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Using the Eight Limbs of Yoga in Psychotherapy: A Phased Model

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Abstract

The eight limbs of yoga are increasingly discussed as a resource for psychotherapy. Most writing describes what the limbs are and how they might be used but says little about the order in which a therapist should bring them in. The gap matters. Practices such as sustained meditation can unsettle people who are not yet steady and the classical order of the limbs was designed for spiritual aims, not clinical ones. This conceptual paper proposes a phased model that arranges the limbs across three overlapping stages of therapy: stabilisation, exploration and integration. Movement between stages depends on two readiness checks, one about safety and steadiness and the other about capacity and consent. Posture and breath work sit mainly in the first stage, the ethical limbs and early attention practices in the second and longer meditation in the third. The final limb, absorption, is treated as a horizon and not as a treatment goal. The model is cyclical, so a client can return to an earlier stage after a setback without this counting as failure. Two flowcharts and three tables set out the logic, the mapping of limbs to stages and the readiness checks. Seven propositions are offered for testing, together with practical decision rules and ethical and cultural considerations. The paper reports no new data. Its aim is to give clinicians, trainers and researchers a clear and testable way of deciding which limb to use, when and for whom.

Key words - yoga, eight limbs, psychotherapy, sequencing, readiness, conceptual model

Introduction

Over two decades, yoga has moved from the studio into clinics, hospitals and therapy rooms. Trials and reviews have linked yoga-based programmes to lower depression, lower anxiety and reduced trauma-related distress, although the evidence varies in quality (Chawla *et al.*, 2023). Most of these programmes rely on postures, breathing and meditation and fewer draw on the full system of eight limbs set out in the Yoga Sutras of Patañjali.

Published work on the limbs in therapy has mostly been descriptive. One useful approach has been to build a typology, classifying the ways in which the limbs can be integrated into psychotherapeutic practice. A typology tells a clinician what is available. It does not say what to do with a particular client on a particular day (Norcross, 2019). Should a person who is still shaky after a recent crisis be asked to sit in silent meditation? Should a values discussion come before or after the person can talk about feelings without being overwhelmed? These are questions of order and readiness.

This paper tries to answer them. It puts forward a phased model that links each limb to a stage of therapy and uses

two readiness checks to decide when a client moves on (Hase, 2021). The model is conceptual. It draws on the yogic system itself, on established ideas about staged treatment and on what is known about the risks of contemplative practice.

The eight limbs in brief

The Yoga Sutras describe eight limbs: ethical restraints (yama), personal observances (niyama), posture (asana), breath regulation (pranayama), withdrawal of attention from the senses (pratyahara), concentration (dharana), meditation (dhyana) and absorption (samadhi). The first two concern conduct and attitude, the next two concern the body and breath and the last four concern attention (Alam *et al.*, 2024).

Three points from the tradition matter here. First, the stated aim of the system is to quieten the fluctuations of the mind. Second, the classical order is a teaching order written for practitioners seeking spiritual liberation and it need not be the best clinical order. Third, the tradition itself offers a shorter preparatory path of discipline, self-study and surrender, suggesting that people were expected to begin in different places. The sutras also give posture only a few verses and the modern emphasis

on posture is largely a twentieth-century development (Rahmani *et al.*, 2023).

Why the order matters

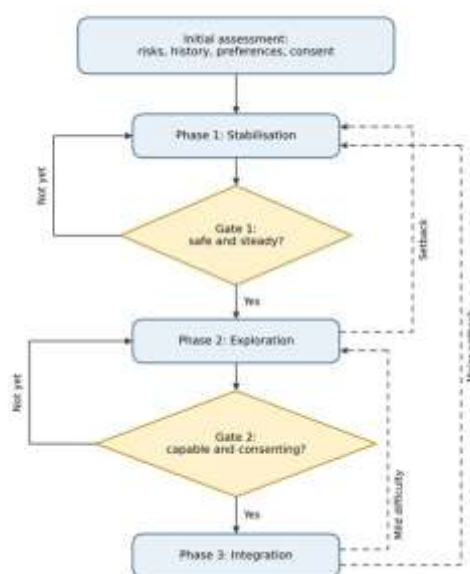
Five points explain why sequence deserves attention.

- **Contemplative practice can cause difficulty.** Studies of experienced meditators report anxiety, fear, emotional numbness, depersonalisation and the return of distressing memories, which in a minority last for weeks or longer.
- **Attention practices bring inner material to the surface.** A person asked to observe their thoughts may meet painful memories with no means of coping.
- **Staged treatment is already standard in trauma work.** Widely used models place safety and stabilisation first, the processing of difficult memories second and reconnection with daily life third. The idea that some stability should come before deeper work applies well beyond trauma.
- **Regulation comes before reflection.** When arousal is high, calm and detached observation is hard, so techniques that lower arousal make more sense early on than those that call for open awareness.
- **Readiness and choice shape outcomes.** Matching an intervention to a client's readiness improves engagement and therapy outcomes depend on the relationship and on the client's sense of choice. A sequence must therefore be offered, not imposed.

