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A Grounded Theory Investigation of Adaptations to Adverse Childhood Experiences

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A Grounded Theory Investigation of Adaptations to Adverse Childhood Experiences

By

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Dedication

To my mother for being my secure base.

To my chair, Dr. Jim Hibel, for being supportive of my work and guiding me through this process. To all traumatized youth adults at home and abroad: "Healing is possible." To all veterans at home and abroad: "War is trauma," and the psychological wounds can be much more insidious than the physical wounds.

ACKNOWLEDGMENTS

To Dr. Jim Hibel, my chair: You have contributed to my understanding that one cannot assume to know if an event was traumatic for an individual without directly asking the individual to share his or her lived experience.

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ABSTRACT

Adverse childhood experiences (ACEs) include childhood sexual abuse, physical abuse, emotional abuse, physical neglect, emotional neglect, and household dysfunction. Much has been reported about the detrimental outcomes associated with these experiences. The associated negative outcomes of ACEs can include addiction, suicide, disability, teenage pregnancy, and early death. However, it is well known that many people experience ACEs and do very well. Rather than viewing negative outcomes only as symptoms of trauma and positive outcomes only as signs of resilience, it is possible to consider adaptations. This study focused on how adults adapted to their adverse childhood experiences. Data were collected based on semistructured interviews with nine members of the ACEs Connection Social Network, an online support group. The data were analyzed using a constructivist grounded theory methodology. A grounded theory then emerged from data, supporting the adaptation construct.

Keywords: ACEs, trauma, resilience, grounded theory, narrative family therapy, posttraumatic growth, double-storied testimony

CHAPTER I: INTRODUCTION

The term *adverse childhood experiences* (ACEs) refers to childhood sexual abuse, physical abuse, emotional abuse, physical neglect, emotional neglect, and household dysfunction. The term *household dysfunction* applies to environments in which a child under the age of 18 lives with one or no parents or whose parent is treated violently, is a substance or alcohol user, has a mental illness, or is involved with the criminal justice system (Chapman et al., 2004; Felitti et al., 1998).

The Adverse Childhood Experiences (ACE) study was developed by two family physicians, Robert Anda and Vincent Felitti (Felitti et al., 1998). Initially, these physicians operated a weight loss clinic (Lynch, Waite, & Davey, 2013). While running the weight loss clinic, Anda and Felitti discovered many of their patients were using obesity as a defense mechanism for protecting against unwanted sexual advances (Lynch, Waite, & Davey, 2013). Participants who had dropped out of the weight loss program reported experiencing sexual or physical abuse during childhood (Anda & Felitti, 2003). In fact, almost all the non-responders to the program had a history of sexual abuse (Anda & Felitti, 2003). Consequently, these significant findings led to the development of the ACE study.

The original ACE study was conducted by the Center for Disease Control (CDC); researchers examined adults' retrospective reports of stressful and traumatic childhood experiences and compared these reports with their current physical and mental health status (Felitti et al., 1998). The original study involved 17,000 adult Californians; two thirds of the participants reported at least one adverse childhood experience and one in six reported four or more adverse childhood experiences (Felitti et al., 1998). The

participants were recruited through mailers distributed to people registered with Kaiser Permanente healthcare consortium. Remarkably, researchers received a 70% response rate to the mailers (Felitti et al., 1998). The study's findings were profound, showing significant correlations between the number of traumatic childhood experiences people suffered and the amount of physical and mental distress they experienced as adults (Felitti et al., 1998).

Traumatic experiences were assessed using the ACE Survey, which measures the number of adverse events an individual experienced as a child (Felitti et al., 1998). Each adverse event is assigned a numerical value, the numbers are summed, and an ACE score is generated (Felitti et al., 1998). According to the original ACE Survey, individuals who experienced four or more ACEs were 242% more likely to smoke, 222% more likely to be obese, and 357% more likely to experience depression (Felitti et al., 1998). A person with an ACE score of 6 was 4,600% more likely to be an IV drug user (Felitti et al., 1998). Additionally, researchers found that a person with four or more adverse childhood experiences was 2.4 times more likely to have a stroke, 2.2 times more likely to have ischemic heart disease, 2 times more likely to have chronic pulmonary obstructive disease, 1.9 times more likely to have a type of cancer, and 1.6 times more likely to have diabetes (Felitti et al., 1998). The life expectancy for someone with six or more ACES was 20 years shorter than the national average (Felitti et al., 1998). A child with four or more ACEs was 46 times more likely to have learning or emotional problems, and a woman with seven or more ACEs was 5.5 times more likely to become pregnant as a teenager (Felitti et al., 1998). Felitti (as cited by Hari, 2015) stated,

> I remember the epidemiologists at the CDC told me those were numbers a magnitude of which they see once in a career. You read the latest cancer scare of the week in the newspaper and something causes an increase of 30% in breast or prostate cancer and everybody goes nuts—and here, we're talking 4,600%. (para. 11)

The findings from the ACE study bring to mind the concept of Occam's razor. Occam's razor, a celebrated dictum in medicine, holds that if a single unifying explanation can be found for multiple symptoms and problems, then the simplest account is likely the correct explanation (Lo & Bellini, 2002). The implication of this is that because trauma seems to be implicated in so many adult health problems, there should be more resources devoted to preventing it and dealing with the effects after it has occurred as well as more efforts to prevent it from occurring.

The findings of the ACE study indicate troubling futures for people who have experienced adverse childhood events (Larkin, Felitti, & Anda, 2014). Fortunately, there is hope. Follow-up research indicates that resilience trumps ACEs. Bernard (1997) stated, "When tracked into adulthood, research worldwide has documented the amazing finding that at least 50% and usually closer to 70% of these 'high-risk' children grow up to be not only successful by societal indicators but confident, competent, and caring" (p. 2). These resilience studies indicate that severe adversity only has major or lasting effects unless important adaptive systems such as cognition and parenting are compromised prior to or as result of the trauma (Masten, 2001).

Purpose and Goals of this Study

The purpose of this study was to develop a theory from participants' adaptations to adverse childhood experiences (ACEs). Specifically, the goal was to develop a unifying theory that connects literature on trauma with literature on resilience. To

accomplish this goal, I conducted interviews with ten people who had experienced ACEs. The interviews were a retrospective report of how participants responded to adversity, specifically, ACEs. The study was intended to bridge the work of trauma, resilience, and narrative family therapy. The findings generated from this study may be relevant to adults working with children in many different sectors, including parents, therapists, educators, coaches, religious leaders, physicians, lawyers, and foster parents. Children who have experienced ACEs often have difficulty concentrating and performing in school and other life domains. Many problem behaviors are adaptations to events happening in children's lives (Ellis, 2015). The potential findings from this study could inform adult survivors on ways others have adapted to childhood trauma.

This information may be especially important for teachers, who often punish children for disruptive behaviors that are actually symptoms of trauma. Further, the findings may be relevant to parents of children who are coping with trauma. Too often, parents punish their children for substance abuse and sexual promiscuity when these behaviors may be attempts to manage symptoms from maltreatment.

In addition, the results generated from the study may be relevant for therapists working with individuals who have experienced trauma. I provide a framework for therapists to view their clients' experiences of trauma and help clients develop resilience. Previous researchers on resilience have examined the phenomenon from a general systems theory framework (Masten & Monn, 2015). Most of the work on ACEs has been generated through large studies with quantitative designs (Masten, 2018). In this study, I sought to gather data from a poststructuralist perspective, using a doublestoried testimony

to guide the inquiry (Denborough, 2008). The doubled storied testimony is a framework to help trauma survivors speak about their experiences in way that helps they reclaim a sense of personal agency (Denborough 2008). The advantage of the poststructural framework was its potential for bringing forth participants' values, hopes, and dreams that may have been left out when viewing their experiences from a normative perspective, which measures resilience using external developmental markers of achievement determined by society's values rather than through people's determinations of what resilience means to them. A limitation of the normative approach is that what is considered adaptive in one context may not be adaptive in another context.

The study of ACEs on adult health arose from Felitti and Anda's study landmark study at Kaiser Permanente in San Diego, California, conducted between 1995 and 1997. Despite robust negative adult health outcomes associated with ACEs, other research by resilience researchers such as the late Sir Michael Rutter and Anne Masten have shown that when protective factors such as caring adults and other environmental supports are present, children who experience adversity do well the majority of the time. Previous investigators approached this topic from a quantitative-based experimental model, testing hypotheses on trauma and resilience, whereas I conducted my inquiry from a postmodern, bottom-up approach. The intention of the qualitative approach was to bring forth themes and perspectives of the participants that are often missed by a quantitative inquiry.

CHAPTER II: LITERATURE REVIEW

The literature review provides a summary of the dominant narrative of trauma and resilience. The first half of the chapter focuses on the dominant discourse regarding trauma and resilience. In this review, I summarize the findings from psychologists and psychiatrists studying these phenomena. The second half of the literature review focuses on how trauma and resilience are conceptualized and addressed in the family therapy literature.

Trauma

The prevailing cultural narrative regarding trauma is that people who have experienced trauma are sick and scarred for life. It is the notion that the experience of trauma leaves them with a "spoiled identity" (Goffman, 2009, p. 2). One example of this is the "crack-baby" phenomenon. The dominant discourse is that a child born to a mother who uses crack cocaine has brain damage and thus little chance for success (Okie, 2009). However, ample evidence shows most "crack babies" do well. In fact, no statistically significant differences in health and life outcomes were found between babies exposed to crack and those who were not (Hurt, Malmud, Betancourt, Brodsky, & Giannetta, 1997; Tierney, 2013). Similar research with opiate-dependent infants has shown that social environment matters more than do the opiates (Baldacchino, Arbuckle, Petrie, & McCowan, 2014). This finding highlights the influence of discourse on shaping public perception: Public discourse on the effects of drugs is often not based on scientific evidence (Tierney, 2013). Other examples of this phenomenon include people shying away from dating individuals who have trauma histories. The dominant story is that people who have endured abuse are likely to be emotionally dysregulated rather than

resilient (Espeleta, Brett, Ridings, Leavens, & Mullins, 2018). However, people who have endured significant trauma are better at evaluating threats to their environments, compared to people who did not experience trauma (Frankenhuis & de Weerth, 2013). The human organism is a remarkably adaptable entity. Rather than being impaired, traumatized individuals adapt to their environments. Many of these adaptations to trauma can be viewed as double-edged traits, encompassing both positive and negative properties. For example, individuals of lower socioeconomic status, who often face greater stressors in meeting the daily challenges of life, exhibit higher levels of dispositional compassion (Stellar, Manzo, Kraus, & Keltner, 2011). In fact, people living in poverty are more generous than are affluent people (Piff, Kraus, Côté, Cheng, & Keltner, 2010). People living in poverty orient to the welfare of others to adapt to hostile environments (Piff et al., 2010). This orientation gives rise to more prosocial behavior (Piff et al., 2010).

Definitions of Trauma

The etymology of the word *trauma* comes from a Greek word that means *wound* (Figley & Figley, 2009, p. 173). In the late 19th century, in popular culture, the word *trauma* began to acquire a new metaphorical meaning. During the Industrial Revolution, Victorian surgeons became puzzled by psychological and physical symptoms appearing in railway accident victims who did not have apparent physical wounds (Erichsen, 1867). The origins of the symptoms, then known collectively as “railway spine,” were hotly debated. The leading German neurologist Hermann Oppenheim suggested symptoms were caused by undetectable physical damage to the spine or brain (Holdorff, 2011). In

contrast to this organic physical explanation and in light of the prevalence of childhood histories of abuse noted among patients with unexplained somatic and emotional complaints (Briquet, 1859), leading French neurologists Jean-Martin Charcot and Pierre Janet theorized that the symptoms were caused by trauma. Trauma was understood as the subjective perception of intensely distressing experiences, which triggered psychological and physical manifestations (also called *hysteria*; Micale, 1995). Sigmund Freud further developed Charcot and Janet's psychological theory. Freud (1962) popularized the notion that intensely disturbing experiences or psychological traumas, especially those occurring in childhood, can have significant impacts on psychological development and psychopathology.

Interpersonal Trauma

Trauma has many causes, including war, natural disaster, torture, and medical trauma; however, the focus of this dissertation was interpersonal psychological trauma. Interpersonal psychological trauma consists of a traumatic event or multiple events that are attributable to the actions of a closely related person (Andrea, Ford Stolbach, Spinazzola, & van der Kolk, 2012). One of the essential qualities to understand the complexity of trauma is context specificity (Stolorow, 2015). This means the trauma that takes place on the battlefield is markedly different from trauma that occurs in the home. Painful affect becomes traumatic when it cannot be integrated into an individual's psyche (Stolorow, 2015). Interpersonal trauma is particularly challenging because it often occurs in the context of a relationship that is supposed to be loving and caring. This challenge stems from cultural assumptions such as "Family is a haven in a cruel world" (White,

1995). This specific type of trauma is known as *betrayal trauma*. "Betrayal trauma occurs when the people or institutions on which a person depends for survival significantly violate that person's trust or well-being (Freyd, 1994, p. 307). Herman (1997 stated,

> Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life. Unlike commonplace misfortunes, traumatic events involve threats to life or bodily integrity, or a close personal encounter with violence and death. They confront human beings with the extremities of helplessness and terror and evoke the responses of catastrophe. (p. 33)

However, interpersonal traumatic events often do not involve a direct physical threat to a person's life. Traumatic events often have a physical component but are not life threatening. However, although these threats are attacks on a person's psyche, the nervous system responds to these events as if they were physical attacks. The metaphor of "paper tigers" has been applied to this phenomenon. The term *paper tigers* refers to the concept that someone who experienced trauma overestimates environmental threats (Hanson, 2009). Most threats are false alarms—"paper tigers" rather than real tigers (Hanson, 2009).

In a therapeutic modality called *somatic experiencing*, trauma is defined as an event that causes long-term dysregulation to the autonomic nervous system (Levine, 1977). Some examples of the effects of dysregulation can be rapid heartbeat and chronic muscle tension. The implied meaning of this definition is that trauma is stored in the body and nervous system (Payne, Levine, & Crane-Godreau, 2015). Trauma is a highly activated but incomplete biological response to threat, frozen in time (Payne et al., 2015). Trauma often results in two states: The person is either hyperaroused or the person is

shut down (Payne et al., 2015). These responses are observed in animals as well as in humans (Levine, 1977).

Dones (2015), a trauma survivor, explained the effect of trauma:

> The thing about trauma is that it just puts you in this place of chronic mourning. You just spend much time mourning losses that were a long time ago and what you will lose in the future as a result. (p. 1)

Pain and Trauma

Pain and trauma often accompany one another as comorbid conditions. Many chronic pain patients report a history of childhood abuse (Goldberg, Pachasoe, & Keith, 1999; Nelson, Simons, & Logan, 2018). Pain is defined as unpleasant sensory and emotional experience associated with explicit or potential tissue damage (Mersky & Bodguk, 1994). From a structural perspective, physical pain is registered in one section of the brain, the thalamus; however, the subjective impact is registered by another part of the brain, the anterior cingulate cortex (Maté, 2010). Ample evidence shows that pain perception, separation distress, and affiliative behavior are all mediated by the brain's opiate system (van der Kolk, 2003). This supports the notion that opiates are central to the attachment system (Panskeep, 1998). Pain-relieving medications such as opiates help to modulate the emotional response to pain rather than alleviating the physical sensation of pain (Maté, 2010).

Pain is mediated by the opioid-attachment systems in the brain (Panskeep, 1998). human bodies secrete endogenous opioids during social contact (Panskeep, 1998). Therefore, childhood maltreatment is a risk factor for opioid dependence (Conroy, Degenhardt, Mattick, & Nelson, 2009). Pain is a warning sign to notice what is going on in the body. However, pain sometimes lingers long after tissue damaged has subsided

and thus no longer serves its evolutionary purpose (Panskeep, 1998). Pain that lasts for more than six months is considered to be chronic pain (Mersky & Bodguk, 1994).

Risk Factors for Trauma

The risk factors for experiencing symptoms of trauma include living in poverty, having a family member with a mental illness, experiencing parental divorce, having a substance use disorder, and having a pessimistic temperament (Hawley, 2000). Family is both a protective factor and a risk factor, depending on the context. Having well-functioning families of origin help children develop resilience as adults. However, having a family that is fraught with violence, abuse, and neglect are key risk factors for developing mental health difficulties. It is well documented that maltreatment has a more harmful effect than does low socioeconomic status on the development of resilience (Cicchetti, 2010). Thus, early life experiences can be either a protective factor or a risk factor for developing resilience.

Neurobiology of Trauma and Resilience

Epigenetics provides a mechanism for short-term adaptations. The word *adaptations* has a positive connotation. Adaptation is good. Gene mutations take generations—humans cannot wait for evolution. To survive, humans must act quickly. Thus, the idea of being able at critical periods to transmit something based on unforeseen circumstances is a very good idea (Yehuda, 2015). This means that the ways genes are expressed has adaptive value for certain contexts (Yehuda, 2015).

Epigenetics refers to environmental effects on gene expression (Yehuda, 2015). Epigenetics means above genes. Toxic levels of stress can impair neural and endocrine

systems, inhibiting the body's capacity for resilience. In addition, the capacity for resilience depends on genetic makeup (Carli et al., 2011). Additionally, the oxytocin receptor gene has been linked to the role of social support in buffering stress (Masten, 2015). Oxytocin is a neuropeptide hormone that induces pleasure, calm, and contentment and actively lowers the stress hormone cortisol (Johnson & Zuccarini, 2010). Further, social support has positive effects on the immune system, which can be affected by trauma (Danese & Baldwin, 2017). Another substance, brain-derived neurotrophic factor (BDNF), has been shown to moderate the effects of stress on the brain (Masten, 2015). BDNF is one of many neuropeptides that seems to foster resilience.

A growing number of researchers have examined the neurobiology of resilience. The current focus of resilience research is the interaction between biological and psychosocial factors (Masten, 2018). Early life experiences provide the foundation for adults' capacity for resilience (McEwen, Gray, & Nasca, 2015). More than any organ in the body, the brain is shaped and modeled by interactions with the environment (Thompson et al., 2001). The brain's growth depends on relationships (Perry, 2012). It is evident that trauma has a physiological signature (Yehuda, 2015). Levine (1997) stated, "Trauma evokes a biological response that needs to remain fluid and adaptive, not stuck and maladaptive" (p. 37). This means biological, neural, and endocrine markers are associated with traumatic experience.

Three major physiological systems—the nervous system, the immune system, and the endocrine system—are tightly integrated (Danese & McEwen, 2012). Psychosocial stressors can trigger the sympathetic nervous into a fight-or-flight response;

consequently, the immune system secretes inflammation to prevent infection should tissue damage occur (Danese & McEwen, 2012). However, when the threat is emotional, inflammation can be harmful because no infection or tissue damage exists for the inflammation to prevent (Danese & McEwen, 2012).

Chronic exposure to psychosocial stressors has been linked with physiological consequences (Danese & McEwen, 2012). Chronic exposure to stress is referred to as *toxic stress*. Toxic stress increases risk for developing psychopathology. Adverse childhood events may result in physiological changes that endure long after the initial threat is over (Danese & McEwen, 2012).

The most consistent finding among maltreated children is impaired prefrontal cortex function (Danese & McEwen, 2012). This impaired function often appears as attention deficits, impulsiveness, and increased motor activity (Danese & McEwen, 2012). In addition, childhood maltreatment has been shown to increase biological aging from studies attributable to decreased telomere length (Danese & McEwen, 2012). Telemore length is a biological marked for aging (Danese & McEwen, 2012). Child maltreatment has been shown to increase inflammatory proteins as early as 12 years of age (Shonkoff, Duncan,Yoshikawa, Fisher, Guyer, & Magnuson).

Neurobiological research on trauma is a rapidly growing discipline. New data have emerged showing that different childhood experiences affect different inflammatory markers (Baumeister, Akhtar, Ciufolini, Pariante, & Mondelli, 2015). For example, physical and sexual abuse affect tumor necrosis factor and Interleukin-6 but not C-Reactive Protein (CRP; Baumeister et al., 2015). This basic level research that may

provide net targeted treatments to address specific effects of adversity. It seems that elevated CRP levels are related to parental absence during development (Baumeister et al., 2015). This information may leads to explanations on how childhood trauma is linked to adult disease but more data is needed to substantiate these claims.

However, despite much promising research on resilience and genetics, humans have no resilience gene (Cicchetti, 2010). The ability to function well despite adversity depends on the interactions among adaptive biological systems and supportive relationships systems. Through the interactions of these systems, gene expression is altered (Cicchetti, 2010).

Individual Risk Factors

Many individual risk factors affect humans' ability to respond well to adversity, including engaging in uncontrolled, negative, self-defeating thoughts. However, in the short term, ruminating thoughts can be positive regarding development of posttraumatic growth if they can help people derive meaning from the trauma experience (Tedeschi & Calhoun, 2004). Ruminating means obsessing over the specific details of the trauma repeatedly. The thought is that it can be positive if the obsession elicits meaning to the events that transpired. It is negative in that people can become stuck and paralyzed by their thoughts. Another example of faulty thinking is to ruminate and dwell over losses about what might have been and replay concerns about the causes of near-miss opportunities (Meichenbaum, 2012).

Behavioral Risk Factors

At the behavioral level, numerous maladaptive patterns are associated with experiencing adversity. These include avoiding trauma-related reminders and activities (Meichenbaum, 2012). Avoidance is contained in the sympathetic nervous system in the flight portion of the fight-or-flight response (Meichenbaum, 2012). This refers to the traumatized individual avoiding situations that might trigger a trauma response. Some people engage in high-risk behaviors by chasing an adrenaline rush (Meichenbaum, 2012). Further, other health-compromising behaviors include smoking, using substances to self-medicate, and engaging in unprotected sex with multiple partners (Meichenbaum, 2012).

Social Risk Factors

At the social level, maladaptation is correlated with perceiving the self as unwanted and having feelings that nobody cares, nobody listens, and nobody can be trusted (Meichenbaum, 2012). Another maladaptive trait is associating with people who reinforce and support maladaptive behaviors (Meichenbaum, 2012). Negative peer groups whose members engage in high-risk behaviors are associated with maladaptation (Meichenbaum, 2012).

Shame

Shame is a primitive emotion that often emerges following a traumatic event (Van Vliet, 2008). From an evolutionary perspective, shame comes from perceived loss of social attractiveness and alters a person's perception of social status in society (Van Vliet, 2008). Shame often occurs following rejection from an attachment figure (Van Vliet,

2008). Brown (2006) defined shame as "an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance or belonging" (p. 45). Shame serves as a warning sign of a threat to the attachment system, indicating a need to repair the attachment bond (Van Vliet 2008). However, despite its adaptive value, shame is implicated in many mental health problems, particularly depression (Van Vliet, 2008).

Some of the terms people use to describe the experience of shame are *devastating*, *noxious*, *consuming*, *excruciating*, *filleted*, *small*, *separate from others*, *rejected*, *diminished*, and *the worst feeling ever* (Brown, 2006, p. 45). Shame differs from guilt, which is feeling bad because of behaving in a negative way, whereas shame comes from having a bad or flawed sense of self (Brown, 2006).

Hypervigilance

Hypervigilance is a common adaptation to trauma. Hypervigilance often appears as a state of constant overdrive in which people constantly scan their environments for threats (Katz, 1997). An exaggerated startle response and irritability often accompany hypervigilance (Heffernan et al., 2000). Hypervigilance helps maintain the high alert levels necessary to evaluate for potential environmental threats. However, because of their hypervigilance, trauma survivors often struggle with developing and maintaining relationships (van der Kolk, 2001). Individuals who have experienced trauma often have doubts regarding the reliability and predictability of other people (van der Kolk, 2001). Thus, people with trauma histories often struggle with intimacy and social isolation (van der Kolk, 2001).

Intergenerational Trauma

Family therapists traditionally track intergenerational transmission of familial patterns because trauma contains a strong intergenerational component (Kerr & Bowen, 1988). One therapeutic model that emphasizes this is the Bowenian family systems therapy approach (Kerr & Bowen, 1988). Bowen (as cited in Kerr & Bowen, 1988) referred to this process as the *multigenerational transmission process* (p. 13). Bowen's theory emphasizes how people's behavior as adults can be explained by what they experienced in their families of origin (Kerr & Bowen, 1988).

Another model that emphasizes how family patterns are passed down from one generation to the next is contextual family therapy. Contextual family therapy highlights how unspoken family legacies are transmitted intergenerationally (Frank, 1984). For example, an unspoken family legacy might be that discipline occurs through corporal punishment; this pattern is repeated from one generation to the next (Frank, 1984). Similarly, narrative therapists discuss how abusive practices can be learned and passed down to subsequent generations (White, 1995). However, a narrative therapist would encourage people to challenge abusive practices that have been passed down across generations in their families (White, 1995). Vast empirical data have shown that many perpetrators of family violence were once victims themselves (Murray, 2006).

Resilience

> Our screwed-up behaviors and thoughts did not just come from nowhere. They are not chemical imbalances, and you are not a freak of nature. Our problems are coded—and sometimes not-so-coded—expressions of what happened to us. (Mackler, 2015, para. 43)

Definitions of Resilience

Resilience is a term with multiple definitions. Walsh (1998) defined resilience as "the ability to rebound from adversity, strengthened and more resourceful" (p. 269). According to Combs et al. (2013), "Resiliency is something that people do together" (p. 43). A key component of resilience is the idea that it emerges from a struggle. Masten (2014) stated, "Resilience can broadly be defined as the capacity of a dynamic system to adapt successfully to disturbances that threaten" (p. 6). Meichenbaum (2012) stated, "Perhaps, the concept of resilience was best captured by Helen Keller, who was born blind and deaf, when she observed, 'Although the world is full of suffering, it is full also of the overcoming of it'" (p. 3). Resilience was originally used in physics to describe the capacity of a material to return to equilibrium after a dislocation (Carli et al., 2011). The major antecedent of resilience is adversity, and the main outcome is a positive adaptation (Fletcher & Sarkar, 2013).

Resilient individuals flex in response to life pressures and strains and return to their original state. Resilience is often developed from controlled exposure to risk, referred to as the *steeling effect* or *stress inoculation* (Rutter, 1999, p. 125). The steeling effect is similar to a vaccine wherein lesser amounts of a virus are given to develop resistance to that virus. This notion of stress inoculation has also been demonstrated among animals. Rutter (2012) stated, "The overall body of evidence from animal models provides convincing evidence of the reality of steeling effects from repeated brief stress experiences that are not accompanied by overall adversity or deprivation" (p. 338).

Positive Adaptation to Trauma

Several different tasks exist in which traumatized individuals compare more favorably, compared to nontraumatized individuals. First, abused children growing up in difficult environments are better at detecting threats because threats are highly relevant to their environments (Frankenhuis et al., 2013). For example, children who were physically abused orient more quickly to angry faces than do their peers who were treated well (Frankenhuis et al., 2013). Second, abused children have exhibited faster reaction times regarding detecting emotion in psychological testing (Frankenhuis et al., 2013). Children reared in harsh environments often seek immediate gratification. This makes sense because in an unpredictable environment, children do not know what the next day may bring. Third, traumatized children often show better attentional flexibility than do non-traumatized children (Ellis, 2015). This means that traumatized children are better at switching from one task to another (Ellis, 2015).

Fluidity of Resilience

One key finding regarding resilience is that people can exhibit resilience at one time in their lives but lack resilience at another time (Masten, 2018). Resilience is shaped by acquiring and adapting to both positive and negative experiences (Masten, 2018). The brain and other biological systems, such as the nervous and endocrine systems, are most adaptable early in life, and thus early life experiences provide the foundation for adaptive responses throughout the lifespan (Shonkoff et al., 2010). However, individuals still can develop resilience as adults; this resilience is just not as robust as resilience in early life (Shonkoff et al., 2010). Everyone has a certain threshold

regarding his or her ability to exhibit resilience. Once the threshold has been exceeded, people may require therapeutic intervention to cope. Simply put, resilience in some hardships does not equal resilience in all hardships.

Social Ecology of Resilience

The social ecological approach to resilience is based on four concepts: decentrality, complexity, atypicality, and cultural relativity (Ungar, 2011). In decentrality, the focus is on the role of the environment in the facilitation of resilience. In high-risk environments, it appears that resilience depends on the amount of resources available more than on individual factors (Ungar, 2011). The principle of complexity is that resilience is context-specific. As mentioned, people can exhibit resilience at one time in their lives and lack resilience at other times. The principle of complexity fits with the systems concept of equifinality: Many different starting points can lead to many different ends (Ungar, 2011).

The concept of atypicality refers to protective mechanisms and risk factors that should not be viewed in a binary way. For example, Wang and Ho (2007) showed that Chinese women have used violence to deal with gendered biases that threaten to disempower women when they enter intimate relationships. In this case, their use of violence is functional—it helps protect women and helps them resist stereotypes imposed on them by young men. Thus, it is important when studying resilience to focus on the environment because the environment often determines an adaptive individual's response. In addition, adaptive functioning is culturally specific. Cultural relativity

means that resilience is often measured by how an individual trait fits within cultural norms (Ungar, 2011).

Traditionally, resilience researchers have assessed individuals' adaptation by exploring factors such as childhood experiences, child-rearing, education, life stages, values, and participation options (Bottrell, 2009). As do cultural responses, these factors depend on the context—that is, what is normal in one culture may not be the norm in a different setting. Perception of an event as stressful depends on subjective appraisal, making it challenging to define stressors objectively, independent of personal meaning making (Weathers & Keene, 2007). It is how events are interpreted that gives them meaning. Ungar's (2004) approach, based on a Foucauldian analysis of discourse, was critical of researchers' views of what was considered normal for a teenager. Traditionally, substance use and participation in a gang would be maladaptive behavior for a teenager. However, when these behaviors are understood in their context, they seem to serve a different purpose. Children living in a chaotic environment often find comfort in substance use because it helps them psychologically escape from the chaos. In addition, substance use serves to calm a nervous system that is overly aroused because of toxic stress. Moreover, membership in a gang can provide father figures to teenagers that did not have fathers growing up.

Posttraumatic Growth

Posttraumatic growth is a concept related to resilience. Posttraumatic growth refers to the experience of developing newfound insights and ideas after having experienced a traumatic event. Tedeschi and Calhoun (2004) stated,

> Post-traumatic growth is the experience of positive change that occurs as a result of the struggle with highly challenging life crises. It is manifested in a variety of ways, including an increased appreciation for life in general, more meaningful interpersonal relationships, an increased sense of personal strength, challenged priorities, and a richer existential and spiritual life. (p. 1)

Posttraumatic growth is not a return to baseline; rather, it is a marked improvement in function (Tedeschi & Calhoun, 2004). *Posttraumatic growth* is a relatively new term, but the idea of developing new skills and abilities from adversity dates back to biblical times (Tedeschi & Calhoun, 2004). Several personal qualities are associated with posttraumatic growth, including personality traits such as extraversion and openness to new experiences (Tedeschi & Calhoun, 2004).

