WORKSHOPS BELGIUM

WORKSHOP 1

FIGHT AND FLIGHT

Thank you for inviting me to come to give this series of seminars. It is a great privilege to be together with you in this major endeavour.

Personal background.

Though today I have come from the other end of the earth, I was born in central Europe and underwent with it its greatest trauma. At that time I did not think that I would ever talk in the Hall of the Generals of Belgium in Brussels, the hub of a united Europe.

Clinical background.

My clinical background is in psychiatry. Since the Holocaust I was interested in trauma in some way; whether in the 6 Day war, the emergency department where I spent 25 years, or in our local bushfires.

As a consequence of my experiences I have had a need to understand whole pictures, I have been able to accept being out of the mainstream, and I could be suspicious of ideologies that swayed masses of people around me.

In a nutshell.

In our seminars we will come to understand the great variety of responses to trauma through 8 survival strategies. They are like 8 notes of an octave and their combinations and permutations, harmonics and overtones give us a dictionary through which we can understand the symphony of traumatic stress and also its opposite, fulfilment.

Two stories

To start us off, I will provide you with two stories. In keeping with where we are in this Hall of Generals, the first story is of a soldier in combat. The other is of a child falling down the stairs. I have chosen two such stories because combat and child abuse have been major motivators of recognition of trauma, and theories in traumatology.

A soldier in combat

Successful soldier

A fortified camp in the jungle is attacked with grenades and machine gun fire. The soldier on duty fires back into the dark, and fends off the attackers.

He is pleased that he **defended** and **saved** his comrades and deterred the attackers.

He feels glad to have **pleased** his commander who praises him in public. He is promoted.

He feels he is a good, **efficient** soldier

He is sorry that in the firing he **killed** an insurgent, but in war it is kill or be killed. In the **struggle** for survival, he defeated the enemy

His actions enhance unit morale, and the **bond** within his unit intensifies. They feel like a family.

Now imagine that things go wrong

The insurgents pierce the defences of the camp and kill three members of his unit. His closest comrade and best friend is wounded. His bowels hang out of his torn uniform. His friend dies alone, calling out for help.

The soldier feels **alone and abandoned** in the dark.

He drags his friend to the hospital, but he is **beyond help**.

He wants to go out into the jungle and **kill** the enemies, but

He sinks into a **panic** and sees enemies everywhere.

He wants to **cry** for his friend but all that comes to mind are visions of his injuries and not having rescued him.

He can't face guard duty, and any noise disturbs him.

He feels a **failure** as a soldier, as a defender of people he loves.

He looks at his unit which is now **fragmented** and he is demoralized. He wants to go home. He is sent home.

He feels that the army conned and exploited him and his comrade.

Decades later

At home he is isolated, reticent, irritable, and avoids anything to do with the army, or anything violent on TV. For twenty years, he is plagued with images of the ambush, which he tries to shut out of his mind. He drinks a lot.

He has periods of depression and suicidal impulses. His wife threatens to leave. “He is not the man I married. He has become violent.”

Treatment

His treating psychiatrist diagnoses PTSD, hospitalises him for a month, and follows him up for twelve sessions. He is treated by a team, whose members give him SSRIs, anger management, alcoholics anonymous, help with how to live in society, and cognitive behaviour therapy, aimed at desensitization to loud noise, and anxiety stemming from the war.

Conceptualization

The soldier suffers PTSD with intrusive and avoidance symptoms. PTSD is a specific illness of traumatic diagnosis, and was invented mainly as a result of Vietnam veterans demanding a diagnosis for their sufferings..

Depression, antisocial personality, phobias, adjustment disorders are seen as comorbid diagnoses, each treated separately. This may be called a scientific rational approach based on the medical premise that symptoms and illnesses can be diagnosed and then treated accordingly with specific treatments. Alcoholism is treated with AA, social misanthropy with social skills training, anger with anger management, PTSD with SSRIs and CBT.

Arousal symptoms are implied to represent past arousals that are relived. They are usually explained as fight and flight responses, which can be traced

back, as in this soldier, to wanting to kill enemies (fight), and fear of being killed (flight).

