

The Post-Traumatic Gazette No. 1

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What are Post-Traumatic Stress Reactions?

Post-Traumatic Stress reactions start with a traumatic stressor “outside the range of usual human experience and that would be markedly distressing to almost anyone,” according to the American Psychiatric Association’s *Diagnostic and Statistical Manual, III-R*. Since it is almost impossible for a non-survivor, or a numb survivor, to understand or imagine what a survivor experiences at the time of the trauma, and therefore to identify what is traumatic, the *DSM III-R* offered four categories of traumatic stressor for diagnosticians and therapists: (1)-threat of death or loss of physical integrity to the survivor (combat, rape, incest, earthquake, etc.), (2)-death, threat of death or loss of physical integrity to family or close friends (survivor does not have to be present) (3)-sudden loss of home or community, and (4)-seeing another person who has recently been seriously injured or killed. These were derived from reality: real nurses and body-baggers had terrible PTSD, just like combat vets, rape and incest survivors, people who lost their homes in fires or floods, or lost their kids on Flight 103 over Lockerbie or in the World Trade Center.

As a person is traumatized, at least for the first time,* the sense of personal safety is shattered. Two things start to happen immediately. The person will strive to survive using three available systems: fight, flight or freeze. What they called the reptile brain in high school biology seems to take over and choose. Military training is designed to get soldiers to always choose fight, but they wouldn’t have to train us to do that if we were natural born killers. Culture and religion often train women to freeze, to take it and endure. In nature, flight is most common.

Simultaneously, while survival is at stake, feelings will shut down and information taken in and processed will become focused so the person can do *whatever it takes to survive*.

Whatever it takes! This is not a polite, well-behaved part of us. It pisses and shits in its fear. It scratches and bites and goes berserk, beating people to death with the

*Many trauma survivors have multiple traumas.

rifle-butt when the bullets are gone. It kicks and gouges. It runs out on its friends, trampling whoever gets in its way. It cowers, unable to get up or to fight, unable to protect those it loves. It may freeze or follow orders that are against all the survivor personally believes in. Survivors may feel shock or shame over what this part of them did.

Let me emphasize something: *this ability to do whatever it takes to survive is God-given or evolution-given, depending on your point of view, but we all have it, and in traumatic enough situations, it will come out or we die*. Extreme situations which trigger this reaction again and again may cause survivors to do things in order to survive which can be hard to look back on later.

This survivor part of us is not able to *listen to reason* either. It does not speak English, nor can it tell time. It is going to be looking for danger from now on whether or not others think it is reasonable.

Real physiological changes occur in the brains of survivors which make them quick to react. In order to live through the trauma, survivors may develop the capacity to go from fine into a killing rage in seconds. That helps them live. They may stop sleeping soundly. Sleep can get you killed. Survivors may be uncannily able to read the moods of those around them because the moods of their abusers defined their lives. They become hypervigilant, searching for physical danger all around and all the time. Due to hypervigilance and lack of sleep, it is hard for them to concentrate on everyday things, although they are concentrating on survival information. They may do poorly in school and believe they are stupid when what they have is a symptom of PTSD. Survivors react faster and more completely to sudden noises (startle response). These are lifesaving skills as long as the survivor is still at risk, still in combat, still living with the batterer or the molester, still living in the bad neighborhood, the bombed-out city. These are reality based, effective survival skills. They keep you alive.

They don’t go away by themselves.

Similarly, shutting down feelings in order to do whatever it takes to survive, or do

your job and help others survive, is a reality based survival skill. If you sit down and cry in combat, you will get killed. If you keep screaming while Daddy hurts you, he may kill you. If you cry in the aid station or emergency room, you won’t be able to save as many lives. Your brain is designed to rapidly adapt to whatever is going on. Numbness is the answer. It is effective. It will help you live. It will help you keep others alive. Your brain’s inborn capacity to rapidly adapt means that what horrifies you the first time becomes nothing much by the third time it happens. But, if you didn’t care, you wouldn’t have to get numb. Being numb is evidence that you do care.

This doesn’t go away by itself either.

Unfortunately when survivors numb fear, despair and anger, all their feelings, even good ones, are numbed. Numbness is comfortable. Thinking about what they have been through is so painful, survivors wind up avoiding thinking about, feeling, or doing anything that reminds them of the trauma. For example, if they feel the trauma was their fault, they may spend the rest of their life having to be right so they won’t ever be at fault again. If they were happy when the trauma hit, they may avoid happiness forever. If they lost those close to them, they may give up closeness.

Most trauma survivors do not know anything about PTSD, so instead of seeking help, they will turn to whatever is available, self-medicating to maintain numbness. Addictions and compulsive behaviors often are rooted in attempts to numb the thoughts and feelings associated with trauma. Until recently, a diagnosis of alcoholism or drug abuse made the effects of trauma invisible: because he’s (or she’s) an alcoholic, alcoholism is the cause of all these problems so he (or she) can’t have PTSD.

