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Boundaries

I've been thinking a lot about boundaries this month because they have always been a difficult issue for Bob and me. I suspect it is for all trauma survivors and their families. Bob seemed to me to have walls that shut me out, and I didn't seem to have any boundaries in either direction. When we disagreed about something, he thought I was saying that he was crazy, and I always thought he was being deliberately bad (because I was always right). Our boundary problems led to a lot of pain.

For trauma survivors developing healthy boundaries is important. Often in the most literal physical sense, trauma is a boundary violation: the bullet entered your body, the fist hit your face. Recovering the sense of your rights over your body, that it is safe to be in your body in this world, can be a monumental task.

Family members can also have difficulty with boundaries, as can therapists. This shows up as efforts to fix people because we need other people to be fine to prove our worth. I used to let Bob's actions and feelings control how I felt about myself. (If Bob was depressed it meant I was a bad wife, not that he'd been through a lot in Vietnam). I invaded his boundaries by trying to control his actions and feelings to "fix" him. (Don't be sad or mad. Don't think that. Don't do that.)) Boundary violations were my way of life. People who tell you you don't need something, usually something they are not doing, therapy or program, are having a boundary problem. Only you can know what helps you. You can only find out by experience. Experience is how one develops boundaries and a sense of self. Many of us have never seen a healthy example of boundaries.

Unhealthy Boundaries

Too Weak: When you become enmeshed in someone else's life and wind up feeling what they feel, doing what they do, and not being you, you have weak boundaries. Under traumatic conditions, however, that can be a survival skill. Many combat vets could read each other and the enemy like a book. Hyperalertness to each other kept them alive. Traumatic bonding between abuser and abused is also a survival skill. Reading the emotions of the abuser and becoming what they want you to be can save your life. It also carries a great price. Being able to sense others' moods is helpful in relationships, but always being what someone else wants you to be (the woman who doesn't mind if he gets drunk/ the guy who will do anything for his wife) is a form of dishonesty which prevents real intimacy. No one can be intimate with someone who

doesn't know what s/he feels, wants, likes or dislikes, or who can't be honest about it, even though such dishonesty developed as a survivor skill.

The weak boundary experienced by survivors who are endlessly triggered because they are so open to sensing danger is a very painful state of affairs. What's outside you controls your inside. Avoiding triggers is helpful, but developing boundaries so things don't set you off is part of recovery. Furthermore, another safety issue is that hyperalertness can lead you to reading danger into a situation where it doesn't exist, causing unnecessary defensiveness or even violence.

Too strong: Walls don't make you safe either. When you hear about the sexual abuse survivor who gets raped by some guy she met in a bar, realize that her wall of numbness prevented her from reading the danger signs. She's not dumb, she's numb. If his buddies died, a veteran may try never to care for anyone again, putting up walls which prevent him from getting the support he needs to heal.

Although aggression (yelling, bossing, rejecting) or isolation (putting up a wall, or simply not being around others) are the usual forms of too-strong boundary, during prolonged inescapable abuse dissociation can be a way of creating a boundary in order to survive. Denial, too, can serve as a boundary (didn't happen/ didn't affect me). So can compulsive behaviors like alcoholism or relationship addiction. Overeating puts up a wall of fat to keep others out. (At the other extreme, the person who always wears skintight clothes may be sending an unconscious message, "I have no boundaries.") Reality keeps breaking through this kind of boundary, sometimes traumatically.

Putting up a wall of numbness or anger can lead you to be abusive because if it "didn't bother me," you may be unable to perceive how it could bother someone else. You can't tell that you are hurting them (or that your numbness is evidence that it did bother you).

Overly strong boundaries require a lot of effort to maintain. Nothing affects you but nothing can get through to help you either. Lots of survivors alternate between weak and too strong boundaries, getting close and then cutting people off, or trusting no one and then quickly becoming totally enmeshed.

Healthy Boundaries: Ideally human beings have healthy boundaries that are like the semi-permeable membrane that surrounds a cell. Boundaries allow you to let out bad feelings so you don't drown in your own waste products. They close to protect you from harm, but they open to let good things through. They allow you to give and receive support, become really close at times (like during lovemaking or intimate conversations or quiet cuddling) yet operate independently at other times. Healthy interdependence is the result.

For me it has been important to recognize that small actions taken one day at a time will help me recover, while great resolutions to change completely and forever (I'll never do that again!) have been both futile and led me to self hatred (What's wrong with me? Why can't I change?) So here is a bunch of suggested small actions

that help strengthen your sense of self, self-respect and self-knowledge , and your acceptance of others by strengthening boundaries. Take what you like and leave the rest. This works if you are a survivor, family member or therapist.

Pause Button: Visualize a pause button when something upsets you and take a moment to pick out an action that might help you rather than reacting in the same old way. Here are a few actions you can take:

Locating yourself in the here and now: When you are struggling with intrusive PTSD symptoms, it can be very valuable to write out on a 3x5 card an appropriate statement for you to read and say over and over:

"I am________. I'm ____ years old. I am in ________ and no one here wants to hurt me." Add to this whatever affirmations are helpful. I need to feel this pain so I can let it go. It's okay if I make mistakes. Having it written out and in your pocket can be a lifesaver. I works best if you pull it out and read and say it till you get relief.