Resilience Theories

Patterson (1991) described the process of families managing demands and capabilities as family members interact. The outcome is either adjustment or adaptation. Richardson et al. (1990) and Richardson (2002) developed the resiliency model. This model incorporates the internal construct of bio-psychospiritual homeostasis, which is influenced by adversity, life events, and protective factors (Richardson, 2002). This means that individuals possess different adaptive mechanisms to enable their bodies to return to homeostasis following threats, similar to the way the physical body returns to homeostasis after a temperature change. Following disruption of homeostasis, a reintegration process occurs, leading to one of four outcomes: a resilient reintegration, reintegration back to homeostasis, reintegration with loss, or dysfunctional reintegration (Richardson, 2002). Resilient reintegration means people improve their level of function after adversity (Richardson, 2002). Reintegration back to homeostasis indicates that

people have returned to their original level of function after adversity (Richardson, 2002). Resilient reintegration with loss indicates people have integrated the adversity back into their lives but lost some level of function as a result (Richardson, 2002). The fourth outcome is dysfunctional reintegration. Richardson (2002) stated, "Dysfunctional reintegration occurs when people resort to substances, destructive behaviors, or other means to deal with the life prompts" (p. 312).

In addition, resilience has been conceptualized as the result of a synergistic relationship between four patterns: dispositional, relational, situational, and philosophical (Richardson, 2002). Further, Haase (2004) developed the adolescent resilience model based on the interaction of three concepts: protective (e.g., family protective, social protective), risk (e.g., individual risk, illness-related risk), and outcome (e.g., resilience, quality of life).

Agaibi and Wilson (2005) developed a generic model of resilience in response to psychological trauma. The model is an integrative person–environment model, emphasizing the interaction between five interrelated variables: personality, affect modulation, ego defense, coping style, and mobilization and utilization of protective factors (Agaibi & Wilson, 2005). In another approach, Gillespie, Chaboyer, Wallis, and Grimbeek (2007) created a model of resilience in operating room nurses, discovering that five variables accounted for 60% of the variation in resilience: hope, self-efficacy, control, coping, and competence.

Bre developed a conceptual model showing that communities and youth often deal with a variety of vulnerabilities and thus need social support and community agency.

Community agency is the principle condition that enhances resiliency and advances well-being (Brennan, 2008).

Denz-Penhey and Murdoch (2008) developed a grounded theory of personal resiliency. Personal resiliency was the main theme found in stories of people who unexpectedly survived a serious disease. In this model, resiliency consists of five dimensions: connectedness to social environment, family, physical environment, experiential inner wisdom, and psychological self (Denz-Penhey & Murdoch, 2008).

Dunn, Iglewicz, and Moutier (2008) developed the "coping reservoir," a conceptual model of medical student well-being (p.45). This model highlights a continuum of inputs, showing that positive actions ("filling the reservoir") and negative actions ("draining the reservoir") can lead to positive outcomes (resilience) and negative outcomes (e.g., burnout), respectively (Dunn, Iglewicz, & Moutier, 2008, p.45).

Galli and Vealey (2008) created a theoretical model of sport resilience. Athletes mentioned adversity, sociocultural influences, and personal resources as factors at the center of the resilience process (agitation), which subsequently led to positive outcomes (e.g., learning and perspective). Palmer (2008) developed a theory of risk factors and resilience in military families. Palmer proposed that the effects of military risk and resilience factors on child outcomes follow indirect pathways involving parental stress and psychopathology—parent–child interactions were considered vital for military children (Palmer, 2008) Violanti, Paton, Johnston, Burke, Clarke, & Keenan (2008) developed the stress-shield model of resilience among police officers. The stress-shield model of resiliency includes personal, team, and organizational factors that lead to

empowerment, which in turn creates adaptive capacity, growth, and job satisfaction (Violanti et al., 2008).

Van Vliet (2008) created a grounded theory of shame and resilience in adulthood. Rebuilding of the self as the primary category marks the process of recovering from a shame event (Van Vliet, 2008). Self-reconstruction occurs through five main processes: connection (assimilation and accommodation), which influence refocusing, accepting, understanding, and resisting (Van Vliet, 2008).

Leipold and Greve (2009) developed an integrative model of coping, resilience, and development. Resilience results from processes used to cope with personal and situational conditions (Leipold & Greve, 2009). Resilience is an important part of the conceptual link between coping and development. Mancini and Bonanno (2009) developed a model of resilience encompassing individual differences, personality, a priori beliefs, identity complexity, positive emotions, and comfort from positive memories. These factors seem to have direct and indirect effects on coping with loss (Mancini & Bonanno, 2009). Appraisal processes and social support are critical as shared resilience mechanisms (Mancini & Bonanno, 2009). Appraisal processes mean how individuals evaluate their experiences. Social support consists of relationships that help buffer the effects of adversity and appraisal process in terms of how people evaluate their circumstances.

Research Approaches to Resilience

Three waves of resilience research have occurred to date (Masten, 2013). In the first wave, researchers described the phenomenon of resilience (Masten, 2013). The

second wave involved discovering how resilience occurs (Masten, 2013). The third wave focused on examining how resilience can be promoted (Masten, 2013). A fourth wave, occurring now, is an interdisciplinary approach that includes neurobiological understanding of resilience mechanisms (Masten, 2013).

Two approaches to conducting resilience research have dominated: variable-focused approaches and person-focused approaches (Masten, 2001). Variable-focused approaches use multivariate statistics to test linkages among measures of degree of risk or adversity, outcome, and potential qualities of the individual or environment that protect against the negative consequences of trauma (Masten, 2001). The findings from these approaches have shown that parenting qualities, intellectual functioning, socioeconomic status, and positive self-perceptions have broad and pervasive correlations with multiple domains of adaptive behavior (Masten, 2001). Further, variable-focused approaches have shown that the effects of negative life events are modest when variables such as intellectual quotient and socioeconomic status are controlled (Masten, 2001).

In contrast, person-focused approaches compare adults who have different profiles within or across time on sets of criteria to determine what differentiates resilient children from other groups of children (Masten, 2001). Researchers using person-focused approaches study samples of people exposed to elevated levels of risk factors to assess development of trauma symptoms (Masten, 2001). The purpose of these approaches is to compare the characteristics of people who are resilient to characteristics of those who are maladaptive (Masten, 2001). The classic Kauai study used this design (Werner & Smith, 1992). Many differences favored the resilient group (Masten, 2001).

For example, resilient individuals had better parenting resources and were more likable as infants (Masten, 2001). As the children grew older, they had better intelligence test scores, more views of self that were more positive, and greater conscientiousness, compared to their less-adaptive peers (Masten, 2001).

Both approaches have specific advantages. The advantage of variable-focused approaches is that they afford a high degree of statistical power regarding predictors and outcomes, which can be used to develop interventions (Masten, 2001). A potential drawback of these approaches is that they may fail to capture the lived experiences of the people under study. In comparison, person-focused approaches keep variables assembled in naturally occurring configurations and are well suited to searching for common and uncommon patterns in lives through time (Masten, 2001). These patterns result from multiple processes and constraints on development (Bergman & Magnusson, 1997).

Ordinary Magic

Resilience appears to be a phenomenon arising from ordinary human adaptive processes (Masten, 2001). Resilience emerges from threats to an individual's or a family's adaptation. These threats are factors such as divorce, domestic violence, child abuse, and poverty (Masten, 2001). Specific instances may occur in which extraordinary talent accounts for an individual's positive recovery; however, the research describes resilience as a normative process (Masten, 2001). Meaning that rather than being a quality reserved for extraordinary folks most people when faced with a adversity are resilient. Resilience is often promoted as something that is extraordinary. The problem with this view of resilience is that it implies resilience is something very difficult to

achieve, reserved for a select few, when resilience is something humans have evolved to exhibit.

A relational element is always present in resilience because it emerges from a particular event or context (Masten, 2001). Because resilience fluctuates throughout the human lifespan, it is helpful to view resilience from a lifespan perspective. For example, a person may have had a tough time as a child but had a turning point when he or she got married. Other turning points could include finishing college, completing military service, and completing a doctoral dissertation. This concept of turning points is a recurrent finding in the resilience literature (Katz, 1997). Specifically, individuals can struggle as children but have turning points in adulthood (Katz, 1997).

Childhood traumas such as sexual abuse, emotional abuse, and physical abuse can inhibit an individual's capacity for resilience. The reason why childhood traumas can inhibit the capacity for resilience is that they often hinder trusting others. Supportive relationships are critical to developing resilience (Shonkoff et al., 2012). However, the paradox is that resilience is also found in individuals with elevated levels of exposure to trauma in childhood (Masten, 2001). Bonanno and Mancini (2008) noted that most individuals experience at least one potentially traumatic event (PTE) in their lifetimes. The term *potentially* is important because it draws attention to the differences in how people react to life events (Bonanno & Mancini, 2008).

Family Resilience

Initially, researchers conceptualized resilience as an innate characteristic that resided in individuals; little attention was paid to families or communities (Landau,

2007). However, as the study of resilience progressed, researchers recognized that family was a fundamental unit of resilience. Walsh (1996) defined family resilience as how families react to stress over time. Oshri et al. (2015) found "family functioning can be conceptualized as a process that channels and promotes the emergence of resilience outcomes" (p. 46). The family resilience approach supports the belief that people heal their traumas through relationships (Rolland & Walsh 2006). As Bateson (1994) contended, adaptation comes out of seemingly chaotic encounters with novelty (p. 8).

Walsh's (2003) family resilience framework has nine components. The first component is belief systems; the essential aspect of this component involves making meaning about events that have occurred (Walsh, 2003). The second component is a positive bias toward overcoming odds (Walsh, 2003). The third element is transcendence, which can appear in religious communities or in secular communities (Walsh, 2003). The fourth component is developing a system that is open to change or adaptation (Walsh, 2003). The fifth component is connectedness, in which members provide support for one another (Walsh, 2003). The sixth component involves building social and economic security (Walsh, 2003). The seventh component consists of matching words to actions (Walsh, 2003). The eighth component is open emotional expression encompassing the sharing of a range of emotions: joy, pain, hopes, and fears (Walsh, 2003). The final element is creative problem solving, which focuses on setting goals and taking concrete steps toward building on success and learning from failure (Walsh, 2003).

Families will often seek a therapist in times of crisis. The therapist helps connect their presenting problems to certain stressful events (Walsh, 2003). A guiding premise of this approach is that stressful events affect the entire family. An intervention in one domain of family functioning is likely to have a synergistic effect on the family as a whole (Walsh, 2003). This approach can be used with any of the strength-based family therapy models (Walsh, 2003). Practitioners of this approach pay specific attention to problems and family stressors and the family's adaptations to these stressors (Walsh, 2003). This approach attends specifically to developmental processes over time, showing how families shift interactional cycles to meet emerging challenges (Walsh, 2003).

Protective Factors

Individual and contextual factors, referred to as *protective factors,* buffer the effects of stress. Richardson (2002) stated, "The character, trait, or situational premise of resiliency is that people possess selective strengths or assets to help them survive adversity" (p. 309). A concise list of resilience factors has remained consistent in the literature, as follows:

1. effective parenting and caregiving;
2. close relationships with other capable adults;
3. close friends and romantic partners;
4. intelligence and problem-solving skills;
5. self-control, emotion regulation, and playfulness;
6. a motivation to succeed;
7. self-efficacy;

8. a belief and hope that life has meaning; and
9. positive schools and communities (Masten, 2009, p. 29).

Wolin and Wolin (1993) identified seven protective characteristics: insight, independence, relationships, initiative, humor, creativity, and morality. Having at least one adult who believes in a child's ability is cited as a protective factor (Masten, 2009). This person is someone who loves unconditionally and maintains a commitment to guide the child to meet the complex demands of life (Brofenbrenner, 1990). This adult may or may not be a family member (Katz, 1997). People transcend their trauma when having current positive attachment figures outweighs past terrors (van der Kolk, 1994). Similarly, Werner and Smith's (1982) phenomenology of resilience included individual characteristics such as having high self-esteem and being female, high IQ, socially responsible, adaptable, tolerant, achievement-oriented, and an excellent communicator.

Resilience is associated with the capacity to make realistic plans and carry them out (Meichenbaum, 2012). Conversely, an inhibited ability to make plans and achieve goals has been correlated with maltreatment (Meichenbaum, 2012). The reason trauma inhibits the ability to make and carry out plans is that traumatized individuals often have impaired executive functioning (Meichenbaum, 2012). The ability to make realistic plans and carry them out is a task-oriented coping style, requiring the ability to match responses to situations (Meichenbaum, 2012). Some situations require a problem-solving approach, and others require an acceptance response. An acceptance response involves accepting that some problems do not have a solution, and this requires emotional self-regulatory skills (Meichenbaum, 2012).

Resilience is further associated with having a positive self-perception of skills and abilities (Meichenbaum, 2012). The ability to regulate strong feelings and impulses is necessary for exhibiting resilience (Meichenbaum, 2012). It is also useful to have some sense of spirituality and values as a moral compass, as well as to view life as having meaning (Meichenbaum, 2012). Finally, the most robust predictor of a resilient adult is having a loving, supportive family (Masten, 2015). Positive relationships help promote resilience (Masten, 2015).

Mental Health and Resilience

After a traumatic event, most individuals exhibit resilience. It has been estimated that about 70% exhibit resilience, and about 30% do not (Meichenbaum, 2012). Exposure to stressful events can be positive if the duration is limited and an opportunity for recovery exists (Meichenbaum, 2012). The process of building resilience is like developing physical strength. Building muscle through weight training works by creating microtrauma to the muscle. The process of lifting weights itself does not build new muscle; rather, new muscle is created by the body's adaptation to the stress placed upon it (Deschenes & Kraemer, 2002). Resilience is formed like muscle is formed, by adapting to stress demands. In addition, a cultural component affects responses to adversity. For example, those in Western cultures would view trauma as the enemy that must be defeated (Meichenbaum, 2012). This contrasts with the approach of those in Eastern cultures—they might view suffering as an inevitable part of life and seek to accept trauma as a companion (Meichenbaum, 2012).

Theory

Postmodern/Social Constructionist Theory

According to social constructionist philosophy, people create knowledge through their own ideas or constructions of the world (Pocock, 1995). The social constructionist position is that all reality is created through language (Pocock, 1995). For example, constructs like femininity and masculinity do not exist on their own—masculinity and femininity are socially constructed through power relations between men and women. A social constructionist therapist uses dialogue to understand the role trauma has played in clients' lives (Pocock, 1995). The postmodern position is that no objective reality can be discovered; rather, reality is created through people's interactions with the world (Pocock, 1995). This contrasts with evaluating the role of trauma using a psychological rating scale. For the postmodern therapist, meaning is formed through social interaction and negotiation rather than remaining lodged inside an individual's mind (de Shazer & Berg, 1992).

Foucault (1980), a postmodern philosopher who influenced the postmodern therapists, would view the practice of reducing the experience of trauma to a numerical value as a form of modern power. Modern power differs from traditional forms of power. In traditional power, the power stems from a central authority figure such as a king or pope (Combs & Freedman, 2012). Modern power is found in the discourses society members value. For example, body image is a form of modern power expressed through the media (Foucault, 1980). Consequently, a discourse course on body image encourages people to compare themselves to external standards of beauty. The key

difference between the two sources of power is that in modern power, people police themselves; the power does not arise from an external source such as law enforcement (Foucault, 1980).

Post structural Theory

Narrative therapy is heavily influenced by poststructuralist philosophy. One of the tenets of this philosophy is to be critical of any "grand narratives" (Combs & Freedman, 2004; Murdoch, 2009). Resilience and adverse childhood experiences are two examples of grand narratives (Combs & Freedman, 2004). A narrative therapist would be careful not to impose these narratives on clients. The danger of imposing narratives on clients is that external narratives might not fit with their lived experiences. Michael White, one of the founders of narrative therapy, was greatly influenced by the writings of Foucault (1980). Foucault believed that practitioners in any field of knowledge who argued for the supremacy of one idea were promoting a discourse of social control (Foucault, 1980; Madigan 1992). Foucault (1980) emphasized that knowledge and power are inseparable. Instead, narrative practices privilege the local knowledge of clients, families, and communities (Ryan, 2001).

In addition, therapists have a certain degree of power and could easily subjugate clients' experiences by imposing their own views. Therapists cannot understand what certain life events mean for clients without asking clients to explain meaning in their own words (Combs & Freedman, 2012). Narrative therapists would consider clients experts on their own lives (Combs & Freedman, 2012). This stance is referred to as an *interpretive shift* (Combs & Freedman, 2012). An interpretive shift is a move away from

experts determining the meaning of people's lives toward people making meaning of their own lives (Combs & Freedman, 2012). This position is radically different from a medical perspective in which doctors rather than patients determine what information is relevant to the case.

Derrida's Theory

The philosopher Jacques Derrida was a major influence on White's narrative therapy (Derrida, 1981). Derrida's ideas contributed to the development of White's concept of the "absent but implicit" (White, 2005, p. 15). Derrida noted how many constructs are mutually dependent on each other (Klages, 2001). For example, darkness means lack of light. This is also true for resilience in the sense that resilience cannot exist without adversity or struggle. Klages (2001) stated,

> What Derrida does is to look at how a binary opposition—the fundamental unit of the structures or a system function within a system. He points out that a binary opposition is algebraic (a = ~b) and that the two terms can't exist without reference to the other—light (as presence) is defined as the absence of darkness; goodness, the absence of evil, etc. (p. 5)

Social Justice Theory

Narrative therapy blends well with a trauma-informed approach because of its emphasis on social justice (Combs & Freedman, 2012). The broad message of trauma-informed care is to create a healthier, happier, and more ethical society (Bloom, 1994). Unfortunately, most mental health issues are treated as personal problems, couple problems, or family problems; they are less frequently addressed as social justice issues (Finn, 2017). In traditional settings, mental health problems are a medical issue, often referred to as an illness. This approach excludes consideration of the fact that most mental health symptoms result from a traumatic experience created by interpersonal

maltreatment or neglect (van der Kolk, 2014). Currently, there are no known objective biomarkers or physical tests associated with any psychiatric diagnosis in the *American Psychiatric Association Diagnostic and Statistical Manual* (DSM-V) apart from the dementias (Carroll, 2013). In contrast, in medical fields such as cardiology, discernable biomarkers of disease are recognized and accepted by all professionals in their respective speacliaties (Whitaker, 2011).

Perpetrators of trauma often suffer no negative consequences. However, people who exhibit negative effects of trauma often suffer negative consequences because of perpetrators' actions. For example, to be reimbursed for social services by an insurance company, patients must be diagnosed with mental health disorders (Whooley, 2010). Having a mental health diagnosis carries a certain stigma. Mental illness is often considered a lifelong disease when it meets the threshold of serious mental illness (Insel, 2008). Thus, insurance premiums can be costlier because of mental health diagnoses. In addition, medical professionals might be quick to dismiss many health complaints as symptoms of anxiety or depression rather than looking for a physical cause. The trauma-informed perspective makes it clear the problem is not only physical or only psychological but rather occurs in relationship between the two.

Martin Luther King Jr. (1963) stated, "Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny" (p. 1). One of the aims of narrative therapy is to restore some level of social justice to trauma. The process of restoring justice to what happened helps heal the trauma that occurred (Denborough, 2013). The organizing mantra of narrative

therapy is that "the person is not the problem, the problem is the problem" (O'Hanlon, 1994, p. 2). The purpose behind this mantra is to separate the problem from the person. Combs and Freedman (2012) stated, "Rather than viewing people themselves as problematic or pathological, narrative therapists look at relationships people have with problems" (p. 103).

Similarly, when practicing from a trauma-informed perspective, therapists ask "What happened to you?" rather than the traditional question, "What is wrong with you?" (Bloom, 1994). This approach also separates the person from the problem. The practice of externalizing in narrative therapy guards against the subjugation associated with assigning pathologizing diagnostic labels to people (Combs & Freedman, 2012).

Therapy

Solution-Focused Therapy

Solution-focused therapy is one of the postmodern approaches in family therapy. Solution-focused therapists assist clients to discover their own solutions to their problems rather than allowing therapists to resolve clients' trauma (Dolan, 1991). A key component of solution-focused practice is the scaling question. The scaling question is when a therapist asks clients to rate their symptoms on a scale generally from 1 to 10, with 1 being the most mild and 10 being the most intense (de Shazer & Coulter, 2012). The scaling question is a way to address the private language problem of trauma (Wittgenstein, 2009). Traumatic memory is private memory; therefore, having a client attach a number to it enables a therapist to assess the duration and intensity of the memory. From a solution-focused perspective, people are not seen as locked into

behaviors contingent on their trauma histories; rather, people are viewed as sculptors of their own futures (de Shazer & Dolan, 2012). In situations in which clients have problems coming to terms with past events, solution-focused therapists would recommend focusing on the strengths and resources that enabled clients to move forward rather than recounting the traumatic events (Dieroff, 2011). Dolan (1991), a solution-focused therapist, drew similar conclusions while working with adults who had experienced childhood sexual abuse. Rather than focusing on clients recounting details of the abuse, Dolan focused on how this information was useful for the current conversation with the client. Dolan's starting question was "Please tell me everything that you feel I need to know for you to know that I understand" (p. 26). Telling the story about traumatic events was useful for the client to feel understood by the therapist and thus helped to build an alliance between therapist and client (Dolan, 1991).

Narrative Therapy

Narrative therapists have a unique perspective on working with trauma. White (2004) stated,

> No one is a passive recipient of trauma. People always take steps to try to prevent the trauma, and even if preventing the trauma is clearly impossible, they take steps to try to modify it in some small way or to modify its effects on their lives, or they take steps in efforts to preserve what is precious to them. (p. 47)

Narrative therapists do not explicitly mention the word *resilience*, but they imply resilience in their questions and attitudes. The narrative therapist collaborates with the client to elicit stories of self (e.g., as resourceful, capable, deserving) that are brought forth, witnessed, and acted upon in encounters with others (Sutherland, Dienhart, & Turner, 2013). In narrative therapy, the client's life story is the major target for

intervention (Tuval-Mashiach et al., 2004. Trauma, by its nature has the potential to disrupt the stability and smooth progression of daily life (Tuval-Mashiach et al., 2004). In narrative therapy, the client's testimony is a story rather than the truth (Combs & Freedman, 2012). The process of therapy is story repair.

Trauma disrupts narrative processing at two levels. The first is at the level of the traumatic event, and the other is at the level of a life story (Wigren, 1994). Three major components of traumatic narratives are associated with effective coping: continuity and coherence, creation of meaning, and self-evaluation (Tuval-Mashiach et al., 2004). Continuity and coherence refer to the ability to maintain a solid narrative about what occurred (Tuval-Mashiach et al., 2004). The creation of meaning involves developing meaning about what occurred. Self-evaluation is the perception of self in the context of what happened (Tuval-Mashiach et al., 2004). Trauma often leaves memories scattered; therefore, having an integrated narrative is essential to the recovery process (Tuval-Mashiach et al., 2004). Building continuity and coherence at the level of the trauma and at the level of general life trajectory is a better outcome for recovery (Tuval-Mashiach et al., 2004). The coping process includes asking meaning questions about the events, such as "Why did this happen to me at this time in my life?" The degree of control people have in the coping process is correlated with a better outcome (Tuval-Mashiach et al., 2004).

Unique Outcomes

To help clients internalize personal agency and develop self-narratives in which they view themselves as accomplished, White developed the concept of unique outcomes

(Carr, 1998). For example, a unique outcome might consist of a child who had horrible grades in high school but becomes a physician or obtains a Ph.D. If clients express emotional pain related to traumatic experiences, narrative therapists might ask what the pain implies about their lives (Carey, 2013). Persistent psychological pain is often a testament to something people value having been taken away from them (White, 2004). The intensity of the psychological pain indicates the degree to which trauma impinged on their value systems (White, 2004). Emotional distress is a way for people to maintain relationships with elements of themselves that have been demeaned and disrespected in the context of trauma (White, 2004).

Psychological pain can also represent people's protest to nonresponsiveness from the outside world—the trauma that they experienced must not have occurred for nothing (White, 2004). In this way, the psychological pain represents a call to restore justice to an individual's life. In contrast, practitioners of a traditional psychological such as cognitive behavioral therapy would view psychological pain as maladaptive thinking that needs to be challenged by a therapist (Edelman, 2012). In narrative practice, the role of the therapist is to help clients bring out parts of self that have not been overtaken by trauma (White, 2005).

Repeated traumas disrupt what people value in their lives. It is useful in therapy to ascertain what people value in their lives by inquiring about their preferred responses to trauma (White, 2004). One of the major goals in narrative trauma work is to help restore clients' sense of agency—the sense that people have some control in affecting their lives (White, 2004). In the resilience literature Schwartz (2018) noted that most

Western psychological approaches refer to individual agency as "hardiness" (p. 3). Hardiness is the tendency toward commitment, control, and challenge to life events (Tedeschi & Calhoun, 2004). Narrative therapists focus on how clients respond to trauma rather than focusing on the details of their childhood memories (Yuen, 2009). Focusing on their responses to trauma helps clients develop a sense of self outside of the trauma, which can later serve as a receiving frame for the trauma (White, 2004). The receiving frame for trauma refers to being able to create enough strength and safety that one can speak about the trauma without being overwhelmed by it.

Double Listening

Double listening is one of the primary concepts associated with narrative therapy. The purpose of double listening when working with people who have experienced trauma is to provide space for them to tell the trauma story and describe their responses to trauma (Marlowe, 2010). It is important when practicing double listening that therapists do not privilege the response over the trauma story, because both are important (Marlowe, 2010). Clients find it helpful for therapists to listen to the story of trauma to validate the experience of suffering (Marlowe, 2010). The purpose of listening to the response to trauma is to foster clients' personal sense of agency (Marlow, 2010).

The dominant goal in treating trauma is to help clients make meaning from their experiences (Marlowe, 2010). Further, narrative therapists encourage clients to use their experiences to aid others who are dealing with similar problems (Denborough, 2008). Narrative therapists often collaborate with their clients to create documents that are double-storied accounts of trauma, meaning they contain the experience of trauma and

the response to the trauma (Denborough, 2008). Often the story of response to trauma is a very "thin" story (White, 2004). The role of the therapist is to help "thicken" the story by asking questions to elicit greater meaning and depth. It is especially challenging to clients who have experienced multiple traumas to express what they value in life (White, 2004). The metaphor of to "thicken" occurs in narrative therapy where the therapist helps clients build upon their stories of resistance to the trauma they endured. Often individuals who have endured multiple traumas find that the world is unresponsive to their existence (White, 2004). In addition, their sense of agency is so depleted that it is hard for them to believe they have any influence on the world around them (White, 2004). The effect of this is a sense of personal paralysis, of feeling stuck in time (White, 2004). Thus, it is important for clients' development to experience a world that is responsive to their existence.

Absent but Implicit

The *absent but implicit* idea is one of the fundamental principles of narrative practice (2005). White (2005) stated, "The notion of the 'absent but implicit' is associated with the idea that, to express one's experiences of life, one must distinguish this experience from what it is not" (p. 15). Resilience fits well with this idea—resilience is the opposite of maladaptation.

The absent-but-implicit idea is found in the practice of asking what clients value in their lives. This is achieved when therapists listen to clients' accounts of their problem stories. During storytelling, expressions of distress, pain, concern, upset, or complaints show clients' attempts to express their preferred identities (Carey, 2009). This concept

comes from Derrida's method of deconstructing marginalized meanings in text (Carey, 2009). How people read a text depends on what is presented (privileged meaning) versus subjugated meaning, referring to what is left out (Carey, 2009). Thus, every story that differs from the problem story is an opening for developing personal agency (Carey, 2009).

Danger of Retraumatization

White (2005) strongly advocated against having people reexperience their trauma. Individuals often forget their preferred responses to trauma (Denborough, 2014). Because "half memories" were people's responses to trauma, White recommended turning half memories into full memories. People who were subjected to abuse as children often have negative and rejecting attitudes toward themselves as adults. Verco and Denborough (2002) stated, "Survivors of childhood sexual abuse have often been recruited into believing that they were somehow responsible for the abuse they experienced (p. 25). Society often recruits individual's that they were responsible for the abuse that they endure. One example is the often heard troupe in response to a women that was rapes is the question, What was she wearing?

Personal Failure

One of the major concepts in narrative therapy is the recognition that many clients who experience trauma maintain an identity of personal failure (White, 2002). Many contexts of life contribute to an acute sense of personal failure, including those in which people are subject to trauma (White, 2002). Carey (2013) stated, "Trauma can have the effect of escalating hopelessness, despair, and emptiness" (p. 770).

Normalizing judgment is a major part of how people adopt an identity of personal failure. Normalizing judgment is related to Foucault's (1980) concept of modern power. Modern power is the practice of individuals' determining their adequacy or self-worth by comparing their lives to other people's lives, based on socially constructed norms (White, 2002). This practice differs from traditional forms of power, which use coercion by governmental institutions to control people's behavior (Foucault, 1980). An example of modern power is using psychological rating scales to determine if a person's behavior is normal or abnormal (White, 2002).

One of the maladaptive responses of people who experienced trauma is evaluating their adequacy based on comparisons to others (White, 2004). The effect of this is a sense of personal paralysis in which people feel stuck in time (White, 2004). The DSM-V can be viewed as form of modern power. When lay people feel sad or worried, they often frame their experience based on this text (Mills, 2014). The DSM-V has been so ingrained in Western culture that many lay people will invoke terminology based on this "boss text" without having any formal professional training (Burstow, 2016, p. 87).

Subordinate Storyline Development

White (2005) developed a methodology for working with children who have experienced trauma. This methodology, referred to as *subordinate storyline development*, was created with the premise that children always respond in ways that minimize the effects of trauma. White (2005) gave some examples of ways in which children respond to trauma:

> The preservation of life in life threatening contexts, finding support in hostile environments, establishing domains of safety in unsafe places,

> holding onto possibilities for life in circumstances that are discouraging of this, developing nurturing responses to others in situations that are degrading of such responses. Finding connection and a sense of affiliation with others in settings that are isolating, refusing to visit trauma on the lives of others in milieus that are encouraging of this reproduction of trauma, healing from the consequences of trauma under conditions that are unfavorable to this, and achieving degrees of self-acceptance in atmospheres that are sponsoring of self-rejection. (p. 2)

One of the goals in subordinate storyline development is to restore children's sense of personal agency (White, 2005). Restoring a sense of personal agency involves enabling children to see that they have control in altering the course of their lives (White, 2005). Restoring a sense of personal agency serves as an antidote to negative identity conclusions of self, such as the idea that people are damaged because of the trauma they endured (White, 2005).

Therapists who focus their work on the trauma their clients endured often reinforce the notion of victimhood (White, 2005). Traditionally, therapists who work in trauma often reinforce discourses in society that reflect the belief that someone who experienced trauma is damaged or broken. Therefore, therapists working with trauma should attempt to bring forth clients' preferred responses to the trauma they experienced (White, 2005).

