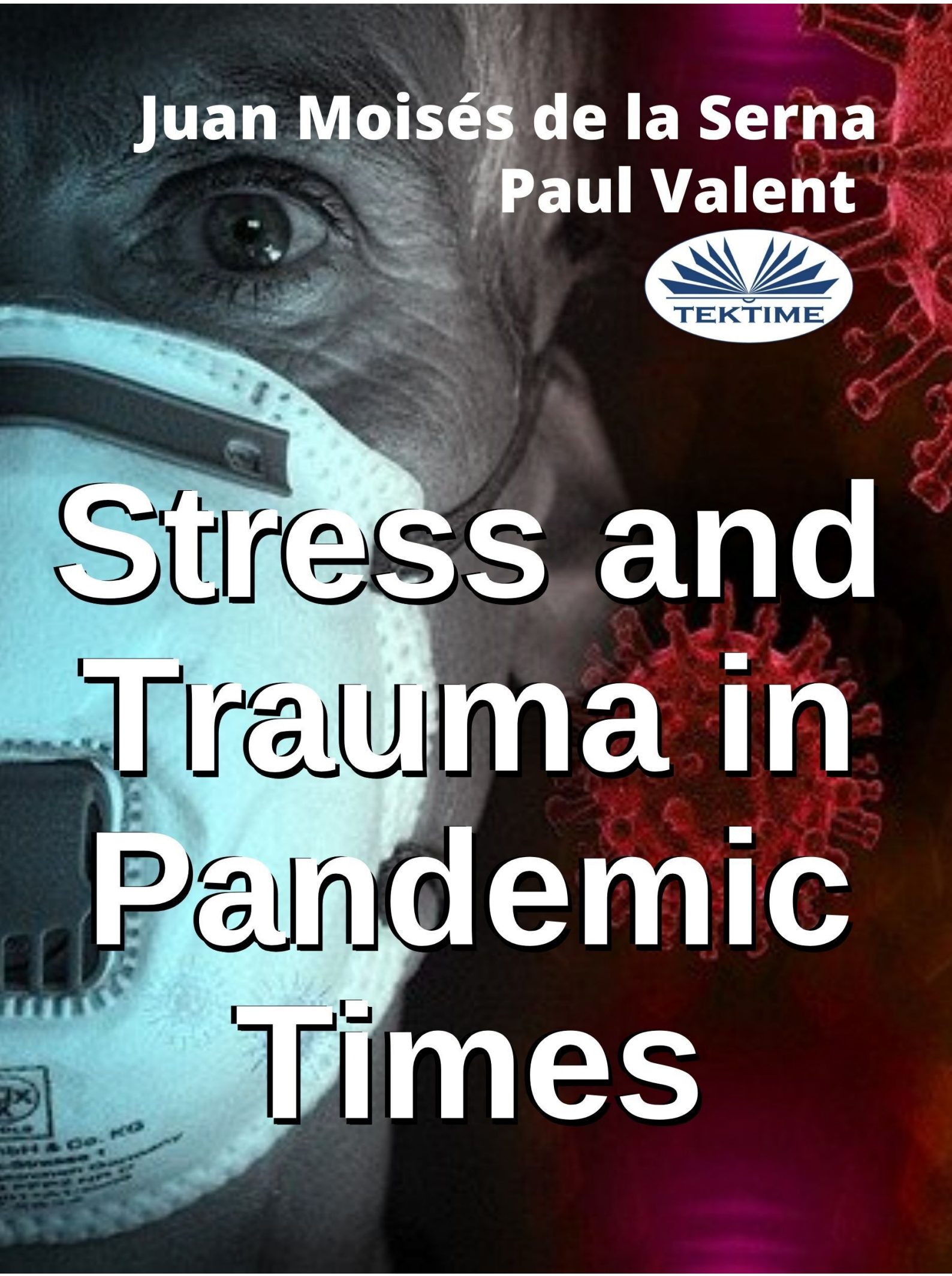
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TEKTIME
Stress and Trauma in Pandemic Times

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«Tektime S.r.l.s.»

Valent P.

