research demonstrates that many forms of treatment (approximately between 30%-60%) are ineffective in treating PTSD symptoms, and therefore a need is present for additional adjunctive forms of treatment to support these individuals that are grouped into that percentage (Sciarrino, DeLucia, O'Brien, & McAdams, 2017). Sciarrino et al. (2017) evaluated seven RCTs in order to assess the effectiveness of yoga as a treatment for trauma and PTSD symptoms.

During this analysis of seven RCTs, Sciarrino et al. (2017) established that yoga was well tolerated by the participants as they expressed positive experiences and minimal undesirable symptoms. They also observed that this form of treatment is a viable option for individuals who fear seeking psychotherapy due to the stigma associated with it (Sciarrino, et al., 2017). These RCTs found that the impact yoga had on treating individuals suffering from PTSD symptoms

was in the moderate range (Sciarrino, et al., 2017). Although the effect sizes were only moderate for this study, this is still promising and with more research and empirical reviews such as these, there is the opportunity to determine more specific data regarding which aspects of trauma-sensitive yoga have the greatest impact on what population (Sciarrino, et al., 2017).

One limitation of this RCT is that it was quite limited in the data and research it reviewed (Sciarrino, et al., 2017). This RCT focused solely on physical yoga postures from a treatment perspective and neglected other features of yoga such as mindfulness and breathing which could have impacted the results (Sciarrino, et al., 2017). The intention of including only physical postures was to reduce heterogeneity across the seven studies reviewed and increase the generalizability of the results (Sciarrino, et al., 2017). The last limitation is that the majority of the studies included in the analysis included yoga as a standalone treatment, while others use it as an adjunctive therapeutic technique, and this could make it difficult to compare results between studies (Sciarrino, et al., 2017).

Price et al. (2017) similarly sought to build on the research indicating that trauma-sensitive yoga is a feasible and promising option as a form of treatment for individuals suffering from PTSD symptoms, although they focused their efforts specifically on females suffering from these symptoms (Price, Spinazzola, Musicaro, Turner, Suvak, Emerson, & van der Kolk, 2017). Their research indicates that individuals who engage in a time-limited yoga program, such as one that lasts approximately 10 weeks, has shown to be effective in reducing PTSD symptoms, including but not limited to those suffering from intimate partner violence (Price, et al., 2017). This type of program has been shown to be associated with many positive outcomes during and post-treatment, such as reduced depressive symptoms and increased overall wellness (Price, et al., 2017).

That said, other research has indicated that they have failed to find a significant relationship between the duration of yoga practice and bodily awareness, satisfaction, stress, and overall relaxation (Price, et al., 2017). That aside, much research has still shown increases in positive psychological attitudes, vitality, good health, relaxation, and a general reduction in PTSD symptoms (Price, et al., 2017). Unfortunately, for those studies yielding positive results, it isn't clear from these findings what limitations may have impacted the results (Price, et al., 2017).

### **Discussion**

As mentioned, sexual violence against female intercollegiate student athletes at the hands of male intercollegiate student athletes is a prevalent and apparent threat that many individuals are faced with (McCray, 2015). A United States based research study recognized that approximately 19.3% of women have been sexually abused during their lifetime (Breiding, 2014). McDermott et al. (2016) also expressed that one third of college males would be willing to force sexual violence on a female if they could be guaranteed they would not be caught (McDermott, et al., 2015). These statistics are significant and demonstrate that female intercollegiate student athletes as a population are vulnerable and susceptible to being subject to this form of violence (McDermott, et al., 2015). It is important to note that these statistics are only inclusive of individuals that chose to report their experiences of sexual violence, as many choose not to report them for numerous reasons (Breiding, 2014).

The correlation between language and violence plays a vital role in determining the impact and outcome of many situations that encompass sexual violence against females, more specifically female intercollegiate student athletes (Coates, & Wade, 2007). Perpetrators that possess a level of power over their victim experience a lesser chance of being convicted (Coates, & Wade, 2007).

Male intercollegiate athletes are part of several levels of power, such as the most obvious, being male (Coates, & Wade, 2007). These individuals also have the luxury of being athletes, well educated, professional, some of which become celebrities due to their successes, among many more, and convictions can cause issues within the organizations they are associated with, as a result the lack of conviction favours the perpetrator and their organization (Coates, & Wade, 2007).

As a society we may minimize the experience of the victim by using certain language that does not accurately represent their reality (Coates, & Wade, 2007). This can impact the outcome of a criminal report, once again favouring the perpetrator as this minimization can create the assumption that the act was less severe than it truly was (Coates, & Wade, 2007). The victim may also be shamed, scolded, or isolated by society for making these statements against these iconic members of the community; this can lead to lowered rates of reporting on the part of the victim due to fear (Coates, & Wade, 2007).

