UNBROKEN:

The Trauma Response Is Never Wrong

And Other Things You Need to Know to Take Back Your Life

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sounds true
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AUTHOR'S NOTE

About the Stories in This Book

The client stories in this book are composites. No story is a single person's story. For protection and privacy, each story has pieces of other people's stories mixed in.

But these composites are not just about privacy, they're also about unity. If you are or have been my client and you recognize your story here, it's because it *is* your story. And it also isn't. Mine is in here too. I want you to know that even in your most isolated, lonely moment, you were not alone.

INTRODUCTION

We Are Not Broken

The cure for pain is in the pain.

Rumi (translated by Coleman Barks)

Every Thursday for the better part of four years, I sat down in my therapist's office and presented him with new evidence of life's bleakness, as if I were showing him a piece of sea glass that I'd brought from a weekend at the beach.

"See? This is proof. Shards. Sharp and broken. That's all there is. It's what the sea is made of. Can't you see it?"

"Yes, I see the glass. I see the shards," he'd say. "But is that really all there is?"

To be fair, I was facing quite a lot of horror at the time. I was surrounded by tragedies, both tiny and enormous. I was twenty-five, both of my parents were suddenly dead, and what was left of my family was splintering under the weight of grief. We had sold our childhood home and my parents' thirty years' worth of belongings—and their six kids—were scattered across three states.

As time marched on, the weight of it all became too much to bear. I started to have crushing migraines, relentless panic attacks, and episodes of vertigo. Life felt like a series of nightmares. If this was what adulthood looked like, I did not want it. In a matter of months, nearly all of my most stable anchors had been pulled out of the sand and I found myself entirely at sea.

The only thing that felt stable was work. So I worked *all* the time. I collected jobs—part-time jobs, full-time jobs, classes to take, classes to teach. I nannied, was a teaching assistant, designed curricula as a contractor, and edited books. The only time I felt okay was when I could forget the circumstances of my life by losing myself in a project—preferably one with a pressing deadline. Free time meant I might have to sit with myself, and I was sure that if that happened, I would drown in my emotions, in this sea I'd discovered made of shards of glass.

Other than the distraction of work, I had exactly two coping techniques: Xanax and jumping jacks. Xanax is, theoretically, an antianxiety medication, but it has a remarkably short half-life. As soon as it wears off, panic can surge up and come bucking through your body like a downed power line. As soon as that happened, I would launch myself up from wherever I was sitting and start doing jumping jacks. My fried, frantic little brain reasoned that if I was doing jumping jacks, at least my heart would be beating fast for a *reason*, which would be a lot less scary than when it raced for *no reason*.

These coping techniques worked, sort of, but there were significant downsides. You can only take Xanax for so long, and there are many situations where breaking out into frantic jumping jacks might raise an eyebrow. What was I going to do if I had a panic attack while I was teaching? Launch into jumping jacks in the middle of a lecture? The only other option seemed to be hyperventilation.

So I didn't go to therapy just to be reminded that there was more to life than pure and abject horror. I was pretty sure there *wasn't* more to life. I went to therapy because my way of life had become unsustainable.

In one of our sessions, I sheepishly mentioned to my therapist that I had started lying on the floor when I felt terrible. I would lie on the floor in the student center, in the grad lounge, in my office, and at home. I contemplated doing it on public transportation and in the street. I was pretty sure that once I admitted this, my therapist would recommend I be committed to an institution.

Instead, he said, "That's a great grounding technique."

"A *what*?"

"A way to ground yourself. You are calming and soothing yourself by coming back to your body and feeling the stability of the floor. How cool that you reached for that without even knowing what it was! It sounds like you know exactly what you need. Maybe you should trust yourself a bit more."

Turns out, when you're feeling lost or frantic, lying on the floor provides an opposing force to the anxiety and activation. If you lie on your back and push your body into the floor, noticing and feeling each of the points where your body touches it, you start to feel mindfully aware of stability, of strength. Things start to feel more secure, and you start to feel more present. If you lie on your stomach and take some deep breaths into your belly, you activate your parasympathetic nervous system by way of the vagus nerve, which slows the heart rate and restores the body to a calm state.

I didn't know any of that at the time. I was just lying on the floor because I *needed* to. Because I was traumatized and grieving. Because I was dizzy and at sea, overwhelmed and trying to remember what land felt like. Because everything had become unbearable. *Not* because I was broken, or weak, or flawed, or doomed to suffer endlessly, but because I was strong, healthy, and aware. Even in dire straits, my poor little body and my fried, frantic little brain had *known* what they needed.

That day, something shifted. I began to see that the impulse to reach for coping strategies is a form of resilience and how that resilience is inherent within us. I began to wonder how many of us might heal if we learned more about that natural impulse to cope and how to stock our resilience toolboxes with coping strategies that work well for us.

It should be impossible to reach adulthood without a toolbox full of well-honed coping tools. Yet nearly all of us do. How did I get to age twenty-five with only *two* coping techniques: Xanax and jumping jacks? Why did I have to discover a fantastic coping exercise like lying on the floor for grounding by *accident*? Why was I ashamed of it? Why don't we teach these kinds of coping techniques in schools?