4. The phased model

The model has three phases and two readiness checks, called gates, between them. The phases overlap and describe the main emphasis at a given time, not a fixed timetable. Figure 1 shows the flow.

Figure 1. The phased model with its two gates



Phase 1: Stabilisation. The aim is safety, steadiness and at least one dependable way of calming down. Work centres on posture practised as body awareness and choice, not physical performance and on gentle breathing, such as lengthening the out-breath (Bentley *et al.*, 2023). The niyama of discipline builds simple

routes. The yama of non-harming is present from the first session, as the therapist's stance and the standard for how practices are offered, not as a topic for discussion (Akshay Krishna & Menon, 2026).

Phase 2: Exploration. With basic regulation in place, the work turns to patterns of thought, feeling and behaviour. The yamas and niyamas become material for reflection, such as honesty in relationships, contentment and self-study. Attention practices arrive gradually. Pratyahara is taught as the ability to turn attention away from a stream of stimuli and reactions and dharana as focusing on a chosen object. The therapist watches for practices being used to avoid feelings (Agrawal & Pandey, 2022).

Phase 3: Integration. The client consolidates change and lives more fully by their own values. If they wish, they may take up longer or more open forms of meditation. Samadhi, the classical peak of the path, is not a clinical target (Bennetts, 2022). It becomes a topic only if the client raises it and has a framework in which to place it.

The gates. Gate 1 asks whether the client is safe and steady enough for exploration. Gate 2 asks whether the client has the capacity and has given informed consent for deeper attention work. Both are judgements made by therapist and client together, not tests and both are revisited over time. Table 1 lists what to look for.

Table 1. Readiness gates

Gate	Main question	Signs of readiness	Signs to wait
Gate 1 (to Exploration)	Is the client safe and steady?	Tolerates moderate emotion; has one working calming skill; no acute crisis; stable relationship with therapist	Recent crisis; frequent overwhelm or shutting down; no reliable coping skill
Gate 2 (to Integration)	Can the client manage deeper attention work and do they want it?	Moves between activation and calm with some independence; observes experience without being swamped; understands the risks and agrees	Practice used mainly to avoid feelings; distress with eyes closed; discomfort with the tradition

5. Mapping the limbs to phases

Table 2 gives the proposed placement of each limb, its main therapeutic use and its main cautions.

Table 2. Proposed placement of the limbs

Limb	Main phase	Therapeutic use	Main cautions
Yama	Phase 2 (non-harming from Phase 1)	Values work, boundaries, self-compassion	Moralising; self-blame; bypassing feelings
Niyama	Phase 1 (routine), Phase 2 (self-study)	Structure, self-reflection, acceptance	Perfectionism; theistic wording needs a secular reading or consent
Asana	Phase 1	Body awareness, sense of agency, regulation	Trauma reactions to body focus; body-image problems; injury
Pranayama	Phase 1 (gentle forms)	Portable calming skill	Panic; breathing or heart conditions; breath-holding techniques
Pratyahara	Phase 2	Less reactivity, control of attention	Can look like avoidance or dissociation
Dharana	Phase 2	Focused attention, interrupting rumination	Intrusive material; frustration
Dhyana	Phase 3 (or late Phase 2)	Sustained awareness, stepping back from thoughts	Dissociation, distress; caution in psychosis-related conditions
Samadhi	Phase 3, only if raised by the client	A horizon of meaning, not a target	Striving for it; confusion with dissociation

Two features stand out. First, the ethical limbs come later than in the tradition. Talking about restraint, truthfulness and self-study assumes some emotional steadiness and an early focus on ethical rules may feel like judgement. Second, posture and breath come forward, because they are the most accessible routes to regulation (Ramirez-Duran *et al.*, 2025).

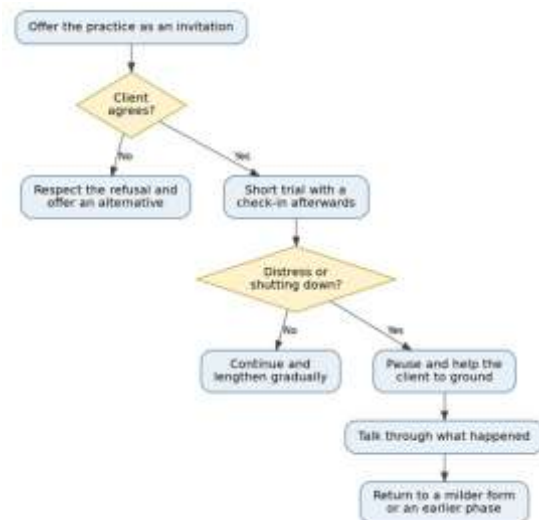
Delivering the model

Four principles apply in every phase.

