

DUBLIN BUSINESS SCHOOL

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**AN EXPLORATION OF THE ROLE OF INTEGRATION IN HEALING
DEVELOPMENTAL TRAUMA**

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Abstract

Developmental trauma occurs at a stage of development when the self is most vulnerable and hence leaves a lasting legacy on the personality. The symptoms associated with developmental trauma are ‘nonverbal iterations’ in which there is no coherent narrative. The memory of early trauma is stored implicitly in the body and it is these implicit memories that manifest as somatosensory fragments, such as distressing body sensations and images. In developmental trauma, the emerging self protects itself by splitting off overwhelming experiences, in the process of dissociation, with the result that the personality becomes split and fragmented. In order to resolve this kind of trauma, this early protective process must be reversed – the dissociated must become associated again. The split off and dissociated parts of the personality must be linked together through integration which can be understood as something that lies at the heart of health and healing. The ‘parts paradigm’ is an effective model for working with this kind of presentation. In this process, the client is facilitated to have an internal dialogue to link different parts together. The non-traumatised, healthy part of the self, offers empathy and compassion to the traumatised ‘child-parts’ and in this process creates internal secure attachments by providing reparative experiences that serve as an antidote to the traumatic past.

INTRODUCTION

This paper will explore developmental trauma and how it can best be treated in a psychotherapeutic context.

The way in which developmental trauma occurs and what the implications are on the development and functioning of the self will be examined in the first chapter. The paper will look at how early trauma leaves a lasting effect on the personality, particularly in its ability to regulate affect. In the second chapter the paper will focus on how developmental trauma is stored in the form of implicit memory. The third chapter will explore the concept of dissociation, examining the key role it plays in the organisation of the personality after early trauma. This will lay the foundation for, in the final section, looking at how the integration of implicit memories and different parts of the personality can lead to the healing and transformation of developmental trauma. The paper will conclude with a critical evaluation of using a 'parts' approach to working with trauma in psychotherapeutic practice.

CHAPTER 1: DEVELOPMENTAL TRAUMA

People with trauma often present with symptoms rather than verbal narratives (Ogden et al, 2006). Traumatic memory often takes the form of reactivated nonverbal memories with incomplete narratives. These symptoms are split off from conscious awareness as sensory perceptions, obsessive thoughts and behavioural re-enactments. People ‘remember events’ through ‘nonverbal iterations’ of traumatic events or through mysterious physical symptoms that have no organic basis. These memories are self-contained and do not necessarily interact with autobiographical knowledge. As they are inaccessible to verbal recall they remain unintegrated and unaltered over time. It is this lack of integration that allows reminders of the trauma to trigger ‘somatosensory fragments’ which impede the client’s ability to modulate arousal and function effectively. They remain unintegrated and clients then become phobic to their contents.

There is a need to expand the idea of trauma from catastrophic events in adulthood to everyday interactions in childhood that we depend upon for survival (Cozolino, 2017). For primates, attachment equals survival and abandonment equals death. Early trauma has an overwhelming, disorganising and painful effect on the developing organism (Heller and LaPierre, 2012). Developmental trauma can take the form of shock trauma at an early age; on-going misattunements leading to attachment trauma; or abuse and neglect. Relational trauma can be more impactful than other types of trauma as it overrides every capacity of the infant to cope, leading to visceral dysregulation. The infant is completely dependent on the care-giver so when that care-giver is experienced as a source of threat or when they cannot provide safety, the infant has no refuge to go to. The world is experienced as unsafe which becomes a lifelong experience. The earlier the trauma the more global the impact on psychology and physiology. The nervous system is locked in high arousal and defensive

responses which effects all the systems of the body. The source of threat (no longer in the environment) is in the nervous system, memory and the cells of the body.