Abuse

The narrative metaphor provides a perspective on the phenomenon of abuse (White, 1995). People often seek therapy because of self-destructive behaviors such as self-mutilation, addictions, and multiple suicide attempts (White, 1995). From the narrative perspective, these acts are a response to abuses people have experienced (White,

1995). The self-destructive expressions of abuse are shaped by the meaning people attach to their memories of abuse (White, 1995).

Many people who have experienced abuse as children and adolescents have experienced the abuse in the context of cultural institutions that should have been loving and nurturing (White, 1995). These cultural institutions include family, extended family, and other organizations that are substitute for families, such as foster care or social service agencies (White, 1995). To experience abuse in contexts that are supposed to be loving and nurturing is both mystifying and confusing (White, 1995). People who have experienced abuse in these contexts struggle with discerning abuse from nurture and exploitation from love (White, 1995). It is evident that cultural discourses influence the effect abuse has on people's sense of self.

Trauma and Memory

White (2004) identified six categories of how trauma impedes various memory systems. The first category is *dissociation.* Dissociated memories are traumatic memories that are not experienced as past traumatic memories but rather intrusive memories that are in the present (White, 2004, p. 69). The next category White referred to as *hierarchical dissolution*. The category emphasizes how trauma affects memory systems in a hierarchical fashion. White claimed that the memory systems that evolve later seem to be more vulnerable to trauma (p. 69). White (2004) noted moderate trauma can inhibit the stream of consciousness part of memory and create a loss of sense of self in individuals (p. 69). The next category White referred to is *uncoupling* (p. 69). Uncoupling occurs when traumatic memories distort people's sense of time and they

cannot differentiate the present from the past (White, 2004). The next category is *meaning* (White, 2004). White identified how traumatic memories affect meaning about self that are much more impervious to change than are other autobiographical memories (p. 69). The next category, *devaluation,* refers to how people who have experienced trauma often come to very negative identity conclusions of themselves (White, 2004, p. 70). White proposed that this occurs because after trauma, individuals devalue things that were once precious to them (p. 70). The final category is *chronicle,* referring to how trauma affects memory in such a way that time is distorted (White, 2004, p. 70). Memory is often scattered and fragmented.

Totalizing Descriptions

Narrative therapists use the term *totalizing* to describe diagnoses such as attention deficit disorder, bipolar, and schizophrenia (Madigan, 1992). These diagnoses distill people's essence into a single pathological label (Madigan, 1992). These mental health diagnoses are frequently manifestations of trauma (Hunter, 2018). Trauma can take the form of hearing voices or experiencing delusions (Hunter, 2018). However, although the terms *resilience* and *trauma* are often useful when describing people's identities, they can be problematic as they are often decontextualized (Schwarz, 2018). Decontextualization can obscure larger structural factors that are economic or political that can either hinder or helps an individual's level of resilience.

The label of trauma is useful for acknowledging the suffering that has been endured. However, the trauma label can be problematic when it stems from the dominant discourse, which emphasizes that people who experienced trauma are damaged or

incomplete (Madigan, 1992). Suffering is an inevitable part of life—it is impossible to go through life without experiencing some form of trauma. One of the primary aims of narrative therapy is to liberate people from the subjugation experienced by totalizing descriptions of self (Madigan, 1992). This liberation means helping people see they are much greater than totalizing labels.

Catharsis

Trauma traditionally is viewed from the lens of catharsis, encompassing the idea that people hold in painful memories; thus, clients' release of these memories in therapy is curative (White, 2005). In fact, the notion of catharsis has a long history in psychology from the time of Freud (White, 2005). White (2005) explained,

> The interpretation of this concept is associated with the idea that human action is founded upon emotional/psychological system that works according to the principles of hydraulic and steam-engine technology; for example, that emotions are held under pressure within this system like a head of steam is held under pressure in a steam engine, and that the 'discharge' or 'release' of this pressure through the appropriate 'valve' will culminate in the desired outcome. (p. 15)

The problem with this view is that it does not give proper attention to the possibility of retraumatizing the clients while they release their traumatic memories. Only when clients see that they must take some personal agency in reclaiming their lives are they able to overcome their trauma.

CHAPTER III: METHODOLOGY

Self of the Researcher

> You own everything that happened to you. Tell your stories. If people wanted you to write warmly about them, they should have behaved better. (Lamott, 2012)

Clients' stories interest me, as a researcher, because I experienced adverse childhood experiences. My intention in sharing my own experience is to be transparent about the biases I bring to this study. In line with Glaser's (2007) axiom "all is data" (p. 1), my own history is data. Thus, I was mindful of my experience as I attended to the lived experiences of my participants. Throughout the research process, I maintained a journal to contain my own biases during the interviews.

My earliest memory of a traumatic experience occurred at age eight when I observed my paternal grandmother emotionally abusing my mother. I was attending my cousin's bar mitzvah when my grandmother publicly voiced disparaging remarks toward Mom. Because I was present, I heard everything she said, and even at that young age, I attempted to integrate it with my limited experience.

In retrospect, I recall this incident as traumatizing—I cared deeply for my mother. The words I heard did not fit with the mother I knew and loved. I was perplexed why my grandmother was so cruel to her. It was obvious to me, even at that early age, this verbal attack was wrong. Today, I view it as abusive. Upon reflection, I suppose my grandmother projected her feelings of loss and sadness onto my mother, who was a kind, innocent victim of her abuse. My paternal grandmother's life was particularly difficult: My grandfather was the leading character in a well-publicized trial. The circumstances were the family secret, unknown to my father and his sister. To my grandmother, Mom

had the life she herself had sought but never realized. Her negative emotions of jealousy were overwhelming. My grandmother was unable to manage her emotions and behave in a socially appropriate manner. It was distressing to me as a young child.

Familial messages are transmitted intergenerationally (Kerr & Bowen, 1988). My paternal grandmother resented the way money was handled in Mom's family, and this difference between the two families became integral to what ultimately turned into child abuse. My maternal grandfather was a successful businessperson; in contrast, my paternal grandparents suffered great financial hardship. My paternal grandmother had a bitter narrative about Mom and her family. Repeatedly, I heard Grandma say, "Your Mom was born with a silver spoon in her mouth." Grandma resented that Mom enjoyed a comfortable lifestyle created by her son, my father. She felt Mom, who stayed at home while we were young, was not deserving of "unearned pleasure." The term *unearned pleasure* is used by drug policy reform advocates to question American disdain for recreational drug use (Szalavitz, 2017, p. 1).

Unfortunately, Grandma inappropriately entitled her son, my father, and I believe contributed significantly to his narcissistic tendencies. Grandma was so frustrated by her own husband's career derailment that she projected her ambition onto her son. Love was measured by productivity and career success. Consequently, Dad became obsessed with his academic career, his productivity, and his pleasure. He did not strongly value our family. Grandma viewed Mom as undeserving and lazy.

Unfortunately, my father carried these abuse messages and projected them onto me. Dad did not value my strengths; he dismissed my learning differences, and because I

was my Mom's son, I was likewise viewed as lazy. I believe this was the genesis of why I became the target of Dad's abuse. No one was as good as he, and because I was so different in terms of strengths, he devalued me. He was physically, emotionally, and sexually abusive toward me and neglectful toward my younger brother. In response, I did what young boys often do; rather than express my feelings, I acted out. Because of these acting-out behaviors, during middle school, I was the "identified patient" in a dysfunctional family system. Therefore, I received support for adolescents who displayed emotional and behavior problems. While in the program, I observed my peers experiencing elevated levels of adverse childhood experiences (ACEs). Specifically, I recall a comment from one of my peers whose parents divorced. He said I would not be able to relate to his experience because, fortunately for me, my family was intact. Another friend in the program experienced the premature death of his young mother. Reflecting on what was happening at that time, I realize that although my family was well functioning, my parents did not have a connected relationship. My parents' marriage was falling apart. I learned later that during that time, my father had extramarital affairs with multiple women.

It is important to note that my paternal aunt reported that Dad bullied her throughout childhood. Not surprisingly, she struggled with regulating her negative emotions as a camp counselor and was fired. Sadly, later in life as the sole caregiver of her mother, who was extremely difficult, a social worker cited her for elder abuse. My aunt called my mother and was the first to identify that she believed my father was abusing me. Mom was in denial, but my aunt said she witnessed it several times during

our recent visit to her home. My aunt had many ACEs, suffered several significant illnesses, and died a premature death from cancer at 55. This poignant story in my own family shows the validity of the ACE correlation to physical illness and early death (Brown et al., 2009).

During this same time, I received a diagnosis of attention deficit disorder (ADHD). There is ample evidence highlighting the relationship between trauma and ADHD (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). Children who have experienced trauma often exhibit signs of ADHD, but mental health professionals often overlook the trauma (Maté, 2000). The symptoms of inattentiveness are often a form of dissociation associated with trauma (D'Andrea et al., 2012). Maté (2000) explained the connection between trauma and ADHD: Symptoms of ADHD such as hyperactivity, lethargy, and shame are closely connected with neurological memories of the distant, stressed, or distracted caregiver (p. 136). Maté's point is that often symptoms of ADHD stem from the relationship between the child and caregiver. D'Andrea et al. (2012) noted, "Dysregulated affective and behavioral patterns found in ADHD following interpersonal trauma may be better conceptualized as one facet of adaptation to extreme stress" (p. 194).

I was 15 years old when my parents divorced; this was another ACE I experienced. Interestingly, I did not experience the divorce itself as so traumatizing. However, the divorce negatively affected my relationship with my father. He chose to move far away and rarely spent time with my brother and me. Additionally, my father remarried, adopted a child, and made his new family the priority. The divorce changed

my relationship with my father and created chronic tension between my two parents. It also created a loyalty conflict in which I felt that if I was for my mother, I was against my father. Unfortunately, I absorbed much of this tension. I categorize the divorce as a chronic strain in my life. Consequently, I have exhibited many of the signs of someone who experienced trauma. I have often been hypervigilant and mistrustful of people. In times of stress, I have had trouble regulating my emotions. Van der Kolk (2001) stated, "Loss of self-regulation may be expressed on other levels as well: as a loss of ability to focus on relevant stimuli, as attentional problems and as an inability to inhibit action when aroused" (p. 7).

My father's primary focus in his own life was on his career. I believe this focus stemmed from the trauma he experienced from his family of origin. My grandfather was a graduate of a prestigious law school. Early in life, his career was derailed because of a legal issue that ultimately ended favorably. Unfortunately, it prevented him from practicing for many years. In response to her perceived loss, my paternal grandmother projected an inappropriate emphasis on her son's achievement, and it surfaced in the following next generation on my career. This is an excellent example of Bowen's family theory multigenerational transmission process (Kerr & Bowen, 1988).

Paradoxically, Dad's unusual intensity on career and performance negatively affected my performance. Sadly, Dad created precisely the outcome he wanted to avoid. I strongly wanted to show Dad I could be successful; however, his intense focus on my career, inherited from his family of origin, significantly affected my performance. My father provided me with the classic case of the double bind. He projected his fervent

desire for me to achieve and yet did many things unconsciously and consciously to undermine my ability to realize my potential. Rather than emphasize my strengths, he pointed to my deficits. His inability to connect with my experience, combined with his punitive ways, further inhibited my early development. His language and unspoken messages were disempowering. He stated in an e-mail, "Have you been brainwashed by your mother into thinking that you are not a worthy person without this label of a Ph.D.?" Even though I have chosen to be a therapist, Dad continued to assert his desire that I become a tennis professional. He said, "When people ask me what you are doing, and I tell them you are a teaching tennis as a pro [before I entered social work], no one looks down on it." The message to me was that I am not good enough or smart enough to deserve a doctoral education. It is especially hurtful because he and all his family members have earned doctoral degrees in their chosen fields.

My Own Resilience

Because of issues I developed in school at an early age, teachers told my mother that I might never go to college. I was never particularly fond of school, yet I have a deep yearning to study and read on my own. Nonetheless, I have a master's degree in social work, I am a licensed mental health professional, I am a supervisor, and as of this writing, I am a dissertation away from earning my doctoral degree. One of the ways I exhibited resilience has been by using my own experience to drive this dissertation. The topic of this dissertation has a high degree of relevance because of my own lived experience. Another way I have shown resilience is by working as a therapist helping other people overcome trauma in their lives. My own experience has spurred activism on

behalf of people who have been marginalized in society. For example, I have organized and participated events in events involving people diagnosed with "mental illness" and people who use drugs.

Interest in Adverse Childhood Experience

I became interested in the ACEs study after learning about it through an online course called the Social Context of Mental Health. This online course was given by the University of Toronto about the social contextual factors that contribute to the condition labeled as "mental illness." Someone in the course posted a link to the ACE study in one of the discussion forums. When I read about the study, I was fascinated by the strength of the correlations between ACEs and adult health outcomes. The ACE study and subsequent research from this framework have provided a scientific framework from which to understand the relationship between childhood trauma and adult health. It has been my experience practicing as a therapist in the fields of mental health and substance use that trauma is the underlying theme of most clients in these programs. The addiction or mental health diagnosis is often a manifestation of the trauma. However, unless it fits the criteria for PTSD, trauma is not the focus of treatment in mental health programs or substance use programs. Treatment is focused on treating disorders of depression, anxiety, attention deficit disorder, schizophrenia, which are usually symptoms of trauma.

The ACE study confirmed many of my observations of the relationship between experiencing childhood trauma and developing mental health symptoms as an adult. Practicing as a therapist, I frequently give my clients the ACE survey to assess the relationship between their childhood histories and adult functioning. I also explain to

them the ACE study. One of the benefits of applying a trauma-informed approach is that it helps reduce the self-blame held by many traumatized people.

However, the danger in focusing on trauma is that trauma is often used as an excuse for not achieving in life. A nationwide effort has been launched to make state and federally funded mental health programs trauma-informed (Walkley & Cox, 2013). According to the Substance Abuse Mental Health Services Association (SAMHSA; 2014), being trauma-informed means acknowledging the widespread impact of trauma and understanding potential paths for recovery. Being trauma-informed means recognizing the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responding by fully integrating knowledge about trauma into policies, procedures, and practices; and actively seeking to resist re-traumatization (Becker-Blease, 2017). Trauma-informed programs are designed to deliver interventions that target trauma. Several trauma/ACE-informed communities have formed across the United States. These communities exist in Tarpon Springs, Florida; Walla Walla, Washington; Philadelphia, Pennsylvania; Camden, New Jersey; Dallas, Oregon; and Alberta, Canada (Walkley & Cox, 2013). A growing number of communities have started implementing trauma-informed policy. In short, a communal effort is required to minimize risk associated with trauma and foster resilience.

Research Question

A body of literature exists regarding the negative health outcomes correlated with experiencing adverse childhood events (ACEs; Anda & Felitti, 2003). Another body of literature has shown that many people are resilient from ACEs, and some are even

stronger as a result (Tedeschi & Calhoun, 2004). My intention in this research study was to look at responses to ACEs as adaptions rather than assigning positive or negative value judgments. My research question was "How do individuals adapt to adverse childhood experiences?" To gather answers to my research question, I posed as a clinical interviewer.

Qualitative Research

Qualitative research involves collecting and analyzing text, images, video, or audio. The main advantage of qualitative research over quantitative research is that researchers can probe into participants' responses as needed (Bickman & Rog, 2009). This contrasts with quantitative research in which data are obtained through standardized instruments (Harré, 2002). According to Harré (2002), "determining the self-confidence of a person with an 'instrument' of a questionnaire is not the same as measuring the temperature with a thermometer" (pp. 171–172). Using a standardized instrument limits the type of information that can be obtained. Most qualitative inquiry is conducted through open-ended questions, affording greater flexibility in the responses that can be gathered (Charmaz, 2006). Thus, conducting qualitative research gives researchers the flexibility to follow leads in the data as they emerge (Charmaz, 2006).

According to Denzin and Lincoln (2005), qualitative research is a situated activity that locates the observer in the world. Qualitative methods involve interpreting reality through a series of representations—for example, field notes, interviews, conversations, photographs, recordings, and researcher memos. At this level, qualitative research involves an interpretive, naturalistic approach to understanding reality (Denzin &

Lincoln, 2005). This means that qualitative researchers study things in their natural settings, attempting to make sense of and interpret phenomena in terms of the meanings people bring to them (Denzin & Lincoln, 2005, p. 3).

Grounded Theory

The grounded theory approach consists of a group of techniques formulated to identify categories and concepts within text, which are later developed into specific theoretical models (Corbin & Strauss, 2008). When Strauss and Corbin (1998) used the term *grounded theory*, they meant theory was derived from the data and analyzed through the research process. In this method, data collection, analysis, and theory are closely related. Strauss and Corbin (1998) explained, "Analysis is the interplay between researchers and data" (p. 13). These specific procedures can enhance the rigor of the analysis and the accuracy of the theory developed from the data.

Grounded theory is a useful tool for studying experiences with the aim of explaining processes or relationships (Lingard, Albert, & Levinson, 2008). The purpose of the grounded theory approach is to highlight basic social processes so that people understand more about their behaviors (Brown, 2012). Grounded theory is an inductive practice wherein theory is generated from immersion in raw data rather than from preconceived hypotheses (Corbin & Strauss, 2008). The main goal of a grounded theory study is to develop a theory based on a systematic analysis of the data (Lingard et al., 2008). The theory will emerge from listening to people and coding the data (Brown, 2012).

Tweed and Charmaz (2012) stated,

> Grounded theory's theoretical, epistemological and technical foundations position well to investigate a broad range of open-ended research questions that focus on processes, patterns and meaning within context and that require the crucial examination of subjectivity of experience and thus lead researchers to begin inquiry from their research participants' point of view. (p. 134)

Using the ideas of Glaser and Strauss (1967) and Strauss and Corbin (1998), my intention was to build a theory regarding the strengths of growing up with adverse childhood experiences. According to Strauss and Corbin (1998), "Developing a theory is a complex activity . . . that entails not only conceiving or intuiting ideas (concepts) but also formulating them into a logical, systematic, and explanatory scheme" (p. 21). Strauss and Corbin specified, "Theory denotes a set of well-developed categories (e.g., themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework that explains some relevant social, psychological, educational, nursing or other phenomenon" (p. 22).

Adhering to the process of grounded theory developed by Glaser and Strauss (1967) and Strauss and Corbin (1998) as the basis of my analysis, I chose to implement the constructionist orientation to conducting grounded theory recommended by Charmaz (2006). Charmaz further clarified that "the very understanding gained from the theory rests on the theorist's interpretation of the studied phenomenon. Interpretive theories allow for indeterminacy, rather than seek causality, and give priority to showing patterns and connections, rather that linear reasoning" (p. 126). Strauss and Corbin (1998) acknowledged interpretive views. My worldview currently aligns with Crotty's (1998) statement:

> In the constructivist view, as the word suggests, meaning is not discovered, but constructed. Meaning is not found in the object, merely

> waiting for someone to come upon it. What constructionism claims is that meanings are constructed by human beings as they engage with the world they are interpreting. (p. 43)

In addition, Charmaz (2006) stated, "Our assumptions, interactions, and interpretations affect social processes constituting each stage of inquiry" (p. 132). I selected Charmaz's constructivist approach because I constructed the data I gathered through my interactions with the participants (Charmaz, 2006). Throughout each interview, I engaged with the participants as well as with the collected data.

Participant Criteria

Interviews were conducted with 10 members of the ACEs Connection Social Network. The demographic requirement was that the participants be between 18 and 64 years of age. The rationale for requiring participants to be at least 18 was that the scientific ACEs research has been studied using retrospective reports of adults reflecting on their childhood experiences prior to age 18 (Felitti et al., 1998). In addition, 18 is the legal age of an adult in the United States; there would be too many ethical hazards interviewing minors who have experienced trauma. In addition, the participants were all less than 65 years old. This criteria was set because 65 is considered elderly by the Nova Southeastern University IRB, and the elderly are considered a vulnerable and protected population according to the Nova Southeastern University Institutional Review Board (IRB) guidelines. At the time of this study, many of participants in the ACEs Connection Social Network lived in the United States; therefore, I delimited the sample to the United States. Participants located outside the United States were excluded from the study. The rational for only including people living in the United States was there could be greater liability if they resided in another part of the world. Specifically, because of language

and cultural differences, the risk for retraumatizing participants could be greater with participants residing in other regions of the world.

The participants self-identified as having experienced adverse childhood experiences (ACEs) through their participation in the ACEs Connection Social Network. I chose the ACEs Connection Social Network to recruit my sample because this large network of approximately 5,000 people has experienced adverse childhood events. When recruiting samples, researchers seek to maximize the possibilities of obtaining data and leads to answer to their research questions (Glaser, 1978). Therefore, the ACEs Connection Social Network was a target-rich environment to obtain data to answer my research question. This network contained a unique community of adults who shared their stories of ACEs and resilience. To date, no study on ACEs has studied people engaged in a social network about ACEs.

After obtaining approval from the IRB, I gained permission to contact the participants from the administrator of the ACEs Connection Social Network website. After I received approval from the administrator, I sent out an announcement on the website to recruit participants for my study. The participants responded to the announcement through e-mail. The interviews were scheduled and conducted over the phone through a secured telephone service called Secure Speak.

Data Collection

Consent and Demographics

The participants in the study were asked to provide consent by filling out a consent form. Participants were instructed to review the consent form and ensure they

understood the parameters prior to participating in the study. Participants received consent forms through e-mail. I addressed participants' questions regarding the details of the study before they signed the consent forms. Informed consent was obtained prior to conducting the interviews.

After participants agreed to participate, they signed the forms and e-mailed the signed consent forms back to me. They were instructed that at any time during the study, they could contact me, my mentor, or the IRB with any questions pertaining to informed consent or participating in the study. In addition, the participants provided basic demographic information prior to the interviews. The demographic information included age, sex, ethnic group identification, level of education, marital status, geographic location, and occupation.

Interview Process

Charmaz (2006) stated, "The structure of an intensive interview may range from a loosely guided exploration of topics to semistructured focused questions" (p. 26). I used Denborough's (2008) double-storied testimony method to guide my interviews. The double-storied testimony was a respectful way to inquire about people's responses to trauma. The questions were carefully structured to be respectful toward people who have experienced trauma. The selected questions were designed to prevent participants from being retraumatized. Implicit in this approach was the assumption that people who have experienced trauma always try to resist trauma or lessen its effects. It was important to remain mindful to avoid further traumatizing the participants when inquiring about their experiences of trauma.

The double-storied testimony method fit well with the resilience construct because it addressed the participants' responses to the trauma they endured. My interview questions addressed participants' responses to trauma rather than inquiring about the specific details of their traumatic experiences. The rationale of this study focused on obtaining data about adaptation to trauma rather than about the experiences of trauma. Another reason for this approach was to mitigate the risk of retraumatizing the participants.

The interviews were semistructured inquiries based on the following questions:

1. Is there someone or something that sustained you through these challenging times? If so, could you tell me something about this?
2. Have there been ways in which you or your community has been able to reduce the effects of trauma/adversity effects? If so, how?
3. If someone else went through similar experiences to you, what suggestions would you offer them that would be helpful for them to recover from such experiences?
4. During the time when you were subjected to this injustice, how did you try to endure this? What did you try to think about?
5. Were there any memories you tried to hold onto? Any dreams?
6. What sustained you through these difficult times?
7. Were there different ways that you tried to endure the different forms of trauma?
8. How have you been able to keep in touch with your hopes and dreams,

despite the negative experiences that you had?

9. Have there been ways in which you have been able to reduce the effects of the trauma in your life? If so, how have you done this?
10. Are these ways of reducing the effects of trauma newly developed or have they been around in your life for some time? What is their history?
11. Have there been particular people who have made a difference? If so, what is it they have done or said that has been significant to you? Why was this significant to you?
12. What stories could you tell other people in the world that made a difference that would convey some of the steps you have taken to reclaim your life from the effects of this trauma?

I adapted these questions from Marlowe (2010) and Denborough (2008). According to Strauss and Corbin (1998), "Every type of inquiry rests on asking effective questions" (p. 73).

Data Management

The data emerged from nine semistructured interviews. Ten participants were interviewed; however, one interview did not record properly and consequently was discarded. Methods for data recording were fully explained to the participants. Because these interviews took place with participants all over the United States, interviews were conducted on a secure telephone service called Secure Speak. Secure Speak is an application that encrypts phone calls, ensuring security and privacy. Immediately after the interviews, I transcribed the audio recordings on my password-protected laptop. I

then listened to the audio on my headphones through my password-protected laptop in a private home office. It was made clear to all participants that confidentiality was maintained by anonymizing participants' names in the transcripts and subsequent documents. I explained to participants that the recorded interviews were stored on a password-protected computer along with any associated data and that all data gathered were secure.

Finally, participants were reminded that they could withdraw from the study at any time with no consequences. Participants were informed that all data would be destroyed three years after the conclusion of the study.

Data Analysis

Before beginning data analysis, I transcribed the raw data from the interviews using Microsoft Word. The data were anonymized to protect the confidentiality of the participants' data. Next, I imported the data into Dedoose, a secure, cloud-based qualitative data analysis program (Dedoose, 2015). Using Dedoose meant the information was stored on an encrypted server on the Internet rather than locally on my computer. Dedoose served as a content management system to store and structure the data.

Data analysis occurred in Dedoose, beginning several hours after the first interview. I used the Dedoose software to create codes, broad categories, and themes from participants' transcribed narratives. Initially, Dedoose was helpful in aggregating a large amount of unstructured textual data. However, I did not choose to use the more advanced tools of the software because they were geared to mixed-methods research, and

this was a purely qualitative study. After examining the data, I combined the interview transcripts in a single Microsoft Word document and used Word's search tool to find more excerpts from the data to support the created codes and categories generated in Dedoose.

The first stage of my analysis involved open coding. Strauss and Corbin (1998) defined open coding as "breaking data apart and delineating concepts to stand for blocks of raw data" (p. 196). This means that I looked at each sentence and tried to categorize it to generate a larger theme. During the open-coding phase, I mined the data line by line. One of the goals of open coding is to determine what direction to take the analysis through theoretical sampling (Glaser, 1998).

The second step of the analysis consisted of focused coding. The codes derived during this phase were more directed, selective, and conceptual, compared to the word-by-word, line-by-line, and incident-by-incident coding applied in the previous step (Glaser, 1978). During focused coding, I used the most frequently used codes to hone in on what was important and meaningful in the analytic process (Charmaz, 2006).

The next step in the analytic process was axial coding. Corbin and Strauss (1998) defined axial coding as "crosscutting or relating concepts to each other" (p. 195). The initial step in axial coding led me toward later decisions about defining core conceptual categories (p. 47). Charmaz (2006) cautioned, "Make your codes fit the data you have rather than forcing the data to fit them" (p. 6). During axial coding, I built upon the conceptual links between codes.

The next step in the analytic process was theoretical coding. Theoretical coding is a sophisticated level of coding applied to the codes selected during focused coding (Glaser, 1978). Glaser (1978) claimed theoretical codes conceptualize how codes may relate to each other as hypotheses to be integrated into a theory. The final step in the analysis was the creation of an interpretive theory based on the data (Charmaz, 2006). An interpretive theory emphasizes understanding rather than explanation and acknowledges truth as provisional (Charmaz, 2006).

Saturation

My analysis ceased when I reached saturation in the data. Saturation was reached when there was a repetition of the themes. Charmaz (2006) stated,

> Saturation is not seeing the same pattern over and over again. It is the conceptualization of comparisons of these incidents, which yield different properties of the pattern, until no new properties emerge. This yields conceptual density that when integrated into hypothesis make up the body of the generated grounded theory with theoretical completeness. (p. 191)

Theory Development

The final step of the grounded theory process was developing a comprehensive theory. The creation of a unique theory distinguishes grounded theory from other qualitative research methods (Charmaz, 2006). In an interpretive theory, truth is viewed as provisional, and social life as processual (Charmaz, 2006). Social is always bound by context and relationships rather than having essential physical attributes to be discovered. I developed a theory from my evaluation of how the emergent categories related to each other. Thus, I achieved my goal of developing an interpretive theory. Finally, after developing the theory, I situated the theory in the relevant literature. I named the theory *empathy is resistance*.

Trustworthiness

Trustworthiness is a general term used in qualitative research to indicate quality control in a research study (Creswell, 2009). I employed several strategies to enhance the trustworthiness of my findings, including member checking, memo writing, peer debriefing, audit trail, and researcher reflexivity.

Member checking. First, I conducted member checking. According to Creswell (2009), member checking is a process whereby "the final report or specific description or themes" are returned to the participants (p. 191). After the interviews were transcribed, I e-mailed the transcripts to the participants to assess if I had captured their narratives properly and to ask if they wanted to add anything more. Participants received segments of their collected data in order to comment, refine, or edit my interpretations and thus enhance the validity of my interpretations. Several of the participants responded and provided valuable insights. I then incorporated the participants' feedback into my analysis. Thus, member checking helped to improve the validity of my study.

Memo writing. Another method of quality control that I employed was memo writing. During my analysis, I created memos to document the analytic process. Memo writing is the process wherein researchers write down hunches and thoughts and outline the steps of their decision-making process (Tweed et al., 2012). By creating memos, I contributed to an audit trail to provide transparency to the data analysis, thus enabling other readers to see how conclusions were derived from the data. Having a well-developed audit trail helped enhance the transparency and integrity of the study.

Peer debriefing. To aid with the accuracy of my analysis, I incorporated peer debriefing. Robson (1993) described peer debriefing as "exploring one's analysis and conclusions to a colleague or other peers on a continuous basis" (p. 404). I practiced peer debriefing by regularly meeting with members of my dissertation committee to review the data and check my interpretations. I incorporated their suggestions into my analysis.

Audit trail. In quantitative research, the term *reliability* refers to the consistency of an instrument. That is, would the instrument perform the same over time? Given this was a qualitative study, there was no formal instrument used except for my interview questions. I addressed reliability through creating a well-defined audit trail. The audit trail detailed how I arrived at my findings, providing transparency to readers.

Reflexivity. In addition, reflexivity supported the trustworthiness of my study. Charmaz (2006) noted, "Just as the methods we choose influence what we see, what we bring to the study influences what we can see" (p. 15). Because of my history with divorce and abuse, and because of my professional work with trauma, it was essential for me to maintain an awareness of my thoughts and expectations regarding my research question. During the process, I noted in my memos when bias arose to keep it in check. Charmaz (2006) addressed reflexivity: "Researchers, not participants, are obligated to be reflexive about what we bring to the scene, what we see, and how we see it" (p. 15).

Strengths

Echevarria-Doan and Tubbs (2005) suggested that grounded theory methodology has strengths and limitations when applied to family therapy research: "The inductive nature of therapists' inquiry, their processes with clients, and the hypothesis-driven

conclusions they [may] develop, are very similar to steps taken by grounded theorists" (p. 55). The main strengths was that this type of research fits well with systematic therapy because this approach is qualitative and reflexive. It is somewhat isomorphic to systemic family therapy.

