

the P R C E S S



A Study Guide

For Use in Treatment and Educational Settings

www.theprocess.info

As You View The Process Think About:

- What core issues might those who have grown up in addicted/traumatized families carry? (See Characteristics of Adult Children of Trauma and Addiction below or pg 8.
- What unusual strengths might those who have grown up in addicted/traumatized families develop? (See Resilience Mandela pg.15.
- What symptoms might an adult child ACOA of an addicted/traumatized family present?
- What symptoms might a child currently living with addiction COA present?

Questions for Sharing in Treatment Centers:

- What feelings and thoughts did this film bring up for you?
- Who in the film do you identify with most and why? Anyone else?
- Who in the film did you not particularly identify with and why?
- What do you imagine the experience of the children in this family is?
- What do you imagine the experience of the addict in this family is?
- What do you imagine the experience of the spouse or partner of the addict in this family is?
- What do you imagine some of the issues that the children who grow up in this family might carry into adulthood?
- What do you imagine are some of the negative lessons about relationships learned by the children in this family and how might these lessons get played out in adult intimate relationships and in parenting?

Questions to Explore in Classroom Settings

- What issues can you identify in those people represented in the film that might stem from growing up with addiction and relationship or cumulative trauma?
- Choose one person and discuss the particular qualities that you feel they exhibit that may stem from growing up with addiction and/or cumulative trauma.
- What types of therapeutic approaches do you think might be helpful in treating an ACOA, addict or co-dependent?
- Referring to the chart below, Characteristics of Adult Children of Trauma and Addiction, on page 8, choose someone from the film and speculate as to which characteristics you perceive they may present with.
- Discuss what some of the core issues the individuals in these families might carry as well as the core issues of the family as a whole.
- Discuss what feelings might be in the affective atmosphere or container of the addicted family.

The Set Up: Living With Addiction

What Happens to the Family When Addiction Becomes Part of It?

Families where addiction is present are oftentimes painful to live in, which is why those who live with addiction are oftentimes traumatized to varying degrees by the experience. Broad swings, from one end of the emotional, psychological and behavioral spectrum to the other, all too often characterize the addicted family system. Living with addiction can put family members under unusual stress. Normal routines are constantly being interrupted by unexpected or even frightening kinds of events that are part of living with drug use. What is being said often doesn't match up with what family members sense, feel beneath the surface or see right in front of their eyes. The drug user as well as family members may bend, manipulate and deny reality in their attempt to maintain a family order that is gradually slipping away. The entire system becomes absorbed by a problem that is slowly spinning out of control. All of this is highly stressful to the body as well as the mind because the body and mind are an interdependent system. In this stressful environment people may become somewhat emotionally deregulated and hyperreactive. Little things become big and big things get minimized as pain is denied and slips out sideways.

Addicted family systems have a "dual-state pattern of behavior. "(Steinglass 1987) There is one family pattern of relating when the addict is sober and another one when the addict is using similar to the manic depressive cycling of bipolar disorder. The dual state patterns are crazy-making for those who are not using a drug. The basic family organization along with particular member to member alliances can change considerably depending on which state is operative. Morality, alliances, family rituals and rules along with the affective and psychological reality are different for each state. In addition, when the addict sobers up they may have little or no memory of their using behavior and may look at the family members who are exhausted, overwhelmed, hurt and angry and wonder why or simply want them to forget about it. This puts children spouses in the position of having to make a painful choice. "do I push my parent away now that they are sober and offering the opportunity for connection and the promise of caring or do I push my own inner world away, my own truth, so that I can connect. Do I abandon them or me?"

During early childhood years, this intense emotional environment can set up a fear of feeling or patterns of attachment that are filled with anxiety and ambivalence. (Ainsworth)As children, COAs may feel overwhelmed with powerful emotions that they lack the developmental sophistication and family support to process and understand. And many resort to intense defenses such as shutting down their own feelings, denying there is a problem, rationalizing, intellectualizing, overcontrolling, withdrawing, acting out or self medicating as a way to control their inner experience of chaos. The COA may be difficult to identify. They are just as likely to be the president of the class, the captain of the cheerleading squad, the A student as they are to act out dysfunctionally. COAs often take on the role of the family "hero" (Wegscheider 1989) and set about the task of restoring dignity to the family as to take on other adaptive roles such as the "Mascot" who brings levity and distraction, the "lost" child who withdraws into self sufficient silence or the "scapegoat" who acts out the family pain that all are feeling but no one is expressing directly. Children may take on more than one role or become fixated in one in particular. And these roles have adaptive as well as maladaptive qualities which makes identifying and treating both the COA and the ACOA complex and multilayered. Pathologizing what actually works or has worked can remove not only defenses but important qualities of resilience. A psycho educational approach can allow the COA and the ACOA to break free of some of the more limiting or maladaptive

aspects of these roles through knowledge and understand as well as emotional and psychological processing without disturbing the adaptive parts.

