

Trauma Bonds

by

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Abandonment and trauma are at the core of addictions. Abandonment causes deep shame. Abandonment by betrayal is worse than mindless neglect. Betrayal is purposeful and self-serving. If severe enough, it is traumatic. What moves betrayal into the realm of trauma is fear and terror. If the wound is deep enough and the terror big enough, the body alters. The system elevates into an alarm state, never safe. Waiting for the hurt again. In that state of readiness the client doesn't notice that part of them has died. The client is grieving.

Like everyone who has loss, the clients have shock and disbelief, fear, loneliness, and sadness. Yet the clients don't notice because their guard is up. In their readiness, the clients abandon themselves. Yes, another abandonment.

What we see is highly addictive attachment to the persons who have hurt the clients. The clients may even blame themselves, their defects, their failed efforts. The clients strive to do better as their lives slip away amongst all the intensity.

These attachments cause the clients to distrust their own judgment, to distort their own realities so much, the clients can place themselves at more risk. The clients are bracing themselves against further hurt. Taking precautions which almost guarantee more pain. These attachments have a name. They are called trauma bonds.

Exploitive relationships create trauma bonds. These occur when a victim bonds with someone who is destructive to them. Similarly, adult survivors of abusive and dysfunctional families struggle with bonds that are rooted in their own trauma experiences. To be loyal to that which does not work - or worse, to a person who is toxic, exploitive, or destructive to the client, is a form of insanity.

A number of signs exist for the presence of a betrayal bond:

1. When everyone around the client is having negative reactions so strong the client is covering up, defending, or explaining a relationship.
2. When there is a constant pattern of non-performance and the client continues to expect them to follow through anyway.
3. When there are repetitive, destructive fights that are no win for anybody.
4. When others are horrified by something that has happened to the client and the client isn't.

5. When the client obsesses about showing someone that they are wrong about the abuse, their relationship, or their treatment of the client.
6. When the client feels loyal to someone even though the client harbors secrets that are damaging to others.
7. When the client moves closer to someone who is destructive with the desire of converting them to a non-abuser.
8. When someone's talents, charisma, or contributions causes the client to overlook destructive, exploitive, or degrading acts.
9. When the client cannot detach from someone even though the client does not trust, like or care for the person.
10. When the client misses a relationship even to the point of nostalgia and longing that was so awful it almost destroyed the client.
11. When extraordinary demands are placed on the client to measure up as a way to cover up exploitation of the client.
12. When the client keeps secret someone's destructive behavior because of all of the good they have done or the importance of their position or career.
13. When the history of their relationship is about contracts or promises that have been broken, which the client are asked to overlook.

They all involve exploitation of trust or power or both. They all can result in a bond with a person who is dangerous and exploitive. Signs of betrayal bonding include misplaced loyalty, inability to detach, and self-destructive denial. Professional therapists can be so focused on their client's woundedness; they will overlook the trauma bonds that may remain.

Finally, consider the context in which trauma bonds are most likely to occur:

- Domestic violence
- Dysfunctional marriages
- Exploitation in the workplace
- Religious abuse
- Litigation
- Kidnapping
- Hostage situations

- Cults
- Addictions (alcohol, drugs, gambling, eating, sex, and high risk)
- Incest and child abuse
- Violence in other lands is closer than before. Terrorism and hatred leak across our borders. No longer can we say that is not our problem. The experience of 9/11 underscores the need for awareness about trauma.
- Between 1985 and 1993 exposure to violence increased 176% for the average junior high school student. Fifty per cent of women in our culture will experience some form of sexual assault during their lifetimes

Effects of Trauma on the Brain

When people are profoundly frightened, trauma creates a biological alteration of the brain. At birth, only primitive structures like the brain stem (which regulates fight/flight) are fully functional. In regions like the temporal lobes (which regulate emotions and receive input from the senses), early experiences wire the brain circuitry.