Limitations

First, grounded theory methodology is challenging and time-consuming because it is difficult to develop a comprehensive theory from data. To prepare myself to explore this topic adequately and to apply this methodology, I studied effective implementations of grounded theory in the literature. I studied in-depth the various leaders in this area of methodology, including Glaser (1967), Strauss and Corbin (1998), and Charmaz (2006) to determine which of their proposed methods would be most useful. Glaser and Strauss (1967) invited their readers to use grounded theory strategies flexibly in their own ways. I viewed grounded theory as Charmaz (2006) recommended, "as a set of principles and practices, not as prescriptions or packages" (p. 9). Charmaz suggested that even the most regimented process may contain surprises because the present arises from the past but is never quite the same; thus, the experience and outcome of a specific process has some degree of indeterminacy, however small (p. 10).

Second, in this study, I obtained retrospective reports of responses to traumatic experiences. My intention was to gather explicit data to understand "how people make sense of their situations and act on them" (Charmaz, 2006, p. 11). However, the limitation associated with retrospective reports is that people's memories may be inaccurate. Inaccuracy occurs because of the fallibility of human memory systems.

However, evidence has shown that despite inherent flaws with retrospective reports regarding recall of memory, memories are accurate in the context of trauma (Patten et al., 2014). The reason that retrospective reports of trauma hold up well is because of their high degree of emotional relevance—highly emotional events are remembered better (Patten et al., 2014). However, after comparing retrospective to prospective reports, researchers have found that adults tend to minimize their degree of exposure to adversity on retrospective reports (Shaffer, Huston, & Egeland, 2008). Hence, retrospective exposure rates are lower than prospective exposure rates, indicating a problem with false negative reports but not with false positive reports, although false positive reports are what critics fear (Shaffer et al., 2008).

A third limitation of this study was the sample size. Having a small sample size prohibits generalizing findings to the population at large. However, qualitative studies typically have small sample sizes (Charmaz, 2006). The strength of the qualitative approach is that it gathers information regarding the "why and how" of human behavior. Because of the in-depth inquiry, qualitative data may reveal information that would be missed in a traditional quantitative approach, which privileges correlations between variables rather than interpretive meanings (Charmaz, 2006). Interpretive theories allow multiple realities rather than provide causality and emphasize patterns and connections rather than linear reasoning (Charmaz, 2006).

The final limitation was that I entered this study with certain biases based on my personal and professional life regarding how people respond to trauma. In addition, I explored the literature prior to conducting this inquiry; I was challenged to discover

something new from the data without reinforcing what I had already known. Also this why there is new literature that emerged after my analysis. My interview question was open-ended but influenced by the theory and practice of narrative family therapy.

Implications

By developing this theory, *empathy is resistance*, I generated unique insights regarding adaptations by people who have had adverse childhood experiences (ACEs). This information adds to literature about the effects of ACEs on adult functioning. Applying empathy is resistance theory as a foundation has possibilities for building comprehensive programs that promote resilience in individuals, couples, families, and communities. The theory may help educators promote resilience by providing a novel framework in which to conceptualize it, thus enabling traumatized children to improve learning. In addition, the new theory may more effectively help therapists serve clients who have experienced trauma. Finally, this study adds to the family therapy literature regarding trauma and resilience.

Summary

A semistructured qualitative approach was used to guide this research because most of the prior research on ACEs has been generated from large-scale quantitative inquiries. Using the qualitative approach allowed me to dive in to the participants lives to gather unique insights about their experiences. Thus, this approach allowed me to develop a broad-based theory from the ground up rather than using traditional top-down methods.

CHAPTER IV: RESEARCH FINDINGS

The research question was "How do individuals adapt to their adverse childhood experiences?" In this chapter, I present the demographic information about the participants. Next, I provide excerpts from my interviews to illustrate themes that make up my grounded theory.

Participant Demographic Information

Table 1 shows the participants' demographic information, gathered during the initial interviews. Table 2 shows the themes and categories that emerged from the data.

Table 1

Participant Demographics

Name	Gender	Age	Race	Religion	Marital	Education	Occupation	Location
Irene	W	59	White	Spiritual	Divorced	BA	Engineer	UT
Paula	W	56	White	Christian	Married	BA	Teacher	CA
Larry	M	60	White	Buddhist	Divorced	Some College	Fireman	WA
Kylie	W	43	White	Spiritual	Partnership	BA	Teacher	MD
Jessica	W	40	White	Spiritual	Divorced	MSW	Social Worker	CA
Gerry	W	60	Black	Spiritual	Divorced	BA	Case Worker	FL
Larissa	W	20	Hispanic	Agnostic	Single	Some college	Student	FL
Carl	M	23	Hispanic	Spiritual	Single	BA	Student	CA
Kayla	W	47	White	Spiritual	Married	MA	Teacher	WA

Table 2

Themes and Subthemes

Trauma Themes and Subthemes	
1. Survival Responses	*3. Maladaptive Responses*
1. Freeze	1. Suicidal ideation
2. Dissociation	*4. Boundaries*
3. Avoidance/suicidal behavior	1. Toxic relationships
4. Hypervigilance	
2. Betrayal Trauma	
1. Perpetrator-as-scammer	
2. Invalidation	
3. Historical trauma	

Resilience Themes and Subthemes	
1. Self-Care	*3. Turning Points*
1. Reading	1. Moving
2. Education	2. Military
3. Food	3. College
4. Drugs	*4. Nature*
5. Exercise	1. Social services
6. Meditation	2. Psychotherapy
7. Faith/spirituality	3. Positive adults
2. Individual resilience	4. Community
1. Reframe	*6. Service to Others*
2. Personality characteristics	1. Sharing stories
	2. Prosocial
	3. Human service
	4. Empathy

Trauma Themes and Subthemes

Theme 1: Survival Responses

The first trauma theme was survival responses (e.g., reptilian response, Levine, 1997, 2008). The reptilian response refers to how these response are more instinctual and other animals with less developed brains also have these responses. The point of beginning with these responses is to highlight how the participants described how when then were experiencing trauma it was initially about survival. Four subthemes under the survival responses theme represent classic responses to trauma found in the literature (Levine, 1997, 2008). These classic responses appeared in the interviews with participants. For example, Carl, a 23-year-old male, said, "Umm, initially, I was in a state of learning to master myself. You could say 'survive in my world.'"

Freeze response. The first subtheme under the survival responses theme was the freeze response. The freeze response is a classic bodily response associated with trauma, also found in animals (Levine, 1997). Jessica, a 40-year-old female, shared,

> You know, I froze. They talk about disassociation where you there but you are not there so I was a freezer and so I would freeze and that carried into my adult life. When I feel threatened, I freeze so that is something I'm working on. I was young when it started, and it went on until around [age] 5. In terms of the timing, it is not all the time by any means, but he had access to me. Umm and my grandparents were kind of my daycare after school so that is kind of when it would happen but, so I would freeze and disassociate. It is hard for me to remember, really, when I think back.

Lester, a 61-year-old male, stated,

> Personally, I think that is why drugs became an issue for some many people, including me. I think it was the desire and partly that cultural thing, but it was mostly, I think, a need to escape. I just kind of repressed it..

Two of the nine participants reported a freeze response to the adversity they endured.

Dissociation. The second subtheme that emerged under the survival responses theme was dissociation. In an example of this response, Kylie, a 40-year-old female, mentioned,

> You know, I don't really recall. I don't really recall thinking about anything, a lot of what happened. I was young, and I did not know what was going on. Umm, while it was happening, so like [age] 7 to 13, you know, I don't know, I don't know how I did it. When I moved in with my dad at 13, I completely dissociated from it, so I completely forgot my body. Until I was like 19 years old and, you know, I started having some PTSD, and I was admitted to the psych ward because that was it, I was done.

Similarly, Lester said,

> To be honest, the thing I think I used the most was dissociation. I have a lot of memory of being alone. I was in my own world anyway and that is where I preferred to stay. I think part of my love of reading books is it was a place to escape to.
>
> I read a lot. That was my escape. The house could be on fire and I wouldn't know it, when I'm reading. I block out everything else. I would read, and it would be my sole focus, everything else would just go away. What do they call that when you detach from yourself? Disassociate—I got pretty good at that, I'd just go away in my head.

Two of nine participants reported dissociation.

Avoidance/suicidal behavior. The avoidance/suicide behavior subtheme under the survival responses theme reflects suicidal ideations. A rich body of literature links childhood trauma to suicidal ideations and suicidal behaviors, as well as to other attacks on the self (Franklin et al., 2017; van der Kolk, Perry, & Herman, 1991). Paula, a 50-year-old woman, shared,

> I never acted on it, but I had thoughts and plans but never acted on it. The closest I came was before I had my son, and I thought about all kinds of things like turning on the gas and just letting it run, but then I thought, I was in an apartment and that might hurt someone else, and I can't do that. I thought about jumping in front of a car or bus, but I thought that would ruin someone's, people's day, and maybe traumatize somebody, so I

> didn't want to do that. [*Note*. Her prime motivation for not completing that act was caring about others].

In another example, Paula explained,

> The closest I got to suicide is I got a bunch of pills, and I was going to take them one night because my husband and were not married but we were living together—I wrote a story about it. It was New Year's, and I cooked my first turkey dinner and that is kind of a big thing for a woman. He went out to go to the office, and he never came home. I made this big turkey dinner and he was gone, and we had moved to Riverside. I didn't know anybody and didn't have any friends, and I just wanted to die. I was going to take the pills, and then I looked in the mirror and saw my face and it was like looking at somebody else, you know, you do a lot of the detaching thing where you look in the mirror and you don't recognize yourself. I saw a hurt little kid in the mirror. It was like, oh my god, this scared little kid, and I realized I was about to kill this scared little kid, so I threw the pills in the toilet.
>
> When I had my son, I decided I had a reason to live. Prior to my son being born, I was kind of suicidal a lot. I remember at that time I needed to take care of the little girl. I [was] called "Paulie" up until then, and I decided I needed to be strong and I was going to be "Paula," and I had people started calling me that. Paula was going to take care of Paulie. It was not until I had my son that I felt stronger, that I had to protect Paulie.

One of nine participants spoke of a suicide attempt.

Hypervigilance. The subtheme of hypervigilance emerged under the survival responses theme. Kayla, a 50-year-old woman, shared,

> Being able to find trustworthy people, that is a challenge too, because I have to rely on my own discernment of who is and who isn't trustworthy. How has that be challenging is that I am hyper protective and hypersensitive. I really rely on my intuition a lot, I am one of those people, and I think there is a lot of us. When you grow up in a household with alcoholics and drug addicts and people who have hot tempers, and then you add the whole idea of someone else where it is supposed to be a safe place, you know, sexually assaulting you, you become hyperaware of people's behaviors and body language and eyebrow raises, and you think, I know what that means. You ask questions, such as who I am going to adjust myself and put myself in a different situation. So, I have become this reader of people. I walk in to this room and assess everybody else's

> emotions based on their facial expressions and how they are holding themselves. You learn to read that so quickly.

Jessica stated, "The one thing I have a tough time doing is chilling out. I am always hyperaroused. My mind is always running and I'm doing 10 things at once and chilling for me is hard." Similarly, Larissa mentioned,

> One benefit from my experience is that I was able to learn how to deal with things on my own and not having to depend on someone. As I have gotten older, it has made me kind of self-reliant. For example, if I need something done, I know I have to get it done. If I feel bad, I don't have to wait for someone to feel better. It kind of taught me to depend on myself and not have to rely on anybody else.

Three of nine participants mentioned hypervigilance.

Theme 2: Betrayal Trauma

The second major organizing theme of the trauma the participants' experienced was betrayal trauma. Several subthemes emerged.

Perpetrator-as-scammer. A subtheme of betrayal trauma was perpetrator-as-scammer. Abuse is particularly troubling in familial environments that are supposed to be loving. The following excerpt shows that people who are abusive to family members may also be manipulative in their professional and public lives. Abusers appear to abuse in both their personal and professional lives. For example, Irene stated,

> We were homeless a lot; my dad was kind of a closeted gay guy and a "Flimflam Man." What is a Flimflam Man? He ran scams on people. He was very manipulative, very good at screwing people over. He was good at getting people to do things for him. I always wondered if he was gay, pretty sure it was confirmed because I found out, yes, he was kicked out of the Navy for being gay. There was always someone he was blackmailing, blackmailing different men. Sometimes all of a sudden, we would have all this money, and then we would be living in the car. I grew up in motels and cars and moving around a lot. He somehow managed to scam social security, he was getting disability payments at 47 and he was double dipping because he was getting disability for himself and the five kids that

> were still at home. He was also getting survivor benefits from my mom's account for all those kids. He was really good at manipulating things. All of a sudden we bought a home in a resort up in Mammoth Mountain. Then shortly after we were homeless again.
>
> So, a social worker finally came and to talked to me, but of course, she was completely scammed by my dad. How so, how did he do it? He told her I was angry because he had fallen on hard times and we were going to have this beautiful house with a pool. Like I said, it was kind of crazy. Umm, and she just believed him.

One of the nine participants described an experience that fit with the perpetrator-as-scammer subtheme.

Invalidation. A second subtheme under betrayal trauma was invalidation. The excerpt from Larissa highlights invalidation of trauma, which resulted in retraumatization:

> I told my mom, about the sexual abuse that occurred when I was seven and then I told my boyfriend I had at the time.
>
> Interviewer: How did they handle it?
>
> Larissa: First, my mom said, are you sure you did not make that up, or you sure that wasn't a dream, are you confused? I am, like, nope. I remember clearly what it was. She felt a lot of guilt because it was someplace that was supposed to be trustworthy, I was supposed to be with people who are taking care of me. So yeah, she felt very guilty. Since it was just her and me.
>
> Interviewer: Did it have any impact that you were sure, and it had happened, and she doubted you?
>
> Larissa: I felt really bad at first. . . . I replied to her, why I would make something up? It happened. When I was five. I am 16, 17 years old now and I am telling you, why I would lie? I got upset at first.
>
> Interviewer: What about your boyfriend at the time?
>
> Larissa: Umm, He wasn't very open about talking about it, but then I felt I had to express it to someone besides my mom. So, then I told him everything that had happened, and he was like, oh you were a kid, it's

> over, it could have been worse. He wasn't very supportive, but he was a kid as well. He was 18 years old.
>
> Interviewer: Was that uncomfortable to you that he reacted that way?
>
> Larissa: Yeah. It was very upsetting, because we had been together since I was 13. So, I had been with him for a while, he was somebody that was supposed to be trustworthy. Now that I think about it, I get it, he probably did not know what to do or say. In that moment, I was very angry. Very very upset. I didn't not want to just tell anyone besides my mom; he was like, the only person that I was, like, yeah, I could trust with that information.

One of the nine participants described an experience that fit with the theme of invalidation.

Historical trauma. The subtheme of historical trauma involves how betrayal trauma experienced by the participants was situated in a greater political and historical context. Excerpts highlight the impact of historical trauma in the form of racism. Gerry shared,

> We were one of the few families that had integrated into this neighborhood in Chicago. This experience was kind of traumatizing to [us] because [we had] to walk through white communities where we get picked on and teased. We had teacher use the N-word.
>
> I also experienced prejudice within my own race. You know because I [am] light skinned and then I was told, you know, the blacker the berry, the sweeter the juice kind of thing. It was just weird.

Jessica mentioned,

> Well, first and foremost, I am white and have white privilege, and I think that has helped me to become resilient despite the trauma that I endured. Even though I didn't really know what that meant until not that long ago, so there is that aspect of it. But also, going along with that, I grew up in a household where my dad would say a lot of racist things. I remember just always being angry; my dad and I would get into fights when I was in junior high about this.
>
> I remember saying to him you can't say that, Dad. He would just say dumb, inappropriate things, and I just knew that was not OK.

Two of the nine participants described experiences that fit with the theme of historical trauma.

Theme 3: Maladaptive Responses

A subtheme of maladaptive responses emerged under the trauma theme.

Suicidal ideation. Three out of the nine participants described experiences with suicidal thoughts.

Theme 4: Boundaries

A subtheme of boundaries emerged under the trauma theme. Boundary issues are often related to abuse, because abusive acts such as sexual abuse clearly show that perpetrators disregard victims' boundaries. Therefore, one of the negative side effects of abuse is difficulty in negotiating appropriate boundaries. "There is freedom in building boundaries around yourself and not apologizing for them" (Oakman, 2017). In a video, Brown (2016) noted, "Boundaries are about respect; here's what is OK for me and here is what isn't." Brown further noted, "If we don't set boundaries and let people get away with behaviors that are not OK, we are just resentful and hateful."

Irene mentioned,

> There have been times in my life where I've been needy, but I am careful about maintaining good boundaries because I would never want to consume somebody, and I expect the same in return. Many people can't do that. People gravitate towards me because I come off with a strong persona, but I am also sweet and gentle.

Kayla stated, "Sometimes the boundary issues are around that are taking on too much leadership in a situation." In a final example, Irene said, "I did have good male mentors. They were very respectful. Never felt sexually taken advantage of, ever, with them."

Two of the participants spoke of how the adversity experienced as children was related to the deployment of boundaries in adult relationships.

Toxic relationships. A subtheme identified as toxic relationships emerged under the boundaries theme. Interpersonal trauma can disrupt human attachment systems (van der Kolk, 1987); one of the ways to recover from these experiences is to seek new relationships. Traumatized people often develop negative attachments because it is better for survival than being alone. "People in fear attach to anyone, even bad attachments" (van der Kolk, 1987, p. 134). Paula said,

> I have had a hard time staying connected to people; it is one of my issues. My first husband at college, he was a classic sociopath/anti-social personality disorder. I hooked up with him and quit college and got pregnant and had my son. My husband was just bad news; he abused drugs and had many women.

One participant described how adversity experienced as a child led to toxic adult relationships.

Resilience Themes and Subthemes

Several themes exemplified moving from surviving trauma to resilience and growth from trauma.

Theme 1: Self-Care

The first major theme related to resilience was self-care. The participants spoke of specific activities or practices that they implemented to reduce the effects of trauma on their lives. Lorde (1988) said, "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare" (p. 131). The reason that self-care is an act of political warfare, especially for trauma survivors, is that interpersonal abuse

frequently results in self-loathing (van der Kolk, 1987, 2015). Therefore, self-love can be viewed is an act of retaliation to the maltreatment.

Reading. The first subtheme under self-care was reading. Many participants mentioned reading to cope and recover from trauma. Reading is noteworthy because it is an inexpensive approach to suggest to people who have experienced trauma. Larry shared,

> I read a lot. That was my escape. The house could be on fire and I wouldn't know it. When I'm reading I block out everything else. I would read and it would be my sole focus, everything else would just go away. What do they call that when you detach from yourself? Disassociate, yea I got pretty good at that.
>
> I think part of my love of reading books is it was a place to escape to. When I was young it was Hardy Boy type stuff. It all based on your ability. In school, they had book clubs and you could order books. Well not Hardy Boy, I can't remember It may have been the Scholastic book club. I would get a whole box full every time we ordered it was crazy. Interestingly enough, I even maintained reading after I had discovered drugs.

Larissa explained,

> When I was kid, I would, like, read a lot, a lot of imaginative type books. I was a huge Harry Potter fan when I was a kid. When I felt bad, that is what I would do, I would mostly read books.

Irene mentioned,

> I don't know, I just think learning to read with such a big thing. It showed that the teacher was kind and cared about me. I went from totally not knowing how to read. I remember looking at letters trying to figure out what they were. The teacher was so proud of me because I [went] into the high reading group by the end of the year. So, I would say, that made the biggest difference of all in my life.

Three of the nine participants spoke of how important reading was in developing their resilience.

Fictional characters. Fictional characters was a subtheme of the larger subtheme of reading. It was interesting how one of the participants relied on fictional characters to provide hope and develop resilience in the face of adversity. Stories the world over are almost always about people (or personified animals; Gottschall, 2012). Stories offer people feelings for which they do not have to "pay the full cost" (Gottschall, 2012, p. 58). The meaning behind the full cost is that individuals can develop relationships with fictional characters; there is no threat of the fictional characters abandoning them. Carl explained this subtheme:

> Carl: Even fictional characters were actually really important in my life. One of the major influences on me actually.
>
> Interviewer: What type of characters?
>
> Carl: It was cartoon characters. It was Naruto. I grew up with Naruto. Yeah, that fictional character Naruto really helped me when I was going through hard times. I have to say Naruto was one of the biggest influences, right next to my mom.
>
> Interviewer: What did the character embody that inspired you?
>
> Carl: So, it's all about perseverance and believing in yourself.
>
> Interviewer: Where does it come from?
>
> Carl: It's a Manga. It started as a cartoon drawn out. Yeah, it's anime, then adapted in television.

One of the nine participants explained the ability to derive support from fictional characters.

Education. Education was a resilience theme under the subtheme of self-care. Kayla explained,

> So, I started taking psychology, and I had to understand my mother a little bit better. I got to understand her and the trauma that she had gone through.
>
> I just thought it was messy human stuff, and it is, but the ACEs framework provided some kind of structure to say, oh, that is what happened to me, but it is not me. Yeah, definitely, it totally helped me see him [her brother] differently and have a lot more empathy for him at times where he was hurting me. I get why he had a raging temper and I get a little more why he could not self-regulate, it makes a lot more sense to me.

One of nine participants described how education helped contextualize the adversity she experienced.

Food. Food was a resilience theme under the subtheme of self-care. Obesity and overeating have been described as negative coping strategies to manage symptoms of trauma (Felitti, Jakstis, Pepper, & Ray, 2010). The experience of one participant in the current study, Carl, fit with the research regarding the connection between childhood trauma overeating, and obesity. Carl was able to change his eating habits as a young adult and lost the weight. Thus, the ACEs affected him, but obesity was not a permanent state. Carl shared,

> Yeah, something that was kind of negative, which was not a good coping thing that I did, when I was around eight when the stress was reaching its peak, I started eating a lot. So actually, I became obese at like 10 years old. I was eating pure junk food. Just like chips, I did not like candy, no sweets. I just ate a lot of junk food like chips and fast food burgers. I would look forward to that, eating junk food to make me feel better.

One of the nine participants mentioned using food to cope with adversity experienced as a child.

Drugs. Drug use was a resilience theme under the subtheme of self-care. Three subthemes related to the participants' negative effects of drugs: dissociating, avoiding

problems, and feeling out of control. The positive effects of drugs were anxiety relief, sense of connection with others, and some cognitive insights. Paula explained,

> Many people who experienced trauma turn to drugs and alcohol. I guess I was lucky, never found a drug I liked. I tried things but never liked anything.
>
> Interviewer: What did you try?
>
> Paula: Oh alcohol, I would get drunk, and it would just make me cry, or I would get into fights and just be told I am not allowed to drink. Smoked a lot of pot, didn't like it, it would make me paranoid. I tried acid a couple of times, didn't like that, didn't like feeling out of control. I tried cocaine one time hated that. Also tried speed a couple of times and didn't like it. It made me feel out of control; I guess some people say it makes the pain go away; to me, it made not aware, and I did not like that feeling.

Irene shared,

> My father started doing LSD; he was a successful man. He was the head engineer for the State of Utah back in the 1960s in Civil Engineering, but he also started doing LSD. But the time I was 12 or 13, he had started doing too many hallucinogens, and he was institutionalized for a while. My personal belief is that there is something valuable to be gained from mind altering substances, but you can't abuse them, and he abused them. He did a lot, a lot of LSD. Some of the best you can get your hands on back in the day. Consequently, he was hospitalized for being psychotic, and he still maintained his job at the State but they gave him a job with much less responsibility.
>
> The first time my father gave me and my brother LSD was when we were in Zion National Park. He comes from Mormon pioneer stock, and he gave it to us there when we were vacationing. So he gave me and my brother about a half a dose of window pane acid, and my younger brother and sister, he gave a quarter with our orange juice, and we didn't know it, but it was a brilliant day, it was lovely. It was not until I started to experiment when I was 14 or 15 that I realized what had happened that day. I was doing LSD on my own when I was around 15 or 16.
>
> Interviewer: What was that like for you?
>
> Irene: Actually, I enjoyed quite a lot. I would take it without anybody around. I would spend time kinda just walking around downtown. Salt Lake City was small back then where you could just walk around and watch people and do things. I did not like coming off of the drugs. I

> found that it was very difficult to come off of the drug. I would become really exhausted and during the comedown and get depressed. As a child growing up, I was really quite anxious and found either if I would take LSD, which I would get from my father or good mescaline or even psilocybin, it calmed my anxiety. You know I was not anxious. It also allowed me to focus more. I wasn't doing school work, but I could just focus on looking at the ground, or looking at the ants, or looking at the trees or just thinking about philosophical questions like predestination and things like that. I recall those kinds of thoughts. But, it was hard on my body and when I would come off of it, I would be really tired for a couple of days. I finally got to the point that I didn't think there was anything more to be gained from those drugs. So, I quit taking them.

Larry shared,

> Hmm, in that they were hugely distracting, yeah. In part of me was of the persuasion. One of the books that were popular then was a book called *Be Here Now*. It was kind of the perception aside from meditation that level on enlightenment could be reached by using hallucinogens. We got that message sort from Carlos Castaneda's books, and I think given some proper mentoring that might have been possible. But, in the world I lived in in Chicago that wasn't happening. I saw people having overdoses, and of course, you went to parties and put on records, and you tripped, and you had lights going on and backlight posters and blah. That is not pursuing enlightenment, that is just escaping for a while. We liked to get into discussions about expanded consciousness and things like that. Since it is mixing up the brain process anyway, what type of intelligent conversations are you having anyway?
>
> I have read with PTSD, there are some efforts to look into MDMA for therapeutic effects, but again that is in a tightly controlled [study] in an environment with therapists. As much as I can respect their thinking outside the box, how are you going to take that to the masses and you're still involving drugs. Since there is a way for the body to heal itself without drugs, so why don't we pursue that instead? I like the fact that people are thinking outside the box and are looking at things that were once considered illegal. Of course, there are going to be emotional reactions. Having seen people freak out and lose their brains and end up in hospitals, I kind of got that. I had people ask me for the acid that had a hard time smoking pot. I was, like, wait a minute, you smoke pot, and it makes you paranoid, and you think I am going to give you something to magnify that? You are talking to the wrong guy.
>
> Interviewer: Did you have any bad trips?

> Larry: Hmm, not with hallucinogens. Actually, that is not true, my last one. My last one was the only time that I was losing control, and I did not care for that. At the time, I had done a lot, and I will not argue that point. And so I was feeling that it was getting out of control, and I told my girlfriend, I am just going to be in here and listen to music, and eventually I will fall asleep, and I just need [you] to check up on me every hour to make sure I am still breathing. If you find that I am not, that is when you call 911 and get me some help.

Larissa said,

> This past February I took MDMA and LSD together, it was very fun. Before the experience, I had a lot of self-loathing, had really low self-esteem, and the experience of taking those drugs helped me to sympathize with myself, and you know what, I love myself. It is really cool seeing a huge difference with how I feel about myself. I felt a lot of self-love, I continue to feel it now in July. Smoking pot helps if I feel very anxious. I can smoke, and I relax. Whenever, I feel sick, I smoke, and it makes any negative feeling I have go away.

When asked what type of drugs she used, Kayla stated,

> All types minus I never did heroin and never shot up or anything like that. I fell into the scene of Grateful Dead lovers and did the whole, you know, working to get to the next concert and so marijuana, cocaine, ecstasy, molly, mushrooms, alcohol.
>
> Interviewer: What benefit did you feel you got from that experience?
>
> Kayla: Umm. Nothing good, I made a lot of really good friends, I experienced a different kind of life, and I would never take it back. It had helped me become myself a little bit more when I met these people. I felt very uncertain of who I was, and I had a really bad self-esteem. I did not think anyone cared about me and I did not think anyone liked me. So it was more about the people, but the drugs did become a way to kind of escape from certain memories and certain things. I mean, even before that when I was in my early 20s and went to the psych unit, I was drinking to the point of blacking out, I dropped out of college because I could not function. So, it was really pure self-medication.

When asked, "When did you first smoke marijuana?" Larissa said,

> I was 16 the first time I smoked. I didn't do it a lot then. Yeah, at first it was just like at a social thing, but then I got older, and I said let me try. I bought some.

Four of the nine participants described how they used drugs to cope with their childhood adversity.

Psychiatric drugs. Psychiatric drugs was a subtheme under the resilience subtheme of self-care. When asked, "Did you take any psychiatric medications?" Kylie said,

> I did, for a while in my early 20s, I was taking Amitriptyline. I was diagnosed with fibromyalgia, and they prescribed that, and I took it for a little bit, and then I did not take anything for a really long time until after I had my son and had postpartum depression and the fibro was really bad and then gave me Cymbalta, and I took Cymbalta for about six years, and now I am medication free.
>
> Personally, I think that is why drugs became an issue for so many people, including me. I think it was the desire and partly that cultural thing, but it was mostly, I think, a need to escape.

One of the nine participants described using psychiatric drugs to cope with adversity.

Exercise. Exercise was a common resilience theme under the subtheme of self-care, representing actions participants used to cope with trauma. Participants explained how exercise helped them. Irene stated,

> I would tell other trauma survivors to exercise so they can feel better about their bodies, so they can function better. That again would be through exercise.
>
> I don't feel like any of my dreams were destroyed. I have traveled the world. I have lived an incredibly active life. I had climbed the Himalayas. I am really fit for my age. I have challenged myself physically more than most people do in their entire lifetime.
>
> We did a double crossing of the Grand Canyon in a day; it was 50 miles and about 12,000 vertical feet. That was a great thing to do. I rode my bike when I was 50 up five Canyons. It amounted to 150 miles and 15,000 vertical feet. I was self-supported, I just had my credit card. I climbed the Himalayas up to 23,000 ft. I did my first marathon in 3:21, which was pretty good. I spent a lot of time climbing in Wyoming doing some pretty major technical climbs. There has been a lot of good kind things in my life. I do a lot of skate skiing; it's like cross country. I was always better than average. I used to do triathlons. I came into the world with a really strong physical constitution. I worked for it, but I actually did not have to work that hard to be better than average. I maintain a

> physical lifestyle and somebody might say that's self-medicating, but I think it's a positive way of self-medicating.

Paula shared,

> One of the things that has helped me to be emotionally healthy is being physically active. It has definitely helped, even as a kid. Just moving, like walking or anything that gets your body moving and active. Physical activity, working out really hard makes you feel better, it keeps you from getting depressed, and when you're angry, you can pound out 30 miles on your bike or whatever and pretty soon you're not angry anymore, and you feel better. I think that is a better feeling than being on drugs.
>
> I was running marathons and completing triathlons, and when I got injured, I could not do that stuff anymore. I did go into a real bad depression.

Two of the nine participants reported that physical exercise helped them develop resilience.