Using the word "I": People often say "You make me feel..." or "That made me feel..." One of the smallest most empowering changes you can make in your thinking is to use the word "I" when you talk about yourself. Replace "you made" or "that made", which is giving away your power, with the words, "I feel..." Even if you feel other people do make you feel good or bad, just phrase it differently. Say "I feel _____ when you_______." Eventually this new way of talking will strengthen your boundaries. Your perspective on your feelings will shift. You may even feel you have more power over what you feel.

Using the word I when talking about yourself can also change your perspective. Many of us habitually say "You want to be nice," when what we mean is "I want to be nice." or "You don't want/need that," when what we mean is "I don't want you to want/ need that." When I said that it really made me think! Today I prefer to say what I mean. It helps me to know myself better and see if I'm in your business.

Separating my feelings from yours:

When someone else's mood controls yours, it means your boundaries need strengthening. Automatically reacting is a lot of work. Identifying it is the beginning of healing. How? Ask yourself is this my feeling or his/hers? If it is not your feeling say to yourself, "I am not whatever. S/he is whatever, (depressed, angry, numb). Or say "I'm me, and I don't have to feel what s/he feels or think what s/he thinks." A simple but effective technique is to keep repeating it to yourself. This seems awkward and stupid at first but it really helps over the long haul. These phrases block the emotion and remind you that you are separate from others.

Visualize a boundary if it helps, a fence between your garden and his/hers. When you can separate what you feel from what others feel, you will find yourself more able to tolerate other peoples' bad feelings, even sympathize, because they will not longer control how you feel. Letting other people feel what they feel (acceptance) is a big part

of intimacy. Learning to have a good day when those around you are having a bad one lifts the burden off them of ruining your day.

Another thing that helps me is to **visualize a glass globe separating me from another's emotions.** When someone picks on me, sneers at me, says something painful, I see the words hit the glass, but they bounce back because, it's their problem, opinion, attitude. I might want to examine it, but I don't have to take it in as the truth about me, nor even react to it, because I have healthy boundaries. Criticism becomes not at all devastating, just information I may or may not find interesting or useful. How people speak and what they say tells us more about them than about us.

Another technique is **Active Listening** which I discuss in *Recovering From The War*. By listening to others and reflecting back what they say, you practice having a boundary with them and you sharpen your perception of the difference between you and them. It's a self correcting process, too. When you listen and hear it wrong, they tell you! You can see how you hear things as opposed to what they actually said. It's really interesting. Learning to actively listen takes a lot of practice. We're usually composing an answer before the other person it through speaking. Survivors have trouble listening, too, because stuff seems so petty or because they have trouble concentrating, a symptom of PTSD. Active listening helps with concentration by focusing you on what the other person is saying, because you are going to paraphrase it : "I'm so angry! My boss moved my desk to where I can't see out the window." Old pattern: "So what!" (minimizing) or "So quit!" (solution) both of which lead to an argument. Active listening: "He really pissed you off!" As you identify the other person's feeling (confirming the boundary) they feel heard and supported and you get practice in healthy boundaries. It's the same when a trauma survivor expresses pain. Instead of saying, "Get over it," learn to paraphrase. Recently a WWII vet was telling me some of his experiences and my paraphrase was, "you really went through hell," which was exactly what he was trying to tell me.

Trauma survivors need to be able to have and tolerate painful feelings because they are normal when you've been traumatized. They are also evidence of what you've been through. Your family, friends and therapists need to respect that and learn to tolerate them too. As they develop healthier boundaries, your bad days won't ruin their days.

Tolerating painful feelings instead of running from them eventually leads to healing (see the HEALS acronym in the last issue). By tolerating a feeling I mean actually feeling it for a short period. HEALS means flashing the letters "Healing" in your mind, which is a good pause button. Explaining to yourself what you are feeling and feeling it for about 30 seconds, Applying self compassion, Loving yourself, and then Solving the problem. Feel the feeling without necessarily believing the feeling reflects reality. I may feel hurt, but that doesn't mean someone meant to hurt me. I may feel guilty, but that doesn't mean I am. It may just be something I'm used to feeling. Most of us were brought up on large doses of guilt.

Identifying what you feel is another way of working on your boundaries. Keeping a list of feelings written down on paper is a good way to start identifying your feelings. Pull it out and look at it if you are having trouble identifying what you feel. You can also start a journal entry describing your immediate reaction (I'm feeling tense... I just yelled at someone...) and look at when you've felt that way before. The intenisty of many feelings comes from a different time zone, often the time of your trauma or childhood. See what that action has been caused by in the past (usually when I'm yelling it's because I'm afraid I won't get some need met. What need am I afraid about now?). This kind of examination can become a very useful habit.

Many trauma survivors are angry and defensive. These feelings are a natural result of having one's boundaries violated. Anger may have saved your life. People who are defensive have healthy fear behind it. However when the traumatic situation is long gone, anger and defensiveness can linger and hurt relationships, leaving you without community or love. Behind anger and defensiveness, there are painful feelings needing to be felt. Stifle them long enough and they blow a hole in your wall, shrapnel hits those you care for, and you feel so bad you retreat behind the wall determined to make it thicker. It's better to work on making it healthier rather than thicker.