Limitations of PTSD

1. PTSD does not take note of *emotions* other than fear/anxiety, many other *trauma related symptoms* such as dysregulation of affect and self, victimization and revictimization (van der Kolk, 1996a) [see Further references document] and *other "comorbid" illnesses or disorders* such as somatization, alexithymia, eating disorders, substance abuse, self mutilation, etc. (see also 3 below)

2. PTSD does not list features of *Complex Post-Traumatic Stress Disorder* (also known as Diagnosis of Extreme Stress Not Otherwise Specified [DESNOS]). In the syndrome symptoms are grouped under somatization; dissociation and alterations in consciousness; affective changes; alterations in perception of the perpetrator; alterations in relationships; changes in identity; and alterations in sense of meaning and existence.

3. Significance of *traumatically determined comorbid diagnoses* may not be appreciated. The majority of trauma victims develop a range of illnesses in addition to PTSD. They include depressive, panic, and generalized anxiety disorders (McFarlane & de Girolamo, 1996); adjustment, dissociative, somatization, borderline, schizophreniform and antisocial disorders (Herman, 1992; Threlkeld & Thyer, 1992; Blank, 1993; Rothbaum & Foa, 1993; van der Kolk, 1996a). Thus premature closure of PTSD as the only post-traumatic diagnosis ignores the possibility that acute polymorphous pictures can develop into a diagnostically polymorphous array of illnesses.

Some of the criticisms may be due to the level of abstraction of the core PTSD criteria of reliving and avoidance. The problem is that they do not tell *what* is relived and avoided, *how* and *why* and how it affects the person. The second problem is its very scientific paradigm. Its reductionist view constricted it to a single syndrome. Its dualism ignored the biopsychosocial whole. Ignoring what could not be measured left out emotions and higher function levels. Though recognizing veterans' sufferings, PTSD lost touch with their rage, guilt (deleted in DSM IIIR), grief, demoralization, alienation, and lost existential meanings. Trauma, which promised to be the soul of psychiatry (van der Kolk & McFarlane, 1996) was sanitized by PTSD. "..PTSD..does not begin to describe the complexity of how people react to overwhelming experiences" (p 15).]]

I will now describe the second story.

Story of child falling.

Reasonable outcome

Child falls down the stairs, and is **crying helplessly**. It wants mother to pick it up and make things better.

Mother responds by **picking up** the child, cuddles and talks to the child.

She takes the child to the stairs and the child **hits** the naughty stairs.

The child won't let the stairs **defeat** it. It climbs the stairs to show who is boss.

Alternately, the child **avoids** the stairs.

Mother **explains** what happened and what to do in the future. The child becomes *competent* going up and down stairs.

The child **adapts** to the realization that it cannot do everything, and must learn.

Mother and child both feel **trust** and **love**.

Now imagine that things go wrong

Child cries because mother threw the child down the stairs.

Mother feels **burdened** by the child, and wants to be left alone to look after herself.

She screams at the child to shut up, and that it is **clumsy** and its fault for falling down the stairs.

The child becomes **enraged** with the pain and with the mother.

The child **avoids** both the stairs and the mother.

The child feels rejected, **cast out, helpless** and alone.

The child feels **defeated** by the stairs and mother.

The child becomes **dejected**. Mother tells it to stop crying.

The child feels mother does **not love** her and feels unlovable.

Decades later

the child, now an adult, comes to a therapist.

Complains of general anxiety with specific phobias of heights, and fears of injury. Has sexual and relationship problems. The person feel inadequate,

