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SHOCK WAVES

A Practical Guide to Living
with a Loved One's PTSD



CYNTHIA ORANGE

“*Shock Waves* shines a light on those who walk with the wounded; it honors their own tattered spirits and offers help. This book defines the art of self-care and how to couple it with caring.”

—Patricia Weaver Francisco, author of
Telling: A Memoir of Rape and Recovery

“An honest and hopeful approach to the important and challenging work of traumatic loss.”

—Thomas M. Ellis, director of the Center for Grief, Loss & Transition and author of *This Thing Called Grief*

“With the earnestness of a teacher, the compassion of a healer, and the credibility of a partner living alongside someone with PTSD, Cynthia Orange has written a truly useful book. She leaves us with the conviction that self-care is not a lofty or selfish goal, but a necessity when in relationship with someone who has PTSD. The story of her own family’s healing is a boon to the soul.”

—Julie E. Neraas, author of *Apprenticed to Hope: A Sourcebook for Difficult Times*

“Cynthia Orange has written a wise, well-researched, and moving book for victims of PTSD and their loved ones. Hers is the voice of hard-earned wisdom from personal journey. I was moved to tears by the authenticity of this honest book.”

—Ann Linnea, author of *Deep Water Passage and Keepers of the Trees*

“*Shock Waves* is filled with wise and down-on-the-ground suggestions for dealing with this pervasive problem in our culture. It is also the story of the author’s own struggle with her husband’s PTSD, narrated with a candor that does not flinch before the heartache and difficulties this disorder represents. Orange offers a next step for those stopped in their tracks, and a realistic hope for those who now can only see the darkness.”

—Dr. Tex Sample, author of *Earthy Mysticism*

Shock Waves

A Practical Guide
to Living with a Loved One's PTSD

Cynthia Orange

Hazelden
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hazelden.org

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Author's Note

THE STORIES EXCERPTED throughout this book are based on actual experiences, relayed to me through interviews and conversations or in response to questionnaires distributed to trauma survivors; to those affected by a loved one's trauma or PTSD; and to therapists, doctors, addiction counselors, or others who work with trauma survivors and those affected by a loved one's trauma or PTSD. Unless otherwise noted, they are presented anonymously to protect the privacy of the people involved. In some cases, some details have been changed to ensure anonymity.

I have intentionally employed the University of Oxford convention of using "they," "them," or "their" with a singular noun such as "loved one," to ensure gender inclusiveness while avoiding the more formal and awkward use of "he or she," "his or her," or "him or her."

For Jessica, Jeff, Oskar, Quinlan, and Michael
The family I treasure; the future I embrace

.....

Contents

Preface	xi
Acknowledgments	xiii
Introduction	1
Chapter 1: Trauma Responses and PTSD: Normal Reactions to Abnormal Events	9
Chapter 2: Acknowledging Loss and Honoring Grief	37
Chapter 3: What about Me? The Importance of Self-Care	53
Chapter 4: Self-Care II: Toward Healthy Interdependence and Dialogue	77
Chapter 5: Self-Care III: Declaring a “Toxic-Free” Zone	101
Chapter 6: Trauma and Addiction: Weathering the Storms	115
Chapter 7: Trauma and Parenting	135
Chapter 8: Rebuilding Your Life	153
Resources and Reading	173
Bibliography	181
About the Author	189

Preface

ALTHOUGH IT SOUNDS LIKE A B MOVIE, our story began in the summer of 1968, at the top of the Empire State Building. I was visiting New York with two girlfriends from Minnesota, and Michael was there with several of his seminary high-school friends from Ohio. Our faces were smooth with youthful anticipation, our lives fairly uncomplicated. We felt an instant connection, and I came home and announced to my best friend, “I met the man I know I could happily marry.” Then he went off to march in the Vietnam War and I marched against it but our friendship remained unshakable; our correspondence honest and constant. Meanwhile, I married someone else, gave birth to a beautiful daughter, and later divorced. When Michael moved to Minnesota in 1973, I finally married my soul mate. He adopted Jessica, and we became an “official” family. I soon discovered, however, that when I married Michael, I also married Vietnam and the trauma he carried from his combat experience.

This book is about our journey and the journeys of others who, like us, have learned to live with the challenges and scars of trauma and the “shock wave” effects of post-traumatic stress disorder (PTSD). While our family’s trauma stemmed from war, there are many other causes for trauma, from physical and sexual abuse and violence, to economic and natural disasters, serious accidents, sudden deaths, and terrorist attacks. As my

family learned, when trauma affects a loved one, it affects the entire family.

Shock Waves is especially for those who, in their efforts to understand and care for their traumatized love one, discover they need care and understanding themselves. *Shock Waves* is a story of healing and healers. Most important, it is a story of hope.

Acknowledgments

ALTHOUGH I DID NOT EXPECT IT, writing *Shock Waves* has been a cathartic step in an ongoing voyage of healing. I want to thank my family of friends who supported me and this book by telling their stories and helping me gather those of others—stories that poignantly show how far-reaching the effects of trauma can be. I am indebted to all who contributed, and I thank them for their candor and courage in revisiting events and experiences that can still cause pain and sorrow. Know that your wise and hope-filled words make a difference.

Special thanks to my sister Dianne Smith, and to dear friends Rick and Sharon Slettehaug for their sharp eyes, open hearts, and honest critiques as they read each draft of each chapter. You never fail to make my work better, my life richer.

Thanks also to Chris Hiben for mysteriously intuiting when I needed to cry, laugh, talk, or play. To Vince Hyman and Mary Brennan for sage advice and Fireside chats.

I am forever grateful to Dianna Diers for her listening ears, wise counsel, consistent support, and deep friendship. Thanks also to Patrick, Sandy, and Sean—healers all. You've graced our lives by giving us strength and guidance when we most needed it.

Thanks to Sid Farrar and Richard Solly at Hazelden who shared my vision for this book and helped it become a reality. Hazelden has been an integral part of my writing life for twenty-five years. I so value the friends I've made there and the important and necessary work they do.

Warm thanks to my editor, Pat Boland, for her artful hand in shaping this book. Your expertise made the process painless, and it was pure pleasure getting to know you as we worked together.

My unconditional love and heart-felt thanks to our daughter, Jessica, who stood strong in the midst of our family's struggles with PTSD.

And finally, I wish to thank Michael—my husband, my soul mate, my partner in life and love. I am awed by your courage and the hard work you keep doing to heal from the wounds of war and to so tirelessly work now for peace. This is our story, and throughout its telling you stood by me—always encouraging me to tell our truths in the hope that this book will help others. I love you more genuinely today than I ever have, and look forward to sharing all our tomorrows.

.....

Introduction

If each day falls
inside each night,
there exists a well
where clarity is imprisoned.

We need to sit on the rim
of the well of darkness
and fish for fallen light
with patience.

—PABLO NERUDA*

The word *trauma* comes from the Greek word for *wound*, and some of the wounds that trauma causes are deep and long lasting, creating, as the title to this book suggests, *shock waves* throughout an entire family system. Throughout these pages, trauma survivors and those affected by a loved one's trauma talk about their experiences and candidly offer what worked for them, and what did not. I believe we learn best through stories, and I am

*Pablo Neruda, ["If each day falls . . ."], translated by William O'Daly, from *The Sea and the Bells*. Copyright © 1973 by Pablo Neruda and the Heirs of Pablo Neruda. Translation copyright © 1988, 2002 by William O'Daly. Reprinted with permission of Copper Canyon Press, www.coppercanyonpress.org.

forever grateful for the wise and courageous voices heard in this book. It was difficult for these men and women to share their stories of pain and healing, but they told them in order to help others. I am thankful beyond measure that so many have reached safe harbor. So take heart. These are stories of hope from those who have caught that “fallen light.”