Families have a remarkable ability to maintain what family therapists call *homeostasis*. When alcohol or drugs are introduced into a family system, the family's ability to self regulate is challenged. Much family communication in the alcoholic system is what we might call a closed system. Because open communication is often impaired, messages become skewed, misinterpreted, not checked out. . "The introduction of a psycho-biologically active drug into a family system cannot help but alter interactional behavior.....presumably changing affective tone, sexual behavior and aggressive and other behavior. Long term central nervous system depression produces lethargy, somnolence, and withdrawal. Cognitive disturbances in an alcoholic will often force the family to communicate in non verbal ways. Investigations of non verbal physical communication, affective feeling tone, interaction rates, as well as the content of verbal interaction, therefore become important in understanding the impact of alcoholism on the family system." (Steinglass 1987). Family members become subsumed by the disease to such an extent they often lose their sense of normal. Their life becomes about hiding the truth from themselves, their children and their relational world. As they do this they come to live a secret life, one in which their secure hold on the so-called normal world starts to slip. Because the disease is progressive, family members seamlessly slip into patterns of relating that become increasingly more dysfunctional. The children are often left to fend for themselves and anyone bold enough to confront the obvious disease is often branded as a family traitor. Family members may withdraw into their own private worlds or compete for the little love and attention that is available. In the absence of reliable adults siblings may become parentified and try to provide the care and comfort that is missing for each other. Or they may become co-opted by one parent as a surrogate partner, filling in the gaping holes and massaging the sore spots of a family in a constant low level of crisis; on the job training for co-dependency. Such families become characterized by a kind of emotional and psychological constriction, where no one feels free to express their authentic selves for fear of triggering disaster; their genuine feelings are often hidden under strategies for keeping safe, like pleasing or withdrawing. The family becomes organized around trying to manage the unmanageable disease of addiction. In their desperate attempts to maintain family equilibrium they invent a novel strategy at each new turn of the disease progression. Some members over-function to restore order and dignity while others under-function providing an alternative focus for their ever-growing problems or defending against their deep fear of ultimate disappointment and failure. They yell, withdraw, cajole, harangue, criticize, understand, get fed up, you name it. They become remarkably inventive in trying everything they can come up with to contain the problem and keep the family from blowing up. The alarm bells in this system are constantly on a low hum, causing everyone to feel hyper vigilant, ready to run for emotional (or physical) shelter or to erect their defenses at the first sign of trouble.

Because family members avoid sharing subjects that might lead to more pain they often wind up avoiding genuine connection with each other. Then when painful feelings build up they may rise to the surface in emotional eruptions or get acted out through impulsive behaviors. These families become systems for manufacturing and perpetuating trauma. Trauma affects the internal world of each person, their relationships and their ability to communicate and be together in a balanced, relaxed and trusting manner. As the "elephant in the living room" increases in size and force the family has to become ever more vigilant in keeping its strength and power from overwhelming their ever weakening internal structure. But they are engaged in a losing battle. The very insidious nature of the disease and humiliating behavior that are its constant bedfellow warp the family's inner

architecture. The guilt and shame that family members feel at the erratic behavior within their walls along with the psychological defenses against seeing the truth all too often keeps this family from getting help until the infection has spread into virtually all of its cells. The development of the individuals within the family as well as the development of the family as a resilient unit that can adjust to the many natural shifts and changes that any family moves through becomes impaired. Initially, addicts may feel they have found a way to manage a pain-filled inner world. Unfortunately, in the long run, they create one. Chronic tension, confusion and unpredictable behavior, as well as physical and sexual abuse, are typical of addictive environments and create trauma symptoms. Individuals in addictive systems behave in ways consistent with the behaviors of victims of other psychological traumas”, in other words, they are traumatized by the experience of living with addiction.

Talking about and processing pain is an important deterrent as far as developing post traumatic symptoms that show up later in life. Intense emotions such as sadness, that are an inevitable part of processing pain, can make family members feel like they’re “falling apart” and consequently they may resist experiencing the pain they are in. And the problems in an alcoholic family system are perpetual. For the family member in an alcoholic system there may be nowhere to run much of the time as those they would normally run to are steeped in the problem themselves. Seeing the problem for what it is often alienates them from other family members. Unresolved childhood pain can become the pain pump that unconsciously fuels problems later in life.

Therapists need to ask direct questions about drinking or using patterns in a family. All too often parents will rally around a child who is acting out the drinking problem that the parents don’t want to face. Children will wind up in a therapist’s office as the “designated patient”. This child provides a welcome diversion for the parents from what is actually going on in the family. Then the parents set about fixing in the child what may actually be a family system problem. If this is not identified, these children may incorporate self loathing qualities into their personality that become part of the picture of the untreated ACOA.

What Happens to the Body When We Feel Traumatized?

Emotions occur in the body as well as the mind. The limbic system is the body/mind neural network that governs our emotions. Our moods, emotional tone, sleep and appetite cycles are some of the areas of functioning that fall under its jurisdiction. Our emotions circulate throughout our bodies as brain/body mood chemicals that impact how we feel. Our experience of fear and other emotions is physical. That’s why when we’re stroking our pet cat, for example, we feel peaceful, when we’re excited we’re “pumped” and when we’re highly stressed we get nervous and edgy.

Our bodies don’t really distinguish between physical danger and emotional stress. The natural fear response associated with our fight/flight apparatus will cause the body to react to physical or emotional “crisis“, by revving up and pumping out sufficient quantities of what are known as “stress” chemicals, like adrenaline, to get our hearts pumping, muscles tightening and breath shortening, in preparation for a fast exit, or a fight. But for those where the family itself has become the preverbal “saber toothed tiger”, for whom escape is not really possible, these chemicals boil up inside and can cause physical and emotional problems. And family members may find themselves in a confusing and painful bind, ie., wanting to flee from or attack, those very people who represent home and hearth.

If this highly stressful relational environment persists over time, it can produce *cumulative trauma*. Because the limbic system governs such fundamental functions as mood, emotional tone, appetite and sleep cycles, when it becomes deregulated it can affect family members in far ranging

ways. Problems in regulating our emotional inner world, can manifest as an impaired ability to regulate levels of fear, anger and sadness. This lack of ability to regulate mood may lead to chronic anxiety or depression. Or, it can emerge as substance or behavioral disorders, for example, problems in regulating alcohol, eating, sexual or spending habits.

The more deregulated the addict's life becomes, the more emotional and psychological pain, they experience. Many increase their substance or behavioral uses and abuses in a misguided attempt to calm their ever increasing inner turbulence. Thus the relationship between trauma and addiction takes hold. Emotional and psychological trauma leads to self medication and self medication or increased use and abuse, leads to emotional and psychological trauma. All of this further deregulates the limbic system.

And because others in the family can become emotionally deregulated through living with the trauma that surrounds addiction, they also become at greater risk for substance abuse or behavioral addictions. Additionally, the rupturing of deep limbic or emotional bonds that have imprinted themselves on our neural systems can leave one feeling "shattered" or "fragmented" making it difficult to pull the lost pieces of self together into a coherent whole.

