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Editorial

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Editorial

Charles R. Figley

Being a member of the “academy,” which takes for granted the safety of my students from the day I stepped into a classroom as college professor nearly 35 years ago, the April 16, 2007, shooting at Virginia Tech University was a shock. It was a tragedy for those who lost their lives or could have and the family and friends who care for them. It was a tragedy for a great university and the entire “Hokie Nation” of alumni and supporters, staff, faculty, and students.

As the details of the shooting emerged, it was clear that this would become a benchmark event that would be discussed and studied for many years among traumatologists and specialists in other relevant fields. Within a few days I was in contact with many faculty there to provide them with whatever emotional or material help they would like. It was during these discussions that it was apparent that what was needed by the larger community of the academy and beyond was a full accounting of this tragedy for current and future trauma scholars. Because *Traumatology* is a scholarly, professional, international journal that publishes original research, theory, practice, and essays relevant to better understanding and helping the traumatized, it is appropriate and necessary to publish a special issue focusing on the immediate and long-term psychosocial consequences of the Virginia Tech shootings.

The Special Issue on the 2007 Virginia Tech Shootings

With this in mind I approached one of the leading experts on mental health aspects of traumatology and on this tragedy in particular: Russell Jones, Professor of Psychology at Virginia Tech. Gradually the purpose, objectives, structure, and procedure to producing a special issue emerged. Next is a comprehensive introduction to the special issue. As with the previous special issue on MHAT-IV report on the

mental health of those American military who are engaged in combat, the journal intends to bring fresh new ideas about the challenges and the opportunities of traumatic events for individuals, groups, families, communities, and cultures.

The focus of this special issue is on how members of the Virginia Tech community of faculty and students from a variety of disciplines experienced, responded to, and considered—personally and professionally—the horrific and tragic event on their campus and its aftermath. Each of the 11 articles first describes the authors’ personal recollections and reactions. This is followed by lessons learned, including how their own field of study informs these lessons. Professor Russell and I invited key faculty members and students who assumed important roles in the wake of the shootings or due to their area of expertise placed them in a useful position to critically assess the event. Recognizing that their submission would go through the normal journal review process of blind (to authorship) review through Sage Publications’ Scholar One Web site for the journal, each author was asked to address at least three question associated with the tragedy:

1. What did you see and experience—both personally and professionally?
2. What did you do in your role as a faculty member and included but went beyond your typical role?
3. What are the lessons learned from this tragedy, with special reference to your field and area of expertise?

Keeping in mind the importance of timing, it is my pleasure to welcome this special issue for journal subscribers and others in time for the first anniversary of the shootings (April 16, 2008). We were also sensitive to the healing potential for the authors in considering and writing their articles as they focus both on their shocking experiences and the lessons that guide their recovery and thriving.

Regular Submissions

The rest of the issue is composed of regular submissions: three articles, six media reviews (four books and two DVD productions), and a letter to the editor. The first article, "The Impact on Solicitors of Exposure to Traumatic Material," by Lila Petar Vrklevski and John Franklin, is one of very few reports on the topic. It is not at all surprising that lawyers are traumatized in the course of their work focusing on violence and abuse. This study focused on criminal lawyers by randomly selecting and testing 100 lawyers, half of whom were criminal lawyers and half of whom never practiced in the area. After acquiring the necessary clearances and permission, the sample completed a battery of measures of their current functioning (stress, anxiety, depression, life events, life satisfaction, sense of safety, interpersonal intimacy, traumatic stress, attachment beliefs, and vicarious trauma, in addition to a demographic questionnaire). Vrklevski and Franklin found that, consistent with their prediction, criminal lawyers reported significantly higher levels of subjective distress and vicarious trauma, depression, stress, and cognitive changes in relation to Self-Safety, Other Safety, and Other Intimacy. Also as expected, they found no differences between the groups in terms of demographic characteristics, satisfaction with work, or coping strategies in relation to work-related distress. For both groups, as found in other studies, multiple trauma histories of the lawyers were associated with higher scores on measures of symptomatic distress. They call for more attention to the mental health needs of criminal lawyers. This should start with proper orientation to both the profession and the specialty area in law school.