A traumatic event is one that causes great stress and distress—either physical or emotional, or both—and children, teenagers, men, and women from all walks of life are exposed to trauma every day. According to the National Center for PTSD, in the United States, about 60 percent of men and 50 percent of women experience, witness, or are affected by a traumatic event in their lifetimes. In writing this book, I talked with and heard from people affected by natural disasters and terrorist events—war, rape and other violence, plane crashes, campus killings, serious accidents, the loss of a child—and from those whose lives were turned upside down by a critical illness or a sudden death.

We may think that truly traumatic events need to be as dramatic as childhood sexual abuse or war. Yet many people experience long-term trauma symptoms as a result of deaths in their families, accidents, natural disasters, or other significant occurrences. Some experts also report trauma symptoms among people who are losing jobs, retirement savings, pensions, and their homes in these days of economic crisis. To highlight one type or cause of trauma over another risks creating a hierarchy of suffering that I seek to avoid in this book. To say one experience or story is not as bad as another is to diminish the person and the pain. As the spouse of a survivor of the Oklahoma City bombing put it, “You just can’t quantify grief.”

Sudden and overwhelming disasters or traumatic events can take a significant emotional toll on survivors, families, and friends. Feelings—for both trauma survivors and loved ones—can become intense and unpredictable. It is normal to experience fear, anxiety, or a sense of helplessness. Some survivors might be more irritable

than usual. Others might be angry or suspicious. Some people may have trouble sleeping, concentrating, or remembering things. It is also common to feel an overriding loss of safety and a need for reassurance that loved ones are all right. Some people react immediately, while others have delayed reactions. All these are very normal responses to an abnormal event, and there is no magic formula that can predict when such unsettling feelings will subside.

Research shows that among those affected by a traumatic event, about 8 percent of men and 20 percent of women may develop post-traumatic stress disorder (PTSD)—a life-altering anxiety disorder with symptoms that last over a month. It is the degree and duration of impairment that distinguishes normal reactions to trauma from PTSD. It was normal, for example, to be afraid to fly after the September 11, 2001, terrorist attacks. It would be another thing, however, if you had to quit your job because you were terrified to travel or you couldn't sleep because of night terrors long after 9/11. Some people, such as first responders or others who repeatedly witness trauma, can also develop PTSD. As Stephen R. Paige, Ph.D., so succinctly put it in his peer-reviewed article for eMedicineHealth, “Simply put, PTSD is a state in which you ‘can’t stop remembering.’”

What is not reflected in statistics about trauma are the millions of loved ones affected by what I call “trickle-down” trauma. Like alcoholism, which is often called a “family* disease,” trauma and PTSD can take a devastating toll on friends and family. Living in a household affected by trauma and PTSD is a bit like trying to swim through mud. With the appropriate help, love, and support, however, families can find clearer water.

My husband dreamed about Vietnam almost every night when we were first married. I'd lie close, match my breathing to his, and wait until his breaths seemed smooth, his sleep restful. But still the ghosts of that war slept between us. When he awakened from a

*Throughout this book, I use “family” in an inclusive sense to represent not only family and extended family, but also significant others and friends affected by a loved one's trauma.

nightmare, trembling and sullen, he shrugged it off as “just a bad dream.” And when this otherwise gentle man exploded with uncharacteristic rage and stalked off lest he strike me, I would be filled with remorse, wondering what I had done to spark such anger. After these infrequent outbursts, I would ask what he was feeling. Michael would usually say “nothing,” or look vacant, not able to identify or name his feelings.

I remember pressing him to talk with someone at the VA (Department of Veterans Affairs) after a particularly disturbing nightmare late in the 1970s—before PTSD was a diagnosable condition. He acquiesced, but came home after the visit claiming he was fine, adding that he felt guilty for even going after seeing all the vets at the VA who were “really messed up and really needed help.” But he wasn’t all right.

Michael tried to shut out ghosts and memories by burying himself in his job as a city planner and exercising compulsively. When our marriage was in trouble and we sought counseling, he blamed his workaholicism, not Vietnam. And then came 9/11, the “Shock and Awe” of the United States’ bombing of Iraq in 2003, and the images of brave troops with boots on the ground and rifles in hand. This was followed with news that his best friend while in Vietnam had committed suicide by dousing himself with gasoline and lighting a match after leaving a fourteen-page suicide note about his combat experience—an experience Michael had shared. Finally, after decades of trying his best to explain away, ignore, or stuff what we now know were trauma symptoms, Michael was diagnosed with PTSD. He got a medical leave from work, and his healing—and our family’s healing—began.

PTSD is a diagnosis that changes as experts continue to learn more about the effects of severe trauma. It is a useful, but at times confusing, measurement tool. In researching this book, I met many trauma survivors who were not officially diagnosed with PTSD. Some experienced the trauma decades ago (before there was a diagnosis for PTSD), yet their symptoms continue. Some, like the

survivors of childhood sexual abuse, may not have remembered the trauma until they were adults, and by then may have discounted their trauma reactions by shrugging them off, thinking, “It’s just the way I am.” Some with many classic symptoms never sought professional help. Others masked their symptoms with alcohol and other drugs. Still others may not have exhibited or disclosed all the symptoms necessary for a diagnosis when they did seek professional advice. Nonetheless, they struggle with the consequences of trauma, and their families usually struggle with them.

I began this book on the eve of our thirty-sixth wedding anniversary. With our lives richer and our days more joyous than ever, it is not easy to sit again on the “rim of the well of darkness” that the poet Neruda describes so well in the poem at the beginning of this introduction, but it feels necessary. In her book *Telling: A Memoir of Rape and Recovery*, Patricia Weaver Francisco addresses the tension that exists when one is filled with both a desire to forget and an obligation to remember. “It is easier to gaze out this sunny window and imagine a world at peace with itself than to look at these memories. I resist, and you who are reading may want to resist. Why go into it then? There are a million sad stories and only one day like this, balmy and just right . . . Why talk about rape when it makes everyone uncomfortable . . . Why not just go on hoping tomorrow will be a better day? Because perfect days are built on difficult mornings.”

I, of course, wish that my husband had been spared his traumatic experience. I wish that Francisco and the millions of men and women like her hadn’t suffered sexual abuse or other traumas. Trauma symptoms are like party crashers who sneak in just when things are going smoothly in a household. But if family members get better informed about the effects of trauma, learn how to talk about it, discover what can trigger symptoms, and get help in sorting out everyday reactions and behaviors from trauma-related behaviors and feelings, they are better able to expose these wily intruders.

With hard work, good self-care, the love of a supportive community, and help from the appropriate professionals when it is needed,

families learn the difference between “getting over” trauma and “working through” the effects of trauma. Sometimes the process of working through means learning to feel again, including the pain. It makes sense that trauma sufferers often stuff emotions or numb uncomfortable feelings, and that their loved ones sometimes adopt these same unhelpful behaviors. But when we can’t feel pain, we usually can’t feel joy either.

