

Editorial Note

This second issue of the year and volume offers important contributions to the field in theory, research, and practice. The first article, "How Fear Differs From Anxiety," poses a simple question and provides a deservedly complex answer. The author is Dr. Don Catherall, Founder and Executive Director of The Phoenix Institute, a nationally known organization that specializes in helping traumatized individuals and families. In this intriguing essay, Catherall applies both phenomenology and neurology to distinguish between fear and anxiety and discusses the implications for treating conditioned fear. Among other things, he identifies and makes distinctions between "Top-Down" and Bottom-Up" processing. Top-down connotes the higher-order, conceptual-linguistic processing that accompanies anxiety and in which the left hemisphere dominates. Bottom-up connotes the sensory-perceptual processing that accompanies fear/terror, and in which the brain stem, midbrain and right hemisphere dominate. Catherall emphasizes that most anxiety stimuli are conceptual-linguistic but the stimuli for human fear/terror are sensory-perceptual, a difference he refers to as Conception versus Perception. When entering a state of fear/terror, one experiences a radical shift from top-down to bottom-up processing (shifting from analytical to the visceral). Here the person focuses exclusively on survival and the right hemisphere dominates. In contrast to functioning during anxiety states, conceptual-linguistic thought processes are severely restricted in this bottom-up processing state. During this period - which may last only seconds -- the frontal regions of the cortex are no longer able to override survival impulses from brain stem and midbrain regions. Catherall cites the evidence that learned, or conditioned fear (i.e., most traumatic stress reactions), involves actual neurological changes in the limbic system, especially the amygdala and hippocampus. The challenge for practitioners is to help the client overcome the unwanted conditioning tied to the traumatic memory. He suggests two critical tasks: the individual must (1) gain some level of access to the bottom-up state in order to habituate or extinguish the conditioned fear response, and (2) also achieve access to the top-down state in order to process the fear experience and establish explicit memory. Thus, treatment involves both states. Clinicians must activate the fear structure and then also help the individual return to a state of top-down processing to fully process the experience and complete desensitization. The latter section of this article discusses the array of treatment choices since they vary with regard to how much they enable the client to enter the bottom-up state. However, he suggests that all effective trauma treatments activate the fear state and eventually facilitate top-down processing. One naturally wonders, however, how well the client can tolerate the fear state sufficiently long enough to be desensitized with the conditioned fear eliminated.

The second article, *A College Community's Vicarious Stress Reaction to September 11th Terrorism*, is written by David X. Swenson and Gerald Henkel-Johnson. Both are professors at the College of St. Scholastica where they completed the study they discuss in their article. Their study examines the acute effects of vicarious exposure to the September 11 terrorist attacks, in their academic community of 1693 students, faculty, and staff. They completed the survey via the Internet with a respectable (37%) response rate. Conducting a virtual survey is another innovation of their report. Their survey focused on lingering, perceived stress symptoms and related coping behaviors. Among the more important findings of their study are that although far from the terrorist attack, and weeks after September 11th, most members of their little academic

community (76 percent) showed one or more substantial symptoms of stress, and nearly a third identified three or more symptoms. The most prominent symptom clusters involved hypervigilance, anxiety, and apprehension about the future. Respondents primarily relied on coping through optimism, reassessing priorities and relationships, giving and receiving support, and becoming better informed on terrorism-related topics. Differences in symptoms and coping preferences were found based on sex, group (student, faculty, staff), and exposure to previous crisis. This study indicates that despite time and distance from the site of the terrorism, all segments of a college community continue to experience some degree of distress. Such distress can interfere with academic performance, personal health, and relationship stability. Rather than rely on formal support service delivery, most appear to rely on established interpersonal relationships. This suggests that providing support to vicarious victims in the future might emphasize training for friends and family, rather than relying on established service delivery systems.

In the final article of Issue 2, a team of Dutch investigators wrote "Personality, Temperament and Attachment Style Among Offspring of World War II Victims." Elisabeth H.M. Eurelings-Bontekoe, Margot J. Verschuur and Bas Schreuder report on an investigation of 109 patients who were second generation victims of World War II and born after 1945. The research team was investigating the suspected association between features of DSM-IV personality disorders, temperament and character dimensions and attachment styles among this special group. This study contributes to a robust literature on transgenerational effects of trauma. They found that, among other things, a majority of these patients can be classified as *insecurely attached*. Moreover, the team found the presence of narcissistic personality pathology, thanks to an innovative method of integrating descriptive and structural data analysis. These findings are instructive. There has been far too little attention to personality disorders and temperament in the traumatology literature. As a result practitioners have few guidelines for assessing and treating personality disorders among the traumatized. These investigators suggest that practitioners should be cautious with second-generation trauma survivors because of their fragile sense of self. However, although self-pathology seems to be the central issue in these patients, they cannot be considered as a homogeneous group in accordance with what is known about narcissistic pathology. Two types of narcissistic patients could be identified from among this traumatized group: the oblivious type and the hypervigilant type. Previous reports have noted that both types of narcissistic patients had to function as self-objects to their parents. Not only were they parentified as children and used as self objects to repair the hurt self esteem of their parents, but these men and women idealized their parents and were over sensitive to parental needs. Finally, the investigators suggest that these offspring of WWII survivors resemble the scoring pattern of patients with PTSD. Of special overlap are the high rates of the narcissistic, antisocial, borderline, obsessive-compulsive, paranoid and avoidant disorders. The author's results are also consistent with a report published in this Journal in 2001 by Lauterbach. Among individuals with PTSD, when compared with those without PTSD, Lauterbach found higher scores on borderline, narcissistic, paranoid, passive-aggressive, self-defeating and schizotypal personality disorders. In contrast to treating those with PTSD, these second generation members suffer a kind of ripple

effect, or secondary traumatic stress effect, of being exposed to the traumatized for so long during the most critical and formative years of human development. This is the new frontier for investigators and practitioners specializing in traumatology. Let us wish them good luck!

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