Embodiment-based Psychotherapy: Applications for Adverse Outcomes of Child Sexualized Assault

by

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Abstract

This capstone project explores the long-term neurobiological and relational impact of childhood sexualized assault (CSA) and outlines how embodiment-based therapies can support adult survivors. The purpose is to highlight that effectively addressing the impacts of trauma requires including the body in the healing processes. The key adverse outcomes identified were attachment trauma, a restricted or inflated sense of relational entitlement, revictimization, complex posttraumatic stress (CPTSD), borderline personality features, fragmentation, and substance use. This paper examines the clinical applications of embodiment-based interventions to address the outcomes of CSA, including Accelerated Experiential Dynamic Psychotherapy (AEDP), Sensorimotor Psychotherapy, Somatic Experiencing, and Trauma-informed Stabilization Treatment (TIST). These modalities can offer a non-pathologizing way to somatically address the long-term neurobiological impact of CSA.

Keywords: childhood sexualized assault (CSA), attachment trauma, sense of relational entitlement, revictimization, bottom-up approach

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Chapter One: Introduction

Overview of Research Topic

Child sexualized abuse (CSA) is an interpersonal trauma that can have significant implications for quality of life in adulthood. CSA was estimated to have been experienced by eight to thirty-one percent of girls and three to seventeen percent of boys worldwide (Brenner et al., 2021; de Jong et al., 2015; Downing et al., 2021; Gewirtz-Maydan & Godbout, 2023). These statistics are even harder to digest when considering that many accounts of CSA are unreported and consequently not represented within these numbers. Underreporting seems to be even more extreme among men as the experience of CSA conflicts with an unhealthy societal standard of masculinity which does not allow for emotional or physical vulnerability. These unhelpful masculine ideals often do not align with how we conceptualize victimhood (Birgas et al., 2021; Downing et al., 2021; Elliott et al, 2004; Maciel, & Basto-Pereira, 2020; Shen & Soloski, 2022; Viliardos et al., 2023).

The experience of CSA can result in a variety of adverse outcomes into adulthood including, anxiety, depression, complex posttraumatic stress disorder (CPTSD), chronic pain, and the use of unhelpful coping mechanisms such as substance use (Birgas et al, 2021; Brenner et al, 2021; Ensick et al., 2021). Further, due to childhood being a sensitive developmental period the experience of CSA often creates significant disruptions in the survivor's attachment system (Dimitrova et al., 2010; Labadie et al., 2018). The sense of safety and trust that is established in early life between a child and their caregivers is essential for wellbeing. The type of attachment style an individual experiences with their primary caregivers in childhood will drastically impact the development of their capacity to emotionally regulate. It further will inform their internal working models which shape their beliefs about themselves, the world, and future relationships in deep-rooted ways into adulthood. Interpersonal traumatic experiences can disrupt an

individual's fundamental sense of safety and trust. This can have detrimental impacts on their subsequent relationships resulting in the person experiencing a pervasive sense of isolation and disconnection (Bowlby, 1969; Herman, 2015; Medley, 2021a).

CSA is characteristic of a significant attachment trauma. The experience of an attachment trauma can foster adverse outcomes for the survivor, specifically, an inflated or restricted sense of relational entitlement, a higher risk of revictimization, fragmentation, substance use, and the presentation of borderline personality disorder (BPD) features (Brenner et al., 2021; Ensink et al., 2021; Fisher, 2017a; Hiebler-Ragger & Unterrainer, 2019; Krause-Utz et al., 2021). Often in situations of repeated CSA or when the perpetrator of abuse is an attachment figure, children will adaptively dissociate or fragment themselves in an effort to manage their trauma. This protective mechanism prevents the integration of knowledge, memory, and emotion which creates a fragmented identity in adulthood with the unintegrated parts responsible for different functions of survival (Fisher, 2017a; Herman, 2015). These outcomes are interrelated and can interact with one another in complex ways that perpetuate the survivors suffering.

An important consideration is how to enhance the quality of life for those who are suffering from the adverse outcomes of CSA and are seeking effective ways to ameliorate their distress. Top-down therapies, specifically Trauma Focused Cognitive Behavioural Therapy (TF-CBT), Cognitive Processing Therapy (CPT), and prolonged exposure therapies (PE), are often cited as the ideal way of treating the impacts of trauma (David et al., 2018; Hendricks et al., 2018; Imel et al., 2013; Resnick et al., 2003). However, there is controversy over the actual efficacy of these treatment methods, due to the harsh exposure to overwhelming emotional experiences. For example, CPT and PE involve intensive imaginal exposure to the survivors' worst experience of sexualized assault, which is often repeated daily (Bohus et al., 2019:

Hendricks et al., 2018; Resick et al., 2003). Although there has been empirical evidence of symptom reduction with the use of these psychotherapies, there are also high dropout rates and low symptom response to treatment (Emmons et al., 2021; Hendricks et al., 2018; Hoge et al., 2014; Imel et al., 2013; Molero-Zafra et al., 2024; Resnick et al., 2003). Dropout rates have been estimated to range from 18% to 52% and these rates increase among participants with a diagnosis of BPD. This is alarming considering the BPD features that can be developed by survivors of CSA (Bohus et al., 2019; Hendricks et al., 2018; Kleindienst et al., 2020; Krause-Utz et al., 2021). The intensity of these treatments risk retraumatization, promote dissociation, further identity fragmentation, and ignore the traumatized part of the person, all of which can increase the adverse outcomes of CSA (Fisher, 2017a, 2017b; Herman, 2015; Ogden, 2020). Further, individuals who experience complex presentations as a result of trauma often have symptoms that exclude them from the research studies. Finally, therapies such as Cognitive Behavioural Therapy (CBT) and related therapies are considered evidence-based which means that they are funded favourably over therapies who have not stored their knowledge in academic writing (Grabbe & Miller-Karas, 2018)

The intention is not to demonize top-down therapies as they have been shown to be effective psychotherapies for many individuals, particularly for the reduction of anxiety and depression (Hendricks et al., 2018; Molero-Zafra et al., 2024; Resnick et al., 2003). However, the hope is to demonstrate that they are often not comprehensive enough on their own as they ignore the experience of the body and the neurobiological impact of trauma. (David et al., 2018; Fisher, 2017a; Herman, 2015, Levine, 2010) Considering this, I propose that the inclusion of bottom-up, embodiment-based therapies is imperative to adequately address the suffering of those who have experienced CSA.

Purpose Statement

The purpose of this capstone is to explore the benefits that embodiment-based therapies may have for those who have experienced CSA and are suffering from adverse outcomes of their experience. I hope to acknowledge potential limitations of top-down therapies in treating trauma, specifically CSA, and to better understand how bottom-up or embodiment-based therapies can support these gaps. The intention of the work is to offer psychotherapists ways to safely ameliorate the adverse outcomes of experiencing CSA and orient towards healing. The research will be guided by the following questions:

1. What are the adverse outcomes that survivors of CSA experience in adulthood?
2. How are embodiment-based therapies applied in practice to address the adverse outcomes of CSA?

Theoretical Framework

The following provides the lens through which the research will be understood and presented. The first lens is attachment theory which imparts an explanation for how the relationship between a child and their caregivers impacts the child's development. Our first attachments are formed in early childhood with our primary caregivers and depending on the attunement, disruption, repair cycle, this attachment can become secure or insecure (Ainsworth, 1978; Bowlby, 1969; Medley, 2021a). Children who are securely attached to their caregivers have established safety, trust, and developed positive internal working models around the self and relationships with others. Conversely, children who have an insecure attachment have developed unhelpful internal working models which are informing them of what they can anticipate from the self and in relationship with others (Ainsworth, 1978; Bowlby, 1969; Medley, 2021a). This earliest attachment continues to influence our attachment system into adulthood.

The attachment style we develop in childhood tends to be relatively stable, but it is not necessarily fixed. Attachment styles can be malleable to significant life events depending on the context and individual differences (Fraley et al., 2021; Medley, 2021a; Shen & Soloski, 2022). Attachment theory it is largely a theory around the development of affective regulation which only occurs within a relationship with a secure other (Schore, 2014).

The second lens is polyvagal theory which offers a way of understanding how our physiological states communicate and why that is imperative to psychotherapeutic work. The human body's autonomic nervous system (ANS) is made up of two main branches. In general terms, the sympathetic branch is responsible for increasing arousal while the parasympathetic branch is responsible for lowering arousal (Levine et al., 2018; Porges & Carter, 2017; Porges, 2011). The longest nerve in the ANS is known as the vagus nerve which moderates the parasympathetic branch. According to polyvagal theory, the vagus nerve is split into two branches. The dorsal vagal complex which is responsible for defensive immobilization or freeze behaviours when confronted with life threatening stimuli. The ventral vagal complex is known as the social engagement system. This is active when there is a lack of threat and safety has been established. Depending on the stimulus, our body will respond with what will offer the best chance of our survival (Levine et al., 2018; Porges & Carter, 2017; Porges, 2011).

Within polyvagal theory, our nervous system responses operate hierarchically. If the individual detects a threat, the first branch involved is the ventral vagal state. When this state is dominant the individual's social engagement system is still online and they can access social strategies to diffuse the threat. If this is unsuccessful, their sympathetic nervous system will adaptively engage, and they will enter a fight or flight response to either defend against or mobilize away from the threat. If this is not sufficient for survival, they will slip into a dorsal

vagal stage which is an immobilization or freeze response that may eventually result in a collapsed state (Levine et al., 2018; Porges & Carter, 2017). A well-adapted nervous system can flexibly fluctuate between responses as appropriate. However, trauma can impact an individual's ability to move flexibly between states and further, repeated trauma can increase the sensitivity of threat detection centres in the brain resulting in chronic sympathetic hyperarousal or parasympathetic hypoarousal (Fisher, 2017a, 2023; Levine et al., 2018).

The third lens that informs my understanding of the literature comes from a therapeutic modality, Accelerated Experiential Dynamic Psychotherapy (AEDP). AEDP is a healing-oriented model that privileges bottom-up experiences and is based in attachment theory. AEDP asserts that all individuals have a healthy core and a capacity for change. The hope of AEDP is to undo the aloneness felt by the individual when they faced overwhelming, unbearable, and potentially traumatic experiences (Fosha, 2018, 2021; Fosha & Yeung, 2006). The AEDP theory of psychopathology assumes that an individual's adverse outcomes are a result of enduring overwhelming experiences without the internal or external resources necessary to support the experience. Healing from traumatic experiences can occur within the context of safe and secure relationships where the individual's innate capacity for healing can be supported. AEDP emphasizes a non-pathologizing stance as the adverse outcomes of overwhelming experiences are thought of as coping mechanisms which are adaptive responses that have kept the individual alive. The responses make adaptive sense in the context of the individual's experience, but they can become unhelpful in the long-term (Fosha, 2018, 2021; Fosha & Yeung, 2006).

Contribution to the field

This research on embodiment-based therapies and their relationship to the outcomes of CSA provides utility to the field of psychotherapy. It will highlight the relationship between the

adverse outcomes of CSA, how they may interact to perpetuate suffering, and the importance of honouring the body's adaptive responses to trauma. The hope is that this capstone will be helpful for practitioners working with individuals who are experiencing the adverse outcomes of trauma caused by CSA and searching for relief. Further, that the exploration of embodiment-based therapies' utility in treating trauma will help advocate for the necessity of including bottom-up processes to effectively address the impacts of trauma. Overall, my desire is that practitioners can incorporate some of these findings into their practice and be better equipped to come alongside clients in their journey to find wholeness and an integration in their lives after experiencing adverse outcomes of CSA.

Reflectivity and Positionality Statement

Through an intersectional feminist lens, I appreciate that my social location cannot be separated from our larger cultural context when building a relationship with clients as a future psychotherapist nor can it be separated from how I interpret this research as a student researcher. For that reason, I believe it is important to explicitly state my positionality and the privilege it affords me. I am a Canadian, able-bodied, white, heterosexual, cisgender woman. My intersecting identities allow me to enter essentially all spaces from a position of privilege, including therapeutic spaces. My personal and professional experiences have both established my interested in researching this topic. In my professional life, the majority of my experience is working with individuals who have experienced homelessness and addiction. Among my clients who I have had the pleasure of getting to know more deeply, a history of CSA is common. In our work together, we witness the adverse outcomes of their experience and the ways that they perpetuate their suffering. The systems in which our work is immersed can often only offer surface level solutions to deeply complex experiences. Further, they do not honour the purpose

that these adverse outcomes have served in keeping the individual alive. These experiences have biased me towards bottom-up approaches which I believe can offer a more profound sense of healing and work to resist pathologizing narratives about our adaptive responses to overwhelmingly traumatic experiences.