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People frequently say that the COVID-19 pandemic is unprecedented. Yet from a bird's eye point of view it has similarities with other pandemics, even other illnesses, and with other stresses and traumas. In fact, each situation of stress and trauma illuminates all the others. People frequently say that the COVID-19 pandemic is unprecedented. Yet from a bird's eye point of view it has similarities with other pandemics, even other illnesses, and with other stresses and traumas. In fact, each situation of stress and trauma illuminates all the others. We are on the cusp of a science of stress and trauma. In this book we indicate how the current pandemic interweaves with that science, both benefiting and contributing to it. In other words, though in this pandemic each person and community feel that their sufferings are unique, in fact they overlap with other areas of suffering that can provide benefit to our collective wisdom. In this book two scientists from different parts of the world have come together to meld their knowledge of stress and trauma and apply it, together with their current observations, to understanding of the pandemic. Reciprocally, because all traumatic situations overlap, lessons from the pandemic will benefit other situations of stress and trauma. Thus the contents of this book are relevant to every traumatic situation. The book is laid out in the following. Chapter 1 considers previous traumatic situations, while chapter 2 compares them with the pandemic. Chapter 3 introduces stress and trauma terms and applies them to the pandemic. Chapters 4-6 explore the range of stress and trauma processes and consequences all the way from cellular to international levels. Chapter 7 explores the dialectic between death and resilience, while chapter 8 summarises the previous chapters. Finally, chapter 9 applies stress and trauma understanding to amelioration and treatment of COVID-19 consequences.

Содержание

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In Pandemic Times
Paul Valent
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Paul Valent was born in Bratislava, Slovakia in 1938. He and his parents survived the Holocaust in Hungary. In 1949 the family emigrated to Australia.

Valent completed his medical studies in 1962, and his psychiatric studies in London in 1967. Back in Australia from 1970 Valent worked in emergency departments of major hospitals and in private practice until 2002.

He developed special interests in psychosomatic medicine, and stress and trauma. He founded and was later president of the *Australasian Society for Traumatic Stress Studies* and founded and was president of the *Child Survivors of the Holocaust group in Melbourne*.

Valent has written numerous books, papers, and chapters related to psychotherapy and trauma (www.paulvalent.com). His latest work was *Mental Health in the Times of the Pandemic*, a precursor to this book.

Juan Moisés de la Serna

Juan Moisés de la Serna has a PhD in Psychology and a Master of Neuroscience and Behavioral Biology. Online Adjunct Faculty.

Nowadays, his research focuses on Potential Factors Influencing COVID-19, and Short- & Long-Term Psychological and Neurological complications after SARS-CoV-2 infection in humans.

In the base of researchgate.net, he was the most read author in Spain in 2020.

Spanish Popular Science Writer, de la Serna has published more than thirty books on Psychology and Neuroscience Topics including AD; PD; ASD; ADHD; EQ; MSD; HiQ.

In 2020 he wrote *Psychological Aspects in time of Pandemic* and *A Psychological Perspective of the Health Personnel in Times of Pandemic*.

Prologue

People frequently say that the COVID-19 pandemic is unprecedented. Yet from a bird's eye point of view it has similarities with other pandemics, even other illnesses, and with other stresses and traumas. In fact, each situation of stress and trauma illuminates all the others.

We are on the cusp of a science of stress and trauma. In this book we indicate how the current pandemic interweaves with that science, both benefiting and contributing to it. In other words, though in this pandemic each person and community feel that their sufferings are unique, in fact they overlap with other areas of suffering that can provide benefit to our collective wisdom.

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Dedicated to all victims of THE COVID-19 pandemic.

Chapter I. Different stress and trauma situations - disasters, wars, Holocaust, etc.

Paul Valent

The COVID-19 pandemic reared its head at the beginning of 2020. Well, we thought initially, another corona virus, no worse than other colds and influenzas, so we hoped and denied. Until it engulfed us, and then we were counting the numbers of infected and dead.

We were unfamiliar with pandemics. How were people to think about it? Was the pandemic like a natural disaster? Or was it an illness like others, where some died others escaped or were left bereaved? Was it like an infiltration by an invisible enemy? Or was the pandemic like a biblical pestilence, along with more frequent fires, storms, and floods, punishing a greedy world?

It was natural to try to conceptualise this unfamiliar danger according to what we already knew. It was also natural to fill in lack of scientific data with magical thoughts.

In this chapter we will look at other circumstances with widespread threats to life and see how their features overlap with and elucidate the current crisis.

Traffic deaths

About 40,000 people die of traffic incidents in the US annually, and 1.25 million die around the world. In addition, 50,000,000 are seriously injured worldwide. In a sense traffic deaths are a low grade chronic pandemic.

Traffic deaths are a prime example of avoidance and denigration of psychological aspects of catastrophes. Historically, complaining survivors were accused of compensation neurosis, while psychological factors among those causing accidents were almost totally ignored.

In fact, close examination of both victims and perpetrators reveals a wide variety of physical, psychological, and social dysfunctions (Valent, 2007).

Natural Disasters

Natural disasters such as fires, floods, and earthquakes are usually short-term circumscribed events that do not threaten the rest of the population. Help pours in quickly from outside to help the victims.

Disasters have arguably been the most scientifically studied mass traumatic situations. They revealed that traumatic events manifest different *phases*: pre-impact, impact, post-impact, recovery and reconstruction. Disaster responses have also been noted to ripple to *secondary victims* such as helpers and children, and can ripple even *across generations*.