We all hate to be told we're angry. I can't tell you how many times I've said "I AM NOT ANGRY," while smoke was probably coming out of my ears. Ditto defensiveness. "Yes, but—" is my clue there. You may have others like black and white thinking (You're either for me or against me).

It can help to **identify the physical part in your body where you feel:** for instance some angry people grind their teeth or clench their jaw or sigh a lot, so if you have trouble knowing when you are getting angry check you body for physical signs or ask your family and friends how they know when you are mad. You may feel fear as a churning stomach. I feel it as total numbness, so whenever I can't feel anything, I know I'm scared. Then I write about the fear till I can feel it, and it passes.

Developing a healthy boundary can also help you **sort out feelings**. You feel pain because of the trauma you were involved in (combat, battered wife, house fire.) That is your right. You don't have to be over it no matter what someone says. It is okay to be in pain. You can feel the pain at your own rate and it will pass. If you feel shame at having been hurt, you can feel it without believing it. You can visualize yourself handing that shame back to your abuser. You may have to do that many times in your head before it becomes part of your boundary, but you didn't cause your abuse, you didn't want it, and you didn't deserve it, whatever anyone says.

Learning who you are: For people who don't think they have the right to be, much less be themselves, deepening your sense of self is an important part of recovery. Start writing a list with the heading: I LIKE.... Start one with THINGS I MIGHT LIKE... Trying new things to see if you like them is one way to get to know your- self. This can be as simple as changing the radio station you usually listen to,

driving a new route to work, trying a new food. You can also keep a list of THINGS I DON'T LIKE. Trying something and not liking it is good. It means you are not afraid to make mistakes and be human. These lists may change with time. Good. It means you are growing.

Other ways of finding out more about who you are include working the 12 Steps especially the written ones (4 and 10), getting into therapy, keeping a journal, or working some sort of recovery book. My experience has been that I do better when I have support. If you start to work a recovery book and become overwhelmed, GET HELP. We weren't meant to handle either trauma or the effects of living with someone who has PTSD alone.

Another way to start working on boundaries is to figure out **who owns the problem?** If Bob is depressed because of his experiences in Vietnam, he owns the problem. If I cannot tolerate his depression and insist on trying to fix him, I have made it my problem. I'm violating his boundaries and making work for myself. I need to detach and let him have his problem. The work I need to do is on becoming able to tolerate his feelings, not either adopt them (getting as depressed as he is or more) or try to change them. There are 22 readings on **detachment** in the Alanon One Day at a Time, (available from Al-Anon Family Groups,). When I was first learning to detach, I read all 22 every day for weeks. Loving detachment isn't ignoring someone. It is listening without adopting or fixing the problem. Practice detachment and you practice boundaries.

Many people, especially men, are solution oriented (**giving solutions violates boundaries**, by the way, unless the person has said "What should I do?"). People who have a problem want you to listen to it and say "that must be hard for you," not "Do this. Do that." Each time a person with a boundary problem listens to someone else's problem without trying to ignore or fix it, he or she is strengthening his or her sense of self and increasing his or her tolerance for other people's emotions instead of avoiding them.

Saying no: Another step in developing boundaries is learning to say no to others and learning to accept no. For trauma survivors, being able to say no to activities that might trigger them is important. As part of learning what you like, saying no to things you don't like is important even if you've always said yes before. Screaming no is a sign that you don't yet feel you have the right to say it. As time passes and your boundaries strengthen, you'll be able to say it politely because you will know inside that you do have the right to say no. Other people do too. Today I can accept no for an answer because it is no longer proof of my worthlessness but simply that person setting his or her limits.

Saying Yes: Once you can say no, you can also begin to say yes for healthy reasons. You may say yes to things you'd like to do but have been afraid to try. You may say yes to people who ask you to do things because you would like to do them and can do

them for free and for fun (not because you should or for a payback). You may even say yes to some things you don't necessarily want to do but you are willing to do because they fit into your value system and help you be the kind of person you want to be (not they want you to be—not people pleasing).

Asking for what you want: once you have more of an idea of who you are, what you feel, what you like, you can ask for what you want. This stops a lot of people because they feel that if they don't get what they want it was all for nothing. That's where the phrase "do the footwork and turn the results over" helps me. Asking early and asking often, so that saying no is okay, also helped me. I used to only ask when I was desperate so it wasn't a request. It was a demand.

Today I do not have to have other people do what I want. I ask for what I want, but I don't have to get it, because someone else's behavior is not a reflection of my worth. The fact that they don't do what I want probably has nothing to do with me. It has to do with their issues because they are separate from me and I am not central to their lives like I am to mine. (I trust that they are human and are going to put their interests before mine.)

When I haven't gotten people to do what I wanted, things have often turned out better than anything I could have imagined.

Perfectionism: Once I learned I stop at my skin, I learned to accept myself and to believe that I was okay even if I wasn't perfect. I'm just me. You are you. When I could accept me, I could accept you and begin to stop trying to violate your boundaries to make you perfect. Perfectionism and healthy boundaries aren't compatible.

