

Melting the Fortress of Developmental Trauma: Integrating the Unintegrated Selves

by

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Abstract

This capstone will address the biological, psychological and spiritual dimensions of developmental trauma. Research suggests that the quality of the attachment relationship between a child and their caregiver influences and shapes the later adult's expectations of interpersonal and intrapersonal relationships (Wilkinson, 2017). This paper will outline the effects of unprocessed and unintegrated early relational trauma on an individual's mind and body. These effects relate to "a cracked architecture of self-regulation and resilience", attachment challenges, dissociation and fragmentation of self, and somatic repercussions (Heller & Lapierre, 2012). The capstone details the various ways those impacted by developmental trauma armour themselves in order to avoid further suffering and violation. Treatment strategies including right-brain-to-right-brain attunement, tracking sensations, and therapeutic touch will be considered as means to assist clients in renegotiating developmental trauma.

Keywords: developmental trauma, attachment, affect regulation, right brain, dissociation, fragmentation, attunement, armouring, somatic, body psychotherapy, therapeutic touch

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Acknowledgements and Dedications

I believe trauma can feel like the residue of the past, still alive in the present – haunting us and tainting each “new” encounter with that original charge, surfacing the once experienced emotions that we have tried to armour ourself against feeling ever since. That armour promises to keep us safe, but it also keeps us stuck, distant and only able to experience washed out emotions. Our connection to ourself and others may feel peripheral, almost as if we cannot fully embrace and receive. As many giants in this field have said before me, the journey of healing our trauma involves learning to surrender safely, to let go of resistance, and to gently and fiercely do it together. Melting the armour that once protected us is an act of bravery, so let us begin slowly... as we shall rebuild ourselves with softness, a strength that is tougher than armour, but gentle as can be, because it welcomes all parts of us to emerge.

I would like to acknowledge and dedicate this work to my family, my friends, my community, and the help of the universe. A special thanks to Ratha Chek, thank you for all the wisdom you teach. And, thank you Agata Burdziuk – I look forward to learning from and with you as I begin my journey in this life’s work. Thank you Ron Manley for your support and guidance in writing this paper, and thank you Bruce Hardy for being my second reader.

Lastly, I wish to dedicate the essence of this project to all of the inner children that have been wounded and continue to heal their intergenerational trauma. This journey is arduous, but we pave it together, with fierce compassion and gentleness.

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Chapter 1: Introduction

Introduction and Topic Overview

The vast spectrum of consequences related to developmental trauma are going to be explored and critiqued throughout this paper as a way to shed light on how “miscoordinated” interactions between a child and their primary caregiver can have long standing negative effects (Tronick, 1989, p. 113).

These chronic miscoordinated interactions, without successful repair attempts, have been observed by various researchers to have a devastating impact on children’s development and working model for attachment (Schoore, 2007; Tronick, 1989). For example, children who have experienced this consistent misattunement to their needs, experience difficulty in regulating their emotions and bodily sensations in their adult years. Research also speaks to difficulties with social engagement if children received chaotic cues and unreliable feedback from caregivers such as “angry faces, frozen expressions, aggressive body postures” but also received attuned and inviting social cues other times (Kain & Terrell, 2018, p. 158). A strong need to isolate in order to protect themselves from additional pain that reminds them of their original suffering, difficulty in connecting with themselves and others due to misinterpretation of behaviours and expressions, and a deep sense of meaninglessness are all symptoms of this misattunement and inadequate social tuning (Heller & Lapierre, 2012; Kain & Terrell, 2018; Schoore, 2007). More often than not, clients come into therapy not fully realizing that their current daily challenges with anxiety, depression, relationships, and identity can sometimes be traced to various survival strategies they learned as a way to armour themselves against additional neglect.

Purpose Statements

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The overarching intent of this capstone project is to better understand the relationship between developmental trauma and armouring. This will be accomplished through:

1. A review of applicable literature in order to highlight the varying ways in which this relationship can be illustrated through everyday experiences.
2. Exploring the nature of dissociative responses in the context of trauma as it interacts with developmental trauma.
3. A review of treatment strategies or helpful therapeutic interventions that therapists can consider using when working with clients with complex trauma. These interventions and various interdisciplinary concepts that speak to dissolving the layers of emotional body armour and dissociation are segmental dearmouring, attunement, tracking sensations, and therapeutic touch.
4. A workshop that intends to connect group participants to their inner child in order to facilitate greater compassion for vulnerable aspects of self that trauma may have disconnected them from.

In order to facilitate and guide the reader, the following research questions will serve as a framework: What is the connection between neglect and developmental trauma? How does developmental trauma impact the mind and body? Does the attachment relationship between the child and caregiver contribute to the later adult's working model for attachment and sense of self? How does mind-body armouring protect individuals and how does it simultaneously harm them?

Conceptual Framework

In this paper, the following theories will be used to provide a lens through which the research will be analyzed: polyvagal theory (Porges, 2011), attachment theory (Bowlby, 1969), and regulation theory (Schore, 2007). Polyvagal theory is a lens that is used in this paper because of the vagal nerve's connection to the autonomic nervous system. According to

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Dana (2018, p. 4), the autonomic nervous system serves as the foundation upon which our lived experience is built”. Particularly, the way people move through the world in terms of turning toward, backing away, sometimes connecting and other times isolating, is guided by the autonomic nervous system (Dana, 2018; Porges, 2011). In the context of developmental trauma, children’s nervous systems are considered to be shaped by their primary caregiver’s responses to their child’s biopsychospiritual needs (Eldredge & Cole, 2014; Schore, 2001). The caregiver’s ability to regulate their child’s hyperarousal and hypoarousal states shapes the child’s ability to self-regulate (Schore, 2001).

According to Yumbul et al. (2010), attachment theory explains how the quality of attachment between children and their caregiver affects the way they form bonds to other attachment figures, such as romantic partners, in their adult years. Bowlby (1969) developed an attachment model that describes various attachment styles that can develop between a caregiver and their child depending on patterns of interaction. When a child’s caregiver is available and responsive, or attuned and coordinated, the foundation for developing a “secure” attachment is possible for the child (Bowlby, 1990). The child is likely to become securely attached to their caregiver because they are confident that their caregiver will demonstrate availability, responsiveness, and helpfulness if they were to encounter adverse or frightening situations (Bowlby, 1990). A child may develop an insecure anxious attachment pattern when the child is uncertain of whether their caregiver will be available or responsive when seeking protection or comfort. The inconsistency in availability and responsiveness from a caregiver, without repair, is at the core of this paper and referred to as neglect (Schore, 2007). The last attachment style that Bowlby (1990) discusses is the anxious avoidant pattern where the child has little confidence that when they seek care, they will be responded to helpfully but rather expects misattunement. As a response, the child learns that their needs are

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likely to be unmet by others and consequently tries to become mostly reliant on their own self to meet their biopsychospiritual needs (Bowlby, 1990).

The theory of segmental dearmouring developed by Wilhelm Reich (1975) and bioenergetics theory created by Alexander Lowen (1975) will also influence this paper. Reich and Lowen both believed that the body armours against overwhelming feelings and sensations by contracting different areas in the body as well as maladapting through unhealthy breathing patterns and postural holdings (Herskowitz, 2001). When children experience caregiver neglect, psychosomatic implications are observed such as: muscular holding patterns, chronic dissociative or hypervigilant states, shallow or rapid breathing patterns, and disembodiment (Schmidt-Zimmermann, 2015).

Contribution to the Field

The value in undertaking this capstone project is to investigate the complex functions of the child-caregiver dyad and demonstrate the impact it has on human development. I intend to make a contribution to the psychotherapy community by outlining the biopsychospiritual components of neglect within the primary attachment dyad and its intrapersonal and interpersonal consequences throughout an individual's life. Additionally, I will present various literature related to the ways individuals who have experienced recurrent neglect adapted to their surroundings by not solely relying on autonomic survival strategies but also through the armouring of their bodies. In this project, I wish to demonstrate the multiple facets of developmental trauma and display the various mind-body adaptations individuals acquire as a way to continue existing in a world where they often feel unsafe in their bodies. Additionally, I would like to draw attention to the experience that individuals who have endured developmental trauma often report – a deep-seated fear of drowning in their emotions if they would allow themselves to feel all of their emotions. Through the literature review, I aim to discuss how attunement and coordinated interactions, tracking

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sensations, and therapeutic touch within a strong therapeutic alliance touches the edges of such warranted fears and can act as a salve for what feels broken and unsalvageable.

Reflectivity and Positionality

According to Warf (2010)

Positionality is the notion that personal values, views, and location in time and space influence how one understands the world. In this context, gender, race, class, and other aspects of identities are indicators of social and spatial positions and are not fixed, given qualities. Positions act on the knowledge a person has about things, both material and abstract. Consequently, knowledge is the product of a specific position that reflects particular places and spaces. (p. 2258)

I believe it is important to bring my social location and identity to light in order to acknowledge that most of my intersecting identities provide me privilege and advantage within the many systems of our Western society including the institution of academia. These very same identities influence and bias my understanding and interpretation of knowledge. My authorial-self positions as a cis-gender, White, middle-class, immigrant, and educated woman. I recognize that my identity (my social self) impacts my performance as a researcher (Walshaw, 2008). Additionally, I recognize that my position of researcher privileges me in knowledge construction and perpetuation of literature that is built upon studies involving primarily White, middle-class, North American individuals.

Positioning myself in this paper can also be tied with what drew me into researching this particular subject of developmental trauma. From a personal level, some of my own childhood experiences and development paved the road of inquiry. Therefore, my curiosity stems from my family dynamics as well as intergenerational dynamics that continue to persevere. From a broader perspective, my curiosity also emerged from interpersonal dynamics that I have observed through my life between myself and others, and between

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people generally. And, the more I observed, the more I wanted to discover the layers of interpretation of these observations. Additionally, I have always wondered how our past still affects our present decisions, beliefs, feelings, and thoughts. Through researching for this paper, I have come closer to understanding how the past can still be alive in the present, and various ways to heal from these wounds.

Definition of Terms

Activation of Sympathetic Nervous System (SNS)/Arousal System

This activation occurs to prepare us for action (Dana, 2008). The SNS responds to cues of danger and triggers the release of adrenaline, which fuels the fight-or-flight response (Schore, 2007).

Activation of Parasympathetic Nervous System: Ventral Vagal Pathway

The activation of this system helps us to respond to cues of safety and supports feelings of being safely engaged and socially connected (Porges, 2011).

Activation of Parasympathetic Nervous System: Dorsal Vagal Pathway

In contrast to the Ventral Vagal pathway of the parasympathetic nervous system, the dorsal vagal pathway responds to cues of extreme danger (Dana, 2008). It takes us out of connection, out of awareness, and into a protective state of collapse or freeze (Dana, 2008). When we feel frozen, numb, out of body, the dorsal vagus has taken control (Schore, 2001; Porges, 2011).