Definition of Terms

Attachment Style

An attachment style is an individual's internal working model that determines their expectations for relationships and perceptions of the self. These internal working models are first developed in childhood based on our experiences with our primary caregivers. In the literature, attachment styles are described as secure or insecure. A secure attachment style is considered to be the most helpful way of relating (Bowlby, 1969; Medley, 2021a; Schore, 2014).

Bottom-up Approach

A bottom-up approach is found in therapies that privilege our nervous system experiences and the felt sense of our affective experiences. Using this approach to increase somatic awareness and developing the mind-body connection is helpful when addressing trauma, as traumatic memories are stored somatically, meaning in the body (Fosha, 2021; Ong, 2020; van der Kolk, 1994).

Child Sexualized Abuse (CSA)

There is variance among the definitions of CSA within the literature. It is most broadly described as any sexualized act between an individual under the age of 18 with a person who is five years older. This definition includes the conceptualization of CSA by a forceful act and through a lack of ability to consent due to age. There is some debate in the literature over which will result in more extreme adverse outcomes (Maciel & Basto-Pereira, 2020).

Coping Mechanisms

In Accelerated Experiential Dynamic Psychotherapy (AEDP), coping mechanisms are described as defense mechanisms that are adaptively developed to block affective experiences that will overwhelm the nervous system. They are behaviours adapted with the hope of managing this overwhelm or activation of the nervous system. These mechanisms have kept the individual alive and for this reason are helpful in the short term. However, when coping mechanisms are relied upon for long periods of time they can become unhelpful and manifest as adverse outcomes (Fosha, 2021; Fosha & Yeung, 2006).

Embodiment

McBride (2021) offered a definition of embodiment which is "the experience of being a body in a social context" (p. 12). This is an important conceptualization of the term as it includes that our experience and relationship with our body's is impacted by our social context. It can impact our political, spiritual, ecological, and relational experiences. McBride explained how, particularly in western cultures, we often adopt disembodiment and can think of ourselves as a mind, or a brain, and think of our body's as just the vehicle responsible for carrying around our mind. This sense of "having a body" instead of being a body. Our personhood is in our body's. Healing comes from restoring connection between the mind and body. Embodiment can change "everything about how we experience ourselves and others, drawing ourselves into deeper wisdom and often providing us with insight that a fragmented way of being could not produce" (McBride, 2021, pg. 12).

Fragmentation

Fragmentation is the structural dissociation between an individual's survival action systems and attachment and social engagement action systems. Fragmentation is often a result of

exposure to chronic trauma and can prevent integration of the self which result in different presentations of isolated parts of the self (Fisher, 2014, 2017b).

Neuroplasticity

Neuroplasticity can succinctly be thought of as the brain's lifelong capacity to reorganize or rewire when presented with new experiences or novel outcomes (Frederick, 2021).

Revictimization

The term revictimization refers to the experience of multiple traumas. It is defined in the literature as experiencing one account of sexualized abuse both in childhood and in adulthood. It is significant in the discussion of CSA as survivors present with a high risk of experiencing adult sexualized abuse. Experiencing physical abuse and witnessing intimate partner violence in childhood also increases the risk of adult sexualized assault (Brenner et al., 2021; Krause-Utz et al., 2021; Maker et al., 2001).

Sense of Relational Entitlement

The term sense of relational entitlement refers to an individual's subjective beliefs and understanding around what they deserve or can expect within relational contexts. In the literature, sense of relational entitlement is described as assertive, restricted, or entitled. An assertive sense of relational entitlement is considered to be the most helpful (Brenner et al., 2021).

Sexualized Assault vs. Sexual Assault

The language we use is important as it has the power to shape how we perceive and respond to behaviour. The term sexual assault implies that this behaviour is a sexual act when it is rather a dangerous expression of violence and power seeking (Al-Saaidi, 2022; Coates &

Wade, 2007). In keeping with the practice of Coates and Wade, this paper will use the term sexualized abuse or sexualized assault in place of sexual assault.

Survivor vs Victim

Here we see again how the use of language is important as it can shape identity. The term survivor is more often associated with self-assessments of strength, power, and resiliency and the term victim as more commonly associated with a perception of the self as weak and passive. However, others feel that the term survivor does not accurately capture their horrific experience of sexualized violence and the outcomes they suffer from as a result of the violence (Mittal & Singh, 2018; Papendick & Bohner, 2017). This is not an exhaustive exploration of the victim/survivor dichotomy as it could be a paper on its own, however, it is important to acknowledge. These terms interact with the intersecting identities an individual holds which can impact how a survivor or victim label is embodied for the individual (Boyle & Rogers, 2020). Therefore, it is imperative to let the individual determine what language they wish to use and in what contexts. For the purpose of this capstone, as it has a broader scope, the term survivor will be used to reference individuals who have experienced CSA.

Trauma

Trauma is often thought of as something that occurs from an overwhelmingly stressful event. This is not necessarily incorrect, however, the actual event is less significant compared to the response of the nervous system. When we perceive the stressful event as fearful or life threatening our nervous system mobilizes to respond against the threat. Trauma occurs when our nervous system's fight, flight, or freeze response cannot resolve back to a resting state. Instead, the activation becomes trapped in the nervous system, and we experience chronic immobility (Levine, 2010; McBride, 2021).

Top-down Approach

A top-down approach is found in therapies that privilege cognition, problem-solving, and planning to understand situations and determine how to proceed. They rely more heavily on the capacity of the prefrontal cortex. However, someone who has experienced a trauma that has resulted in the adaptation of their limbic system to be more sensitive to the perception of threat does not always have access to their prefrontal cortex. Trauma is thought to live in the limbic system which is designed to respond to threat before our conscious brain can even detect it (Fisher, 2017a; Fosha, 2021; Reagan, 2021).

Trajectory of Following Chapters

This capstone is organized into three chapters, the introduction, a literature review, and a discussion and application section. This first chapter has introduced the topic, provided the research questions and the frameworks from which I have approached the literature, and explained how the research can contribute to the field of psychotherapy. Chapter two will explore the link between some of the adverse effects of CSA, specifically the relationship between attachment trauma, a restricted or inflated sense of relational entitlement, revictimization, complex posttraumatic stress, borderline personality features, fragmentation, and substance use. Understanding how the adverse outcomes of CSA may present and relate to each other is vitally important when approaching work with clients who are hoping to find relief from their symptoms of this interpersonal trauma. Equally as important is understanding the adaptive nature of our responses to trauma as this knowledge serves to minimize the tendency to pathologize symptoms and allows us to approach the work in a way that can support clients' capacity for healing. Chapter three outlines some applications of embodiment-based psychotherapies when working with individuals who are experiencing the adverse outcomes of

CSA. These approaches can help untangle the interconnected relationship through which these adverse outcomes can perpetuate one another.

Chapter Two: Adverse Outcomes of Child Sexualized Assault

Child Sexualized Assault

There are distinctions made within the research around the definition of child sexualized assault (CSA) and the impact the abuse has on the survivors based on the variabilities in the experience. The variabilities are gender of survivor, age of survivor at time of the CSA, relationship to the perpetrator, chronic abuse versus single occurrence, and use of force comparatively to CSA due to lack of age to consent. First, I will highlight some of the distinctions made within the definition of CSA. Most broadly, CSA is described as any sexual act that occurs with an individual who is under 18 years old and another individual who is at least five years of age older. Other definitions varied by the age of the individual being 16 years old. This variability is likely accounted by location as the age of consent differs between countries and even between states in the US. The definitions also diverged in the conceptualization of CSA as only unwanted sexualized behaviour from a perpetrator who is at least five years older than the individual (Maciel & Basto-Pereira, 2020; Maker et al., 2001). This definition excludes CSA by lack of age to consent. There is some discussion in the literature if the impact of CSA by lack of age of consent is less severe compared to CSA by use of force. Some research reported that CSA by use of force resulted in increased intensity of adverse outcomes in adulthood (Aebi et al. 2015; Papalia et al. 2018). Opposingly, others found that there was no evidence of increased severity of adverse outcomes in adulthood between CSA by use of force compared to lack of age to consent (Maciel & Basto-Pereira, 2020).

Considering the variabilities in the gender of the survivor, binary statistics show that the experience of CSA is found to be more prevalent in women compared to men. Further, that women's experience of CSA tends to occur at an earlier age, be more chronic, and more likely to be perpetrated by a close attachment figure. However, it is difficult to fully understand the distinctions in these statistics as CSA experienced by men is hugely underreported. The understanding around the impact of the age of the survivor at the time of abuse is that the earlier onset of abuse the more severe the adverse outcomes become. There is some research that showed that when the duration of the abuse continued into adolescence or began in adolescence the externalized related adverse outcomes became more severe (Hurren et al., 2017). CSA constrained to childhood seems to result in more internalized adverse outcomes. Other research found that CSA constrained to childhood had a more pervasive impact on adverse outcomes for boys whereas CSA constrained to adolescence was related to more severe externalized adverse outcomes for girls (Maciel & Basto-Pereira, 2020).

Experiencing chronic CSA has been shown to result in stronger severity of adverse outcomes in adulthood comparatively to single occurrence of CSA. This is particularly the case if the individual has parental figures as a secure attachment base, feels comfortable enough to disclose their abuse, and their disclosure is met with acceptance, care, and appropriate action. In these circumstances, the perpetrator of abuse is typically not a primary caregiver. The impact of the adverse outcomes on the individual has been found to be more severe when the perpetrator is an attachment figure. This type of relationship to the perpetrator can have a significant impact on the survivor's attachment system. The following will be outlined further when discussing mediating factors. Overall increased severity of CSA, as measured by chronic abuse, use of force, and abuse by an attachment figure, particularly if they are living in the home of the

survivor, has been seen in the literature to increase the intensity of adverse outcomes (Fletcher, 2021; Maciel & Basto-Pereira, 2020; Maker et al., 2001; Shen & Soloski, 2022; Shore, 2001).

The previously noted research highlights the distinctions made in the field around the experience of CSA. However, in the practice of psychotherapy there is the benefit of having the individual directly in the room with us. The survivor is in the position to offer information about what was most personally impactful about their experience. Having the research to inform our practice is extremely helpful but, because that information is based on what was found to be most prominent in the group tested, it is important to remember that the impact of each experience can vary depending on the individual. In summary, it is essential to remain curious about the information being offered from the individual we are working with as they are the expert on their own experience. Considering our definition of trauma, it is not only the event that defines trauma but rather the response of our body, more specifically an interrupted deactivation of our nervous system's survival response. A prominent AEDP practitioner, Hilary McBride (2021) described an event becoming trauma when we feel "overwhelmed and powerless" (p 58). The founder of Somatic Experiencing therapy, Peter Levine's (2010) explained that "trauma occurs when we are intensely frightened and are either physically restrained or perceived that we are trapped. We freeze in paralysis and/or collapse in overwhelming helplessness" (p.48). The presence of fear along with the freeze or immobilization response is significant in the manifestation of trauma. Addiction expert and physician, Gabor Maté (2010) agreed that "trauma is not a disease, but rather a human experience rooted in survival instincts" (p. XIII). This means differentiating between factors that made up someone's experience of CSA is less significant than their body's response to their experience, which is what may be contributing to the adverse outcomes they are reporting. The following will explore the interconnected relationship between

the adverse outcomes of experiencing CSA, specifically attachment trauma, restricted or inflated sense of relationship entitlement, revictimization, complex posttraumatic stress, BPD features, fragmentation, and substance use. Each of these seem to be rooted in the body's adaptive survival responses that have been adversely impacted by trauma and perpetuated by disrupted development of attachment systems (Levine, 2010; Schore, 2001).

Adverse Outcomes

Attachment Trauma

Attachment theory states that within a healthy attachment system, children naturally reach out to their attachment figures when in distress and the caregivers have an innate instinct to respond. The attachment system is evolutionarily advantageous as it is designed to promote the child's survival. Children's internal working models develop based on if or how their primary caregivers respond (Medley, 2021a). When a child's emotional expression is responded to with empathy and coregulation the child learns that emotions can be safely felt and expressed. Within this context they can develop a secure attachment style (Ensink et al., 2021). Individuals who have developed insecure attachments in childhood are assumed to have experienced their primary caregivers rejecting, shaming, or inconsistently responding to their affective experience instead of offering acceptance or modeling regulation (Ensink et al., 2021; Markin et al., 2018). Consequently, individuals with insecure attachments have learned that their emotions are unsafe, can have feelings of shame around emotion, and often employ unhelpful coping mechanisms to regulate (Fosha, 2021; Schore, 2014).