“Inability to recall important aspects of the trauma,” is another of the ways avoidance and numbing may work. This means the person cannot remember exactly what happened. Many trauma survivors forget in order to survive. This is well documented in the scientific literature for combat veterans, torture survivors, battered women,

child sexual abuse survivors, natural disaster survivors and others, as well as in personal narratives. The recent attacks on traumatic amnesia by the parents of incest survivors, involving memory experts who know nothing about trauma and therapists who were trained back in psychiatry's denial and delusion period (from Freud to 1980), will be the subject of a future issue. (see Vol. 1, No. 4, False Memory Syndrome vs. Lying Perpetrator Syndrome)

Survivors usually also feel that no one can understand what they've been through, which is reality. Another form of numbing and avoidance is that they may feel like they're not going to have a long life. This is realistic if the survivor has seen a lot of people killed. Survivors may also lose interest in what they once liked to do. What is the point? Small children are likely to go back to baby talk or forget their toilet training. Survivors may also feel like they have no emotions or be told by their loved ones that they have none. They may even be so numb to the damage that was done to them that they become perpetrators and cannot understand what the fuss is all about. "What are you crying for? I'm pulling my punches."

Survivors may also have learned to dissociate, to literally not be there, to survive. Automatically checking out of stressful situations will make it hard to have relationships or to work in therapy.

Numbness will make it hard for survivors to take care of themselves. Feelings are there to tell us how to do that. If you can't tell what you feel, you can't choose healthy behaviors for yourself.

I've just described two of the symptom categories psychiatrists use to diagnose PTSD: hypervigilance and numbing. I've described them in this way because I think it is important for survivors, families and therapists to understand that *this is not some random collection of weird behaviors, but appropriate and effective biologically based reactions to extreme stress. They have a purpose: survival.* These reactions develop under conditions that most of us cannot imagine or comprehend, although such conditions are common in our society.

A person has to have two hypervigilant symptoms and three numbing symptoms, not present before the trauma, to be diagnosed with Post-Traumatic Stress Disorder. That means if the survivor already had PTSD from a previous trauma which the therapist doesn't know about and is already numb, the survivor may be misdiagnosed.

Most trauma survivors turn out to have multiple traumas, but the diagnosis of PTSD was formulated as if trauma was rare and only happened in isolation from the rest of life.

It is normal to be affected by trauma, but not every one who is traumatized gets diagnosable Post Traumatic Stress Disorder. There is a great range of post traumatic reactions because people are different, have had different life experiences, and have different capacities and skills. Some people do okay during the trauma, others crack. Some people have no reaction till another trauma, years later. Most people will find that post-traumatic reactions come back when there is subsequent trauma. Some people seem to alternate periods of extensive numbing with periods of explosive hypervigilant behavior or intrusive reexperiencing (the third category of PTSD symptoms). If the alternation is severe enough, they will never be diagnosed with PTSD because the symptoms won't be present at the same time, but their lives will be scarred by the trauma nonetheless.

These PTSD survival skills tend to become less appropriate and less effective with time and can wind up being really crippling ineffective behaviors. For a healing perspective, we need to keep in mind that *the behaviors of trauma survivors are direct evidence, sometimes the best evidence, of what they have survived, of their experience.* They are also evidence of ingenuity, creativity and courage. Reframing the behaviors in this light can be an enlightening experience for the survivor, families, friends, and therapists. Instead of being bad behaviors, they become useful evidence about the nature of the trauma or traumas and the guts and brains of the survivor, who, after all, survived.

Along with three numbing symptoms and two hypervigilant symptoms, to be diagnosed with PTSD, survivors must also reexperience the trauma in some form. The most dramatic of these reexperiencing phenomena, the flashback, forced the recognition of PTSD by psychiatrists.

Psychiatrists were trained to deny that traumatic events did affect people despite evidence from concentration camp survivors and World War II veterans. When Vietnam veterans were having flashbacks in the halls of the VA hospitals, some professionals were able to break this denial and see real people really suffering. They had to acknowledge the flashbacks, so they cre-

ated a diagnosis centered around reexperiencing reactions. Psychiatrists tend to think of it as a weird reexperiencing disorder instead of a natural-but-now-not-so-useful survival-skill disorder. I think a more healing perspective focuses on the effectiveness of the skills the person developed to survive, (hyperalertness and numbing). The other approach makes it easy to stigmatize survivors for the very behaviors which helped them survive.

Apparently sharing about traumatic experiences is also necessary for human beings because people who can't, for whatever reason, develop reexperiencing symptoms. Survivors are reexperiencing when they cannot stop thinking (or talking) about the trauma, when they are dreaming about it, or flashing back to the experience, feeling like it is happening again, even if they are drunk or on drugs. Reexperiencing also includes being upset on anniversaries of the trauma or by things that remind the survivor of the trauma. New wars, highly publicized rape, murder, battering and incest trials all affect survivors. Having a physiological reaction to something that reminds the survivor of the trauma is also a form of reexperiencing. The sound of a helicopter overhead sends a rush of adrenaline through many veterans. Someone raped in a stairwell may find herself sick and dizzy in any stairwell.