Armouring

A protective psychological attitude and muscular tension that occur as a result of overwhelming experiences (May, 2016, p. 40). Mind-body armouring develops to protect individuals from further psychological, emotional, physiological, and spiritual violation, pain, and challenges.

Attunement

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“Two basic dimensions of affect attunement – the caregiver’s concern for and receptivity to the infant’s affective experience, and the caregiver’s matching or mirroring of aspects of that experience such as intensity, timing and shape/contour. It is a form of perceptual and emotional engagement with another person characterized by mutual attention, empathy, and intersubjectivity” (Moenter, 2020, p. 1). A therapist uses attunement when they become aware of the client’s ongoing experience of safety and danger. Just as a caregiver is responsible for tracking their child’s affective states, the therapist can step in by identifying and reflecting the client’s experience through tone of voice, body postures, and gaze.

Bottom-up Processing

This term refers to how regulation or dysregulation in the nervous system impacts cognitions and emotions (Heller & Lapierre, 2012).

Capital “S” Self

Internal Family Systems conceptualizes the capital “S” Self as “the undamaged essence of a person that manifests qualities like acceptance, compassion, and clarity” (Schwartz, 2013, p. 808). This Self is can be seen as the original self underneath all the other parts of themselves and often have the eight C-words that characterize Self such as: courage, creativity, clarity, connectedness, confidence, calmness, compassion, and curiosity.

Co-regulation

The interactive process that begins in early life where the caregiver plays a critical role in shaping and supporting the self-regulation development of their child. Co-regulation varies because children and youth’s needs differ depending on which developmental stage they are in. For example, co-regulating in infancy looks like anticipating needs and responding to cues, providing physical and emotional comfort through speaking calmly and giving affection when the child is in distress or dysregulated (Murray et al., 2015).

Developmental Trauma

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Distinguishing developmental trauma from other types of trauma can be challenging. The Adverse Childhood Experiences (ACE) Study demonstrated that children exposed to certain environments, experiences, and family dynamics face increased risk of physical and psychological challenges as adults (Kain & Terrell, 2018). The ACE study correlates childhood neglect and abuse with the later development of disease and this has been shown to have the capacity to alter our genetic expression (Kain & Terrell, 2018).

Implicit Memory

The implicit branch of long-term memory stores information that is out of our conscious awareness and verbal experience (Heller & Lapierre, 2012). This information is said to constantly influence our functioning and includes the bodily memory of skills, habits, routines, and the memory of our emotional and relational responses (Heller & Lapierre, 2012). Implicit memory is non-conceptual and non-linguistic – therefore, techniques to access it are best used through bottom-up somatically-based approaches (Heller & Lapierre, 2012).

Interoception

Interoception is considered the 6th primary sense (Porges, 2011, p. 76-77) alongside the other 5 external senses (vision, audition, smell, touch, and taste). These 5 are not the sole source of stimulation directing the infant's behaviour, thoughts, and emotions. Interoception is the ability to sense internal states and bodily processes through interoceptors located on the heart, stomach, liver, and other organ cavity (this sixth sense is crucial to the infant's survival). The 6th sense represents a functional awareness, with both conscious and unconscious dimensions, of what is happening inside the body (Porges, 2011).

Pendulation

Pendulation refers to a person's innate primal rhythm expressed as movement back and forth from contraction and expansion, eventually opening up to more and more expansion

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(Levine, 2010). The skill of pendulation allows therapists to help clients move through difficult sensations into those of expansion and “goodness” (Levine, 2010, p. 80).

Self-Regulation

This is the term used to describe our ability to return in a timely way to baseline or the capacity to remain in the window of tolerance. Self-regulation can also be understood as the way we manage our emotional state and to calm ourselves during times of heightened emotion – when we become fearful, deeply sad, angry, or frustrated (Kain & Terrell, 2018, p. 67). But it can also describe our ability to listen to and tend to our needs in all the spheres – biological, psychological, emotional, and spiritual. Self-regulation is said to develop through interactions with caregivers (Murray et al., 2015; Schore, 2001).

Top-down Processing

This type of processing refers to how cognitive structures of the brain impact the emotional and instinctive systems of the body (Heller & Lapierre, 2012). Top-down can be seen as how our thoughts, judgments, and identifications affect how we feel and impact the nervous system’s capacity for regulation (Heller & Lapierre, 2012).

Outline of the Remainder of the Paper

The remaining chapters will address the various psychological and biological factors contributing to developmental trauma, along with the mind-body consequences, and the interventions therapists may want to use to facilitate healing.

Chapter two outlines research on the biopsychospiritual dimensions of trauma and the relationship between trauma and armouring. Dissociation as a survival strategy and response to trauma, and various treatment strategies for trauma are also addressed and critiqued. Lastly, chapter three outlines a workshop proposal aimed at helping individuals who have experienced developmental trauma connect with their Inner Child. The workshop will

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incorporate psychoeducation and various experiential exercises to help individuals contact and connect with their Inner Child in order to facilitate healing.

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Chapter 2: Literature Review

Relationship Between Trauma and Armouring

Biopsychospiritual Dimensions of Developmental Trauma

Attachment and Needs of Children. This portion of the capstone paper will begin by addressing the effects of children's exposure to attachment neglect on psychological and behavioural functioning (Crittenden, 2006). The following effects have a devastating impact on the development of children: maladaptive self-protective strategies, unintegrated cognition and affect resulting in a poor psychological balance, affect dysregulation, unstable core self, shame, and disconnection from self and others (Crittenden, 2006; Heller & Lapierre, 2012; Sharhi, 2013). According to Tronick (1989), healthy development is linked to the "experience of coordinated interactions" between the child and caregiver "characterized by frequent reparations of interactive errors and the transformation of negative affect into positive affect" (p. 112). On the other hand, adverse development relates to continual periods of "interactive failure and negative affect" (Tronick, 1989, p. 112).

As children, we are born completely dependent on our caregivers for our survival (Kain & Terrel, 2018). When a child's biological needs for safety, bonding, co-regulation and connectedness are neglected by caregivers, their development becomes compromised (Kain & Terrel, 2018; Heller & Lapierre, 2012). Parents and caregivers play an essential role in helping young children soothe their intense emotions (Kain & Terrel, 2018). This can be observed through findings that emphasize the importance of emotional communication between children and their caregiver (Tronick, 1989). If their needs do not get met, they cease to develop an internal working model suited for recognizing and meeting those needs as adults and their ability to self-regulate becomes compromised (Heller & LaPierre, 2012). Therefore, the quality and stability of the attachment relationship between the child and their

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primary caregiver shapes the individual's future expectations of what relating to self and others will look like (Wilkinson, 2017).

According to Schore (2001), the primary task of early development is the transfer of regulation from the external (i.e. relying on others to feel regulated) to the internal (i.e. developing the capacity to self-regulate) (Sidoli & Blakemore, 2000). When a child is supported by their caregiver in developing the ability to move toward internal regulation, they in turn are better able to process their environments and distinguish between real and perceived threats (Kain & Terrel, 2018). Since self-regulation is a learned process, the attachment-based interactions between a child and their primary caregiver are considered foundational in this learning. In fact, Eldredge and Cole (2014) stated that the caregiver lends their mature nervous system to assist the child in developing their own capacity for self-regulation. The lending of the nervous system can be seen as the process of attuning to or misattuning to a child's needs (Kalsched, 2020; Ogden & van der Kolk, 2006, p. xxii). For example, a child may hear a door slam loudly or become startled by a pet's sudden movement and more often than not, the child perceives these small disruptions as potential threats to their survival (Kain & Terrel, 2018). A "misattuned" or uncoordinated caregiver may not notice their child's distress or misunderstand the magnitude of the impact on the child's developing nervous system; therefore, they may fail to pick the child up to provide it physical comfort, and use soothing language to help calm the child's neurobiological fight-flight response (Kain & Terrel, 2018). Therefore, the caregiver was not able to help the child "process these vehement, life-threatening, intensely negative emotions" or help to regulate the "overwhelming bodily states" that go with them (Kalsched, 2020, p. 138; Kalsched, 2013). The caregiver's misattunement to the child's needs prevents co-regulation to occur (Fisher, 2017). If misattunement without repair is chronic and recurrent, the traumatized child learns that they must "process and contain these emotions and bodily states all by

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themselves” (Kalsched, 2020, p. 138). However, “the child is too small, vulnerable and overwhelmed to be able to do it alone so dissociative defenses do it for [them]” (Kalsched, 2020, p. 139).

Neurobiological research indicates that children are born with an attachment system that is activated when the child is in stress or perceives stress (Bureau, Martin & Lyons-Ruth, 2010; Schore, 2008). Continuing to use the example above, when the child’s attachment system was activated by the pet’s sudden movement, this system led the child to “proximity-seeking behaviours” – for example, crying – toward the caregiver who is most likely to provide comfort and protection (Bureau, Martin & Lyons-Ruth, 2010, p. 49). Since the caregiver presented as misattuned by reacting to the child’s expressions of emotions and stress inappropriately (i.e. not picking the child up or not being fully present to soothe the child back to homeostasis), the arousal regulating process was compromised (Schore, 2008). When the child’s sympathetic nervous system was activated through being startled, the caregiver’s miscoordinated interaction and what followed as a lack of interactive repair perpetuated the negative affective states to last for long periods of time. Research demonstrates that sustained early attachment ruptures caused by neglect and chronic miscoordination contribute to the formation of developmental trauma, which is considered to be the loss of regulatory capacity (Bureau, Martin & Lyons-Ruth, 2010; Schore, 2001, 2008, 2009). Tronick (1989) indicated that “seven-month-old infants of the most disengaged mothers show the greatest amounts of protest, and infants of the most intrusive mothers look away the most [and repeatedly engage in self-directed regulatory behaviours], and that the infants of the most positive mothers express more positive affect” (p. 116).