It is no wonder that families such as these produce a range of symptoms in their members that can lead to problems both in the present and later in life. Children from these families may find themselves moving into adult roles carrying huge burdens that they don't know exactly what to do with and that get them into trouble in their relationships and/or work lives. This is why PTSD can occur, it is a *post* traumatic reaction in which symptoms related to being a COA emerge in adulthood, or in the ACOA. The traumatized child lives in frozen silence until finally the frozen feelings of the child emerge in adult actions and words. But it is the wounded child still searching for a place to put their unprocessed, unspoken pain.

The Effect of Familial Trauma on Children

All of us arrive as infants needing to learn the skills of emotional regulation and self soothing. We learn limbic regulation by being in the presence of adequate external regulating relationships, such as parents and siblings. When the family environment does not model good balance and regulation children can have trouble acquiring this skill. They internalize what surrounds them. And not only do they internalize it mentally and emotionally, it becomes part of their neurological wiring. (Schoore 2004)

Trauma in childhood can seriously impact development throughout life and can have pervasive and long lasting effects. The amygdala, which is a brain center for the fight/flight/freeze response, is fully functional at birth. This means that a baby is capable of a full blown trauma response. The hippocampuses, which is where we assess stimuli as to whether or not it is threatening, is not fully functional until the age of four to five.(Aram 2004). In addition, the prefrontal cortex is not fully mature until around age eleven or older. This means that when a child is frightened, they have no way of understanding what is going on around them. They do not have the developmental capability of assessing frightening stimuli as to it level of threat nor do they have the cognitive capability to understand what's happening. They need an external modulator, namely a parent, to help them to regulate themselves and calm down. Even a sibling, caretaker or pet can help an anxious child to even out their emotions. Without this help, the painful stimuli may become locked in a sensory memory that lives within the self system without insight, understanding or regulation. The content of the memory has a significant unconscious component because reason has not elevated it to the thinking level. It is stored as a sensory memory without reason, insight, and understanding. It is an emotional mind/body accident waiting to happen. Waiting to be triggered and felt in the here and

now, waiting to emerge, not only from the mind, but from the body as well.

Characteristics of Adult Children of Trauma and Addiction

1. ***Learned Helplessness*** A person loses the feeling that they can affect or change what's happening. When this becomes a quality of personality.
2. ***Depression*** Unexpressed and unmet emotion lead to flat internal world – or agitated/anxious depression. Anger, rage and sadness that remain unmet or unexpressed in a way that leads to no resolution.
3. ***Anxiety*** Free floating anxiety, worries and anxieties that have no where particular to pin themselves or look for a place to project at, phobias, sleep disturbances, hyper-vigilance
4. ***Emotional Constriction*** Numbness and shutdown as a defense against overwhelming pain. Restricted range of affect or lack of authentic expression of emotion.
5. ***Distorted Reasoning*** Convolution attempts to make sense and meaning out of chaotic, confusing, frightening or painful experience that feels senseless.
6. ***Loss of Trust and Faith*** Due to deep ruptures in primary, dependency relationships and breakdown of an orderly world.
7. ***Hypervigilance*** Anxiety, waiting for the other shoe to drop – constantly scanning environment and relationships for signs of potential danger or repeated rupture.
8. ***Traumatic Bonding*** Unhealthy bonding style resulting from power imbalance in relationships and lack of other sources of support.
9. ***Loss of Ability to Take in Caring and Support*** Due to fear of trusting and depending upon relationships and trauma's inherent numbness and shutdown
10. ***Problems with Self Regulation*** The deregulated limbic system can manifest in problems in regulating many areas of the self system and

thinking, feeling and behavior. Go from 0 – 10 and 10 – 0 without intermediate stages, black and white thinking, feeling and behavior, no shades of gray as a result of trauma’s numbing vs. hi-affect.

11. *Easily Triggered*

Stimuli reminiscent of trauma, e.g., yelling, loud noises, criticism, or gunfire, trigger person into shutting down, acting out or intense emotional states. Or subtle stimuli such as changes in eye expression or feeling humiliated, for example.

12. *High Risk Behaviors*

Speeding, sexual acting out, spending, fighting or other behaviors done in a way that puts one at risk. Misguided attempts to jump start numb inner world or act out pain from an intense pain filled inner world.

13. *Disorganized Inner World*

Disorganized object constancy and/or sense of relatedness. Internal emotional disconnects or

Fused feelings (e.g., anger & sex, intimacy and danger, need and humiliation)

14. *Survival Guilt*

From witnessing abuse and trauma and surviving, or from “getting out” of an unhealthy family system while others remain mired within it.

15. *Development of Rigid Psychological Defenses*

Dissociation, denial, splitting, repression, minimization, intellectualization, projection, for some examples or developing rather impenetrable “character armor”

16. *Cycles of Reenactment*

Unconscious repetition of pain-filled dynamics, the continual recreation of dysfunctional dynamics from the past.

17. *Relationship Issues*

Difficulty in being present in a balanced manner; a tendency to over or under engage, explode or withdraw or be emotional hot and cold. Problems with trusting, staying engaged or taking in love and caring.

18. *Desire to Self Medicate*

Attempts to quiet and control turbulent, troubled inner world through the use of drugs and alcohol or behavioral addictions.

From Trauma and Addiction, Dayton 2000 (van der Kolk 1987, Krystal 1968)

What Happens When ACOA's Have Their Own Families?