Perfectionism is another big issue for trauma survivors who may feel if they had just been good enough or done it right, the trauma wouldn't have happened. So they try to be perfect or to raise perfect kids. Another variation is the trauma survivor who says it didn't affect him or her but is heavily invested in proving it by being perfect and having a perfect family. When I'm violating you to make you perfect I do not have healthy boundaries. If I'm letting you violate me to make me perfect, I don't have them either. With boundaries I can set limits, say no, have and express my own opinions, keep out of other people's business especially business between two other members of my family (no triangulating), learn who I am, and let other people be and grow.

Physical Boundaries: No one has the right to touch you or your stuff without permission. "Please don't touch me," is a perfectly polite statement and no explanation is required. "Why not?" on the other hand is rude, intrusive and a boundary violation.

Physical boundaries also include having your own space. After being very close one way to return to normal boundaries without quarreling is to simply go do something in a different part of the house from your partner.

You don't have the right to touch others or their things without permission unless you are a parent pulling your kid out of harms way. Please don't take it personally if someone doesn't want a hug. You don't know what they've been through. Please don't make your kids hug you or anyone else. You set them up for abuse that way. Please don't hit them either. It makes them hyperactive and confuses love and violence in their minds. Try to see what the child needs that s/he isn't getting and meet that need directly. It is usually attention. If you fail and spank, don't give up. You can always say you made a mistake because you are human and you are sorry and start over again the next minute. This sets a good example that no one is perfect.

Spiritual Boundaries: One of the worst forms of abuse is spiritual abuse. True spirituality is something you find for yourself not something that is thrust down your throat along with a bunch of rules. No one has the right to tell you what to believe. Different people need different answers. I think that's why there are so many different spiritual and religious paths. Not because one is right and the others wrong, but because they all have something that someone needs. I have no argument with someone who says "This is the answer that works for me." Someone who says "X is the answer for everyone," doesn't have good boundaries. They usually want your money too.

For years, I practiced my boundaries by **writing out the Serenity Prayer every morning:** Grant me the serenity to accept the things I cannot change (I wrote in people places and things that were bothering me), the courage to change the things I can("my own actions, reactions, perceptions, what I'll put up with"), and the wisdom to know the difference.

The wisdom (and the willingness) to know the difference comes with practice. The courage to change the things I can showed me what was inside my boundary; accepting the things I can't showed me what was outside my boundary. **Seeking a higher power also helps** with boundaries. If I'm playing God of course I have no boundaries, but if I'm not God then I am finite and do have boundaries. **Accepting help from others** and learning to **take what I like and leave the rest** strengthened my boundaries, too. When I thought we all had to think and be alike, I didn't have boundaries. Today I do.

Living with healthy boundaries is far easier than living without them. I am no longer the prey of emotions that fluctuate with every outside influence. Sometimes I get more reactive, but I know I don't have to continue to react. I call it recycling, and I choose to use the tools I've learned to change my reactions by taking action. I don't give up when my old patterns come back. I look inside to see what's going on with me. If you find yourself saying "I should be over this," let go of that perfectionism and black and white thinking, get out your feelings list and your journal, figure out whose problem it is, practice your boundaries. It's another opportunity to grow. PM

About Medications For Combat PTSD

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NOTE: Do not take yourself off any prescribed medication without consulting your physician. Show him this article if you are concerned. Dr. Shay is the author of two wonderful books for veterans, *Achilles in Vietnam* and *Odysseus in America*

This was prepared as educational material for combat veterans, but may be useful to others, such as veterans' spouses, non-physician mental health professionals. It is in the public domain and may be duplicated and distributed freely.

A. Point of View: Everything I say here is my point of view, and carries no claim of special authority. Also, what I say here is no way complete. I have left out many important subjects, such as drug interactions, what medical conditions forbid the use of a given drug, overdoses and toxicity, and most specific side-effects. Also, many psychiatrists who also care about combat veterans will disagree with what I say here, particularly about the benzodiazepines like Ativan.

Combat PTSD is moral, social, philosophical, and spiritual injury. The biological nature of human beings is to be moral, social, philosophical, and spiritual, so the injury also shows itself as medical disorders.

Healing is psychological, social, spiritual -- no medicine can cure combat PTSD. However, healing can never mean a return to 17-year old innocence. Healing means building a good human life with others -- a life that a veteran can embrace as his own. Combat trauma brings about long-lasting changes in brain chemistry. We do not know whether these are permanent or can be reversed by psychological/social healing. A few existing medications can help some men with some symptoms of PTSD. We also do not know whether this changes the long-term outcome for the better, but the human payoff in reduced suffering is unmistakable.

B. A brief course in pharmacology

1. Therapeutic effects (benefits) and Side-effects: Drugs are dumb chemicals -- they don't know what they are. They aren't born in a laboratory with a word spelled out across their foreheads "Anti-depressant!" or something like that. Most have been discovered by accident. Almost every drug known has multiple effects on the body. Which effect is a therapeutic (beneficial or main) effect and which is an unwanted side-effect is a human decision, not a chemical decision.