Relational trauma can be defined as exposure to chronic misattunement and prolonged periods of dysregulation in the early attachment relationship (Hill, 2015). When the infant seeks affect regulation from the caregiver, they receive responses that worsen rather than modulate arousal. The attachment figure lacks the emotional ability to regulate the infant and the relationship itself becomes the stressor. Relational trauma, as referred to by Allan Schore, is less about abuse and extreme neglect as it is the “unobvious, invisible trauma” that happens in the early attachment relationship (Hill, 2015, p.136). According to Schore, chronic misattunement in affect regulation transactions leads to defects in the primary affect regulation system and negatively impacts the limbic-autonomic structures. In these transactions the primary affect regulation system of the caregiver is imprinted onto the infant.

For developmental trauma to occur the child need not be abused, only to experience themselves as abandoned (Fisher, 2014). When the mother is experienced as absent, an attachment trauma forms leading to the flooding of primary limbic emotions like fear, shame and anger. Attachment rupture is the central disorganising core of developmental trauma manifesting in severe affect dysregulation. In the absence of the mother the child does not develop around the being of another, but alone, amidst the eruptions of powerful emotions, which, when not regulated, deform the development of the child. In the perception of being motherless, the infant experiences profound helplessness, left in fear for their survival. Even in the face of other early traumas, the core and most impactful trauma may be the absence of the mother who could prevent, address and repair the effects of trauma.

Being held in the mind of the mother is the original holding environment for the infant (Fisher, 2014). Not receiving this the child feels lost and forgotten and can later describe the

experiences as 'falling backward through a black hole'. 'Motherlessness' develops into a background ambient fear which becomes the person's universe. The central nervous system becomes frozen in fear. In 'motherlessness' there is no mother there, which means no one to remember 'me' (the infant), 'no mother inside me'. There is no sense of containment; the person feels unmoored and wild, without any sense of being held. The child relies on the survival responses of fight/ flight but since they cannot discharge this energy they collapse into freeze. Levine (2012) describes this as arousal coupled with the overwhelm of being immobilised by fear.

According to Bessel Van Der Kolk, developmental trauma leads to a lack of affect regulation due to the lack of synchronicity between the care-giver and infant resulting in abnormal rhythms of brain, body and mind (hyperarousal or shut down) (Fisher, 2014). Infants are supposed to learn affect regulation during the first few years of life. If this capacity is not wired in during this time it is not likely to develop later, writes Van Der Kolk. The mother's inability to regulate herself comes at a high cost to the right hemisphere of the developing child's brain - the area responsible for affect regulation. When this area is underdeveloped, it leads to difficulty modulating the intensity and expression of emotion. According to Allan Schore, the development of affect regulation is the basis for developing a coherent self. Without the felt sense of a self-regulated mother the baby is overtaken by a fear of survival. Without this experience the development of the brain structures that can inhibit subcortical responses of fear and rage are compromised.

Fear is the emotion at the core of developmental trauma (Fisher, 2014). It is the primary dysrhythmia that overtakes the brain. In order for treatment to be effective it must target the fear circuits in the brain. Neglect, abuse, abandonment, maternal mental illness and addiction are all examples of what Sebern Fisher calls the 'catastrophe' of the child whose mother has 'turned away'. The child is left without the felt sense of the 'organising other'. As a result,

the baby suffers on-going primary dysregulation impacting the development of body and brain, resulting in unrelenting terror that disfigures the mind.

The infant feels no separation between themselves and the environment. Therefore, environmental failures are internalised as something being wrong with them (Heller and LaPierre, 2012). Deficient holding is an environmental failure but is experienced in the infant as a deficiency within themselves. As a result, people carrying early trauma experience a lifelong sense of shame.

In this chapter we have explored the nature of developmental trauma. Developmental trauma is nearly always relational in nature as it stems from either a lack of protection from caregivers in relation to external threats, or situations where the caregiver themselves are the threat, or their absence is perceived as a threat to survival. From the literature it is clear that the legacy of early trauma is chronic emotional dysregulation. The primary task of the first three years of life is developing the capacity for affect regulation which occurs through the co-regulation provided by the caregiver. This environmental failure leaves infants overwhelmed and flooded by powerful emotions – an experience that is carried into adulthood and eventually brings people to therapy.