There are three types of insecure attachment styles outlined in the literature. If an individual does not develop a secure internal working model, they either develop an anxious, avoidant, or disorganized way of relating. According to attachment theory, individuals with an

anxious attachment styles had caregivers who responded inconsistently to their needs. In this context, the individual has learned to react more strongly if they are going to get their survival needs met. For those with an avoidant attachment style, their caregivers are thought to have seldom met the child's needs. The individual then learns that they must rely solely on themselves if they want to survive. In the case of a disorganized attachment style, the caregiver is a source of danger to the child while the child simultaneously still requires the attachment system for survival. A disorganized attachment style is common when the primary caregiver is the perpetrator of abuse (Ainsworth, 1978; Birgas et al, 2021; Bowlby, 1969; Labadie, et al., 2018; Medley, 2021a; Schore, 2014).

Research has shown that many survivors of CSA report experiencing distressing levels of disruption in attachment security and present with an insecure attachment style (Dimitrova et al., 2010; Labadie et al., 2018). This suggested that CSA would constitute a significant attachment trauma which can result in the development of an insecure internal working model that will disrupt the individual's ability to find a sense of safety or trust with themselves or within relationships into adulthood. Individuals who have experienced CSA often report interpersonal difficulties in adulthood. This may be due to a negatively impacted capacity for closeness. Maintaining closeness and intimacy with others may feel very unsafe if someone's internal working models have learned that isolation is best for survival. However, we also rely on community and social connection for survival. The tension between these instincts may manifest as seemingly disorganized responses from the individual. This behaviour can complicate relationships and can often leave the individual dislocated from community which further disrupts their ability to heal from trauma (Dimitrova et al., 2010; Herman, 2015; Schore, 2014). Additionally, early attachment trauma may interrupt the right brain to right brain communication

between the child and their caregiver which in the long-term will impact the development of helpful affect regulation strategies. The right brain can be considered the social and emotional brain and is responsible for emotional regulation which can only develop when in relationship with a secure other. Without this right brain to right brain communication the individual is unable to learn essential emotional and social functions. Our capacity for emotion regulation is reliant on the development of regulatory abilities that occurs within relationship to our primary caregivers, including the ability for regulation in connection with others known as "interactive regulation" and self-regulation known as "auto-regulation" (Fisher, 2014, p. 2, 2017a; Schore, 2014). Without the ability to rely on interactive or auto-regulation, we are left to face overwhelming experiences alone and forced to rely on unhelpful coping mechanisms. These impacts on the attachment system may contribute to some of the other adverse outcomes experienced by survivors, specifically, unhelpful levels of relational entitlement, revictimization, fragmentation, substance use, and the development of BDP features, all of which will be explored in this paper (Brenner et al., 2021; Fisher, 2017a; Fosha, 2021; Labadie et al., 2018).

Restricted or Inflated Sense of Relational Entitlement

An individual's sense of relational entitlement (SRE) is their subjective beliefs of what they deserve or can expect within relational contexts. Considering this in relation to attachment, an individual's internal working models, which have developed based on their attachment experiences, inform them about their level of relational entitlement. Depending on the level of SRE, it can be helpful or unhelpful to interpersonal functioning. Individuals are thought to either adopt an assertive, inflated, or restricted SRE. An assertive SRE is considered to be helpful and to develop within the context of a secure attachment relationship (Brenner et al., 2021; Medley, 2021a; Tolmacz & Mikulincer, 2011). An assertive SRE, also known as adaptive SRE, is

associated with conscientiousness and reflects that the individual has confident levels of self-esteem. Subsequently, they can set realistic boundaries, hold expectations that are appropriate to the relational context, and determine their capacity for what they can offer others (Brenner et al., 2021; Tolmacz & Mikulincer, 2011).

Inflated and restricted types of SRE are both known to be unhelpful and can be linked to traumatic attachment experiences, including CSA. Inflated and restricted levels of SRE are associated with insecure attachment styles, low levels of self-esteem, depression, and loneliness in adulthood. An individual with an inflated SRE believes their needs should be prioritized over the consideration of others' feelings, rights, and wellbeing. The development of an inflated SRE is considered to be an adaptive response when an individual's needs were never met in childhood. Similar to the context of an avoidant attachment style, the individual learns that they must depend solely on themselves for survival. An inflated SRE is often present in situations where the individual has experienced either childhood neglect, abuse, or their caregivers ignoring their affective experiences. It may also offer a piece of the explanation for when survivors of CSA occasionally become perpetrators in adulthood (Ainsworth, 1978; Brenner et al., 2021; Medley, 2021a; Tolmacz & Mikulincer, 2011).

The right brain, also known as the "emotional parts of the personality", is responsible for our survival responses, specifically, fight, flight, freeze, submit or attach (Fisher, 2017a, p. 57). A renowned trauma therapist, Janina Fisher conceptualized these nervous system responses as parts of the individual. Each of these will adapt their specializations to support our survival and are informed by our attachment systems. For example, a child who developed a state of hypervigilance to defend against "frightened or frightening" parental behaviour is relying on their fight part to keep them safe against aggressive behaviour (Fisher, 2014, p. 4; Liotti, 2011).

Future threat detection may result in the fight part signaling a need for aggression that can be expressed internally or externally. In the case of an inflated SRE it seems this part is expressed externally as a previously adaptive protection strategy that is no longer helpful (Brenner et al., 2021; Fisher, 2014, 2017a, 2017b; Medley, 2021a).

When an individual has a restricted sense of entitlement, they believe their needs are not worthy of being met, they can be disconnected from what needs or boundaries would even be helpful for them within a relationship, and often act in service of others needs or enjoyment. Accordingly, CSA survivors who have developed an internal working model that internalizes these harmful beliefs are even more vulnerable to experiencing revictimization (Brenner et al., 2021; Tolmacz & Mikulincer, 2011). Considering our nervous system responses, fight, flight, freeze, submit or attach, as parts, it seems that the submit part may be dominate in the case of a restricted SRE. For example, a child may learn that submission in the face of abuse is the best way to avoid additional harm and promote their survival or the survival of other vulnerable people that would otherwise be subjected to the abuse. The survival strategy of "giving into others" is selected by the submit part which kept the individual alive in childhood and can perpetuate their suffering in adulthood (Brenner et al., 2021; Fisher, 2014, 2017a, p. 59., 2017b; Tolmacz & Mikulincer, 2011).

A restricted SRE is associated with low levels of self-esteem. In some instances, the individual may attempt to acquire self-esteem externally by pleasing others. In this case the attach part of the self seems the most dominate survival strategy. Our threat detection can become hypersensitive after experiencing trauma and can signal danger when there is a disruption in the attachment system. One might try to establish safety by attaching to another, particularly if they have not had the chance to develop auto-regulation and rely on interactive

regulation in the presence of overwhelming affective experiences. In this context, a restricted SRE can be associated with an anxious attachment style. (Brenner et al., 2021; Fisher, 2014, 2017a, p. 59, 2017b; Tolmacz & Mikulincer, 2011).

Revictimization

The history of CSA significantly increases the individual's risk for revictimization in adulthood (Brenner et al., 2021; Krause-Utz et al., 2021; Maker et al., 2001; Walker & Wamser-Nanney, 2023). An individual's attachment style can also interact with the risk of revictimization. The thought is that individuals who have an anxious attachment only feel regulated when in connection with another which leads them to seek out relationships and increases the probability of engaging with an abusive individual (Brenner et al., 2021; Krause-Utz et al., 2021).

If a child's primary caregivers consistently appeared frightened or were frightening, the developing attachment system can become complex. Innate proximity seeking behaviour towards the attachment figure to establish safety also becomes associated with danger. This tension between the safety responses results in fragmentation so that each survival response can operate independently based on the best chance for survival depending on the context cues. The brain that has experienced trauma is now unintegrated and can attach to the primary caregivers or fight or flee from the primary caregivers depending on which response will function the best to keep them safe. This dynamic is informing the attachment system and can be repeated with significant attachment figures in adulthood. In this case, when threat is detected our trauma response of attach may be able to establish safety within our attachment system and the fragmented attach part can potentially feel safe despite the situation being harmful. Additionally, the conflict between the parts of the survival responses feels familiar to the individual's attachment system, and because safety can be found in familiarity it may reinforce this dynamic (Brenner et al.,

2021; Fisher, 2014, 2017a; Krause-Utz et al., 2021; Rogers et al., 2023; Walker & Wamser-Nanney, 2023).

The SRE dynamics within relationship can heighten the risk of revictimization as well. An individual with a restricted SRE who is in an abusive relationship is likely to prioritize the other's needs which can lead to a complex and harmful relational dynamic. Conversely, if the perpetrator has an inflated SRE the likelihood of them feeling entitled to the other person to fulfill their own needs will also increase. Further, individuals who have experienced CSA often find establishing trust, autonomy, and personal initiative challenging in adulthood. Their attach part can seek these qualities and protection in powerful authority figures. The risk of revictimization is higher in these relational contexts, particularly when paired with a restricted SRE. Characteristics of a restricted SRE may result in the individual acting passively when confronted with threatening situations often to reduce the amount of violence and to maintain affection. This survival response of seeking proximity to the attachment figure may have been adaptive in childhood but results in additional harm in adulthood (Brenner et al., 2021; Herman, 2015; Tolmacz & Mikulincer, 2011; Walker & Wamser-Nanney, 2023).

An additional consideration is that some individuals who have experience CSA rely on substances to help cope with overwhelming emotional experiences. The effects of substance use have been associated with a decrease in self-protective behaviours, threat detection, and a subsequent increase in vulnerability which further increases the risk of revictimization (Rogers et al., 2023; Walker & Wamser-Nanney, 2023). Further, a component that interacts with history of CSA and attachment trauma are features of BPD. There is a higher rate of survivors of CSA among individuals with BPD features compared to other diagnoses. The features that make up a BPD diagnosis leave the survivors at an even higher and more frequent risk of revictimization.

This has been seen to be the experience for individuals who have symptoms of PTSD as well. It seems that these symptoms can increase someone's vulnerability to experiencing revictimization (Krause-Utz et al., 2021; Pratchett & Yehuda, 2011).

PTSD, CPTSD, and Complex Trauma

Posttraumatic stress disorder (PTSD) is the body's response to the exposure of a traumatic event that can include complex cognitive, emotional, somatic, and behavioural symptoms. The symptoms typically include re-experiencing the traumatic experience in the present, avoidance of any reminders of the traumatic experience, and the body persistently sensing threat which results in heightened arousal and hypervigilance. Living with PTSD can significantly impact an individual's enjoyment and engagement in daily activities with their community and social relationships. Within the research there is a strong association between the experience of CSA and receiving a diagnosis of PTSD in adulthood. Rates of PTSD are higher among adult populations that have experienced abuse in childhood compared with adults who do not have a history of CSA. However, this casual correlation has been questioned in the literature as there has been evidence that after experiencing CSA the prevalence of PTSD is lower in children compared to in adults. The relationship between PTSD and CSA may be more complex. Some hypothesize that the symptoms of PTSD are not fully present until adulthood. These are known as "sleeper" effects of abuse that are not fully expressed until adult development. (Pratchett & Yehuda, 2011, p. 478) Another thought is that children may have delayed reaction to their experiences of abuse until adulthood when they can truly conceptualize the danger they were in. The most compelling explanation is that the experience of CSA does not directly result in adult PTSD but may make an individual more vulnerable to experiences in adulthood that

could have an outcome of PTSD (Karatzias et al., 2017; Mccreevy & Boland, 2022; Pratchett & Yehuda, 2011).

The increased vulnerability to developing PTSD in adulthood after experiencing CSA is thought to be facilitated by two adverse outcomes of abuse in childhood. The first is that early life stress, or the experience of CSA in this context, can disrupt the hypothalamic-pituitary-adrenal (HPA) axis. The HPA axis is a part our nervous system's stress response which is responsible for mobilizing our body's when confronted with a threat. As mentioned previously, our body's have the ability respond to danger with the most adaptive survival strategy within the given scenario. However, trauma can result in our threat detection centres becoming extra sensitive to potential danger stimuli. Any stimulus that is associated with the trauma warns our body of danger. As an adaptive protection response, we then go directly from the stimulus to survival response. The chronic sensitization of the HPA axis can manifest as hypervigilance and lead the individual to use unhelpful coping mechanisms to find relief or rely on depression and dissociative behaviours to escape from the discomfort (Fisher, 2014, 2017a; Mccreevy & Boland, 2022; Pratchett & Yehuda, 2011; van der Kolk, 1994). When we perceive threat, our nervous system prepares us to take the action necessary to promote our survival. If the activation of our fight or flight response is not discharged to the point where our nervous system can restore a resting state, we become at high risk for developing PTSD symptoms. Levine (2010) described this concept as the "global activation" being "all dressed up with nowhere to go" (p. 14). Without the body taking meaningful action to discharge the activation in the nervous system it can later be expressed as PTSD symptoms.