A healing perspective on reexperiencing is that this is an appropriate and effective message from the survivor's inner self that he or she has been through something that is too much to deal with alone. We are human, a species that is interdependent, that forms families, bands, tribes, communities, and talks about stuff. Survivors were not meant to face this alone as if they were polar bears or some other solitary non-verbal species (although they may wish they were).

The brain is a "better-safe-than-sorry" system. It would rather you get a million false alarms than be surprised by danger once. Part of reexperiencing may be the brain going haywire, triggering full alerts in an attempt to keep you safe.

Reexperiencing is circumstantial evidence that a person has been through too much to handle alone. Reexperiencing can also be seen as appropriate and effective because it sends more people to get help than anything else. Finally, human beings are communicators. Turning the flashes of non-verbal memory in the reptile brain into a narrative memory in the frontal

lobes seems to stop most reexperiencing.

Although this is not part of the current diagnostic criteria, I believe the message from the inner self can come as a physical symptom. Somatization (the development of physical symptoms) has disappeared from studies about PTSD although it was the primary symptom in soldiers' heart, hysteria, railway hysteria, shell shock and combat fatigue. People who will not listen to their own need for healing often experience a lot of physical symptoms. The body is trying to tell the story that can't be told. In light of George Vaillant's recent findings that 56% of WWII Harvard-educated combat vets without "diagnosable" PTSD were chronically ill or dead by age 65, this looks like a field ripe for study.

Many trauma survivors also appear to reenact their traumas, self-mutilating, getting themselves into the same type of trouble over and over, or doing to others what was done to them. These behaviors probably serve the same unconscious purpose of speaking the unspeakable. Although such behaviors have been observed, they are not enumerated in the diagnosis yet, and may never be. That doesn't mean we can't keep them in mind in our search for healing.

For a survivor to be diagnosed with PTSD, three numbing, two hypervigilant and one reexperiencing symptom have to last a month. If you have seventeen numbing symptoms, one hypervigilant and are not reexperiencing this month you won't be diagnosed with PTSD, but traumatic events will be ruling your life.

Symptoms may come on soon after the trauma or fifty years later. That is the post in PTSD. It is normal for symptoms to come up again in the face of further trauma and in times of high stress. It is normal to be affected by trauma. 17 % of the teenagers in Detroit have diagnosable PTSD according to one study. Another study showed that 69% of the surviving spouses of police officers killed in the line of duty have diagnosable PTSD. 66% of Vietnam veterans exposed to high war zone stress have had diagnosable PTSD at some time since the war and 33% still do today. Several studies of WWII combat/POW veterans in the hospital for other problems have shown that at least 50% of them have had PTSD and about 30 % still do.

Israeli studies show that people who have been traumatized react faster and more deeply to each subsequent trauma.

In addition, the effects of a traumatic stressor are worse when the cause is human neglect, betrayal, or human cruelty.

There are other post traumatic reactions which have not been studied including workaholic doctors. Family system effects are just beginning to be studied, but many survivors manage to look good at great expense to their families. A child playing the role of family hero is not seen as a sign of family dysfunction, but as proof of good psychosocial adjustment. As a community of survivors, family, friends, and therapists, we need to look at our experiences, examining *everything* to see how it relates to trauma because what happens to people affects them.

Denial and discounting are the skills society has developed to deal with trauma, as expressed in "It wasn't that bad," and "Aren't you over that yet?" Statements like these cause secondary wounding in trauma survivors. They reinforce the mistrust trauma evokes in all survivors who no longer can believe that the universe is fair and just. Secondary wounding by the medical community has been a serious problem, from the incest survivor, revealing her rape by her father and being told by the male psychiatrist (trained to believe this), "You know you wanted it," to the thousands of misdiagnosed, mistreated Vietnam veterans of the seventies, (many of whom are now dead).

It is a problem that still persists.

In DSM IV, published in 1995, the APA has dropped the list of what is traumatic, and the all important sentence which points out that if it would be upsetting to almost anyone and it isn't to this person then maybe that's one of the symptoms of PTSD, and added the peculiar phrase that the person has to have felt "fear horror or helplessness" at the time.

Most trauma survivors that I know *can't* feel. The diagnostician or therapist is the one who may be able to call up appropriate feelings (eg grief, rage) about the incident. The survivor shouldn't have to and probably can't without a lot of healing. *What this really says is that if bad things happen to you and you don't feel the authorized feelings, they weren't bad.* This is neither logical nor scientific. It will create a class of good survivors who get diagnosis and treatment, and another (bad) class who due to numbing get misdiagnosed and mistreated, just as veterans were after Vietnam. If the APA really needs to list feelings, a more realistic

and more diagnostic set would include disbelief, betrayal, feeling nothing, and feeling comfortable. The latter two would signal to any experienced therapist that this person already had PTSD before this latest stressor. Many people have multiple stressors over the course of a lifetime, and have already developed PTSD long before they see a professional. Most trauma survivors never do see a professional.