When early trauma/deprivation are present, the circuitry to and within the temporal lobes are profoundly affected, resulting in emotional and cognitive problems. Our primary brain goes into stimulation and is flooded with neurochemicals. When the source of the fear goes away, the chemicals go away. The person experiences cravings. They can become attached to trauma. People become reactive human beings-going from stimulation to action without thinking. PTSD is reacting years later to early trauma events

Two factors are essential in understanding traumatic experiences. How far our systems are stretched and for how long. Some events happen only once or just a few times, but the impact is so great that trauma occurs. Trauma by accumulation sneaks up on its victims. They become acclimatized. Traumas that are horrendous and long lasting are the worst. Such was the holocaust. Or Vietnam or 9/11.

Emotional scars can be so severe that generations descended from those surviving will react in ways that still reflect the original trauma. No amount of normalcy makes it safe. Patterns and attitudes evolve far beyond the individual and are incorporated into family and society.

Here are nine predominant ways that trauma continues to affect people over time. They are:

1. Trauma reaction
2. Trauma arousal
3. Trauma pleasure
4. Trauma blocking
5. Trauma splitting
6. Trauma abstinence
7. Trauma shame
8. Trauma repetition
9. Trauma bonds

1. Trauma Reaction

Definition: Physiological and/or psychological alarm reactions from unresolved trauma experience.

Clinical Patterns: Flashbacks; intrusive thoughts; insomnia; triggered associations; troubling dreams; physical symptoms; hyper vigilance; living in extremes; bipolar cycles; Borderline Personality Disorder; victims of violent crimes, soldiers, sexual abuse survivors

Coping mechanisms would become overwhelmed to the extent that they could not function. Now remember that the brain, body, and nervous system will adjust. They will acclimatize. So for survival they continue by burying the horrifying experiences into compartments in the brain. Later, sometimes many years later, the compartments start to leak. The veteran re-experiences the terror and at times with the same realism of the original experience. Therapists call this Post Traumatic Stress Disorder or PTSD. The stress of the trauma continues long after the actual traumatic event. Living in such reactivity takes a toll on the body. For example, women who were sexually abused as children are eight times more likely to have cancer than women who were not abused. Some researchers make a strong case that the impact of trauma is encoded right down to a cellular level.

Clinical Strategies for Trauma Reactions:

- Cognitive reframing of trauma experiences
- Hypnotic desensitization
- Teach PTSD concepts
- Implement relapse prevention and other skills
- Controlled breathing
- Stress management techniques
- Developing meaning from victimization
- Therapeutic storytelling
- Systematic desensitization
- Re-experiencing the trauma in a safe environment
- Deep muscle relaxation
- Thought stopping strategies
- Guided self-dialog
- Role playing
- Covert modeling
- Diaries and self-monitoring
- EMDR

2. Trauma Arousal

Definition: Seeking/finding pleasure in the presence of extreme danger, violence, risk or shame.

Clinical Patterns: Sado-masochism; sex offending; prostitution; high risk experiences; arousal addiction.

Some soldiers in Viet Nam used sex as a way to escape the horror of war. They experienced sex in ways that are irreproducible in a peace time country. High risk sex had become like a drug which stimulated the system (like amphetamines), as an antidote to the pain. Coming home meant they could

find no parallel experience, so they simply became violent. It was the closest way they could experience that rush.

Some girls had their first sexual experiences under scary or even violent conditions. They found it pleasurable and felt responsible. As adults the only way they can be orgasmic is if a man is hurting them. Their behavior becomes supercharged and highly addictive. They may work as prostitutes or hit the S and M clubs. Either way they find willing partners who will re-victimize them.

Some executives, in an effort to compensate for horrible experiences as children, find an exhilaration in the climb to power. As CEO's of billion dollar corporations they only feel alive when dealing with crisis or huge risk. Leveraged buyouts, takeovers, and acquisitions become the "bets" of just another form of compulsive gambling.

Hooked on the stress of extraordinary power and the risk of losing everything, they cannot leave their job. Deal making twenty hours a day, they can hardly sleep or be with their families. They play with traumatic possibility and cannot leave it alone. For recreation they love high speed motorcycles, sky-diving, and other high risk diversions.

