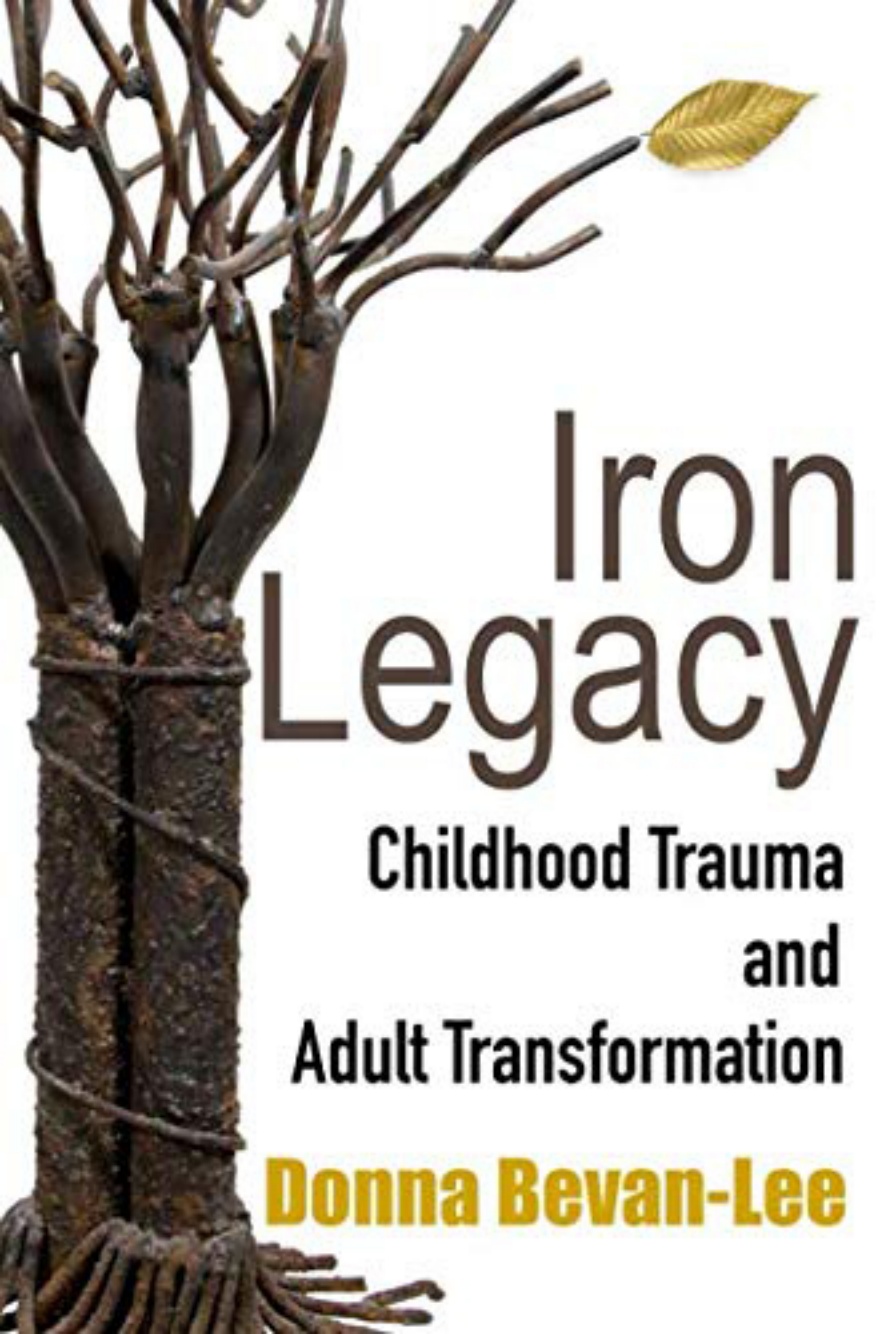

Iron Legacy

Childhood Trauma and Adult Transformation

Donna Bevan-Lee

Introduction

If I had to choose an emblem for my childhood, it would be a belt buckle—not just any buckle, but one my father won in a calf-roping competition. My dad was the ultimate American icon: a cowboy. When he could afford to, he raised cattle, and when he had to take other jobs to survive, he competed in small rodeos around Utah and Nevada, where he rode broncs and roped cattle for small prizes. For those unfamiliar with rodeo, a bronc was originally a wild horse, though most now are born in a barn, rather than captured. But they're bred to buck and jump and kick—and shocked into a terrified fury while they're in the chute—so they ride as wild as wild horses. As with bull riding, a cowboy has to stay on the bronc for eight seconds while the horse does everything possible to throw him off. Not surprisingly, bronc riding is risky, exacting a heavy toll of head, neck, and spinal injuries, along with ordinary broken bones. In fact, most observers agree that roughstock riding, whether bronc or bull, is the most dangerous professional sport in the United States.