Adding the words "fear, horror, or helplessness," to the diagnosis has made it more inclusive in one important sense. It keeps therapists from "pooh-pooh-ing" experiences that terrified individual survivors. The words fear horror or helplessness were added to the diagnosis because trauma turned out to be far more prevalent than the APA expected. (Yes, I am laughing!) The whole diagnosis of PTSD reflects the upper middle class idea that trauma itself is rare. It ain't!

Rather than redefining trauma as evoking particular emotions, I'd like to see us open our eyes to the invisible effects of trauma.

We must become aware of the costs to survivors, society and families of all forms of numbing and hyperarousal including socially acceptable dysfunctional behavior. By ignoring it, we often simply put off to the next generation the cost and effort of recovering from trauma, and the effects of trauma increase geometrically. This is particularly true because something which might be mildly traumatic to a grownup, particularly one who is numb, is terrifyingly traumatic to a small child. As Beverly James points out, the well known phenomena of the "good" hospitalized child who "misbehaves" when the parent shows up is actually a terrified traumatized child displaying learned helplessness and the freeze response who becomes brave enough to voice his or her terror when the parents are around.

What else can't we see?

One of the facts we need to face is that PTSD is an epidemic. For every incest survivor, every battered woman, every combat veteran, every holocaust survivor, every survivor of a fire, plane wreck, night club fire, rape, torture, mugging, hurricane, tornado, earthquake, every cop, nurse, firefighter, EMT, for everyone whose pain is not listened to and felt and accepted and healed, the effects of the trauma spread geometrically. Drug abuse, AIDS, heart disease, obesity, (go to page 8, column 1) all related to the epidemic of PTSD through

the compulsive behaviors people use to numb their pain and the inability to take care of one's self which numbing causes.

If 17 % of the teenagers in Detroit had tuberculosis, it would be a national emergency. Because they have PTSD, and PTSD is not acknowledged nor well understood, no one is talking about it. But we can.

New notes: Because it is so distressing for many professionals to know about trauma, there is a historical record of a period of acknowledgement followed by a period of denial and forgetting. Right now there are conflicting currents. The American Psychiatric Association has transformed the description of traumatic stressors in DSM III into a numbing ritual in which big Latin-rooted words alternate with the word "or" until the person reading it is practically asleep. This makes it hard to comprehend when someone has been traumatized

There are even academics who are once again doubting the diagnosis, saying it is overused. This is quite popular with those who don't like paying the entire costs of war.

In addition soldiers resent the term PTSD. It feels like a stigma, and is treated as one in some commands. In Canada they use the term Occupational Stress Injury and include anxiety and depression as well as PTSD. Here some military psychiatrists are using CSI, Combat Stress Injury, which service members find less stigmatizing. I suggest Stress Injury with subtypes: Occupational for first responders, peacekeepers, etc; Combat for soldiers; Crime for survivors of rape, incest, interpersonal violence; Disaster; Betrayal; Neglect, etc.

Service members, unlike previous wars, are being sent back into harm's way on medications *with* PTSD. This illustrates the ethical problems inherent in military psychiatry, which like surgery, focuses on getting people back into action. Is it safe? Probably not. People with PTSD can be hypervigilant and overreact, instead of being vigilant and react with appropriate force.

Will it make them worse to go back with PTSD? Yes it will. But that is their job, and many of them want to go.

Book Reviews

PTSD; A Complete Treatment Guide by Aphrodite Matsakis, Ph D, New Harbinger, 1994,

If someone in your family has PTSD, or you are a therapists who needs to learn about it, a book like this is pure gold. The dedication of this book says, "Hopefully... this book will help teach respect and compassion for trauma survivors and their pain." The right attitude!

Dr. Matsakis' healing perspective on PTSD is unmarred by the need of so many therapists to have 'perfect' clients who recover at their rate and to their specifications. Her writing is based on years of experience in the Vet Center program and dealing with child sexual abuse survivors. It shows!

PTSD; A Complete Treatment Guide contains Part I: An Overview of PTSD, and Part II: The Therapeutic Process. There are also 28 extremely useful handouts for therapists to use with PTSD clients. Warning Signs, the first handout, is worth the price of the book.

Dr Matsakis says, "This book is not a crash course in PTSD Therapy, but rather a preliminary overview..." It is a very thorough overview. She provides an excellent list of further resources, too.

The continual reiteration of the ideas that client safety comes first, that the therapist moves at the client's pace, and that therapists are teaching clients skills to replace the ones that kept them alive makes this a safe book to recommend. Dr Matsakis points out that recovery is a slow process.

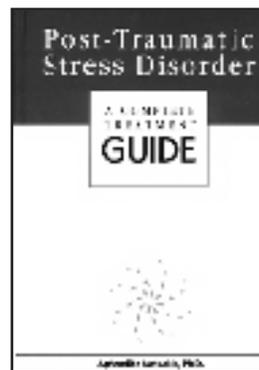
Every effort is made in this book to show therapists how to treat clients with respect and consideration and not provide them with any more of the secondary wounding experiences which are so common in our culture and even in psychiatric practice, like being misdiagnosed, or never being asked about traumatic events or being told you should be over it.