Attachment-related ruptures can be seen to facilitate the development of various strategies the child adopts in order to elicit their caregiver’s attention or to protect themselves (Crittenden, 2006). Toddlers may learn to inhibit or exaggerate displays of negative or

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positive affect if they have been severely punished, severely intruded upon, or unattended to (Crittenden, 2006; Tronick, 1989). For example, imagine a mother playing peek-a-boo with her child and after some time the child disengages and begins to use self-directed regulatory behaviours such as looking away and sucking their thumb in order to shift their emotional state during the peak intensity of the game (Tronick, 1989). If the toddler is ready to re-engage the mother they may turn back and look at the mother and if they are not ready, they may continue to disengage. If the toddler is not ready to engage and continues looking away and the mother elicits the toddler's attention continuously with no apparent engagement from the toddler, interactive error and miscoordination occur and the toddler's level of distress escalates (Schore, 2001; Tronick, 1989). The mother and toddler's affective communication "changes the emotional experience and behaviour of the other" (Tronick, p. 112). By protesting through the use of gestures, postures and vocalization, the toddler signals to the mother that she should be changing what she is doing. If this affective interactive exchange without repair is prototypical for the child and mother, the child may develop a strategy of turning away and becoming overly reliant on self-directed regulatory behaviours and less likely to solicit their caregiver (Crittenden, 2006; Tronick, 1989). According to research, "with the accumulation and reiteration of success and reparation, the infant establishes a positive affective core, with clearer boundaries between self and other" (Tronick, 1989, p. 116). Moreover, the infant is better able to "elaborate [their] other-directed affective communicative and self-directed regulatory capacities and to be able to maintain engagement with the environment in the face of stress" (Tronick, 1989, p. 116).

Schmidt-Zimmermann (2015) stated that children's needs during their developmental years include "connection, care, touch, movement and loving maternal regard" (p. 553). Research highlights the importance of the child's immediate environment as being a place that does not interfere with its "basic organismic rhythms" of contact, retreat, waking, and

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sleeping (Schmidt-Zimmermann, 2015, p. 553; Schore, 2009). Therefore, when a child is unhappy, they are able to cry and be comforted by caregivers, and when a child is angry, the child is accepted (Carleton & Padolsky, 2012). Attachment researchers propose that a child develops an attachment bond and an “internal working model of attachment” based on generalizations of their caregiver’s daily reactions to the child’s “proximity, comfort-seeking behaviours” and needs (Bowlby, 1969; Bureau, Martin & Lyons-Ruth, 2010, p. 49).

However, Crittenden (2006) argued that proximity is less important because the child’s attachment system prompts them to adopt strategies that ensure the availability of their caregiver. For example, a child may have to split off anger or armour parts of themselves in order to maintain the availability of their caregiver.

Bowlby’s pioneering attachment research concluded that the (co-)regulation of the child’s physiology is one of the major elements that occurs within the attachment process (Bowlby, 1969; Kain & Terrel, 2018). Schore (2001) emphasized the mutual interaction between the child and their caregiver, and “the child’s alarm signals the parent, who may also become alarmed, but who steps in to perform a nurturing function. The child’s transition to a more settled state will in turn influence the caregiver’s state” (Kain & Terrel, 2018, p. 70).

The Right Brain. According to Heller and Lapierre (2012, p. 6), the “cumulative effects of chronic early neglect and abuse adversely influence brain development and negatively impact the nervous system, endocrine system, and memory” (Kain & Terrell, 2018). Schore (2001) spoke on the biological dimensions of developmental trauma by highlighting the link between right brain hemisphere function, attachment and traumatic stress. The right brain’s critical period of maturation occurs within a child’s first two years of life and its development is stimulated by interactions with the primary caregiver since it contains the major circuitry for attachment and emotional regulation (Wilkinson, 2017; Schore, 2001, 2003). Therefore, the right brain’s functions are impacted by the attachment

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relationship and its development is structurally susceptible to and negatively affected by “prolonged episodes of intense and unregulated interactive traumatic stress” (Schore, 2001, p. 237).

Attachment research on the infant and caregiver dyad has emphasized the dominance of the right brain in the first twelve months of life and highlighted that the right brain enables only an “implicit or procedural registration of affective experience” (Eldridge & Cole, 2014, p. 83; Schore, 2003). In the first year of life, these exchanges are exclusively preverbal as “the mother’s mind enable[s] the infant’s mind, her right orbitofrontal cortex standing proxy for her infant’s until it is ready to come on line” (Carvalho, 2002, p. 159). The child’s right hemisphere develops through exchanges and communications between the child and their primary caregiver (Lenzi, 2008, p. 1124; Schore, 2003). Furthermore, the foundation of these exchanges is based on the caregiver’s ability to understand the child’s needs and “on the imitation of the infant’s facial expressions...this promotes a social dialogue that influences the development of the infant self” and their eventual ability to self-regulate (Lenzi, 2008, p. 1124).

Data from an MRI study supported the theory that the right hemisphere is more involved than the left hemisphere in emotional processing (Lenzi, 2008). Therefore, the infant is “matching the rhythmic structures of the mother’s [regulated or] dysregulated arousal states” (Schore, 2008, p. 758). This “synchronization is registered in the firing patterns of the right brain regions” which are dominant for survival (Schore, 2008, p. 758). If the primary caregiver’s nervous system was often dysregulated and misattunement without interactive repair was chronic, the infant’s reaction was of overwhelmingly high arousal and terror (Carvalho, 2002). This combination of high arousal, contraction, withdrawal, and freeze creates “systemic dysregulation that affects all of the body’s biological systems”,

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leaving the child and later adult with a narrowed range of resiliency (Heller & Lapierre, 2012, p. 7).

Urban (2003) underlined the primary factors determining trauma as “the nature of the external event” or environment, “the nature of the internal world” and “how the two interact” (p. 172). Menakem (2017) further describes trauma by proposing that it can be a response to a “long sequence of smaller wounds” or a response to anything that the body experiences as “too much, too soon, or too fast” (p. 57). As small children, we need our caregivers to provide us a sense of safety, as well as the necessary feedback to help us differentiate between safety and threat – both internally and externally (Kain & Terrell, 2018). When the child’s social environment is chaotic and lacks consistent feedback about safety versus threat, the child’s and later adult’s ability to differentiate between these two possibilities becomes compromised (Kain & Terrell, 2018). Their social “safety system” is negatively impacted and consequently primes the child to tune more acutely toward the assessment of danger and limits their ability to recognize safety (Kain & Terrell, 2018, p. 72). This leads us to the question of, what do adults who have experienced developmental trauma have in common?

Effects of Developmental Trauma in Adults. This could be a paper itself, but the main effects include the following: “interoceptive dysfunction”; a “cracked architecture of self-regulation and resilience”; the need to use interpersonal distance to feel safe (isolation); shame; compromised energetic boundaries leading to being “flooded by internal and environmental stimuli”; and a sense of meaninglessness (Heller & Lapierre, 2012, p. 8). Kalsched (2020) described that adult clients who have experienced early trauma experience both a “powerful urge toward life and an equally powerful force against life” (p. 138). Herman (1992) and van der Kolk et al. (2005b) arranged symptoms of developmental trauma into categories describing the dysregulation of the following areas: unmodulated affect and impulse control, attentional and dissociative problems, self-perception, difficulty negotiating

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relations with others, somatization and systems of meaning (Carleton & Padolsky, 2012).

However, complicated adaptations to prolonged developmental trauma do not only disrupt a person's ability to regulate their emotions and autonomic functions, but also impacts the body and its health and expressions. Ogden (2006, p. 3) particularly outlined the following adaptations: "affect posture, breathing, freedom of movement, heart rate, respiration musculature and gestures" (Caldwell, 1997; Lowen, 1975; May, 2016; Reich, 1975; Schmidt-Zimmermann, 2015).

Embodied Analysis: A Reichian Model of Emotional Body Armouring

According to Bureau, Martin and Lyons-Ruth (2010)

Traumatic events of the earliest years of infancy and childhood are not lost but, like a child's footprints in the wet cement, are often preserved lifelong. Time does not heal the wounds that occur in those earliest years; time conceals them. They are not lost, they are embodied. (p. xiii)

As the quote above alludes to children's wounds being concealed by time and stored within their bodies, Wilhelm Reich too explained that "unprocessed, unintegrated experience such as physical or psychological trauma can be held in the body...and create disruptions and imbalances in the body structure, movement and flow of energy" (Bass, 2014, p. 153; Reich, 1975). Reich contributed to the field of body-oriented psychotherapy by highlighting the correlation between mental states, emotional states and body postures as well as bringing forth the embodied basis of trauma (Heller & Lapierre, 2012; Sletvold, 2011). A student of Reich's named Alexander Lowen conceptualized the "endless circle of reciprocity" of mind and body by outlining that experience (i.e. increasing fear) affects somatic expression (i.e. increasing panic breathing), whereas somatic expression (i.e. increasing panic breathing) in turn affects experience (i.e. increasing fear) (Friedman & Glazer, 2009, p. 379).

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Pret (1999) also emphasized this feedback loop by describing emotions as residing both in the body as “informational chemicals” as well as existing in “another realm” beyond the physical; the one we experience as “feeling, inspiration, love” (p. 763). According to Pret (1999), the emotions move back and forth, “flowing freely between both places”, therefore they connect the physical and nonphysical (p. 763). The circulation of the “biochemicals of emotion” occurs in the body, giving a physical reality to emotions (Pret, 1999). Lowen (1975) addressed emotions as having a threatening quality when they are linked to traumatic experiences and because they have the potential to activate autonomic responses, they can generate fear in people. Therefore, individuals may suppress these emotions by developing “chronic muscular tensions that do not allow any flow of excitation or spontaneous movement to develop in the relevant areas” (Lowen, 1975, p. 65). According to Lowen (1975), people often suppress their fear because it has a paralyzing effect and their rage because it feels too dangerous. They will also “suppress their awareness of pain because they cannot support that pain” (Lowen, 1975, p. 65). Lowen (1975) contextualized this act of suppression or “restrictions on living” as not being “voluntarily self-imposed” but as a “means for survival in a home environment and [Western] culture that denies body values” (p. 43). Being “armoured, distrustful, and enclosed is second nature in our culture” (Lowen, 1975, p. 50; Heller & Lapierre, 2017).

Armouring. Reich believed that addressing developmental trauma had to first be elucidated through “recognition, understanding, and loosening of barriers that he named [*body*] *armour*” (May, 2012, p. 40; Reich, 1975; Rosin, 2012). The armour can be described as a protective psychological attitude and muscular tension reflecting the body component (May, 2016). Reich described armouring as the “first line of defense against threatening feelings” (Friedman & Glazer, 2009, p. 379). He explained in detail how body armouring leads to the “freezing, restriction, distortion, or displacement of psychic and vital functions”

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(Schmidt-Zimmermann, 2015, p. 554); “Armouring represents the physiological anchoring of emotional repression” (Herskowitz, 2001, p. 24). Reich (1975) believed that traumatic childhood experiences are alive for the adult only insofar as they are “anchored in a rigid armour which continues to operate in the present” (p. 787). He emphasized that “each muscular constriction contains the history and meaning of its origination...” (Schmidt-Zimmermann, 2015, p. 555).