When ACOA's enter intimate relationships in adulthood their feelings of dependence and vulnerability that are an important part of any intimate relationship may make them feel anxious and at risk all over again. Feeling vulnerable and unable to defend themselves adequately due to the meaning they made around the painful events of their childhood when this may have been actually true, they may rely on the strategies that they used in their alcoholic systems in order to regain their emotional equilibrium. They may perceive themselves as helpless even if they are not. Beneath the level of their awareness, the ACOA worries that chaos, out-of-control behavior and abuse may be looming around the corner, because this was their early childhood experience. Children who have been traumatized by living with addiction become very adept scanners; they are constantly reading their environment and the faces of those around them for signs of emotional danger, a manifestation of hyper vigilance. If they sense emotions in another person that make them feel anxious, they may lapse into people pleasing in order to alleviate potential "danger". They may have learned as children that if they could calm and please their acting out parent, their own day might go more smoothly i.e. they might experience less hurt. (Van der kolk 2005) These people pleasing strategies get carried into intimate relationships in adulthood. They may be so convinced that distress is at hand that they experience mistrust and suspicion if problems are solved smoothly. They may even unconsciously push a situation in a convoluted self-protective attempt to ferret out potential danger until, through their relentless efforts to avoid it, they actually create it. Or they may freeze all over again, act out in rage, collapse into helplessness, withdraw or a combination of the above. And so the pattern of strong feeling leading to emotional danger, chaos, rage and tears is once again reinforced and passed along in a mindless blast of triggered emotions into the present that belong primarily to the past. At these moments the ACOA is stuck in and reacting out of the survival parts of the brain, what is getting triggered is a sense memory from childhood with little reason and understanding attached to it. The more advanced parts or the cortical brain where thinking and reasoning take place is temporarily overwhelmed and shut down. They become all action and no observing ego or internal witness. Adults who were traumatized as children don't remember things well or necessarily in order. Memories return in fragments and glimpses and they are not always obviously related.

And because trauma is a body/mind phenomenon, when trauma related memories emerge they often come with a sensorial content (shakes, shivers, heart pounding etc) (Levine 1997) because the body that was revved up for fight or flight became thwarted in its urge to act. Just as an animal shakes off fear to bring itself back into balance, the human body is trying to shiver and shake its way back to equilibrium. Part of healing this will include bringing a therapeutic closure to these hungers for action (Moreno 1964) so that the mind can let go of the urge for what amounts to unfinished business or open tensions (Moreno 1964).

Traumatic Bonds

Those who live in families that are traumatizing often form what are known as *traumatic bonds*. If someone is unable to escape chronic traumatic abuse they are more likely to develop both traumatic bonds and PTSD. This traumatic bonding is partly the result of feeling dehumanized and "robotized" by the abuse. They may become emotionally numb as part of the trauma defense and their capacity for real intimacy may become disrupted by the regular trauma. The intensity and quality of connectedness in addicted/traumatizing families can create the types of bonds that people tend to form during times of crisis. Alliances in addicted families may become very critical to one's

sense of self and even survival. Alliances can become very intense among children, for example, who are feeling hurt and needy without proper parental support. Or one parent may co-opt a child and form a bond against the other parent. Or traumatic bonds may simply get seared into place as family members repeatedly face threatening, frightening and overwhelmingly painful experiences and hunker down in emotional dugouts together until the barrage of explosions passes. As the family members fear increases so does their need for protective bonds. Trauma may lead people both to withdraw from close relationships and to seek them desperately. The deep disruption of basic trust, the feelings of shame, guilt and inferiority combined with the need to avoid reminders of the trauma all foster withdrawal from close relationships or social life. But the terror of the traumatic event intensifies the need for protective attachments. The traumatized person therefore frequently alternates between isolation and anxious clinging to others or in bonding with the perpetrator as the victim's dependency grows through abuse along with their need for perceived protection. Factors that can contribute to bonds becoming traumatic are:

- If there is a power imbalance in the relationship.
- If there is a lack of access to outside support.
- If those who we would naturally go to for caring and support are unavailable or are, themselves, the abusers.
- If there are wide inconsistencies in styles of relating that induce both states of high need/anxiety alternating with high need/fulfillment. (See Model for Addicted/Traumatized Family System)

All too often the confusion in these types of relationships is that they are neither all good nor all bad. Their very unevenness can make the nature of the bond all the more difficult to unravel. In the case of addiction this is an all too familiar dynamic. The addicted parent, for example, may swing between being attentive, generous and caring to being abusive, neglectful and rejecting. One minute they are everything one could wish and the next they are miserably disappointing. This also sets up relationship models for the entire family and demonstrates lack of continuity and responsibility. Some family members addicted or not may mimic this relationship style while others may over function to fill in all the missing gaps becoming overly responsible... All of these types of bonds become styles of relating that get played out in relationships throughout life. Traumatic bonds formed in childhood tend to repeat their quality and contents over and over again throughout life. Abusive bonds can become traumatic bonds. For example the bond between an abusing parent and child may repeat itself when the abused child grows up and marries an abusing spouse or reverses roles and becomes an abusive parent to their own child. Through projective identification or because of choosing people who have a corresponding psycho/emotional set-up, these bonds find new homes in willing hosts. They get revived, repeated and relived over and over and over again.

| Characteristics of the Addicted/Traumatized Family System | | |
|--|---|--------------------------|
| Extreme R.O.F | Balanced Range of Functioning | Extreme R.O.F. |
| High Intensity | <i>emotional modulation</i> | Shutdown |
| Over-functioning | <i>balanced functioning</i> | Under-functioning |
| Enmeshment | <i>balanced-relatedness</i> | Disengagement |
| Impulsivity | <i>self regulation</i> | Rigidity |
| Grandiosity | <i>healthy self image</i> | Low self worth |
| Denial | <i>reality orientation</i> | Despair |
| Caretaking | <i>balanced care of self and other</i> | Neglect |
| Abuse | <i>talking things out rather than acting them out</i> | Victimization |

High Intensity vs. Shutdown/Dissociation

When family members become emotionally overwhelmed with too much *intense* emotion and they have no way of staying safe, they may *shut down or dissociate* (freeze/flight) in an unconscious attempt to preserve themselves much in the way a circuit breaker flips when the wattage overwhelms the capacity of the circuit and threatens to cause damage. Shutting down is a trauma response. (Van der kolk 1987) This alternating pattern of *high intensity vs. numbing* becomes a quality that underlies many personal and family dynamics. It is the black and white pattern spoken of so often in addiction circles, the Jekyll/Hyde syndrome that characterizes the alternating worlds of the addicted family system. These swings between high intensity and shutting down or dissociating that characterize the trauma response become central to the operational style of the family. All or nothing tends to characterize the family that contains trauma.