Illustrations: Think of the well-known drug Elavil (generic name: amitriptylene). What is it? An anti-depressant you say? Why is it used in the Intensive Care Unit to stabilize the heart beat of certain patients? Not because depression causes their irregular heart beat. Why is it used by neurologists to treat migraine? Not because

depression causes migraine -- and the doses that work for migraine are usually too small to touch a depression. The point is, of course that a drug doesn't know what it is. Its successful human uses make it an anti-depressant, a migraine drug, an anti-arrhythmic.

What about side-effects? Again, this is a matter of the human purposes involved. Think of the anti-depressant trazodone (most common trade name: Desyrel). Its most prominent side-effect is drowsiness. I prescribe trazodone fairly often as a sleep medication to veterans who are on fluoxetine. It has the advantage that it doesn't lose its effect with repeated use (which also means there's little withdrawal syndrome when the veteran stops it), and it's almost useless as a pill to kill yourself with. So here the side-effect is the main effect and the anti-depressant effect is a side-effect. -- Is anybody confused yet? Important to remember: When a drug has several different effects, each effect has its own way of unfolding in time. How long a drug takes to produce its different effects, is often different for each effect. The side- effects may hit immediately and the main effect only develop after several weeks! With another drug it's the opposite, with the main effect coming on immediately and the side effects happening later. An analogy: Think of a plant on your window sill. You've been away for the weekend and its gotten dry and droopy. You give it water and the leaves begin to respond almost as soon as the water goes on -- the plant responds as soon as the water reach- es the roots. If the roots dry out, again the plant wilts again. This is like a pharmaco-kinetic effect. If you put some fertilizer in the water, on the other hand, this reaches the roots as fast as the water reaches them, but you may not see any result for days or weeks. This is because the plant has to build new parts in its own cells. This is like a pharmaco-dynamic effect.

Example: Most anti-depressants reach the brain quickly, but take several weeks to have an anti-depressant effect. This is probably because the changes that have to take place in the cells take that long to happen. However, some side-effects like a dry mouth or drowsiness happen quickly because they do not require cells to make anything new, but only to do what they're already doing faster or slower.

2. Tolerance and Withdrawal

I will use alcohol as the example, because most people have considerable knowledge about it. They just haven't realized that they can transfer this knowledge to other drugs. Pharmacologic tolerance is a critically important subject. Consider a very heavy drinker, who drinks every day and more or less all day. Most of the time he is not drunk, in the sense of staggering or slurring or not thinking clearly. He may function quite well at his job with a blood alcohol level that would put a non-drinker almost in a coma. This is because the drinker has developed a tolerance to alcohol. His brain has adjusted to alcohol's presence and slowly adjusted its machinery to get everything back to normal. This adjustment is called pharmacologic tolerance, and it takes a while to happen. The brain has developed a steady, compensating excitation to

balance the steady sedating effect of chronic alcohol. When the two are exactly in balance, the drinker thinks and behaves more-or- less normally. If the alcohol is suddenly removed, the brain becomes dangerously over-excited resulting in delirium tremens, DTs. The compensating excitation corrects itself much more slowly than the alcohol leaves the body. This whole set of events is called a withdrawal syndrome. The same kind of DT-like withdrawal syndrome of dangerous over-excitement (seizures, hallucinations, etc.) happens after sudden withdrawal from high doses of other sedating drugs that people get tolerant to, such as barbiturates, benzodiazepines (such as Valium), etc. A good rule of thumb is that a patient who has become tolerant to a given drug effect will get a withdrawal syndrome when he or she stops it suddenly. It's often possible to make sense out of the specifics of a withdrawal syndrome as the "mirror image" of the original drug effect that the person got tolerant to.

Not all of the effects of a drug are subjectively detectable in any way to the person taking it and so tolerance to these undetectable changes may also not be subjectively felt. However, during cold-turkey withdrawal from the drug a withdrawal syndrome may develop that is the mirror image of effects that the person was never aware of. An example of this is caffeine withdrawal headaches. Most people are unaware of any blood-vessel narrowing effect of caffeine, but once tolerant to this effect, abrupt discontinuation of caffeine will cause headaches due to blood-vessel dilation.

The largest tolerance and the most severe withdrawal reactions happen with long-term use. However, with some drugs, there can be a miniature version of the whole picture with a single dose. Again, alcohol gives a good example: A man who knocks many drinks back one after another and then stops is much more drunk when his blood alcohol level passes a given point on the way up, than later when his blood alcohol level passes the same point on the way down. This is called acute tolerance, because his body has already adjusted to the presence of the alcohol in the few hours since he started drinking. The next morning during the hangover he has a mini-withdrawal syndrome making his nervous system overly sensitive -- for example how loud every sound seems -- is the mirror image of how much alcohol deadened sound when he was drunk.

An analogy: You are running a motor boat on a certain compass heading, say due north, on a windless day (no alcohol). Now a cross-wind begins to pick up (gradually increasing steady drinking) and you gradually adjust the rudder to keep on the same heading. Now you are still heading due north, despite the heavy cross-wind. Suppose the wind suddenly dies (suddenly stop drinking, cold turkey) and you keep the rudder where it was -- you start going in circles (withdrawal syndrome).