Yoga. Yoga was a subtheme under the resilience subtheme of exercise. Yoga appears to help people who have suffered trauma better regulate their nervous system (Dale et al., 2011, p. 98). Jessica mentioned,

> Within the last 10 years, I have discovered yoga, and that has been huge saving grace for me. Teaching me how to get into my body. Obviously, I have body issues just because of my sexual abuse history. Getting into my body and being there with it and breathing through stress and all of that, so that has been really beneficial to me.
>
> Interviewer: Any type of yoga?
>
> Jessica: It's Iyengar yoga. Yoga has been a very big part of my life. I am hoping to maybe turn that into doing something with kids. That's one thing I have a hard time doing is chilling out. I am constantly hyperaroused. My mind is always running, and I'm doing 10 things at once, and chilling for me is hard, so it is really good for me to learn that. At least I can go there for 90 minutes a couple times a week and clear my mind.

One of the nine participants reported practicing yoga, which helped her resilience.

Martial arts. Martial arts was a subtheme under the resilience subtheme of exercise. Gerry said,

> I was into martial arts, and I did have a lot of coins in my little purse, I did beat the crap out of them. You know. So I was looking into all sorts of ways to better myself fitness-wise—how to fight, even.

Similarly, Larry said, "I do yoga regularly; I stretch regularly, I am in a Krav Maga class. So, I keep myself active. I do all those things to promote posttraumatic growth."

Two of the nine participants reported engaging in some form of martial arts, which aided their resilience.

Meditation. Meditation was a subtheme under the resilience theme of self-care. Carl explained using meditation: "For me personally, it's about finding inner peace. Learning to control one's thoughts by meditation and breathing." Larissa detailed her experience with meditation:

> Well, also sometimes I meditate; that helps.
>
> Interviewer: When did you start doing that?
>
> Larissa: I did it sporadically when I was, like, 15. Then I stopped, I started again at 18, then I stopped. Recently, around six months ago.
>
> Interviewer: Do you do it by yourself or with a group?
>
> Larissa: Umm, when I was younger, I did it with my mom. We would meditate together. Then, as I got older, now I just practice meditation on my own by myself.
>
> Interviewer: Any particular style of meditation?
>
> Larissa: I just lay down and try to not think of anything, and then I just concentrate on the sound of my air conditioning. It is kind like white noise, umm, and that helps me relax and calm down and get my mind thinking about other things.
>
> Interviewer: How did you get into meditation?

> Larissa: Well, my mom used to talk to me about it when I was younger. I did it a little bit with her. When I got older, now I met new people and a lot of them meditate. They explain to me how they benefited from it, so I thought I could benefit from it too. Cause I was having a very hard time. Umm, with just, with how I was feeling and a lot of anxiety and a lot of depression, so that is how I started again with meditating and it's helped, it's helped a lot.

Larry shared,

> I use TRE, which stands for trauma releasing exercises. I would say TRE and meditation are my primary practices.
>
> Interviewer: How often do you meditate?
>
> Larry: Almost every day. Yeah, I practice Tibetan Buddhism.
>
> Interviewer: Have you done the silent retreats?
>
> Larry: I have not yet.
>
> Interviewer: Are the ways of reducing stress new?
>
> Larry: Newly developed. Meditation, not so much. I started meditating about 15 years ago.
>
> Interviewer: Where was that?
>
> Larry: That was back in Minnesota when we lived there. It was at the time of my separation from my wife. I was looking at it restoratively; I think because of what I read in Rick Hanson's books, it was keeping my amygdala and my hippocampus just off the edge of failure and part of why I do it, I know it helps a lot. I just like being quiet. I have a constantly active mind. So, it is great for that discipline.

Three of the nine participants reported engaging in some form of meditation, which helped to foster their resilience.

Faith and spirituality. Faith and spirituality was a subtheme under the resilience theme of self-care. Here are some excerpts that show how faith and spirituality related to resilience: Kayla said,

> Suddenly because my relationship with God made a lot more sense, I allowed some trust to occur there and, in the Bible, it says that He allows things to happen that aren't positive; He does not create them but He will turn them for good.

Jessica explained,

> I think there was a sense of some sort of purpose, you know, that I am not just here to have a shitty life. That there is something more out there, then again, I am. I have a problem with a lot of religions, but I have always had a sense that I was part of something bigger and more important than the circumstances I was under.
>
> Interviewer: What was that sense what were you apart of?
>
> Jessica: Umm. You know, that there is a whole universe out there that we are all connected from a human being, to animal to the blade of grass, that there is an overall accountability. That something that happens negatively on one side of the world can really affect the whole other side of the world and have a weird butterfly effect or something.

Two of the nine participants described how faith and spirituality contributed to their resilience.

Theme 2: Individual Resilience

Several subthemes emerged that indicate individual resilience.

Reframe. Reframe was a subtheme under the individual resilience theme. Reframe represented a resilience-based theme wherein the participants were able to change the meaning of the adversity they experienced. This process involves changing the meaning of an event to accentuate the positive. For example, Gerry said, "I never put up with any crap from anybody else. That was my empowerment. That was my ok this is not you rather it is the result of things that happened to me." Irene stated, "I see that these things have not completely ruined my life it depended on what I chose to do with

it. . . . I would guess that just regarding personality types, I am a more optimistic person than a pessimist." Kayla said,

> When I am stuck in this situation, what are multiple things I can be doing to change the environment? I think in learning to control things, you find out whether you have control or you don't. There are some things you don't, and there are some things you can change. Unless you try to change them, you feel stuck. I seldom feel stuck in my life because I feel like there are options and that has been positive.

Larissa stated,

> I felt so bad because I wanted to have a dad to be there with me to celebrate certain milestones. I was very sad, and I know there were a lot of moments thinking, "I don't have a father, I don't have a father," but it's like, I do have a father, it's just in the form of my mother and in other male figures in my life.

Three of the nine participants described experiences that fit into individual resilience theme of reframe.

Personality characteristics. Personality characteristics was a subtheme under the individual resilience theme. Kayla said,

> The word that I am looking for has to do with being a divergent thinker. Like OK, here I am stuck in this situation, what are multiple things I can be doing to change the environment?

Similarly, Irene indicated, "I rely on myself as well, as a strong person. Somewhat of an optimist. I have that characteristic about myself that I generally feel that there is hope."

Two of the nine participants mentioned specific aspects of their personality helped them achieve individual resilience.

Theme 3: Turning Points

Under individual resilience, the subtheme of turning points included moving, military, college, and having kids.

Moving. Gerry described her experience of moving:

Then my mom called me, and she said, "What happened, I want details." I was, like, you can't handle the details. My senior high school year, I moved out and moved in with my grandmother. I moved into grandmother's home. I stayed with her for about a year, and then I went to the military.

Military. Regarding the military, Gerry said,

I ended up joining the military. I was one of six women who at that point had graduated from military police school. That was hard. They could kill two birds with one stone being that I am Black and the other being female.

Growing up, there were a lot of turning points and opportunities to be strong, and what I mean by that is, that they had just opened up the military police field to women. They were doing away with the women's army corps about the time that I came in. We went through the same training as the guys did and then I had the opportunity to be a military police officer, which is something I said I was going to do since I was a young girl.

College. Kylie stated,

A phone conversation a couple days later, my father's words for me were "You are a waste of a life," and I was, like, wow, that is pretty harsh. I think I know my dad, and I know where that was coming from, and that is more coming from his disappointment because I was first of three children, I was the youngest, the first to graduate high school. The first to go to college, I was the first to do many things, and he had a lot of hope for me, and he knew who I was. Completely not living up to his hopes and dreams. So, those words really stuck with me. I was, like, no, I am not going to be a waste of a life, I have a life, and I have something to offer to this world, and I am not going to waste it. At the time it was the worst thing he could have said, but it was a real driving force for me to live a productive life.

Having kids. Paula mentioned,

When I had my son, it helped me to understand that I had been abused. You look at your own kid and see it. I was like, Oh my god, I would never treat my child like that. I didn't want him to be in poverty like way I grew up.

So I moved out on my own before I turned 17. I got a job as a dishwasher. What really helped was California came up with a test that

> you can get out of high school if you passed it, and I passed it. I hitchhiked with a friend to take the test.

Three of the nine participants reported specific turning points that were catalysts for their individual resilience.

Theme 4: Nature

Nature was a subtheme under the individual resilience theme. Kayla mentioned,

> Regarding animals, I would say that they have a place in the natural world—and nature soothes me. I love to be in the mountains, in the woods, at the seashore—I appreciate animals/creatures as part of that experience. I find I seek nature more than animals. Nature, now, is a place of sanctuary, solace, and healing. I receive a feeling of safety and freedom of mind when out of doors. I think about boundaries (physical, emotional, sexual, spiritual, and mental) as I write this. Perhaps my mental boundaries find and require rest in nature. And perhaps, I now need that respite, at this point in my life much more than before. The rest from vigilance that I needed at an earlier age around physical, sexual and emotional boundaries was different, and my animal interactions provided me safe creatures to touch, pet, to which to express love, fear, sadness without inappropriate demands.

One of the nine participants mentioned spending time in nature helped to promote individual resilience.

Animals. Under the nature subtheme was the subtheme of animals. Several excerpts provide support for the resilience subtheme of using animals for attachment needs. Kayla said,

> I had a horse, and the horse that I had was on the property where I was in danger from time to time. So, I would escape in nature being outside and feeling that freedom having that confident in an animal.

Irene said,

> I have dogs that I dearly love; they give me a lot of joy.
>
> Yes, I enjoy animals still today, but I would not say that I am not emotionally reliant on them as priority companions. I prefer people to talk to.

Two of the nine participants reported that they met their attachment needs from animals.

Theme 5: Social Support

Social support was a subtheme under the resilience theme. Excerpts from the interviews provide support for the subtheme of social support. Irene mentioned, "I would say that my friendship network has been really important to that [sustaining through tough times]." Carl stated,

> Most importantly, one of the things that I recently began to understand is the power of social networks. I think I always have social, but I was a little shy as well as young person, so I didn't have a big social network. Around the age of 20, I started seeing if I had this social network and acted friendly toward people and practice prosocial behaviors and people reciprocate, and it just helps. It contributes to building more friends and acquaintances, and it gives you more resources as well. It is crazy because evolutionarily speaking, that is how humans are wired.

Gerry indicated,

> I guess for me is having people who were willing to recognize that there was a pain in the variety of ACEs that were experienced. Shared among some people, so there was the commonality, so if I had friends that also suffered from the same types of trauma, and we could connect by sharing.

Kayla explained,

> The conversations I have had with friends is reminding them what happened to them as children was not their fault, that they don't own the behavior of adults in their life; and even though it impacted them. It is kind of addressing the shame and saying you don't own that you felt that shame, and you are not the source of that, and it was externally put on you. Helping people just see that sometimes. I think it is helpful. That shame often keeps us quiet and reinforces our silences and when there is silence, you create a world where you are in that denial, and you feel that you have something to hide, and then people can't know you. I think that at least for me, being known and accepted for who I am and all I have been through is really important. I just want to know that I am lovable, and I want to be able to be vulnerable to that.

Three of the nine participants expressed statements that fit with the individual resilience subtheme of social support.

Social services. Social services was a subtheme under the resilience theme of social support. Next are excerpts from interviews that supported the theme of social services. Paula explained,

> At the time, there was something called voluntary placement if you were having trouble with your kid. With voluntary placement, you were able to ask for foster care as a parent to get the kids out of your house for a cooling-off period.
>
> I ended up going into foster care at age 15, and then even told my foster mother that I would only be there for a couple of months. I was basically the brat that was just mad at my dad. He was a wonderful man, I was going to want to go back to. This program got me out of my house and away from my dad, which saved my life.
>
> Interviewer: How was the foster mother?
>
> Paula: Mixed bag, I was safe, and I wasn't getting beaten up, but he was kind of cold and detached, it was very complicated.
>
> Yeah, real minor compared to what I grew up in, it was very complicated. Yeah, there was some abuse, my foster dad choked me twice. Including the night they took me out of there because I was mouthy. Of course, I told her I thought I was going nuts and needed to be in counseling but we lived way out in the country so that would have meant her taking me somewhere. So she was, like, no, you don't want to do that while you're in foster care because it will be public records. None of it will be private.
>
> Oh wow, hmm. I think I was very lucky. There were supports there; you know the fact that there was voluntary foster placement and even though the foster parents weren't the best, but it saved my life. The opportunities to get an education it provided were great.

One of the nine of the participants highlighted how integral social services were to her recovery from adversity.

Psychotherapy. Psychotherapy was a subtheme under the resilience theme of social support. The following excerpts provide evidence for the theme of psychotherapy

in facilitating resilience from trauma. Irene said, "Sometimes talking to a therapist is a good thing because it helps put that context back into line." Larry stated, "I have seen therapists over the years and with my ex-wife, not one of those therapists brought up the word trauma. Never even bothered mentioning trauma or even PTSD." Jessica explained,

> I would say a counselor in my late 20s being able to rely on her and go in and kind of lose my shit and know it was OK to do that. I pull it together and would be, like, nothing is wrong again, that was really useful [emotion regulations were cathartic].
>
> I went back into therapy. I found out about all the research being done on ACEs, found the ACE website, and my therapist has been doing EMDR therapy with me. She has begun to turn off all that background music, which I didn't think was possible. I guess the background music would be PTSD memories, which I've learned are stored in a different more primitive part of the brain, and EMDR helps you turn them into regular memories instead of trauma memories or flashes of memories. Amazing I've carried all this shit with me for 56 years, and now I'm making it go away. As a result, now I also have fuller more complete memories of my childhood, and they are not so emotionally charged.
>
> I have also been to therapy many times in my life off and on. That is one of the ways I have tried to deal with this.
>
> Interviewer: When did you first going to therapy?
>
> Jessica: So, I started probably when I was 25, going through my divorce. I got married young, married my college sweetheart at the time. We were married at 23 and divorced at 26 and that was very traumatic for me because he was pretty much the first man that I ever trusted. I honestly had issues with men given that I had to sort out not having a great father and an uncle who molested me. So my relationships with men were strained. So, he was the first man that I ever really trusted, so us getting divorced was really difficult for me. I gained a bunch of weight. I was also going to grad school at the time, so I just had a lot on my plate. I was pretty miserable, I was kind of depressed. So, that is when I started going to therapy for the first time. Then I went to therapy again through my graduate program. Actually, it was a requirement in my program that we see someone for, like, 12 sessions.

Larissa mentioned, “My university has a mental health center, and I would go there sometimes to talk to a therapist there and she helped me.” Irene shared,

> I just know if with Susan, my therapist, if I call her and I’m in a crisis, I know she’ll be there for me, but I’m never in a crisis. She is my therapist. I would never take advantage of that. There have been times in my life where I’ve been needy, but I am really careful about maintaining good boundaries because I would never want to consume somebody. I expect the same in return, but a lot of people can’t do that. People gravitate towards me because I come off with a strong persona but I am also sweet and gentle.

Jessica said, “I mean I've been out of school for 12 years now; it was really helpful. It was in the context that you couldn’t really help others until you tapped in your issues.”

Five of the nine of the participants described how psychotherapy was beneficial to gaining individual resilience and recovery from adversity.

Positive adults. Positive adults was a subtheme under the resilience theme of social support. Several excerpts support the theme of a positive adult in fostering individual resilience. Jessica indicated,

> Yeah, I had coaches, and also had some amazing teachers, you know. I had love at home. It was not like I was completely neglected at home, it was just my family was not very sophisticated in understanding how to deal with the trauma we were experiencing. No one ever talked about it. For me, being in school doing well, having teachers that kind of mentored me, and then having coaches, kept me out of a lot of trouble. I had friends that were doing drugs and cutting class, and I was not doing any of that because I know I would not be able to do what I was doing if I was not going to school.

Larissa stated, “So when I was going through tough things as a kid, it was mostly my mom. Then I as have gotten older, it has changed more toward friends and stuff.” Gerry mentioned,

> Mr. Williams, my junior year high school teacher, said, “You could do so much more with yourself because you are so strong and you are such a

> leader, but I see you just half-stepping." By half-stepping, he meant I was just doing enough to get by. He knew that could I be so much more. Those words kind of stuck with me my junior year in high school. At first I was, like, oh wow; after that, I started getting really good grades.

Kayla explained,

> So, my dad when I first started kind of remembering what was going on, I was drinking really heavy, you know, I was only 20, so I was not old enough to be in the bars. My dad said, "You keep coming home like this I am kicking you out of the house." So I came home one night at three o'clock in the morning stumbling, I could not even make it. He said, "Don't even bother coming, you can take yourself right back out because I told you if you come back in like this you are done, see ya, you don't live here anymore."

Larissa explained,

> Oh well, I didn't have a lot of friends, it would usually be like one or two, like, I would just talk to them when I would be going through something, and they would tell me it's OK, you know. Or they would invite me to come to their house, and we would play. Mostly kind of distract me from it rather than actually help me. I was mostly around like 16 or 17 that I would talk to my friends about it. I also had a boyfriend, and he helped sometimes too. Now I am more open; if I have something going on, I try to address it right away instead of suppressing it. Now it is more with my friends and now I can actually talk through it.

Irene said,

> I have friends, I'm really good at meeting people, engaging people; I do have a few close friends that I trust. I maintain a physical lifestyle.
>
> Nannies. With the sexual abuse, I don't remember disassociating because the abuse was intermittent. When we had the nannies, I was fine. He would not bother me. My aunt, and uncle and some of my nannies. Some older guys that were respectful and helped me as well.

Six of the nine participants mentioned that positive adults in their lives were catalysts for their individual resilience.

Community. Community was a subtheme under the resilience theme of social support. Here are some statements that highlight the community aspect of individual resilience. Community serves an extended family system. Irene shared,

> I would tell people to find a community where you feel like you belong and where people, are loving and nonjudgmental. I don't know where that community is for these people, but it could be just one or two people who you can trust, and it is important to find a safe environment. When you have been severely traumatized, nothing seems safe.
>
> Interviewer: Where did you find your community?
>
> Irene: Initially I found it with my husband and his family. They became the family I never had. I am still close with his mother. I still help my former husband. I found my community within my husband's family.

One of the nine participants mentioned that community fostered individual resilience and recovery from adversity.

Theme 6: Service to Others

Service to others was a subtheme under the resilience theme.

Prosocial. Prosocial was a subtheme under the resilience subtheme of service to others. The following excerpt from Carl directly exemplifies prosocial behavior:

> Most importantly, actually one of the things that I recently began to understand is the power of social networks. I kind of, I think I was always social but I was a little bit shy as well, so I didn't have a big social network, but as I was around the age of 20, I started seeing if I had this social network, and you are friendly toward people, and you practice prosocial behaviors, then they will kind of reciprocate, and it just helps. It helps to build more friends and acquaintances, and it gives you more resources as well. It is crazy because evolutionarily speaking, that is how humans are wired.

Paula indicated, "I'm a caretaker. I think that has been my drug, my way of getting away from the pain."

Two of the nine participants described how their service to others helped enhance individual resilience and their recovery from adversity.

Sharing stories. Sharing their stories was a subtheme under the resilience subtheme of service to others. Participants spoke of sharing their stories of trauma and recovery with others in a public forum. This was a recurring theme in the interviews. For example, Gerry said,

> Whether you do it with a friend or you actually get counseling, and I tell you, when I had my breakthrough, when I had to really address everything instead of holding it in, it happened out of the clear blue sky. The social service agency I was working for was beginning to start a group home for adolescent boys that were seriously emotionally disturbed [SED], and a lot of these kids had trauma. One kid had a sexual abuse history. So, working with those kids and doing some self-disclosure by sharing some of my experiences with them was really helpful to my recovery.
>
> What I guess for me is having people who were willing to validate it. Recognize that there was pain in the variety of ACEs that were experienced. Shared among some people, so there was commonality. So, if I had friends that also suffered from the same types of trauma, we could connect by sharing.

Kayla indicated,

> You know it is interesting because just in the last five years or so, I have gotten the courage to share some things and there are other things that I am still not that excited to talk about.
>
> Started sharing my story when I was a teenager just with friends, and when I would see that sadness, or when I could tell something was wrong. I was able to ask the right questions and forge the relationship to create the trust and safety, and when they would share something with me, I would often offer something back, and say, yes, I get that and here is how I get that. So, it is kind like testing the water, and very often I would ask people to trust me before I trusted them and them.
>
> I was about 16 or so, but my aunt actually disclosed to my father that she was molested by the same person in her family and suggested perhaps I had the same experience. When that had happened, it kind of blew up a little bit and it was not my choice to disclose and yet. I was put in a situation where I was being asked to disclose, and there was something cathartic in that. In a way I didn't have the option, and the lid blew off, and things erupted and got a little crazy, and I felt a little

> betrayed and all that kind of stuff. Then afterward, I guess after enough time I felt better, and to not have it a secret and that helped, and in the long run, I guess my perspective is that it is better if somebody does disclose. Matter of fact, it probably would have been better if she had disclosed when I was three or five or seven and not waited until I was a teenager because at that time, it had stopped because I made it stop. It was more when I was three, six, or seven that I really did not have much power so. Anyway, if someone had blown the lid off earlier, maybe that would have been traumatic at the time, but it probably would have been better. Just really started to disclose things more publicly about a year ago and decided to do so within a church context.
>
> I would have to say that I really felt inspired spiritually to share my story. It was something that I felt that I needed to do for myself because there may have been other people who I needed to do it for too. It seemed like a big risk to me at the time, but it did not end up being one. I have a lot of support.

Jessica mentioned,

> I didn't talk about it because my family, we just didn't do that, and I am now 40 years old, and I am finally beginning to tell my story. Just in the last 6 to 12 months, I have been disclosing to people that I am a survivor of sexual abuse. Telling your story and finding others around you and doing things that make you happy, whether it is writing or music or riding a bike or doing things that fill you up and make you feel happy and just doing more of that.
>
> Well, first and foremost, you have to share your story. You know, that is something that I am coming to terms with. I think when you do that, it frees you, and you will find that you are not alone. So, I think that is key, knowing that you are not alone in this and that other person have experienced what you have experienced. There is kind of a weird camaraderie in that.

Irene explained,

> I think the other thing is finding someone you can talk to that you feel really safe with and that you can be your true authentic self and share your story and not be judged and just begin to connect with others on it.

Three of the nine participants said that sharing their testimony of trauma in a public forum helped them embody individual resilience.

Human service. Human service was a subtheme under the resilience subtheme of service to others. Here are some excerpts that support the theme of human service.

Gerry shared,

> When I became a counselor, I had survivors group with people who have experienced sexual abuse or domestic violence. I ran groups for adults as well as kids. So then I was a victim of sexual abuse, being exposed to domestic violence as a child too. I channeled all that and became the advocate for the underdog, I always root for the underdog.
>
> By seeing the good work that I do, I acknowledge the fact that I am a survivor and have helped others survive.

Paula explained,

> Once I had my son, I knew things needed to change. One of the things I started doing was the battered women's movement. Which was kind of a new thing at that time and that was really helpful. I started [turning point] volunteering when I was still married to that guy. I started volunteering at the shelter and taking crisis calls from battered women and that was kind of empowering. I could not save my mom, but I could save other women.

Larissa said,

> I am also involved in an advocacy club at school. Oh yeah, it has been great, I feel like I can make a difference for other people and it's not just people in my local area, it can benefit people worldwide. I got to meet people of similar ages that have similar thoughts as myself at conferences. I have also learned a lot about myself, what things I believe in, what I agree with, and what I don't agree with. It has helped me shape what I want my career to be. I want to be a physician, but I want to concentrate more on advocacy, but from a medical perspective.

Jessica said,

> There is a reason why I went into child welfare. Specifically, working with abused kids. There is a reason why that is what I gravitated towards and where I ended up for many years. Just having that lens and wanting to save those kids. Like I saved myself, and I do believe that I saved myself. There were other adults in my life, but my parents didn't take me to see a therapist or help me talk about my feelings. They didn't process it with me. I had to kind of figure all this stuff out on my own. You know my hopes and dreams have changed a lot of over the years, I had known that I have wanted to work with people, and I wanted to help people somehow.

> I have always known that I have wanted to work with families, in particular, umm, you know, I guess they haven't changed that much, but they have evolved, they have gotten a little more finite. The have become more specific in how I am doing that. How I am making my greatest contribution to the world.

Four of the nine participants described how their experience of childhood adversity led them to work in the human service profession and thereby build individual resilience.

Empathy. Empathy was a subtheme under the resilience subtheme of service to others. It seemed that the experience of adversity enhanced the participants ability to be empathetic to other people from various different groups. Two of the nine participants described how they connected with people from LGBT groups despite identifying as heterosexual. This example shows the experience of childhood diversity maybe a catalysts for bridging ingroup and outgroup differences.

Summary

Nine participants were interviewed and recorded, and later, the interviews were transcribed. Participants described the effects trauma had on them. They described different responses that are often classically described in the literature, such as fight, flight, and freeze; dissociation; and hypervigilance. After reflecting on the interviews, I wondered if their descriptions were based on their actual experiences or whether they were instead influenced more by societal discourses on childhood trauma that typically frame these experiences in a particular way.

Participants described different strategies they used to manage their traumatic experiences. These strategies included activities such as meditation, exercise, and reading. I classified this category of activities as self-care because it encompassed self-

driven activities to increase participants' resilience. I particularly noticed that many of the participants mentioned reading .

In addition, many of the resilience factors the participants described involved relationship-oriented activities. The first of these was psychotherapy; some of the participants mentioned talking to a psychotherapist was the first time they felt believed by a professional. They described other adults in their lives who helped to promote resilience. Obtaining social services was also mentioned as helping several of the individuals get the proper support to develop better lives for themselves. Later, the resilience themes emerged on a broader scale. Public testimony of their stories appeared to promote resilience. Many of the participants were driven to get involved in social causes, which furthered their resilience.

CHAPTER V: DISCUSSION AND IMPLICATIONS OF THE STUDY

What happens to people matters to them. Adverse childhood experiences (ACEs) strongly influence adult health (Felitti et al., 1998). Previous researchers have found a dose-response relationship between the number of ACEs experienced and the number of negative adult health symptoms (Anda et al., 2006; Chapman et al., 2004; Clark, Caldwell, Power, & Stansfeld, 2010; Felitti et al., 1998; Koskenvuo, Hublin, Partinen, Paunio, & Koskenvuo, 2010; Schilling, Aseltine, & Gore, 2008; Turner, Finkelhor & Ormrod 2010, Walker et al., 1999). This dose-response relationship means the frequency of ACEs experienced as children directly relates to the number of adult health conditions. Researchers have proposed a causal mechanism, referred to as *toxic stress* (Shonkoff et al., 2012, p. 241). It is thought that prolonged stress affects the major bodily regulatory systems, making an individual more prone to diseases ranging from diabetes to multiple sclerosis (Shonkoff et al., 2012).

One of the unique aspects of this study was that I interviewed participants who were familiar with the ACE study. The ACE study was the seminal study conducted by Felitti and Anda at Kaiser Permanente that showed the dose-response relationship between the number of ACEs and adult health outcomes (Felitti et al., 1998). Thus, the participants made sense of their resilience from the perspective of their awareness of the ACE study. Traditionally, definitions belong to the definers rather than to the defined (Morrison, 1987). Specific to adversity, survivors do not define the terms *resilience* and *trauma*; researchers and policymakers define these terms. However, defining people's realities for them can be one of the most insidious and devastating forms of power wielded by mental health professionals (Spandler, Anderson, & Sapey, 2015).

In this study, the process was reversed. I discovered the meaning the participants attributed to the trauma they endured. Listening to people's stories, told in their own words, reaffirms their humanity and may give rise to fresh ways of building their resilience (Rich, 2009).

ACEs affect adults in a variety of nonspecific ways (Cecil, Viding, Fearon, Glaser, & McCrory, 2017). Descriptions of ACEs have emerged largely from cultural discourses on physical abuse, domestic violence, sexual abuse, and neglect (Tal, 1996). Many ACEs have involved relationships between victims and perpetrators and between males and females (Tal, 1996). Relationships matter. For example, narratives of female sexual abuse survivors have shown that American men perpetrate violence systematically and regularly upon American women, implying U.S. society is complicit in the oppression and subjugation of women (Tal, 1996). For example, the term *damaged goods*, often attributed to women who have endured sexual violence, has historical roots stemming from women being considered property of men (Brownmiller, 1975, p.18). This idea originated from rape cases in which women's lowered value (as "damaged goods") resulted in the loss of face suffered by an owner who could not protect (or could not control) his property (Brownmiller, 1975).

In this chapter, I organize themes contextually in accordance with my interview questions. At the beginning of the interviews, I oriented the questions to the trauma; later in the interviews, I asked questions about participants' responses to the trauma. The resilience-based responses centered on making meaning of what happened. For example, connecting with other trauma survivors for support and solidarity was central to the

meaning-making process. In addition, participants connected their personal struggles to broader social justice-based causes such as domestic violence. Therefore, the participants' replies fit with the altruism born of suffering theory (Staub & Vollhardt 2008). At the beginning of the interviews, the participants described their experiences regarding "reptilian" survival strategies—freeze, dissociation, and hypervigilance. Reflecting on these strategies, I questioned how much of their response was attributable to a "surveillance of self" stemming from the dominant belief that people who experience trauma exhibit these responses. In fact, one of the participants described her identity in exactly this way. She said, "Yup, I was a freezer." It is noteworthy that she used the past tense to show her progress.

Doubled-Edged Traits

Despite these survival-based responses, which are typically viewed as negative, I discovered these responses were double-edged. For example, responses such as dissociation, freezing, and hypervigilance often served a protective function (Burstow, 1992, 2003, 2005). This protective function was consistent with a feminist perspective that reframes trauma symptoms as "coping skills" rather than organizing them around the "PTSD" (Burstow, 1992, p. 112). Much of the negative aspect of these responses occurs when a person continues to exhibit the response when the threat is over (Burstow, 1992). These survival-based responses are problematic when the response does not match the environmental context (McCarthy-Jones, 2017). For example, suicidal ideation does not seem to have any positive qualities; however, suicide could be a consequence of having a greater sensitivity to stress. So the the increased sesntive stress has both negative and

positive aspects. In the interviews with survivors, I found that empathizing and caring for others interrupted the participants from acting on their suicidal thoughts. This shift in their thinking fits within the theory of altruism born of suffering (Staub & Vollhardt, 2008; Vollhardt; 2009; Vollhardt & Staub, 2011). This shift in thinking seems to fit into the double-edged category because the positive shift was incubated by a negative affective state.

Trauma Themes and Subthemes

From the data, I found four trauma-related themes that encompassed ways participants coped with trauma and led successful lives.

Theme 1: Survival Responses

The first trauma theme revealed in the analysis related to survival responses to traumatic events. These classic responses emerged organically from the interviews. Throughout the literature, these responses have been identified in humans as well as in nonhuman primates (Levine, 1997, 2010).

Freeze response. The first subtheme under the theme of survival responses to trauma was freeze response. This classic bodily response associated with trauma also appears in animals (Levine, 1977). According to Levine (1997), "Physiologists call this altered state the 'immobility' or 'freezing' response. It is one of the three primary responses available to reptiles and mammals when faced with an overwhelming threat" (p. 16). Sexual assault is a form of trauma that appears to contain the salient elements associated with tonic immobility in nonhuman animals, namely, fear, contact, and

restraint (Suarez & Gallup, 1979). Tonic immobility is protective in the sense that it signals to the attacker that the animal is hurt or dead and to leave it alone (Levine, 1997).