Some professionals (clergy, physicians, attorneys) will have sex with those entrusted in their care (parishioners, patients, clients). Some of these develop a pattern of high risk sex that is clearly addictive. Most were sexually abused as children who learned to connect their sexuality with fear. As adults they feel most sexual when it is dangerous or risky. One of the characteristics is that each episode is at greater risk than the previous until they are inevitably caught.

Addiction specialists talk about the "arousal" neuropathway of addiction. Gambling, high risk sex, stimulant drugs, and high risk activities serve as examples of this category. Stimulation and pleasure compensate for pain and emptiness. In sex alone the possibilities are endless: sex offending, sado-masochism, prostitution, and anonymous sex – all rely on danger fear to escalate the sexual high. Some relationships are saturated with arousal.

Escalators – supercharged sex, violence, dramatic exits, passionate reconciliations, secrets, and threats of abandonment all in the context of "if anybody ever found out about this there would be hell to pay." This is how soap operas can be so compelling. They are vicarious arousal with scripts based on betrayal. As we shall see, high arousal which comes from fear and danger can be an important ally of trauma bonding.

3. Trauma Pleasure

Definition: seeking or finding pleasure and stimulation in the presence of extreme danger, violence, risk, or shame. It is a frequent outcome of trauma.

Clinical Patterns: Signs of its presence are:

- Engaging in high risk, thrill seeking behaviors such as sky-diving or race car driving
- Seeking more risk because the last excitement was not enough
- Difficulty in being alone, calm, or in low stress environments
- Use of drugs like cocaine or amphetamines to speed things up or to heighten “high risk” activities
- Feeling sexual when frightened or when violence occurs
- Seeking high risk sex
- Loving to gamble on outcomes
- Sustained, steady tasks are difficult
- Seeking danger
- Constant search for all or nothing situations
- Associating with people who are dangerous to you

Arousal accesses a neuropathway which is very compelling. If your brain adjusts to it, you would need the stimulation simply to feel “normal.” Then it can become addictive and interfere with your life. You will not want to give it up. The alarm state induced by trauma becomes the gateway to many forms of addictive arousal. Yet there are other strategies for coping with trauma that also can become addictive, including efforts to block the trauma out.

Clinical Strategies for Trauma Arousal:

- Conduct assessment for addiction
- Initiate addiction treatment
- Teach concepts of multiple addictions
- Establish a relapse prevention plan
- Introduce Twelve-Step support
- Create alternative “high” options
- Initiate trauma resolution strategies

- Connect addiction relapse with trauma work

4. Trauma Blocking

Definition: Efforts to numb, block out, and overwhelm residual feelings due to trauma.

Clinical Patterns: Compulsive overeating; excessive sleeping; alcoholism; depressant drugs; satiation addictive responses. Numbing. Comforting. Relaxing. Anesthetizing. Anything to escape the uncomfortable feelings. High arousal? Something to calm the nerves. Slow down. Bad memories? Anything to obliterate the interior world. An analgesic fix to make it bearable.

Some use alcohol. Some use drugs. Some do both. Compulsive eating creates comfort and drowsiness. Watching mind numbing TV wastes time but avoids reality. Excessive sleeping becomes like a butterfly in a cocoon, only there is no intention of coming out.

Survivors block their pain. One of the leading factors in relapse for alcoholics is that as they get sober, their memories return. Rather than face the pain they start to drink again. More and more studies show that they may switch to other addictions. Addiction becomes a solution to the trauma. The neuro pathway involved here is called satiation. Behaviors and substances that induce calming, relaxing, and numbing create electrochemical reactions in the brain that serve as an analgesic “fix,” The neurochemical bottom line is anxiety reduction.

For the trauma survivor this means avoiding the fear. Addiction therapists use the term “compulsive” to describe the repetitive efforts to calm the mind. The problem here is that, again, the brain will adjust and the behavior will become necessary in order to feel normal. Then it is hard to stop because it has transformed into an addiction.