I remember a story about how Kirk Douglas had a stroke that left him unable to speak. In suicidal despair over being a famous actor with no voice, he loaded the gun he had used in his 1957 film with Burt Lancaster, *Gunfight at the O.K. Corral*. When he stuck the gun inside his mouth intending to pull the trigger, the barrel bumped a sensitive tooth, and the alarming pain caused him to reflexively remove the pistol. As Kirk Douglas discovered, sometimes feeling pain can save your life. He eventually learned how to speak again and became an advocate for stroke victims. Like many who survive and learn to integrate the effects of trauma, Douglas said his life—even in his eighties—was filled with new beginnings.

As I stress in chapter 1, “Trauma Responses and PTSD: Normal Reactions to Abnormal Events,” post-traumatic symptoms are normal reactions to abnormal events, but the shock waves that trauma sends out can tear families apart if they don’t take care of themselves and get the help they all need. Ernest Hemingway wrote, “The world breaks everyone and afterward many are strong at the broken places.” Chapter 2, “Acknowledging Loss and Honoring Grief,” emphasizes the necessity of mourning what we and our loved ones have lost in the wake of trauma.

Because we received the support we needed and connected with experts who helped us understand what PTSD is and how trauma can affect all family members, we are stronger as individuals and as a family. Taking care of yourself as you struggle to navigate the tumultuous waters of a loved one’s trauma or PTSD is not easy, but it is essential—which is why much of this book focuses on self-care for those who love and care for trauma survivors. To extend the water

metaphor a bit, taking care of self is like damming a river for power production. In times of drought, the river flows slowly or not at all. A dam collects the water and creates an energy reserve so power can be tapped as it is needed. This is what self-care is all about. When we take good care of ourselves, we create a reservoir of energy, patience, and love that will be there when we need it. Chapter 3, “What about Me? The Importance of Self-Care,” offers ways in which readers can balance personal needs and care-giving responsibilities.

One of the goals of this book is to help readers expand their circles of support. When we seek help, we model for children that such an action is healthy and positive, giving them permission to ask for guidance. Chapter 4, “Self-Care II: Toward Healthy Interdependence and Dialogue,” discusses the importance of mutual support groups, friends, and healthy activities that provide interaction and support outside the home. Chapter 5, “Self-Care III: Declaring a ‘Toxic-Free’ Zone,” suggests ways to deal with anger. At the end of the book, I have included a list of helpful organizations, books, Web sites, and other resources.

When Michael was diagnosed with PTSD, I felt a surge of relief that at last we could name the unspeakable. At the time of his diagnosis, I had worked as a writer in the area of addiction and recovery for almost twenty years. It helped me immensely to look at Michael’s trauma and PTSD through the lens of the Twelve Steps, because the Steps provide such practical tools that help individuals accept what they cannot control—whether or not they belong to a recovery group. While it is not uncommon for trauma sufferers to try to numb themselves with alcohol or other drugs, substance abuse can also be a problem for other family members who struggle to support their loved one. In chapter 6, “Trauma and Addiction: Weathering the Storms,” I discuss co-occurring disorders and related issues and have included suggestions on how the Twelve Steps can be used as a healing tool.

Good self-care is particularly important for parents in trauma-stressed families so they are better able to raise resilient children. Chapter 7, “Trauma and Parenting,” discusses the effects of trauma on children and offers ways in which parents can provide security

and stability in the midst of its aftereffects. In chapter 7, I have included prevention strategies, communication tips, a discussion and examples of “teachable moments,” and resources for support.

In chapter 8, “Rebuilding Your Life,” I talk about living and growing in trauma’s wake. Eventually, Michael learned from his memories instead of being imprisoned by them, and because he and I now have a better understanding of how trauma affects families and can talk about how it has affected our own, our partnership is stronger. We are more honest with each other now and better able to accept responsibility for our own actions and reactions. We laugh more, relax and play more, and when we argue, we fight more fairly. When trauma symptoms appear, as they occasionally still do, we are better able to identify them as responses, not character defects.

Our family continues to grow healthier, but every day there are more families who struggle as we did to stay afloat in the tsunami that is trauma. Michael and I are both committed to doing what we can to help them.

If you are reading this book, you have probably been touched by trauma or know someone who has been. I applaud you for tending your wounds; for having the strength to pick up a book and learn more about trauma. Knowledge is an important step in healing, and it is a step *forward*. It is my wish that you will find hope and comfort in these pages as well as helpful information you can put to use. I hope you will emerge convinced that you are not alone in your journey.

Let the healing begin.

Trauma Responses and PTSD: Normal Reactions to Abnormal Events

Waking Him

Quietly she calls him
“Daddy . . . Daddy, are you sleeping?”
She has to begin the waking slowly,
if she is too sudden, he will uncoil
a fierce spring rusted loose.

Gently she must nudge him back
into the world of fenced-in yards
and refrigerator art, and away
from the shadowy echoes of rotten canvas and death.

She knows her child hand is not enough
because she is in some of those dreams,
staggering with him, shoeless through mud.
That is all he will say. He tries
to protect her from the terror, but she hears
the screams at night. She already knows.

She must use caution in the waking.

AS I REREAD THIS POEM our daughter wrote when she was still a teenager, I realize that she grasped the presence and shock wave effects of my husband's post-traumatic stress disorder (PTSD) before we knew enough to name it.

There is power in naming. For example, I have late-onset asthma. Prior to its diagnosis a few years ago, I was exhibiting symptoms that increasingly nipped away at my sense of self. I've always enjoyed hiking, but grew discouraged when I got winded on even short walks. Michael would patiently wait for me to catch my breath or firmly grasp my hand to help me up hills that only months before had been easy for me to climb. I felt old, out of shape, and horribly embarrassed that I could not keep up with my husband. We both valued our walks. They were special times to reconnect, slow down, and really be together, and I worried we might lose them.

When I finally saw my doctor, he ordered a pulmonary function test that I flunked. Yet I felt an almost happy relief when he said I had asthma. My doctor prescribed an inhaler and offered other guidance. I grew stronger, able to walk farther and more vigorously on each outing with Michael. We talked about how concerned Michael had been, and we were both buoyed by the knowledge that this was a problem that had a course of action. It could be treated. I would get better. There was power in the knowing, in the naming.

This is how we felt when Michael was finally diagnosed with PTSD in 2003. With that diagnosis came the realization that there were things we could do and experts we could each consult. We came to understand that so many of our actions and reactions over the course of our marriage were linked to trauma and PTSD. The pieces of the puzzle were coming together. We grew stronger and closer.

PTSD did not become an official diagnosis until 1980 when the American Psychiatric Association added it to its *Diagnostic and Statistical Manual of Mental Disorders*, but the effects of trauma on human beings are well documented throughout literature and history. In fact, Greek author and "father of history" Herodotus wrote of fifth-century B.C. warriors with PTSD symptoms. In his *A Short*

History of PTSD, Steve Bentley writes of how Herodotus describes an unwounded Athenian soldier who went blind after seeing his comrade get killed and how a Spartan was so shaken by battle he was nicknamed “the Trembler.”

Shakespeare and Homer have described the effects of trauma, and post-traumatic stress symptoms are also described throughout U.S. military history. In Civil War times, PTSD was called *soldier’s heart* or *Da Costa’s Syndrome*, after Jacob Mendes Da Costa, the doctor who described an anxiety disorder with symptoms that mimicked heart disease. In World War I, doctors called it *shell shock*, or *combat fatigue*, and in World War II it was also known as *gross stress reaction*.