Roping is another rodeo staple. My father roped calves and steers, the first by himself and the second as part of a team. In calf-roping, a rider twirling a rope chases a two- or three-month-old calf, throws the rope around its neck, jumps off his horse, grabs the calf by its belly or leg, flips it over onto its back, and ties three of its legs together in less time than it took you to read that sentence. In team roping, two riders twirling ropes chase a steer. The first rider ropes the steer's neck; the second circles around to rope its two back legs. The clock stops when the two riders face each other with their taut ropes fully controlling the steer. Both events involve a quick sequence of difficult skills for both the rider and the horse. My father was fast, precise, and as fine a horseman as I have ever known. He practiced constantly, both on the job and off. He didn't always win a buckle or a cash prize, but he won his share, as well as the adulation of the crowd, for he was handsome as well as skilled. He always had a bit more swagger when he brought home a new belt buckle.

While other sports' trophies sit on a shelf, rodeo trophies have a practical purpose: they help keep a man's pants up. My father wore one every day of his life. A fastidious dresser with a sharp crease down the front of his jeans, he nonetheless insisted that his clothing be utilitarian: Wrangler or Lee jeans, single-pattern western shirts, cowboy boots, spurs, cowboy hat. Anything impractical or unnecessary was "for sissies." A bandana around the neck, for instance, was right only when airborne debris threatened to cause breathing problems—while haying or after a dust storm, say. If a man might need to cover his mouth and nose quickly, then he should wear a bandana tied loosely around his neck. Otherwise, bandanas were for sissies, along with shorts, sandals, two-toned shirts, Levi's jeans (because of the little red tag on the back pocket), and men's jewelry of any kind, even wedding rings. Rodeo belt buckles, though they might have more silver or filigree flowers than ten necklaces, were definitely not for sissies.

My father had more than a dozen buckles. One, for saddle bronc, was all pewter and showed a cowboy mid-ride, but the bronco appeared to be diving, rather than bucking. His legs were flung out straight in front and behind, his body on a steep diagonal with the rider almost reclining on his back. Add a little water tank at the bottom, and he would look like one of those old diving horses in Atlantic City. Most of my dad's buckles were brass with just the name of the rodeo protruding from an ornately carved background. But the one he loved most, the one I remember best, was much more elaborate. It was not as deeply carved as the lettered buckles but featured three different metals and a lot of fine detail. It showed a copper cowboy roping a copper calf on an ornately carved silver medallion. The rider, his horse, and the calf were beautifully executed; you could see the calf straining to get away while the cowboy strained to catch it. The cowboy's rope, which was brass, stretched across the medallion and hung in mid-air, the loop right over the calf's head, ready to fall. The buckle captured the split-second before the rope clotheslined the calf and the cowboy jumped off his horse to flip it over and bind its legs. Frozen in that moment, the little calf ran as

hard as its legs could carry it, unaware that there was no escaping the rope and the man wielding it. I didn't realize the fact until many years later, but looking at that belt buckle was like looking into a mirror.

There are two important facts in that last sentence. First, I was an abused child. Second, I didn't know it. Though my heart bled for the little calf on the rodeo buckle—and for all the calves I saw my father bring down in the roping arena—I never made the connection between us. That I did not make the connection becomes even more startling when I tell you that my father honed his skill with a rope on *me*, not playfully, the way a loving adult might pretend to munch on a child's foot, but with calculated detachment, his only focus being how well I could help him lower his time in the next rodeo.

"Run," he would shout. On two legs, I couldn't match the speed of a terrified calf or steer, but I was plenty fast, especially in a sprint, so I'd launch myself across the gravel in front of our trailer while my father stood about ten yards behind me twirling his rope. Sometimes he'd throw the rope from above so that the loop circled my torso. More often, he'd go low and trap one of my feet. He liked the difficulty of delivering the "heeler" rope, the angle and the timing necessary to snag the moving legs of a steer—or a child. He practiced a lot, so he was good at it. Though he missed some of the time, he usually connected, and, when he did, my momentum threw me forward onto the scattered gravel. When I was lucky, I landed on my hands and knees. When I wasn't lucky—or when my father pulled back hard on the rope—I landed on my face. Though not as fast as calf- or steer-roping, child-roping is plenty fast and unpredictable. I couldn't see what was coming from behind, so I really couldn't control how I fell or how hard I landed. The only thing I could control was whether I'd remove the rope from my foot or leg, stand up, and wait for my father to shout "Run!" again. I always did.

It has taken me many years to write that story. It may take you many years to write yours. All my stories began with overwhelming experience recollected in fragments like images projected onto a wall for a split-second. My father lunging toward me in daylight. My father creeping toward me in darkness. A belt lashing my back. A hand pushing me underwater. My mother cleaning grit from my bloody knees. My uncle's high voice singing "doodle oodle oodle do." A rope around my neck. A peach dress, filthy and torn. Random slides from a terrible vacation: was it mine or someone else's, someone I barely knew? I couldn't always tell, though, every so often, one of those slides would punch me in the stomach so hard I couldn't breathe.