Trauma blocking is an effort to numb, block out, or reduce residual feelings due to trauma. Signs of satiation or efforts to block include:

- Difficulty staying awake
- Drinking to excess when life is too hard
- Always looking for something to do uncomfortable being at rest
- Preoccupied with food and eating
- Feeling anxious and “behaving” to make feelings go away
- Using drugs to escape

- Getting “lost” in work
- Eating excessively to avoid problems
- Using depressant drugs as a way to cope
- Using TV, reading, and hobbies as a way to numb out
- Sleeping as a way to avoid
- “Bingeing” when things are difficult
- Working so won’t have to feel
- Wish to “slow down” one’s mind.

Any trauma of sufficient magnitude will create this response in your neuropathways. In alcoholism for example there is much research to show that alcoholics (and indeed addicts of all kinds) probably are born with an insufficiency of certain receptor sites in the brain. That is why alcoholics can often list other alcoholics in their families going back many generations. Being raised in an alcoholic home is also traumatic.

All these factors are commonly recognized. In Vietnam, however, we had young kids with no history of alcohol or drug abuse in the family and a stable history of emotional health who came back from the war drug addicts and alcoholics. Their ability to function became impaired. Simply said, the war overwhelmed them. They used drugs and alcohol to cope. And their brains accommodated.

Survivors will often use a combination of strategies to cope. A common pattern is to use high arousal activities of intensity, pleasure, or stress and then follow with blocking strategies to balance the arousal. Drug addicts for example, will mix uppers and downers. Or consider the man who is having anonymous, high risk sex with other men in parks and streets.

When he returns home ashamed and exhausted but cannot sleep because of the excitement, he has learned to drink a six pack and eat until his stomach is uncomfortably distended. He passes out oblivious. Caught up in vicious cycles of arousal and blocking, his behaviors serve as a one-two punch to the painful memories of his childhood sexual abuse. He is caught. His memories will never relent. And his addictions will kill him – one way or another.

Clinical Strategies for Trauma Blocking:

- Differential diagnosis of addiction
- Confront patterns of blocking behavior

- Initiate addiction treatment
- Teach concepts of multiple addictions
- Establish relapse prevention plan
- Introduce twelve step supports
- Create alternative ways for anxiety reduction
- Initiate trauma resolution strategies; connect addiction relapse with trauma work

5. Trauma Splitting

Definition: Ignoring traumatic realities by “splitting off” experience and not integrating into personality or daily life.

Clinical Patterns: Avoiding reality through excessive daydreaming; compartmentalizing parts of self to reduce tension; fantasy addictive responses such as romance addiction or artistic or mystical preoccupation; living double life; extreme procrastination; dissociative disorders including multiple personality disorder.

Escape. Find another reality to go to if the one you’re in is too painful. Like the holodeck on the Enterprise of Star Trek. When members of the crew were distraught or needed a break they would go to the holodeck and create a fantasy that through holographic imagery seemed very real. Many episodes used the holodeck as a counterpoint or even a plot. At the end of each adventure, however, the routine of being on a Federation starship would return, as would the problems.

Similar stories are told by children who were sexually assaulted. They will recount how they would imagine themselves flying around the room or doing something they like as they were being fondled or penetrated. They were separating themselves from a reality too painful to bear. At the time it was an important coping strategy.

Therapists call this “splitting”- the victim learns to split off the uncomfortable reality or “dissociate” from the experience. They can do this by focusing on another reality or by creating an unreality or fantasy. When this coping style becomes a pattern which interferes with living life it is called a dissociative disorder.

Splitting takes many forms. Sometimes it works as amnesia. The survivor does not remember significant facts about the trauma. Sometimes survivors will find themselves in places or doing things and they have no idea how they got there.

Or they are in reality but feel detached from their body (flying around the room). People will make jokes (the lights are on but no one is home) because they have no understanding of the process. When there are different realities, sometimes different personalities will form. We call this multiple personality disorder.