Because war and trauma go hand in hand, and we’ve probably had battles as long as we’ve had people on this earth, post-traumatic stress and PTSD symptoms are commonly linked to soldiers. But, as Bentley points out, there are also early accounts of trauma’s after-effects among civilians such as Samuel Pepys, an Englishman who lived in London during the 1600s. Fortunately, Pepys kept a diary in which he entered his account of the Great Fire of London in 1666. Although his own house was saved, he describes his great fear, insomnia, and nightmares that persisted long after he witnessed the disaster.

Railway crashes were fairly common in the early nineteenth century, when the term *railway spine* was used to explain the post-traumatic symptoms of survivors of these accidents. Bentley describes how English author Charles Dickens told of his own horror at seeing the dead and dying when he was involved in a railway collision in 1865. “I am not quite right within,” Dickens wrote in a letter after the event, and he remained “baffled” as to why his shaking and uneasiness grew worse, not less, as time passed.

The World War II term *gross stress reaction* actually made its way into the very first *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)* created by the American Psychiatric Association in 1952. This diagnosis described acute psychological responses to those who had experienced problems from an extreme stressor (with

no mention of any possible long-term effects). *Gross stress reaction* was dropped altogether in *DSM-II* in 1968, and mention of a stress-related anxiety disorder didn't reappear until 1980 in *DSM-III*, when *post-traumatic stress disorder* was first included.

We can thank our Vietnam veterans and those who worked with them for getting PTSD accepted as a legitimate and diagnosable medical condition with long-lasting effects for the millions of people who experience serious trauma. In the early 1970s, a group of psychiatrists used *post-Vietnam syndrome* to describe delayed reactions like the depression, anger, isolation, and sleeplessness they observed among these veterans. Their advocacy on behalf of these veterans led to *post-traumatic stress disorder* being entered into *DSM-III*.

Since 1980, the criteria for diagnosing PTSD have been argued over, tweaked, and expanded. The most recent diagnostic features appear in *DSM-IV* (2000), and might change again in *DSM-V*, due out sometime in 2012. PTSD expert Dr. Judith Lewis Herman of Harvard University says that an additional diagnosis called *complex PTSD* is needed to describe symptoms of long-term trauma, in which a person experiences repeated trauma over the course of months or years. Complex PTSD can result from situations such as prostitution brothels; long-term domestic violence; long-term, severe physical abuse; childhood sexual abuse; organized child exploitation rings; concentration camps; and prisoner-of-war camps.

The yardstick used to measure PTSD will probably never be perfect, but it is important for the medical and therapeutic communities, the Department of Veterans Affairs (VA), patients, and insurance companies to have a tool by which to measure symptoms and design appropriate treatment.

Shock Waves is not an academic text about trauma and PTSD. It is intended to help family and friends better understand what *they, and their loved one*, might be feeling and experiencing—whether or not the trauma survivor has had an official diagnosis of PTSD. If you have a friend or family member who has experienced severe trauma, this book will help you see how untended symptoms can spill over

and affect you (or those closest to the trauma survivor) to the point where you also experience problems.

A PTSD Diagnosis

To be diagnosed with PTSD, *DSM-IV* specifies that a person must have been exposed to or have witnessed a traumatic event that involved actual or threatened death or serious injury to oneself or others. PTSD can also come from experiencing the unexpected or violent death, serious harm, or threat of harm, of someone close to you—family member or not.

*I work in Manhattan, and when 9/11 happened my daughter was only five. For years she was terrified that when I went to work, I might not come home. She knew that I worked on the twenty-second floor of a much taller building, and she was afraid that a plane would hit the tall building I worked in, and I would not be able to get out. For the first year after that horrible event she had nightmares about people leaping out of burning buildings. It's been eight years. My daughter is thirteen now, and while she feels pretty confident that I will come home at night, she is still scared of being in really tall buildings.**

In a PTSD diagnosis, the person's response to the trauma involves intense fear, helplessness, or horror. In children, the response might show up as disorganized or agitated behavior.

Duration and Intensity

To be classified as having PTSD, the traumatized person must have symptoms in three areas (reliving the trauma, avoidance and numbing,

*Indented text throughout this book represents the words of others: trauma survivors, those affected by a loved one's trauma or PTSD, and those who work with trauma survivors and their families. These persons are presented anonymously to protect the privacy of those involved, and in some cases, some details have been changed to ensure anonymity.

and hyperarousal) and these symptoms must last for more than one month.

Those diagnosed with PTSD have difficulty going about their daily tasks because their relationships, jobs, and often every aspect of their lives are significantly affected by their symptoms.

Reliving the Trauma

For people with PTSD, the traumatic event is reexperienced in one (or more) of the following ways:

- Recurrent or intrusive thoughts, images, or memories of the event. Young children may show signs of PTSD in their play, speech, or drawings.
- Nightmares or distressing dreams in which the trauma re-emerges. Children might have frightening dreams with no recognizable content.
- Flashbacks, illusions, or hallucinations. These images might cause the person to act or feel as if the traumatic event was still occurring, giving him or her a sense of reliving the experience.
- Mental or emotional anguish when something happens to trigger a recollection of some aspect of the event. For children abused by a family member, it could be seeing that uncle at a family reunion years after the abuse occurred. For those who have lived or worked in war-torn areas, a car backfiring may sound like an explosion or gunfire.
- Physical reactions when something triggers a memory of the trauma. For example, a person may react to a trigger with a stomach ache, a pounding heart or rapid breathing, sweating, or a severe headache.

Traumatic recollections might be triggered by an anniversary of the trauma; certain odors, sounds, textures, tastes, or sights; a medical procedure; an activity that replicates some aspect of the event; some-

thing that ignites fear like a close call on the freeway; certain places or spaces; a movie; a song; or by any event or stimulus.

Avoidance and Numbing

People with PTSD adopt certain strategies to avoid places, objects, or people that remind them of the traumatic event. In a person diagnosed with PTSD, three (or more) of the following need to be present:

- An effort to avoid thoughts, feelings, or conversations associated with the trauma
- An effort to avoid activities, places, or people that bring the trauma to mind
- An inability to remember an important aspect of the trauma
- A noticeable disinterest in doing things that were enjoyable before the traumatic experience (often called *psychic numbing* or *emotional anesthesia*)
- A feeling of detachment or estrangement from others
- Difficulty having or showing loving feelings or being intimate or sexual
- A sense of a foreshortened future in which the person doesn't expect to have a career, marriage, children, or a normal life span

Hyperarousal

People with PTSD are anxious or on the alert, making it difficult for them to relax. In a PTSD diagnosis, according to *DSM-IV*, two (or more) of the following symptoms are present:

- Difficulty falling or staying asleep (which could be due to nightmares about the trauma)
- Irritability or outbursts of anger
- Difficulty concentrating on or completing tasks

- Hypervigilance (which is an extreme sense of caution that may sometimes resemble paranoia)
- Exaggerated startle response

Acute, Chronic, and Delayed Onset PTSD

DSM-IV refers to three distinctions under the PTSD umbrella that specify onset and duration of the symptoms:

- **Acute PTSD** refers to symptoms that last less than three months;
- **Chronic PTSD** refers to symptoms that last three months or longer;
- **Delayed Onset PTSD** refers to symptoms that did not appear until after six months or more have passed between the traumatic event and the onset of symptoms.

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WHAT'S IN A NAME?

Take a moment to review the diagnostic criteria for PTSD. Remember that it is *normal* to be upset after a trauma. It is *common* to have some of these PTSD symptoms after experiencing or witnessing a traumatic event. While it may be tempting to identify your loved one, yourself, or someone you know as having PTSD, leave the actual diagnosis up to a professional.