Body armour is structured in muscular “segments” comprising organ and muscle groups that have functional contact with one another and are capable of accompanying each other in the expression of emotion (Herskowitz, 2001; Reich, 1975). However, many segments can collaborate in a larger expression of emotion (Herskowitz, 2001). For example, one individual may express anger by firing an angry look at the source of anger; in another instance, the same person may express a deeper anger with not only their eyes but also a roar through a snarled mouth and clenched fists (Herskowitz, 2001). Although in this particular example the individual is expressing their anger, many people do not due to a multitude of factors such as social and self-pressure to conform and keep a calm appearance, a history of abuse or neglect due to expressing emotions, or other negative experiences that condition people to withhold and suppress their emotions (May, 2016). As a result, people develop a holding pattern (armour) in the body “as a holding together, a defense against a fear of falling apart” (May, 2016, p. 40).

Armour Segments. The first segmental arrangement of the muscular armour is called the “ocular” segment (Reich, 1975). In the armoured ocular segment, there is a contraction and immobilization of almost all the muscles of the eyes, eyelids and forehead (Reich, 1975). The individual usually presents with expressionless or bulging eyes, rigid eyelids, chronically knit brows or a lack of emotiveness in their forehead (Herskowitz, 2001; Reich, 1975). Therefore, the eyes are blocked from expressing a range of emotions and people with this

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armouring have often lost the ability to cry; they are armoured from expression and may appear mask-like (Reich, 1975). Consequently, the individual who experiences armouring in this segment may struggle with dissociation and depersonalization as well as clumsiness in thinking, moving, and concentration (Herskowitz, 2001; Reich, 1975).

The second segmental arrangement comprises the “oral” segment (Reich, 1975, p. 760). This segment contains the entire musculature of the chin, pharynx, occipital, and the muscles around the mouth (Herskowitz, 2001; Reich, 1975). According to Herskowitz (2001), when the oral segment is free of armouring, it moves freely in expressing silly or angry faces, and collaborates with the eye segment in expressing “wide-eyed, open mouthed fear” (p. 48). Dissolving both the ocular and oral segment through touch-work and various expressive exercises helps to release the suppressed impulse to cry (Reich, 1975).

Reich (1975) referred to energy as being bound in the chronic muscle contractions (armour) and through the liberation of these armoured segments, the energy begins to flow and discharge through “wave-like” movements through the individual’s body. The individual’s body initially responds to the discharging of energy through shivers and the sensations of pins and needles. As the discharge continues, the individual may experience spasms in the deep musculature of the segments and struggle between the “impulse of the [energetic] current and the [fresh] armour block” (Reich, 1975, p. 764). A fresh armour can surface when there is more freed energy to discharge than the client is capable of discharging (Reich, 1975). The therapist can help the client manage the anxiety that they may be experiencing through tracking of sensations, the felt-sense, and touch, therefore, soothing and moving the client through new counter-armour that may emerge (Reich, 1975).

The third segment is comprised of the deep musculature of the neck and the sternocleidomastoid muscles – the “Neck” segment (Reich, 1975). By assessing the movement of the Adam’s apple, a therapist may be able to tell when a client’s impulse to cry

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is unconsciously and literally “swallowed” (Reich, 1975). The emotions are suppressed through the act of swallowing, therefore, Reich (1975) believed the gag reflex needed to be liberated.

The fourth segment contains the “chest” (Reich, 1975). This segment can be subdivided to include all the intercostal muscles, the large chest muscles, the shoulder muscles and in-between the shoulder blades. Clients often experience shallow breathing which Reich (1975) believed to be “the most important instrument in the suppression of any kind of emotion” (p. 769). The attitudes of being “self-contained” or “self-controlled” are the “major manifestations of the chest armour” (Reich, 1975, p. 769). Consequently, clients complain of a “knot” in their chest, which Reich saw as a place that “heartfelt crying, sobbing and unbearable longing” originates from. Herskowitz (2001) emphasized that when newborns are separated from their mothers for an extended period of time, “increasing and persistent muscular tension in the chest area” forms and is accompanied by “inadequate breathing” (p. 53).

The fifth segmental arrangement comprises the “diaphragm” and the organs below it (Reich, 1975). This segment can expand and contract freely when the client’s chest armour loosens and they can breathe consciously and deeply (Reich, 1975). The loosening of the fifth segment can cause a contraction in the middle of the abdomen – the sixth segment. This segment consists of the rectus and transversus abdominus and the lower sections of the back muscles (Reich, 1975). According to Reich (1975), the sixth segment is the easiest segment to dissolve. The last segment is referred to as the “pelvic” armour (Reich, 1975). Symptoms of pelvic armour display as irritability of the bladder, numbness of the genitals, and dulled sensations (Reich, 1975).

Developmental Trauma and Armouring: Why does the Body Armour?

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According to May (2016), people armour because they may be fearful of falling apart if they allow themselves to feel. Clients who have experienced developmental trauma often point to an area above the umbilicus where they feel “dependency needs” and pains around “issues of existing” – May (2016) used the term “umbilical longing” to describe this phenomenon (p. 42). When the client cries, they release suppressed emotions and they begin to slowly relax their internal holding and the muscle tension relaxes from the body (May, 2016).

People who have endured early childhood trauma become “disembodied” in order to escape the emotional pain (Schmidt-Zimmermann, 2015). The core of the “genuine spirit of the child is cocooned inside the fortress, all the while becoming isolated, alienated, and cut off from life and interactions with others” (May, 2016, p. 40). The child’s psychobiological pattern of defense becomes activated in order to protect the vulnerable self (Kalsched, 2013).

According to Kalsched (2020), developmental trauma can lead to powerful dissociative responses which “injures [the person’s] capacity to feel” (p. 136). Heller and Lapierre (2012) discussed how the child succumbs to dissociation when previous responses of protesting and expression of anger do not get met with a proper response from their caregivers: “if the infant’s need is not appropriately responded to, the infant escalates the demand, ramping up the sympathetic branch, protesting the lack of response, and finally erupting in anger” (p. 11). When anger and other forms of protest are ineffective, not possible or dangerous, children maladapt through “resignation, shutting down the angry protest and the need itself” and move into the freeze response (Heller & Lapierre, 2012, p. 12). The survival strategy of freeze develops as an “attempt to protect the attachment relationship by foreclosing core expression, anger, aggression, and ultimately authenticity” (Heller & Lapierre, 2012, p. 11).

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According to Herskowitz (2001), infants discover that holding their breath can momentarily decrease the intensity of the huge emotional pain they are feeling. If the child's caregiver often neglects or misattunes to the child's needs, perhaps the child may develop an armoured chest by early childhood in order to diminish the experience of further pain (Herskowitz, 2001). The "unfulfilled needs" and "unresolved feelings" are bound in the body and nervous system "in the form of undischarged arousal", which is held as "physical tension" or as "collapsed states" (Heller & Lapierre, 2012, p. 16; Herskowitz, 2001; Reich, 1975). The armoured adult may conduct their life in such a way that they can avoid exposure to pain and limit their exposure to life's experience (Herskowitz, 2001). According to Heller and Lapierre (2012), the child's life force became distorted as they maladapted to "environmental failure" (p. 9). Thus, if the now adult is unable to process their developmental trauma due to a multitude of social and personal factors, they are likely to misattune to their own child's attachment-based expression of needs and pain (Herskowitz, 2001). This cycle has the potential to create the conditions for intergenerational trauma.

Dissociation as a Survival Strategy

Genesis of Dissociation and Developmental Trauma

Neurobiology of Dissociation. Numerous studies have demonstrated that childhood trauma particularly alters the maturation of the limbic system, producing neurobiological alterations including "affective instability, inefficient stress tolerance, memory impairment and dissociative disturbances" (Schore, 2007, p. 753; van der Kolk, 1996). According to Schore (2007), traumatic stress in childhood could lead to "self-modulation of painful affect by directing attention from internal emotional states" (p. 762). The right brain hemisphere is not only significant for regulating affects but also for attention, pain processing, and is considered the "locus of the emotional or corporeal self" (Schore, 2007, p. 760). Therefore, the right-brain strategy of dissociation (i.e. disconnecting from bodily self, emotions, and

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others) represents the ultimate defense for blocking emotional pain (Heller & Lapierre, 2012; Schore, 2003, 2007).

Schore (2007) established that dissociation reflects the inability of the “right brain implicit self-system” to recognize and process external stimuli, and on a “moment-to-moment basis integrate them with internal stimuli” (p. 761). This respective “failure of integration of the higher right hemisphere with the lower right brain hemisphere induces an instant collapse in both subjectivity and intersubjectivity” in the short term and a blockade of emotional development in the long term (Schore, 2007, p. 753). Consequently, a person’s thoughts, feelings, behaviours, memories, and/or events and experiences “do not seem to belong to [them]” (Boon, Steel & Van Der Hart, 2011, p. 44). Experiences feel as if they have a “not me” quality and this dissociative sensation has a deep impact on the person’s sense of self (Alayarian, 2019, p. 594; Schore, 2007).

This “sudden implosion of the implicit self and the rupture of self-continuity” can facilitate an inner division of the personality (Schore, 2007, p. 761; Van der Hart, Nijenhuis & Steele, 2006). Schore (2002, p. 32) indicated that dissociation reflects a “severe dysfunction of the right brain’s vertically organized systems that perform attachment, affect regulation, and stress modulating function, which in turn impair the capacity to maintain a coherent, continuous and unified sense of self” (Wilkinson, 2003, p. 32). The collapse of the implicit self is “signaled by the amplification of the parasympathetic affects of shame and disgust, and by the cognitions of hopelessness and helplessness” (Schore, 2007, p. 760).

Aspects of Dissociation. According to Mosquera and Steele (2017), there are three distinctive categories of experiences that are referred to as “dissociation”: division of the personality (Van der Hart, Nijenhuis & Steele, 2006), symptoms of depersonalization and derealisation, and detachment (spaciness, thinking of nothing, dorsal vagal shutdown). Boon, Steel and Van der Hart (2011) claimed that the dissociative parts of the personality are not

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separate identities or personalities in one body, but rather “parts of a single individual that are not yet functioning together in a smooth, coordinated, and flexible way” (p. 45).

People who dissociate often attest to suddenly being unable to feel an emotion or sensation in their body (Boon, Steel & Van Der Hart, 2011; Schore, 2007); they may sensationally be experiencing emotional numbness. However, another part may be experiencing too much, for example, overwhelming feelings (Boon, Steel & Van Der Hart, 2011). Therefore, Schore (2007) concluded that people who have experienced developmental trauma tend to dissociate in order to escape overwhelming emotions associated with the traumatic memory or its trigger, and that dissociation can be interpreted as “representing a nonverbal response to the traumatic memory” (p. 760). Allen and Coyne (1995) highlight that initially, children may have used dissociation to cope with the neglect they were experiencing, however, they continue to dissociate for the purpose of “defend[ing] against a broad range of daily stressors, including their own posttraumatic symptoms, pervasively undermining the continuity of their experience” (p. 620). In this vein, Schore (2002, p. 32) described dissociation as a “severe dysfunction of the right brain’s vertically organized systems that perform attachment, affect regulation, and stress modulating function, which in turn impair the capacity to maintain a coherent, continuous and unified sense of self” (Wilkinson, 2003).