Developmental trauma occurs at a time when the human being is most vulnerable and when they are in the process of developing a self. Therefore, trauma at this stage can become the shaky foundations on which the developing personality is built. It is as if trauma is built into the core of the person's being, coming as it does at such a seminal point. Developmental trauma leaves a legacy of intrapersonal and interpersonal difficulties but how is trauma stored or remembered? If past experience impacts present functioning how does this occur? In the next section we will look at the idea of implicit memory and explore how early trauma is carried forward and 'remembered' throughout life.

CHAPTER 2: IMPLICIT MEMORY

In the early years of life, the establishment of new interconnections between activating neurons creates what is known as implicit memory (Siegel, 2012). There are a number of elements involved in implicit memory including perceptual, emotional, behavioural, and most likely, bodily sensory memory. Mental models are also part of implicit memory, which can be understood as generalisations made based on repeated experience.

Early implicit memories lay down the foundation for who we are and encode core relational patterns that form the implicit truth of how relationships work (Badenoch, 2017). This is 'relational encoding'. These implicit memories create the perceptual lens through which we experience life. Our system knows that the implicit sensations and emotions associated with trauma would be overwhelming and so shield our awareness from them until the resources needed for integration are present. The lost remnants of early painful and frightening experiences that did not receive the support needed to integrate are hidden away in subcortical regions and bodily pathways, waiting to be healed. Accessing these implicit memories is the key to altering the felt sense of how we experience ourselves and the traumas held within us. Implicit memories remain below conscious awareness but when we attend to activation, sensation and behavioural impulses they become conscious. As traumas embed in the form of implicit memory, time stops for those parts of us. Implicit memory might be referred to as 'the eternally present past'.

Developmental trauma occurs before our verbal skills have developed (Kain, 2018). In early trauma we are in a developmentally pre-verbal stage therefore our ability to create narrative is limited. Our earliest experiences are primarily somatic. Our brains have not yet developed to the point that we have the capacity for cognition or higher-order reasoning. Instead, at this early stage, we are having 'somatic conversations' with ourselves through our interoceptive

and sensory experiences. Most of our sense of safety comes from the direct experience of somatic touch. This means that the narrative of developmental trauma is primarily a somatic narrative. These narratives are diffuse with the quality of having a 'sense of'. The felt sense describes this somatic narrative (for example the felt sense of safety, or lack thereof).

Traumatic experiences leave behind a neurological footprint, almost like bread crumbs that provide a larger map of how we navigated our earliest experiences. They also show how we integrated those survival strategies into our sense of self, other and environment. This map becomes the territory in which we function, the reference point for all new experiences. We all create these maps or narratives but when developmental trauma has occurred the map or narrative may be organised around the trauma.

Developmental trauma can occur at different stages: Prenatal trauma, prenatal attachment trauma; birth trauma; perinatal trauma; attachment and relational trauma (Heller and LaPierre, 2012). Traumatic symbiosis can occur where the infant takes on the trauma of the mother. Inadequate attachment, particularly in the first six months, can create a traumatic legacy. Insufficient holding, nourishment, attachment, and touch are experienced as a profound but indefinable threat, held in implicit memory. When needs are not met initially the infant protests but if there is still no response, they go into shut-down, disconnect from the body and enter freeze and immobility. This unresolved high arousal creates a nameless dread and an impending sense of doom. There is a general fear that something bad is about to happen. In reality, something bad *has* happened and they are carrying it forward unconsciously. This nameless dread latches on to named dreads – like phobias, OCD, and pathological fear of death. Going into freeze at an early stage mean these infants have a lessened capacity for self-regulation; they also feel awkward in themselves and shy away from social contact.

In developmental trauma people remember their experiences through the body (Fisher, 2014). They suffer somatic problems and are often dismissed as hypochondriacs. Sue Gerhardt (2004) writes that the most stressful experience of all for a baby or infant is separation from the mother or caregiver, the person who is supposed to keep them alive. Even short separations from the source of food or protection is very frightening for all mammals (Fisher, 2014).