There is power—both positive and negative—in attaching a name to a cluster of symptoms. Having a diagnosis can be a relief to some people, but sometimes fear of being branded with PTSD keeps those who are deeply troubled in the aftermath of trauma from getting much-needed help. Many people with post-traumatic stress symptoms worry they might be seen as weak, crazy, or undependable by others if they ask for help; some think seeing a therapist could hurt their jobs.

Untreated post-traumatic symptoms (whether or not they turn out to be PTSD) can grow worse and negatively affect an entire family. Such symptoms can also be related to other treatable physical or mental health problems, so it is important to get guidance in sorting out what treatment is most appropriate.

Try not to get hung up attempting to figure out if someone's symptoms constitute PTSD, but do seek help if you sense your life might be spinning out of control.

And if there is a PTSD diagnosis, recognize that defining a disorder does not define the person. A person with cancer, for example, is not the disease. We are unique tapestries, made up of varied patterns and different threads. We are so much more than a title, an experience, an illness, *or* a diagnosis.

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Normal Stress vs. Trauma

Life is filled with stressful times, but the moments usually pass and, with them, the stress. A frustrating home repair finally gets accomplished, or we break down and hire a plumber; a child passes an exam, or we hire a tutor; we make up with our partner after an argument; or a consistently crabby coworker at last apologizes. Some events, like births, a marriage, the natural death of an elderly parent, a new job, new house, or new town, can cause longer-lasting and greater stress, but they're still pretty common occurrences, not trauma. The child is born, the wedding takes place, the parent is mourned, the job gets more comfortable, the boxes get unpacked, and life goes on.

Stress performs an important function in our lives, and not all stress is bad. If a small child runs into the street, for example, our body's stress alarm system jolts us into action. Our heart rate speeds up and adrenaline pumps through us, allowing us to react quickly. We scoop up the child, plant her on safe ground, and breathe deeply once the danger has passed. This type of stress reaction is our body's way of protecting us by helping us stay focused and alert. The stress

response can help us be sharper when we do things like negotiate with a boss, make a presentation, or communicate with a friend in a sticky situation.

Extreme or chronic stress is another matter. For caregivers and families of trauma survivors, constant stress is often an unwelcome visitor.

I was a mess for many years before my husband got help with his PTSD. I carried a lot of stress for the whole family, and my health was poor. My immune system became weak. After he completely broke down, I was a wreck. I cried when anyone asked me a personal question such as "how are you?" I was unable to reach out to others compassionately.

When you live with a trauma survivor, you often live in a tension-filled environment where emotional abuse is not uncommon and the fear of physical abuse only adds to the extreme stress you are already feeling. Studies have shown that men and women who experienced the trauma of physical abuse, sexual abuse, or emotional neglect as children may be more likely to be abusive in intimate adult relationships than those who did not have these experiences. The victims of this ongoing domestic abuse (both emotional or physical) can also develop post-traumatic symptoms.

Symptoms of chronic stress like tension headaches, fatigue, and irritability become so familiar, they often go unchecked. But these symptoms are related to that same instinctive response that causes us to rescue a child from danger. They are our body's way of telling us that we need to take notice. In the case of rescuing a child, that alert prompted us to move quickly. In the case of stress symptoms, we're being alerted to pull back and slow down, if even for a moment. Prolonged or excessive stress can lead to medical problems and depression.

You might say that *normal* stress is a bump in the road of life that you navigate over or around with minor difficulty. Trauma, however, is like a California highway after an earthquake—the road suddenly

opens up, you lose control, and you slide in, terrified. The damages sustained will vary from person to person.

Different people have different trauma thresholds, just as they have different pain thresholds. While some people exposed to traumatic events do not develop PTSD, others go on to develop the full-blown syndrome. What's important to keep in mind is that it is absolutely appropriate to react to trauma with powerful emotions. In "Disaster and Your Mental Health," the National Mental Health Association (NMHA) pointed out that after 9/11, "for most people, the intense feelings of anxiety, sadness, grief, and anger have been healthy and appropriate."

Here are some common reactions to trauma that the NMHA compiled:

- Disbelief and shock
- Fear and anxiety about the future
- Disorientation; difficulty making decisions or concentrating
- Inability to focus
- Apathy and emotional numbing
- Irritability and anger
- Sadness and depression
- Feeling powerless
- Extreme changes in eating patterns; loss of appetite or overeating
- Crying for "no apparent reason"
- Headaches or stomach problems
- Difficulty sleeping
- Excessive use of alcohol and [other] drugs

Notice how almost all of the above *common* responses to trauma show up in the *DSM-IV* criteria for PTSD. Remember, it is the *intensity and duration of reactions and feelings* that distinguish common reactions to trauma from PTSD. Think of it this way: Two people are exposed to the same germs in the same setting, and both end up getting colds.

One is miserable for a week or so, but recovers completely. Symptoms grow worse for the other person, however, and progress into serious pneumonia. Trauma can affect anyone, young or old, rich or poor. The more disturbing the trauma, the greater the risk for PTSD.

Reacting to trauma and even having PTSD does not mean we're weird or crazy; it means we're human beings with the capacity to feel deeply. That's not a bad thing.

What Do PTSD Symptoms Look Like in “Real Life”?

Sleep disturbances not only affect the trauma survivor, they can also interfere with the sleep of partners and children. As Jessica's poem so poignantly reveals, she learned early on to “begin the waking slowly” and not startle her dad by poking him or calling to him too loudly if he was sleeping. The dreams aren't as frequent now, but Michael (like so many others with PTSD) still has occasional nightmares.

Survivors of sexual abuse, for example, may carry such powerful body memories that they see their molester in dream after dream—even though the abuse occurred decades before, in their childhood. Some trauma survivors so dread these nightmares that they medicate themselves with alcohol or other drugs in an effort to numb themselves to sleep. Others may fight sleep altogether and suffer the physical maladies that accompany insomnia.

Nights bring it all back to me, because that's when my stepfather would sneak into my room when I was just a little girl. When I do sleep, I usually sleep so lightly that I awake suddenly, startled by any creak, any footstep. My jumpiness, of course, wakes my partner, then we're both crabby the next day because of lack of sleep. If I do manage to sleep deeply, my nightmares are so vivid that my whole body tenses to ward off the dream attacker and I awake sore, with clenched fists.

I thought I was used to the nightmares, but just recently, Michael leaped to the foot of the bed and yelled for me to “take cover” be-

cause he imagined he heard a mortar round go off. Although a fairly common part of the post-traumatic landscape, such dreams can be frightening to trauma survivors and those who love them.

I was the victim of random violence, and my mind just could not stop trying to process the experience. Each dream always had me trying to avoid getting shot, being trapped, and getting absolutely blown away. Think violent video game, only worse. The nightmares continued on and off for years. The first year was horrible. There were times when I would wake up during the night on the floor next to my bed, thinking the attacker was coming down the hallway toward my second floor bedroom. I remember having processed my options for escape. More than once, I had to talk myself down from just jumping out of my window and falling to the cement patio fifteen feet below. . . . [If it weren't] for therapy teaching me skills to find reason in the midst of these dream hallucination sequences, I'd have jumped. There were many times when I hadn't slept, was exhausted, and feared sleeping, that I wished it would just be over. I wanted to die to be free of the terror.

Sometimes, family members not involved in the actual catastrophic event are nonetheless bothered by intrusive dreams and images of what they imagine their loved ones suffered:

For the past two years, I have had recurrent nightmares of the airplane crash that killed my husband and our close friend. I was supposed to be his copilot that day. . . . In the dream, I'm flying in the air behind the plane and I try to tell him to abort the landing, to get out of there, to save themselves. Consciously, I know he's gone and will never be coming home, but emotionally, I was not ready to let him go.