Emotional modulation is a skill that becomes internalized through regular exposure to modulating relationships such as mothers, family members or one to one and group therapeutic relationships. It can also be aided through regulating activities like meditation, yoga, massage, deep breathing and exercise; activities that quiet and soothe the limbic system.

Over functioning vs. Under Functioning

In a maladaptive attempt to maintain family balance, some family members *over function* in order to compensate for the *under functioning* of others. Over functioning can wear many hats; parentified children may try to take care of younger siblings when parents drop the ball or strive to restore order or dignity to the family who is rapidly slipping. Spouses may over function to maintain order and “keep the show on the road” while the addict falls in and out of normal functioning. Others in the system may freeze like deer in the headlights, unable to get their lives together and make useful choices. The learned helplessness associated with the trauma response, in which one comes to feel that nothing they can do will make a difference, can become an operational style that manifests as under functioning. It is possible that the addict themselves, along with others in the system, may do both, over functioning to make up for periods of under functioning.

Balanced functioning is the obvious in between of over and under-functioning. When we do what is appropriate to the circumstance and when we have conscious choice around the degree to which we function. The program slogan, “take the next right action” can help the under-functioner who becomes overwhelmed with the thought of taking care of themselves or undertaking tasks, to break down any task into manageable components or the over-functioner to modulate their frenetic activity. “One day at a time” can assist both the over-functioner and the under-functioner to manage feelings of being overwhelmed.

Enmeshment/Disengagement

Enmeshment or fusion is generally seen as an attempt to ward off feelings of abandonment. It is a relational style that lacks boundaries and discourages differences or disagreement, seeing them not as healthy and natural but disloyal and threatening. Dissension is not well tolerated and disagreement discouraged. The unspoken rule is

“don’t rock the boat”. *Disengagement* is the other side of enmeshment or fusion. Family members see the solution to keeping pain from their inner worlds from erupting as *avoiding* subjects, people, places and things that might trigger it. This leads to an emotional *disengagement*. Family members move into their own emotional and psychological orbits and they don’t share their inner worlds with each other. This may give rise to covert alliances where a couple of family members ally and form covert bonds.

Balanced relatedness is neither a withdrawal from another person nor a fusion with them. It allows each person their own identity and to move in and out of close connection in a natural, modulated fashion.

Impulsivity vs. Rigidity

When emotional and psychological pain cannot get talked out it often gets *acted out* through impulsive behaviors instead.

Impulsive behavior can lead to chaos, wherein a pain filled inner world is surfacing in action. Painful feelings that are too hard to sit with explode into the container of the family and get acted out. Blame, anger, rage, emotional, physical or sexual abuse, collapsing into helplessness, withdrawal or yelling, over or under spending and sexual anorexia or promiscuity are some ways of acting out emotional and psychological pain in dysfunctional ways that engender chaos.

Rigidity is an attempt to manage that chaos both inwardly and outwardly. Adults in an addictive/traumatizing family system may tighten up on rules and routines in an attempt to counteract or ward off the feeling of falling apart inwardly or outwardly. And family members may tighten up in their personal styles becoming both controlled and controlling. There is no middle ground where strong feelings can be talked over or even explode momentarily but then be talked through toward some sort of tolerable resolution. Impulsive behavior is a manifestation of high intensity and rigidity is a manifestation of shutting down, clamping down or being physically present but psychically absent, following empty forms and rules. Again, the tendency to alternate between black and white in thinking, feeling and behavior, with no shades of gray, which reflects the family’s problems with regulation.

Self regulation is a basic developmental accomplishment that allows the growing child and eventually the adult to regulate their thinking, feeling and behavior so that it is within an appropriate range for the situation they are engaged in.

Grandiosity vs. Low Self Worth

Feelings of *low self worth* and shame can plague those within the addicted family system. Not feeling normal, experiencing themselves as different from other families, and hiding the painful truth of family dysfunction can all contribute to those in an addicted family system feeling bad about themselves.

Grandiosity is a common defense against feelings of worthlessness. Feelings of helplessness, frustration, shame and inadequacy get covered up with grandiose schemes and fantasies. Family members may not understand how to take baby steps toward success or getting their lives together. Frustrated and disheartened they may take refuge in grandiose ideas of themselves and their plans in life as a way of wading off ever-

growing unconscious fears that their lives are somewhat unmanageable or they cannot seem to get things to work out for them.

A healthy self image can tolerate the normal flux in positive and negative feelings about the self without sinking into pervasive feelings of worthlessness or boomeranging into grandiose fantasies as a way of defending against those painful emotions. A healthy self image or good self esteem is probably one of the most important components of emotional immunity and well being.

Denial vs. Despair

Addicted or traumatized families are often very threatened by what they perceive to be the looming destruction of their family as they know it. Their very place in the world is being threatened; the ground beneath them is beginning to move. *Denial* is a dysfunctional attempt to put a good face on a bad situation by denying the impact addiction is having on the family system and the presence of the proverbial “pink elephant in the living room” who is taking up ever increasing amounts of space. Reality gets rewritten as family members attempt to bend it to make it less threatening; to cover up their ever growing *despair*. Family members often collude in this denial and anyone who attempts to turn the spotlight onto harsh reality of addiction may be perceived as disloyal. They run in place to keep up appearances (to themselves as well as others) while feeling a sense of *despair* constantly nipping at their heels. Again we witness the cycles between extremes that is so characterize addicted/traumatized family systems.

Reality orientation or an ability to live with life on life's terms is an important part of recovering one's balanced sense of self and orientation toward the world.