When an individual experiences their familiar surroundings as unfamiliar, strange, unreal, or dream-like, symptoms of dissociative “derealization” are often at play (Boon, Steel & Van Der Hart, 2011). These symptoms of unfamiliarity and estrangement from familiar places undermine a person’s sense of continuity regarding their sense of self and their environment (Boon, Steel & Van Der Hart, 2011; Schore, 2001). Moreover, the symptoms of derealization may be related to “parts of the personality that are living in trauma time”, that

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is, individuals confuse the present with the past and struggle to experience the present as real or familiar (Boon, Steel & Van Der Hart, 2011, p. 50).

On the other hand, “depersonalization” refers to “feeling estranged from yourself and your body” or experiencing watching oneself from outside one’s body (Boon, Steel & Van Der Hart, 2011, p. 48). Similar to derealization, depersonalization often involves dissociative parts of the personality (Alayarian, 2019). Schwartz (2021), developer of somatic Internal Family Systems theory (IFS), claimed that different parts of one’s personality have at some point in time helped the individual survive situations that were devastating and overwhelming to one’s system. These “protector” parts of one’s personality developed to prevent any pain or emotions from past hurts to overwhelm the individual’s system (Schwartz, 2021, p. 88). Although IFS claims that all parts have a positive intention and came about out of necessity, these “protector” parts tend to use the body and its energies through behaviours that may not be serving the client’s wellbeing, such as dissociation, addictive behaviours, muscle tension, chronic illness and many more (Schwartz, 2021, p. 87).

In Reich’s (1975) “Character Analysis” theory, he proposed that individuals survive trauma and neglect by armouring their soma against future violations. Schwartz (2021) similarly noted that “if the protector part’s job is to contain, suppress, hold, and control, it may use the muscles and fascia” (p. 89). Schwartz (2021) explained how protectors manage the energies by affecting the joints, pelvic and respiratory diaphragms, throat and jaw, shoulders, and lower back (p. 89). Additionally, they may activate the endocrine and nervous systems toward fight, flight and freeze (dissociation) to protect the individual from connecting with the vulnerable parts and wounds conceived through early relational trauma (Schwartz, 2021).

Dissociative Splitting: Psychosomatic Armouring as Protection Against Further Violation

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Schore (2007) emphasized the importance of viewing dissociation as not only a cognitive response to trauma but also as a “lack of integration of sensorimotor experiences, reactions, and functions of the individual and [their] self-representation” (p. 760). “Somatoform dissociation” can thus be summarized as the major mechanism for “strangulations of affect” and against “bodily hurt” (Schore, 2001, p. 237). Alayarian (2019) addressed the function of dissociation representing “the immune reaction of repressing pain” which “creates a state of neutrality, a sense of existing behind a wall, where life seems to be going on beyond reach, somewhere out there” (p. 594). The pattern of repressing pain through dissociation primes the individual to shift into dissociation at lower levels of stress and it makes it challenging to exit the state of “conservation-withdrawal” (Schore, 2001, p. 237). During these intervals, the individual is shut down to the external and internal environment, therefore, they are closed and “impermeable to attachment communications and interactive regulation” (Schore, 2001, p. 237). If this pattern is a basal state, the individual may tend to avoid emotional contexts that are particularly novel and have more “complex affective information” – this avoidance prevents emotional learning to occur, and “prevents any advances of right brain emotional intelligence [and growth]” (Schore, 2001, p. 237).

Armouring Through Splitting. Childhood trauma is often experienced as a “psychic catastrophe” and dissociation represents “detachment from an unbearable situation”, “the escape when there is no escape”, “a submission and resignation to the inevitability of overwhelming [and uncontained], psychically deadening danger”, and as last resort strategy to protect one’s self (Schore, 2007, p. 757). As a result, this shutdown state is a “primary regulatory process” an individual uses throughout their life when stress arises (Heller & Lapierre, 2012; Schore, 2007). As the individual passively disengages to conserve energy, their physiology changes as well, their heart rate, blood pressure and respiration decrease, whereas “pain numbing and blunting opiates are elevated” to produce an analgesic sensation

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(Schore, 2007, p. 757). Individuals who have experienced childhood trauma “learn to alter an unbearable reality” and continue to function by suppressing their thoughts, minimizing and denying their experiences, and disengaging attention from both inner and outer worlds (Herman, 1992, p. 381). According to Urban (2003), if a child experiences only occasional rather than chronic misattunement from their caregiver, they may respond with a successful act of “healthy” dissociation (p. 171). The child may use dissociation for the “conscious redirection of attention away from pain” which “dispels traumatic experiences from consciousness that can otherwise overwhelm psychic structure and functioning. Therefore, this allows the individual to “process and digest the occurrences within a safe psychic space” (Urban, 2003, p. 171). This method of suppression, minimizing, and disengagement can often be seen as a way to redirect from pain in individuals who fall more on the avoidant spectrum of attachment styles (Bowlby, 1990).

Heller and Lapierre (2012, p. 9) stated that when an individual denies their experiences as an attempt to manage trauma, the individual uses a regulation strategy referred to as fragmentation and therefore “sacrifices unity to save [themselves]” (Fisher, 2017; Schore, 2007). Van der Hart et al. (2004) suggested dissociation can be understood as an organized division of the personality. This division consists of the “insufficient integration” of two or more systems of ideas and functions that “constitute personality” (p. 907). Although dissociation tends to create barriers of communication between different parts of the self, Bromberg (2001) suggested that the psyche does not begin as an integrated whole, but in fact it is considered nonunitary in origin. The psyche continues as a “multiplicity of self-states that maturationally attain a feeling of coherence which overrides the awareness of discontinuity” (Bromberg, 2001, p. 244). The IFS model proposes that humans are a collection of subpersonalities with sub-minds and self-states referred to as parts (Fisher, 2017; Schwartz, 2013).

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According to Schwartz (2013), various trauma therapies propose that the existence of subpersonalities and their fragmentation is a psychopathological consequence of traumatic experiences. However, the IFS model advises against this theory of parts by highlighting the function of parts as “innately valuable components of a healthy mind” (p. 808). Additionally, IFS claims that “a fully functioning inner system requires these sub-minds, each with their own perspectives, talents, and resources to function well” (Schwartz, 2013, p. 808). Therefore, Schwartz (2013) declared that trauma does not create these parts, but rather “forces many of them out of their naturally valuable functions and healthy states, into protective and or extreme roles and makes them lose trust in the leadership of the Self” (p. 808).

When a child endures relational trauma through the developmental years, Fisher (2017) claimed that it is safer for the child to “adapt using a system of selves rather than becoming a fully integrated self” (p. 25). This pattern of “dissociative compartmentalization” can be understood as “trauma-related procedural learning” (Fisher, 2017, p. 25). For example, when a child is experiencing abuse by attachment figures, the only source of safety and protection simultaneously “becomes the source of immediate danger” (Fisher, 2017, p. 26). In this circumstance, the child is caught between two conflicting sets of instincts because the attachment action system drives the child to seek proximity and safety from their caregivers while the defense system drives the child to protect themselves through fight, flight, fawn, or dissociate before they get too close to the terrifying caregiver (Fisher, 2017; Schore, 2001). For children who live in unsafe environments, dissociative splitting is “necessary to manage this irresolvable struggle between two such strong emotional and physical drives” (Fisher, 2017, p. 25).

The attachment system and the defense system assist neglected children in adapting to changing internal and external demands (Fisher, 2017). For example, children are expected to

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be socially engaged with their peers at school while equally engaged in learning (Fisher, 2017). However, at home, a child's parent may oscillate between being withdrawn or neglectful, nurturing some of the time and violent at other times (Fisher, 2017). Therefore, a child's ability to "rapidly shift from state to state as needed to deal with different threats" is essential to surviving this environment (Fisher, 2017, p. 26). Responding with different states such as playfulness, hypervigilance, or panic is critical in order to protect themselves from dangerous conditions and unmet biological needs. According to Fisher (2017, p. 25), these different drives or systems can be labelled as "part(s) of the personality" (Schoore, 2001). Neuroscience emphasizes the brain's propensity to "develop neural networks that fire together and encode complex systems of traits or systems that represent aspects of our personalities or ways of being" (Fisher, 2017, p. 25; Schoore, 2001). Therefore, as an adult, the same child may demonstrate signs of "internal splitting" through the discrepancy of how they show up at work versus at home (Fisher, 2017). The adult could be highly functioning at work when "stimulated by positive triggers" while "regressing at home or in personal relationship because of the trauma triggers associated with those environments" (Fisher, 2017, p. 27). To give meaning and dignity to fragmentation, it is important to note that "each part represents a way of surviving dangerous conditions" and a way to approach self-protection in compromising environments.

Treatment Strategies: Renegotiating Developmental Trauma

Right-Brain-to-Right-Brain Connection: Witnessing and Attuning to Client and Self

According to Bromberg (2006)

When the therapist is able to relate to each aspect of the patient's self in terms of its own subjectivity, each part becomes increasingly able to coexist with the rest and in that sense is more subjectively linked to the others. The linking of self-states

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necessarily increases a person's sense of wholeness, but the active ingredient in treatment that makes this possible is human-relatedness. (p. 27)

Therapeutic Alliance. The therapeutic alliance can be summarized as representing a function of the extent to which the client and therapist are able to maintain a strong affective relational bond, which is continually negotiated within the dyad, as they collaborate on the tasks and goals of therapy (Safran & Kraus, 2014). Parallels have been drawn between the "affective coordination" seen between mother and infant and those that occur within the therapist-patient exchange (Safran & Kraus, 2014, p. 2). Through a process of mutual regulation, "[caregivers] help the child attain nontraumatic state transitions by appropriate interactive responsiveness to the child's subjectivity" (Bromberg, 1994, p. 244). Through a child's developmental process, an attuned caregiver must "smooth out awareness of the changes and transitions across states of consciousness" (Bromberg, 1994, p. 244). If a client did not receive much coordinated interactions, how can we as therapists step in and help repair and smooth out awareness of self-states (Schoore, 2007)?

Attachment communications of those who have experienced trauma are "implicit, affective and nonverbal" (Schoore, 2007, p. 762). Neurobiological research has determined that implicit, non-verbal affective communication occurs "right-brain-to-right-brain" (Schoore, 2007, p. 763). Since the right brain is dominant for the recognition and spontaneous expression of emotions, as well as the home of the implicit self, at the core of the therapeutic alliance is the emotional communication between therapist and patient (Schoore, 2003, 2009). The essence of the therapeutic relationship can be seen as "unconscious affect regulation expressed in rapid nonverbal emotional communications at levels beneath conscious awareness" (Schoore, 2007, p. 762). So, the question begs, how can therapists relate empathically to unexpressed emotions (Maroda, 2005)?