- **Invitation over instruction:** Practices are offered as options that the client may change or decline.
- **Small steps:** Practices begin short and lengthen only as tolerance grows.
- **Plain language:** Sanskrit terms are optional. A limb can often be introduced by its purpose, such as "a way of slowing the breath".
- **Steady monitoring:** The therapist checks in after practices and treats a negative reaction as information, not resistance.

Figure 2 shows how these principles work within a single practice.

Figure 2. Decision flow during a practice



Movement is not one-way. Illness, loss, relapse or a hard session may send a client back towards stabilisation and this is expected. A client in the integration phase who loses a job, for instance, may return to breath and body work for several sessions (DiClemente & Crisafulli, 2022). The model is better pictured as a spiral than a ladder.

Propositions for testing

A conceptual model is useful only if it can be shown wrong. Table 3 lists seven propositions.

Table 3. Testable propositions

No.	Proposition
1	Clients who begin attention practices before learning a regulation skill will report more distress and drop out more often than those who learn regulation first.
2	Body and breath practices offered as invitations will improve later tolerance of exploratory work more than the same practices given as directions.
3	The ethical limbs will help more when introduced as reflective questions than as rules as and more in Phase 2 than in Phase 1.
4	A poor match between the limb used and the client's phase will weaken or reverse the expected benefit.
5	Structured clinical judgement of the two gates will predict adverse experiences better than diagnosis alone.
6	Therapists, who practise what they offer and are trained in contemplative safety, will follow the model more closely and see fewer adverse events.
7	Planned return to an earlier phase after a setback will be linked to better retention and outcome than pressing on.

Propositions 1, 2 and 4 suit randomised comparisons of different sequences and the rest suit mixed-methods, observational or single-case designs.

Practical decision rules

The following rules are starting points for discussion, not established guidelines.

1. When in doubt, stay in or return to Phase 1. Delay costs little, whereas premature exposure to demanding practices may cost a great deal.
2. Treat distress during a practice as a signal, not a test of resolve.
3. Defer deep attention practice for people with a history of psychosis, marked dissociation or unresolved severe trauma and during the acute phase of any serious disorder. A longer first phase is usually the better route.
4. Check body-related risks before introducing posture or breath work, including eating disorders, chronic pain, heart or lung conditions and pregnancy.
5. Ask what a practice is doing for the client. If it lowers awareness without changing how the client relates to experience, adjust it.
6. Stay within professional scope. Therapists should not pose as yoga teachers and yoga teachers should not offer psychotherapy.

Ethical and cultural considerations

Bringing a spiritual tradition into a clinical setting raises questions that a technical model can overlook.

Clients should be told that the practices come from a religious and philosophical tradition, that they can be used in a secular form and that they can be declined. Consent should include a plain account of possible difficulties, particularly where the therapist holds a position of authority (Doron *et al.*, 2025).

Critics have argued that moving contemplative practices into clinical and commercial settings can strip them of context and reduce them to stress-control techniques. Yoga is also not a single tradition (Crosswell *et al.*, 2024). A clinician should be honest about what is being borrowed and attentive to the client's own cultural and religious relationship to yoga. Some clients, especially those for whom yoga is a living religious practice, may prefer that it is not used in therapy, while others may welcome it as a familiar resource.

Discussion

The main contribution of this paper is a change of question. Earlier work asks what forms of integration exist. This paper asks which limb should be used, when and for whom. Answering that requires a sequence and the sequence proposed here departs from the classical one on purpose. The traditional order was built for people seeking spiritual liberation. Therapy has different aims and its first duty is to avoid harm.

The model borrows two habits from psychotherapy: staged treatment and attention to readiness. Its gates are judgements, not instruments, which keeps it usable in ordinary practice but leaves it open to inconsistency between clinicians. Turning the gates into measurable criteria is the most pressing task for research (Yıldız, 2026).

There is also a risk that a phased model is read as a rigid protocol. It is not meant to be. The phases overlap, clients move back and forth and the therapist's judgement and the client's choice outrank the model. Used well, it should give structure without removing flexibility (Center, 2025).

For training, the model suggests that safety and sequencing belong in the core curriculum, alongside supervised experience of the practices themselves. For research, it supplies testable claims, including the possibility that the order of practices matters in its own right, separate from their content. If the propositions are not supported, the model should be revised or dropped. That willingness to be wrong is what separates a framework from a preference (Samanta, 2026).

Conclusion

The model is conceptual and untested and its phases, gates and mapping rest on reasoned judgement that may prove wrong in places. Evidence on adverse experiences comes mostly from meditators not psychotherapy clients. Treating the limbs as separable loses something of a tradition in which they support one another. The three-phase structure is a simplification and the model was framed for individual therapy, so group settings may need adjustments.

The eight limbs can enter psychotherapy in many forms and the next question is how to choose among them. This paper proposes matching limbs to phases of treatment and releasing them through gates based on safety, capacity and consent. Body and breath come first, reflective and attention work follow and sustained meditation comes last with room to return whenever the client needs it. Whether the model holds is an empirical matter and the seven propositions are there to make it answerable.

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