Generally, mortality and morbidity from all kinds of illnesses increase in proportion to severity and duration of specific stresses and traumas. The nature of what survivors, secondary victims, and communities experience varies very widely across physical, psychological, and social scenarios.

Early researchers found for instance symptoms as wide ranging as reliving aspects of disasters (PTSD), but also confusion, apathy, grief, depression, survivor guilt, shame, hopelessness, alienation, and struggle for meaning.

Valent (1984, 1998) after the Australian Ash Wednesday bushfires classified these varied responses according to biological, psychological and social manifestations of instinctual survival drives ranging across time place and persons, and ranging from instincts to spiritual dimensions. For instance, a man believed an angel appeared in the flames and its wings were about to envelop him. A boy believed his angry mother was a witch and he took a magic pill to ward off her evil.

Disasters have highlighted the fact that helpers generally are secondarily affected, especially if their rescue efforts fail. Helpers may empathically resonate with victims' distress or feel guilt and shame for not having been able to help them.

Actually, victims' traumas radiate not only to helpers but to family and community members, and may resonate across generations.

Wars

Wars, more than traffic accidents, have demonstrated extreme inadmissibility and denial of psychological symptoms in soldiers. Their complaints were treated as malingering and cowardice. Yet millions of soldiers, many of them decorated, broke down, proving that everyone was vulnerable to extremes of stress and trauma.

Though psychological consequences of combat have been recorded since the ancient Greeks, it was only in the 17th century that Hofer compiled excitement, 'imagination', gastrointestinal symptoms, torpor, prostration, and depression in Swiss soldiers into a syndrome he called melancholia. This concept lasted 150 years, until in the American Civil War longing for home and lack of discipline (called nostalgia) were added to melancholia.

In World War One, after some resistance, initially physical stress symptoms were acknowledged, mainly of the heart. Irritable heart, neurocirculatory asthenia, and effort syndrome were common diagnoses. Shell shock was added, thought to be a result of explosions that caused minimal brain damage. Eventually pure traumatic psychological illnesses had to be acknowledged due to the massive numbers of mental breakdowns.

The seminal work to emerge from World War One was Abram Kardiner's (1941) The Traumatic Neuroses of War. Kardiner described a very wide variety of symptoms that related to traumatic events and which could be relived in nightmares and flashbacks. They could merge with other neuroses and physical symptoms. Kardiner emphasised that all symptoms were meaningful in terms of earlier traumas, even if these traumas were unconscious.

Interestingly, the so-called Spanish flu pandemic of 1918 that killed 50 million people worldwide and also ravaged World War One combatants was not mentioned among war casualties on either side of the conflict, in order to not reveal one's military vulnerability. This was a stark example of how political forces can suppress recognition and treatment of pandemics. The flu was called Spanish because Spain, neutral in the war, acknowledged the flu.

In World War Two, the lessons of the previous war had to be relearned. Like trauma itself, traumatic neuroses were repressed. This is a warning that lessons of the current pandemic must not be forgotten.

Once combat breakdowns were acknowledged, new type of scientific research ensued. It found that psychological breakdowns were associated with the intensity and duration of the threat of death and the number of comrades killed. In severely stressed units, all soldiers ultimately broke down. We learned that irrespective of people's strengths and vulnerabilities, everyone was eventually breakable.

World War Two revealed the importance of morale. *Morale* consisted of motivation to accomplish important goals and confidence in one's ability to do so. It also consisted of one's identity being conceived as being part of a group, the group being more important than oneself. The group was the body, the leader its head, and oneself a body part. Morale was the antidote to the anxiety of annihilation.

With defeat of goals and loss of comrades confidence sagged and *demoralisation* set in. The military group lost its esprit de corps. Individuals felt abandoned in a dangerous world for no good reason. Discipline collapsed, officers were killed by their men, and atrocities occurred.

As in world War One, Grinker and Spiegel (1945) validated Kardiner's findings of a wide range of responses in traumatised soldiers. They referred to 'combat breakdown' as 'a passing parade of every type of psychological and psychosomatic symptom, and unadaptive behaviour.' Be it depression, hysteria, somatic symptom, phobia, etc, all symptoms were once more understandable in terms of traumatic incidents that soldiers had endured.

Bartemeier et al (1946) added to Grinker and Spiegel's findings a kind of final definitive traumatic picture of the war. They called it 'combat exhaustion'. Its features were fatigue, slowness,

withdrawal, moroseness, and loss of concentration and interest. In its full-blown form young soldiers looked like old men who walked like automatons, totally exhausted, retarded, and apathetic.