Addiction is an important partner to the dissociative process. Psychedelic drugs and marijuana, for example, are hallucinogenic and create an altered reality. Mystical and artistic preoccupation and some forms of excessive religiosity and spiritual practice create altered mental states and can be highly addictive. The features of addictive disorders to sex, food, drugs, gambling, and alcohol are preoccupation and obsession.

It, too, has a set of neuropathways that are distinct. Addictions here are called the “fantasy” addictions and often accompany arousal and obsession. Some sex addicts for example, have a pattern of falling in love and as soon as the romance starts to subside, finding another romance. They live for the thrill and borrow endlessly on the promise of this is the lover that will make the pain go away.

An example is the compulsive gambler who buys lottery tickets with the family grocery money and obsesses about winning. He endlessly fantasizes about how he will spend the money he will win and how his profound financial difficulties will be behind him. Sadly he is not able to face his difficulties because he retreats so often into fantasy, he starts to act as if the fantasy is reality.

Addicts will talk about the split in realities and feeling like they are two persons: the real person who has values and keeps commitments and the out of control addict whose compulsivity destroys everything important to the “real” person. Stevenson wrote the story of Dr. Jekyll and Mr. Hyde to explain the experience of alcoholism. Addiction and trauma specialists are starting to understand that this “addictive personality shift” is very similar in its processes to multiple personality disorder.

Trauma splitting then is ignoring traumatic realities by “splitting off” experience and not integrating these experiences into personality or daily life. Signs of dissociation include:

- Dissociative episodes – feeling separate from body as a reaction to a flashback
- Avoiding stories, parts of movies or reminders of experiences
- Withdrawal or lack of interest in important activators because of experience
- Experiencing confusion often

- Living in a ‘fantasy’ world when things are tough
- Tendency to be preoccupied with something other than what is needed
- Lost in fantasies often rather than deal with real life
- Having a life of “compartments” that others do not know about
- Being a daydreamer
- Difficulty concentrating
- Avoiding thoughts or feelings associated with trauma experiences
- Inability to recall important details of experiences
- Procrastinating, interfering with life activities
- Tendency to be accident prone
- Hooked on “romance” as a way to avoid problems
- A problem with “putting off” important tasks
- Living a “double life”
- Loving romance fantasies
- Sometimes live in an “unreal” world
- Use of marijuana or psychedelics to hallucinate.

All of us seek the holodeck at some point in time. The problem starts when we have been hurt so badly we wish to stay there.

Clinical Strategies for Trauma Splitting:

- Assess for multiple personality disorder/dissociative disorders
- Assess for fantasy addictive responses
- Strategies for integration of realities/selves
- Teach how to retain focus within reality framework
- Connect trauma issues with dissociative or addictive patterns

6. Trauma Abstinence

Definition: Compulsive deprivation which occurs especially around moments of success, high stress, shame or anxiety.

Clinical Patterns: DSM Axis I disorders including Anorexia Nervosa; Sexual Aversion Disorder (sometimes known as sexual anorexia). Additional patterns include: compulsive saving; agoraphobia and other phobic responses; poverty obsessions; success avoidance; self-neglect; underachieving; workaholism.

Compulsive deprivation or abstinence occurs especially around memories of success, high stress, shame, or anxiety. Most important, deprivation is driven by terror and fear which we already know impacts powerfully on our brains.

In deprivation survivors might:

- deny self basic needs at times like groceries, shoes, books, medical care, rent, heat
- avoid sexual pleasure
- hoard money and not spend money on legitimate needs
- perform in “underachieving” jobs
- feel very guilty about any sexual activity
- spoil success opportunities
- have no interest in eating for periods of time
- see comfort, luxuries and play activities as frivolous
- skip vacations because of lack of time or money
- attempt diets repeatedly
- avoid doing “normal” activities because of fears
- be often “under employed”
- vomit food or use diuretic to avoid weight gain
- have low interest in sexual activity
- have difficulty with play

While there are many faces to traumatic abstinence, common elements do exist. First is the long shadow of family neglect. Neglectful families teach lessons about self-care and self-esteem. The family environment allows children to become comfortable with deprivation. The neglect of children becomes self neglect in adults.