The next article is the third is a series of articles written by Ron Ruden, an internist (medical doctor) in New York with a PhD in chemistry (Northwestern University). This may account for his success in designing a model that accounts for complex neurobiological phenomena and also have practical applications for both traumatology and general practice medicine. Ruden's first article in the series was published in this journal in 2005, "A Neurological Basis for the Observed Peripheral Modulation of Emotional Responses," which laid the groundwork for understanding of the neurobiology of emotional responses. His second article published in the journal in 2007, "A Model for Disrupting an Encoded Traumatic Memory," built on his previous article in accounting

for memory encoding disruption as a direct result of exposure to traumatic events.

This article, "Encoding States: A Model for the Origin and Treatment of Complex Psychogenic Pain," goes to the heart of the challenges of most physicians: determining how, why, and if patients are experiencing pain and finding the proper remedy. Of special concern to physicians like Ruden are the aches and pains clients report that are "un-anatomical in distribution." That is, there is no apparent physical or medical explanation or treatment and, therefore, perceived to be psychogenic in origin—complex psychogenic pain (CPP). Ruden suggests that the origin is a traumatic event and that CPP is co-encoded centrally and during a traumatizing event where the individual experiences rage or fear with concomitant pain but is constrained from responding to the circumstances. In contrast to nociceptive pain, which is caused by physical injury to body tissues, Ruden speculates that CPP is encoded as dissociated from the event but activated by specific triggers. These are stimuli that recreate similar emotional, somatosensory, or cognitive states as those experienced during the traumatic event. These triggers activate not only the memories but also the traumatic pain and various vasomotor processes affecting nerves and muscles that cause the blood vessels to constrict or dilate (e.g., blushing and fainting). To Ruden it is a neurobiological process that precludes simple forgetting; that CPP or trauma-related pain is generated from amygdala efferents and is encoded in such a manner. Successful therapy extinguishes the pain. This requires either "delinking" or disrupting reconsolidation of the amygdala-based linkage between the memory and the emotional/somatosensory response or directly inhibiting amygdala outflow. In other words, to effectively eliminate the trauma-related pain, one must "delink" the memory from the pain. Succinctly, this is an explanation for psychological desensitization affected by standard exposure, cognitive-behavioral and other treatment approaches of which the only explanation until now has been psychological learning (i.e., information/emotional processing) theory. The opportunity now is to operationalize and test Ruden's alternative explanation for why people become, remain, and become free of trauma-related symptoms that include pain.

Similar to the previous one, the final article focuses on addressing and eliminating or at least controlling pain. In the article, "Energy Psychology

in Disaster Relief,” David Feinstein, PhD, a clinical psychologist who practices in Ashland, Oregon, provides an overview of energy psychology for the reader, with particular application to helping disaster survivors. His more than 35 years of experience in helping clients with a wide variety of experiences, including surviving disasters, lead him to fully understand and then embrace less conventional approaches to reducing pain through what he describes as “energy psychology.” Dr. Feinstein explains that this form of treatment induces wanted psychological change by various techniques that are combinations of “imaginal” exposure (guiding the client to remember real events or wished-for scenarios of the same events using their various senses) to traumatic memories

that are combined with some form of physical interventions derived from acupuncture, yoga, and related systems. The psychological change varies from shifts in affective, cognitive, or behavioral patterns, or a combination. Dr. Feinstein reports how this form of applied clinical psychology has been useful in non-Western cultures that reject traditional, mainstream approaches to helping those who have survived disasters—be they caused by humans, nature, or some combination. He discusses and then suggests applications to disaster survivors of four “tiers” of energy psychology interventions, including (a) immediate relief/stabilization, (b) extinguishing conditioned responses, (c) overcoming complex psychological problems, and (d) promoting optimal functioning.