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According to Schore (2007), “when the therapist gives up trying to understand the patient (shifts out of left brain) and instead creates (right brain) attempts to know his patient through the ongoing intersubjective field they are sharing that moment, an act of recognition (not understanding) takes place” (p. 763). This focused right hemisphere dominant interaction is essential for working with clients who have experienced developmental trauma because a child’s early life is a predominantly right-brained, embodied experience (Wilkinson, 2017). Additionally, much of the child’s early interactive experience is considered to be held in the adult self’s implicit memory (Schutz, 2005; Wilkinson, 2017).

The Benefits of Attunement. In therapeutic co-created contexts, it is essential that the clinician is attuned to the client’s ongoing experience of safety and danger, especially to the client’s hyperarousal and hypoarousal affect (Schore, 2007). Enactments are seen as opportunities to focus on dissociative defenses, negotiate the enactment, and potentially expand the client’s affect tolerance (Safran & Kraus, 2014; Schore, 2007). Wilkinson (2014) proposed that affective engagement in therapy “enables new emotional learning to occur”, and that such learning has the potential to bring about a profound change in the client’s inner patterning of relating intrapersonally and interpersonally (p. 539). Moreover, the therapeutic relationship acts as an interpersonal resource and a means to develop trust and safety as well as beginning the process of “attuned pendulation toward and away from the activating traumatic material in order to lead to the completion of the blocked fight/flight/freeze response” (Eldredge & Cole, 2008, p. 87).

Schore (2007) stated that attuning to the client and self requires a therapist’s closest attunement to the “unacknowledged affective shifts in [their] own and the client’s self-states” (p. 763). The practice of attuning to clients assists therapists in identifying and imitating the client’s sensitivities in “gesture, movement, voice and speech tonality, gaze, posture, and muscular expressions” (May, 2016, p. 41). Bass (2014) intensified the act of attunement by

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introducing a phenomenon called “symbiotic communication” in which the therapist feels in their own body some aspect of the client’s subjectivity (p. 162). For example, “when I am able to hold that experience and my own subjectivity at the same time, and distinguish them, that is my therapeutic double consciousness” (Bass, 2014, p. 162).

For many people, the anticipation of closeness and attunement “evokes implicit memories of hurt, betrayal, and abandonment” (Ogden & van der Kolk, 2006, p. xxv).

Although feeling seen and understood helps most people feel calm and in control, there is always the possibility that it may precipitate a reliving of the trauma, especially for individuals who have experienced abusive intimate relationships (Ogden & van der Kolk, 2006, p. xxv). For these clients, trust may take time to establish and it is essential to help them create a sense of control by working on developing their physical boundaries and exploring ways of regulating physiological arousal (Ogden & van der Kolk, 2006).

Additionally, therapists can help clients in exploring and identifying previous experiences of safety and competence in order to activate memories of what it feels like to experience pleasure, joy, power, and other strengthening emotions (Ogden & van der Kolk, 2006). Since individuals who have endured developmental trauma have often experienced inconsistency, unpredictability, and privacy invasion, it is suggested that therapists provide supportive interventions such as “clarification, affirmations, empathy, holding, and containing patients’ painful states of mind” (May, 2016, p. 40).

Repair Through Attunement. In the ongoing intersubjective field, misattunements, collisions and repairs are all part of the therapeutic process and considered common (Dana, 2018; Wilkinson, 2017). According to Safran and Kraus (2014), repairing ruptures such as strains, tensions, and breakdowns in the therapeutic alliance fosters growth and insight in both client and therapist. The therapist is tasked to create the conditions for clients to become progressively safer in tolerating potential flooding of affect (Wilkinson, 2017). Therefore, as

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their threshold for autonomic hyperarousal increases, the less the need for dissociative processing because the client is developing a greater capacity to process the full complexity of the relational experience in the moment (Wilkinson, 2017). During this process, ruptures can occur between therapist and client that may be stemming from misattunement and the loss of co-regulation (Dana, 2018). Misattunement is said to begin when “one person’s autonomic state shift triggers a corresponding shift from the other person” (Dana, 2018, p. 124). According to Tronick (1989), healthy mutual coordination between caregivers and children happens about 30% of the time, with ruptures and active repair happening the rest of the time. Dana (2018) superimposes this dynamic over the therapeutic relationship and proposed that the goal is not to avoid these “normal experiences” but to “create a habit of tracking the ruptures and making repairs” (p. 124). Therapists must facilitate reconnection after a rupture has been made by addressing the moment when the work became “too big of an autonomic challenge” for the client, take responsibility for the misattunement, and name it for the client (Dana, 2018, p. 126). Since many clients who have experienced developmental trauma have a history of relational ruptures without repair, the unexpected moments of rupture within the therapeutic relationship are “opportunities to offer clients a disconfirming experience, an experience of repair” (Dana, 2018, p. 126).

Repair can be approached differently by therapists depending on the type of alliance rupture (Muran, 2017). In “withdrawal ruptures”, clients tend to respond to misunderstandings and challenges in the therapeutic relationship by turning to silence, offering minimal responses to questions or engagement, or becoming very agreeable and compliant to the recommendations from the therapist (Safran & Kraus, 2014, p. 3). Therapists can approach this type of rupture by facilitating exploration of “interpersonal fears and internalized criticisms” that prevent the client from expressing negative feelings (Muran, 2017; Safran & Kraus, 2014, p. 3). In contrast, “confrontation ruptures” may present through

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the client's expression of "anger, resentment, or dissatisfaction with the therapist" (Safran & Kraus, 2014, p. 2). In response, the therapist may empathically engage with the client as a means to facilitate the expression of "disowned feelings of disappointment, hurt, vulnerability, and the need for nurturance" (Muran, 2017; Safran & Kraus, 2014, p. 3). Through this engagement with more complex emotions and encouragement to express such emotions, the therapist helps the client discover that neither they nor their relationships will necessarily be ruined by aggressive and complex emotions (Muran, 2017).

Attunement of Parts

When a therapist becomes attuned to a client's parts, Schwartz (2013) proposed that the goal is not to eliminate the parts but rather to "help them relax into the knowledge that they no longer have to be so protective" (p. 808). Fisher (2017) emphasized the positive evolutionary function of parts as a means to survive or persevere. In helping clients link different parts to the survival response that drive their actions and reactions, clients' experience of automatic shame and self-doubt become challenged (Fisher, 2017). For example, "automatic passivity and the inability to say no feels less shameful when connected to a young child submit part whose sense of safety is tied to pleasing others..." (Fisher, 2017, p. 26).

Attuning to a client's parts and helping clients attune to their parts encourages their parts to surface in the present moment (Schwartz, 2013). This process can begin by asking the client to select an emotion or belief that is interfering in their life that they wish to get to know or change (Schwartz, 2013). If a client responded with wishing to change their shyness, the therapist can link this cognitive thought to the client's body by asking the client to locate the shyness in their body and then asking them how they feel toward the shy part (Schwartz, 2013). Furthermore, the therapist can ask the client to find parts of them that hate their shyness and begin to negotiate an open space so the client can un-blend from these parts and

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facilitate the client's Self to emerge with curiosity and acceptance for all the parts residing within them (Schwartz, 2013). According to Schwartz (2013), parts fear the consequences to the larger system or to themselves if one part takes over, therefore they often fight for influence. Helping clients identify key inner players and facilitating acceptance of parts serves to de-polarize parts and create integration (Schwartz, 2013).

The Tracking of Sensation Through Somatic-Based Therapies

Several traumatologists such as Peter Levine and Pat Ogden have developed clinical techniques to work with clients who have experienced significant developmental trauma that aim to "enable the release of blocked responses to trauma that are encoded somatically" (Eldredge & Cole, 2008, p. 79). According to these traumatologists, the blocked and subsequent storage of the trauma response is neurophysiologically determined and located in the body (Eldredge & Cole, 2008). Therefore, the trauma is most readily reached through "attending to the body experience of both patient and therapist" (Eldredge & Cole, 2008, p. 79). Bass (2014) similarly proposed this attendance to the body of client and therapist through the term double consciousness that was discussed in the last section.

A primary focus on the "sensate" experience of the client, rather than focusing on the cognitive features of experience is said to enable the completion of a blocked response to trauma (Eldredge & Cole, 2008). According to Heller and Lapierre (2012, p. 269), the practice of felt sense allows us to "form meaning from bodily experiences" and is considered essential to integrating top-down and bottom-up processing. In fact, "felt sense perceptions bring together the awareness of our body's reactions concurrently with emotional responses and thoughts, and the combined experiences, each belonging to a different order of being, allow us to make meaning of our internal world" (Heller & Lapierre, 2012, p. 270). It is important to help clients become aware of their moment-to-moment internal experience because often tracking the felt sense is not a common practice (Heller & Lapierre, 2012).

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Ogden and van der Kolk (2006) proposed that many children and adults who have experienced trauma struggle with the capacity to utilize their emotions as guides for effective action. Since emotional feelings are said to arise from internal bodily sensations, these clients may experience an activation of emotions but they lack the ability to recognize and verbally identify what they are feeling and sensing physiologically (Garfinkel & Critchley, 2012; Ogden & van der Kolk, 2006). As a result, these individuals experience a disconnection from their needs as well as interoceptive dysfunction (Porges, 2011; Kain & Terrell, 2018).

According to Heller and Lapierre (2012), “on the somatic level, to access the felt sense is to retrieve the knowledge and wisdom implicit in bodily experience” (p. 270). On the mind level, “it is a process of developing a capacity for sustained, focused attention that supports relaxed, nonjudgmental awareness so that internal processes, both psychological and physiological, can truly be heard and tended to” (Heller & Lapierre, 2012, p. 270). May (2016) suggested that individuals who have suffered early developmental trauma become “disembodied in order to escape the emotional pain” (p. 43). Past experience of trauma is often embodied and re-enacted in present physiological states and action tendencies such as breath, gestures, sensory perceptions, movement, emotion, and thought (Ogden & van der Kolk, 2006, p. xxiv). A therapist can make contact with the client’s body through directing the client’s awareness to sensation, breathing, changes in posture, and direct touch (Levine, 2010; May, 2016). Moreover, therapy can be a place where clients learn to become acquainted with observing the “ebb and flow of internal experience, mindfully noticing whatever thoughts, feelings, body sensations, and impulses emerge” (Ogden & van der Kolk, 2006, p. xxv). As a result, individuals learn that it is safe to not only have feelings and sensations but also that it is natural for them to oscillate in response to internal and external stimuli (Eldredge & Cole, 2008; Levine, 2010). Therefore, clients begin the journey of

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understanding themselves less from mental knowing and more from organic, embodied knowing (Newman, 2014).