Dr Matsakis discusses the difficulties of dealing with PTSD clients. She talks about reframing symptoms for the client, for example, pointing out that self mutilation can be a way of trying to tell what happened or of showing forbidden feelings. She points out how difficult some of this work is and makes it clear that not everyone can or should do it. I had trouble reading parts of the book, and following her advice in Warning Signs, took a break. I also got some fantastic insights into my own life while reading it. I believe in being an educated consumer of health services, so if I or someone in my family were traumatized, I would read everything I could on the subject. This is a good place to start. □

The Way of the Journal, by Kathleen Adams, MA, Sidran Press

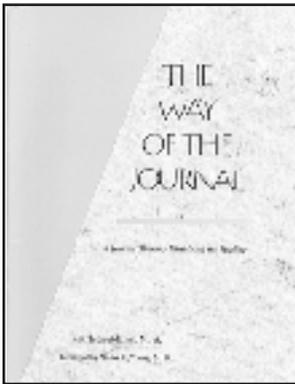
I bought my copy of this book at a meeting of the International Society of Traumatic Stress Studies. The Sidran Foundation (sidran.org) is a "nonprofit organization devoted to education, advocacy, and research on behalf of people with psychiatric disabilities." including PTSD. It deserves our support!

A lot of recovering people use writing as a tool but find it depressing or overwhelming. This book offers a place to practice new journaling techniques. There is a ten day program, very carefully planned to lead from



very structured to unstructured writing. I found it extremely helpful and I've been journaling for years.

Designed specifically for trauma survivors, this book is so full of wise suggestions that I can't praise it too highly. It is addressed to both survivor and therapist, and I (family member) also found it very useful. Ms Adams urges the reader to pick the techniques



that are helpful and not use the ones that aren't. The book has an excellent opening section on How To Use This Workbook.

Since I've been in a 12 Step Program for 7 years and am not as rebellious as I once was, I read it and followed most of the directions including filling out the contract with myself.

Ms Adams has excellent suggestions for structuring a journal and using it as a container for thoughts/feelings and energy.

Has a good section on additional resources.

Achilles In Vietnam by Jonathan Shay, MD, Atheneum, 1994, \$20.00.

Jonathan Shay works with guys who have severe chronic PTSD many of whom survived incredible trauma in Vietnam and the loss of all their friends. Surprisingly enough they have a lot in common with Achilles, a hero of the Iliad.

Achilles goes berserk, literally, and avenges the death of his best friend by killing prisoners and mutilating the body of Hector. What Dr. Shay points out is that when people do these things, it is under the worst of circumstances, and they suffer for it for the rest of their lives. Much of the focus of PTSD studies has been on the

effects of having bad things happen to you. It is rare for anyone to study



the effects of doing things in the heat of battle which are hard to look back on. Those who have been exposed to abusive violence pay every day for such

experiences. This is a fascinating book and it expands our understanding of combat related PTSD.

Conceptions we think of as universal, such as devaluing the enemy or trying to keep a stiff upper lip when someone is killed are contrasted with the Greek customs of honoring your enemy (otherwise where is the honor in fighting him?) and communal mourning for the dead.

If you know a veteran who has been "exposed to abusive violence," in the sanitary phrasing of mental health professionals, this book might bring some insight into the devastation such experiences bring. Dr. Shay discusses the healing that has happened for his clients as they tell their stories and are heard.

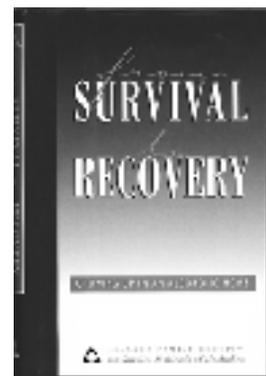
From Survival to Recovery: Growing Up In An Alcoholic Home, Al-Anon Family Groups, 1994.

Alcoholism and PTSD are intertwined. Whether one causes the other is immaterial when the family members are trying to recover. Some adult children of alcoholics are recovering from PTSD caused by the things people do when drunk, others from the effects of growing up in a place where the rules are "don't talk, don't think, and don't feel," just like the rules in a PTSD home.

This book is written by recovering Adult Children of Alcoholics within Al-Anon. "Because we have varied

needs in Al-Anon we are encouraged to take what we can use from each other's ideas and leave the rest behind. No two people will work the program in exactly the same way...we encourage newcomers simply to come to meetings and see for themselves ... [this] allows trust to build slowly and allows identification with other members to develop naturally." (p. 77-78) A surprising number of the sharings are by incest and child abuse survivors who have recovered in Al-Anon both with and without therapy. Many were unaware of the sexual abuse until they began to recover in Al-Anon and stopped the other-centered obsessive caretaking and/or controlling behaviors which, though socially acceptable, are so addictive, so crippling, and so useful to numb pain. Others had no idea the violence they suffered inside the family had affected them at all.

