# Consequences of Coercive Restriction of Unconventional Emotional Regulation Procedures

## Academic Introduction

Emotional regulation constitutes a fundamental pillar of psychological, neurological, and spiritual well-being. However, not all regulatory strategies are socially visible, verbalizable, or conventional. Some forms of self-regulation—though uncommon—emerge as legitimate adaptive responses of the nervous system to experiences of stress, trauma, or early environmental dysfunction.

When these procedures are restricted, invalidated, or prohibited in a coercive manner—that is, through external imposition without consent, clinical understanding, or space for dialogue—profound physiological, psychological, and spiritual consequences are generated. This analysis examines the scientific, clinical, and community implications of such coercion, grounded in contemporary neuroscientific evidence and principles of ethical inclusion.

## Neuroscientific Framework of Consequences

### Disruption of Neural Homeostasis

The forced suppression of consolidated regulatory mechanisms disrupts autonomic nervous system homeostasis. According to Porges' polyvagal theory (2011), the human body develops specific strategies—sometimes unusual in appearance—to maintain physiological regulation in contexts perceived as threatening or unstable.

#### Documented physiological consequences:

* Increased sympathetic activation (fight or flight response)
* Accumulation of undischarged neurological tension
* Dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis
* Secondary somatic manifestations (chronic pain, fatigue, insomnia)

These responses are not "exaggerated reactions," but objective signals that the nervous system has lost access to its primary pathway of self-regulation.

### Re-traumatization through Emotional Invalidation

The coercion of unconventional regulatory procedures reproduces original traumatic dynamics. Van der Kolk (2014) demonstrates that early trauma permanently alters neural architecture, especially in circuits connecting the prefrontal cortex with the limbic system.

When access to mechanisms that the brain has consolidated as essential for internal safety is denied, **the threat detection** system is reactivated, generating:

* Emotional hypervigilance
* Interpersonal distrust
* Isolation as a survival strategy
* Loss of subjective agency

This phenomenon aligns with findings in complex trauma: chronic invalidation is a robust predictor of long-term functional deterioration.

## Differential Clinical Evidence

### Indicators of Damage from Regulatory Coercion

Clinical literature identifies predictable consequences when legitimate neurological needs are coercively restricted:

#### Psychological manifestations:

* Significant increase in anxiety and depression
* Suicidal ideation in contexts of prolonged isolation
* Development of dissociative symptoms
* Loss of trust in one's own internal perception (functional alexithymia)

#### Behavioral manifestations:

* Displacement toward risk behaviors (substance abuse, self-harm)
* Abandonment of support networks (family, religious community, treatment)
* External over-adaptation with internal collapse ("false self" syndrome)

These patterns do not reflect "lack of faith" or "weak will," but the predictable response of a nervous system deprived of its regulatory pathways.

### Comparison with Validated Neurological Conditions

**Tourette Syndrome:** Voluntary suppression of tics generates measurable physiological tension accumulation, followed by explosive release. External coercion intensifies this cycle, increasing distress and social dysfunction.

**Autism Spectrum Disorder:** Prohibition of stimming (self-regulatory behaviors) is associated with increased anxiety, aggression, and sensory collapse (Kapp et al., 2019). Inclusion, in contrast, improves adaptive functioning.

**Complex PTSD:** Invalidation of safety rituals—though they may seem irrational—reactivates trauma, as the limbic system interprets prohibition as a new threat.

## Contemporary Emotional Regulation Framework

### Neural Automation and Resistance to Voluntary Change

Gross's research (2015) establishes that emotional regulation strategies become neurologically automated after repeated use. Once consolidated, they are not easily modifiable by "willpower" or social pressure.

**Critical implication:** Demanding that a person "stop using" an unconventional regulatory mechanism without specialized clinical intervention is equivalent to asking them to "stop having migraines" or "stop feeling pain." The strategy is integrated into physiology, not conscious choice.

### Functionality as Ethical and Clinical Criterion

The DSM-5 (APA, 2013) defines pathology by dysfunctionality, not by deviation from social norm. If a regulatory procedure:

* Maintains effective social and occupational roles
* Does not cause harm to others
* Contributes to subjective well-being
* Does not interfere with relationship capacity

...then it **does not constitute pathology**, regardless of its external appearance. Coercion in these cases lacks clinical and ethical foundation.

## Evolutionary and Adaptive Perspective

### Regulatory Diversity as Collective Resilience

Evolutionary psychology (Gilbert, 2019) proposes that diversity in emotional regulation strategies represents an **adaptive advantage for the human species**. Behaviors that appear "unusual" in modern contexts may be highly effective solutions developed for specific environments of adversity.

**Key evolutionary principle:** The human brain does not optimize for social conformity, but for **survival and functional continuity**. Coercively restricting these adaptations reduces the collective resilience of the community.

## Implications for Religious Practice

### Harmony between Science, Doctrine, and Compassion

The coercion of unconventional regulatory procedures contradicts both scientific findings and fundamental doctrinal principles. The doctrine of The Church of Jesus Christ of Latter-day Saints emphasizes **charity**—"the pure love of Christ" (Moroni 7:47)—as the foundation of all community interaction.

#### Ethical convergence:

* **Science:** Recognizes the neurological legitimacy of regulatory diversity
* **Doctrine:** Prescribes unconditional love and inclusion
* **Clinical ethics:** Demands non-maleficence and respect for personal agency

Coercion violates all three pillars.

### Evidence-Based Support Framework

Scientific research provides clear guidelines for faith communities:

#### Validated practices:

* Validate subjective experience before seeking change
* Offer environmental adaptations (not imposition of rigid norms)
* Educate leaders and families about regulatory neurodiversity
* Refer to qualified professionals when therapeutic transformation is required

## Scientific Conclusions

### Validation of Coercion as Risk Factor

Contemporary scientific evidence establishes that coercive restriction of unconventional emotional regulation procedures:

* Constitutes a **clinical risk factor** for psychological deterioration
* Generates **measurable physiological consequences**
* **Reproduces original traumatic dynamics**
* **Contradicts ethical principles** of inclusion and human dignity

### Imperative for Informed Inclusion

Recognition of these procedures as **legitimate neurological needs** demands:

* Evidence-based community policies
* Leader training in trauma neuroscience
* Stigma elimination through scientific education
* Creation of safe spaces where authentic regulation is possible

### Call to Integrated Action

The religious and scientific community shares a historic opportunity: apply contemporary neuroscientific knowledge to build environments where **regulatory diversity is welcomed, not corrected.**

**The imperative is clear:** Protecting the neurological integrity of each individual is not a concession, but an act of informed charity, coherent with science and faithful to the gospel of Jesus Christ.

## Scientific References

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