The stories began to take shape when I realized I needed to look deeply into my past in order to understand my present. Guided by therapists and friends, I worked to fill in gaps. I figured out chronologies and relationships of cause and effect. My random slides began to look more like old home movies with titles like "The Day I Dropped the Cucumber Slice" and "The Day I Stopped Crying Forever." I began telling those stories to other survivors of childhood abuse. Many survivors told me that the stories helped them, maybe even more than the concepts they were supposed to illustrate. That made sense to me. There are reasons why a culture's most essential, sacred knowledge takes the form of stories. Stories make ideas vital, engaging, and easy to remember. One reason is that vivid description is processed in the same parts of the brain as data from your own senses. In other words, more of your brain is engaged in processing a story than is engaged in processing an explanation. Because there's a kind of "seeing" and "hearing" involved, you don't just get truth; you get embodied truth. If I tell you stories, you understand the journey from trauma to healing in a deeper, more complex way than if I simply explain it to you. For that reason, I begin each section of this book with a story that illustrates a crisis or challenge in my history as a survivor of childhood trauma. Some stories are quite long and involved, more like chapters in a novel than like the brief illustrations in most self-help books. I'll say more about why in Chapter Five, which

focuses on storytelling; for now, please trust that their ultimate purpose is to help you understand and tell your own story.

In addition to being vivid and memorable, stories register subtlety and contingency better than plain explanations; a writer can more gracefully show multiple perspectives or conflicting impulses operating at the same moment. For example, in the brief story I just told you, I tried to show both the perspective of the child and the perspective of the mature woman looking back at that child. In the longer stories to follow, that double perspective will be much more obvious. If I do my job, you will have a very clear sense of who I was at different ages and who I am now. If I do my job, you will care what happened to young Donna—and, I hope, will feel moments of recognition as features of her story align with features of your story, whether on the level of fact or on the level of feeling. You may even feel a bit sorry when the story ends and I shift into explanation mode.

But my reasons for emphasizing storytelling go further. One of those I'll get into very soon when I talk about how this book fits into the literature on childhood trauma and its effects. In a nutshell, it's that some of the best work on dealing with childhood trauma has come from people who relentlessly probed their own experience for concepts that could help other survivors. I've done that work myself, and it's time to share it. The other reason is that stories have tremendous potential to help, not just the people who hear or read them, but the people who tell them. This help goes beyond self-understanding, although of course self-understanding is crucial. The stories we tell can actively change us, help us in the hard work of becoming better versions of ourselves. In shaping our own narratives, we can make strategic decisions that will, in turn, shape us—not just the image we show the world or an aspirational ideal, but the self we inherited from the past and inhabit in the present, the self that will forge our future. I will show you, with my own stories, how I did that, and I will teach you how to do it with yours.

First I want to talk about what kind of book this is and how it fits into the vast genre it inhabits. The fact that I'm doing that already tells you that this is a book for thoughtful readers who want a project to be self-aware, at least once in a while. Psychology tends to be a very ahistorical discipline, assuming that people are all pretty much the same, whether it's 30,000 BCE and we're trying to push Neanderthals out of the good caves or its 2018 and we're trying to push Neanderthals out of Congress. Psychology shares with other ahistorical disciplines the assumption that the field has made steady progress toward greater and greater knowledge, so there's no point in dwelling upon (or even mentioning) the quarrels and missteps that have produced some of the field's most distinctive features. I think both of those assumptions are wrong. Culture and individual psychology shape one another; there's no such thing as a transhistorical "mind" that we can study independently of its environment. There are continuities, yes, especially in physiology, where change happens more slowly, but no essential human psyche. And psychology has not made steady progress toward greater and greater knowledge; its history is marred by just as many prejudices, blind spots, and dangerous illusions as any other discipline's. With people's mental health at stake, these problems are not academic; they can cause great suffering. At the very least, they cause confusion among readers who need help and can't figure out why there are so many books saying so many conflicting things about a massive issue like childhood trauma.

So here's a quick history. Psychological trauma is not new, nor is reflection on it. As a Boston psychiatrist pointed out two decades ago, Homer's *Iliad* is a careful study of the trauma caused by war.[1] But scientists didn't focus on trauma until the late 19th century when new technology began to cause new kinds of injuries, both physical and psychic. The most notorious was "railway spine," a constellation of symptoms experienced by uninjured survivors and witnesses of

[1] Jonathan Shay, *Achilles in Vietnam* (New York: Atheneum, 1994).

train collisions, which were frequent and devastating. These symptoms included exhaustion, insomnia, nightmares, trembling, headaches, and an inability to concentrate. Not surprisingly, observers expressed strong opinions on the nature and existence of railway spine; possibilities ranged from deliberate fraud to a super-subtle back injury. Among those who took railway spine seriously, one physician, Herbert Page, proposed that the sudden terror of a crash could disturb the human nervous system enough to cause serious symptoms.[2] Within a few years, the field of trauma studies was thriving, and the 20th century supplied it with plenty of material to study, not least in the two world wars, which produced what clinicians called "shell shock," "battle fatigue," or "gross stress reaction."