How much tolerance develops to each drug effect varies a lot from effect to effect and from person to person. A person may develop rapid tolerance to a nasty side-effect, such as dizziness. This means the dizziness actually goes away, not that the patient just gets used to it.

So this person can bear with the drug and wait around for the main effect to kick in. Another person may never get tolerant to the dizziness side-effect and cannot make use of that particular drug. There's no iron-clad way to predict a given person's sensitivity to each of the effects of a given drug or how fast, if at all, he will become tolerant to each effect.

C. Things that help

1. What are some characteristics of a good drug for combat PTSD?

a. Makes something better for the veteran b. No tolerance develops for therapeutic effect c. No attraction to abuse

d. Cannot be used as a suicide vehicle

e. Can be used safely without blood tests

f. Does not cut a person off from the world or from himself

g. Few, bearable side-effects

2. Some good drugs for combat PTSD now.

a. Serotonin reuptake inhibitors such as fluoxetine, sertraline, paroxetine (trade names: Prozac, Zoloft, Paxil)

The main effect of fluoxetine on combat vets with PTSD whom I've worked with is to allow them more time to think before they act, particularly in anger. It does this without sedation or cutting a man off from himself or the world. The duration of anger, once aroused, is also shorter. Greater self-mastery of anger leads to an increase in self-respect and relief from a sense of humiliation. Most men feel humiliated after they go off on people in situations they really would not have, if they had had the freedom to choose. In addition to this, fluoxetine may have a direct anti-depressant effect in combat PTSD. Fluoxetine effects on self-control and rage may take many weeks to kick in, although I've seen it as soon as a week. Fluoxetine is practically useless as a drug to overdose on, if the goal is suicide. All anti-depressants have been known to give long-time depressed people the energy to kill themselves, and fluoxetine is no different. Many combat veterans go through brief periods of intense despair during the first few months that they are feeling generally better, more alive, and are coming out of their bunkers. Support from other veterans, family, therapists is especially important during those times -- nobody should try to go through it alone, or have to. Someone trying to go through it alone, might try to kill himself during one of these times of despair. Remember that this is no special risk with fluoxetine, but is a risk when anyone recovers from severe depression. Several vets I've treated have had bouts of despair like this, but none has ever tried to kill himself during one, because support and therapy are built into the program I'm a part of. The much publicized claim that Prozac has special powers make a previously non-suicidal person violently suicidal is without good foundation. Fluoxetine does have side effects, which not everyone can stand, and it doesn't work for everyone. A full discussion of side-effects,

some of which depend on the dose and others not, would be too long for this summary.

Fluoxetine is the first drug of its type to be released for use. Other drugs in the same family have now come along, sertraline (Zoloft) and paroxetine (Paxil). They have been tried by many combat vets around the country, and from what I hear they are not a lot different than fluoxetine as far as main and side-effects. In the relatively limited number of men I have treated with paroxetine and sertraline, this has been what I have heard from them. Paroxetine has a 24 hour half-life and no active metabolites [what the body turns the parent drug into], so if the actions of the drug are otherwise identical to fluoxetine, it will be a superior drug from a safety point of view, because it doesn't hang around in the body so long. But on the down side, paroxetine may be expected to (and is reported to) have a withdrawal syndrome because it leaves the body so fast.

b. Buspirone (trade name: Buspar)

This anti-anxiety drug works differently from the benzodiazepines (like Valium). Like anti-depressants it takes a few weeks to kick in. It takes effect gradually, like the tide coming in. It usually has few side-effects and may help some people with intrusive thoughts and nightmares. Buspirone has no street value and is almost useless as a suicide pill. I am not aware of drugs in this family coming along, but I hope there will be. I have recently read the report of a colleague who works with combat veterans that the best results with buspirone come at doses above 60mg/day. I do not yet have enough personal experience with patients who have tried this, to confirm or deny this report.

c. Beta-adrenergic blockers (e.g., pr pranolol, nadolol, atenolol; trade names: Inderal, Corgard, Tenormin)

This family of drugs breaks the mind-body-mind vicious cycle in rage reactions, by blocking the body effects of adrenalin. For example, if someone at work says something offensive about Vietnam vets, the words start the mind working into rage. The rage starts in the mind -- but within a second the body responds with adrenalin, which makes the gut burn, the heart pound, the muscles tense. These body changes send loud messages back up to the mind. For some veterans, the roar of the body drowns out all thought and shuts out everything else coming in. When adrenalin is roaring, it's impossible for most people to think clearly and to take in non-combat possibilities in the situation. This is the mind-body-mind vicious cycle that beta-blockers break up. By blocking the adrenalin effect on the body they prevent the roar of the body from drowning out all thought and choice about what you really want. "Is it really in my interests to rip this guy's lungs out? Is it really what I want to do?" When adrenalin is roaring these questions sometimes cannot be heard.