I knew about nightmares after trauma, but I had never heard of “daymares” until a friend of ours with PTSD described how disturbing

it was to walk down a street in broad daylight and feel certain he saw a stranger's head in front of him explode, which was one of the images burned into his brain from his trauma. Since his revelation, I've heard of others who struggle with daytime hallucinations.

What made it really hard was the dreams converted immediately into hallucinations. Even as I tried to wake myself out of dreams, they became embedded in my waking reality. I couldn't tell when I was awake or asleep; what was real or imagined. It all blurred.

Often, something—a sight, smell, sound, or texture—will send someone back to the traumatic event.

Dealing with the [body] remains was the main source of my PTSD, and these experiences have a life of their own even to this day. For me, the remains are connected as a constant daily reminder to things like airports, aircraft noise, the smell of gasoline and jet fuel, funerals, and aluminum in any form or shape. These things have the same power to evoke disturbing memories, run the tape loop in my head, of the death and destruction in Vietnam. It's crazy! I just put plastic handles on the drawers and vanity in my bathroom. I hate the plastic ones, but every time I use the brushed aluminum ones, I remember the coffins.

Adaptive Behaviors

Now that our family has learned more about PTSD, we understand that some of Michael's symptoms were adaptive behaviors that kept him alive in Vietnam. He said one of the best pieces of advice he got in his first days in combat came from a more experienced soldier who told him to "leave the world behind." Vietnam, he said, was the only reality, and those other things were distractions that could get you killed. "He was right," said Michael. "While I was there, I didn't have a past or a future. All I had—all I could have—was 'war time.'"

Many rape and trauma victims also describe numbing and detachment (shutting down or feeling “outside” of one’s body) as adaptive strategies during their trauma.

Shutting down after the first rape was easy. I was only thirteen and my family was acting weird, like they had all been attacked, so I didn't feel welcome to share my fears. Too, the police never pursued a suspect. I confronted the city judge about it, and he told me I wouldn't be able to pick him out in a lineup because they would all look alike and be dressed alike. So I buried everything inside.

Difficulties arise when trauma survivors “reenter” the world and find that, months later, they are still numb.

I have learned that if you suppress your feelings, as I did for decades, your feelings will eventually bite you in the ass before you know what hit you. I have had two nervous breakdowns, but I am learning who I am and how the sexual traumas in my life have affected me, and I'm learning that it's okay to feel the way I do as long as I acknowledge my feelings, identify where they are coming from, and face them head-on. In other words, I'm living through hell right now.

Many withdraw or isolate themselves. Others describe “going through the motions” of living, blocking out the past, and not daring to think about the future.

I remember the wives of firemen saying that their husbands went to work that day on 9/11, and it was like an alien took over their bodies and came home in their place.

Hypervigilance

Hypervigilance is another survival skill that serves survivors well under certain circumstances. First responders, soldiers, and women

who find themselves in threatening situations, for example, learn to quickly scan their surroundings for potential dangers—actions that can keep them and others safe. For many trauma survivors, being alert becomes instinctive and natural, and they are able to relax once they have assessed a situation and figured out an escape if an emergency were to arise.

When caution grows into extreme (and long-lasting) hypervigilance, however, it is a post-traumatic symptom that can interfere with day-to-day life.

The most lasting impact of the shooting is hypervigilance. For years I didn't go anywhere without instantly, subconsciously, and sometimes consciously mapping out escape routes. Any room, any home, any meeting place. I knew windows, doors, hallways to get out. I mapped distances I could leap from a window to safety. I always kept my back to a wall. I'd go to meetings and have to use every therapy trick in the book to not freak out that an angry person was going to pull a gun and trap me in the room. When you are running calming exercises in your head, it's hard to hear the questions being asked. I developed two parallel minds: one that was present to reality and one that was present to my fear. People probably didn't notice me clutching a little marble in my left hand to work out the fear mind while my right hand held the marker to write on the flip charts. Literally, a tool in each hand . . . [one for each mind].

How a Loved One's Symptoms Can Affect Others

I remember so clearly the day my therapist asked, “Who is helping you with *your* war?” I wept in gratitude that someone was at last connecting the dots and helping me understand there was something more going on in our household than “she’s demanding; he’s distant.”

For so many years, I took responsibility for our family’s emotional well-being. I couldn’t sort out what things were my responsibilities,

what things were Michael's, and what things needed joint attention. Michael often dodged getting in touch with his feelings by escaping into workaholism or compulsive exercise. He was a perfectionist, and he attacked house projects with the same compulsion. If I tried to help with yard work or projects, he would often go back over what I had done, bringing it up to his standards. Although he took care not to openly criticize the way I kept house, I sensed his disapproval and badgered him to tell me what he was feeling. Unable to identify his feelings, he'd walk away and I'd get angry or depressed, feeling rejected and unloved. We got very good at our respective dysfunctional behaviors. I often felt like an inadequate partner and a whiner. What right did I have to complain about a good father and hardworking husband?

I worried about his nightmares, and wondered about his insatiable need to see every movie about Vietnam. The war stories he told me early in our marriage were seared in my mind, but he filed them away deep within himself and buried the photographs from Vietnam he had shown me deep in the attic. He didn't talk about Vietnam until Jessica was in eighth grade. Her social studies teacher asked if any of his students' parents had served in the war, and Jessica told him that her dad had. Michael agreed to come in and talk to Jessica's class, and he struggled to get through his presentation. When the inevitable "Did you kill anybody?" question came, he tried, unsuccessfully, to give the honest answer, "It was my job to kill people," through his tears. He came home distraught and sullen, and Jessica came home looking frightened and confused.

Still, we didn't see the link between his trauma and our problems. We partied hard with friends and played hard with Jessica. We got very good at ignoring our problems (if you don't count my therapy for depression, Michael's workaholism, or our couples' communication class). If anyone asked how we were doing, we'd say "great," and usually believed it. And when I asked Michael how he was, he often replied, "It's a good day, nobody's shooting at me." What's that line about denial not just being a river in Egypt?

As we discovered, a loved one's trauma can affect families in many

ways. Without warning or intention, individuals with PTSD symptoms often experience intrusive memories or dreams that are so vivid they reexperience the initial trauma and react with grief, guilt, fear, or anger.

For many, many years now, I get rambunctious at night. It got so bad, I was bruising my wife so often, that we've had to sleep in separate rooms ever since. It helps to sleep with a light on because I used to wake up in the middle of a nightmare where there's an attacker after me, and turning on the light made him disappear. Even though I have been going to both group and individual therapy, I still lash out a lot during my nightmares. Three years ago, I was sleeping in the lower bunk bed in my son's fishing camp, and I punched the upper bunk rail so hard I broke the ring finger of my right hand.

Although anger can be a natural—even healthy—emotion, it can also have unhealthy expressions that lead to marital, relationship, or family difficulties; job problems; and loss of friendships.

My son with PTSD has anger issues. He has dreams and sleep issues, so he takes sleeping pills. He drinks excessively and fights when he is drinking. At a family wedding, my son wanted to go to the pool and had an argument with the [hotel's] night manager. They eventually called the police and called us down from our room. Once, he fell asleep when he was in the shower. My older son called us at 2:00 in the morning because he didn't know if he was dead or alive. When he isn't drinking, he's a wonderful, loving kid, and we all enjoy him. His brothers and sisters aren't that patient. They feel we should let him deal with his own problems and not interfere. They think if he messes up and goes to jail, he may finally realize he has a problem.