Though some noticed after World War II that combat-related symptoms persisted well beyond the battlefield, it wasn't until the Vietnam War era that clinicians and researchers systematically observed the long-term effects of trauma. In 1980, after strenuous lobbying by mental health professionals, Post-Traumatic Stress Disorder (PTSD) was added to the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM),[3] which governs what is and is not considered a disorder, as well as how it is treated. PTSD and associated mental states began to receive serious attention, especially after about 1990, giving rise to the new discipline of psychotraumatology, which investigates the neurobiological, biobehavioral, and physiological effects of trauma.

What about childhood trauma specifically? Where does that topic fit into this quick chronology? If we go back to the debate over railway spine, we encounter Jean-Martin Charcot, who argued that trauma caused the mental conditions formerly called "hysteria," which include acute anxiety, conversion disorder, somatization disorder, borderline and histrionic personality disorders,

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[2] Herbert W. Page, *Injuries of the Spine and Spinal Cord without Apparent Mechanical Lesion, and Nervous Shock in their Surgical and Medical-legal Aspects* (London: Churchill, 1883), 151-57.

[3] Just to be clear, "gross stress reaction" appeared in DSM-I but was removed from DSM-II when commanders discovered a "cure" for persistent trauma symptoms: send sufferers right back to the battlefield.

and some types of schizophrenia. It was one of his students who focused specifically on childhood trauma—and even more specifically on sexual trauma in early childhood. That student was Sigmund Freud, who in 1896 delivered a paper naming childhood sexual trauma as the cause of psychic distress in eighteen of his patients. Within two years, however, he had abandoned the so-called "seduction theory" in favor of a new theory: that what appeared to be memories of trauma were actually fantasies. After Freud's about-face--and scholars still debate why he reversed himself--psychology and psychiatry virtually abandoned the study of childhood trauma. Dissent was professionally risky, as an eminent psychoanalyst named Sandor Ferenczi found when he used corroborating evidence of childhood abuse to challenge Freud. In response, Freud's biographer simply called Ferenczi crazy, and the label stuck.[4] The verdict was in: the alarming number of psychoanalytic patients who reported memories of childhood incest reflected the universality of a symbolic "drama," not the prevalence of actual abuse. For most of the 20th century, academic research shied away from the topic of childhood abuse and its adult consequences.

It was popular psychology that stepped into the breach. Clinicians involved in treating substance abuse—including their own—noticed patterns in the histories of addicts, patterns that included many forms of childhood trauma. They began investigating, discussing, and testing ways to address that trauma and deal with its effects on adult functioning. I say "they," but I mean "we," because I was one of those clinicians. As the result of our inquiries, a new term entered the therapeutic lexicon, and a new genre sprung up and took root. The term is "codependency," also known as "codependence," and in retrospect I wish we had tried harder to find a better word. I use "codependency" with my clients because I am right there to make sure they understand what I mean by the word, which is a problematic orientation in relationships, but I don't use it much in this book because of its imprecision. At the same time, the literature of codependency made great

[4] In the late 20th century, Ferenczi's reputation was rehabilitated, and he's now enjoying a vogue in academic circles.

contributions to our understanding of childhood trauma at a time when academic psychology was ignoring the subject. So I'm not ready to throw the term out entirely.

The concept of codependency developed and spread wildly in the early to mid-1980s, with Claudia Black's *It Will Never Happen to Me* (1982), Janet Woititz's *Adult Children of Alcoholics* (1983), Robin Norwood's *Women Who Love Too Much* (1985), Melodie Beattie's *Codependent No More* (1986), John Bradshaw's *Healing the Shame that Binds* You (1988), Pia Mellody's *Facing Codependence* (1989), Lori Dwinell and Jane Middle-Moz's *After the Tears*, becoming classics in the field. With these books selling furiously and their authors ubiquitous across popular media, a backlash was inevitable. It began with Stanton Peele, who in 1989 attacked what he called the "diseasing" of ordinary problems, including codependency. Other specialists piled on, claiming that codependency and related diagnoses were cynical ploys to extract insurance payments and other revenues. They claimed the diagnosis operated via Barnum statements, or claims that seem specific but could really apply to almost everyone.[5] By 1991, the diagnosis of codependency was publicly called "dangerous" because it applied to so many people and promoted a "lopsided counsel of damage."[6] In other words, how could the millions and millions of people buying codependency books and watching Bradshaw on television and seeing therapists and participating in Codependents Anonymous or Adult Children of Alcoholics, how could *all those millions of people* be suffering from the effects of childhood trauma? To academic psychologists, psychiatrists, and mainstream medicine generally, the question answered itself: they couldn't. It must be a scam. Like children who think the world disappears when they close their eyes, they assumed that what they had failed to see simply didn't exist.

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[5] Classic Barnum statements include "You have a great deal of unused capacity which you have not turned to your advantage," and "At times you are extroverted, affable, sociable, while at other times you are introverted, wary, reserved."

[6] Keynote address to the national conference of the American Association for Marriage and Family Therapy by psychiatrist Steven J. Wolin. Cited by Michael J. Lemanski on Addiction Info.