Attuned Touch and Segmental De-Armouring To Welcome The Body Back

According to Heller and Lapierre (2012), adults who have suffered early childhood trauma often experienced a lack of healthy, appropriate, nurturing touch during their developmental years. In fact, skin to skin contact is considered to be our earliest experience of co-regulation outside of the womb (Kain & Terrell, 2018). Touch research demonstrates that healthy touch during a child's early development helps to develop an individual's ability to "notice cues regarding [their] own experience of regulation" such as settling, the pleasure of feeling well-fed, and a sense of safety (Kain & Terrell, 2018, p. 454).

Before discussing various intentions for using therapeutic touch, it is essential to note ethical considerations of therapeutic touch (Caldwell, 1997; Heller & Lapierre, 2012). Heller and Lapierre (2012) described touch as a complex therapeutic intervention "imbued with cultural conventions, gender-sensitive issues, and veiled power games" (p. 271). Touch can sometimes trigger implicit emotional experiences that can quickly flood and overwhelm clients (Heller & Lapierre, 2012). Therefore, it is critical that therapists acquire touch training and thorough touch history of clients who consent to being touched (Caldwell, 1997). For example, therapists can engage clients in conversations surrounding the client's history of touch during their developmental years in terms of reporting the touch they received, the touch they provided, and touch that they witnessed (Caldwell, 1997). Additionally, therapists can encourage clients to be curious about the feelings that arise from being touched (Caldwell, 1997). In the same vein, therapists should continuously assess their own motivations for using therapeutic touch moment by moment (Caldwell, 1997).

The use of therapeutic touch can be rooted in various conscious motives such as mirroring, de-armouring, and containment (Caldwell, 1997; McNeely, 1987). According to

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McNeely (1987), a client may benefit from being mirrored in pushing or pulling against, dancing with or screaming with to help clients recognize connection over alienation.

Mirroring can be seen as providing support, especially for people have never had their assertiveness or other forms of expressions reflected and supported (McNeely, 1987). De-armouring the body's segments through light touch to deep massage can help surface "certain images and memories, both positive and negative, [that] are so imprisoned in body tissue that they may never appear" in talk therapy until released through touch (McNeely, 1987, p. 131). Although most touch motivations provide some sense of containment, the sole intention of containment touch can look like physically holding a client who is reliving grief from early trauma for the purpose of providing them enough co-regulatory support to stay in the pain of the experience (McNeely, 1987). Kalsched (2020) would describe this act as a way to "restore the injury of the capacity to feel" because one is allowing oneself to fully experience the pain of that past experience in the present (p. 142).

Heller and Lapierre (2012) discuss a case where attuned touch was regarded as "an antidote to [the client's] dissociation" (p. 248). Being touched helped the client "feel the surface of her skin and literally locate herself in time and space" (Heller & Lapierre, 2012, p. 248). Somatoform and psychoform dissociation can create a sense of having a lack of an integrated image of one's body and its boundary as well as struggling to inhabit one's body (Heller & Lapierre, 2012; Schore, 2007). In the case, the therapist began the session by asking the client to identify an area of their body that they perceived as wanting attention. When the therapist began touching that area, the client could start their journey in paying attention to the body and its relationship to emotions, memories, and the self (Heller & Lapierre, 2012). Moenter (2020) emphasized the importance of the clinical application of attuned touch to help individuals who have experienced developmental trauma and who often feel a sense of disconnection from their bodies and environments. Since touch is considered

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to be at the foundation of relational experience, being touched, held and comforted by an attuned therapist allows clients the opportunity to repair early developmental ruptures and increase their self-regulation abilities (Heller & Lapierre, 2012; Moenter, 2020).

Summary

Overall, it is important to note the implications of developmental trauma in a client's presenting concerns. Tronick (1989) proposed that adverse development relates to continual periods of "interactive failure and negative affect" between the child and their primary caregiver (p. 112). Clients often seek therapy to address concerns that they may not see as rooted in or linked to past interactive ruptures in their first relational experiences. In their current reality, clients may report feeling routinely triggered, numb, anxious, depressed and disconnected from themselves and others. Additionally, they may struggle with processing deeper, intense emotions (Kalsched, 2020, p. 138). Therefore, the therapeutic alliance can nurture a dynamic where past miscoordinated interactions can be explored through present attuned and coordinated interactions. The therapist can facilitate an environment where the client develops a wider capacity to explore the spectrum of emotions through felt-sense and attuned therapeutic touch. As a result, the client can better integrate fragmented aspects of self that were once necessary for survival and containment, but no longer serve the client in their daily life. The therapist can help the client become aware of these fragmented aspects of self by linking them to various survival strategies, and collaboratively nurturing strategies that serve the client's wellbeing.

Limitations and Future Implications

While much of the research used in this paper contributes to understanding the various impacts of developmental trauma on individuals, I would like to note the implications of universalizing such findings. Azar (2010) reported that people from Western, educated,

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industrialized, rich, and democratic (WEIRD) societies represent as much as 80 percent of study participants, but only 12 percent of the world's population. Therefore, if we are a part of these Western societies and inhabit a white, educated body, can we be more critical on how the research applies to unrepresented people instead of assume that there is little variation across human populations? Additionally, can the academic community and education system create further awareness and accessibility to researchers and study participants that are representative of non-western perspectives, values, and norms? I am curious to seek further knowledge on the development of humans through lenses outside of WEIRD societies. Henrich, Heine and Norenzayan's (2010) findings suggested that members of WEIRD societies, including young children, are amongst the "least representative populations one could find for generalizing about humans" (p. 61).

I would also like to bring awareness to the fact that almost all studies contributing to this paper referred to a child's primary caregiver as being their mother. Although this can be assumed as a norm in most cultures, I believe that consistently assuming a child's primary caregiver is their mother excludes the possibility of a child being raised by other gendered or non-binary folk, or LGBTQ+ parents. As a result, further misrepresentation and a lack of research on human development outside of the normalized heteronormative family dynamic creates a gap in literature and in the minds of researchers, readers, and society as a whole. Therefore, it is important to represent caregivers that are not cis-women mothers in order to foster developmental frameworks that are inclusive of all family constellations.

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Chapter 3: Discussion

Research has demonstrated that children who have experienced trauma are susceptible to developing a specific worldview that incorporates their sense of betrayal and pain (van der Kolk, 2005a). Therefore, they may “anticipate and expect the trauma to recur” and are shown to respond to even minor stresses with hyperactivity, aggression, defeat, or freeze (van der Kolk, 2005a, p. 11). Being constantly on guard, these children and future adults attempt to organize their relationships around the expectation or prevention of abandonment or victimisation (van der Kolk, 2005a). To protect and defend themselves against future suffering, individuals try to forget those painful experiences (Hanh, 2010). When an individual connects with the experience of suffering, they may feel that they cannot bear it. As a result, they may attempt to repress their feelings and memories deep down (Hanh, 2010). Therefore, it may be that many adult individuals who have experienced developmental trauma have not dared to face the child within for many decades (Hanh, 2010).

According to Carr and Hancock (2017), effectively addressing developmental trauma can look like enabling a person to “regain a sense of safety in their bodies” and helping them to complete the unfinished past by “overcoming the fear of confronting their helplessness and shame, their fear of traumatic memories, and the fear of involvement of life itself” (p. 3). In this workshop, I use psychoeducation and experiential exercises to help participants feel safety within their bodies and address the fear that often accompanies feeling emotions. My goal is to facilitate an inner bonding of the participants’ Adult aspect of their personality, their external action-oriented, rational left-brain self, to their Inner Child, the vulnerable, soft, feelings-oriented right-brain self. I believe this is essential because research proposes that part of the trauma work is “restoring our childlike selves”, for example, our “vulnerability, intuitiveness, sense of wonder, imagination, innate wisdom, and ability to feel our feelings” (Paul, 1992, p. 35). This childlike self has not aged or changed with our growing adult

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experience, however, trauma impacts one's ability to connect with this aspect of self (Paul, 1992). Therefore, I plan to facilitate this workshop in order to help individuals tap into their childlike self, or their Inner Child.

Workshop Details

This workshop is called "Connecting With Your Inner Child" and it is designed for folks who have experienced developmental trauma, or identify with having experienced a challenging childhood and feel they have lost touch with their inner child, or anyone who wishes to develop a deeper connection to their inner child. I provide options for participants to label their inner child self in other ways if they do not resonate with the term inner child. Other options can include the emotional self, the vulnerable self, the intuitive self, the tender self, the wise self, the feelings-oriented self, or any other name participants most resonate with (Hanh, 2010). I consider options to be essential because I believe people can have greater access to the vulnerable aspects of self when they have choice in its' name.

The workshop is 180 minutes with a few 15 minute breaks, and participants must be at least 19 years of age to attend. Because of the deep emotional nature of this workshop and the potential for re-traumatization, there will be a strong suggestion for participants who wish to sign up that they have a therapy session booked during the week of the workshop in order to debrief and process their experiences. Additionally, in order to ensure that any safety concerns are addressed, I will obtain written consent from participants in order for me to follow-up with their therapist, if necessary and appropriate, regarding their experiences in the workshop. The workshop will offer plenty of information and psychoeducation on distinguishing the inner child self and the adult self as well as various experiential exercises such as:

- Opportunities for each individual to reflect on their inner child self
- Discover how their inner child vocalizes

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- Visualizing a place that participants feel safe in for the purpose of engaging their inner child, and
- Re-parenting the inner child if they feel wounded

A large aspect of this workshop is to facilitate reflection and engagement between participants as a means for folks to share their feelings and experiences, to learn from each other, and to normalize and relate to one another's experiences. The deeper intention of this workshop is to facilitate a space where people feel safe enough to let their guard down at least a bit more before they arrived, and allow their inner child to step into the space in order for their adult self to bond with their inner child. This act of softening to one's tender self will hopefully encourage each participant to soften to each other's tender selves thereby evoking healing in community. Creating a space of coordinated interactions interpersonally and intrapersonally in the present moment touches upon missed childhood experiences of attunement (Tronick, 1989). As a result, the workshop intends to address adaptations to trauma and current day threats such as shame, isolation, and dysregulation by providing a safe space where folks are invited to actively share or to witness and engage in a silent way.

Workshop Introduction

Prior to diving into the content of the workshop, I will share my background and credentials, intersecting identities, land acknowledgement, and passion for doing and facilitating inner child work, especially related to developmental trauma. Thereafter, I plan to outline the components of the workshop such as psychoeducation on distinguishing the inner child self and the adult self as well as various experiential exercises. I will then transition into outlining the significance of brainstorming guidelines that function to create a safe and personalized container for participants to engage in. My intention is to facilitate a discussion where each participant feels that they can participate in the creation of the culture of the container.