The second outcome that increases the risk of developing adult PTSD is the experience of revictimization. It has unfortunately been established that a history of CSA is strongly associated

with the experience of revictimization in adulthood. The impact trauma has on our stress response combined with the high risk of revictimization offers an explanation for why individuals with a history of CSA may be more vulnerable to developing adult PTSD. Additionally, research found that the disruption in attachment relationships which often accompanies CSA was an essential factor when considering how these two outcomes impacted the development of PTSD in adulthood (Brenner et al., 2021; Krause-Utz et al., 2021; Levine, 2010; Mccreevy & Boland, 2022; Ogden & Fisher, 2014; Pratchett & Yehuda, 2011).

Complex posttraumatic stress disorder (CPTSD) includes the symptoms typically associated with PTSD, with the addition of what is known in the literature as disturbances in self-organization (DSO) symptoms. This term refers to key features of CPTSD which are emotional dysregulation, persistent negative concept of the self, and consistent interpersonal challenges. These outcomes are often a result of repeated interpersonal trauma, such as the experience of CSA. Individuals who experience CPTSD symptoms typically report a high frequency and variety of childhood trauma over a longer period of time comparatively to those with PTSD which is often an outcome of a single traumatic incident. The term complex trauma is distinct from CPTSD as complex trauma refers to the experience of ongoing and repeated interpersonal trauma that can lead to the formal diagnosis of CPTSD. Comparatively, acute trauma is a single traumatic event that can result in the diagnosis of PTSD (Emmons et al, 2021; Karatzias et al, 2017; Ong, 2020).

There are two primary distinctions between PTSD and complex trauma. The first is that complex trauma is an interpersonal trauma meaning that there is a relational component to the trauma that often starts in childhood. For example, this would include chronic neglect and unmet needs, death of a primary caregiver, or physical or sexual abuse from attachment figures. The

trauma that occurs due to relationship trauma can have significantly different impacts than trauma that occurs from an accident or natural disaster. The second distinction is that there is the experience of multiple traumas. The symptoms that occur from experiencing one traumatic incident versus many repeated traumas can present very differently. In particular, if the individual can benefit from their secure relationships with attachment figures and maintain or restore their sense of safety. Conversely, chronic trauma perpetuated interpersonally can drastically disrupt an individual's sense of safety and the capacity to trust others and the self. Trauma can make the body feel unsafe and unpredictable. Re-establishing safety and feelings of empowerment and connection to the body and the self are essential in treating complex presentations of trauma. Herman (2015) explained that "restoring control to the survivor is the guiding principle in recovery" (p. 20). If this is not considered in psychotherapeutic work, high rates of drop-out are shown to occur (Emmons et al, 2021; Herman, 2015; Karatzias et al, 2017; Ong 2020).

BPD Features

It is important to establish that Borderline Personality Disorder (BPD) is a common outcome of CSA because of the adverse experiences that survivors of CSA have lived through rather than CSA as a result of BPD features. Key features of BPD are emotional dysregulation, an unstable sense of self sometimes to the point of dissociation, difficulty trusting others, and a hypersensitivity to rejection from others (Kleindienst et al., 2020; Krause-Utz et al., 2021). The development of these features is adaptively logical in the context of experiencing a significant attachment trauma, especially when considering the extreme nature of CSA, yet the diagnosis is highly stigmatized. There is a disproportionate number of women diagnosed with BPD and it serves to label the person as personality disordered, rather than traumatized. Research has

demonstrated that children who have a disorganized attachment style are more likely to experience dissociation symptoms and be diagnosed with BPD in adulthood. A critical contributor to the development of a disorganized attachment style is the experience of consistently frightened or frightening parental behaviours. Splitting of parts of the person is an adaptive response to acquire resolution between the innate drive for proximity seeking with the attachment figured and subsequent proximity to a frightened or frightening caregiver resulting in a fight or flight response (Brenner et al., 2021; Fisher, 2014, 2023; Herman et al., 1989; Liotti, 2011; Lyons-Ruth et al, 2006; Sansone et al., 1993).

Affect dysregulation is commonly cited as the largest contributor to psychopathology for individuals with a BPD diagnosis. Considering attachment theory, if the individual has experienced a severe attachment trauma and subsequently is insecurely attached, it is not surprising that they have not developed a large capacity for emotional regulation. They have not had the opportunity to benefit from right brain to right brain communication in childhood which impacts their ability to develop auto-regulation skills. Further, without a secure base they are unable to rely on interactive regulation. Interactive regulation may be even more difficult to access if being in relationship with others cues threat detection. Being able to feel safety and trust within relationship is thought to be directly related to our attachment experiences. Without the embodied association of security and proximity to attachment figures our capacity for closeness and intimacy can become limited which can further contribute to challenges in emotion regulation (Brenner et al., 2021; Dimitrova et al., 2010; Fisher, 2014, 2023; Fosha, 2021; Schore, 2014).

Experiencing their affective world would require the survivor to be confronted with large amounts of emotional pain. This could be extremely frightening outside the context of a safe and

secure attachment or helpful affective regulation skills. The unsafety the survivor feels in their affective world may lead them to block their emotional experience through coping mechanisms, including substance use, self-harming behaviours, and entering protective dissociative states when confronted with these emotions. The long-term reliance on unhelpful coping mechanisms can significantly impact survivors' wellbeing, relationship with the self, and how they go on to relate within their adult relationships (Fosha, 2021; Krause-Utz et al., 2021; Markin et al., 2018).

Self-harming behaviours have several functions. Distressing instincts are thought of as communication from trauma related dissociated parts. In the case of self-harming behaviour, it is considered a response from the fight part which uses aggression to establish safety. Trauma can significantly increase the sensitivity of the body's threat detection centres. Subsequently, any trauma related stimuli can trigger a response from the ANS, which are our survival strategy responses. When there is a lack of external danger the impulses of the fight part are turned internally which results in regulation of the ANS. The sensation of regulation is the start of a tolerance building cycle. The self-harming behaviour results in short-term relief from the nervous system activation, which is followed by the negative impacts of the self-harming behaviour which increases the need to use the self-harming behaviour as a regulating coping mechanism. With repeated use, the body will build a tolerance to the regulating effects of the self-harming behaviour and overtime more extreme regulating behaviour will be needed to acquire the same level of relief. In this way the regulating behaviour can become quite life threatening, however, the thought is that for the individual, the affective experience of the trauma responses seem more distressing compared to the harm caused from the self-destructive behaviour (Fisher, 2017a, 2017b; Walsh, 2007).

The research consistently shows that BPD is highly correlated with the experience of childhood trauma (Fisher, 2023; Herman et al., 1989; Liotti, 2011; Sansone et al., 1993). Fisher argued for the importance of reconceptualizing BPD from disordered personality to a traumatic attachment. Our ANS is capable of sympathetic hyperarousal states or parasympathetic hypoarousal states, the latter known in polyvagal terms as a dorsal vagal state (Porges & Carter, 2017; Porges, 2011). The previous has outlined that when our nervous system is presented with a threat, it will innately respond with the strategy that is most adaptive for survival. One of the impacts that trauma has on our nervous system is to encourage the formation of hyperarousal autonomic habits or hypoarousal autonomic habits. Hyperarousal symptoms can look like chronic hypervigilance which can manifest as mistrust within relationships, separation anxiety, hyper-fixation on establishing safety within relationships, intense and overwhelming affective reactions, high sensitivity to rejection, and self-harming behaviours. Hypoarousal symptoms can manifest as muted affective experience, detachment and avoidance of relationships, feelings of hopelessness and shame, numbing, and dissociation. Some individuals with trauma may alternate between these two autonomic experiences. Each of these symptoms are attributed to BPD but are also symptoms of a traumatized nervous system. Fisher argued that if an individual presents with these behaviours we can either conceptualize their experience as CPTSD or contribute to their suffering, due to the associated stigmatization, and understand their experience as BPD (Fisher, 2023).

The question of if CPTSD and BPD can be considered two different diagnostic names for the same experience is debated within the literature. There is significant symptom overlap between CPTSD and BPD and the two diagnoses often occur comorbidly. The research that differentiates between the two diagnoses argued that despite the symptom overlap, specific

symptoms such as emotional dysregulation, negative self-image, and subsequent interpersonal challenges present differently which makes distinct categories of diagnosis necessary. Emotional dysregulation in CPTSD is commonly associated with difficulties in auto-regulation leading to dissociative symptoms. Comparatively, emotional regulation seen in BPD is thought of as intense expressive affective reactions and emotional lability. The sense of self in CPTSD is known to be a stable perception of shame and worthlessness, and the sense of self in BPD is thought of as unstable and fragmented. Finally, interpersonal challenges in CPTSD often center around a fear of closeness whereas interpersonal difficulties in BPD often stem from a fear of abandonment and shifts in behaviour with the goal of preventing real or perceived abandonment (Ford & Courtois, 2021; Frost et al., 2020a; Frost et al, 2020b; Owczarek et al., 2023). Considering Fisher's (2023) conceptualization of traumatic attachment and how this will show up as hyperarousal or hypoarousal autonomic habits it seems that CPTSD is describing and individual with hypoarousal habits and that BPD is describing an individual with hyperarousal habits. Due to the punishing nature of the stigma associated with BPD it could greatly benefit the individual to conceptualize these sets of behaviours as traumatized attachment (Fisher et al., 2023; Ford & Courtois, 2021).

Some research is concerned that not discerning between the two will result in a lack of treatment efficacy, particularly as a BPD diagnosis is often accompanied by self-harming behaviours (Ford & Courtois, 2021; Frost et al., 2020a; Frost et al, 2020b; Owczarek et al., 2023). However, other research has found that self-harming behaviour was associated with BPD, PTSD, and CPTSD. Considering this, it does not seem that approaching psychotherapeutic work with an individual as if they were experiencing traumatic attachment instead of either BPD or CPTSD would negatively impact treatment outcomes. If conceptualizing any adverse outcomes

as how the experience of trauma is presenting within the nervous system, self-harming behaviours would be addressed. However, outside of a psychotherapeutic context, specific diagnostic criteria may be necessary and potentially helpful for clients to access resources from systems. In some cases, this may even include accessing psychotherapeutic services. Unfortunately, the designation of BPD is often unhelpful in a systems context so it may still be more beneficial to reframe the behaviour as an outcome of traumatic attachment (Fisher, 2023; Owczarek et al., 2023).

Fragmentation

As previously stated, the interaction between frighted or frightening parental behaviours with the innate attachment proximity seeking behaviour in childhood results in adaptive fragmentation. The adaptive impulses to reach out to attachment figures when in distress also conflict with the nervous system's protective responses. Fragmentation is required to allow for the survival response to operate independently of one another. This phenomenon is referred to as structural dissociation, which involves actual physical fragmentation of the brain. The two hemispheres of the brain are connected at birth but the structure that connects the left and right brain, named the corpus collosum, does not fully develop until 12 years of age. The right brain dominates for most of childhood. During this time, the experience of the right brain transpires moderately independently from the experience of the left brain. Childhood trauma impacts the developing corpus collosum and often results in underdevelopment which results in challenges related to integration of operations between the left and right brain (Fisher, 2014, 2017a; Herman, 2015; Liotti, 2011; Lyons-Ruth et al, 2006; Ogden, 2020).

Our left brain is thought of as the part of the self that is driven by the daily necessities of life and our right brain is known to be the part of the self that is responsible for our survival

responses, fight, flight, freeze, submit, and attach. The goal of these functions is to keep us safe and protect us from harm. The objective of our left-brain psychobiological system is sociability, attachment, and exploration. However, a degree of safety is required to do this successfully. In the context of fragmentation, Fisher (2017a) conceptualized the experience of the left brain as the "going on with life part" of the self and the experience of the right brain as the "trauma related parts" of the self (p. 57). If children are existing in dangerous environments, both aspects of the self are needed. For example, children will need to employ the "going on with normal life" part when attending school in order to socially engage and take in new information. If they have a primary caregiver who displays threatening or neglectful behaviours at home the "trauma related" parts of the personality will employ to establish their safety. Such experiences increase the amount of time the child's brain is developing without right to left brain communication and results in the underdevelopment of the corpus collosum. In adulthood this can result in individuals being "hijacked" or flooded by their trauma-related parts or the experience of chronic depression and dissociation as a resource to disconnect from their trauma related parts (Fisher, 2014, p. 7). The 'going on with life parts" will continue with daily tasks, such as those that are necessary for functioning at work, raising family, and taking care of the home. However, the trauma related parts, fight, flight, freeze, submit, and attach can be activated during day-to-day life and manifest in unhelpful symptoms, such as hypervigilance and mistrust, self-harming behaviours, intense and overwhelming emotions, or depression and anxiety. Ogden (2020) described this as one part of the person experiencing too little of the trauma and the other part experiencing too much of the trauma. These parts remain unintegrated for survivors of trauma (Fisher, 2014, 2017a; Ogden 2020).