The impact of sexual violence on female intercollegiate student athletes extends beyond the above and can have severe mental and physical consequences (McCray, 2015). The trauma associated with these experiences can manifest in many different forms, some of which are physical and others mental (Levine, 2010). When triggered, these victims will enter a state of arousal that can generate symptoms relating to that of fight-flight-freeze, such as racing heart, sweating, and muscle tension to name a few (Levine, 2010). Anxiety, depression, and phobias are some consequences that can manifest as a result of being subject to sexual violence (World Health Organization, 2012).

There are many treatment modalities that can support this population in their recovery, but this capstone focused on trauma-focused Cognitive Behavioural Therapy (TF-CBT) and Trauma-Sensitive Yoga (TSY) (Cohen, et al., 2012; Emerson, 2015). Both methods approach

their clients from a Trauma-Focused lens, putting the individual and their very unique needs at the heart of therapy (Cohen, et al., 2012; Emerson, 2015). TF-CBT takes an integrative and collaborative approach to treatment and recovery by incorporating individuals who are considered to be the clients' resources (Cohen, et al., 2012; Deblinger, Pollio, & Dorsey, 2016). Female intercollegiate athletes, and females in a more general capacity, have a tendency to value social support and collaborative approaches which would encourage the use of collaboration in treatment methods (Steidinger, 2014). This thought is evident in the sporting world where females tend to favour partnership, teamwork, and comradery in order to achieve a common goal (Steidinger, 2014). TF-CBT takes a three-phased approach, beginning with learning and understanding the available coping skills to the client in phase one, trauma narration processing in phase two, and closure or reintegration in phase three (Cohen, et al., 2012; Yasinski, et al., 2016).

The intention of incorporating TSY into treatment is to facilitate utilizing the body in a purposeful manner to promote awareness of the mind-body connection (Emerson, 2015). Many individuals experiencing the consequences of their traumatic event(s) tend to disconnect from their body and many of the symptoms unconsciously live in the body (Emerson, 2015). Bridging this mind-body gap can allow the client to slowly and gently release the trauma they have been storing; this can be done by engaging in the act of interoception and intentional awareness (Emerson, 2015). This type of therapy can be complex while still providing many benefits, both from a mental and physical perspective (Polsgrove, Eggleston, & Lockyer, 2016; Nguyen-Feng, et al., 2018). Some of the physical benefits include enhanced athletic performance of some forms of yoga and could appeal to female athletes seeking treatment for sexual trauma (Polsgrove, Eggleston, & Lockyer, 2016).

These therapies have been reviewed in many randomized-controlled trials (RCTs) and meta-analyses to determine their effectiveness (van der kolk, et al., 2014; Hilton, et al., 2017; Sciarrino, et al., 2017; Price, et al., 2017; Jensen, et al., 2014). In TF-CBT, Yasinki et al., (2016) found that the ability of the clients' caregiver to emotionally process the information being provided during the trauma narrative phase, or phase two, was predictive of the adolescent reducing their inclination to internalize or externalize their symptoms. This article also sheds light on the idea that if the caregiver or trusted member of the community involved in the client's treatment has a tendency to blame or shame the client, this was found to worsen the adolescents' proclivity to internalize or externalize their trauma symptoms (Yasinki, et al., 2016). These findings articulate the importance that caregivers play in the treatment of their adolescent (Yasinki, et al., 2016). Jensen et al. (2014) conducted a study to evaluate the effectiveness of TF-CBT and found that in comparison to solely TAU, TF-CBT reduced clients' depressive and anxious symptoms while improving the clients' general mental-health and functioning.

In regard to TSY, van der Kolk et al. (2014) conducted an RCT that indicated the incorporation of TSY decreased symptoms of PTSD. It also decreased symptoms of depression when compared to the control group (van der Kolk, et al., 2014). The results of this RCT indicated that the interoceptive and physical aspects of yoga rather than solely the social features of the treatment groups were imperative in generating positive results (van der Kolk, et al., 2014).

Hilton et al. (2017) reviewed literature on the inclusiveness of meditation as an adjunctive treatment in addition to the clients' therapy as usual (TAU), and found that PTSD symptoms decreased significantly in comparison to TAU. Lastly, Sciarrino et al. (2017) conducted an evaluation of seven RCTs and discovered that this type of therapy is a viable

option for individuals who may be intimidated by typical psychotherapy due to the stigma associated with it.

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