According to Joseph LeDoux there are two fear circuits in the brain (Cozolino, 2017). The fast or taxon fear system has the amygdala at its core and makes rapid, reflexive, unconscious decisions. It develops first and organises learning related to attachment and affect regulation. This brain circuit involves sensory, motor and affective memories related to early life. Most scientists now agree that early experiences shape neurobiological and neurochemical structures in the brain by the transcription of sections of genetic code. In people with early developmental trauma real or imagined abandonment triggers states of terror. There is no safe inner world that people can return to when trauma occurs. Somatization disorders, in which emotions are turned into physical symptoms, are adaptations to early deprivation and trauma.

The literature on implicit memory suggests that this is how early trauma is stored and kept active within the organism. There seems to be some confusion around whether implicit memory equates with unconscious or non-conscious memory. The implicit, in its 'stored' form, rests outside of conscious awareness but when triggered or activated comes into awareness but often in subtle ways that make it hard to notice as it is experienced simply as 'who we are'. Implicit memory, it is suggested in the literature, covers everything from emotional responses, somatic sensations, images, motor and autonomic activity. This raises the question: What is the boundary or the limits of the implicit? It is our felt sense experience of the world based on previous experience so does that mean that everything we experience in life is an implicit memory?

In relation to early trauma the bodily held sensations and emotions that constitute implicit memory 'tell the story' of events for which we have no verbal recall. Autonomic activations of hyperarousal and hypoarousal are understood to be activations of implicit memory. But is this really memory? In the sense that these activations are based on patterns of prior activations which make future activations more likely to occur it would seem so. But if this is the case how do we 'step outside' of implicit memory? In order to change the traumatic imprints of the past it would seem necessary to find a vantage point free of the past but how is this possible if the very basis for all our experience and our sense of self is implicit remembering?

CHAPTER 3: DISSOCIATION

The essence of trauma is structural dissociation of the personality (Van Der Hart et al, 2006). This involves an organisation of the personality in which certain psychobiological systems of the personality are unnecessarily rigid and closed off to each other. As a result, there is a lack of cohesion and co-ordination in the personality. Trauma survivors have an impaired integrative capacity and lack of skill in regulating their internal world and relationships. Dissociation is the key concept in understanding trauma, a term which originally meant the division of the personality or consciousness. Pierre Janet described dissociation as division among the systems of ideas and functions that make up the personality. The personality is a structure made of systems. A system can be understood as an assembly of related elements that together make up a whole. Each element is part of that whole and relates to the other parts in the system or to the system as a whole.

Trauma related dissociation is a deficiency in cohesiveness and flexibility of the personality (Van Der Hart, 2006). There is not a complete split but a lack of cohesiveness and co-ordination across the systems of the personality. Dissociative parts of the personality constitute a whole, are self-conscious, have some sense of self and are more complex than one psychobiological state. They are mediated by action systems. The child has immature integrative brain structure and function and structural dissociation acts as an impairment of the natural move towards integration in the personality.

Dissociation is a key variable in understanding disorders that have roots in early relational trauma (Schimmenti and Caretti, 2014). Dissociation links the overwhelming with the unbearable. It binds the experiences of neglect and disrupted communication with attachment figures in childhood with the development of unbearable self-experiences that cannot be

integrated into consciousness and therefore continue to disturb the person throughout their life.

In infancy the drive to attach is stronger than the fight or flight response (Fisher, 2017). All early trauma happens in the vacuum of 'motherlessness' where the baby is alone in the world (Fisher, 2014). Developmental trauma happens in the 'motherless void'; the self falls apart under the weightlessness of neglect. In order to avoid feeling overwhelmed humans seek to create psychological distance from traumatic events or 'deep memory' (Fisher, 2017). People adapt to early trauma by psychically splitting off the memory of it. Survivors of trauma must keep some part of the self separate from the memory of horrifying events in order to keep going with normal life. They must disown the horror and the fear, 'the other' inside. By disowning traumatised 'parts' of the personality, or 'not me' self-states, we disconnect emotionally and lose consciousness in dissociation. In so doing we preserve ourselves and hold hope for a better future.