It's not because we are broken. It's because our understanding of trauma, and of our natural responses to it, is broken.

I discovered just how broken it is when I was in graduate school. At the time, not only was I learning how to cope with my own tragedies, both tiny and enormous, but I was also looking at trauma and its effect as part of a larger question about the psychology of identity. As I went down the rabbit hole into the history of the study of trauma, I quickly found that the field of psychology is still embroiled in a war about which kinds of events count as traumatic and which do not. No wonder I had made it to age twenty-five without any coping mechanisms! The field of psychology couldn't even get straight on what trauma *was*, let alone how people could cope with it and heal after responding to it.

What began as a study of identity became an interdisciplinary PhD dissertation on the psychology and neurobiology of the trauma response. But I didn't want everything I was learning to stay locked in the ivory tower. So alongside my dissertation, I got a life coach certification and kicked up a part-time practice. I wanted to tell as many people as I could what they were not going to learn in a traditional therapy session: That their brains and bodies were responding to overwhelm to keep them alive. That they didn't have to be ashamed of being traumatized. That the symptoms they were dealing with made sense and could be worked through. That there were tools that we could use to figure out how to counter those symptoms together. I felt compelled to help those who were struggling the way that I had.

In the past ten years, I've worked with *many* different kinds of people as a coach: military veterans; first responders; emergency room (ER) and intensive care unit (ICU) doctors; victims of sexual assault, incest, and child abuse and neglect; previously incarcerated folks; gang members; those who have lost a loved one to murder; individuals who are terminally ill; people who are chronically in pain; those trying to manage complicated grief; and people struggling after breakups, divorce, career transition, and traumatic loss. Though their stories are just about as diverse as you can imagine, what they all have in common is the desperate desire to learn how to come home to their bodies, their relationships, and the world after it has been shattered.

I have two goals for this book. The first is to undo what you think you know about trauma and replace it with what we *know* to be true after 150 years of study. As I explain in chapter 1, we have knowledge and research that shows that our previous understanding of trauma, as well as much of our understanding of trauma today, is deeply flawed. The psychological community—and thus society—used to think that the trauma response was pathology, weakness, and dysfunction. Now we *know* it is the body's natural response to threat, a sign of function and strength. In chapters 2 through 7, we'll look more closely at facets of the trauma response that are too often overlooked or misunderstood. If you have experienced traumatic events in your own life, seeing yourself in the stories of my clients will help you recognize and relate to the trauma without shame.

The second goal is to arm you with science-based coping tools that can help you wrangle what traumatic experiences leave in their wake. I want you to have a whole toolbox of coping tools, not just two. And I want you to know just how and when to use these tools. You can go and buy top-shelf tools, but if you don't know how to use them, you won't be able to build a single goddamned thing. You'll find these tools at the ends of chapters 2 through 7.

When it comes to healing after a traumatic experience and coping with the lingering symptoms of the trauma response, progress doesn't look like not having needs. It looks like learning to recognize those needs and meet them wholeheartedly. One of humanity's greatest traits is that we are malleable. We naturally adapt. What we sometimes forget is that this means we can *readapt* as well. When our coping mechanisms become unhealthy or no longer serve us, we can pick new ones. But to do so, we must be willing and ready to recognize and meet our changing needs. Only when we bring our symptoms and behaviors into the light, without shame, can we *do* something about them.

If you are struggling with the aftereffects of trauma, this book will help you drop the shame so you can understand and work with your kick-ass neurobiology—the kick-ass neurobiology that kept you alive but is now getting in your way. It will also teach you how to work with

your biology's automatic responses so that you can have more sovereignty over your body and your life.

If you are trying to help someone else as they struggle with the aftereffects of trauma, this book will help you understand that person better. This will make it possible for you to anticipate their trauma responses, not personalize them, and help your person navigate more sustainable, connected coping.

No matter who you are, I hope that above all you will come away with the understanding that trauma does not equal brokenness. That's a myth, a fallacy. The idea that traumatic experience breaks us is based on shame and bad science. What our traumatic experiences reveal is that though we can be bent, dented, or bruised, we *cannot* be broken. That, in fact, we are the *unbroken*.

CHAPTER 1

Repairing Our Understanding of Trauma

Trading Shame for Science

> No trauma has discrete edges. Trauma bleeds. Out of wounds and across boundaries.
>
> **Leslie Jamison**

Forget everything you think you know about trauma. Most of it comes from outdated definitions, poor societal understanding, and science that has since been overturned by new technology. Too often we think of trauma in terms of what happened—like an attack, a natural disaster, a serious accident or illness, a war, or a loss.

What if, instead, we thought about trauma in terms of the *reaction* an experience causes?

Something is potentially traumatic when it overwhelms the nervous system enough to cause our emergency coping mechanisms to kick into gear. These mechanisms are designed to save our lives—and they do. But to do so, they pull energy and resources from some of our other systems, including those that help us orient ourselves in the world and organize our memories.