Caretaking vs. Neglect

Caretaking can be an attempt to attend to in another person what needs to be attended to within the self *e.g.* personal, unconscious anxiety or pain may become displaced and identified not within the self but within another person then we set about relieving them of “their” symptoms rather than attending to our own. It is a form of care that is motivated by our own unidentified needs rather than a genuine awareness of another's. Because this is the case, *neglect* can be its dark side. We neglect or don't see what is real need in another person because we can't identify real need within the self. Neglect can take the form of, ignoring or not seeing another's humanness, withholding care, nurturing and attention, a shutting down of the relational behaviors that reflect attunement and connection. Neglect can be particularly difficult to treat because there is no easy behavior to pin wounded feelings on. Clients are left feeling they have too many needs to meet and mistrustful of deep connection.

Balanced care of self and others is part of living a healthy life.

Abuse vs Victimization

Emotional, physical and psychological *abuse* is unfortunately all too often present in families that contain addiction and trauma. Abuse is part of the impulsivity that so characterized families where feelings are acted out rather than talked out. The other side of abuse is *victimization*. The all too often dynamic in which the abused child becomes the abusing parent, having felt helpless and victimized as a child, for example, they act out their childhood pain by passing it on in the form in which they got it rather than

identifying and feeling their own helplessness and rage at being a victim of abuse. In this way trauma related or addiction related familial patterns of relating become intergenerational.

Balance can be achieved when intense emotions can be tolerated both within the self and within the emotional container of the relationship. When this is possible, painful feelings, even if they explode momentarily, can be worked through toward some sort of resolution. After a disconnection occurs a reconnection can occur which will represent a slight step up in relating, healing or interpersonal awareness and understanding.

Those who have experienced trauma may experience some of the following issues when they attempt to re-enter adult intimate relationships. They may:

- Avoid intimate relationships because they unconsciously fear another interruption of the affiliative bond (isolation)
- Recreate relationship dynamics that mirror their original trauma (reenactment)
- Unconsciously project unhealed pain and anger from the original trauma into present-day intimate relationships (transference)
- Become enmeshed in intimate relationships in an unconscious attempt to protect against abandonment (fusing)
- Distance their partner when they enter a dependent relationship (withdrawal)
- Later respond to situations that trigger them by shutting down, or with an intensity of emotions appropriate to the original traumatic situation (triggering)
- See their partners in intimate relationships as alternately all good or all bad (splitting)
- Misread signals from others, overreacting to signals that threaten to stimulate old pain (Alexythimia)
- Lose the ability to let go and be playful in intimate relationships (loss of ability to fantasize, symbolize)
- Lose the ability to trust and have faith in intimate relationships (interruption of affiliative bond)
- Lose their capacity to accept support (numbness, shutdown, unresolved pain)
- Engage in sensation-seeking behavior (high intensity / shutdown)
- Self medicate with drugs and alcohol (self medication) (Dayton 1997)

Parents with a family history of trauma and/or addiction may tend to:

- Have trouble tolerating their children being rejected by anyone.
- Tend to violate their children's boundaries by being unnecessarily intrusive and overly curious about their child's affairs or push them away and withdraw or both.
- Have a difficult time negotiating the vicissitudes of intimacy with their children and establishing an overall evenness in relating.
- Overprotect their children even when it is not in their children's best interest or push away the child's needy/dependent sides or both.
- Not know what normal is and consequently have trouble understanding what behavior to accept or foster as normal in their children and what behavior to discourage.

- Have trouble having relaxed and easy fun with their children.
- Have impulsive features that they act out in their parenting.
- Feel somewhat different from other families.
- Attempt to over control family life and the lives of their children.
- Have trouble establishing healthy boundaries with their children, positioning themselves either too close or too far.
- Withdraw when hurt or become attacking, may have trouble modulating their responses
- Have trouble generating healthy family rituals and allowing for the natural ebb and flow that accompanies them. They may become too important or minimized as to importance or both.
- Layer their unresolved historical emotions onto their relationships with their children.(Dayton 1997)

Duel Diagnosis and the Dry Drunk Syndrome

If there is a duel diagnosis, which is so often the case in addiction, the diagnosis of addiction is properly dealt with by removing the substance, but the underlying diagnosis, for example of depression, anxiety, PTSD, may not be dealt with. Recovery is about more than recovering from substance abuse. It is also and very importantly about recovering from the other diagnosis or the symptoms that may have been self medicated in the first place. And even if there is no duel diagnosis, the addict will still need to engage in a full recovery process in order to deal with the emotional and psychological complications that stemmed from the addiction. If they do not do this, they are asking both themselves and their family members to live with emotional and psychological burdens that can keep the family and the individuals within it mired in dysfunctional patterns of relating that get passed along through the generations, commonly referred to as “passing on the pain”.

Recovery is equally important for those who have lived in, developed their sense of self and learned relationship skills in an addicted/traumatized family. Without a rigorous program of treatment and recovery for all concerned, the dysfunctional personality styles and relationships developed in this non optimal environment will tend to recreate themselves over and over again.

Trauma and Addiction as an Intergenerational Disease Process

Children of addiction are four times more likely to become addicts themselves and these statistics don't include multiple addictions such as food, sex, gambling, work addiction etc. Nor do they include those who marry addicts. Many feel that there is a genetic predisposition to addiction and there is certainly evidence that this may be the case. However, even putting genetics aside, the emotional, psychological and behavioral patterns that get passed down through the generations put each generation at risk for perpetuating the trauma related dynamics that lead to emotional problems across a wide range of indicators and addiction if rigorous treatment doesn't intervene. In this way, addiction and psychological problems become a family illness that is intergenerational.

Resilience

Not all children who grow up in less than optimal homes fail to thrive in adulthood. Some of the common traits that resilient children share according to Wolin and Wolin, is a strong, bonded relationship with at least one other person, usually within the extended family network, often a grandmother, aunt or uncle. In treating ACOAs is very important to identify the qualities of strength

and resilience that they possess. ACOAs can be marvelously adaptive and resourceful. As the Italian proverb goes “what doesn’t kill you makes you stronger”. Many COAs and ACOAs develop unusual personal strengths.