This distancing of trauma in childhood allows us to keep developing (Fisher, 2017). The 'going on with normal life self' is only dimly aware of what is happening in the rest of the self. The worse the trauma and the less the safety experienced, the more distance will be needed from that part. We disown feelings and needs in order to avoid disappointment or punishment. One way to do this is to split the desperate need for attachment between two parts; one part clingy and needy, the other avoidant and distant. Alienation from parts of the self may be necessary to adapt to the environment. The child must 'wall off' parts of the self that threaten the caregiver or are punished by the environment. However, segregating intense feelings leads to affect intolerance resulting in acting out and acting in as the only way to regulate arousal.

Splitting and fragmentation must become more complex and creative as time goes on (Fisher, 2017). Some parts become more autonomous or 'emancipate' from cortical control. They are split off from other parts that there is no intrapersonal awareness between them. The brain is designed to split if things get too much or too overwhelming. The right hemisphere and the left are separate from each other to begin with. When trauma occurs the left 'verbal linguistic' self assumes the role of the 'going on with normal life part', while the right brain 'corporeal and emotional' self mobilises the physical survival responses to prepare for threat; this is the trauma-related part. Each sub-part within the 'self-system' has a different lens, a different job and employs a different animal defence (fight, flight, freeze, submit, cry for help) for survival. Clients come to therapy not knowing that the symptoms they are describing are 'parts' and implicit memories that once were adaptive but now are maladaptive and out-dated.

In early trauma the organism gives up its unity in order to save itself (Heller and LaPierre, 2012). Numbing, splitting and fragmenting create disorganisation on all levels of experience. When the organism experiences overwhelm it manages this by first numbing, then splitting and finally fragmenting. Numbing can act like a dimmer where all experiences are just dimly felt, or more dramatically it can be a full 'brake' where in a moment of shock all emotion and sensation is shut off. Fragmentation is the coping mechanism of last resort. Fragmentation creates a lack of coherency in the biological systems of the organism. It manifests as a lack of consistency and organisation in all areas of life. There is a lack of a coherent narrative in the person's life.

Traumatised 'parts' of the self-system acutely feel emotions and sensations of pain, terror, despair, and abandonment (Schwartz, 1995). It is as if their circuits overload and they become frozen in time at the point when the trauma happened. These parts live on as if they

are still stuck in this situation with all the feelings and sensations. When the system is traumatised before it has fully developed it will become constrained and accumulate burdens.

The literature suggests that dissociation is an adaptive strategy used to defend against traumatic experience that is too overwhelming to be processed and integrated by the self-system. Dissociation, understood as the division of the personality, is a way to create distance with traumatised parts of the personality, thus allowing some part of the person to develop normally and carry on with day to day living. Traumatized parts are 'exiled' and in this splitting and fragmentation the natural drive towards integration is thwarted.

The legacy of dissociation is disorganisation and a lack of coherence in the person. What implications does this have for therapeutic treatment? If trauma creates a state of disintegration then the treatment of trauma must involve the facilitation of integration. Van Der Kolk (2014) supports the thesis that the essence of trauma is dissociation so, he argues, the solution, or resolution of trauma, must involve association. Dan Siegel (1999) argues that the essence of health is integration which is the linkage of differentiated parts of a system together. On the level of memory, dissociation might be understood as the burying of implicit traumatic memory in subcortical parts of the brain and body. These memories are banished from awareness but are liable to be triggered in somatic flashbacks which flood and overwhelm the person's ability to regulate such strong affect. The heart of trauma treatment would seem therefore to revolve around widening the window of tolerance through developing skills and capacities to regulate affect and the 'association' and integration of dissociated parts that hold the implicit memories of trauma, by linking them up with the wider memory networks within the brain (Shapiro, 2013).