Within a decade, they were proven wrong by one of their own, a physician named Vincent Felitti. While my colleagues and I were wondering how to help the huge number of trauma survivors in our practices, he was wondering about some patients struggling with obesity. A specialist in preventive medicine, Doctor Felitti couldn't figure out why nearly half the participants in his weight-loss program had quit, most when they were losing weight. Quitting when they were failing he could understand, but half of his patients dropped out after substantial losses, which simply made no sense to him. To find out why, he studied their medical records and made his first startling discovery: the dropouts shared an unusual pattern. They were not chubby babies, and they did not gain weight gradually over time. Starting at birth, they maintained normal weights until a huge, sudden weight gain rendered them obese. More baffled than ever, Dr. Felitti interviewed the dropouts to gather more data, looking for links between obesity and other phenomena. In one interview, he jumbled his questions and inadvertently asked a woman what she weighed when she first became sexually active.

"Forty pounds," she replied.[7]

Sure, at first, that he had misunderstood her answer, Dr. Felitti soon discovered that her experience was not unique among his dropouts. Of the 286 dropouts he and his colleagues interviewed, most had been traumatized in childhood, had gained their weight in response, and had been unable to lose it, except temporarily.

Stunned by these results, Dr. Felitti presented his findings to a conference of obesity specialists in 1990. Their response was a mean-spirited echo of Freud: the dropouts had manufactured the abuse to explain their failure to lose weight. Nonetheless, the conference led Dr. Felitti to Dr. Robert Anda, an epidemiologist at the Center for Disease Control (CDC), and the two of them recruited 17,421 subjects for a survey of the relationship between childhood events and

[7] Jane Ellen Stevens, "The Adverse Childhood Experiences Study: The Largest Public Health Study You Never Heard of," *Huffington Post*, October 8, 2012. My debt to this article goes far beyond two quotations, and I highly recommend it to anyone interested in the history and influence of the ACE study. Stevens also edits a news site called ACES Too High that reports on ACE-related research.

adult health called the Adverse Childhood Experience (ACE) Study. Recruits were members of Kaiser Permanente, so they were not a pure cross-section of the US population but a cross-section of employed and insured people. From 1995 to 1997, these people completed a detailed biopsychosocial (biomedical, psychological, and social) questionnaire plus ten yes/no questions about the most common forms of childhood trauma.[8] They also underwent a complete physical examination and extensive laboratory tests. This study was unlike any previous research in its consideration of many kinds of trauma, rather than a single stressor, and in its overall scope: number of subjects, breadth of health information, and duration of follow-up. The CDC continues to track the 17,421 subjects and collect data on their health and well-being.[9]

Initial results of the study stunned even the researchers. Dr. Anda told a reporter that when the data came in, he broke down: "I saw how much people had suffered, and I wept." Two-thirds of the respondents had at least one ACE, and one-fifth had three or more. Even more alarmingly, the more adverse experiences in childhood the greater the incidence of a huge range of adult problems, including addiction, depression, headaches, heart disease, pulmonary disease, cancer, academic difficulties, and absenteeism from work. One in six people had a worrisome score of four ACEs, and one in nine had five. Considering that the study subjects were employed and insured, these staggering numbers may even be low relative to the overall population.

This time around, Dr. Felitti's data were not dismissed as attempts to rationalize personal failure. He and Dr. Anda, along with colleagues at the CDC and major universities have published hundreds of papers on the ACE data in prestigious peer-reviewed journals. Yes, there are a few critics who claim that "self-reporting" yields imperfect data—though I'm not sure how else we could

[8] Dr. Felitti focused on the categories mentioned most frequently in his initial obesity study. A copy of the original questions may be found here and a 2014 version here. Other researchers supplement the original, adding questions about ACEs such as racism and neglect. Links to these versions may be found here.
[9] Comprehensive, up-to-date information, articles, raw data, and other resources may be found on the CDC web site dedicated to the study.

collect information on childhood trauma—but Felitti's and Anda's research has far more fans than critics. In the past two decades, it has begun to transform the fields of psychology, medicine, public health, social work, education, and criminal justice. Professionals in those fields now routinely speak of ACEs and adopt "trauma-informed" or "trauma-sensitive" policies, programs, and practices. Local leaders have developed radical new approaches to everything from school discipline to family court procedures to housing. As of 2017, there were forty trauma-related bills making their way through eighteen state legislatures, many concerned with better identifying and treating at-risk children in settings such as health care and education. My state, Washington, passed a bill in 2011 creating a public-private partnership to research the causes of ACEs in communities and to devise innovative solutions. Vermont passed a similar bill last year. Around the country, as basic information-gathering expands to include ACE-related questions, people researching a broad range of issues are discovering that childhood trauma plays a larger-than-anticipated role. As one neuroscientist phrases it, "Adverse childhood experiences are the most basic cause of health risk behaviors, morbidity, disability, mortality, and healthcare costs."[10]