Couple it with high arousal events such as domestic violence or sexual abuse and you have a neurochemical cocktail that is hard to beat. The antidote to being out of control is to be in super control. Maybe the only way to control survival is to freeze like a hunted animal. Ask nothing. Do nothing. Attract no attention. Yet the fear mobilizes the body. Adrenalin, cortisol, endorphins, and norepinephrine pour into the body. In a constant state it can become addictive.

All the conditions are there: obsession, profound neurochemical changes, and a mechanism to manage the fear. Addiction specialists have long recognized the role of addictive deprivations. Anorexia or self-starvation has all the characteristics of drug addiction and is regarded as a fear based, endorphin mediated process which can be terminal. Even more important is the role of deprivations in serving as a balance to other excessive out of control behaviors.

It is common with professionals such as clergy, physicians, and attorneys to have excessive out of control aspects of their lives rooted in extreme deprivation. The bottom line is: where ever addiction is, there will also be deprivation. If not addictive in its own right, the deprivation becomes a life stance which, in part, is a solution to traumatic experience.

Clinical Strategies for Trauma Abstinence:

- Assess deprivation role in other addictions
- Teach connection extremes as dysfunctional balance mechanism
- Assess compulsive deprivation
- Confront disabling beliefs about being non-deserving
- Seek patterns of deprivation
- Develop incremental “use” strategies
- Create relapse prevention strategies
- Connect relapse with trauma issues
- Learning to play as healing

7. Trauma Shame

Definition: Profound sense of unworthiness and self hatred rooted in traumatic experience.

Clinical Patterns: Shame cycles; self-mutilation; self-destructive behavior, expressing self hatred through suicidal ideation; shame based personality; depression; co-dependency personality disorder.

Shame does not just originate from a perpetrator blaming the victim, although that happens often. Trauma can also leave a feeling of being defective or flawed because of the trauma. Sometimes they are “ashamed” of their reactions to trauma – that they are no longer like other people. Shame represents a fundamental break in trust. People who become “shame based” have core beliefs that they are unlovable, that if people knew what they were really like they would leave, and that there is no hope for change. They do not trust anyone to care for or about them on their own merits, especially if the trauma has significant betrayal by trusted persons.

Survivors will try to compensate by driving themselves to meet unreachable standards in order to gain the acceptance of others. When they fail they add to their existing shame. An example would be the dieter on a rigorous diet who binges, feels ashamed at the lack of self-discipline, and tries even harder. Addiction specialists see the whole binge purge phenomenon described earlier as rooted in shameful feelings about self.

Trauma specialist also note that one of the changes in brain functioning is that all experiences are processed as extremes. Reactions are totally one way or another. There is no mid ground which is what happens with addiction and deprivation. People lose the ability to operate in a balanced way which further adds to the shameful feelings at the survivor’s core.

Shame can result in an obsessive self-hatred which is more than feeling unlovable. It is also more than being depressed, which often happens to those mired in trauma-based shameful feelings. It can become a merciless unforgiving stance with oneself for which the only ultimate solution is suicide. Much time is taken up in thinking about destroying oneself.

Another form is in self-destructive behavior – that is doing things which are bound to damage oneself or doing things that would sabotage any success. Clinicians are struck by how victims of trauma, especially in which there is violence, will become violent with themselves.

Self-mutilation, cutting or hurting themselves, and placing themselves in high risk situations are all rooted in self hatred. Even in thought they can dwell on torturous images of violence to self.