Even when the individual's daily adult life is safe and stable, the trauma related parts may be sensitive to threat detection. Any traumatic interpretations can inform the trauma related parts that they are in the same danger as they were in childhood. The parts become activated with the goal of ensuring survival. The trauma related part that responds can vary by person or context. For example, the flight part might respond by escaping through unhelpful coping mechanism, such as substance use, disordered eating, or self-harming behaviours to find relief. The fight part may manifest as irritability and mistrust to push others away or suicidal and self-harming behaviour, attach parts can adopt self-sacrificial behaviours to stay in connection with another, and a submissive part might be overwhelmed by depression and shame, and so on. The behaviour of the parts can be differentiated in this way (Fisher, 2014, 2017a; McBride, 2021; Ogden 2020).

McBride (2021) conceptualized the trauma related parts "hijacking" the system as "memory cookies" (p. 69). The metaphor is that imagine you are baking cookies, using all the necessary ingredients. Once the cookies are baked it is impossible to remove the flour, butter, and chocolate chips but keep the salt. McBride explained that "separate things have become something else in combination" (p. 69). Experiences of trauma work the same way with the nervous system. Every ingredient of the trauma experience combines in a way that prevents them from being separated again. This is our body's adaptive response to keep us safe. It can be both unhelpful and helpful at times. Even if we experience just one trauma ingredient the body automatically cues the trauma response parts. This is an important and helpful process to keep us safe from danger. It can also be unhelpful as just one ingredient of trauma does not indicate that the trauma is reoccurring. However, in an attempt to keep us safe, the trauma related parts can hijack the "going on with life" parts when presented with even a single trauma ingredient

(Fisher, 2014, 2017a; McBride, 2021; Ogden 2020). Porges (2011) originated the term "neuroception" to refer to our threat detection centres. Our neuroception is an instinctual response which occurs below our conscious awareness and that scans our environment for different levels of safety. Due to neuroception, we either determine that the environment is safe, dangerous, or life-threatening and our nervous system responds accordingly. We will neurocept life-threatening danger in the presence of any "trauma ingredients" or cues that are associated with the initial trauma and our nervous system will respond by trying to keep us safe, but without being confronted with actual danger our survival responses begin to disrupt our overall functioning (Ogden & Fisher, 2014; Porges, 2011).

Substance Use

The popularized mantra from Maté (2008) reads "The first questions is not why the addiction, but why the pain?" (p. XIX). The significance is that addiction is a normal response to trauma. This has been apparent in the literature since the rat park experiment was carried out in the late 1970s by Alexander Bruce (2010) and colleagues. The researchers created a rat habitat that resembled a naturalistic environment as closely as possible in a laboratory setting, which came to be known as rat park. The rats' dietary, social, curiosity, and activity needs were met in rat park opposed to typical laboratory metal cages where the rats are subjected to social and sensory isolation. The rats in each environment had unfiltered access to morphine. After observing the morphine consumption, it was clear that the rats housed in rat park had little interest in the morphine compared to the isolated rats. This result was consistent even when the experimenters forced the rats in both groups to consume morphine regularly until cessation would result in withdrawal symptoms. This highlights the adaptive use of addictive substances to cope with unbearable emotional pain and the adverse outcomes of trauma, including the

subsequent challenges in emotional regulation (Alexander, 2010; Fletcher, 2021; Herman, 2015; Manley & DeJong, 2014).

There is consensus in the literature that a history of CSA is associated with an increased risk of use of addictive substances in adulthood. This is thought to be in part due to the relationship between attachment and development of interactive and auto-regulatory abilities. The experience of a significant attachment trauma can interrupt the early relationships where these abilities are formed. The literature has linked challenges with emotional regulation to an increased risk of substance misuse. In these contexts, it seems that the individual has not had the benefit of learning how to discharge activation in their dysregulated nervous system in safer ways and instead has adapted to relying on substances in attempts to regulate their ANS. Addictive substance use is a form of self-destructive behaviour that functions in the same way that self-harming behaviours do. The engagement with addictive substances provides short-term relief from the activation in the nervous system, which is then followed by adverse outcomes, such as negative social consequences or revictimization, which reinforces the need for the use of their regulatory tool. Often the exposure to the body's trauma responses feels more life threatening for the trauma survivor compared to the self-destructive behaviour itself (Fisher, 2017a; Fletcher, 2021; Hiebler-Ragger & Unterrainer, 2019; Manley & DeJong, 2014; Walker & Wamser-Nanney, 2023; Zdankiewicz-Ścigała & Ścigała, 2020).

The experience of CSA can significantly alter an individual's sense of safety, ability to trust others, and ability to maintain intimacy and closeness with others. Their systems of attachment no longer function to connect the survivor to their communities resulting in the individual experiencing a pervasive sense of loneliness and isolation. Alexander (2010) emphasized our need for psychosocial integration, which he described as "a profound

interdependence between individual and society" which meets our need for social belonging and our "equally vital needs for individual autonomy" (p. 58). Alexander argued that interdependence with community offers us identity, makes life meaningful, purposeful, and even joyful at times. Dislocation is the experience of an intense lack of psychosocial integration, which involves "psychological and social separation" from one's community (p. 59). Alexander's dislocation theory of addiction posits that addiction is one way of adapting to pervasive dislocation. Unfortunately, the outcomes associated with addictive substance use can serve to further perpetuate dislocation. The individuals with a history of CSA who are unable to establish safety within relationships and are consequently consistently isolated from their communities are experiencing an intense state of dislocation. This can be a significant contributor to the use of addictive substances amongst individuals who have experienced CSA as substance use can manage the emotional pain of dislocation. Alexander argued that even the most harmful addictions are more "life sustaining" compared to "social exclusion and aimlessness" (p.62). It is an unhelpful cycle as reduction in use of addictive substances requires connection with others, but this is not possible when connection and intimacy feel dangerous and cue survival strategy responses (Alexander, 2010; Dimitrova et al., 2010; Fletcher, 2021; Herman, 2015).

Mediating Factors

Relationship to the Perpetrator

The research has shown that adverse outcomes of CSA are more severe when the perpetrator of abuse is a parental caregiving figure compared to a peer or acquaintance. Unfortunately, CSA is most often reported to be perpetrated by a significant attachment figure. The experience of this type of interpersonal abuse is known to evoke intense feelings of fear, loss, betrayal, and a lack of autonomy, all of which can be carried into adulthood. Often the child develops an internalized sense of blame and shame. A young child needs their caregivers for

survival. Consequently, as an adaptive strategy when the child is confronted with an awareness that something is wrong, they determine that the cause is themselves and not the caregiver, and the blame and sense of inner badness becomes internalized. This can manifest as acceptance of poor behaviour from others and apathy around protecting oneself in adulthood. This horrific type of betrayal from an attachment figure significantly disrupts the individual's sense of trust and safety that is essential for experiencing secure relational attachments throughout life. The lack of trust colours every relationship and the survivor's ability to form intimate, mutual, and stable relationships can be severely compromised. When traumatic events are related to attachment figures, the individual may feel uncomfortable with closeness and intimacy as the felt sense of safety cannot be established in the nervous system. The sensation of closeness and intimacy has become a trauma ingredient which signals danger. The survivor can have difficulty developing quality relationships which leads to social disconnection and often perpetuates symptoms of trauma (Bigras et al., 2021; Dimitrova et al., 2010; Herman, 2015; Liotti, 2011; Maciel & Basto-Pereira, 2020; Mucci, 2019).

An attachment figure perpetrating CSA is a clear example of frightened or frightening parental behaviour. These are the contexts in which adaptive fragmentation and disorganized attachment styles develop. The child is constantly forced to manage a paradoxical dynamic of seeking safety and trust from unpredictable and dangerous caregivers. The development of an attachment style in an abusive environment can complicate the internal working model of the survivor. The attachment figure becomes both the cause of fear and harm but can also act as the source of comfort. The child lives in an erratic environment where they are never certain of the type of parental behaviour they will be presented with and subsequently adopt a remarkable ability to perceive danger. This pervasive sense of unsafety demands a constant state of

hypervigilance in childhood which can lead to fragmentation. The fragmentation occurs due to impacted corpus callosum development and the need for different parts of the self to respond to a variety of threats. The "going on with life" parts of the self and the trauma-related parts of the personality become well defined (Bigras et al., 2021; Fisher, 2014; Herman, 2015; Liotti, 2011; Maciel & Basto-Pereira, 2020).

CSA perpetrated by an attachment figure is a type of attachment trauma that brings a complex and confusing understanding of how care and connection are received and experienced. These circumstances can further lead to a restricted sense of entitlement in adulthood. A restricted sense of entitlement is often reinforced in childhood experiences as compliant and trusting behaviour can prevent the experience of additional aggression or harm to loved ones. These horrifying childhood experiences can inform the survivors internal working model in ways that lead to the survivor seeking care and connection within contexts that result in experiencing revictimization. This can be exacerbated when the individual does not have secure attachment relationships to buffer the distressing experience or to model non-harmful, genuine care and connection (Brenner et al., 2021; Bigras et al., 2021; Fisher, 2014; Herman, 2015; Liotti, 2011; Maciel & Basto-Pereira, 2020; Mucci, 2019; Shen & Soloski, 2022).

Attachment as a Protective Factor

Unfortunately, a majority of CSA survivors experience significant disruptions in attachment security and present with insecure attachment in adulthood. However, the intensity of the adverse outcomes of CSA seems to be related to the quality of the survivor's attachment style. The research has found that survivors of CSA who have positive intimate relationships are less likely to develop trauma symptoms that perpetuate into adulthood and are less impacted by the adverse outcomes in general. Survivors with family factors that were considered protective,

such as secure attachment relationships, were found to be experiencing, at most, only slightly more adverse experiences compared to the average population. Survivors of CSA with secure attachment orientations had a significantly decreased risk of developing trauma related symptoms such as PTSD, depression, anxiety, and dissociative symptoms. Secure attachment relationships seem to protect the survivor's capacity to maintain closeness and intimacy which appears to be an essential factor. Secure social supports can buffer the negative impacts of trauma through re-establishing safety and trust, access to interactive regulation, and developing a capacity for autoregulation (De Jong et al, 2016; Dimitrova et al., 2010; Ensick et al., 2021; Shen & Soloski, 2022). Interestingly, some literature indicates that survivors of CSA who had secure childhood attachments were less likely to display anxious attachment behaviours in adulthood compared to the average population. Yet, secure childhood attachment did not mediate avoidant attachment behaviours in adulthood for survivors of CSA. One explanation offered is that individuals who display more anxious attachment behaviours may be more likely to disclose their abuse and access their desired care (Shen & Soloski, 2022). Other research demonstrated that the experience of caregivers being supportive upon disclosure of CSA lowered avoidant attachment behaviour (Godbout et al., 2014).

The literature suggested that secure attachments formed in childhood or established in adulthood are known to decrease the severity of adverse outcomes of CSA. Our internal working models that manifest as our attachment styles are first developed in childhood and are considered to be relativity stable. However, they can continue to be informed by adult relationships due to the neuroplasticity of the brain. There was previous debate that neuroplasticity only occurred in the early stages of life. However, it has been established that the brains capacity for neuroplasticity is fortunately accessible throughout our lifespan. This offers some flexibility to

our internal working models and subsequently our attachment styles in adulthood (Bowlby, 1979; Dimitrova et al., 2010; Fosha, 2021; Mucci, 2019; Shen & Soloski, 2022).

Embodiment-based Therapies

The growing understanding of the neurobiological impact of trauma has highlighted the essential need for, what I will refer to as, embodiment-based psychotherapies or bottom-up therapeutic approaches. The acknowledgement that trauma is foremost a bodily based experience has resulted in the increased use of embodiment-based psychotherapies when working with the impacts of trauma. The outcomes of trauma were historically considered a "mental problem" but as Levine (2010) has said "trauma is something that also happens to the body" (p. 31) Considering the context of CSA, developmental trauma has an impact on most of our body systems, including neuroendocrine systems, neurotransmitter systems, and attachment systems. Trauma can become "deeply etched" into the body (Grabbe & Miller-Karas, 2018, p. 2; Levine, 2010; Schore, 2001; Yuhas, 2020). Using a bottom-up approach to work with the embodied trauma is an essential component to symptom reduction for individuals who are suffering from adverse outcomes of CSA. Top-down approaches have been shown to potentially reduce preliminary symptoms of fear and anxiety but may overlook survivors' embodied feelings of shame, self-blame, mistrust, and aloneness if used preferentially (Forde & Duvvury, 2021). Our bottom-up processing centres instinctively communicate with our body while our top-down processing is a slower language-based analysis. This process occurs in our neocortical or "thinking" brain which is being called upon in top-down psychotherapeutic approaches. However, trauma has a major impact on our body's subcortical survival responses which cannot be reached through top-down processing. Traumatic memories are primarily encoded in our limbic system and brain stem, not in our neocortex. Therefore, psychotherapies that ignore the

body's involvement in trauma will consistently be limited (Forde & Duvvury, 2021; Grabbe & Miller-Karas, 2018; Levine, 2010; Ogden & Fisher, 2014; Sollmann, 2023; Yuhas, 2020).