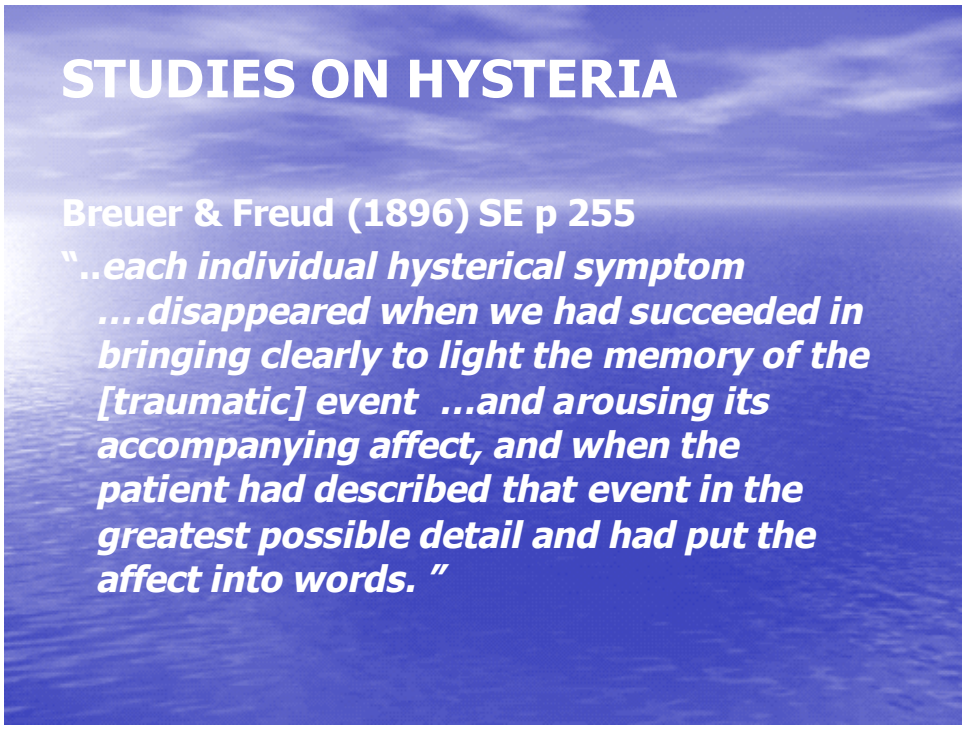
and insecure, the spouse is constantly berating, and is threatening to leave, which brings on panic attacks. Anger with the spouse is impossible because of fear of extreme retaliation. Has waves of crying an depression. Feels defeated, and at times suicidal.

Treatment

The therapist diagnoses multiple problems as a result of childhood traumas. The therapist is a caring, well meaning support who listens without judgement. Explains the nature and source of the many symptoms, and provides alternative views in the present world. For instance, she goes with the patient to the stairs and walks down beside the client encouragingly. The client starts to challenge the therapist who is tolerant of the client's assertiveness and anger. A trusting bond develops. The person gains self-confidence and challenges a superior at work, who come to respect the client more. The spouse stops being a mother image, and is seen to have problems for which the patient offers help.

Conceptualization

Many aspects of the trauma are relived as many ripples reaching a wide variety of symptoms. This reverberates with early psychoanalysis. For instance, in Breuer & Freud's Studies on Hysteria, (1896) SE p 255