In this book, people tell in their own words how damaging trauma is to the child. For therapists, memory experts and those who seek to develop the theory of trauma, this book is an invaluable resource. For survivors of similar trauma, it is a message of hope and healing. Al-Anon offers an inexpensive alternative and/or supplement to therapy.



In some areas, there are no Al-Anon Adult Child focused groups. Some A l - A n o n oldtimers do not believe in ACOA issues. This is called denial. Their

attitude (probably based on fear) does not represent Al-Anon as a whole. This book—written by a committee of Al-Anon adult children and sharing the experience, strength, and hope of many members—represents Al-Anon as a whole and demonstrates the heal-

How to begin to recover

It is normal to be affected by trauma.

That is the most important message in this newsletter. Recovery is healing your life. You'll have a scar. You'll also know what to do if the pain comes up again. Trauma never stops affecting most trauma survivors. Those who forget or deny how much pain they were (or are) in can't help others, can barely help themselves. They hurt others with remarks like "I was in a real war," or "Put it behind you!"

PTSD symptoms, numbing, hypervigilance and reexperiencing, are hints to get help! They helped you survive, but they do not go away by themselves. People have to warp their lives to control them. They can become both ineffective and a source of constant pain. When that happens, it is possible to change.

If you are in pain because of the way your life is today, you can change your life. It will be a slow process. Pain will come from the memories of what you survived and from frustration at new stresses and slow progress. **It is okay to be in pain.** That is the first principle of recovery. Your experiences were painful. You survived the pain of the actual trauma, and you can survive the memories. To recover you need to know at least a part of what you survived, to reconnect your feelings to those events, and mourn your losses.

Treat yourself with respect. Respect your experiences and your problems. Your symptoms are circumstantial evidence that you have been through a lot. PTSD is normal when you have been traumatized. You are not weak, weird, or unusual. If we could live through something without it affecting us, it wouldn't be trauma and we wouldn't be human. Admitting we're human and we have problems is respectful of ourselves. Many trauma survivors minimize the effects of what they've been through (It didn't affect me!) and then wind up resenting people for not respecting their pain. This is human but not very effective.

There is no rush in recovery. Recovery is based on acceptance. I have been traumatized. It did affect me. Why wouldn't it? I

have skills that kept me alive which are now causing me trouble. I'm closed off from my feelings and from others. This makes my life lonely and difficult. I am in pain from my memories because what I went through was painful. I need help.

It's ok to need help

It is ok to ask for help.

Help is available from therapists who are well trained in the field of trauma. Ask about training and experience and pick someone you are comfortable with.

For years, 12 step programs were the only help available to survivors who self-medicated with alcohol or drugs. Thousands of veterans, incest and domestic violence survivors and others have dealt with PTSD by going to Alcoholics Anonymous, Al-Anon, Overeaters Anonymous and other 12 step programs. I started going to one to get help with my problems in living with a guy with PTSD, but since I knew about PTSD, I saw it everywhere. It was clear to me that the people who get diagnosed and get help from the psychiatric community are the tip of the iceberg. Many 12 steppers mistrusted everyone and everything except the 12 step fellowship they were in for good reason. Their traumatic experiences had been ignored and discounted and their self-medication called willful misconduct or self-indulgence. They had been insulted, misdiagnosed, drugged and told it was all in their head.

There were people who thought they were stupid because they couldn't concentrate in school but thought being battered hadn't affected them because they always had a job and could take a beating from anyone, people who had stayed drunk for 20 years, married a series of alcoholics, or weighed 300 pounds and never connected it to their traumas. Trauma was invisible to the survivors who thought it shouldn't bother them. Yet, using the steps they were slowly recovering; some simply through working the steps of the program. Others needed and became able to seek outside help.

It takes time to get better. Getting better is the reward for taking the time to

recover. Getting better is a slow process. The physiological arousal in which many trauma survivors live makes it difficult for survivors to take in the kind of information needed to heal. This is part of the brain chemistry of survivors. It is not resistance. People can talk about changing but all survivors see is their lips moving. The words and concepts make no sense. This is because they are taking in survival information: who's in the room, where are they sitting, where is the door, how are they reacting to me? In twelve step meetings we have a saying which describes this process: "came, came to, came to believe," meaning we got ourselves to meetings (or therapy), eventually we started to be able to hear what was being said, and finally we came to believe it could work for us too.

Safety first. Survivors won't feel safe with a therapist or group until they have, over time, experienced safety. Why should they? When they have been treated with respect, not discounted, not pushed to hurry up and recover (which are secondary wounding experiences and make PTSD worse), they will feel safe and know it because they will be able to hear and understand what the therapist or group is saying in a new way. A good therapist or 12 step group will let you take your time and treat your traumas with respect. Badly trained therapists often exhibit what I like to call "a profound and pervasive narcissistic sense of entitlement," which manifests itself as "I'm a therapist. You should trust me. I can fix you." An honest therapist will say he or she may be able to help you work on this problem.