When our neuroception detects threat, our nervous system enables us to respond with either fight, flight, or freeze. A large amount of activation is needed for our nervous system to mobilize our body to protect ourselves against threat. When we are not able to discharge this activation due to actual or perceived physical and social restraints, we rely on our freeze response. We become immobilized and consequently the activation cannot be released or discharged. It instead remains trapped in the nervous system resulting in a chronic state of nervous system activation. This chronic dysregulation of the autonomic nervous system when paired with intense fear can result in trauma (Levine, 2010; Porges, 2011; Manley & DeJong, 2014; Solloman, 2023). However, Levine (2010) argued that is important for therapist and their clients to understand that the immobilization response has helpful adaptive functions. Understanding the innate and supportive nature of our body's response is an essential part of healing from the impacts of trauma. Weakness and morality-based judgements only serve to shame our reactions "which drive them deeper inside the body and compound the trauma" (McBride, 2021, p. 57). In an effort to honour and avoid pathologizing our body's' survival responses, I will note the adaptive functions of our freeze response here outlined by Levine (2010). Frist, the freeze response is our body's final effort for survival. Second, the body's stillness offers a degree of invisibility from dangerous others. Third, it can prevent other members of the community from being the target of aggression. Finally, the freeze response is accompanied by a protective analgesic effect that decreases physical and emotional pain. In summary, it is our body's best attempt at protecting us in the face of inescapable threat. In a therapeutic context, bottom-up psychotherapies can help resource the client in a way that allows

their body to safely discharge the activation that has become immobilized in their nervous system (Solloman, 2023).

McBride (2021) formed a concise summary of other factors that are important to understand and appreciate about the systems that keeps us alive in the face of threat and trauma. First, our brain and body are intimately connected and communicate constantly. This is referred to as the brain-body connection and it is designed to facilitate survival and social connection. McBride stated that "survival and social connection are so closely connected that they are interdependent" (p. 56). Additionally, our survival responses are not innately harmful but helpful adaptive responses that show up when our survival or social connections are threatened. However, if we chronically remain in our survival responses our body and brain adapt in a way that makes it "easier to remain in our survival responses than get out of them" (p. 57). Finally, our bodies have an incredible capacity to heal. The brain-body system is exceptionally adaptive, and we can use internal and relational safety cues to get out of our survival responses and into a state of rest. Porges (2011) would refer to this as a ventral vagal state. McBride added that because social connections are integral to our survival, our nervous system can get back to safety more quickly in the context of a secure relationship where we can begin to engage in the processes of healing.

Our survival responses adaptively turn off our prefrontal cortex, part of our "thinking" brain, and put the activation towards parts of the body that are necessary to carry out our survival response. When our nervous system is dysregulated, we have limited access to our prefrontal cortex. Top-down psychotherapies are trying to call on skills that our body's are not able to retrieve unless we have established a safety in the body. Because the thinking brain is inhibited when the nervous system is dysregulated words and language are not the most helpful way to get

back to safety. Embodied and bottom-up therapeutic approaches can honour the body's protection systems and slowly help the body feel safe enough to manage the activation in the nervous system in helpful ways. When we neurocept a level of safety that allows our ventral vagal system to engage, our body can start to understand that the traumatic event has happened in the past and we are no longer in active danger (Fisher, 2017a; Manley & DeJong, 2014; Mcbride, 2021; Ogden & Fisher, 2014; Yuhas, 2020).

I will note a few of the founders of somatic or body-centered therapies whose work has informed my understanding of embodiment-based psychotherapies and subsequently the following application section. First, is Pat Ogden the founder of a somatic therapy, called sensorimotor psychotherapy, which has many applications in working with trauma. Second, another somatic therapy that is significant in trauma treatment, called Somatic Experiencing Therapy, was developed by Peter Levine. The third is Diana Fosha who is the founder of Accelerated Experiential Dynamic Psychotherapy (AEDP). AEDP is an embodiment-based therapy in that it privileges bottom-up experiences. It can serve to facilitate the processing of overwhelming affective experiences of trauma through corrective relational experiences which can have a profound impact on our neurobiology due to neuroplasticity. The final found to be noted is Janina Fisher. Fisher developed a psychotherapy for working with outcomes of complex trauma called Trauma-Informed Stabilization Treatment (TIST). It is not explicated stated as a bottom-up therapy, but it is based in part on internal family systems and Pat Ogden's sensorimotor therapy. Consequently, many elements of TIST are somatically based. Using fundamentals of these embodiment-based psychotherapies the following chapter will explore some of the applications of embodiment-based therapies when working with the adverse

outcomes of interpersonal trauma (Fisher, 2017a, 2017b; Fosha and Yeung, 2006; Fosha, 2021; Levine, 2010; Manley & DeJong, 2014; Ogden & Fisher, 2014).

Chapter Three: Application of Embodiment-Based Therapies

Myth of Self-regulation

Bonnie Badenoch (2017), a renowned trauma therapist with over 30 years of experience in the field, presented the idea that we often treat self-regulation as a moral imperative. This is unfair as we are not born with a circuitry for regulation, it must be cocreated with another individual. Often these individuals are our primary caregivers. However, when we experience trauma or significant attachment disruptions, this is not possible. Further our survival is wired in with the need for social connection. We are not meant to exist alone in world, and Badenoch argued that we all rely on co-regulation throughout our lifespan.

Often the assumption is that therapeutic healing is present when clients increasingly need less support from the therapist. However, when working with trauma, Badenoch (2017) argued that this is a process that can oscillate. Clients may need a higher level of support at some points in their therapeutic experience compared to other periods of time. It does not necessarily represent a decline in wellbeing or an over dependency on the therapist if the support required does not steadily decrease. The deeper we engage with overwhelming emotions the deeper the need for the support of another to hold us within their boarder window of tolerance. Further, the deeper our relationship with clients the more they can benefit from our coregulatory support and feel safe enough to engage with their previously overwhelming emotions. In this way, the level of coregulatory support may even increase towards the end of therapeutic work as clients feel steadily safer to dive a little deeper (Badenoch, 2017; Fisher, 2014; McBride, 2021; Schore, 2014).

If we have not previously had the chance to cocreate regulation circuitry, we do not have the capacity to self-regulate. When we expect clients with trauma to be self-sufficient and self-regulate, we are asking then to tap into something that might not be accessible. Our capacity to tolerate overwhelming affective experiences is dependent on our regulating circuity acquired typically early in life with our primary caregivers. Without interactive regulation in childhood, the development of regulating circuitry is disrupted. In these contexts, children do not have access to auto or interactive regulation and instead often rely on fragmentation in order to compartmentalize overwhelming experiences. In adulthood, when a traumatized client is under the stress of overwhelming emotions, they will often rely on their compartmentalization or dissociation strategies when in need of soothing. This process can masquerade as self-regulation. They have instead slipped into their left brain or "going on with life" parts and ignored the trauma related parts. This is unhelpful as the trauma related parts will find a way surface, These parts also need to be heard and honoured (Badenoch, 2017; Fisher, 2014, 2017a, 2017b).

Simplistically, the right hemisphere of our brain is the relational part of the brain. It is responsible for our survival responses but also for tracking what is going on within social interactions. It can sense the aliveness of the present moment, has a higher paradoxical capacity, and values diversity, emergence, and relationships. Lots of right brain to right brain communication is understood nonverbally and tracked unconsciously. The left hemisphere offers stability. It values systems, organization, tasks, and behaviours, over relationships. It is objective, and the aliveness of the present moment does not exist here. The left brain does not have capacity for relational circuity, subsequently when it is dominant there is no felt sense of connection. Top-down processing relies on the left brain and bottom-up processing recruits the right brain. It is very helpful when the two sides are integrated. If they work together with the

right brain in the lead, we can access presence and connection while benefiting from the stability of the left brain. With how our individualistic and capitalistic North American society is structured, we can often go about our day existing exclusively in our left brain. When we are consistently in the left brain, where there is no sense of felt connection, we are gathering cues that we are alone and subsequently must rely on the self for regulation. Therefore, we find adaptive, but unhelpful ways to manage our overwhelming experiences on our own (Badenoch, 2017; Schore, 2014).

Badenoch (2017) explained a concept of internalized others, which is that through mirror neurons, we take in others' emotional states, bodily sensations, and intentions all while encoding what that person looks, sounds, smells like. We also simultaneously encode how our body feels in that moment of interactive regulation. In this way we start to create this inner community of people whom we have internalized. The outcome of this processes is that we now have an ability to always have access to effective co-regulators. Therefore, according to this theory, when we are speaking about self-regulation, we are instead referring to co-regulation by our internalized others. In the context of psychotherapy with traumatized clients, engaging in relationship and bottom-up processes that support internalization may be more helpful compared to teaching skills for self-regulation. The learning of new skills relies on top-down processing through the prefrontal cortex which abilities are inhibited when we are dysregulated. Considering this, benefiting from interactive regulation with another and then being able to connect with the felt sense of this experience may be more accessible way of offering traumatized clients a capacity for self-regulation. As the capacity for self-regulation increases so will the access to the prefrontal cortex and subsequently the ability to acquire new skills.

Levine (2010) highlighted the benefit of interactive regulation in the face of overwhelming stress in describing his experience of being hit by a car. He explained that he was able to lean into his body's involuntary movements which allowed his nervous system to complete its response to the life-threatening event which prevented him from becoming traumatized. He asserted that despite his years of experience and knowledge in this area, his body would have not been able to go through this process if he was alone. He credits a thoughtful and kind bystander who provided relational safety cues that allowed his body to feel safe enough to complete the survival response. He explained that the warm presence of the bystander sitting beside him while he waited for the ambulance "bypassed the rational frontal cortex to reach directly into the recess of my emotional brain" which provided him enough regulatory support to engage with overwhelming sensations (p. 13).

Undoing Aloneness

The concept of "undoing aloneness" is a significant piece of practice in AEDP. The thought is that adverse outcomes are fundamentally a result of an undesired sense of aloneness when confronted with overwhelming affective experiences. The experience of emotions can easily become overwhelming as attachment trauma often prevents the ability to develop effective affect regulation strategies. In the context of attachment traumas, we often start to internalize that our emotions are unacceptable as the presence of them disrupted the attachment system in childhood. For a child, this disruption can be life threatening. The lived experience has informed the internal working models that the experience of any emotion is dangerous, which results in an association of emotions with feelings of fear, worthlessness, and shame. The individual is essentially having feelings about having feelings. The true feelings are known as the core affect and the others are often referred to as secondary emotions. The experience of unhelpful

secondary emotions, such as shame and worthlessness, exasperates the individual's feelings of loneliness which can result in an unhelpful cycle of isolation and increase in adverse outcomes. Often, in order to protect themselves from experiencing overwhelming emotions alone, clients will use coping mechanisms to avoid any emotional experience. The therapeutic work is then to undo the client's aloneness by offering unconditional acceptance of emotions and interactive regulation while together we experientially process the painful emotions that were overwhelming to process alone. The core affective experiences are thought to be inherently adaptive, meaning that experiencing them to completion in the context of a safe and secure relationship results in positive transformation. Transformation is thought of as our innate ability to heal and self-right. Everyone has the capacity for transformation (Fosha, 2021; Fosha & Yeung, 2006; Markin et al., 2018; Medbo, 2024; Medley et al., 2021a, 2021b).