Dissociation. The second subtheme under the theme of survival responses to trauma was dissociation. Van der Kolk (1987) explained the role of dissociation: "Dissociation is adaptive: it allows relatively normal functioning for the duration of the traumatic event and leaves a large part of the personality unaffected by the trauma" (pp. 186–187). Several of the participants described that they dissociated during the time they are victimized and described it being necessary for their survival.

Avoidance/suicidal behavior. The second subtheme under the theme of survival responses was suicidal behavior. The findings from the data gathered in this study showed that empathy and compassion were protective factors that prevented individuals from carrying out the act of suicide. I inferred from the data that the participants' experiences of trauma heightened their empathy, which prevented suicide attempts. Early childhood adversity appears to lead to biological and genetic changes that increase the likelihood of reacting to stressors with suicidal behavior (Brodsky, 2016). Research from epigenetics has shown that traumatic experiences can alter stress hormones, which may lead to greater likelihood of suicidal behavior (Brodsky, 2016).

Hypervigilance. The third subtheme under the theme of survival responses was hypervigilance. Hypervigilance, a trait often observed in those with traumatic histories, can be considered a double-edged trait. Hypervigilance protects individuals by affording them a greater sensitivity to threats, which can help them avoid dangerous situations (Ellis, Bianchi, Griskevicius, & Frankenhuis, 2017). However, hypervigilance makes it

challenging to develop trusting relationships (Ellis et al., 2017). Trusting relationships are critical for allowing those recovering from trauma to enjoy successful lives (National Scientific Council on the Developing Child, 2004). Many people exposed to trauma have experienced heightened sensitivity to threats in their environment (Ellis et al., 2017). Trauma-exposed children often exhibit information-processing biases that facilitate rapid identification of environmental threats (Ellis et al., 2017). One such bias involves heightened perceptual sensitivity to anger (Ellis et al., 2017).

Children with trauma histories identify anger using less perceptual information than do those without trauma histories (Ellis et al., 2017). Traumatized children often classify a wider range of emotions as anger than do children who have never experienced trauma (Ellis et al., 2017). For example, Kayla said, "I have become this reader of people. I walk into this room and assess everybody else's emotions based on their facial expressions and how they are holding themselves. You learn to read that so quickly." Moreover, trauma-exposed children exhibit attention biases to threatening social information (Ellis et al., 2017). These attention biases include faster attentional engagement and delayed attentional disengagement from anger (Ellis et al., 2017). In social situations, evidence has shown that children exposed to trauma are more likely to notice threatening cues and ignore and generate hostile attributions, compared to children without trauma histories (McLaughlin & Lambert, 2017, p. 5). According to the polyvagal theory (Porges, 2007), however, this heightened sensitivity of the autonomic nervous system might dampen the ability to express socially "trusting" behaviors (Porges, 2007). Many of the participants in the study described being hypervigilant—some even

used the word. The positive link that has not been emphasized in the literature is that their hypervigilance also made them more aware of the suffering of others. Connecting to the suffering of others was pivotal in their resilience. The other side of hypervigilance described in the literature is a blunting of the brain's reward pathway (Teicher & Samson, 2016). The participants did not describe their reward pathway being blunted. However, this finding is not well known in the public consciousness and may account for why the participants did not describe it. A blunted reward pathway could lead some people who have endured adversity to seek high-risk physical activities such as extreme sports. The participants did not describe having trouble deriving pleasure from their rewards.

Theme 2: Betrayal Trauma

The second trauma-related theme emerging from the data was betrayal trauma, referring to the type of trauma participants experienced. The participants described that their abuse was perpetrated by family members or family friends rather than strangers. This fits in to the category of betrayal trauma. Jennifer Freyd a psychologist developed the term *betrayal trauma* in 1996. Betrayal trauma refers to a social dimension of psychological trauma, independent of posttraumatic stress reactions (Freyd, 1996). Betrayal trauma occurs when the people or institutions on which a person depends for survival violate that person's trust or well-being (Freyd, 1996). Childhood physical, emotional, or sexual abuse perpetrated by a caregiver can be considered a betrayal trauma (Freyd, 1996). One key feature of this type of trauma is that it challenges belief systems regarding the benevolence, predictability, and controllability of the world (Tedeschi & Calhoun, 2004).

The timing of the trauma is important. Research has shown that trauma has the greatest impact on the brain and nervous system during two sensitive periods (Olsavsky et al., 2013). The first period occurs during the toddler years (Olsavsky et al., 2013). The second sensitive period occurs during the peripubertal years, the period between childhood and adolescence (Morrison, Narasimhan, Fein, & Bale, 2016). The term *sensitive period* evolved from an earlier term, *the critical period* (Morrison et al., 2016). The difference in the two terms is important. From the critical-period perspective, abuse or deprivation during this time damages the child for life (Morrison et al., 2016). However, mental health professionals now know that with psychosocial intervention, a lot of these detrimental effects can be reversed (Morrison et al., 2016). Thus, the term *sensitive period* implies the brain is more sensitive during specific times, but the damage can be reversed.

Perpetrator-as-scammer. Under the betrayal trauma theme was the subtheme of perpetrator-as-scammer. This subtheme represents the permeability between people's public and private lives. Encountering "scammers" in an adult's business lives could potential indicate abuse is taking place in their domestic environments as well. This abuse may take the form of physical violence against their partner or physical and or sexual against their children. This subtheme fits with sociological imagination theory (Mills, 2000). Employing sociological imagination requires studying people's biographies and placing their biographies in the societies in which they live (Thompson, Cox, & Stevenson, 2017). Mills (2000) states, "Perhaps the most fruitful distinction with which

the sociological imagination works is between 'the personal troubles of milieu' and 'the public issues of social structure'" (p. 8).

Invalidation. Under the betrayal trauma theme was the subtheme of invalidation.

Invalidation is as an experience in which people's thoughts, feelings, and experiences are disregarded, trivialized, or negated (Linehan, 1993). One of the participants described how her experience of sexual abuse was invalidated and lead to some issues with anxiety and depression later in her life. Invalidation is a common experience for people who have experienced traumatic events (Hong & Lishner, 2016). Like betrayal trauma, invalidation can occur on the interpersonal level as well as at the institutional level (Hong & Lishner, 2016). The experience of invalidation makes it more likely people may develop mental health disorders such as borderline and bipolar disorder if they have experienced abuse (Hong & Lishner, 2016). However, one of the limitations of Hong and Lishner's research was that the researchers linked invalidation to DSM categories, rather than highlighting how the experience of invalidation leads to less resilience and more trauma-related symptoms. Researchers at the British Psychological Society have recently attempted to create an alternative diagnostic framework to the DSM-V, called the Power Threat Meaning Framework, that gives greater meaning to trauma and power structures (Johnstone & Boyle, 2018).

Invalidation often appears in childhood trauma (Theimer & Hansen 2017). First, the original trauma occurred; next, a secondary trauma occurs when other people do not believe the testimony, often blaming the survivor. For example, after survivors of childhood trauma report their abuse, family members may question whether the event

actually occurred (Theimer & Hansen, 2017). Further, family members may question the significance of the event and the degree and intensity of the perpetrators' actions (Theimer & Hansen, 2017).

A parallel process occurs at the macro level (Nemeroff, 2017). However, a disparity exists in the level of funding for research into childhood maltreatment (Nemeroff, 2017). Nemeroff noted the disproportionate amount of overall NIMH funding compared to the funding given to research on the link between child maltreatment and adult psychopathology. In fact, some researchers have dismissed the significance of childhood maltreatment and, specifically, childhood sexual abuse (Rind, Tromovitch, & Bauserman, 1998). In addition, acknowledging trauma means members of society need to acknowledge the role they have played in allowing abuse to occur. The reasons for the funding disparity are beyond the scope of this dissertation.

Historical trauma. Under the betrayal trauma theme was the subtheme of historical trauma. This subtheme represents one of the negative side effects of experiencing childhood maltreatment: internalization (Van Vliet, 2008). Internalization occurs when an event such as sexual abuse creates feeling of self-doubt in the victim. However, trauma occurs in a historical context (Luckhurst, 2013). This perspective differs from a biological psychiatric perspective in which mental suffering resides specifically in the brain. In addition the perpetration of trauma also has a historical context (Luckhursat, 2013). One of the participants identified how her abuser held certain racist beliefs. This help her to contextualize the experience of abuse from a historical racial lens. She also expressed that due to her position as educated Caucasian female she

has certain privileges that other females from minority groups are less likely to have. This particular individual recognized her privilege and used it in her work as a macro social worker.

Understanding that trauma is historical provides a context for the experience and helps to lessen the weight on the individual by placing culpability in oppressive societal systems (Burstow, 2003). By making the personal impersonal, victims can escape from themselves (Fisher, 2014). This approach depersonalizes the abuse and can help facilitate resilience (Burstow, 2003).

Trauma in the form of racism or sexism can be tied to greater social and political movements. Doing social justice work can be empowering for trauma survivors. Feminist scholars have referred to the connection between multiple systems of oppression as *intersectionality* (Crenshaw, 1991). Intersectionality is a call to address the connections between systems of oppression such as patriarchy, sexism, and racism, rather than focusing on them as single issues (Crenshaw 1991). Crenshaw coined the term *intersectionality*; however, the historical origins go back to earlier Black feminist thinkers such as Lorde (1984), who said, "There is no such thing as a single-issue struggle because we do not live single-issue lives" (p. 183).

Regarding trauma, the idea of intersectionality is relevant because trauma is rarely one event or issue (Quiros & Berger, 2015). Sexual abuse, emotional abuse, and physical abuse often coexist, yet policymakers create programs focused on single policies to address issues such as sexual abuse, child abuse, and domestic violence (Quiros & Berger, 2015). In the literature on childhood maltreatment, this is referred to as *poly*

victimization (Finkelhor, Ormrod, & Turner, 2007). Recently, researchers have examined the intersectional effects of different forms of maltreatment (Cecil et al., 2017). Further, Felitti and Anda (2010) showed that if any one category was experienced, there was an 87% likelihood that at least one additional category was present. Thus, like gender discrimination and racism, childhood trauma fits an intersectional framework. The crux of an intersectional analysis involves thinking about the problem of sameness and difference and its relation to power (Cho, Crenshaw, & McCall 2013). For many survivors of childhood trauma, their identity as trauma survivor trumps their other marginalized identities. Diaz (2018) explained, "It fucked up my childhood. It fucked up my adolescence. It fucked up my whole life. More than being Dominican, more than being an immigrant, more, even, than being of African descent, my rape defined me" (p. 2). However, the implication is that a focus on childhood trauma has the potential to unite individual across racial and political divisions.

Theme 3: Maladaptive Responses

The third trauma-related theme was maladaptive responses.

Suicidal ideation. Several of the participants spoke of having suicidal thoughts. Suicidal ideation is often linked to the experience of childhood trauma (Van der Kolk, Perry, Herman 1991). One noteworthy links was that what interrupted the participants from acting on their suicidal urges was thinking about their attachments in their lives. One participant spoke of passively trying to kill herself by walking in front of a car; she said she could not do that because she thought it might ruin the driver's day.

Theme 4: Boundaries

The fourth trauma-related theme was boundaries. Boundary issues often relate to abuse—for example, an abusive act such as sexual abuse clearly shows perpetrators' disregard for victims' boundaries. Therefore, one of the negative side effects of abuse is difficulty negotiating appropriate boundaries (Goelitz & Stewart-Kahn, 2013).

Positive relationships appear to be a mediating factor in helping people negotiate boundaries (Perry, 2001). This finding is consistent with other literature, which has shown that abusive and neglectful relationships can make it difficult for people to set appropriate boundaries (Goelitz & Stewart-Kahn, 2013). Therefore, it is logical that a victim of abuse would have challenges negotiating relational boundaries. In addition, a dominant trope exists that childhood trauma results in boundary issues for adult survivors (Connors, 1996). Whitehead (1993) stated, "Maladaptive boundaries are a crippling long-term consequence of abuse (p. 1).

Toxic relationships. Under the boundaries theme was the subtheme of toxic relationships. Interpersonal trauma can be disruptive to human attachment systems (Bowlby, 1969). One way to recover from these experiences is to seek new relationships. "People in fear attach to anyone, even bad attachments" (van der Kolk, 1987, p. 134). Traumatized people often develop negative attachments because it is better for survival than being alone. Thus, people will enter relationships with other abusive or dangerous people, as several participants reported. Several of the participants described that they got involved with relationships that could be described as toxic.

Resilience Themes and Subthemes

Six resilience themes emerged from the data. Participants gave examples of moving from surviving trauma to resilience from trauma, identifying specific self-care activities or practices they implemented to reduce the effects of trauma on their lives.

Theme 1: Self-Care

The first resilience theme was self-care. Self-love was an act of protest to the maltreatment that occurred. "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare" (Lorde, 1988, p. 132). The reason that self-care is an act of political warfare for trauma survivors is that interpersonal abuse frequently results in self-loathing (Grossman, Spinazzola, Zucker, & Hopper, 2017).

Reading. The first subtheme under the self-care theme was reading. Reading emerged as a strategy to cope and recover from trauma. Reading is noteworthy because it is an inexpensive approach for people who have experienced trauma and does not require professional intervention. The theme of reading came as a surprise to me, even though from the perspective of narrative therapy, it makes sense that narrative would be important to participants. Participants mentioned they found books, particularly fiction, helpful, independent of my narrative-inspired questions. One participant, Larissa, emphasized that she found imaginative books were quite helpful. Another participant, Carl, emphasized imagination: He drew inspiration from fictional Japanese animation characters.

Reading fictional literature expands the topics available in narrative therapy. The imaginative and fantasy nature of the text appeared to be important to the participants.

Discussing literature with people who have experienced trauma can be helpful (Dillon, 2011). One important aspect of reading literature is that this coping strategy does not prescribe meaning to the experience (Perry & Szalavitz, 2017). Le Guin (2004) stated, "A reader reading makes the book, brings it into meaning, by translating arbitrary symbols, printed letters, into an inward, private reality (p. 218). The meaning of a text depends on the interpretation of the text, just as the effect of an event depends on the meaning attributed to it (Kurtz, 2018). Author James Baldwin (as quoted in Howard, 1963) said,

> You think your pain and your heartbreak are unprecedented in the history of the world, but then you read. It was Dostoevsky and Dickens who taught me that the things that tormented me most were the very things that connected me with all the people who were alive, or who ever had been alive. Only if we face these open wounds in ourselves can we understand them in other people. (p. 89)

Reading helps people gain cognitive space from their own experiences as well as contextualize their private experiences in the greater world (Le Guin, 2004). It is not surprising that people who have experienced trauma find reading helpful: The brain has evolved to process and encode information as story (Haidt, 2012). Haidt explained, "The human mind is a story processor, not a logic processor" (p. 281).

Reading helps readers connect with others' lived experiences of pain and thereby generate empathy. Dillon (2011) wrote,

> Books allowed me access to other worlds, worlds where there were endless possibilities. In my imagination, the characters and stories in books captivated and entranced me, became meaningful to me to the extent that I internalized them so that I felt less alone and the world still held some magic and wonder. My sense of justice burnt inside of me the whole time. I knew that what my abusers were doing to me was wrong. I began to dream of a world where one day I would be safe and free and loved. (p. 143)

Similarly, Haig (2015) said, “There is this idea that you either read to escape or you read to find yourself. I don’t really see the difference. We find ourselves through the process of escaping” (p. 130). This quote is consistent with some of the participants’ experiences with reading as a means of dissociating and relieving anxiety. Reading seemed to be a purposeful form of escaping. Perhaps they found themselves through escaping or thought that by escaping, they would discover a preferred reality.

Fictional characters. Fictional characters was a subtheme of the larger subtheme of reading. It was interesting how one of the participants relied on fictional characters to provide hope and develop resilience in the face of adversity. At first, this seemed odd and inauthentic, the idea that someone could develop resilience from something that was not real. However, upon further reflection, it makes sense—much of resilience is psychological in nature rather than material (Fletcher & Sarkar, 2013). Gottschall (2012) related to the practical value of stories: “Stories the world over are almost always about people (or personified animals). . . . Stories offer us feelings we do not have to pay the full cost for” (p. 58). Similarly, Solnit (2013) said, “I found books and places before I found friends and mentors, and they gave me a lot, if not quite what a human would” (p. 29).

Food. The second subtheme under the self-care theme was food. The views of Carl, one participant in the current study, aligned with previous research regarding the connection between childhood trauma, overeating, and obesity. However, Carl was able to change his eating habits as a young adult and lose the weight. Therefore, ACEs affected him, but obesity was not a permanent state. Obesity and overeating have been

described as a negative coping strategy to manage symptoms of trauma (Pettway, 2014). The original ACE study arose from operations in a weight-loss clinic (Felitti et al., 1998; Felitti, Jakstis, Pepper, & Ray, 2010; Felitti & Williams, 1998).

Eating food helps to engage the parasympathetic nervous system, which is often underactive compared to the hyperaroused sympathetic nervous system in people who have experienced trauma (Kobayashi, Lavela, Bell, & Mellman, 2016). The parasympathetic nervous system is referred to the rest and digest system (Harris, 2018; Woods & Stricker, 2014). Further, research has shown that eating sugary foods can lower the stress hormone cortisol, which is often overactive following trauma (Tryon et al., 2015). Food has psychoactive and as well as social effects for trauma survivors. The social effects regarding food and obesity are often overlooked (Felitti,, Jakstis, Pepper, & Ray 2010). One of Felitti's (1998) patients said, "Overweight is overlooked and that is the way I need to be" (p. 28). Previous researchers prior to Felitti (2010) have tried to define obesity by looking at biological markers such as the hormone leptin (Felitti et al., 2010). In fact, Felitti et al. (2010) made an astute observation, labeling leptin as an intermediary mechanism rather than as a cause. (D'Argenio, Mazzi, Pecchioli, Di Lorenzo, Siracusano, & Troisi, A. (2009) show that sexual or physical abuse but also less severe forms of early-life stress are linked to the development of obesity later in life, and psychological dysfunction is not the only mechanism mediating the elevated risk of obesity in persons exposed to early-life trauma (p. 546). D'Argenio et al. research show that there are physiological links between early life stress and developing obesity as an adult.

Drugs. The third subtheme under the self-care theme was drugs. The subtheme was further divided into three subthemes, self-medication, substance use, and psychedelic drugs.

Self-medication. A subtheme under the drugs subtheme was self-medication. A prevailing societal narrative is that trauma survivors use recreational drugs to "self-medicate" trauma (Khantzian, 1997). Implicit in the phrase *self-medicate* is the assumption that if they are medicating without a doctor, they are misbehaving. This moral judgment is indicative of medical paternalism (Flanigan, 2017). The self-medication narrative was embedded in one participant's words: Kylie said, "I was drinking to the point of blacking out, I dropped out of college because, you know, I could not function. So, it was really pure self-medication." This is an example of how an academic idea—in this case, self-medication—has entered the public consciousness. Kylie framed her substance use from the perspective of self-medication. Media coverage on recreational drug use overwhelmingly focuses on harm; when any mention of benefits appears, it is about medical or physical health (Szalavitz, 2016, 2017).

Another aspect of the drug-related narrative is the tension between pharmacological Calvinism and psychotropic hedonism (Klerman, 1972). Pharmacological Calvinism represents a distrust of drug use for nontherapeutic purposes; that is, drugs that make users feel good are morally bad (Klerman, 1972). From the perspective of pharmacological Calvinists, the pleasure derived from drug use is inauthentic because it is "unearned" (Klerman, 1972, p.4). The dominant American value system supports drug use only for therapeutic purposes under the supervision of licensed

physicians (Klerman, 1972). A major threat to pharmacological Calvinism comes from youth culture, whose members distrust adult authority on drugs and embrace a more hedonistic view of drug use (Klerman, 1972).

A prevailing cultural narrative is that trauma survivors use recreational drugs to "self-medicate" their trauma (Khantzian, 1987). In addition, people who had ACEs are more likely to abuse drugs or become addicted compared to people who have not experienced ACEs (Felitti, 2004). The ACE study showed that people with six or more ACEs were 4,600 times more likely to become IV drug users (Felitti, 2004). It is noteworthy that the participants in my study did not identify with using intravenous (IV) drugs despite having many adverse experiences.

Further, the term *recreational* is misleading, because much illicit drug use is not concerned simply with getting "high" but with reducing anxiety and suppressing the memory of traumatic events or the reality of current circumstances (Moncrieff, Cohen, & Porter, 2013). There is no categorical distinction between drugs prescribed by doctors for mental health problems and those used for recreational purposes (Moncrieff et al., 2013). All these drugs act on the brain to produce an altered state that is either pleasant or unpleasant (Moncrieff et al., 2013). One key point is the context in which recreational drugs are taken. Recreational drugs are often consumed with friends and thus can be helpful in building relationships, whereas psychiatric medications are generally consumed alone. In addition, the term *self-medication* includes the notion that illicit drugs are harmful to traumatized individuals and they would do better taking psychiatric drugs to manage their symptoms. However, my findings confirm the research literature

showing that psychiatric drugs are not very helpful to trauma survivors (Nemeroff et al., 2003).

Despite the harms associated with recreational drugs use, they confer benefits as well to trauma survivors. The most commonly approved pharmacological agent for treating trauma is selective serotonin reuptake inhibitors (SSRI; Locci, Khan, Khan, & Pinna, 2018). One of the main dangers with SSRI drugs is a side effect that can decrease empathy and dampen emotions (Kajanoja, Scheinin, Karukivi, Karlsson, & Karlsson, 2018). In addition, they often lead to sexual side effects such as impotence and diminished sex drive (Kajanoja et al., 2018). SSRI drugs produce dysphoria and dull emotions, and this is thought to be a mechanism of action by which they lead to increased suicidal and homicidal behaviors (Moncrieff et al., 2013). SSRI drugs contrast with illicit drugs that users consume to feel euphoria. The medical community views drugs that produce euphoria as dangerous because of their high abuse potential (de Zafra, Markgraf, Compton, & Hudzik, 2018).

None of the participants I interviewed spoke of having any longstanding abuse or addiction problems. This may have been unique to this sample; moreover, individuals who were still having issues with drugs might have been ashamed and therefore less interested in sharing their experiences. However, some participants reported that the drugs covered up their problems and used them as a way to escape. Further, several of the participants reported having positive experiences with drugs, particularly psychedelic drugs. Another common report from the participants was that one of their siblings struggled with drugs. It seems that these particular participants did not identify with any

long-standing drug problems. In fact, none of the participants reported using IV drugs, which showed that none had an extreme recreational drug habit. This group fit into the category of experimenting with drugs rather than being heavy users. They seemed to confirm the narrative that they experimented with drugs when they were young but gave them up as adults. Another interesting point is that the literature shows antidepressant drugs—an FDA-approved class of drugs for treating posttraumatic stress disorders—are usually not very effective (Williams, Debattista, Duchemin, Schatzberg, & Nemeroff, 2016). Psychotherapy has been shown to be much more beneficial to trauma survivors, compared to pharmacologic treatments (Williams et al., 2016).

However, drugs may provide a sense of attachment, particularly opiate drugs that bind to the mu receptor (Panskeep, 1998). The Mu-receptor is the receptor site that provides that euphoric and analgesic effects of opiates. Research shows that the attachment bond between infant and mother is mediated by the brain's endogenous opiates (Panskeep, 1998). Relationships can activate the endogenous opiates—the natural painkillers in human bodies. All drugs of abuse are pain killers that numb pain—for example, alcohol, cocaine, opiates, and cannabis (Maté, 2010). Thus, all drugs of abuse affect the dopaminergic system in the brain (Maté, 2010). This pathway also activates when people help others (Jiang, Bachner-Melman, Chew, & Ebstein, 2015).

Substance use. Another subtheme under the subtheme of drugs was substance use. People who have experienced ACEs are more likely to abuse drugs or become addicted, compared to individuals who have not experienced ACEs (Felitti, 2004). As mentioned, the ACE study showed that participants with six or more ACEs were 4,600 times more

likely to become IV drug users (Felitti, 2004). It is noteworthy that the participants in my study did not identify with using IV drugs despite having many adverse experiences. Not using IV drugs was significant because societally, IV drug use is highly stigmatized (Plant, 2002). IV drug use is often a marker that drug use has progressed to a problematic level.

Despite the harms associated with recreational drugs use, using recreational drugs provides benefits to trauma survivors (Moncrieff, 2017). Many of the harms associated with recreational drugs stem from their legal status rather than from their chemical structure (Buchanan, 2015). Other harms include the risks of contaminated supplies and contact with the criminal justice system (Buchanan, 2015).

Some of the participants in this study described periods in their lives during which they had problematic relationships with drugs. However, none of the participants spoke of having any long-standing abuse or addictive problems. This finding was consistent with the literature showing that most people stop using drugs problematically when life becomes tolerable (Lewis & Shelly, 2017). However, this finding may have been limited to this sample. Individuals who are having issues with drugs might be ashamed and therefore reluctant to share their experiences. However, some of the participants reported the drugs masked their problems and provided a way to escape.

Psychedelic drugs Many of the participants acknowledged they used drugs in their healing journeys and developed insights from them. However, they all realized drugs were not a long-term solution. Several of the participants reported having positive experiences with drugs, particularly psychedelic drugs. This class of drugs has been

shown to benefit people who have experienced trauma (Sherwood & Prisinzano, 2018). A resurgence of interest in conducting research on psychedelics has emerged, particularly regarding trauma survivors (Sherwood et al., 2018). Classic psychedelics such as LSD and psilocybin mushrooms have low abuse potential, are nontoxic to the brain, and may increase neurogenesis (Bogenschutz & Johnson 2016). *Neurogenesis* refers to the growth of new nerve cells (Curtis, Kam, & Faull, 2011). This finding is relevant for people who have experienced trauma because trauma can inhibit neurogenesis, specifically in the hippocampus, which is critical to learning and memory (Shonkoff et al., 2012). Classical psychedelics have also been shown to decrease suicidality and psychological distress in a U.S. adult population (Hendricks, Thorne, Clark, Coombs, & Johnson, 2015).

A major side effect of psychedelic drugs is that they can create psychological disturbances, commonly known as "bad trips" (Barrett, Johnson, & Griffiths, 2017, p.155). However, the drugs' positive effects have included promoting a sense of universal connection and unity (Nour & Carhart-Harris, 2017). The drugs commonly considered psychedelics all work on the 5-ht2a serotonin receptor as agonists (Vollenweider & Kometer, 2010). Meaning that they turn on this specifics serotonin receptor site The drugs in this class are LSD, THC, psilocybin, MDMA, and mescaline (Vollenweider & Kometer, 2010). These drugs essentially turn on the 5-ht2a serotonin receptor (Vollenweider & Kometer, 2010). A prominent psychedelic activist from the 1970s, Terrence McKenna (1991), described his experience with LSD: "I remember being nineteen years old, twelve hours in an LSD trip. I was sitting under a tree and I just

started to weep and I saw what my upbringing had done to me" (p. 153). Participants mentioned such psychedelics in the interviews.

In sum, many participants reported having siblings who struggled with drug addiction. None of the participants in this study identified with having an enduring substance use issue. This finding countered the narrative that having childhood trauma leads to long-term drug addiction. In this sample, none of the participants reported using IV drugs, which showed none of them had an extreme recreational drug habit. Instead, this group could be categorized as experimenters rather than heavy users. They seemed to reflect the narrative that they had experimented with drugs when they were young and then gave them up as adults. Interestingly, the literature has shown that antidepressant drugs (the FDA-approved class of drugs for treating posttraumatic stress disorders) are usually not very effective (Williams et al., 2016). Trauma survivors have found psychotherapy to be much more beneficial, compared to pharmacologic treatments (Williams et al., 2016).

Exercise. The fourth subtheme under the self-care theme was exercise. Exercise has been shown to exert many positive effects on the brain and nervous system, including neurogenesis through increased levels of brain-derived neurotrophic factor (BDNF) in the brain (Karatsoreos & McEwen, 2013). BDNF is associated with recovering from conditions such as depression as well as with reduced levels of cortisol, which can become abnormally elevated because of chronic stressors (Karatsoreos & McEwen, 2013). The effects of exercise are so profound neurobiologically that exercise can be considered akin to a psychoactive drug (Viña, Sanchis-Gomar, Martinez-Bello, &

Gomez-Cabrera, 2012). Ratey and Hagerman (2008) wrote, "Exercise is like Miracle Grow for the brain"(p. 196). However, although exercise has tremendous benefits for promoting physical and mental resilience, it can also lead to physical injury. Several of the participants noted how they got injured from exercise, and this led them to periods of depression. This makes sense given that physical pain and emotional pain both activate the brain's neural alarm system (Eisenberger & Lieberman, 2004).

Using exercise as a strategy to cope with trauma and develop resilience was a common theme in the data. For example, Irene's story aligned with this idea. Irene said, "I maintain a physical lifestyle. . . . Somebody might say that's self-medicating, but I think it's a positive way of self-medicating." This statement alludes to the societal bias that it is better and morally preferred to "medicate" with exercise rather than with drugs. Paul said,

> Two years ago, I got injured at work and one of the things that has helped me is being real physically active. That is another thing that has definitely helped even as a kid. Just like walk or doing something that your body is moving and active. I was running marathons, doing half ironman triathlon, and I have always been very active. When I got injured, I could not do that stuff anymore and I did go in to a real bad depression.

I re-introduced this quote to emphasize that exercise like drugs is not totally benign and can lead to adverse effects like pain and depression.

Yoga. Yoga was a subtheme within the category of exercise. Yoga has been closely linked to mindfulness; the Buddha was said to practice yoga postures to relax his body so he could sit in meditation (Feuerstein, 2003). Yoga appears to help people who have suffered trauma regulate their nervous systems more effectively through repetitive

movement patterns (Dale et al., 2011, p. 98). One of the participants, Jessica, described how yoga had helped her:

> I have discovered yoga and that has been huge saving grace for me. Teaching me how to get in to my body. Obviously, I have body issues just because of history, getting into your body and being there with it, and breathing through stress, and all of that, so that has been really beneficial to me.

Often the breath is linked to the movement; developing conscious control of the breath can help relieve anxiety-related symptoms associated with trauma (Emerson & Hopper, 2011). Because yoga is typically practiced in a group, it can also provide a sense of community (Gulden & Jennings, 2016).

Meditation. The fifth subtheme under the self-care theme was meditation. Meditation has been extensively studied in the last 20 years for its psychological benefits (Davidson & Dahl, 2018). Specifically related to trauma, meditation helps people gain a sense of control over their affective states, which can feel dysregulated from trauma (Thompson, Arnkoff, & Glass, 2011). Mindfulness, a form of meditation, may increase resilience in those who have experienced trauma because it offers an alternative response to the dissociation that often occurs following trauma (Thompson et al., 2011). In addition to psychological benefits, mindfulness can positively influence some of the physiological consequences of trauma (Thompson et al., 2011). In general, mindfulness has been modestly associated with reducing alterations in markers of inflammation, cell-mediated immunity, and biological aging (Black & Slavich, 2016). One of the participants, Larissa, described how meditation helped her. Larissa said, “It is kind of like white noise, umm, and that helps me relax and calm down and kinda get my mind thinking on other things besides just like this is horrible type stuff.”