Wolin and Wolin have created what they call a resilience mandala, or those qualities that are resilience enhancing. They are:

- Independence
- Creativity
- Relationships
- Insight
- Humor
- Morality
- Initiative

Some of the risk factors for children that can lead to psychological and emotional problems later in life are:

- Poverty
- Overcrowding
- Neighborhood and school violence
- Parental absence
- Unemployment or instability

These can be the children who are likely to wind up in the health care or penal system. However some children grow up in the middle of all this and still come to have productive lives and relationships. Wolin and Wolin studied these children and their growth into adulthood in order to identify the attitudes and qualities that resilient children and adults seemed to possess and what factors might have contributed to building them. They discovered that resilient children tended to have:

- Likable personalities from birth that attracted parents, surrogates and mentors to want to care for them. They were naturally adept recruiters of support and interest from others and drank up attention, care and support from wherever they could get it.
- They tended to be of at least average intelligence reading on or above grade level.
- Few had another child born within two years of their birth.
- Virtually all of the children had at least ONE person with whom they had developed a strong relationship, often from the extended family or close community.
- Often they report have an inborn feeling that their lives were going to work out.
- They can identify the illness in their family and are able to find ways to distance themselves from it; they don’t let the family dysfunction destroy them.
- They work through their problems but don’t tend to make that a lifestyle.
- They take active responsibility for actively creating their own successful lives.
- They tend to have constructive attitudes toward themselves and their lives.
- They tend not to fall into self destructive lives.

Wolin and Wolin in studying resilient adults found that they tended to have:

- Found and built on their own strength:
- Improved deliberately and methodically on their parents lifestyles
- Married consciously into happy, healthy and or strong families
- Fought off memories of horrible family get togethers in order create their own rituals.
- There tended to be what Wolin and Wolin refer to as the “magic two hundred mile” radius between them and their families of origin, enabling them to stay somewhat apart from the daily fray of potential family dysfunction.

Wolin and Wolin found that the price these persons tended to pay were:

- Stress related illnesses.
- A certain degree of aloofness in their interpersonal relationships.

Healing the Emotional Body along with the Mind and Spirit

Implications for Treatment

Part of what addicts, ACOA's and codependents are doing in recovery is rewiring their body/mind systems to be able to tolerate increasing amounts of emotional and psychological pain without blowing up, shutting down or self medicating. This limbic reregulation happens slowly and over time. A week or a month or even a year is not enough time to accomplish this intricate mind/body task. It may take years for clients, to accomplish these deep changes and may require a combination of body work, therapy and twelve step programs. Talking about traumatic memories may be the very last phase of healing from them. Full healing may encompass:

- Developing the ability to manage their own level of physiological arousal without becoming so anxious and fearful that one cannot tolerate the emergence of traumatic memory and the accompanying physiological sensations.
- Limbic rewiring I.e. spending time with adept external regulating relationships in order to repattern the deregulated limbic system e.g. therapy, twelve step programs, hobby groups, faith groups, relationships with animals.
- Creating a new support network or revitalizing aspects of existing ones.
- Doing body work such as yoga to heal the nervous system and bring it back into balance
- Regular exercise that can stimulate the body's natural opoid or self soothing systems.
- Getting sufficient rest and relaxation.
- Adopting good nutritional habits
- Massage which produces calming body chemicals through touch and the relaxation response.
- Finding alternative ways self sooth and to attain a "feel good" state such as exercise, meditation/relaxation/breath work, finding meaningful activities and hobbies.
- Doing the family of origin, present day family work in order to work with issues that contribute to using and dysfunction.

Some of the tasks of recovery that those who have lived with addiction and/or trauma need to practice are to develop the ability to tolerate strong emotions without acting out along with enough emotional literacy so that problems can be talked out rather than explode or implode. The cerebral

cortex "has more inputs from the limbic system than the limbic system has coming from the cortex" (Schoore 2004) Consequently our emotions highly impact our thinking and choice making processes.(Damasio 1999) Integrating these emotional messages with our reason is part of how we come to better understand ourselves and develop emotional literacy. But the body will also need to develop emotional strength; it will need to heal the nervous system that has become deregulated through trauma.

Issues relating to addiction or being the adult children of addiction often get misdiagnosed. ACOAs may present across a wide range of symptoms such as depression, anxiety disorders, eating disorders, gambling, sexual or borderline symptoms. But it is difficult for healing to take place solely on a psychological level without understanding the full picture of both trauma and addiction. When it does occur, it can often be traced to a long term relationship with an empathic therapist and the sense of belonging and patient natural reworking of limbic bonds that occurs through twelve step programs. And because the types of trauma that occur in homes often constitute ruptures in relationships and often are at the hands of primary caretakers upon whom we depend for nurturance and survival, the implications for treatment are complicated. That is, the very vehicle that will lead us eventually back to health (i.e., relationships in therapeutic situations such as one-to-one or group therapy or twelve-step programs) are those situations that have become fraught with pain and anxiety.

Often times, in searching out these original wounds therapists need to keep in mind that there will be what is referred to as model scenes (Lachman 2002) or scenes that carry an intricate web of symbolic meaning and dynamics for the client. These scenes may be a sort of amalgam of many overlays but, as in a dream, they have a depth of meaning and significance that the mind has shaped over a period of time. I these sorts of scenes that we see emerge in *The Process*. People have been traumatized do not necessarily remember things perfectly or in order. Memories are fragmented and tend to fill out over a long period of time as the client becomes a little bit stronger each day. Consequently there is no one scene, no one conversation and no one method to use in trauma treatment. A combination of approaches that includes long term work with the body, mind and emotions and changes and adapts with the changing client is most prudent. What works at one stage of treatment is not necessarily what is needed at another.