Most of the time, when our emergency mechanisms activate, they get toggled back off pretty quickly and our nervous system regains normal function. Sometimes, though, we have trouble finding the off switch,

and the emergency system stays on. Chronically activated emergency systems trick us into thinking we are constantly in danger, and what was an isolated incident becomes a never-ending feedback loop. Our nervous system starts to perceive nearly everything as danger, which radically changes how we feel in our bodies and in the world.

When this happens, we need someone to help us retrain our system to toggle back off by providing a safe haven for us to process and feel. When this relational process cannot (or simply does not) happen, what was potentially traumatic becomes a *lasting trauma*.

Sounds simple and logical enough, right? To keep a potentially traumatic experience from becoming lasting trauma, we just need to find someone (or more than one person) to help us cope in the short term and reset our system in the long term. So what keeps that from happening?

There could be many things affecting each of us individually, but as a trauma researcher, I can point to one big reason that affects all of us: shame.

We have been fed a great societal lie that says continuing to suffer after experiencing a traumatic event is something we should be ashamed of. We are told that suffering after trauma is something that should be kept to oneself. It is, after all, a sign of weakness, proof of a great and intractable character flaw. There is the trauma, and then there is the way you respond to the trauma, and if you do not respond with the kind of automatic, effortless, and sparkling resilience that makes other people feel comfortable, then you have failed. You *are* a failure.

Unfortunately, this lie is a long-standing one, and it is rooted in how the study of trauma has developed throughout the history of clinical psychology.

THE HISTORY OF THE STUDY OF TRAUMA

The history of the study of trauma can be divided into five phases, one of which we are in now. I promise not to bore you with unnecessary historical detail, but a few key moments reflect how we understand and view trauma today in some important ways. Looking at what we know about the study of trauma so far, we can see how it has shaped our current

understanding in harmful ways. That knowledge is critical as we assess and update our current understanding of trauma.

Phase One

The first phase took place in ancient Egypt, where depressive symptoms coupled with baffling physical episodes in women were termed "hysteria" and believed to be the result of a "wandering uterus." Curative methods were designed to "move" the uterus back to where it belonged. Hippocrates, who you may know as the father of the practice of medicine and the namesake of the Hippocratic oath, believed that hysterical symptoms such as anxiety, tremors, convulsions, and paralysis could be traced to sexual inactivity. The cure, accordingly, was sexual activity, which was thought to restore women and their uteruses to their proper function.

Though this might seem absurd, it's worth remembering that in the absence of modern medical technology, diagnostics and treatments in the ancient world were based almost entirely in hypothesis. Further, though the idea about the origins of hysteria turned out to be wrong, ancient Egyptians were right about many other things. Even without modern technology, they successfully treated bone breaks, dental issues, and many other aches, pains, and diseases.

Later cultures argued about whether abstinence or more sexual activity was the better cure, but the idea that the cluster of symptoms originated in the dysfunction of female reproductive organs remained unchanged for a long time.

The psychiatric community consistently failed to find a sustainable, successful treatment for hysteria. It became regarded as the mental illness most difficult to treat, and women who suffered from it were relegated to insane asylums and subjected to either neglect or torturous experimental methods.

Phase Two

The second critical phase in the history of the study of trauma took place in western Europe in the late 1800s when a group of influential

psychologists became taken with the unsolvable problem of the hysterical woman. Jean-Martin Charcot, Sigmund Freud, Josef Breuer, and Pierre Janet all found themselves spending most of their time with their hysterical patients, and together they made some of the first strides in understanding what was going on with them.

In the mid-1860s, Charcot brought attention to the problem with his famed "Tuesday night lectures." These lectures drew crowds who came to watch hysterical women "perform" their symptoms on stage.

In 1895, when Freud and Breuer published their work *Studies on Hysteria*, they theorized that the cause of hysteria was past trauma. Though Freud and Breuer are complicated figures in the history of psychology, the breakthroughs they made in their study of trauma still shape the way that we understand it today. Completely by accident, Freud and Breuer discovered that their patients' untreatable symptoms could always be traced back to a precipitating event that was too emotionally overwhelming to process in the moment. They theorized that an inability to process an upsetting event because of an extreme emotional response caused that event to get stuck in the psyche somehow and cause chronic symptoms. They hoped that if they could help their patients process the initial event and bear some of the unbearable emotions, the symptoms would cease. We may take this idea for granted now, but at the time, the theory that some kind of event could explode the recording and processing system in the brain and lead to chronic mental health issues was a radical one.

Janet came to the same conclusion while working separately from Freud and Breuer. He was the first to connect the theory of dissociation to traumatic memories. This connection explained why hysterical patients often experienced an altered state of consciousness that made them feel as though they had "left the room." Like Freud and Breuer, Janet speculated that intense emotions have an effect on the mind's ability to process an event and led the mind to create a different kind of memory, one that is somatic (bodied), rather than cognitive (mental), and manifests in dreams, hyper-aroused states, and flashbacks.

Had the history of the study of trauma continued to proceed as fruitfully as it began in the late 1800s, there is no telling how far it might have