Martial arts. The sixth subtheme under the self-care theme was martial arts. Martial arts, like yoga and meditation, promotes focused attention. Cultivation of focused attention through practicing martial arts seems to help promote resilience (Diamond & Lee, 2011). One of the participants, Gerry, said learning martial arts was "empowering" because it gave her strategies with which to defend herself. She said, "One of the things I did for myself was I started taking martial arts. I learned how to throw a knife like you wouldn't believe." The beneficial aspect of martial arts is that it incorporates the focused attention of yoga and meditation while also providing skills for self-defense and thus can increase feelings of safety (Diamond & Lee, 2011).

Faith and spirituality. The seventh subtheme under the self-care theme was faith and spirituality. The participants spoke of how spirituality and making meaning of a world larger than themselves was part of their healing. Some mentioned organized religion. One of the participants spoke of how a church group was the first context in which she shared her experience of trauma publicly because it was a place she felt safe. Faith has shown protective effects for those exposed to trauma (Reinert, Campbell, Bandeen-Roche, Lee, & Szanton, 2016). Religious involvement factors (spirituality, intrinsic religiosity, religious coping, forgiveness, and gratitude) can be effective coping mechanisms to improve mental health outcomes for survivors of childhood trauma (Reinert et al., 2016).

Theme 2: Individual Resilience

The second resilience theme was individual resilience. Individual resilience encompasses ways participants attributed their resilience to something internal rather than

something received through relationships. One of the reasons I did not focus on this was because I was biased by a modern definition of resilience in which resilience has been emphasized as a process rather than as a trait (Masten & Cicchetti, 2016). I also am more interested in more broader based themes so my analysis focused more in that direction. However, personality traits can affect how people respond to adversity. Two subthemes emerged from the data.

Reframe. The first subtheme under the individual resilience theme was reframe. Many of the participants described what I termed a *reframe*. The reframe consisted of being able to reassess a negative event to see the positive within it. Watzlawick, Weakland, and Fisch (1974) claimed

> to reframe . . . means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better, and thereby changes its entire meaning. (p. 120)

Participants mentioned the reframe idea, but I found it was not a very developed category. Perhaps because of my emphasis on relationship processes, I did not examine the individual aspect of resilience as much. My analysis tended to focus more on broader themes related to social justice and prosocial behaviors rather than on individual cognitive models.

Personality characteristics. The second subtheme under the individual resilience theme was personality characteristics. The participants noted that part of their resilience was innate, that they were born with a "strong constitution," and that they were fighters. For example, Irene said,

> I came into the world with a really strong constitution. What difficulties arose, I found different people who I could turn to and get help from. It was not a constant thread or a constant person in my life. No, there wasn't one particular person. My belief system was that I was strong and I could weather through this.

Another participant, Gerry, said, "I was a tough girl."

Theme 3: Turning Points

The third resilience theme was turning points. Trauma that occurs in the family environment can affect how people approach developmental milestones. For many of the participants, certain turning points were catalysts for their resilience—for example, moving away, joining the military, going to college, and having kids. All these turning points involved creating new identities apart from a traumatic environment. However, even though having kids was transformative for many of the participants, having kids also seemed to bring back some of the memories of abuse. Specifically, the participants described that having kids made them realize how abusive their own childhoods had been; yet, having kids allowed them to raise their children according to their own values.

The four major turning points identified in study were moving away, joining the military, going to college, and having kids. Gerry spoke about becoming a military police officer:

> Growing up, there were a lot of turning points and opportunities to be strong, and what I mean by that is that they had just opened up the military police field to women. They were doing away with the women's army corps about the time that I came in. We went through the same training as the guys did and then had the opportunity to be a military police officer, which is something I said I was going to do since I was real young.

Paula described having her first child as a turning point: "When I had him, it helped me to understand that I had been abused. You look at your own kid and see, oh my god, I

would never treat my child like that. I didn't want him to be in poverty like I grew up in."

The resilience literature contains descriptions of the turning-point concept. For example, researchers have described turning points as experiences that are perceived as life changing by the person who lives them (Pillemer, 2001; Tavernier & Willoughby, 2012) or as the opening of opportunities during periods of life transition (Werner & Smith, 2001). Rutter (1996) described turning-point experiences as involving a marked discontinuity in development that results in a change in the quality and direction of a person's life trajectory. Rutter noted these experiences do not just have short-term consequences but have the potential to effect change over the long term. Further, turning-point experiences are not universal experiences of development but rather occur among certain individuals or groups (Rutter, 1996). Thus, the types of experiences perceived as life changing may vary. There is evidence that those who can draw some positive effect from a negative experience are more satisfied with their lives than those who cannot (Tavernier & Willoughby, 2012).

Theme 4: Nature

The fourth resilience theme was nature. Participants spoke of how nature had a soothing effect on their nervous systems. Levinson (1972) stated, "One of the chief reasons for man's present difficulties is his inability to come to terms with his inner self and to harmonize his culture with his membership in the world of nature" (p. 6). Much research has been generated regarding the therapeutic effects of nature (Li et al., 2011). Being in nature seems to confer benefits for the immune system and the nervous system

(Li et al., 2011). Walking in nature confers specific benefits to the sympathetic nervous, compared to walking in an urban environment (Li et al., 2011). Spending time in nature was a theme of resilience that emerged from the interviews. This finding is salient because both the immune and nervous systems can be adversely affected by the stress created by adverse childhood experiences (Danese & Baldwin, 2017).

Animals. The subtheme under the nature theme was animals. Animals can provide a secure attachment for people. Many of the participants spoke of how important animals were to their healing process. When attachment systems have been threatened by abuse and neglect, animals can provide a "secure base" (Parish-Plass, 2008, p. 14). One of the negative symptoms attributed to people who have experienced trauma is intrusive memories (Ehlers et al., 2002). Animals can serve as a reminder that the danger is no longer present, providing a grounding effect (Yount, Ritchie, St. Laurent, Chumley, and Olmert, 2013). This grounding effect is helpful in coping with posttraumatic stress disorder (Lefkowitz, Prout, Bleiberg, Paharia, & Debiak, 2005). Animals can supplement human relationships with a different type of attachment. In some cases, traumatized people find human romantic relationships too stressful and prefer to derive their attachment needs from pets (van der Kolk, 2015). Animals exemplify how the fundamental role of relationships is beyond language and about attachment.

Theme 5: Social Support

The fifth resilience theme was social support. Humans are interdependent organisms. The participants in the study spoke of how social support was useful in getting through challenging times. People come into the world dependent on caregivers

and leave the world dependent on caregivers. People who experienced emotional trauma as children have difficulty trusting other humans; however, developing healthy connections with other people is essential to the healing process (van der Kolk, 2014). Social support has been shown to strengthen the immune system (Feeney & Collins, 2015). Trauma has a profound effect during sensitive periods, particularly during the peripubertal period (Morrison et al., 2016). One of the most important brain structures, the prefrontal cortex, which is involved with attention and executive function, grows significantly during this period. Animal studies have shown that receiving social support during stress in the peripubertal period can have significant neuroprotective effects (Morrison et al., 2016). Social support has been shown to be a protective factor in humans who have experienced trauma (Platt & Koenen, 2013). "An adequate support system may attenuate the devastating effects of early deprivation" (van der Kolk, 1987, p. 39). Cohen (2004) provided the following definition of social support:

> Social support refers to a social network's provision of psychological and material resources intended to benefit an individual's capacity to cope with stress. (p. 676)

One important aspect of social support is that it is less hierarchical than psychotherapy or other forms of professional support.

Social services. The first subtheme under the social support theme was social services as a path to recovering from adversity. The participants spoke of social services as extremely helpful to the recovery process. Far less research has been conducted on social services facilitating resilience than on other factors that promote resilience, such as individual, family, and school factors (Ungar, 2012). This theme was consistent with Ungar's (2012) social ecology theory of resilience. Proponents of this theory have stated

that resilience is a process wherein an individual's resilience depends on the availability of resources in his or her environment (Ungar, 2012).

Viewing resilience as an interplay showing how social service systems respond to adversity—in other words, as a contextually specific construct—reveals that most of the change in a sample of abused and neglected children can be accounted for by structural changes to the children's environment (e.g., school; peer supports; and restricted, reduced, or supervised access to perpetrating parents) rather than as individual qualities alone (Sroufe, Egeland, Carlson, & Collins, 2005). Garbarino (1976) coded New York counties for family income levels and economic and community resources. Garbarino found that 38% of the variance in child abuse reports was explained by the low resources of the county rather than by individual family income, demonstrating that where someone lived had more influence than did their personal income and resources. Similarly, some have said zip code influences resilience more than does genetic code (Graham, 2016).

Paula, one of the participants, described how the social services she was able to access were life saving for her. Even though she still suffered some maltreatment while in foster care, it was much better than being with her biological father, and it helped her gain independence. Paula stated, "Going to foster care got me out, . . . which saved my life."

Psychotherapy. The second subtheme under the social support theme was psychotherapy. Participants reported therapy was helpful to contextualize their experience and reduce self-blame. Psychotherapy is beneficial in facilitating recovery from trauma because it helps individuals integrate their narratives (Neimeyer, Herrero, &

Botella, 2006). Typically, traumatic memories are fragmented as a reptilian survival strategy (Brewin, 2011). Therapy can help people who have experienced trauma integrate their experiences (Siegel, 2009). When compared with pharmacological interventions, psychotherapy is much more effective in addressing symptoms of childhood trauma (Nemeroff et al., 2003). One of the importance aspects of therapy for trauma survivors is that it may be the first time survivors tell their stories and are believed. Dillon (2011) said, "I experienced the restorative power of truth telling—to tell and to be believed was an enormous relief, tremendously comforting and liberating" (p. 146). Survivors telling their trauma stories in the context of psychotherapy is particularly powerful because of the authority therapists carry. The participants also described how the psychoeducational aspect of therapy was helpful for them. Specifically, they explained how traumatic stress work was helpful for their recovery.

Positive adults. The third subtheme under the social support theme was positive adults. The participants identified different figures in their lives such as teachers and coaches that served as positive adults. Clinical studies of individuals with histories of abuse have shown that the availability of a caring and stable parent or alternate guardian is one of the most important factors that distinguishes abused individuals with positive outcomes from those with negative outcomes (Kaufman, 2006). These healing relationships begin in the family but can also include neighbors, providers of early care and education, teachers, social workers, and coaches (Shonkoff & National Scientific Council on the Developing Child, 2015). These positive relationships formed at critical developmental stages create turning points in facilitating a resilient response. Having

interactions with a positive adult during a time of adversity has two major effects. First, it helps to reduce negative feelings toward self (van der Kolk, 2014). Second, it helps restore belief in the benevolence of the world (Vollhardt & Staub, 2011).

Community. The fourth subtheme under the social support theme was community. Community was a prominent theme in the participants' testimonies of their resilience. Resilience is a multifaceted process that often "takes a village" to flourish after significant trauma. Community serves as an extended family system. The participants discussed how they found community and described how community helped in their recovery process. One of the participants, Yvonne, described the importance of community:

> To find a community where you feel like you belong and that these people are loving and nonjudgmental. I don't know where that community is for these people, but it could be just one or two people who you can trust and it is important to find a safe environment.

She emphasized the most important aspect of community was that it helped to create feelings of safety. She emphasized that as a trauma survivor, she was biased toward perceiving her world as unsafe.

Theme 6: Service to Others

The sixth resilience theme was service to others. What connects people is vulnerability rather than success (Palmer, 2016). The writer Alice Walker's father emphasized this point: " You want to encourage people by appearing as if you have it all together, but I frankly feel it's better to share that you don't because that's the truth and that's the reality of people (p. 74). This view challenges the widely held societal belief that people need to help themselves before helping others. This view also contrasts with

the adage that "hurt people hurt people." Many people (and groups that have experienced adversity) feel vulnerable from the effects of adversity. Thus, they may respond by seeing other people as dangerous and thereby becoming hostile and aggressive. Others may have difficulty functioning or exhibit mental health problems (Staub & Vollhardt, 2008). Yet some who have suffered from violence have reclaimed meaning and turned toward others, becoming caring and helpful, a phenomenon that has been referred to as *altruism born of suffering* (ABS; Staub, 2003, 2005).

Prosocial behaviors make people feel good, and one of the mechanisms of action is dopamine release (Jiang, Chew, & Ebstein, 2013). The specific neurobiology implicated is that prosocial behavior seems to act on the D4 dopamine receptor (Jiang et al., 2013). Helping other traumatized people recover changes a person's identity (Franzier et al., 2013). "Prosocial behavior following trauma may signal information about one's recovery from the trauma and reduce stigma about being a victim" (Frazier et al., 2013, p. 293). If trauma survivors perceive other victims as more like themselves than do nonvictims, and if this perceived similarity increases helping, perceived similarity might explain the relation between trauma exposure and prosocial behavior (Wayment, 2004).

One of the participants, Gerry, highlighted this idea in her narrative. She stated, "I identify as a victim of sexual abuse as well as being exposed to domestic violence from my parents. I channeled all that and became the advocate for the underdog. I am always for the underdog." Grossman, Sorsoli, and Kia-Keating (2006) showed that rooting for the "underdog" was a common theme in how people exhibit resilience.

Sharing stories. The first subtheme under the service to others theme was sharing stories. Inviting people to share their stories can be tremendously empowering for trauma survivors (Herman, 1992). Many trauma survivors welcome a chance tell their stories. Jessica elucidated this idea:

> Well, first and foremost, you have to share your story. You know, that is something that I am kinda coming to terms with. I think when you do that, it frees you, and you will find that you are not alone; so, I think that is key, knowing that you are not alone in this and that other people have experienced what you have experienced. There is kind of a weird camaraderie in that.

The concept of sharing stories aligns with Herman's (1992) reference to storytelling as public truth telling, the "common denominator of all social action" (p. 208).

Among the participants, sharing often occurred in groups with other survivors who had experienced trauma. When trauma survivors share their stories, it can be considered a form of testimony. Use of the word *testimony* in a psychotherapeutic setting implies that the subjective, private pain is seen in an objective context (Agger &Jensen, 1990). For many trauma survivors, telling their stories can be the first time that someone recognizes the truth and impact of what the survivors endured.

I inferred from participants' testimonies that integration is an essential aspect of trauma healing. A natural physiologic adaptation is to dissociate and cut off the connection to the negative experiences of traumatic events (Brewin, 2011). This natural physiological response occurs in the brain and nervous system (Brewin, 2011). Thus, it is logical that a major part of the healing experience is being able to talk about the experience publicly. Publicly sharing the story of survival helps connect the private pain to the culture that allowed abuse to occur. Further, telling the story can inspire others to

embark on their own healing journeys. Finally, it appears that sharing the story of survival helps lift some of the weight of the trauma.

Human service. The second subtheme under the service to others theme was human service. Many of the participants described working and volunteering in the human services as vital to healing the trauma they experienced in childhood. Similarly, Falzone (2016) said,

> Sometimes that is really healing, for a person to realize that their health problems are related to broader social injustices. [However,] until the oppression stops happening there can really not be true healing. But it's a step because it takes the blame away from the individual as being defective and puts the issues in context of where to place the blame. (p. 6)

Many of the participants engaged in human service-oriented work, and this appeared to connect to their resilience. These findings fit with the "helping helps the helper" theory (Zemore, Kaskutas, & Ammon, 2004). The helping helps the helper theory was generated from observing 12-Step support groups that encourage older members to mentor newcomers to the programs (Zemore et al., 2004).

Empathy. The third subtheme under the service to others theme was empathy. Among the participants, empathy was a major protective factor for suicide. This finding is important because childhood trauma is a major suicide risk factor (Perroud, 2016). In fact, in 2012, suicide was the second leading cause of death globally among people aged 15 to 29 years, with an estimated 80% to 90% suicide deaths attributable to mental health or substance use disorders (Whiteford et al., 2013). The World Health Organization (WHO; 2014) reported that in 2013, more people died from suicide than from wars or natural disasters combined. Empathy is highly related to prosocial behaviors and to the types of social justice-oriented work in which many trauma survivors engage (Frazier et

al., 2013). Connecting experiences of trauma to larger social justice issues helps trauma survivors contextualize their experiences, thus facilitating integration (Frazier et al., 2013). Further, contextualization helps reduce the self-blame typical of trauma victims (Frazier et al., 2013). Additionally, integration is critical in addressing dissociation, a symptom exhibited by many people who have experienced trauma (Berntsen & Rubin, 2007).

Theory

It is crucial to note that this portrayal of trauma and resilience exists in a Western context. This theoretical understanding of trauma came from interviewing people who were raised in adverse familial environments in the United States. Trauma scholars have emphasized that the United States is a trauma-organized society in which its citizens are routinely exposed to "traumatogenic environments" (Bloom & Reichert, 1998, p. 9). The notion that the self can be altered by external adverse events is a relatively new concept (Luckhurst, 2013). For example, the diagnosis of PTSD that reifies this concept is only three decades old (Luckhurst, 2103). Modern, globalized society can be viewed as a "wound culture" whose members are intrigued by reports of deep psychic injuries that are believed to explain all pathology (Seltzer, 1997, p. 3). The trauma perspective is an example of this wound culture. A major function of the postmodern perspective is about challenging grand narratives (Shore, 2017).

In addition, the United States is a deeply therapeutic culture in which people are told they should seek out professional help for traumatic experiences (Furedi, 2004; Loseke, 2017). Further, the United States has a culture of victimhood as well as one of

redemption (Cole, 2007). It is a culture of redemption in that traumatic experiences are celebrated only when they have a redemptive component. We celebrated the traumatized child that grows up to be a successful CEO.

From a narrative therapy perspective, when there is an abuse of interpersonal power, there is always resistance to that power (Combs & Freedman, 2012). Melanie Kaye (2007), drawing from her experience as a rape counselor, explained, "People always resist as they can, how they can" (p. 235). This means humans naturally resist abuse; however, the story of resistance is often subjugated and hidden from public view. Through this study, I discovered that survivors of ACEs describe their experiences initially as trying to survive in a chaotic environment. The earlier the chaos is experienced, the more profound the effects on the brain and nervous system. In fact, just as children can learn foreign languages much more quickly than can adults, children's brains process chaos and threats more dramatically than do adults' brains (Winfrey, 2018). Children's survival strategies move into what I referred to as *self-care*, coping strategies children employ to manage their symptoms. These self-care activities can extend beyond simply managing the symptoms, toward fostering self-development.

Reading was one of the strategies that emerged as a prominent theme. Imaginative fiction, or what some have referred to as *visionary fiction*, appears to be a catalyst for "decolonizing" a mind invaded by trauma (Imarisha, 2015, p. 3). Imarisha (2015) stated, " Decolonization of the imagination is the most dangerous and subversive form there is, for it is where all other forms of decolonization are born. Once the imagination is unshackled, liberation is limitless" (p. 3). One of the key benefits of

reading is that it can promote fantasy and activate greater imagination in the belief of a more egalitarian world. The science fiction writings of Ursula Le Guin (2004) and Octavia Butler (2001) are examples. Karl Marx (as quoted in Graeber & Wengrow, 2018) professed, "What makes us human is our power of imaginative reflection" (pp. 11–12). Martin Luther King Jr. also shared some of this imaginative vision, as evidenced by his famous "I Have a Dream" speech (King, 1963). One of the participants stated that he explicitly derived support from fictional characters; others empathized how important imaginative fiction was for their recoveries.

Experiencing interpersonal and structural violence at home sensitizes people to the same violence in the world (Staub & Vollhardt, 2008). For the study participants, social services, although imperfect, provided resources and facilitated recovery from trauma; some of the participants described how grateful they were to have access to certain resources that were available in their local community. At times, social services provided the ability to leave a chaotic environment and achieve a level of independence.

Although providing trauma survivors with individual support is essential—for example, providing psychotherapy, it is also critical to provide them with opportunities to help others. Humans have evolved to have a desire to be helped and to help others (Zemore et al., 2004). The quality of help offered after trauma can change the course of a survivor's life from a trajectory of avoidance or even violence, toward a trajectory of helping others (Staub & Vollhardt, 2008). Help that is genuine and connecting provides hope that there is good in the world (Staub et al., 2008).

A credentialed therapist confers a level of authority in society. This authority stems from the United States' deeply therapeutic culture (Furedi, 2004). When trauma survivors tell their stories to therapists, and therapists validate that what was experienced was traumatic, the practice alleviates some of the shame the survivors carry (Hari, 2018). Re-storying the experience in a confidential therapeutic relationship helps create a coherent narrative, which may be currently fragmented because of the dissociation that accompanies the trauma memory (van der Kolk, 1998).

Drugs, traditionally viewed as a negative coping mechanism following trauma, seemed to be a learning experience for the participants. Psychedelic drugs showed some positive effects in terms of self-development. However, drug use can be viewed in the larger context of altering mental states. Sigel (2018), a journalist, reported on drugs: "The desire to alter our consciousness, dull our pain, confirm our beliefs, vent our rage, consume our way to freedom—these things are endemic to our species" (p. 4). Drugs are just one way to alter mental states. Food and exercise can also have robust effects on mental states. People's preference for exercise over drugs is a moral judgment—certain types of exercise, such as extreme sports, are more dangerous than are recreational drugs.

Invalidation is often experienced by trauma survivors. The experience of invalidation seems to be connected to developing posttraumatic stress responses and other mental health pathologies. Therefore, it is critical for trauma survivors to connect with people who validate their experience. This validation can come from professionals, friends, or family members.

I found in my interviews the response to adversity flows from individual to relationship, and from relationship to larger societal–community relationships. The experience of trauma can help connect people across various identities, across race, religion, and socioeconomic differences (Vollhardt & Staub, 2011). The trauma-informed movement and the #MeToo movement have helped raise awareness about these issues. However, larger political interests are often impervious to change (Giridharadas, 2018). One reason they are so resistant to change is that the folks in political power often disconnect legitimate economic and social grievances from psychological and emotional problems (Hedges, 2018). Giridharadas (2018) provided an insightful analysis about why these power structures are so difficult to change. His analysis shows how most of the drivers of social change have been privatized and rely on the donations from wealthy elites (2018). Regarding the trauma informed movement, the Center For Youth Wellness in San Francisco is great example of this. CEO Nadine Burke Harris (2018) is pediatrician; she is a leading figure of the trauma informed movement. All of her top donors are wealthy private companies, including Google and the Lisa and John Pritzker Family Foundation (Center For Youth Wellness, 2018). Giridharadas (2018) explained the elites try to create social change in ways that do not change the fundamental wealth and income inequalities. Another point Giriharadas (2018) makes involves the relationship between elites and thought leaders. Much of the knowledge that is conveyed in the public sphere about trauma is delivered by "thought leaders" rather than by "public intellectuals." Drezner (2017) defineed a thought leader as an intellectual evangelist (p. 9). The thought leader develops a singular worldview around that idea and

proselytizes it to anyone nearby (Drezner, 2017). Nadine Burke Harris is an example of a thought leader regarding ACEs; her Ted Talk on childhood trauma has over a million views (Harris, 2015). In contrast to a thought leader, a public intellectual has a much broader scope of knowledge and serves as a critic on wide range of public policy issues (Drezner, 2017, p. 8).

Another salient point is that thought leaders are encouraged to focus on the victim apart from the perpetrator (Giridharadas, 2018). Grant (2017) emphasized the need to focus on the victim: " In the face of injustice, thinking about the perpetrator fuels anger and aggression. Shifting your attention to the victim makes you more empathetic, increasing the chances that you'll channel your anger in a constructive direction (p. 160). The danger in what Grant (2017) and other thought leaders have said is that they separate a person's victimhood from the context, and this can be dismissive of the many factors—such as poverty, lack of resources, racism, and sexism—that can make it challenging for the person to move out of victimhood.

Empathy Is Resistance

From speaking to the participants who endured ACEs, I found some patterns that can form a theory about how people are resilient from adversity. Initially, participants described symptoms of trauma, such as freeze, dissociation, and hypervigilance. Dominant tropes around psychological trauma clearly influence how individuals frame their experiences (Bourke, 2012). Therefore, it makes sense that the participants described their experiences using what I refer to as *mammalian* trauma responses.

Consistent with the views of feminist scholars, I view these symptoms as coping skills rather than as symptoms that make up a "mental illness" (Burstow, 2005).

The next phase of the recovery process the participants described involved practicing activities such as exercise that boosted mood and promoted resilience. This I referred to as *self-care* because these activities were primarily solitary practices participants used to ease their trauma-based symptomatology. One noteworthy activity was reading. Reading in particular was helpful because it generated meaning, which can be influenced by adverse life experiences (Mar, 2011). Reading also helped participants generate empathy for other characters (Mar, 2011). The mental relationships developed through reading did not come with the costs of real-life relationships.

I classified drugs in the self-care category. Despite drugs being seen as a negative response to trauma, I found their effects can be viewed on a spectrum. If people are distressed, altering their mental states through psychoactive substances is a normal response to mental pain. In extreme situations, use of drugs can be viewed as an attack on the self. However, some of the participants said using drugs was part of their journey to self-discovery. Psychedelic drugs have been shown to facilitate this journey; in addition, some researchers have shown psychedelic drugs promote prosocial and altruistic behavior (Dolder et al., 2016).

Social support was a major source of resilience for the participants. Social support has three levels: support from peers, support from professional helpers such as therapists, and support from macro-level services such as social services.

In the next phase of the recovery process, participants noted a shift from self-focused activities toward others. This fits with the literature on altruism born of suffering (Staub & Vollhardt, 2008). The participants used their heightened empathy to be of service to others. According to (Lim & Desteno, 2016), "Individuals who have experienced adversity attest to increased tendencies both to perspective-take and to place value on the welfare of others in need" (p. 180). Perhaps this response improves relationships between ingroups and outgroups (Staub & Vollhardt, 2011). An example of this would be an African American trauma survivor finding solidarity with a Caucasian trauma survivor. The relevance of this is that traditionally individuals exhibit prosocial behavior only to in groups they join based on something like shared ethnicity or religious identity (Staub & Vollhardt 2011). It appears that the experience of having endured trauma can make people more likely to show prosocial behaviors toward people outside their immediate group (Staub & Vollhardt 2011). A key point is that helping others helped to buffer against suicidal urges and other attacks on the self, which are some of the common negative effects of trauma (van der Kolk, 2014). This buffer contributed to posttraumatic growth because it helped participants contextualize their experiences in the larger web of social justice. Doing social justice work helps survivors create new meaning to the suffering they endured (Staub & Vollhardt, 2008, 2011). Specifically, fighting for justice helps facilitate societal reconciliation (Gibson, 2006). Social justice-oriented responses provide a sense of meaning that people can act on. A sense of meaning is tangible and actionable rather than purely cognitive. This notion of public justice connects with narrative therapy in practices such as "outsider witness" (Combs &

Freedman, 2012, p. 1049). Outsider witness groups consist of people who are therapists or community members; they serve as listeners to client stories of resistance to trauma (Combs & Freedman, 2012).

Betrayal trauma was an organizing theme for adverse childhood experiences. Betrayal trauma occurs when caregivers or institutions on which children depend for survival significantly violate the children's trust or well-being—for example, physical, emotional, or sexual abuse perpetrated by childhood caregivers (Freyd, 2008, p. 76). The participants in this study had family members who abused them, neglected them, or both. Betrayal trauma often leads to the double-edged trait of hypervigilance, the exaggerated search for or awareness of environmental threats (Rollman, 2009). The double-edged nature of hypervigilance shows the real oscillation between the trauma responses and resilience responses (Ellis & Del Giudice, 2014). One of the most consistent neurobiological findings of childhood trauma research is enhanced anticipation of threat (Teicher & Samson, 2016).

The converse of this bias toward danger is could be a suppression of the reward response (Teicher, 2016). Meaning that when someone has something positive happy in their life they only get minimally aroused. However, suppression of the reward response did not seem to appear in the data I collected. It could be that unlike hypervigilance, this idea of a suppressed reward response has not been mentioned in popular discourse around trauma. In the literature, as well as in practice, people are often labeled as either resilient or traumatized (Masten, 2009). However, there is fluidity between the two categories, and the boundaries between these two poles are quite permeable (Ellis & Del Giudice,

2014). Hypervigilance can be positive because it helps people protect themselves and avoid threats (Ellis & Del Giudice, 2014). In addition, hypervigilance often serves to make the traumatized more attuned to others' negative affective states, thus leading to greater empathy (Ellis & Del Giudice, 2014). However, hypervigilance can also be negative—for example, hindering the ability to form secure attachments (Vrticka, & Vuilleumier, 2012). Attachment is a deep and enduring emotional bond that connects one person to another across time and space (Bowlby, 1969).

As mentioned, a benefit of hypervigilance is that it often leads to a more acute ability to detect emotions in others, particularly negative states (Ellis & Del Giudice, 2014). People who have experienced betrayal trauma often carry the trait into organizations, schools, and workplaces (Freyd, 1996, 2008). One participant experienced a repeated betrayal trauma. The social service system that was supposed to help the abused child initially was invalidated because the social worker sided with the perpetrator rather than with the abused. Later, the foster parent abused the already traumatized child. However, a positive outcome of this experience was the participant's rejection of a mental illness diagnosis, a rejection that paradoxically enhanced her recovery. That is, rejecting the diagnosis of chronic mental illness helped her. This is relevant today. Acceptance of "mental illness" has increased, and people have been encouraged to accept their "disease" and seek treatment. This example shows that sometimes it is better to reject the label. Paula said,

> Unfortunately, more than once I've come across mental health professionals who have tried to disable me. They don't believe in my strength and ability to cope. Example, I went for emergency outpatient care several years ago, when I had a major PTSD moment, break, nervous

> breakdown, whatever you want to call it, it was triggered by my youngest daughter's self-destructive behavior and my inability to protect her.
>
> In any case, I needed help, and an outpatient hospitalization program helped me to get my bearings and to go on with life. It was a fight however to keep from being put on several psychotropic drugs to help me "deal with my pain." At one point, the psychiatrist told me if I wouldn't take the drugs he was prescribing, than there was no point in my being in the program because it wouldn't help me. Well, I didn't take the drugs, and I'm just fine.
>
> About a year later, I offered emotional support to a coworker who went to the same program for help; she took all the drugs, saw herself as broken, gained 60 pounds, and had to be inpatient hospitalized three separate times to get off all the drugs so she could function. How you see yourself makes a difference.
>
> After finishing the hospital program, I tried to find a therapist to work with, and I'll never forget the lady I went to telling me there was no way I'd be able to work or function without months of therapy, I was just too broken. She wanted to write me off work. Bullshit. We all lose our balance from time to time, those of us with high ACE scores (no legs) maybe more often than others, but that doesn't mean we can't regain it quickly and go on, maybe quicker than those who never learned to deal with adversity.