When they can hear, survivors can begin to work on safety issues, understanding and protecting themselves from triggers, learning to handle anger and fear. Survivors can develop the capacity to respond rather than react, like having a pause button instead of an on-off switch. Sobriety is necessary if you've been using alcohol, drugs, food or some behavior to numb your feelings. You can't heal what you can't feel.

Once safety has been established, trauma work may begin. Rushing through trauma work is to be avoided. When you feel safe

enough, you will remember. Some people use hypnosis to speed this up. Experienced therapists now prefer to let memories surface when they will.

Today in many communities, after a crisis all the rescue workers debrief each other. They get to talk about what happened, what they saw, smelled, heard, felt, what they wanted to have happen and how it all turned out. Debriefing is what trauma work is about. You don't have to know every detail or relive every moment of trauma. As you talk about what happened to you and feel the feelings you had to suppress to live, you will relearn the broad variety of human feelings, because they have all been suppressed along with the painful ones. Recovery will help you understand yourself and be understood. This is a very healing experience for people who have felt like no one could ever understand what they have been through.

Groups are particularly helpful in recovering from trauma. You are not alone. Others have been through similar pain. It helps to see others progress, to learn ways to grow yourself, and to help those who come after you.

Searching for the right help is important. You need to be comfortable enough with the therapist or group. On the other hand searching for the perfect group or a therapist who will never make a mistake can put off recovery for life. The therapist or group is not going to fix you. They (therapist, other group members) provide you with information and a variety of skills, and you do the work.

A word on drugs: There is no drug for PTSD. If you choose a well trained therapist, short term drug therapy may help with physiological arousal and enable you to benefit more from therapy in the beginning.

Helpful concepts:

It is okay to hurt. As a survivor, you need to go through the process of mourning which takes about two years if your mother dies of old age in her bed at home and you were expecting it. Traumatic losses take longer.

Mourning has five stages:

Denial is screaming "No! No!" at the time of the trauma. It is also "Never happened?" and "Didn't affect me?" When there is no help, denial is a survival skill, but being

stuck in denial for years is usually pretty painful.

Rage: People get stuck in the rage stage, too, screaming and lashing out at everyone around them, or coldly angry and unable to change.

Bargaining: Stuck bargaining includes veterans who will only get well if the VA gets perfect or if Nixon or Fonda goes to jail, the child abuse survivor who will only get well when patriarchy is gone, or the survivor who will only get better when he or she finds a perfect therapist.

Sadness: The sadness stage is very difficult for most survivors because of our feel-good culture. Being sad is practically illegal. Sadness refused leads me to deep depression, but today if I start to feel depressed, I ask myself what do I need to feel sad about. If I can identify and feel it, I don't get depressed. Sadness needs to be felt. What happened to you was sad, painful, grievous. The only way out is through. Those feelings won't kill you. It is okay to grieve. Grief is part of life.

Acceptance is the final stage. Yes this did happen. It was bad and it has affected me. I have a scar, but I survived. In time, I may be able to use my experiences to help other survivors.

Recovery takes persistence and patience. "Progress not perfection" is a good motto. Recovery is not a smooth swift rise out of the depths of pain or numbness. It is a rough climb with many slips and lots of hanging on at new rough places in the climb.

"We recycle" is a slogan that will help you laugh when you slip. Acceptance of the slowness of the process is hard but it's reality. Since PTSD symptoms can come back with new stress, knowing that it is normal to recycle can help you continue to recover.

It takes what it takes and it takes as long as it takes. Human beings hardly ever change quickly except under extreme stress, so be easy on yourself. In response to the idea, I should be over this, remember this slogan (made up by yours truly) "Everything after the word should is bullshit."

H.O.W.? Honesty, openness, and willingness are characteristics that will help anyone recover. These things did happen and do affect us (honest). We can find help if we

look (open). We try suggestions from others who have recovered or have worked with others who have recovered (willing). This is not to say that every idea or suggestion will work for you. Some won't. Some will be very uncomfortable, but will have a healing effect on your life, like getting sober.

Yet. If those ideas scare you, the most healing word in the English language is yet, as in I can't do that yet... Someday you will when you are ready.

Willing to vs Wanting to: There is also a great deal of difference between the words "want" and "willing." Spelled differently. Mean different things. Willingness may mean I do things I don't want to do! If I wait till I want to do the things that will help me recover, I may never recover.

We heal by degrees. You don't have to heal perfectly or on someone else's schedule. People do this work in stages and have to take breaks from it.

Feelings are facts: you feel what you feel. It doesn't have to be reasonable, justified, or what other people feel. Feelings do not have brains. They are not logical! Part of recovery is learning what you do feel so you can take care of yourself. Trying to take care of yourself without knowing what you feel is like trying to budget without knowing your income.

Feelings are not facts: Emotional reasoning is a distorted way of thinking common in our society: I feel it therefore it is true. I feel hurt therefore he/she meant to hurt me. I feel guilty therefore I am guilty. Many of us tend to feel hurt by or guilty about everything. It comes with our culture, but we don't have to believe it.