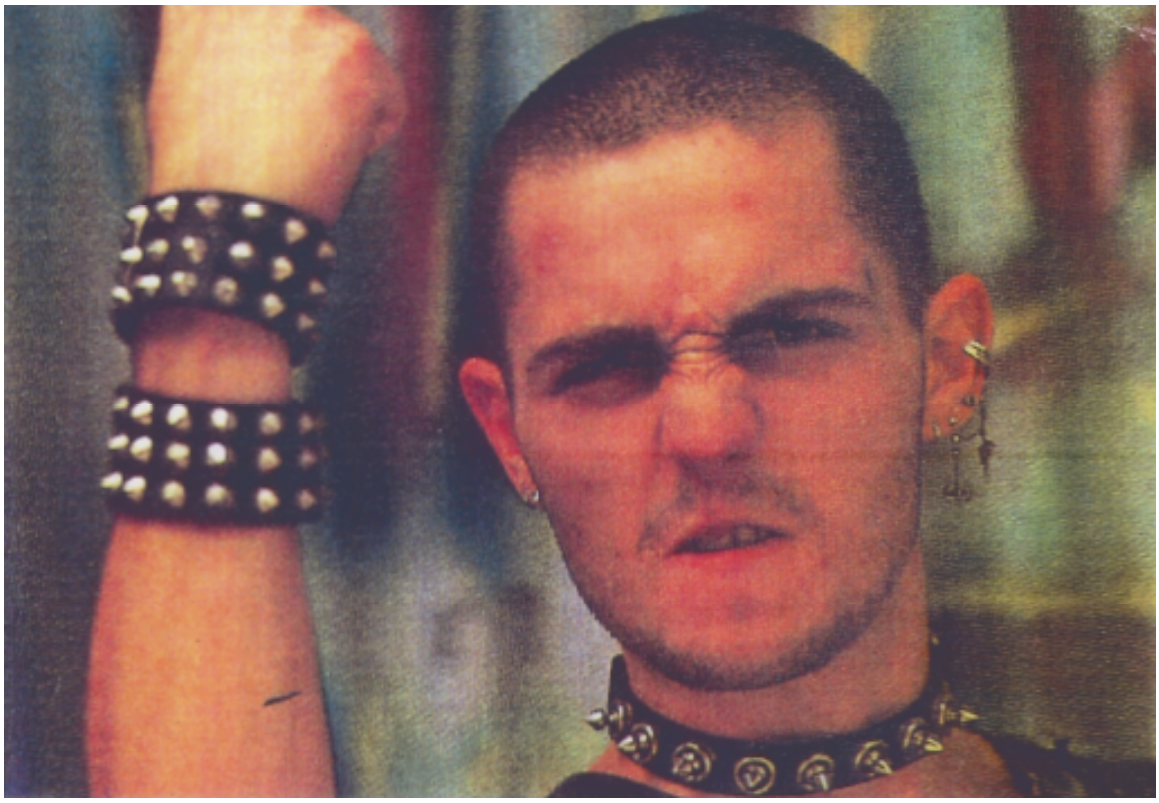
Summary

I have now summarised the dilemma of our three day workshop. The rest is filling in the detail.

The two different cases typify the thrusts in traumatology from combat and child abuse. The former was well suited to phenomenological/diagnostic conceptualization, the latter to psychodynamic conceptualization.

To start with the details of survival strategies- both the soldier and the child suffered fight and flight arousal symptoms. These are two well known survival strategies. I want to show that they suffered (or fulfilled) 6 other survival strategies too. But first I want to deal with fight and flight.

Fight



***Please also refer to Table 1

Darwin described this survival response under the rubric of anger. He described its threatening and aggressive accompaniments.

Humans fight when individually or communally threatened, or if their territory is threatened. They manifest then xenophobic and territorial tendencies (Ardrey, 1967).

In addition to external aggression, humans are peculiar in having evolved disgust and revulsion. These feelings accompany riddance of internal poisons through excreta such as vomit and faeces. Disgust, revulsion and excretory attributes may be parts of xenophobia. Foreigners may be labelled dirty and stinking.

Aim of Fight is to be rid of danger.

Flight

Darwin described Flight under fear. While Fight is red and hot, *fear* is yellow and cold.

Arousal, fear, terror, freezing, fright, startle and anxiety are central features of PTSD.

What I want to highlight is that concentration on PTSD may restrict attention to fight and flight arousal responses. It may tend to obscure the soldier's other initial responses and their permeation into symptoms. These other responses may be anguish for not having rescued his comrade and lasting guilt; the feeling of isolation and abandonment in a dark cruel world;

depression as a result of not being able to grieve his friend's death and all his ideals; sense of failure as a soldier; sense of defeat by the enemy and by his own fears; feeling exploited by his superiors, army and country; loss of trust and desire to make significant relationships that will be broken.

In the child we may only notice hitting or avoiding the stairs. We may ignore the cries for help, inadequacy, sadness, defeat and lovelessness.

Concentration of Fight and Flight obscures the consequences of 6 other survival strategies.

Advantages of survival strategies

Our 8 survival strategies, we will see, will provide a framework for the very wide and disparate symptoms arising from attempts to survive threats to life. These are ubiquitous survival responses, used in everyday life like the falling child, or in severe traumatic situations like combat.

Summary

The clinical cases of the child and the soldier indicate something of the span of traumatology, and in our case, the complexity of responses in traumatic situations.

We have started to explore the two best known survival strategies- fight and flight. Both the soldier and the child had fight (especially the soldier) and flight (especially the child) responses. In the next workshop we will examine three more survival strategies.