In this case, Paula's resistance to a paternalistic approach to helping enabled her to be resilient. Her behavior is an example of resistance as resilience.

Recommendations for Future Research

Drug Use and Trauma

Many questions regarding resilience from adverse childhood experiences warrant further exploration. One is the relationship between illicit drug use and adverse childhood experiences, specifically regarding using psychedelic drugs to treat the symptoms of childhood maltreatment (Mueller et al., 2017). Resurging experimental research has focused on using psychedelic drugs to alleviate symptoms stemming from traumatic experiences (Sessa, 2012). Psychedelic drugs are unique compared to other illicit drugs it is near impossible to have a fatal overdose, compared to other recreational

drugs such as opiates, alcohol, or amphetamines, which are other common recreational drugs people self-administer deal with symptoms of trauma (Argento et al., 2017). Psychedelics can help individuals access traumatic memories that are inaccessible during regular waking consciousness (Pollan, 2018).

It is important to acknowledge that illegal drug use has positive as well as deleterious effects (Hart, 2014). Public policy researchers have focused solely on the detrimental effects of drug use. For example, organizations such as the National Institute of Drug Abuse (NIDA) have focused on the negative effects of illicit drug use while neglecting the benefits (Hart, 2014). In this study, to mitigate this bias, I intentionally asked the participants about the benefits they derived from their drug use. In addition, in concert with narrative therapy, I was seeking to explore an alternative story to the dominant trope that self-medication is all bad.

Currently, American society is experiencing an "opioid epidemic" (Walters, 2017; Siegel, 2018). One explanation for this is that synthetic opiates such as Oxycontin were aggressively marketed to doctors to treat pain (Szalavitz, 2018; Walters, 2017). This enabled greater access for individuals to obtain opioids for recreational use (Walters, 2017). Childhood trauma is a major driver of opioid demand for recreational use (Heffernan et al., 2000) The term *opioid* is denotes that the drug is a synthetic opiate rather than derived from the opium poppy plant. However, the effects on the brain are the are very similar whether they are opiates or opioids as they both activate the brains opioid receptors (Dickenson, 1991). Childhood trauma is clearly a major factor in problematic opiate use (Shin, McDonald, & Conley, 2018). However, the relationship of

trauma to opiate use has been absent in the public conversation (Sullivan, 2018). The discourse surrounding the opiate crisis reflects the collective invalidation of the effects of emotional trauma on U.S. society (Sullivan, 2018).

With the legalization of recreational cannabis, attitudes toward recreational drug use are shifting in the United States and abroad (Carliner, Brown, Sarvet, & Hasin, 2017). Many people use recreational cannabis to manage trauma symptoms (Betthauser, Pilz, & Vollmer, 2015; Mason, Russo, Chmelka, Herrenkohl, & Herrenkohl, 2017). Many of the participants in this study spoke of their own marijuana use and described the role it played in their experiences of trauma and resilience. Ending the prohibition on cannabis has brought to light the blurred line between recreational use and medical use of psychoactive substances for managing trauma-related symptoms (Moncrieff et al., 2013).

In addition, psychedelic drugs are used in indigenous healing ceremonies and have been for thousands of years (Carhart-Harris et al., 2018) These ceremonies are often led by shamans who ingest the drugs alongside community members (Carhart-Harris et al., 2018). This process is markedly different from the paternalistic way doctors (dressed in white coats to signal a hierarchy in the relationship) administer psychiatric medications. In mental health crises, doctors give psychiatric medication by force against people's will (Kirk, 2017). It appears regarding trauma, the distinction of recreational drugs versus medical drugs is a regulatory distinction rather than a scientific one.

Sharing Stories

Another remarkable finding that should be researched further is the role of sharing experiences of trauma publicly, including exploring how sharing contributes to the

healing process. It appeared that participants sharing their stories with others created an identity shift from being trauma victims to becoming survivors and extended beyond that to becoming advocates. A common trope exists that people must fix themselves in therapy before they can help others. From the interviews, it seems people could offer others much support without being perfect themselves.

Social Activism and Resilience

Another area of exploration is the role of social activism as a component of trauma healing. Social activism can help people contextualize their experiences of personal injustice in a larger collective experience. Sometimes people are motivated by their own suffering to relieve the suffering of others (Vollhardt & Staub, 2011). This perspective shows that rather than being victims, disadvantaged members of society can contribute to social justice worldwide (Vollhardt & Staub, 2011). Having trauma survivors frame their problems embedded in larger social problems may help reduce the self-blame that many trauma survivors carry. In addition, this approach may offer a sense of social support as people connect with larger communities of like-minded people.

Solnit (2016) wrote, “Power comes from the shadows and the margins that our hope is in the dark around the edges, not the limelight of center stage” (p. XVI). A practical consideration for this point is the fact that traditional social service providers often create separate programs for LGBTQ people; however, there appears to be value in having people from different marginalized groups interact with one another to provide mutual aid and support. Vollhardt and Staub (2011) noted, “The possibility that one’s own suffering can increase the ability to understand others’ adversity, and possibly even

lead to the inclusion of outgroup victims in a common ingroup, could have important implications for social justice" (p. 314).

Historical trauma and racism were not included in the original ACE study but are now being conceptualized as adverse experiences (Cronholm et al., 2015). Historical trauma and racism represent an opportunity for further research to illuminate existing theoretical constructs. One reason for this exclusion of historical trauma and racism is that the ACE study was conducted in a health context rather than a social justice framework (Feletti et. 1998). Racism and historical trauma tend to fit within a social justice framework. There is a an emerging body of literature highlighting how racism affects health (Assari, 2018).

In addition, future researchers could focus on specific adverse childhood experiences. For example, the deleterious effects of emotional abuse have been shown to have greater statistical significance compared to other forms of adverse childhood experiences, such as physical abuse, sexual abuse, and neglect (Miller, Esposito-Smythers, Weismoore, & Renshaw, 2013). Studying emotional abuse might yield some unique insights and may encourage policymakers and helping professionals to take the effects of Aces more seriously. One reason most people do not acknowledge emotional neglect could be because this form of maltreatment is passive rather than active. However, despite being a passive form of maltreatment, researchers have found emotional neglect causes deleterious effects (Bateman & Fonagy, 2010). In fact, the literature has shown the emotional component of maltreatment may be the core factor linking childhood abuses to adulthood psychopathologies (Bateman & Fonagy, 2010).

Finally, most research on trauma has been studied with low socioeconomic groups. Because trauma is prevalent in affluent groups as well, it would be worthwhile to study adverse childhood experiences in affluent groups.

I derived several potential research questions from my grounded theory. First, what is the relationship between child maltreatment and abusive behavior outside of the home? I discovered through this study a real fluidity to abuse—when it occurs in one domain of life, it is more likely to surface in another. Another potential research question is "What is the role of solidarity between trauma survivors and other marginalized populations?" I discovered that participants who identified as heterosexual found solidarity with people who identified as queer. This finding highlighted the idea that solidarity regarding trauma has the potential to bridge individual differences such as sexual orientation. Other potential research questions include:

- How is reading therapeutic for trauma survivors?
- What role does psychedelic drug use play for trauma survivors?
- Is empathy a protective factor for trauma survivors against suicide?
- Is there a link between empathy and hypervigilance?
- What role does social activism play in helping trauma survivors recover?
- Is vulnerability more connecting than success?
- What are the perspectives of family members about how they could have intervened when abuse was occurring?
- What are the perspectives of other bystanders who witnessed childhood maltreatment but did not respond to it?
- How do female trauma survivors define the relationship between their multiple identities as female and survivor of trauma?

Political Views

Political views regarding childhood adversity would be interesting to explore. People who have experienced childhood trauma tend to hold more extreme political views compared to people who have not experienced trauma (Randles, Heine, Poulin, & Silver, 2017). Participants in this study appeared to be left of center on the political spectrum. I did not specifically ask them about political viewpoints; however, their affiliations did leak out during the interviews.

Religious Views

Faith, religion, and spiritual beliefs seem to be influenced by childhood adversity and could warrant further exploration. Most of the participants seemed to identify as more spiritual than religious, and some reported they were atheists. This area was beyond the scope of this study; however, some identified as being religious and felt that their faith was integral to their recovery process.

Gender

Men perpetrated much of the trauma experienced by participants in this study. In a recent review, Kearl (2018) showed that women experience about twice the amount of sexual violence experienced by men. Kearl reported, "The United States will never be 'the land of the free' if 81% of women and 43% of men face sexual violations that cause them pain and prompt many to alter their lives in significant ways" (p. 33). Historically, feminist scholars have deconstructed the influence of patriarchal culture and its influence on sexual violence (hooks, 2004). Tal (1996) explained violence against women:

> All American women are threatened with violence, regardless of their race or class, just as all Jews were in danger in Nazi Germany. Money and

> connections can help only to a point: a woman alone in Central Park after dark is a potential target whether she is an advertising executive or a welfare mother. (p. 26)

Neurobiological research has elucidated gender differences in the stress responses between men and women (Lupien & Juster, 2016). It would be interesting to discover how these neurobiological differences affect social status between men and women in society and influence their experiences of trauma and resilience. For example, being raised by a single mother provided me with lived experiences of the intersectionality between abuse and patriarchy. Specifically, women in the United States are not economically compensated for their work as primary caregivers (Blau, 2016). There is also a large economic disparity in pay between men and women (Blau, 2016).

Policy

Historically, many policy decisions have focused on the supply side of problems—for example, passing laws to mitigate obesity and drug abuse, prohibiting certain drugs, and taxing tobacco and sugary foods (Szalavitz, 2017). The findings from this study show that this approach misses the mark. Most public health problems are demand-driven, and so it should come as no surprise that supply-restricting solutions inevitably fall short by not addressing the demand side of the equation (Szalavitz, 2017). The unasked question: "What is missing in people's lives that they turn to drugs, alcohol, food, and tobacco for relief?" The answer to this question is complex, but it is clearly the right question (Brumage, 2017). The response should move away from a punitive position that can cause shame toward providing access to healthier coping mechanisms.

Limitations

Several limitations affected this study. First, I did not have the authorization to conduct theoretical sampling through follow-up interviews. Conducting follow-up interviews would have fostered greater sensitivity with the data, which would have helped me develop more nuanced themes, categories, and theory. This limitation occurred because it would have posed a potential risk to the participants, problematic in the context of this dissertation.

Sample Limitations

The study was conducted using participants recruited from the ACE Connection Social Network website, comprising a self-selected group of educated, employed, high-functioning people. The sample was predominantly Caucasian and female. Further, although the participants were recruited from the ACE Connection Social Network website, they all seemed to be more inclined toward interest in social justice issues. I inferred there participation in the Ace Connection may have biased them to be more inclined to social justice work because of their participation in this group than trauma survivors that were not part of this group. It would have been interesting to interview people with adverse childhood experiences who possessed attributes that were more selfish. Further, it would have been interesting to interview people with high ACE scores from settings such as homeless shelters, domestic violence shelters, drug rehabilitation facilities, and community mental health centers to learn how those groups are resilient.

Conclusions

Relevance to Family Therapy

Adverse childhood experiences (ACEs) represent a breakdown in family systems. These experiences are common in the general population (Halfon, Larson, Son, & Bethell, 2017). They are even more common in families that are symptomatic and engaged in therapy or social service settings such as foster care (Rebbe, Nurius, Ahrens, & Courtney, 2017). However, many parents have inherited trauma from previous generations and are not even conscious of it (Wolynn, 2017). The literature on ACEs has been generated from disciplines such as pediatric medicine, psychiatry, psychology, and social work. Family therapists should be well trained in addressing adverse childhood experiences and resilience. One of the salient findings from this study was the importance of empathy in adapting well to trauma. Empathy can be taught and nurtured through a therapeutic relationship (Berkhout & Malouff, 2016). One of the novel findings of this study was that empathy seemed to protect participants from suicidal ideations, suicide attempts, and other self-harming behaviors. Empathy also seemed to be part of their healing processes—the participants often spoke about performing community service activities that helped them heal.

Family Therapy Education

The Trier Social Stress Test is a research tool used to measure how people react to stress (Kirschbaum, Pirke, & Hellhammer, 1993). The test involves imagining speaking in front of a fabricated stern and critical audience (Kirschbaum et al., 1993). My experience of taking the clinical qualifying exam in the Marriage and Family Doctoral

Program reminded me of this tool. In the clinical qualifying exam, I had to present videos of myself performing therapy to demonstrate to the faculty that I had achieved a sufficient level of mastery. The faculty asked questions, and after subsequent attempts, I passed the exam. I assert that students who have experienced trauma would have experienced these types of situations as more threatening, compared to those who have not experienced trauma. While I attended the doctoral program, the name of the exam changed from *clinical qualifying exam* to *clinical portfolio*, signifying a more collaborative approach. This shift produced language that was less threatening.

Numerous researchers have administered the Trier Social Stress Test to trauma survivors and sampled blood and cortisol to discern inflammatory markers (Pace et al., 2006). The results have shown people who experienced trauma have significantly higher biomarkers for inflammation than those who did not experience trauma (Pace et al., 2006). The significance of this finding is that trauma history among students in Graduate Marriage and Family Therapy programs should be considered. Faculty should be cognizant of how qualifying exams might trigger trauma survivors and discuss how to support them through graduate school. One of the ways this experience could be less stressful to trauma survivors is to give them more control of the experience. Traumatized people often feel they lack control (van der Kolk, 1989).

Wounded Healer

Carl Jung coined the term *wounded healer* over 50 years ago, and it continues to generate interest among practitioners in the mental health field (McMullen, 2015). According to Barr (2006), wounded healers make up 73.9% of mental health

professionals, defined here as people who have experienced a psychological or physical trauma and have attributed their career choices to these experiences. Russel, Gill, Coyne, and Woody (1993) compared the family-of-origin experiences of MSW social work students with the family-of-origin experiences of business, guidance and counseling, and education students. The rate of occurrence of sexual victimization in childhood was 31% greater for the MSW students than the rates for the students in the other three cohorts (Russel et al., 1993). In addition, the MSW students were more likely to have experienced severe family conflicts and to report having a family member with a substance abuse problem, compared to the other groups (Russel et al., 1993).

Similarly, Rompf and Royse (1994) linked early psychosocial trauma with the later social work career choice. Black, Jeffreys, and Hartley (1993) found that social work students reported a significantly greater frequency of early life family trauma when compared with a sample of business students. Esaki and Larkin (2013) studied child service providers' adverse childhood experiences and found a high prevalence of ACEs in this populations. Esaki and Larkin (2013) reported approximately 70% of participating workers in this child-serving agency reported at least one of the ACE categories (p. 34). Researchers have suggested that promoting helpfulness and awareness of others' suffering early in life can lead to an interest in and identification with the helper role, leading to the choice of a helping profession later in life (Grossman et al., 2006; Shakespeare-Finch & Copping, 2006).

During my first month of therapist training in an MSW program, I learned about the responsibility of being a mandated reporter of child abuse. Learning about the

responsibility of being a mandated reporter triggered memories of my own experience of child abuse. My psychiatrist was negligent in failing to report the abuse from my father. However, his reasons for doing were valid—reporting may have compromised my father's ability to make a living as a physician, which would have negatively affected my entire family. The part that my psychiatrist failed to consider was that by not reporting the abuse, he failed to validate my experience as the victim. This failure had further consequences; reporting his abuse may have prevented my father from adopting a child, as he did when he remarried.

Trauma Certifications

Trauma, specifically, *trauma-informed care*, is a "buzzword" in behavioral healthcare (Cutcliffe, Travale, & Green, 2018). Many trauma certifications have arisen because of the industry demand that therapists be "trauma competent". This response can be understood under the framework of the so-called therapy industry (Moloney, 2013). Neoliberalism is an economic ideology that emphasizes that competition is the defining feature of human relationships (Monbiot, 2016). Several scientists have shown neoliberal, universalist rationalities containing a causal logic associated with construct of resilience (Chandler, 2014; Joseph, 2013). Schwarz (2018) stated, "The concept of resilience may be at risk of reproducing power imbalances and discrimination within our society" (p. 2). This is because the resilience often prioritizes an individual's agency while minimizing certain contextual factors (Schwarz, 2018).

The psychotherapy industry operates under the logic of a neoliberal capitalist framework that incentivizes competition and profit, often at the expense of human

welfare (Coyne, 2017; Moloney, 2013). One of the consequences of neoliberal economic policies is the privatization of public services. After many formerly state-run mental health services became privatized, a "trade in lunacy" emerged (Scull, 2015, p. 134). The profession of psychotherapy can be seen as growing out of the privatization of mental health care (Moloney, 2013; Scull 2015). Moloney (2013) stated, "Therapy industry sells us illusions about our ability to better our lives through individual effort" (p. 3). According to Schwarz (2018), resilience and mental health can be considered commodities in a neoliberal culture (p. 6). The practice of psychotherapy is tethered to the state regulatory bureaucratic framework of professional licensing in the United States. One of the original aims of professional licensing is to protect the public from incompetent professionals or charlatans (Friedman, 2009). However, research has shown that licensing and certification do not protect the public from harm (Rogers, 1973). In fact, professional licensing often creates a monopoly for an industry such as psychotherapy (Friedman, 2009). In addition, professional licensing has other effects and consequences (Rogers, 1973). Rogers (1973) stated, "When our own lasting helpfulness is clearly evident, then we will have no need for our elaborate machinery for certifying and licensing" (p. 383). Rogers emphasized that all the attention toward credentials detracts from the focus on improving people's lives, where it should be directed.

Next, I present some guidelines for mental health professionals who seek to be "trauma-informed." Every mental health practitioner should have a strong foundation in understanding the concept of trauma, including its history, effects, and treatments—specifically, how the idea of trauma has developed from Freud, to the Vietnam war, to the

feminist movement, to its present-day iteration as the #MeToo movement. Practitioners should understand psychological symptoms such as dissociation, hypervigilance, and avoidance; learn how they manifest clinically; and be familiar with at least the basics of the research underlying these concepts.

In addition, mental health practitioners should have a basic neurobiological understanding of the mechanisms of trauma. This includes understanding the stress response and basic brain anatomy. Basic brain anatomy includes the functions of the amygdala, hippocampus, and prefrontal cortex. It is essential that practitioners are comfortable taking a trauma history and asking their clients about distressing childhood events, such as rape and incest, which are culturally taboo conversation topics (Read, Hammersley, & Rudegeair, 2007). The clinician should be sensitive to how marginalized identities of race, class, gender, sexual orientation, and disability status intersect with trauma (Bowleg, 2017).

In addition, having experienced trauma can qualify individuals for certain disability accommodations (Levin, Kleinman, & Adler 2014). It is essential for therapists to be able to assess the impact of trauma to advocate for disability accommodations (Levin et al. 2014). This could means things such as extra time on tests in school or other things such as veterans disability benefits due to PTSD (Levin et al. 2014).

In terms of specific treatment, there is no one modality that is most effective across all clients who have experienced trauma. Research on relevant common factors shows that all models of therapy are approximately equally effective; the therapeutic relationship accounts for the majority of the treatment effects (Duncan, Mille, Wampold,

& Hubble, 2010). Another common factor in psychotherapy is therapists' allegiance to their preferred models treatment model. This means that the more that therapists believe in their preferred models, techniques, or practices, the more effective their therapy (Duncan et al., 2010).

Many providers of certifications such as the Rapid Resolution Trauma Therapy certification have claimed that their modality can "clear" trauma after a minimal number of sessions (Connelly, 2016, p. 1). This type of guarantee is hyperbole. In treatment of trauma, it is helpful to think of the symptoms and the treatment of those symptoms in a hierarchical manner. First, the acute phase of trauma often affects such basic functions as sleeping, eating, and toileting. Van der Kolk referred to the acute phase of trauma as a "gut wrench" to highlight how acute trauma is a bodily response (Tippet, 2017, p. 2). It is only when these symptoms are managed that the next phase can occur.

In the second phase, psychotherapy can work by reducing the sense of shame concerning the trauma experienced. I call this phase *private truth telling*. Having a therapist acknowledge and believe that what the victim experienced was both wrong and real is beneficial to the survivor. The process of therapy can help integrate the trauma memory that is often fragmented because of trauma.

The third phase is the social phase of trauma recovery, in which trauma survivors share their experiences with peers. This sharing helps bring the experience of recovery out of the private sphere and into the public realm. In this realm, it can also be helpful for trauma victims to engage in social services, which can occur in the form of support groups. This phase can include sharing their trauma stories in the public sphere. This

serves two purposes: First, it helps to create an identity shift from victim to survivor. Second, telling the story in public can be a way to achieve some level of justice for what happened. To be believed by a large group of people can feel empowering. This relates to outsider witness practice in narrative therapy (Combs & Freedman, 2012).

Further, the sharing phase of the recovery process can help people find meaning in what happened. It is also the time when many survivors start offering support to other traumatized people. This can help to create a larger sense of meaning through developing a "survivor mission" (Lifton, 1987). A survivor mission is when a trauma survivor takes on certain cause such as domestic violence or sexual abuse do to their own survivor hood and makes it their life's mission to advance a specific cause. Taking action in a survivor mission can also help normalize the stress response: The purpose of the stress response—specifically, of cortisol—is to propel people to take action (van der kolk, 2015).

This framework is not intended to be prescriptive. The recovery process does not have to follow this sequence—in fact, most healing is not linear (Yoder, 2015). One of the errors in trauma techniques and certifications is that they are often prescriptive. In today's mental health industry, to obtain certifications requires fidelity to a model, with a senior practitioner determining the level of performance (Duncan, Miller, Wampold, & Hubble, 2010). This means that a therapist has practice a model that is often manualized to some degree meaning that there is a guide on how to conduct the therapy session. The senior level trainer that grades the junior level therapist and awards a certificate when the performance level is satisfactory. An important danger in this approach, however, is that

the creator of the model often maintains a "guru" status (Coyne, 2017). This guru status can create a power imbalance, which may lead to abuses of power.

Because many practitioners are trauma survivors themselves, another important factor in trauma recovery treatment is the imposter syndrome. The imposter syndrome means that students never feel they are worthy of professional status because of self-doubt (Langford & Clance, 1993). Even with many years of experience and education, students still feel that they are not competent enough be effective therapists. This feeling of incompetence is often exploited by people who run the certification companies (Coyne 2017; Jarett, 2013). Students are led to believe that if they get just one more certification, they will be competent enough to help their clients and will then be financially successful.

Joining a trauma practice group that is operated democratically rather than run by a so-called guru may guard against some of the dangers of professional trauma training. This collective approach to management is challenging; however, it can offset some of the potential dangers of trauma certifications caused by their top-down nature. The collective approach may be challenging because it requires democratic, shared decision-making, which may be hard to accomplish when there is no clearly defined leader. People might assume esteemed trauma practitioners are immune to abuses of power but recent events show that they are not. Renowned trauma expert van der Kolk was recently fired from his own trauma center for allegedly mistreating his employees (Kowalczyk, 2018).

Postmodernism

A postmodern perspective is useful for examining how discourses are situated in a historical framework (Foucault, 1980). Further, a postmodern perspective may help when deconstructing how knowledge is embedded in power relationships (Foucault, 1980). The original intention of postmodernism stemmed from an incredulity toward to grand narratives and a desire to guard against totalitarianism (Shore, 2017). Regarding trauma, a postmodern perspective holds that reality is constructed by narrative. However, conceptualizing the effects of trauma as existing only in narrative can result in dismissing the physical effects of childhood maltreatment. Although the neurobiological effects of trauma has been abundantly substantiated in neuroimaging studies (Teicher & Samson, 2016), the imaging studies do not provide meaning to the experiences of the abused. Reducing trauma to a problem seen only through the lens of neurobiology obscures the cultural, social, and historical aspects of trauma. Another danger in the postmodern frame is that although this philosophical approach can generate humility of truth claims, it can sometimes lead to inaction (Blomley, 1994). The humility of truth claims refers to looking at truth claims on how they often serve to maintain power structures. The postmodern stance can lead to inaction when it is taken to the extreme.

Currently, humans live in an important epoch in history regarding the significance of childhood maltreatment, particularly regarding sexual violence. The #MeToo campaign and the allegations against Harvey Weinstein and other celebrities and politicians have shown that stories of sexual abuse are being heard and politicized (Bardall, 2017; Kearl 2018). Prevention is the best approach to minimizing the effects of

adverse childhood experiences. However, to move forward, people need to acknowledge the effects of trauma. One of the crucial steps to recovery is believing survivors.

For a variety of reasons, survivors have often been dismissed and even blamed for the violence that occurred. One reason is the lag time between the event and victims coming forward with their testimonies. The length of time between the event and the disclosure may vary because dissociation occurred after the event; thus, survivors may not remember the events until years afterward (Paine & Hansen, 2002). However, it appears that when survivors join together, as they have with the #MeToo movement, they have a larger social and political impact (Bardall, 2017).

It is crucial to recognize that healing cannot occur without justice, and justice cannot occur without healing (Denborough, 2014, Rasras 2005). Helping people find justice can be healing; yet this approach is frequently neglected in the psychological field (Rasras, 2005). Denborough (2014) stated, "The person is not the problem, the problem is the problem, and the solution is not only personal" (p. 1). I interpret the last part of the quote to mean the solution lies in pursuing social justice through collective action. Therefore, encouraging trauma survivors to take action by getting involved with activism appears to help them in their healing journeys.

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APPENDIX A: PARTICIPANT CONSENT FORM

NOVA SOUTHEASTERN UNIVERSITY
College of Arts, Humanities, and Social Sciences

Consent Form for Participation in the Research Study Entitled:
Adaptation to ACE: A Constructivist Grounded Theory of Individuals Adaptations to Adverse Childhood Experiences

Funding Source: None.

IRB protocol #:

Principal investigator(s)
Jeff Friedman
1800 South Ocean Drive apt 2410
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Co-investigator(s)
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For questions/concerns about your research rights, contact:
Human Research Oversight Board (Institutional Review Board or IRB)
Nova Southeastern University
(954)-262-5369/Toll Free: 866-499-0790
IRB@nsu.nova.edu

What is the study about?
You are invited to participate in a research study. I am interested in speaking with individuals that have experienced adverse childhood events. My goal is to develop a new theory about how individuals adapt to these events

Why are you asking me?
You are invited to participate because you are a member of the ACEsconnection. In order to participate in the study, you must live in North America, be between the ages of 18 and 65, and be an English language speaker. You must have had a least one adverse childhood experience as defined by the ACE Study, prior to the age of 18. These adverse childhood experiences may have included being subjected to emotional abuse, physical abuse, sexual abuse; being raised by one or no parents, witnessing domestic violence, having a family member incarcerated, or having a family member with a mental illness or substance use disorder. There will be approximately 10 participants in this study.

NOVA Southeastern University
Institutional Review Board
Approval Date: JUN 17 2016
Continuing Review Date: JUN 16 2017

Initials: _____ **Date:** _____ **Page 1 of 3**

What will I be doing if I agree to be in the study?
You will be asked to meet with the researcher, Jeff Friedman, for an interview, taking approximately 1 hour of your time. The interview will be a phone interview. The interview will consist of questions formulated by Jeff Friedman, as well as any additional questions that may arise as a result of your response(s). The overarching question will be: How do individuals adapt to their adverse childhood experiences?

Is there any audio or video recording?
This research project will include audio recording of the interview. It will be a telephone based interview. The audio from the interview will be recorded over a website called SecureSpeak which is a service that records and encrypts phone calls providing a high level of security. This audio recording will be available by the researcher, Jeff Friedman, the IRB, and the dissertation chair or committee. The recording will be transcribed by Jeff Friedman using headphones in his private home office. Jeff Friedman will de-identify any name mentioned during the interview to protect confidentiality using pseudonyms. The recording will be kept securely in Jeff Friedman's home office in locked safe to which only he has access. The recording will be kept for 12 months and wiped clean after that time. Because your voice will be potentially identifiable by anyone who hears the recording, your confidentiality for things you say on the recording cannot be guaranteed, although the researcher will try to limit access to the recording as described in this paragraph.

What are the dangers to me?
The risks to you are minimal, meaning they are not thought to be greater than other risks you experience every day. Being recorded means confidentiality cannot be guaranteed. Sharing your experiences about adverse childhood experiences may bring forth unpleasant or unhappy memories. If this happens, Jeff Friedman will try to help you to work through these memories. If you need further help, he will provide referral sources. These services are not included in the study, and any costs incurred are your responsibility. Privacy is an additional risk, however, Jeff Friedman has established procedures to keep all your audio files confidential. If you choose to discontinue your participation in this study at any time, for any reason, you have the ability to request you wish to discontinue and for Jeff Friedman to refrain from sharing information that makes you uncomfortable. If you have questions about the research, your research rights, or if you experience an injury because of the research please contact Jeff Friedman at (954) 494-9914. You may also contact the IRB at the numbers indicated above with questions regarding your research rights.

Are there any benefits for taking part in this research study?
There are no direct benefits.

Will I get paid for being in the study? Will it cost me anything?
There are no costs to you or payments made to you for participating in this study.

How will you keep my information private?
Confidentiality is of optimum importance for academic research there is always the potential for

a breach of confidentiality, although unlikely. However, all information obtained in this study is strictly confidential, unless law requires disclosure. Your data will be de-identified with the use of pseudonyms in place of any other actual name mentioned during the interview. Pseudonyms will be used throughout the interviews and transcription process. The IRB, and/or Dr. Jim Hibel, (dissertation chair) may review research records. All data will be stored in a locked safe in the home office of Jeff Friedman, on a password protected computer, and will be kept for about 12 months. Every effort will be made by the researcher to ensure the security and confidentiality of your information throughout this entire process.

What if I do not want to participate or I want to leave the study?
You have the right to leave this study at any time or refuse to participate. If you do decide to leave or you decide not to participate, you will not experience any penalty or loss of services you have a right to receive. If you choose to withdraw, any information collected about you **before** the date you leave the study will be kept in the research records for 36 months from the conclusion of the study and may be used as a part of the research.

Other Considerations:
If significant new information relating to the study becomes available, which may relate to your willingness to continue to participate, this information will be provided to you by the investigators.

Voluntary Consent by Participant:
By signing below, you indicate that:

- This study has been explained to you.
- You have read this document or it has been read to you.
- Your questions about this research study have been answered.
- You have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury.
- You have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights.
- You are entitled to a copy of this form after you have read and signed it.
- You voluntarily agree to participate in the study entitled: Adaptations to ACE: *A Constructivist Grounded Theory regarding adaptations to Adverse Childhood Experiences*

Participant's Signature: _____ Date: _____

Participant's Name: _____ Date: _____

Signature of Person Obtaining Consent: _____

APPENDIX B: BIOGRAPHICAL SKETCH

Jeffrey Friedman is a Licensed Clinical Social Worker and community activist. He has worked in a variety of settings including psychiatric hospitals, drug treatment centers, and assisted living facilities. He currently maintains a private practice in Aventura, Florida.