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Introductions and Creating Container Culture

After I introduce myself and the workshop, I encourage participants to introduce themselves popcorn style and contribute 1-2 guidelines or expectations that they have regarding interactions within the container. While the participants share their expectations, guidelines or needs, I proceed to write them down on a whiteboard if the workshop is facilitated in person or in the chat box if it is offered through an online platform. Once folks are finished sharing their guidelines, I highlight the importance of each participant's needs and expectations as contributing to the formation of our container. I then provide two of my expectations surrounding inclusion of all people and mindfulness around not sharing details of participant's trauma in order to prevent re-traumatization.

Resourcing

As discussed in Chapter 2, individuals who have experienced developmental trauma can have nervous systems that are highly attuned to changes in the external environment and internal environments (Shahri, 2013). As a result, individuals can become hijacked into various survival strategies that may create intense emotional and physiological dysregulation. Therefore, I invite participants to be mindful of their emotional capacity during the workshop and consider their own internal or external resources that provide soothing and emotional regulation if they notice themselves feeling charged, out of body, spacey, or anxious and agitated. In case people do not have resources or have not considered resourcing, I also suggest and demonstrate the following resources to experiment with and take into their life when they notice themselves feeling unbalanced:

- Placing one hand on the heart, and the other hand on the belly and noticing how those areas rise and fall with each breath (Levine, 2010; Moenter, 2020)
- Touching a soothing object such as a soft blanket or a pet and noticing what happens to the level of activation in the body (Moenter, 2020)

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- Firmly planting your feet on the ground and imagining roots growing from the bottom of your feet, through the foundations of the building and into the earth
- Feeling the chair or couch or floor hold your weight and allowing yourself to be held, feeling the touchpoints meeting the chair or couch or floor (for example, back leaning against the couch)
- Placing a weighted blanket on your legs to ground and notice any changes (Moenter, 2020)
- Rubbing your palms together until you create heat, then placing your hands over your eyes and feel the warmth on your skin
- Stand up and raise your arms to the ceiling on the inhale, and bring them to your side and bend down to touch the ground on the exhale. Repeat a couple of times to create movement
- Tapping your left and right arm, your left and right leg, your collarbone and chest to facilitate energizing or discharging of energy
- Visualizing a time where you really enjoyed doing something, starting to notice any sensations in the body, taking a moment to be with it and feel it and appreciate the joy

Break – 15 minutes

Workshop: Connecting to the Inner Child

Find your word...

I invite participants to find a comfortable sitting position with the option of closing the eyes or gazing gently in front of them. Beginning by taking a deep breath in through the nose and deep exhale through the mouth. Allowing the crease between the brow to soften, relaxing the jaw. Softening the shoulders by pressing them down and away from the ears. Lastly, I guide the participants to feel a thread pulling them up from their spine while also allowing gravity to hold their muscles. Once the participants appear to be relaxed, I invite

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them to intuitively feel into a word that embodies their connection with their inner child, tender self, etc. I inform them that the word can represent a color, sensation, image, or anything that comes into their consciousness. For example, the word could be warmth, softness, emptiness, sun, earth, green, instinct and so on. For a few minutes, I allow silence for participants to explore and identify a word, then gently bring participants back into the room. I then open up the room for anyone that would like to share their word. After sharing, I encourage the participants to hold on to their word throughout the workshop.

Experiential Exercise: Congruence of Child and Adult Selves

To begin exploring the relationship with the inner child, I ask participants to recall a time in their life that they felt conflicted about something and took an action that opposed what their instinct or intuition wanted. For example, something that caused them to be split between what they think they should do or feel and what they felt they wanted on an instinctual, emotional level (Paul, 1992). When they took a decision that felt incongruent in their thoughts, feelings and actions, I encourage them to explore what that was like. “What sensations are you noticing as you are reflecting on this time? What emotions are surfacing? Any images?” I then encourage participants to share 1-2 words that characterised their inner experience as they reflected.

Subsequently, I invite participants to reflect on a time that they felt congruent in their thoughts, feelings, and actions – a time that their intuition and their rational self was aligned. Again, I encourage participants to notice how that sense of congruency feels for them. “What sensations are you noticing as you are reflecting on this time? What emotions are surfacing? Any images?” I end this experiential exercise by asking them to share 1-2 words that characterized their inner experience during this exercise.

Psychoeducation: Who is our Inner Child?

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According to Hanh (2010), our inner child represents our vulnerability, intuitiveness, sense of wonder, imagination, innate wisdom, and the ability to feel our emotions. Childhood trauma, consistent life challenges, and Western society systems impact our connection to this vulnerable part of ourselves (Fisher, 2017). If our primary caregiver was not able to help us as children to process overwhelming emotions or help us to regulate the “overwhelming bodily states” that go with these emotions, we became conditioned to process these vehement emotions and bodily states on our own (Kalsched, 2020, p. 138). However, children are “too small, vulnerable and overwhelmed to be able to do it alone so dissociative defenses do it for [them]” (Kalsched, 2020, p. 139). Therefore, we may have never learned how to approach our vulnerable parts of self safely. Therefore, we may have pushed and continue to push our vulnerability into the shadows, hoping that we can have the control over ourselves and others that we did not have as children. This soft, vulnerable, feelings-oriented, concerned with being rather than doing self can be called our inner child (Paul, 1992). Our inner child may be wounded and casted into the shadows by our Adult Self as a way to protect that vulnerable self from further neglect. However, when we abandon our feelings or disconnect from them, it may temporarily protect us, but this disconnection can also create inner turmoil and the unrest we experience as discontentment (Paul, 1992).

Psychoeducation: Who is our Inner Adult Self?

The Adult part of our personality can be seen as the left-brain, analytical, rational, conscious mind (Hanh, 2010; Paul, 1992). The Adult Self takes action and sometimes forgets to lean into experiencing moments (Paul, 1992). Furthermore, the Inner Adult is the logical thinking part of us that has collected knowledge through our years of experience in the world – the Adult Self is learned (Paul, 1992). It is the “choice maker regarding intent and actions”, it is always the Adult that chooses our actions, as it often is in families (Paul, 1992, p. 38). The Child within cannot take actions on its own behalf, for example, they cannot cook meals,

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earn money, provide shelter, call a friend and so on. Paul (1992) claims that “taking action on behalf of our Inner Child is the job of the Adult” (p. 38). However, it is important to note that acting on behalf of the Child does not mean that the Adult indulges every request from the Child, instead it tries to nurture and support both aspects of self (Paul, 1992).

Inner Bonding and Distinguishing Voices

When the Adult Self and the Inner Child are at war, we experience disconnection from ourself and others, as well as inner turmoil. Therefore, how can we unlearn the ways we interact with our vulnerable self or needed to learn in order to survive neglectful circumstances and begin bridging our Inner Adult with our Inner Child? How can we learn behaviour that is loving and nurtures and supports our own and others’ emotional growth (Paul, 1992)? How do we connect the two selves? Before we further reflect on uniting them, I believe it is essential to give voice to the two selves. Therefore, I open up the space for participants to reflect on examples of how their Adult voice sounds like and how the Child voice may communicate. I give the participants the option of sharing what they have reflected on and then provide a few examples and ensure that these examples are just examples and that they may not represent individual experiences. Learning to decipher our Adult voices and our Child voices can create more clarity in our inner worlds and help us understand our needs, and how to better meet those needs.

Break – 15 minutes

Interacting With the Inner Child

To begin the process of interacting with our Inner Child, it is essential that we listen to them with compassion (Hanh, 2010). Sometimes, the wounded child within us needs all of our attention and it needs to be embraced tenderly and reassured that we will not leave them unattended (Hanh, 2010). We can include our inner child by inviting them to join us in some of our activities. For example, when you climb a beautiful mountain, invite your child within

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to climb it with you (Hanh, 2010). When you contemplate the sunset, enjoy a delicious meal, or sip on your favourite warm beverage, invite your inner child to enjoy it with you.

Forming a connection with your inner child also involves talking to them. We can invite our inner child to come with us into the present moment and begin to offer them a sense of protection. You may wonder how we can talk to the child in a way that helps them feel safe. A place to start can be to take the child's hand and acknowledge their suffering (Hanh, 2010). We then may begin to understand that many of our current desires are the continuation of our original desire to be safe (Hanh, 2010). Therefore, when we offer a nurturing and reassuring place for our inner child to express themselves (and their pain), it helps to expose the original fear from childhood to the light of awareness (Hanh, 2010).

Contacting the Inner Child

In the last part of the workshop, I gently assist participants into a visualization where they can meet their Inner Child and begin to form a relationship with them or enhance their current bond. I invite participants to make any adjustments before settling into stillness and choose between closing their eyes or gazing gently in front of them. I encourage them to connect to their breathing, allowing their face and shoulders to relax, with sit bones gently sinking into the chair. I give participants a few minutes to tune into their body and connect with their breath and then ask them to imagine a place where their Inner Child may feel safe to meet them. This place may be inside or outside, in the forest, at the beach, in the desert, in the mountains, near a river, at the core of the earth, on a cloud. What does it look like, sound like, smell like? It is important for this place to resonate with you and your Inner Child.

When you make contact with your Inner Child see if you can allow kindness, compassion, patience, and curiosity to create energy and a filter of communication between you and them. Provide your Inner Child the space to show you their tenderness and vulnerability through words or actions. If memories surface, allow them to slowly pass by,

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but begin to feel into those tender emotions that they may leave behind. Gazing into your Inner Child's eyes, feel if it is okay to invite them into your present moment. If it feels right, hold their small, warm body in your arms and slowly allow the Inner Child's body and self merge with yours, as if they were moving into your heart space. That is where your Inner Child naturally lives. Allow yourself in this moment to feel the wholeness that may emerge from sensing both your Adult Self and Inner Child residing in you. I then allow space for the participants to bond with their Inner Child.

Sharing, Feedback, and Closing of the Container

After a few minutes, I slowly bring participants back into the room. I encourage them to take a few minutes to ground back into their bodies using a resource. Subsequently, I open up the room for anyone to share their visualization experience or ask any questions about it. After, I ask the participants if they have any comments or questions about the workshop as a whole and invite them to provide any feedback regarding what they found most helpful and additional information that they wished they learned. I inform participants that if they wish to share their feedback further, they will have the opportunity to do so in the feedback form that will be sent out a week after the workshop. I wrap up the workshop by providing an optional exercise of writing a letter to their Inner Child to facilitate further connection and bonding if needed. In the letter, the participants are encouraged to acknowledge their Inner Child's presence and reassuring them that they wish to acknowledge and nurture their wounds. After a letter or two to the Inner Child, notice if the Inner Child has something to write back!

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