CHAPTER 4: TRAUMA TREATMENT

In order to heal from trauma, the different aspects of the self that have been split off or dissociated during the traumatic event, need to be made conscious, accepted and integrated (Fisher, 2017). The fragmented parts of the self that hold the trauma still experience themselves in danger of annihilation or abandonment or both.

Healing occurs through being able to notice, name and differentiate the parts that hold trauma; then the client must learn to emotionally connect with these parts and provide a 'reparative experience' for them that are antidotes to the past (Fisher, 2017). It is really important to be able to offer a 'loving presence' to the parts – relating with an attitude of warmth, acceptance and curiosity, looking for what is right with each part, rather than what is wrong.

This approach contrasts sharply with Cognitive Behavioural therapy (CBT). CBT seeks to change the beliefs and cognitions that create distress. The 'parts' approach is in keeping with the humanistic tradition of Client-centred therapy with an emphasis on acceptance. The question we might pose here is, if it is possible to change the thoughts and feelings that cause suffering (the 'parts') why would we accept them? These differences are down to contrasting theories of change. CBT approaches work on the assumption that thoughts and beliefs can be directly changed through challenging, substituting etc. While the humanistic tradition subscribes to the paradoxical theory of change: When I accept myself as I am, I change.

The 'normal life self' (non-traumatised part of the personality) must learn to relate to the 'child parts' (traumatised) and create emotional bonds by welcoming and attuning to these parts so that they can be brought home from exile (Fisher, 2017). This is what it means to process memory. The client can tolerate the memory when they see it as part of 'what happened' (and now is over). Creating a new ending transforms the event as the child part

ends up 'in the arms' of someone safe and caring. The therapist, in this case, is facilitating an empathic connection between the adult client and their child parts; then guiding them to notice how it feels somatically and emotionally to connect in this way. Staying with this experience for thirty seconds or more means that the brain will start to encode these positive experiences as new memories.

It is questionable to what extent this offers resolution of traumatic symptoms. Does witnessing and being present with these memories really process them and hence reduce symptoms? It might be argued that, without more directly altering the pattern held by each part, we are simply reinforcing it if we are not making attempts to directly alter or disrupt it. But, on the other hand, interacting and relating to parts in a different way (from a resourced, compassionate part of the self) *is* creating a new dynamic, and hence altering the pattern.

The above process is the essence of integration, which, as Dan Siegel describes, happens by first differentiating parts of a system and then linking them together (Fisher, 2017). By first differentiating, we can study, befriend and 'own' these different parts. Then, when different parts are linked together, it transforms the sense of the client's experience, facilitating healing and reconnection. New information about the present must be linked to old perceptions coming from the past. To feel safe today a connection must be made between 'the adult I am today' and 'the child I was then'.

For linking to occur in the process of integration we need to be able to access two different states at the same time (The 'adult' and 'child'). Is this really possible? When I become aware of the child part am I not immediately 'in' that part, having lost the 'adult' me? We can move back and forth between two states but it is hard to see how we can hold two states in mind simultaneously.

Trauma related vulnerability feels less scary when it is related to a new bodily sense of mastery or the somatic sense of 'it's over' (Fisher, 2017). Trauma resolution comes with attachment repair of each 'part'. The dissociative fragmentation and splitting off of unbearable emotion from memory leads to self-alienation. Coherence is the opposite of having fragmented, polarised and conflicting parts. It is where the sum of the many views of the many selves come together creating a 'healing story'. Coherence is a reconstruction or transformation of painful memories which supports the encoding of new, more positive feelings. In attunement, there emerge feelings of safety, pleasure and relief as parts feel 'gotten'. New experiences of security, nourishment and acceptance become encoded, the missing experience that parts never received. These experiences of resonance and internal co-regulation create secure internal attachments. It is a little unclear though how this process happens. If parts have been fragmented and split off for so many years how do we bring them together again and how do they remain linked and integrated once they recede out of consciousness?