Children, especially, can be frightened by these symptoms and start to worry about their parent's well-being or their own safety.

I remember the night he flew into a rage about something that was inconsequential. The kids were pretty little then. He threw a chair across the dining room and broke it. He cried and begged me for forgiveness, but I was frozen and couldn't respond with compassion.

Those with PTSD may also avoid places or experiences that could trigger memories. They may avoid going to the store, the movies, or restaurants, or doing things that were enjoyable for the family before the onset of PTSD. Sufferers become numb to feelings and withdraw from interpersonal interactions, except perhaps with those who have been there, such as other veterans or other survivors of an accident or disaster. This isolation can leave loved ones feeling rejected, lonely, and confused.

I was eight months pregnant when the Pentagon got hit on 9/11. My husband got out, in shock, but he lost twenty-eight of his friends. Our baby was born [soon after], but got very sick, and we were in the process of moving. My husband had no chance to grieve. Then he was sent to Iraq. I think he was already dealing with PTSD issues from 9/11, which got worse from Iraq. He wasn't sleeping and became very isolated. He didn't want anything to do with me or the family. He shut down and became very indifferent. I was lonely, whether or not he was here. I remember telling him, "You're here, but not here. Your body is here, but your mind is elsewhere. You're like a robot."

Hyperarousal shows up as difficulty sleeping, impaired concentration, being easily startled or highly irritated, or acting unduly concerned for personal safety and the safety of loved ones. These symptoms can be easily misinterpreted as hostility or distancing, causing children, spouses, and loved ones to feel uncared for, frightened, and insecure.

A minister molested my wife when she was only twelve, and she can't stand to be touched unexpectedly as a result of that trauma.

The kids and I know not to give her spontaneous hugs or shake her shoulder to wake her up, but sometimes friends or family forget and reach out to her in a gesture of affection. She gets this frightened look in her eyes when that happens and just goes stiff or seems ready to bolt. It took us a long time and a lot of therapy before she could relax enough to be sexually intimate, but things are much better now than they used to be.

Work can also be a challenge for some people with PTSD because they feel inadequate, anxious, overwhelmed, or depressed, or they may have trouble concentrating. Resultant money issues can add to stress at home, causing arguments and fear. Men and women with PTSD may also dive into a job and work obsessively to avoid thinking or feeling the effects of trauma.

After the war, I wanted to have sleep patterns like normal people, but that didn't work for me. I'd work until I was physically and mentally exhausted and then I'd finally fall asleep by one or two in the morning and then sleep to five or six a.m. I'd work long hours or if I wasn't working, I'd do something else, fifty to sixty hours a week. I might go to bed but I'd either not sleep or only sleep for an hour and then I'd wake up thinking about Vietnam and go for a ride on my bike or something else to escape the thoughts.

Attempted and Completed Suicide

Perhaps the most tragic consequences of PTSD are attempted and completed suicides. This woman survived war and rape, and, thankfully, lived to tell the story of how close she came to killing herself. Her account reminded me of the Kirk Douglas story, only in her case it was her cats, not a bad tooth, that saved her.

I loaded my .357 magnum (the one I slept with every night) with hollow-point bullets so it would blow off half of my head, then I spun the cylinder and cocked the hammer. I was ready to

fire, when my two cats came running in and jarred me back to reality. I took my finger off the trigger, uncocked the hammer, lowered the gun, and took out the bullets. Then I put the gun away and picked up my cats.

Some stories, however, don't end as well.

Kevin and Joyce Lucey sign their emails with their names, adding, the line: "The proud parents of Cpl. Jeffrey Michael Lucey, a 23-year-old USMC reservist forever. Succumbed to the hidden wounds of PTSD on 06/22/04." I use their real names here because they have been very public about their son's suicide. When Jeff returned from Iraq, Joyce said they watched him fall apart. He had panic attacks, trouble sleeping, nightmares, and poor appetite, and he was isolating himself in his room. He was depressed and drinking. When his dad called the local Veterans Affairs office to describe what was happening, they said it was classic PTSD and said Jeff should come in as soon as possible. He was admitted for four days, and during that time he told the VA about the three methods of suicide he had thought about—overdose, suffocation, and hanging. This was not relayed to his parents, however, and he was released June 1, 2004, with the VA telling them Jeff couldn't be assessed for PTSD until he was alcohol free.

Jeff got worse, and his parents tried to get him help, but received no guidance on how to handle the situation. Like many worried family members, they became as hypervigilant as trauma survivors. They hid knives and took away anything they thought Jeff might use to harm himself, even disabling his car. Civilian authorities said they couldn't help either, because Jeff was drinking. On June 21, Kevin described Jeff as being in a total rage. This time Kevin called the Vet Center and said the "angel" who answered calmed both Jeff and Kevin down. Just before midnight, Kevin said Jeff asked him for the second time in ten days if he could sit on his dad's lap and rock him like he used to when Jeff was little.

At the March 2008 Winter Soldier hearings where veterans of the Iraq and Afghanistan wars gave accounts of their experiences,

Kevin Lucey ended his testimony by saying, “The next day I came home. It was about 7:15. I held Jeff one last time as I lowered his body from the rafters and took the hose from around his neck . . .” Here’s what they said when I asked Kevin and Joyce how they dealt with Jeff’s suicide:

Each family has to handle it in their own way, but it never crossed our minds not to be open. We felt it was a tragic way to die, but a tragedy would have been further promoted if we had lied about how he had died. At his wake, we just put it out there. Some of his unit was there, and we begged them not to do as Jeff did—we knew the officers were concerned about two other men. . . . We met one of the officers six months later and he told us that both of them came up and said they needed help.

We’ve gotten lots of calls from distraught families who are worried about their sons and daughters. There was a family about thirty miles from us who saw our story on television and called us for help. Their son’s name was also Jeffrey Michael, just like our son. We referred them to the right people and got a note about three months ago, saying “your Jeffrey saved our Jeffrey.” We don’t want others to go through what we did. People need to know that PTSD can be lethal.

These stories are not meant to scare or depress you, and you may never have to deal with the threat or reality of suicide. However, it is important to know, as Kevin Lucey put it so well, “PTSD can be lethal”—as can other post-trauma behaviors like depression or alcohol and other drug abuse. Although women attempt suicide more often than men, men are more likely to succeed in killing themselves during a suicide attempt. Research shows that among people who have had a diagnosis of PTSD at some point in their lifetime, approximately 27 percent have also attempted suicide.

When traumatized loved ones are in such despair that they are in danger of hurting or killing themselves, their family and friends

can become overwhelmed with worry or paralyzed by their feelings of fear and helplessness. Any sense of normalcy a family may have enjoyed before these trauma symptoms appeared often vanishes as more and more attention is focused on the traumatized loved one. Many concerned family and friends become hypervigilant in their efforts to keep their loved one safe, as the Luceys did with Jeff.

Kevin and Joyce Lucey would give anything to have their son back, and they mourn his death every day. But they emphasize that as much as they miss him, they have learned that his suicide was not their fault. While they will always carry a burden of loss, they do not carry the additional burden of guilt. Ultimately, “to be or not to be” is an individual and independent choice. We can support, try to help, and try to understand our loved ones, but we cannot control their lives *or* their deaths. We cannot fix them; we can only love them unconditionally, and we can take care of ourselves as we experience the shock wave effects of our loved one’s trauma.