Signs of shame in trauma survivors include:

- Feeling bad about oneself because patient felt experiences were his/her fault
- Feeling lonely and estranged from others because of experiences
- Engaging in self-mutilating behaviors (cutting oneself, burning self, etc.)
- Engaging in self-destructive behaviors
- Enduring physical or emotional pain most people would not accept
- Avoiding mistakes at “any cost”
- Avoiding experiences that feel good
- Feeling bad when something good happens
- Suicidal thought; suicidal threats; attempted suicide
- Inability to experience certain emotions (love, happiness, sadness, etc.)
- Feeling as if patient must avoid depending on people
- Dim outlook on future
- Trying to be perfect
- Feeling unworthy, unlovable, immoral or sinful because of experiences
- A sense that others are always better than patient

Clinical Strategies for Trauma Shame:

- Bibliotherapy on shame
- Shame reduction strategies
- Teach visualization and affirmation
- Intense family of origin work
- Restructure faulty or shaming belief
- Teach nature of shame cycle

8. Trauma Repetition

Definition: Repeating behaviors and/or seeking situations or persons who recreate the trauma experience.

Clinical Patterns: Re-enactment; efforts to resolve unresolvable; obsessive compulsive disorder; repetition compulsions.

Reenactment. Therapists use the term “repetition compulsion” which means repeating behaviors and/or seeking situations or persons which recreate the trauma experience. Ralph was reliving a story out of his painful history. Some people will find themselves in the same situation with the same type of person over and over again in their lives. Yet like Ralph, they may never link it to the original traumatic experience. Reenactment is living in the unremembered past.

Some survivors repeat not only the same scenario but also the exact behavioral experience. A nurse was hospitalized many times for depression and feeling suicidal. She kept telling people that she had this problem with masturbation. Usually this problem was ignored because it was not seen as relevant to her suicidality.

Finally, a perceptive therapist explored what the masturbation was really about and it was not just masturbation. It was autoerotic asphyxiation. She would hang herself in her closet while compulsively masturbating. In her art therapy she drew a picture of her father raping her at the age of ten. In the picture the father is strangling her.

What the therapist then learned was the whole story of how she was sexually abused and then locked in a closet. So all the elements of the original scenario are there: sexual stimulation, strangulation, extreme danger, and the dark closet. She was compulsively reenacting that scene from her childhood. As much as she tried to stop it, she could not. She was so ashamed, the only way she could ask for help was to be suicidal.

Another form of reenactment is to victimize others the way you were victimized. One incest father talked about how when he was a kid he was told by his parents that as an uncircumcised child his foreskin needed to be stretched regularly or he might not be able to be sexual as an adult. This led to the sexual abuse he experienced as a child and he did the same with his own children.

When the grandparents were brought into therapy they were asked which doctor had prescribed stimulation of the foreskin. The grandfather responded, “It was not our doctor, it was my father’s doctor.” This piece of medical advice had been given in the late 1890’s and was part of sexual abuse across four generations.

In part, trauma repetition is an effort by the victim to bring resolution to the trauma. By repeating the experience, the victim tries anew to figure out a way to respond so the fear can be eliminated. Instead the victim simply deepens the traumatic wound. Note that repetition like shame can draw heavily on the other forms of traumatic impact: reactivity, arousal, blocking, splitting, and deprivation. Shame and reenactment simply become intensifiers to the mind altering experience of trauma. They become allies of one another. They form a devastating combination when they are part of a trauma bond in which there has been betrayal.

Presenting Symptoms of Trauma Repetition:

- Inability to stop a childhood pattern
- Doing something destructive over and over from early life
- Reliving over and over a “story” out of patient’s past
- Engaging in abusive relationships repeatedly
- A desire to redo an early trauma experience
- Reverting to things done as a child
- Repeating painful experiences
- Doing compulsively something to others that was done to patient as a young person
- Doing things to others that were done to patient in his or her family
- Having thoughts and behaviors that do not feel good repeatedly
- Preoccupation with children of a certain age

Clinical Strategies for Trauma Repetition:

- Assessment for obsessive compulsive disorder
- If perpetrator, focus on fixated vs. regressed issues
- Cognitive restructuring of key experiences and key beliefs about those experiences
- Abreactive recreation of experience through visualization to reduce experience’s power

- Disrupt systemic cycles that occur in the family system that draw upon this experience for power or that empower the trauma

9. Trauma Bonds

Definition: Dysfunctional attachments that occur in the presence of danger, shame or exploitation.