In the context of complex trauma, there are some distinct considerations. The experience of trauma can result in the emergence of maladaptive affective experiences. Fosha (2021) explained that "whereas the adaptive core affective experiences *are* transforming, the maladaptive affective experiences *need* transforming." (p. 14). Some maladaptive affective experiences are overwhelm, chronic shame, fear without any resolution, unbearable aloneness, fragmentation, helplessness, and brokenness. It is not helpful to work with maladaptive affective experiences in the exact same manner as core effective experiences as they do not adaptively complete when experientially processed. However, they are still valuable in that they hold significant information about our lived experience. They are thought of as a "split-off" from the core self, and without being felt and witnessed by a safe other they cannot integrate into the core self. The process of transforming maladaptive affective experiences is the client slowly recognizing that, for example, their experience of abuse was not a reflection of them, but

someone else's grave deficit. This can be difficult because as a child, often the survivor internalizes the blame as is it less threatening then placing it on the caregiver, whom they need to survive. What they attributed as self-deficiency was actually necessary survival responses that allowed them to remain attached to a harmful caregiver. For example, often survivors carry a lot of shame around not fighting back but instead becoming immobilized. When in actuality that was their body fighting back using the freeze response, which offered the best chance of survival under the circumstances. Included in this process is honoring that these adaptive responses were necessary for survival as a child, but as an adult they are no longer needed. A process of celebrating how those parts have helped you and letting the sense of safety soak into the body so that they know you no longer need protection. This sense of safety is easier to establish in the context of a secure relationship, where, once established, we are no longer alone and can engage in the process of healing (Fosha, 2021; Levine, 2010; McBride, 2021; Medbo, 2024; Medley et al., 2021a, 2021b)

I will note that it is vitally important that as practitioners, we are comfortable engaging safety with our own affective experiences. If we are not embodied in this way, we will not be able to join the client in their affective processing and, once again, they will be left alone with their overwhelming emotions. If we are not able to help contain their affective experience through interactive regulation and relational safety cues the client will be alone with their suffering. This felt sense of abandonment will reenforced the fear of being overwhelmed by their affective experience and we have not cocreated the space to develop effective regulation strategies (Levine, 2010; McBride, 2021). Our comfort with our affective experiences allows us to remain as what Fisher (2017b) refers to as an auxiliary cortex and a neurobiological regulator. When clients engage with implicit traumatic memories their prefrontal cortex becomes inhibited

in service of their limbic system. The limbic system is where the survival responses are stored. Their ability to verbally track their own experience is lost. The psychotherapist needs to become the auxiliary cortex in order to help the client make meaning about their trauma related reactions. In childhood, attachment figures acting as external neurobiological mediators is critical for developing affect tolerance as this process expands our window of tolerance. In many cases of trauma, this attachment system has become disrupted, and the child has not been able to grow a "spacious and flexible" window of tolerance (Fisher, 2017b, p. 54). In summary, the psychotherapist must be successfully regulated to be able to join the client as a neurobiological regulator and offer effective interactive regulation.

Moving Towards a Secure Attachment

John Bowlby's (1979) theory of attachment regarded our attachment styles to be reasonably stable throughout our life span. He proposed that our attachment styles would characterize our behaviour from the "cradle to the grave" (p.129). Expansions on Bowlby's theory of attachment have found that attachment styles are not necessarily fixed, and it is possible to move from an insecure attachment to a secure way of relating through neuroplasticity and corrective attachment experiences. The transition from an insecure attachment to a secure attachment has become known in the literature as earned secure attachment. Opposite to continuous-secure attachment which represents a secure attachment formed in childhood and carried into adulthood. Individual's with earned-secure attachments are found to report more experiences of childhood trauma, loss, and abuse, including sexualized abuse compared to continuous-secure individuals (Feinnberg, 2015; Fosha, 2021; George et al., 1985).

Our internal working models that inform our attachment style are developed by information gathered from our lived experiences. Our earliest lived experiences are with our

primary caregivers, and these are what form our initial attachment style. Attachment styles can be resistant to change in that we often interpret the information gathered from our lived experiences in ways that confirm our previously established assumptions about ourselves and others. However, because interpersonal experiences play a large role in shaping our attachment styles they can be changed within appropriate environments. For those who have experienced a significant attachment trauma, a therapeutic environment can be one of these contexts where clients can work towards an earned secure attachment. A therapeutic relationship can offer an interpersonal experience where the body and the mind can become familiar with a secure way of relating. Relationships that embody a felt sense of acceptance and trust seem to be significant in moving towards earned-secure attachment systems. These seem to be qualities that contribute towards a felt sense of safety (Feinberg, 2015; Fraley et al., 2021; Frederick, 2021; Fosha, 2021; Manley & DeJong, 2014). Fosha (2021) advocated that "trauma is healed by championing the innate healing capacity of neuroplasticity in a safe, attached therapeutic relationship." (p. 5).

A secure attachment system relies on an attuned caregiver that can engage in right brain to right brain communication. We benefit from a secure attachment system by learning how to effectively regulate and interact with our affective world. Insecure attachments are fostered when caregivers neglect or reject the child's emotional needs. This is experienced for the individual as disconnection from the attachment system. Survival and our need for social connection are intimately intertwined, particularly in childhood when the individual is reliant on their primary caregiver for their basic needs. Subsequently, disconnection from the attachment system becomes a threat to our survival. Eventually the child adaptively learns to avoid engaging with their affective world to prevent disconnection from their attachment system. (Fosha, 2021; Frederickson, 2021; McBride, 2021; Schore, 2014). In AEDP, our genuine emotional experience

is referred to as our core affect. Those who have developed an insecure way of relating have learned to put up defenses against their core affect as a form of protection. However, our survival strategies or coping mechanism can negatively impact us over time as they can "compromise individuals' inborn ability to feel, communicate, and share their core affective experience." (Frederick, 2021, p.193). Our bodies and affective world offer us large amounts of wisdom, when we block these sensations and information off, we are losing a helpful resource. To reengage with our core affective experiences, we can engage in new relational experiences where our affective world is accepted and does not threaten the attachment system. In the context of therapy, AEDP refers to this as corrective attachment experience where we as psychotherapist can make it clear to the client that they will not be left alone with overwhelming emotions. Instead, the therapist will operate as a secure base and offer an "embodied willingness" to meet the client with interactive affect regulation. (Frederick, 2021, 190). From this secure base the client ideally will feel safe enough to explore their core affective experiences and benefit from positive neuroplasticity. Through the repeated experience of a secure way of relating, change can be made on a neural level. In the same way that a clients internal working models were based on previous lived experiences, they can be updated based on here and now experiences. This process of unlearning can take time as the individual's nervous system needs to feel safe enough to explore outside of their internal working models early beliefs on relating and trust their capacity to rely on coregulation. Additionally, time is needed to grow their capacity to take in the genuine care and empathy of another (Fisher, 2014; Fosha, 2021; Fosha & Yeung, 2006; Frederick, 2021; Markin et al., 2018, Ogden & Fisher, 2014).

When any form of positive transformation occurs, AEDP therapist use an intervention known as metatherapeutic processing, commonly referred to as metaprocessing. The purpose of

metaprocessing is to bring the client's progress towards their goals to attention and make it explicit. Metaprocessing serves to soak the transformation into the client's nervous system and acknowledge the felt sense of it in their body. In the context of moving towards a secure attachment, metaprocessing might look like using immediacy to explore what the client is physically feeling or sensing about their way of relating with the therapist. This process helps consolidate the learning from the new lived experience. It also serves to shift our human evolutionary bias of attending to negative experiences towards more frequently attending to positive experiences (Fosha, 2021; Fosha & Yeung, 2006; Frederick, 2021; Markin et al., 2018). Elements of metaprocessing are found in Rick Hansen and Richard Mendius' (2009) practice of "taking in the good". We inherently scan for, remember, and recall more unpleasant experiences comparatively to positive ones. This is adaptive in that it is beneficial to our survival to recall what was dangerous, fearful, or life-threatening. However, it also results in our memory having a bias for negativity. The practice of "taking in the good" offers a way to become more mindful of positive experiences so we can fully take them in and help balance this inherent negative tilt. Hansen and Menduis instructed to acknowledge positive facts as experiences and "savor" them by maintaining your attention on the experience. Next, focus on the emotions and accompanying bodily sensations and let them fill the body. The authors suggested to imagine this affective experience entering deeply into the body like "sun warmth into a t-shirt, water in a sponge, or a jewel placed in a treasure chest in your heart" (Hansen & Menduis, 2009, p. 69). In the same way as metaprocessing, this process serves to consolidate the positive lived experiences into our body memory.

Ogden (2020) makes an interesting distinction between trauma interventions, which she considered to be bottom-up interventions, and attachment interventions, which focus on the

relational or emotional aspects of the attachment disturbances. Ogden recognized that interventions that belong to trauma and those that belong to attachment disturbances always overlap. Attachment disturbances can often be referred to as attachment trauma for this reason. Ogden emphasized that when we experience trauma, it exists in our nervous system's survival defenses which can be reached through bottom-up processes. Engaging with these first to slowly increase the client's bandwidth to stay with their body's is imperative before exploring the deep emotional and relational wounds of the attachment trauma. Again, the nervous system needs to feel safe enough to explore outside of the mechanisms, or parts of themselves, that they have adapted to keep their overwhelming emotions at a safe distance.

Safety Discharging Activation

The freeze or immobility response is not inherently traumatizing. It is our body's most adaptive response to a threat when fight or flight are not effective options to protect ourselves. The immobility response becomes traumatizing when it does not resolve and becomes coupled with fear. Our survival responses are hierarchal, because of this when we start to move out of immobility our fight response is accessed which often manifests as intense anger or rage. When experienced abruptly, these emotions are overwhelming and fear inducing, especially if we do not have effective regulating strategies. When our fight response mobilizes, our prefrontal cortex shuts down to send energy to other parts of the brain and body and it becomes difficult to observe and understand our drives and sensations. Instead, the emotions and sensations are overwhelming and to manage the rage them we supress it, turn it inward, and shut back down into immobilization. This cycle prevents the response from every fully completing and which then results in the activation becoming trapped in the nervous system. Levine (2010) described this fear-immobility cycle that perpetuates trauma starting as a state of immobilization, then

moving out of immobilization and feeling arousal sensations, then becoming overwhelmed by sensations instead of moving through the activation response, then experiencing fear and helplessness and returning to immobilization. To prevent this cycle, the psychotherapist and the client work towards "uncoupling" the fear from the immobility to restore the client's ability to terminate immobility when it is no longer useful (Levine, 2010, p. 68).

Levine (2010) offered that the fear that perpetuates immobility can be organized as two separate fears. Frist is the fear of entering immobility. In a state of immobility, we feel numb, vulnerable, and helpless. The experience is described as similar to the sensations of sleep paralysis. However, slipping into this while being awake throughout the day. The more sensations and experiences we resist due to fear the more our body encodes them as being dangerous which ends up compounding the fear when the sensations inevitably surface. The second is the fear of exiting immobility. When we move out of immobility are nervous system prepare us for a counterattack, either fight or flight. It is accompanied by intense and overwhelming activation that is typically manifested as rage. Individual fear that this overwhelming rage will result in violence against other and it often can become turned towards the self in the form of depression and self-harming behaviours. These paradoxical fears keep those who have experienced trauma "trapped between feeling too much (overwhelmed and flood) or from feeling too little (shut down and numb) and unable to trust their own sensations" (Levine, 2010, p. 136). The individual then flips between paralysis and "misdirected rage". Socially, this can be unpleasant which contributes to the individual becoming further isolated and prolonging their symptoms of trauma (Herman, 2015; Levine, 2010).

Levine explained that without "education, preparation, titration, and guidance" a tolerable exit from immobility cannot be experienced (p. 88). Titration is known as slow renegotiation

with the trauma by gradually experiencing small doses of the sensations instead of being flooding with them all at once. A part of the psychotherapist's role is to help contain the overwhelming emotions. Levine noted that it is important to establish that containment is not suppression. It can be conceptualized as building a large enough container to hold overwhelming emotions and sensation or expanding one's window of tolerance. In other words, it is working with the client to maintain the capacity of the prefrontal cortex and the social engagement system while experiencing primitive sensations of the survival response (Levine, 2010; Ogden & Fisher, 2014). Along with titration, the psychotherapist can increase the client's confidence around engaging with their sensations by first acknowledging any positive shifts in the client's posture or facial affect. By first engaging with a pleasant sensation, it might gradually give the client assurance to explore the entirety of their affective world (Levine, 2010).

The energy that our body's mobilized as a response to threat can become stored as an "unfinished procedure within the implicit memory of the sensorimotor system." (Levine, 2010, p. 93). When we detect a stimulus that is associated with the trauma memory our body and muscle mobilize as if the threat is present in the here and now. We can use the remobilization to discharge that energy that has been stored in the nervous system. The therapist can track postural, gestural, facial, and psychological shifts throughout session to help bring them to the client's awareness. If we tune into the body, our sensorimotor memory can inform us of which movements will aid in completing our action systems which once complete, will naturally discharge the energy in the nervous system. Ogden offered us an example of this process with her client. When talking about the content of the client's distress, the client reported feeling trapped which has symptoms of immobilization. Ogden recognized this as a thwarted flight response. The client and Ogden then practice walking around the room, focusing on their legs,

and noting how their bodies could carry them to and from certain objects. The client reported feeling present and aware of her legs. The movement allowed the client's social engagement system to remain on while she consciously completed the flight response (Levine, 2010; Ogden & Fisher, 2014). Levine (2010) offered a similar example when he was tracking his client's unacknowledged micro moments. While his client was talking about her stressors, she began to extend her arms and hold her wrist at right angles, as if to push something away. Levine first mirrored her motion and then brought her movement to her attention. He asked her to repeat the movements slowly and tap into how her arms physically feel when she makes the motion. The pace of motion is important as quick exaggerated movements can override feeling the sensations. Slow movements allow us to remain focused on the sensations. The client goes through a process of discharging energy though pushing something away, which starts to discharge energy from the fight response. This is a process of feeling sensation, pulling away, and going back into the body or the sensation, rather than going into all the sensation at once and flooding the system. Linking of resources is a helpful tool to aid against flooding. In the example Levine's client, she was able to detect the solidness of her arms and legs and later visceral feelings of warmth and expansion in her chest. Together, these resources allowed her to gradually experience the overwhelming sensations and complete the actions cycles. As she could go into the sensation and bring herself back by grounding herself with her resources. In the case of Ogden's client, she used eye contact with Ogden as a grounding relational resource. When Ogden returned her eye contact, the client reported feeling safer and being able to breath deeper. The client was using her attach survival response and when it was met by Ogden, her social engagement system could remain on instead of protecting herself with immobilization (Ogden & Fisher, 2014). If it is accessible, being curios about the sensations can also offer an effective grounding tool. Levine (2010) explained that

"curious exploration, pleasure and trauma cannot coexist in the nervous system; neurologically, the contradict on another." (p. 175). This contradiction makes curiosity helpful when trying to keep our social engagement system turned on while we explore our bodily sensations in order to complete action systems and discharge energy from the nervous system.