In addition to the nature of traumatic memory and years of disloyalty to the family or of being ostracized for "telling the truth" can keep children not only telling a lie to the outside world but living a lie within them well into adulthood. This absence of talking through painful circumstances may keep traumas from being understood and placed into a psychological framework, causing developmental deficits and clinical symptoms. Traumatic memories are often somatized, repressed, disassociated or lost to consciousness through some form of defensive exclusion (Bowlby, 1973). As we've previously discussed, traumatic memory storage is at least partially associated with the parts of the brain that were formed early in man's evolution as fight, fight and freeze responses designed to preserve survival. The cortex or the part of the brain where we think about and reflect upon what we do was developed later in human evolution. Because of this we may have difficulty in reflecting upon, remembering or placing into a context memories related to trauma. This can manifest in therapy, as what may appears to be resistance. Because the cortex was not fully involved in the storage of traumatic memories, those experiences may not have gotten thought about and put into a logical context and sequence. Consequently, they can be difficult to access through reflective talking for trauma survivors who are removed from their internal experiences through psychological and emotional defenses and this may manifest during therapy.

Recovering people also need to develop new relationships that will teach them the skills of limbic regulation such as those found in therapy, twelve step rooms and healthy lifestyle companions. These healing relationships offer the experience of new, external limbic regulators from which to internalize the skills of emotional regulation. Talk alone does not inscribe new hardwiring into our neural networks. (Lewis 2000). For this to occur we need to log the necessary hours in the presence of others who are able to experience emotion within a reasonably regulated range; who are experiencing balance and pleasure in their lives. Adding new relationships as well as nourishing, creative and physically enhancing activities such as hobbies, exercise and relaxation can help to reregulate a limbic system that talk alone cannot reach.

Tian Dayton M.A. PhD TEP is the author of *The Living Stage: A Step by Step guide to Psychodrama, Sociometry and Experiential Group Therapy* and the best seller *Forgiving and Moving On, Trauma and Addiction* as well as twelve other titles. Dr. Dayton spent eight years at New York University as a faculty member of the Drama Therapy Department. She is a fellow of the American Society of Psychodrama, Sociometry and Group Psychotherapy (ASGPP), winner of their scholar's award, executive editor of the psychodrama academic journal, and sits on the professional standards committee. She is a certified Montessori teacher through 12 years of age. She is currently the Director of The New York Psychodrama Training Institute at Caron New York and in private practice in New York City. Dr. Dayton has masters in educational psychology, a PhD in clinical psychology and is a board certified trainer in psychodrama, sociometry and group psychotherapy.

**For more information on Dr. Dayton's books and tapes log onto
tiandayton.com**

**For more information on the process and for downloadable journaling sheets log onto
theprocess.info**

References

- Alcoholics Anonymous (1953). *Twelve steps and twelve traditions*. New York: Alcoholics Anonymous World Services, Inc.
- Amen, D.G. (1998) *Change Your Brain, Change Your Life*. New York: Three Rivers Press.
- Aram, S Lecture, The Meadows, New York City, 2004
- Damasio, A. (1999) *The Feeling of What Happens*. New York: Harcourt, Inc.
- Dayton, T. (2005) *The Living Stage: A Step by Step Guide to Psychodrama, Sociometry and Experiential Group Therapy*. Deerfield Beach, FL: Health Communications.
- Dayton, T. (2000) *Trauma and Addiction*. Deerfield Beach, FL: Health Communications.
- Dayton, T. (2005) *Modern Mothering: How to Teach Your Kids to Say What They Feel and Feel What They Say*. New York, NY: Crossroads Publishing.
- Dayton, T 1997 *Heartwounds*, Health Communication; Deerfield Beach, Fla.
- Greenspan, S. (2000) *Building Healthy Minds*. Persus Publishing. New York, New York
- Howard, P.J. (2000) *The Owner's Manual for the Brain*. Atlanta: Bard Press, 2000.
- Krystal, H, 1968, *Massive Psychic Trauma*, Madison, Ct., International Universities Press
- Levine, P.A. (1997) *Waking the Tiger: Healing Trauma*. Berkley, CA: North Atlantic Books.
- LeDoux, J. (2002) *The Synaptic Self*. New York: Viking Penguin Group.
- Lewis, Thomas, M.D., Fari Fmini, M.D., and Richard Lannon, M.D. *A General Theory of Love*., New York: Vintage Books, A Division of Random House, Inc., 2000.
- Moreno, J.L. (1964) *Psychodrama Volume 1*. Ambler PA: Beacon House.
- Pennebaker, J. W. (1997) *Opening Up: The Healing Power of Expressing Emotions*. New York: Guilford Press.

- Pert, C.B (1999) *Molecules of Emotion: Why You Feel the Way You Feel*. New York: Simon & Schuster.
- Rosenthal, N.E. (2002) *The Emotional Revolution*. Secaucus, N.J.: Citadel Press/Kensington Publishing.
- Schore, A.N. (in Press) *The Right Brain, The Right Mind and Psychoanalysis*. Guilford Press. New York, N.Y.
- Russell, P. (1979) *The Brain Book*. New York: Plume.
- U.S. Dept. Of Health & Human Services, Center for Substance Abuse Treatment
Screening and Assessing Adolescents For Substance Use Disorders: Treatment Improvement Protocol (TIP) Series 31 DHHS Publication No. (SMA) 99-3282 Printed 1999
- Van derKolk, (1987) *Psychological Trauma*. Washington D.C: American Psychiatric Press, Inc.
- Van derKolk, (2005) Lecture, New York City, The Body Keeps Score, presented by The Meadows, October 23rd, 2005
- Wegscheider, S Another Chance:1989 Hope and Health for the Alcoholic ... Edition: 2nd – Health Communications
- Woititz, J. (1983). *Adult Children of Alcoholics*. Hollywood FL: Health Communications, Inc.
- Wolin, S.L. (1993) *The Resilient Self*. New York, NY: Villiard Books, a Division of Random House, Inc.