Clinical Patterns: Abusive/conflictual ties like “War of Roses” or “Fatal Attraction;” systemic setups like Lucy & Charlie Brown; abuse cycles such as those found in domestic violence; misplaced loyalty as in cults, incest, or hostage situations; depression; rage or debilitation resentment; co-dependency.

What do the following people have in common?

Joan was petrified. Her best friend was getting married in a Catholic church. She dreaded anything that would remind her of the priest she had been involved with for eight years. She could hardly stand not being with him. Being with him was worse. Especially when she found out she was one of many. To be in a church again would be agony. Perhaps he could change. Perhaps he would be there.

Fred could not believe it. Here he was doing it again. He was helping his ex-wife – a woman who lied to him for years about her affairs, who attacked him viciously both in and out of the courtroom, who lied to the children, his own family, and friends, and who in typical fashion ignored her own attorney’s advice, thereby destroying the company he built.

Yet there was a snow blower he saw on sale, and there was snow on the ground. She had no way of dealing with that in her new house, and it felt good to help her this way. Maybe she will notice.

To belong to Reverend Jones group was to feel simultaneously deeply cared for and deeply afraid. For all the good that was done, very little dissent was tolerated. Even moving out of the country did not help. When the congressman came to investigate, some decided to leave. All were shot trying to escape. The rest committed suicide rather than go against the community. Over nine hundred and fifty people died out of loyalty.

They are all struggling with traumatic bonds. Those standing outside see the obvious. All these relationships are about some insane loyalty or attachment. They share exploitation, fear, and danger. They also have elements of kindness, nobility, and righteousness. These are all people who stay involved or wish to stay involved with people who are dangerous to them. Emotional pain, severe consequences, and even the prospect of death will not stop their caring or commitment.

Clinicians call this traumatic bonding. This means they have a certain dysfunctional attachment that occurs in the presence of danger, shame, or exploitation. There is often seduction, deception or betrayal. Always there is some form of danger or risk.

Some relationships are traumatic. Conflictual ties as seen in movies like “War of the Roses” or “Fatal Attraction.” What Lucy does to Charlie Brown around holding the football every year is a betrayal we have grown to expect. Abuse cycles such as those found in domestic violence are built around trauma bonds.

Misplaced loyalty as found in exploitive cults or in incest families or in hostage and kidnapping situations. Codependents who live with alcoholics, or compulsive gamblers, or sex addicts and will not leave no matter what their partners do may have suffered enough to have a traumatic bond.

Presenting Symptoms of Trauma Bonds:

- When you obsess about people who have hurt you and they are long gone (obsess means to be preoccupied, fantasize about, and wonder about even though you do not want to)
- When you continue to seek contact with people whom you know will cause you further pain
- When you go “overboard” to help people who have been destructive to you
- When you continue being a “team” member when obviously things are becoming destructive
- When you continue attempts to get people to like you who are clearly using you
- When you trust people again and again who are proven to be unreliable
- When you are unable to retreat from unhealthy relationships
- When you want to be understood by those who clearly do not care
- When you choose to stay in conflict with others when it would cost you nothing to walk away
- When you persist in trying to convince people there is a problem and they won’t listen
- When you are loyal to people who have betrayed you

- When you are attracted to untrustworthy people
- When you keep damaging secrets about exploitation or abuse
- When you continue contact with an abuser who acknowledges no responsibility

Clinical Strategies for Trauma Bonds:

- No contact contracts
- Teach strategies for detachment
- Support self-help groups that can provide perspective
- Teach concepts of “bonds” and systemic repetition
- Explore pay-offs of bonds
- Disrupt beliefs around “uniqueness”
- Support grief through ritualization around change