Some vets feel that these medications weaken them, because they associate being pumped up with adrenalin with their personal strength. When someone is over-

medicated on these drugs (which started life as blood pressure meds) he is weaker because his blood pressure is too unstable, but this is usually not a problem with a correct dose. Tolerance does not develop to the anti-adrenalin effects of these drugs. Massive overdoses of a beta-blocker can be fatal, by dropping the blood pressure and slowing the heart to the point that the brain is not getting enough blood flow.

d. Low-dose lithium

Some respected practitioners of PTSD pharmacotherapy speak highly of lithium to help veterans maintain their self-control when they are angry. This means doses of about 600mg/day, far less than is usu- ally need to treat bipolar affective disorder (manic-depressive disorder), and does not imply that the doctor recommending this thinks that the veteran is manic-depressive. I agree that this can help some veterans, but I have found fluoxetine to be more reliable. It is also safer, in that lithium is readily fatal in a large overdose. For a vet- eran who cannot tolerate fluoxetine and whose life has been blighted by explosive violence, low-dose lithium may be a good thing to try.

3. Secondary drugs: Small but useful

1. Trazodone for sleep: Trazodone is a non-toxic anti-depressant that has a useful side-effect: It causes drowsiness, and people don't get tolerant to this effect. Because fluoxetine slows the rate that the liver breaks down trazodone, much lower doses are needed for sleep by patients on fluoxetine than people who are not on fluoxetine.

2. Quinine for nocturnal myoclonus

This is the "sleep jerks." If quinine works, the veteran himself may not notice much but his wife has much better sleep.

3. Brief, low dose, self-administered anti- psychotic drugs when the veteran is struggling against urges toward violence, and hospitalization is not possible.

The key here is brief treatment on an as-needed basis, controlled by the veteran himself. The doses needed have been low, and I prefer the sedating anti-psychotics like thioridizine and mesoridizine, which appear to carry the least risk of dangerous (neuroleptic malignant syndrome) or possibly irreversible (tardive dyskinesia) complications. An unexpected additional use for these drugs also involves brief, low-dose treatment: to help someone who wants to get off marijuana get through the withdrawal syndrome.

4. What about future medications?

Many combat veterans with PTSD feel dead inside. It is possible that this psychic numbing comes from the brain making its own opium-like substances, and that opiate blockers can give people back their feelings. It is not yet clear whether this works.

I hope the future will bring a drug like clonidine (trade name: Catapres) that people do not develop a tolerance to. In my experience, about one out of five combat veterans with PTSD experience major improvement of almost all of their PTSD

symptoms on clonidine -- but the heart- break has been that they grew tolerant to it in about a week. Any future drug in this family that does not induce tolerance to this effect will relieve much suffering. A new drug in this family, guanfacine (trade-name, Tenex) has recently appeared, but I have no experience with it and have not heard any reports of usefulness to combat veterans with PTSD. The most helpful drugs are likely to be ones that don't yet exist.

D. Things to avoid

One of the useful things I do for veterans I see is help them identify and get off of drugs that they use (whether prescribed by doctors or not) that are harming them. Some of what I say here is likely to be controversial.

1. Why benzodiazepines (like Valium, Xanax, Ativan, etc.) are problems in combat PTSD

Disinhibition: All the drugs in this class are similar to alcohol. Some people who "lose all their inhibitions" on either alcohol or benzos or both. This "dis-inhibition" can affect practically anything that a person thinks he might like to do -- but doesn't do -- when sober. It has included suicide and murder, but most often involves saying things that cumulatively do great damage to a veteran's life. A lot of family stress among veterans comes from things said to wives and children the veteran wishes he hadn't said, the moment it was out of his mouth. One of the inhibitions that benzos weakens is the inhibition about saying hurtful things to people we love. Memory loss: All of the benzos weaken the ability to remember what happened a short time ago, including things you yourself did or said. The more potent the benzo, the more it wipes out short-term memory -- this is probably why Halcion (generic name: triazolam) has been such a bad actor, it's one of the most potent. Here's a little scene that everyone has experienced one way or another:

"I'm going out for cigarettes -- want anything?""Quart of orange juice and a box of Pampers.""OK" Half hour later you're back -- with your cigarettes! No one is 100% on things like this, but people on benzos are sometimes close to zero.

Short-term memory is something that everyone needs to make relationships work, at home, at work, or anywhere. There's the additional stress that combat vets have when they find themselves for- getting -- they have been in real situations where people died because someone for- got. The tension and guilt that this creates in everyday life can be unbearable, and veterans often do not know that their benzodiazepines are responsible for memory lapses.

Confusion of pleasant side-effects with main effect: The pleasant, couple-of-drinks, or drowsy feeling that you get when you first take a benzo (especially the ones that are rapidly absorbed into the blood) is a side-effect that most (not all) people get tolerant to. Because it comes on at the same time as the anti-anxiety effect, it is natural for patients to think that this pleasant feeling is the anti-anxiety effect. One of the strengths of the benzos is that people do not get tolerant to the therapeutic anti-

anxiety effect. A very common problem is that people feel the drug is quitting on them when they become tolerant to the pleasant side-effect, and become very afraid that their anxiety symptoms will return. Often out of fear of fear, they double up on their meds and pressure their doctors to increase their dose. This natural confusion of a gradually weakening, pleasant side-effect with the main effect is responsible for some addictive properties of the benzos. Mini-withdrawal syndrome between doses: Benzos differ from each other mainly in their pharmacokinetics, that is, how fast they go into the body and how fast they leave. Mini-withdrawal reactions are particularly likely to happen with the benzos that leave the body quickly, such as Halcyon (generic name: triazolam). This is why people who take this drug for sleep often wake up in the middle of the night because they are in the withdrawal phase. Though Xanax does not leave the body quite as fast as Halcyon, it is particularly prone to giving mini-withdrawals between doses. My observation has been that many combat vets on Xanax have periods of anxiety and irritability during each day that do them great harm, and which, in my view are mostly mini-withdrawal reactions between doses.