Public awareness of these discoveries is another matter. When Senator Heidi Heitcamp (D-ND) and Representative Danny K. Davis (D-IL) introduced the Trauma-Informed Care for Children and Families Act this past spring, the silence was deafening. The media have shown some interest in individual trauma-informed projects and policies but not much in the ACE study or what it revealed about the prevalence and the consequences of childhood trauma. There was a burst of media attention in 2012, including pieces in the *New York Times*, *Salon*, the *Huffington Post*, and *This American Life*. After that, national press coverage dwindled, and I don't see much evidence that the general public knows how widespread or serious childhood trauma is. They certainly aren't aware of some of the ACE study's more surprising findings, such as data linking the most adverse outcomes

[10] Dr. Casey Hanson, "The Neurobiology of Trauma," lecture, April 12, 2017.

to sustained emotional, rather than physical, abuse. I think that most Americans still believe that childhood trauma is relatively rare and that only the most severe corporeal forms, such as incest, do lasting damage. Perhaps the reality—that trauma is commonplace, myriad, and destructive—is just too disquieting to contemplate. Nonetheless, as a society we must address an issue that is, as one of the world's leading medical journals phrases it "a human rights violation and a global public health problem."[11]

After Dr. Felitti demonstrated conclusively that childhood trauma is both devastating and common, scholars finally got to work on the problem of childhood trauma and its adult consequences. Since the turn of the century, solid research has begun to emerge from academic departments. Unfortunately, this research hasn't offered much in the way of treatment. As a recent dissertation puts it, "The devastating effects of untreated adverse early childhood experiences have long lacked sufficient clinical attention.[12] In other words, it's more essential than ever to bridge the gap between academic psychology and the field observations of therapists who have been treating codependency. If we look in both places, rather than just one or the other, we find concrete steps that survivors can take to help themselves.

The literature of codependency has a lot to offer. One of its strengths is the deep reading of personal experience, which is something academic psychology has just started to do in the new genre of autoethnography, which looks very much like what I have done here, only with more footnotes. Autoethnography, which originated in anthropology is "an approach to research and writing that seeks to describe and systematically analyze personal experience in order to understand cultural

[11] R. Gilbert, C.S. Widom, K. Browne, D. Fergusson, E. Webb, and S. Janson, "The burden and consequences of child maltreatment in high-income countries," *Lancet*, 2009, 373(9657): 68-81.
[12] Michelle Farivar, *The Play's the Thing: A Qualitative Analysis of Participation in Theatrical Experience for Individuals with a History of Traumatic Stress*, Los Angeles, CA, Alliant International University, 2017.

experience."[13] Transplanted to psychology, it seeks to understand behavior rather than culture, but the method is the same: to gain large insights from a rigorous and searching examination of a single life. Some of the best codependency books have been doing that for years—Melody Beattie's work comes to mind—and I think it's no accident that a 2017 Ph.D. dissertation, an autoethnography by a survivor of both sexual and emotional abuse, is deeply indebted to classics of the codependency field written by my colleagues in the 1980s.[14]

At the same time, it's important to understand the limits of writing on codependency. Some writers do generalize too much, claiming flat-out that everybody is codependent. This claim weakens the link between childhood trauma and codependence—either that or it defines trauma so broadly that no child could possibly escape it, in which case we do a disservice to the tens of millions who suffered particular hardship and eliminate the incentive to identify help children who are suffering that hardship right now. If trauma is universal, then there's no point in developing programs to target sufferers and ameliorate their suffering. I'll admit that I occasionally see rhetorical value in overstating the extent of codependence—I have done it myself when I wanted clients to feel less alienated—but, on the whole, I think it does more harm than good.

Let me say a bit more about why so that you can read codependency literature more thoughtfully. Uncritically claiming that most, if not all, people are codependent does something that's subtle but dangerous: it privatizes a public problem. When a pattern describes an entire population, it's no longer a symptom of private trauma; it's a social problem. We may work privately to mitigate the effects on us—and I would absolutely recommend that we do—but a real solution will be a public solution. Everyone busily excavating their private trauma will get us only so far if part of the problem is traumatic systems, which it would have to be if everyone were traumatized.

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[13] Ellis, C., Adams, T., & Bochner, A. (2010). Autoethnography: An Overview. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 12*(1). doi:http://dx.doi.org/10.17169/fqs-12.1.1589.

[14] Gina Smith, *Up, Down, Out: An Autoethnography of Parental Alcoholism and Resilience*, Saybrook University, Oakland, CA, 2017.

Even where codependency is not universalized, the literature does tend to ignore its social dimensions. For example, right now we're seeing a rise in toxic perfectionism, a problem I will discuss later in this book. That kind of perfectionism can originate in private trauma, of course, but a culture-wide spike probably owes more to factors such as the increasingly competitive "gig economy" or the pressure to curate a flawless social media profile. Shopping addiction is another such problem, where relentless marketing and pro-consumption ideology keeps many people on the edge of compulsion regardless of their personal histories.