It is ok to feel more than one contradictory emotion at the same time.

Respect your emotions but don't necessarily believe them and don't act on them in old ways. People can change by acting in new ways until new feelings come. Waiting till they feel like changing is a dead end for most people!

When trauma survivors begin to get better it is very scary for family members. Underlying this is the fear that if you change you may not love them any more. You may wonder why they have problems since they

weren't traumatized. Next issue I'll talk more about the effects of living with PTSD, of seeing someone hurting and doing all you can to help and having it all be useless.

Don't compare: Compassion is something that develops in recovery. You will see that what each person has lived through is the worst thing he or she has been through. Remembering how you felt after the first fire-fight, the first beating, the first time someone in your neighborhood was gunned down, before you got so numb, will give you empathy and compassion for others.

Recovery leads to autonomy, the feeling of being whole, the ability to change when necessary and the ability to regulate yourself. These are important concepts to people who may feel they have lost great parts of themselves. You may not get all of yourself back, but you can get some of it back. For people who have been stuck in survivor skills, being able to change is freedom, and for people who could be blowing up one minute and numb as a stump the next, the ability to regulate these reactions is pure joy.

Recovery will bring back joy into your life. It will be mixed with pain because this is real life, but learning to feel the pain lets it pass and the periods between the pain will get longer and longer and better and better.

One final word, no matter what you did to survive, you do deserve to recover. Many survivors feel guilty for surviving, or for not doing enough, or for overreacting. During the recovery process, your feelings about this may change. If you find that some of your guilt has a realistic basis, you can make amends for your actions. ¶

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Statement of Purpose

The Post-Traumatic Gazette is a newsletter for all trauma survivors, from veterans to rape victims, earthquake survivors to prisoners of war, their families, friends and therapists. It is dedicated to the idea of healing one day at a time from experiences which forever change a person's view of the world.

This first issue is intended to set out a healing perspective on PTSD which has developed from my own experiences and from the work of respected professionals. In this perspective we see trauma as the problem, and PTSD reactions as creative and life-saving solutions to the problem of trauma. They worked. The survivor is alive.

We believe it is normal to be affected by trauma, there is help, and it is okay to ask for help. PTSD is not rare. It is not unusual. It is not weak to have PTSD. It is normal to be affected by trauma. We can't repeat that too often.

Traumatic experiences bring to the fore survival skills which are valuable and useful at the time of the trauma, but which usually become less valuable, less useful and less effective with time.

We believe that survivors become stuck in problem behaviors when their pain is not acknowledged, heard, respected, and understood. Denial plays a great part here (didn't happen/ shouldn't affect you). Putdowns, dismissal of their pain, misdiagnosis and other forms of secondary wounding keep survivors stuck.

Recovery is a slow process which doesn't come easily or painlessly. The survivor must be heard, feel understood, and reconnect to a community. The Gazette is aimed at helping to form such a community. Recovery takes time. The survivor sets the pace. Recovery is not a race, and recovery doesn't erase the trauma as if it had never happened. Trauma may always affect survivors. PTSD symptoms may come back under further stress, but the negative effects can be minimized as the survivor learns what they are and feels empowered to take care of him or herself. True healing is knowing it is okay to ask for help again. Rather than trying to put trauma behind us and forget it, I believe in another deeper kind of healing where we never forget, where we keep the memory alive of what happened to us and to others and we use our knowledge to keep traumatic things from happening to others.

We also reach out, acknowledge the pain of other trauma survivors and encourage them to talk. We can make a difference.

This perspective also emphasizes that survivors and family members and therapists are human and are doing the best they can. Recovery is about learning better ways and letting go of fear, even fear of change. Slow growth is good growth.

This perspective differs from the sometimes still prevalent attitude that trauma couldn't affect a really well balanced person and also from the hurry up and get it all out so you can get well school of treatment. Respect for the survivor is implicit in this perspective. We don't rush survivors and we don't dismiss their pain. Instead of comparing pain, survivors and survivor groups are encouraged to respect each other's pain and to focus on what they have in common and to share recovery. Each person's unique experience and pain is respected.

In this perspective we also acknowledge the pain of the families of trauma survivors which often develop ineffective patterns as they try to cope. We seek to create a caring community of people who have been affected by trauma and share information on how to heal one day at a time.

I hope the PTG will be packed full of stuff which will be helpful to every reader. Other goals of the PTG are:

- To work towards a more scientific diagnosis of Post Traumatic reactions based on observation of what is traumatic and on all the trauma related behaviors of people who have been traumatized,
- To provide new information on the treatment of PTSD and up-to-date sources of good information on safe and effective help
- To show the connection between PTSD and substance abuse/compulsive behavior.
- To raise public awareness of the epidemic of PTSD and it's enormous cost to society in rising rates of violence and substance abuse.
- To discuss implications of the inter-generational transmission of PTSD in professions, families and cultures.
- To develop public policies which will be helpful for trauma survivors.