Healing Our Fragmented Parts

As covered in chapter two, the fragmentation of the brain results in adaptive structural dissociation between the left "going on with life" brain and the right trauma-related brain, which is responsible for our survival responses, fight, flight, freeze, attach, and submit. This response is adaptive in that it allows us to maintain our functioning required in daily life while keeping the overwhelming sensations of the trauma related parts at bay. However, suppression of the trauma related parts of the self is not an effective long-term solution as they can hijack our systems. Our affective responses related to trauma related parts are intense and can be overwhelming to experience, particularly for individuals who have not has a chance to develop effective interactive or autoregulation abilities. Often this result in the individual instinctively disconnecting from their emotions and sensations to avoid the overwhelming and subjectively dangerous experience. The survival responses are often turned against the self. For example, the fight response is thought to contribute to self-destructive behaviours. Physical self-harm can offer the individual adrenaline and endorphin effects which result in a sense of regulation overwhelming emotions and sensations. Disordered eating, processes or substance addictive behaviours can help numb the emotions and sensations. Suicidal ideation can also grant the individual a sense of control over their waring parts. The experiencing of the trauma related parts is often much scarier for client compared to the risky self-destructive behaviours that offers them

short-term from relief from these overwhelming parts (Fisher, 2014, 2017a, 2017b; Levine, 2010; Ogden & Fisher, 2014).

Fisher (2017a, 2017b) founded Trauma-Informed Stabilisation Treatment (TIST), which is a psychotherapy that mediates trauma related self-destructive behaviours by helping to engage with the fragmented parts of the individual. The first imperative is establishing a sense of safety with the client. The going on with life part has access to the prefrontal cortex, but this access is inhibited when the trauma related parts detect threat and activate. Keeping the client regulated enough to access their prefrontal cortex depends on the ability of the psychotherapist to offer interactive regulation. The ability to socially engage with the therapist, learn, understand, and retrieve new information is reliant on the activation of the prefrontal cortex. The first task of TIST is to increase activity in the prefrontal cortex. In this case the psychotherapist role is to be the client's neurobiological regulator and auxiliary cortex so that they can offer psychoeducation about traumas impact on the nervous system and fragmentation, working towards decreasing shame by normalize the responses of the trauma related parts, help identify which parts might be arising, and make new meaning that challenges internalized sense of defectiveness. The going on with life part has the ability to be curious and notice experience, so even those experiencing severe fragmentation will always have a part of them that can engage with those abilities. A part of the process of establishing safety is to need to create a sense of safety for each part. "Each part represents a different approach to self-protection" and therefore should be celebrated and honored (Fisher, 2017a, p. 57). We can honor are parts by respecting the ways that they are managing the protection of the self. Each part can have different needs and responses. Ogden (2014) shared her work with a client that demonstrates this processes brilliantly. Ogden explained that, while mentioning her childhood trauma, her client's eyes intensely locked into

hers in a manner that suggested she must maintain the eye contact for survival. This behaviour is characteristic of the attach part, which felt safe when using the eye contact as a relational regulator. Ogden also noticed that while the client made eye contact her body also pulled back and she would occasionally break on contact to glance towards the door. Ogden recognized these behaviours as her flight part neurocepting danger from the proximity, which equally needed to be honored as much as her attach part. Ogden and the client established safety with this part by Ogden moving her position gradually away from the client until the flight part no longer felt threatened, while remaining close enough that the attach part could feel safe via eye contact. By honoring both parts' efforts for self-protection, the client's prefrontal cortex and social engagement system could remain online (Fisher, 2014, 2017a, 2017b; Fosha, 2021; Ogden & Fisher, 2014).

Ogden (2020) discussed the importance of being aware of each of the dissociative parts. If we are not sensitive to the needs of multiple parts of the self, we might unintentionally override one part instead of integrating them. When parts of the self are overridden, it is similar to suppression, they come out in even stronger and more unhelpful ways. Ogden shared about a client who had experienced severe trauma and felt protected by holding a posture that collapsed her body into herself. In session, she expressed feeling the intense need to open-up and found this lovely and welcoming posture, sitting straight up with her arms held out. This could look like healing and signal that her social engagement system was online. However, if we do not explore the parts somatically, we risk overriding the needs of other parts. When experientially engaging with the posture, the client reported that she felt vulnerable, afraid, and exposed. The new gesture was overriding the tight and frightened parts that needed to feel protected. Ogden and the client had to find a way to somatically integrate the needs of these two parts. The client

found that when she sat with a straight posture and wrapped one arm in front of herself, her tight and frightened part relaxed as that gesture spoke to the frightened part of herself. Integrating these parts allowed her to safely be in her body and remain socially engaged (Ogden, 2020).

The second task of TIST is to begin using parts language, instead of the possessive "I" language. In this way the client can attribute their unhelpful behaviour to the action tendencies of the parts. Using this language, the client can begin to differentiate between themselves and their trauma related parts. Clients are asked to practice noticing the different impulses and sensations of the parts, including any preparatory impulses to high-risk self-destructive behaviours. The third task is to begin to differentiate which impulses and sensations are associated with each part. For example, impulses to self-harm could be communication from the fight part, impulses to escape could be communication from the flight part, and extreme efforts to avoid abandonment could be communication from the attach part. The fourth and final task of TIST is to learn to dis-identify with the parts. Because all our trauma related parts and going on with life parts share the same nervous system, it is easy to become blended with the trauma related parts and loss the sense of self that has mastery and enjoyment of life. If the client can adopt the thinking that they are not their parts, and instead use language like, "there is a part of me that would like to harm my body", this will naturally cue curiosity. In this way, dis-identification between the self and the parts interjects curiosity between experiencing the emptions and then the impulse to act self-destructively. As curiosity is a quality of the "going on with life" part this will engage along with the prefrontal cortex and the individual will have much more control over how they might regulate themselves. This processes also becomes easier as the client can orient to the here and now, whereas the trauma related parts are typically responding to an implicit memory from out past. Fisher (2017b) referred to this as inviting the trauma related parts to be "here" instead of

"going there" where the self is able to provide a caring and safe emotional, relational, and somatic experience for the trauma related parts. Essentially the client's going on with life parts are learning how to work effectively with their parts. Eventually Fisher's therapeutic process results in the creation of an earned secure attachment system between the parts, where there is an embodied sense of trust and safety in the self. Fisher explained that secure attachment is not established based on one event, it is rather based on a consistent "emotional and somatic experience" (Fisher, 2014, 2017a, 2017b, p. 253; Ogden & Fisher, 2014).

Fisher (2017b) noted that clients can use their ability to fragment to their advantage in healing their unwanted dissociative symptoms. We often forget that dissociation is a "mental ability, not just a symptom" (p. 245). For example, medical professionals must use dissociative splitting to retrieve lifesaving medical information from their brain under high stress situations. As well as for athletes to access their peak performance during critical moments during a game. Dissociative splitting becomes unhelpful when it occurs involuntarily when the trauma related parts hijack the nervous system or blend with the going on with life parts and prevent them from functioning effectively. Clients with structural dissociation can use this ability to truly connect with the needs of the split parts without being influenced by the self. This allows the individual to intentionally put the need of the parts first, giving them the chance to appropriately response to those needs, creating safety within a secure attachment system, and preventing them from unhelpfully hijacking the system (Fisher, 2017b).

Expanding Window of Tolerance

Our capacity to tolerate our emotional, cognitive, and sensory experience is known as our window of tolerance. When our social engagement system is on, and we have access to our prefrontal cortex we likely within our window of tolerance. When we detect threat, we might

start showing signs of hypoarousal or hyperarousal. Again, this is not an inherently negative response. Our body can access survival responses to keep us alive. It becomes unhelpful when we can no longer get back into a restful state within our window of tolerance or when our bodies overestimate the perceived threat causing our nervous systems to become "hijacked" by our survival activation systems in response to neutral stimuli. For those who have experienced trauma, their window of tolerance can become very narrow therefore small amounts of stress can signal danger and prompt their nervous system into dysregulated states. This prevents them from being able to engage in a connecting and wholesome life. We are able to expand our window of tolerance with practice. However, it is not helpful if clients are flying out of their window of tolerance or do not trust that we can find out way back together. This can be retraumatizing. It is a process that must be done safely and one reason why establishing a felt sense of safety is a significant first step of trauma processing (Fay, 2021; Fisher, 2014; 2017a, 2017b; Levine, 2010; Manley & De Jong, 2014).

Deirdre Fay (2021) wrote a wonderfully approachable book that offers those who have experienced trauma a guide to becoming safely embodied. The approach was first applied to group therapy, but the skills are flexible in that they can be explored in one-on-one therapy sessions, or the book can be used by clients between therapy sessions if they are looking for more resources besides the hour a week that they are able to engage with their therapist. The skills were developed based on attachment theory, internal family systems, sensorimotor psychotherapy, and Fay's extensive experience in yoga and meditation. She outlined nine core skills in the book all of which are meaningful, important, and can contribute to expanding our window of tolerance, but for the purposes of providing an easily applicable tool that psychotherapist can offer their clients in therapy I will explore skill four. Skill four is useful for

working with those who hope to safety broaden their window of tolerance, it is known as "separating facts from feelings".

Each of us have a different window of tolerance, which is not stagnant. It can be influenced by our life events, maybe a particularly stressful week or month, or be significantly impacted by complex trauma. For those who are chronically fluctuating from a state of hyperarousal to then hypoarousal to contain their overwhelming experiences, being within the window of tolerance often feels boring. It is helpful to establish with clients the amount of space they have in their window of tolerance and where their nervous system typically sits. Fay (2021) offered an example of a client who often uses worrying to get out of a state of hypoarousal. It was a helpful mechanism to allow him to generate some feeling and get out of a numb state. However, the worrying itself was overwhelming and would push him back into to a depressive hypoarousal and the cycle would continue as such. Fay also noted that even pleasant emotions can push us out of our window of tolerance, as anything that is unfamiliar can become overwhelming and signal threat. When our body begins to send signal of alarm, it is helpful to find ways to slow down and assess if we are way outside of our window of tolerance or just on the end. Working alone the edge can slowly expand our tolerance. A useful tool for this is what Fay refers to as separating facts from feelings. This can help stabilize our inner world and serves to differentiate what is happening in the present instead of the traumatic past. In this context, the facts are the observable data, and the feelings are how we felt about those facts. If we noticed out body when we simple consider the simple, bare facts of a situation, not much goes on in the body. It might even feel boring. This is a helpful way of getting back to the edge of your window of tolerance when processing overwhelming sensation and emotions. Fay provided an example of this when she was working with her client who heard the loud noise outside the room and

noticed a man outside the counselling window. The client when into hypoarousal. Fay asked the client what just happened, but only the facts. If the client does not have access to their prefrontal cortex, Fay suggested listing the facts for the client until their social engagement system comes online and they feel ready. Once the client is able to state the facts, which are what occurred outside the person, they are invited to explore what happened inside the body, the sensations, maybe emotions. If the client starts to go outside their window of tolerance, the client and therapist can come back to the facts. The facts act as an effective grounding resource that is not inside the body, which often feels unsafe for those who have experienced trauma. The swing between the facts and feeling gradually expands the window of tolerance (Fay, 2021).

Closing

The adverse outcomes of complex trauma from experiencing CSA can have a profound impact on individuals' lives. The previous explored some specific outcomes of CSA which were attachment trauma, a restricted or inflated sense of relational entitlement, revictimization, complex posttraumatic stress, borderline personality features, fragmentation, and substance use. It further explored, how these outcomes are related and how their relationship can serve to perpetuate suffering. By inviting the body into the treatment of these adverse outcomes, clients and psychotherapists can find ways to alleviate suffering and increase quality of life for survivors of CSA. Honoring our body's wisdom and listening to how these adverse outcomes have been trying to protect us is an important avenue to being able to experience a more wholesome and full life.

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