We can also be grateful for the families who tell the truth about their loved one’s suicide, because the stories just might cause a trauma survivor or family member to get the help she or he needs. In this way, the voices of those lost to us by suicide are still heard.

Warning Signs for Suicide

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK (see sidebar) if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms or medications, or by other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless

- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped—like there’s no way out
- Increasing alcohol or other drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

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CALL 1-800-273-TALK (1-800-273-8255)

IF YOU OR A LOVED ONE IS IN CRISIS

Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) if you are feeling desperate, alone, or hopeless. It is a free, twenty-four-hour hotline available to anyone in suicidal crisis or emotional distress. Your call will be routed to your nearest crisis center. The hotline is staffed around the clock by trained counselors, and this service is free and confidential. In addition to helping you on the phone, counselors can provide information about mental health services in your area. More information can be found on the National Suicide Prevention Lifeline’s Web site at www.suicidepreventionlifeline.org.

Who should call?

- Anyone who feels sad, hopeless, or suicidal
- Family and friends who are concerned about a loved one
- Anyone interested in mental health treatment and service referrals

Why should you call?

The Lifeline Network answers thousands of calls from people

in emotional distress. There are many reasons for their calls. Please call for any of the following reasons:

- Suicidal thoughts
 - Information on suicide
 - Information on mental health
 - Substance abuse or addiction
 - To help a friend or loved one
 - Relationship problems
 - Abuse or violence
 - Economic problems
 - Sexual orientation issues
 - Physical illness
 - Loneliness
 - Family problems
-

Healing from Trauma Is a Family Affair

Family members hang in delicate balance, connected at the center like a wind chime. If something—good or bad—tugs at one member, the others may lose their equilibrium and come clanging together noisily. This reaction is especially true for families who have loved ones struggling in the aftermath of a traumatic event. People who shared their stories in this chapter describe how a loved one shut down, withdrew, or seemed like an alien or robot. Family and friends are often left feeling confused, angry, sad, worried, or lonely when the loved one they knew so well changes in the wake of trauma.

The Greek poet Agathon wrote, “Even god cannot change the past.” As much as we’d like to erase a loved one’s trauma, we cannot, any more than we can spare them or control the hard work of their healing, which often means they are learning to feel again. But we can educate ourselves about trauma and its effects and take good care of ourselves as we stand beside them while they heal.

When you familiarize yourself with the common reactions to trauma and the symptoms of PTSD, you change the lens through

which you see the world. When Michael and I first saw the 1993 movie *Fearless*, he hadn't yet been diagnosed with PTSD, but we were strangely drawn to this film and the ways in which Jeff Bridges' character changed dramatically after he survived a plane crash in which his business partner was killed. In fact, we were so moved by the film that we immediately bought it for ourselves. When we watched it again after we understood more about PTSD and trauma, we cried together at the story's poignancy and the mirror it was for the millions like us who have been affected by trauma. It's not that we now see PTSD symptoms around every corner; it's that we have a heightened awareness and tenderness for ourselves and others.

Knowledge led us to action, and action led us to healing and a fuller sense of happiness. There's freedom in that realization. As Miriam Greenspan writes in her book *Healing through the Dark Emotions*:

For those who desperately need a way to feel more hopeful, resilient, and joyful, take heart! The emotions that appear to afflict us can be the vehicles of our liberation from suffering. Experiencing our grief, fear, and despair in a new light, we renew our capacities for gratitude, joy, and faith. We grow in courage and compassion. We approach the world with less fear and more wonder. We have more energy for changing the things that matter. These gifts can only be found when we are unafraid to dance the dance of dark emotions in our lives.

Let's dance.

THE SERENITY PRAYER

There are several versions of the *Serenity Prayer*, so enthusiastically embraced by Alcoholics Anonymous (AA) when it was discovered in 1948. It has been variously attributed to an ancient Sanskrit text, to Aristotle, to St. Augustine, St. Francis

of Assisi, and others. AA generally credits this version to theologian Reinhold Niebuhr:

God, grant me the serenity
To accept the things I cannot change,
Courage to change the things I can,
And wisdom to know the difference.

You don't have to be religious to recite this prayer; you don't even have to believe in a god. This simple twenty-five-word statement is a good reminder, however, that we aren't god. We can't control the fact that our loved one experienced a deep trauma, and we can't control our loved one's responses to that experience. However, we can ask for guidance and muster the courage it takes to change our own thinking and actions. We can arm ourselves with knowledge about trauma and its effects, and we can replenish our own reserves so we will stay healthy and so we will have the patience it takes for our loved one and our family to heal.

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About the Author

CYNTHIA ORANGE HAS WRITTEN EXTENSIVELY about addiction and recovery, parenting, and post-traumatic stress disorder. She co-facilitates a caregivers' support group, and she and her husband (a Vietnam combat veteran) often speak to audiences about the effects of trauma and war in their continuing involvement with veterans and veterans' issues. She is an award-winning writer who has published hundreds of articles, columns, and guest editorials in newspapers, magazines, and literary journals. She is the author of several books, and contributed to the popular meditation book *Today's Gift*.

Hazelden, a national nonprofit organization founded in 1949, helps people reclaim their lives from the disease of addiction. Built on decades of knowledge and experience, Hazelden offers a comprehensive approach to addiction that addresses the full range of patient, family, and professional needs, including treatment and continuing care for youth and adults, research, higher learning, public education and advocacy, and publishing.

A life of recovery is lived “one day at a time.” Hazelden publications, both educational and inspirational, support and strengthen lifelong recovery. In 1954, Hazelden published *Twenty-Four Hours a Day*, the first daily meditation book for recovering alcoholics, and Hazelden continues to publish works to inspire and guide individuals in treatment and recovery, and their loved ones. Professionals who work to prevent and treat addiction also turn to Hazelden for evidence-based curricula, informational materials, and videos for use in schools, treatment programs, and correctional programs.

Through published works, Hazelden extends the reach of hope, encouragement, help, and support to individuals, families, and communities affected by addiction and related issues.

For questions about Hazelden publications, please call 800-328-9000 or visit us online at hazelden.org/bookstore.

Praise for *Shock Waves*

"Cynthia Orange has produced a beautiful, inclusive, and powerful book that names trauma and provides helpful resources for survivors and all who love them. Using her own family and experience, she weaves the heart-thread of story through incredibly useful information, guidance, and hope for recovery."

—Christina Baldwin, author of *Life's Companion and Storycatcher*

"Solid advice for taking care of oneself and one's family in the wake of a member's traumatization."

—Don R. Catherall, Ph.D., author of *Back From the Brink* and editor of the *Handbook of Stress, Trauma, and the Family*

"Distills the essence of what is known about PTSD and its effects on families in a gentle, clear, and readable book of suggestions for healing."

—Patience H. C. Mason, author of *Recovering from the War* and publisher of *The Post-Traumatic Gazette*

Cynthia Orange shows readers what the symptoms of PTSD—post-traumatic stress disorder—look like in real life. In *Shock Waves*, readers find practical insights on how to respond to substance abuse and other co-occurring disorders, manage their reactions to a loved one's rage, find effective professional help, and prevent their children from experiencing secondary trauma. Each chapter includes tips, questions,

and exercises to help readers incorporate the book's lessons into their daily lives and interactions.



Photo by Michael Orange

CYNTHIA ORANGE has written extensively about addiction and recovery, parenting, and PTSD. She also co-facilitates a caregivers' support group.

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