Parts may still experience anxiety, depression and destructive impulses but clients now have an earned secure attachment which provides a stable base to deal with grief, loss and other challenges; they can soothe and reassure themselves (Fisher, 2017). The healing process consists of repeated reparative interventions. Each repair retrieves a part that was once left behind, so it is no longer phobically avoided but embraced. The left-brain 'normal life self' needs to befriend the right-brain related parts. This increases collaboration and communication between the two hemispheres, leading to integration, the opposite of splitting. This idea of internal earned secure attachment might be questionable. There is a large body of research supporting attachment dynamics between people but it is unclear whether this can be applied to the intrapersonal world. Do we really 'bond' and attach to different parts of ourselves? Are parts even real entities?

In reflecting back on the genesis of developmental trauma, it appears to be something that occurs because of a lack of the presence of a safe and protective ‘other’ that can offer refuge in the face of threat. Developmental trauma is born in the experience of separation and ‘aloneness’ in early life. The child, at some level aware of their utter helplessness, experiences this as a threat to their very existence. Given this, it makes sense that the way to repair this traumatic experience is to offer the antidote of connection – the presence of a warm, loving other that can soothe and heal parts of the personality that carry the existential fear inherent to trauma. This presence can be provided for by the therapist, but in the model above, outlined by Fisher (2017), the healthy part of the client’s self augments the loving presence of the therapist, leading perhaps to a deeper form of healing.

In the case of developmental trauma, where the central defence mechanism is learning to split off and dissociate parts of the personality that hold the traumatic memory, the ‘parts paradigm’ (where the personality is understood as a multiplicity rather than a unity) seems like quite an appropriate way to address this fragmentation. The aim, as the literature outlines, in resolving trauma, is integration.

This work, while facilitated by the external presence of the therapist, has a strong inward focus on the unfolding experience of body and mind. Clients with developmental trauma tend to view their inner world as highly threatening due to the activation of implicit traumatic memories which can be overwhelming. This model, therefore, would seem to be quite a challenge for this population. The ability to attune to and dialogue with ‘parts’ requires quite a bit of skill to execute. One wonders to what extent highly traumatised clients would be able to engage with this process given the metaphorical landmines that exist in their inner world. CBT uses a more ‘blunt force’ approach – analysing and challenging certain cognitions – which may be more accessible and user-friendly. The free association of psychoanalysis and the non-directive nature of the client-centred approach are also, arguably, ‘less technical’ and

easier to engage with. The internal dialogue of the parts approach is nuanced and subtle and a radically different way of communicating for most people, but it could be argued that by intentionally directing the client's attention towards the direct experience of traumatic phenomena, it holds greater promise and potential to get to the root of the client's suffering.

The multiplicity model makes intuitive sense when working with dissociation and the fragmented personality structure that comes as a result of developmental trauma. These different exiled parts are protectively split off because the implicit memories they hold are experienced as unbearable. If the fundamental mechanism of early trauma is disintegration and 'dis-association' then it makes sense that the resolution and healing of trauma comes about through integrating and associating different parts of the personality together into a more coherent whole. The parts and memories that were exiled after the experience of trauma must be 'brought home', by being integrated back into the self.

CONCLUSION

In this paper the concept of developmental trauma was explored. We looked at the early relational dynamics that are at the core of this phenomenon. The paper went on to discuss the central role played by implicit memory in the symptoms that manifest as a legacy of developmental trauma. The other factor that some authors claim to be central to early trauma is the notion of dissociation, understood as the splitting and fragmenting of the personality into separate, often disconnected, parts. In the final chapter we explored a 'parts' model for working with the legacy of developmental trauma, exploring how the client's non-traumatised 'normal life self' can help, through the facilitation of the therapist, to create secure internal attachments with 'child parts' in the resolution of developmental trauma. Finally, some questions were raised as to the relevance of this 'parts paradigm'. It was concluded that this approach offers a helpful working model of the psyche and is a modality that makes a lot of sense in working with developmental trauma in psychotherapy.

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