Possible dangerous peculiarities of Xanax in PTSD during withdrawal: The staff of the in-patient PTSD unit at the American Lake VA in Washington State have published a paper reporting extreme violence by combat vets treated for long periods with Xanax and then taken off of it. This was apparently more frequent and more severe than what they found taking their patients off of other benzos, such as Valium. Several Vietnam combat veteran peer counselors whom I respect very highly, feel that Xanax has done a lot of harm. Xanax has some unique properties among its cousins in the benzodiazepine family. In lab tests Xanax acts the opposite at low blood levels of how it acts in the larger amounts actually used in medical practice. When you think about it, every- body passes through a low blood level twice when they take a pill -- once when the pill is just being absorbed in the body and once when the body is almost done getting rid of it (unless, of course, the person takes the same pill again, before the first one is completely gone). Whether this is what causes the problems with Xanax is not clear right now.

2. Why you owe it to yourself to find out the effects of caffeine on your life

The pharmacology of caffeine is horribly complicated: it's not just one drug, it's really three, each of which can have a differ- ent effect on different people. The way it's three drugs is that it's the original caffeine, then the body converts it into theobromin, which the body then converts into theophyllin. The peak effects of these three successive drugs are roughly two hours for caffeine, four hours for theobromin and six hours for theophyllin. The good effects that any of these three drugs can have is feeling more awake, energetic, and optimistic. The bad psychological effects that any of these three drugs can have are anxiety and depression. A given person does not necessarily react to all three the same way. (I'm not talking here about the well-known effects of caffeine on sleep—this is another important topic in itself. What many

people are unaware of is that at very high doses— like 15+ cups of coffee a day — caffeine can reverse on you and it can be impossible to stay awake, unless the caffeine is stopped.)

Someone who reacts badly to caffeine itself has usually found that out long ago, because the anxiety and/or depression hits them soon after the big mug of coffee. These people know it's not for them. But there are literally millions of people who feel good after caffeine itself but have bad reactions to either theobromin or theophyllin (four or six hours after that big mug of coffee) and just think it's their life that's out of whack, not their brain chemistry. There is no way to tell whether caffeine and its metabolites are responsible for your anxiety and/or depression unless you take yourself off it completely for several weeks. This means coffee, tea, Coke, Pepsi, Mountain Dew, Jolt, headache pills with caffeine. Some people are so sensitive to it that even the small amount of caffeine in decaffeinated coffee and in chocolate causes psychiatric symptoms. If you decide to take yourself off caffeine to see what your life is like, don't go cold turkey. Taper yourself off over a week or so, or you are likely to get severe withdrawal headaches.

3. Yohimbine: Yohimbine (brand names: Actibine, Aphrodyne, Yocon, Yohimex) is absolutely contraindicated in combat PTSD. It causes flashbacks and panic attacks. This drug is sometimes used to treat impotence.

4. Why ANY illegal drug is a problem for combat vets with PTSD

The problems and appeals of specific illegal drugs in combat PTSD is a very big subject that can't be covered here, but all illegal drugs cause the following problems for combat vets with PTSD. Expense is the first problem -- I know there are Vietnam vets who have been very successful financially, but the men I know who have severe, chronic PTSD have a heroic struggle to make ends meet. I know it's stating the obvious, but the first problems of illegal drugs is the expense.

The second problem is much more subtle -- Getting illegal drugs involves you in relationships with and obligations to people you normally wouldn't let within a mile. Most of the combat vets I know have a very sharp eye for quality in human beings, and feel constantly tainted by the people they get involved with to support their habits.

The third problem is that situations of real danger and the presence of weapons gets in the way of healing from PTSD. In this country and time it's not possible to sustain a drug habit over a period of years without running into situations that rekindle PTSD because of their real combat elements.

The fourth problem is the wors—using illegal drugs often puts veterans in situations where they bring down other vets. Calling for rescue is a very common way of bringing down other vets, even if the rescue is "successful." Users need to be rescued from the medical complications of their habits, from the pressure of debts to dealers, and so on. Vets who have been on rescue missions are put back into combat-

mode and are wired for weeks after a rescue. Sometimes users bring down other vets by asking them for dangerous favors (e.g., "hold this for me till I come for it" where "this" is a parcel of drugs or drug- related weapons or money). And finally—this is really obvious but it needs to be said--if a fellow vet is trying to stay clean and you're using, this amounts to a standing invitation to break out.

I downloaded
"About Medications for Combat PTSD" off the internet: www.dr-bob.org/tips/ptsd.html. It was posted 10/1/95. I found it very helpful.
Dr. Shay's comments on Valium gave me an explanation for words that had bothered me for years.
Bob was also prescribed Xanax at one time. It made him mad. Now I know why. —P.M. Ed.