Why does it matter? If both social and individual problems cause dysfunction or pain, why do we need to distinguish them? I've already mentioned one reason: that to solve problems, we have to understand their causes. But, even before we solve them, we have to understand where a problem originates so that we can deal with the emotions it generates. In Chapter Twelve, we will learn about carried emotions, which originate outside of us but which we experience as our own, often in extreme and disruptive ways, such as sudden rage or overwhelming shame. We can carry such emotions for other people, but we can also carry them for groups, communities, institutions, and whole cultures. When we discuss carried feelings, we'll learn about descendants of Nazi war criminals who carry the guilt, not just of their individual family members, but of the whole regime. That's an extreme example, but the phenomenon is not uncommon, and it's valuable to understand where your pain originates so that you can restore it to its rightful owners.

Another problem with the literature of codependency is the flip side of its greatest virtue. "Our angels are our demons," says a friend of mine, and indeed it's often true that the same trait can be both a strength and a weakness. In this case, the deep probing of personal experience that is such a virtue of codependency literature can lead writers to over-generalize from their own lives. Robin Norwood famously said either you recognize yourself as a "woman who loves too much," or you're in denial. That's the fallacy of the false dilemma, which reduces a complex range of options to a

single pair of opposites ("You're with me, or you're against me," or "America: love it or leave it"). It's important to read critically, to realize that no book has all the answers you need, and to be wary when an author tries to foreclose disagreement by suggesting that it's likely a "symptom" of something undesirable.

Reading critically also involves being alert to oversimplification and the overuse of taxonomic systems. We human beings *love* classification, whether it's by astrological sign, somatype or position in a dysfunctional family: hero, scapegoat, lost child, or mascot. I'm a mesomorphic Saggittarian hero; what are you? There's a reason magazines such as *Cosmopolitan* regularly feature articles titled "What's your animal love style?" We take the quiz to learn whether we're a "cuddle bunny" or a "curious monkey" or a "protective mama bear" or a "lone wolf," and sometimes the answer offers food for thought. Schemes can conceal as much as they reveal, however. Lots of people either fall through the cracks because their experience doesn't fit any category, or they over-identify with one category when, in fact, they fit more than one. The minute I decide I'm really a mesomorphic Saggittarian hero, I begin to minimize my endomorphic tendencies, my long history as a scapegoat, and my Aquarius moon. Taxonomies and models are common in codependency literature; we should absolutely use them to think about ourselves but avoid adapting our unique experience to someone else's paradigm. With those cautions, we can glean a lot from codependency literature.

If we discover that childhood trauma is negatively influencing our adult lives, what do we do about it? Will remembering what happened to us and understanding how that experience continues to affect us actually help? As someone who has been a therapist for more than forty years, I'm convinced that self-understanding has immeasurable value, both in itself and as the foundation of positive change. But the kind of understanding that really helps is not easy to achieve. It requires the

courage to face painful truths and the commitment to keep going when the process becomes uncomfortable—and it *will* become uncomfortable. Some people fantasize that the process of personal growth will feel natural, like "coming home" to an authentic self. Yes, there are moments like that, as well as moments of pleasure in discovery and mastery. But much of the process feels quite *un*natural: awkward, forced, artificial, less like coming home than like colonizing Mars.

For those of us with histories of trauma, what's "home" is the dysfunction we grew up with and the coping strategies we evolved to deal with that dysfunction. Consciously or unconsciously, we gravitate toward situations that replicate those familiar patterns, and we often bail out of situations that challenge them. Many of those bail-out strategies are unconscious. We're working on an exercise from this book, making notes about a childhood incident, when boredom overtakes us. The incident we're reflecting upon suddenly seems trivial, a waste of time. Important tasks clamor for our attention, and we're suddenly struck by how self-indulgent it is to ponder things that happened such a long time ago. We look out the window at a neighbor painting his fence, and we think *that's* how a responsible adult behaves, and, before we know it, we're up a ladder replacing a window screen without even suspecting why our attention was hijacked. And boredom is just one, relatively benign, way our minds steer us away from uncomfortable topics and the feelings they arouse. When investigating our histories, we may also feel much stronger aversions, including intense fear and shame, along with uncomfortable physical sensations. Also commonplace are cravings for the distraction (or oblivion) of drugs, alcohol, gambling, compulsive sex, and other addictive behaviors. When doing the work described in this book, it can be a challenge to remain focused long enough to discover exactly what happened to us and how it's influencing our lives.

Moreover, as valuable as self-knowledge is, it's rarely enough to heal the effects of childhood trauma. As we'll discuss in Chapter Three, trauma affects the developing brain, and its influence is both conscious and unconscious. Because understanding happens at a conscious level, we have

impulses, reflexes, reactions, thoughts, feelings, sensations, and perceptions that understanding leaves untouched. For that reason, one of the best books on trauma in recent years, Bessel van der Kolk's *The Body Keeps the Score,* champions movement-based approaches, from yoga to psychomotor therapy, along with more traditional talk therapy. I too recommend a mixture of cognitive and somatic techniques, some traditional, some newly prominent, some my own innovation. I designed these techniques to work together as a comprehensive program, but they can readily be used piecemeal, alone or with other therapies. In every case, I supply instructions, work sheets, and supporting materials, such as audio recordings. But before I go into specifics, let me make a few general points about healing.

In researching trauma and its effects, scholars have begun to devote systematic attention to differences among survivors with similar histories. Such studies are simplest after an isolated catastrophe such as a plane crash, where survivors of roughly the same event[15] can be compared; nonetheless, the past 25 years have seen a number of longitudinal studies dealing with complex trauma, or trauma that is repetitive and prolonged, including childhood trauma. The quality that allows people to survive trauma and mitigate its effects is resilience, which is technically the ability to recover from or adjust to deformation caused by stress. Though resilience may seem like a personality trait we either have or don't have; it's more deeply understood as something we *do.* Developing resilience involves:

1. taking back control over how we view our experiences.
2. finding meaning in those experiences.
3. exercising our creativity.
4. developing mindfulness.
5. seeking support.

[15] The word "roughly" acknowledges that no two people experience exactly the same event, just as no two siblings grow up in exactly the same family.

6. working to reinvent ourselves.
7. cultivating humor, optimism, or both.[16]

Some of these methods may seem a bit beside the point: how does creativity relate to childhood trauma? Because resilience is a relatively new focus of research, the mechanisms of influence are not always clear, though theories abound. Dr. Brené Brown, for example, believes that acts of creation, from ceramics to songwriting, help us move insights from our heads into our hearts and into our daily lives.[17] Writer and trauma survivor Jen Cross goes further, claiming that creativity has transformative power because it is fundamental to who survivors are.

> Creativity *is* us. We who are survivors of intimate violence are always creating, given our ability to adapt to horrifying, unendurable situations. . . . Trauma and creativity are inextricably linked, and, I believe, creativity can pull us through the after-effects of what was done to us, and what we did to survive.[18]

What matters is that the link between creativity and resilience has been repeatedly demonstrated, so it's a valuable tool regardless of why it's effective. My own experience has taught me that creativity is not something to put aside while we do the serious work of recovery; it's an essential part of that work.

Everything else on the list is essential too, so each section of the book will emphasize several of the activities and attitudes that cultivate resilience. Though all of them inform and reinforce one another, we'll highlight several at a time to better understand their role in healing from childhood trauma.

Section I: taking back control of how we view our experience.

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[16] Adapted from Smith (2017), who cites Metzl (2009), Flasch (1988), Taylor (1983), and Almeida, (2004).
[17] Brené Brown, *Rising Strong: How the Ability to Reset Transforms the Way We Live, Love, Parent, and Lead* (New York: Random House, 2017).
[18] Jen Cross, *Writing Ourselves Whole: Using the Power of Your Own Creativity to Recover and Heal from Sexual Trauma* (Coral Gables, FL: Mango Publishing Group, 2017) 295. Note: page number from the e-book, which is off.

Section II finding meaning in our experiences and exercising creativity.

Section III: mindfulness.

Section IV: seeking support.

Section V: taking back control, exercising creativity, and working to reinvent ourselves.

Section VI: all of the above plus cultivating humor and optimism.

As you can infer from this brief summary, many of these categories overlap. For example, mindfulness fosters equanimity and compassion, which in turn foster a quiet but profound kind of optimism: a sense that things really are all right, just as they are. To me, that's far more effective than a cheery affirmation taped to the bathroom mirror or a resolution to use positive words and phrases, which ignore the complex sources of negative thinking and the heroic role it may have played in a survivor's life.

In combination, all of the material in this book seeks to guide survivors of childhood trauma toward resilience, both by demonstrating how I developed it and by explaining how other survivors can. If you recognize your own experience in these pages, I believe that this information can help you feel better and function better than you do now. I won't promise deliverance from your past in ten lessons or seven steps; nor will I ever imply that dealing with childhood trauma is easy or simple or straightforward. It's anything but. If I sometimes sound like a cheerleader, it's because I want to encourage you along this difficult path that we're both navigating. I'm not descending a mountain holding a pair of stone tablets; I'm climbing with you, and I have some knowledge and some kit to share. If they help, I'm thrilled, and if they don't, I fervently hope you find some that do. In fact, one reason this book includes notes and bibliography is to give you a sense of what information is out there and how it might serve you.

In that spirit, I'm going to end this introduction with the best description of resilience that I have read. It's in a dissertation that cites a conference paper, so it's on the obscure side, yet it

perfectly expresses my motives for writing this book. Building on the idea that resilience is more verb than noun, the author defines resilience as "a phased process damaged persons must move through to reach eventual thriving and transcendence . . . a kind of mastery, where the capacity to face, address, integrate, and transform one's worst fears and darkest moments can, going forward, lead to new strength and empowerment."[19] If that sounds optimistic, the reason is that I have watched hundreds of people realize the benefits of this "phased process," including me. I hope you'll find them too.

[19] Richards, R. (2009). *Dreams of perfection: A tribute to Del Morrison*. Paper presented at the annual meeting of the American Psychological Association, Toronto, Canada. Cited in Smith (2017).