Post-War. For the first time, close attention was provided to returned soldiers. It became obvious that in many soldiers symptoms did not clear when away from combat. They could even last unabated for decades. Further, symptoms could erupt months or even years after the war. Still vivid, symptoms from war could in time interweave with civilian stresses and traumas.

Mental Health Professionals. For the first time, too, mental health professionals were themselves subjected to observation. It was found that most psychiatrists saw themselves as part of the war effort. They denied breakdowns; rather they harangued soldiers to greater efforts and gave pejorative diagnoses such as malingerer when these efforts failed. Again we see how power politics can sway scientific mental discourse.

The Vietnam War. With defeat, demoralisation manifested in poor discipline, drug addiction, refusal to fight, murder of officers, and atrocities. Subjectively soldiers felt alienated, numb, angry, guilty, unable to trust and love. They were devoid of a sense of justice, morality, meaning and purpose.

Of returnees, 38% were divorced within six months. A third of federal prisoners were Vietnam veterans. Still, once again mental health consequences of veterans in agony were denied.

Eventually they marched in their thusands to have their anguish recognized. It was only then that the politics of psychiatry granted them a diagnosis- post-traumatic stress disorder (PTSD). It contained a limited recognition of all the travails that veterans were reliving or suppressing.

Civilians in Wartime. Though their circumstances were different, nevertheless civilians were also threatened by death and injury. The extent of mental injury depended on circumstances similar to soldiers: faith and leadership, the degree and duration of destruction, victory or defeat, and the proportion of the population and loved ones killed or injured.

In the London blitz morale was high except in the minority who were severely affected. The nature of their mental disturbance was varied, as it was with soldiers. In Hiroshima, following explosion of the atom bomb, the surviving population resembled soldiers with combat exhaustion.

Children in Wartime. Even when shielded by adults, children nevertheless experience bombings and mayhem, and they absorb adults' fears and emotions. Children's vulnerability is reflected in their relatively high morbidity and mortality rates compared to adults. And when parental shields are ripped away children's suffering is extreme. In young children psychosomatic and behavioural symptoms dominate in expressing their distress. Older children suffer symptoms similar to adults.

The Holocaust

The Holocaust was the most total and widespread persecution of a people in history. It led to the deaths of six million Jews. The consequences of this genocide were well documented and have been followed now over three generations.

In the lead-up to their annihilation, psychiatric illnesses, suicides, hypertension and angina were reported to have increased. In concentration camps up to half the prisoners just died within weeks. Some, called musselmen, hovered between life and death. They were emaciated, old-looking people, emotionally numb, and cognitively deficient. Their survival reflexes disappeared and they appeared as silhouettes of humanity. Most died. They resembled those suffering combat exhaustion, but they were traumatised through another, ultimate level.

Those who survived the Holocaust did so through a combination of luck and intense resolve, hope, and maintenance of meaning. Nevertheless, post-war they suffered a range of biological, psychological and social illnesses. Over subsequent decades their morbidity and mortality rates were higher than for the rest of the population.

Psychological sequelae of the Holocaust, huge as they were, were once again denied for two decades. Initially physical symptoms were acknowledged. Eventually it was obvious that Holocaust survivors suffered a wide plethora of symptoms and problems.

Survivors were tormented by irreconcilable losses, survivor guilt, rage, despair, depressions, psychosomatic illnesses, and loss of meaning and purpose. They attempted to find meaning in quick marriages, having children, and hard work.

Children. Nine-tenths (one and a half million) Jewish children were murdered in the Holocaust. Most who survived were separated from their parents, hidden by strangers. The children numbed their feelings, were supremely obedient, and lived day by day awaiting a miraculous end to their suffering.

Post-war, children were denied recognition of their sufferings. They had to deal silently and unknowingly with their war experiences, which, unrecognised, still pervaded them. They dealt silently with losses of their childhoods and their dreams. Like one of the authors (PV), child survivors of the Holocaust were recognized only in the 1990s when the children were in their fifties (Valent, 1994). It was only then that they started to process their traumas.

Second generation survivors were greatly influenced by the Holocaust through their parents. They carried negative emotions, sensations, images, judgements, and attitudes that were incomprehensible to them, as their parents often maintained a conspiracy of silence about their experiences and what the children signified for them.

Perpetrators and their children. Nazi Germany produced extremes of violence and atrocities, but they could occur elsewhere, such as the atrocities that were documented in Vietnam.

Antecedents of violence are as wide as those for trauma. They include poor family relationships, deprivation, poverty, social turmoil. They can harness fear, group pressure, dehumanisation, and opportunism to commit atrocities that would be abhorrent in normal circumstances (Valent, 2020).

Children of perpetrators have a dilemma. They can either identify with their parents and grandparents as some neo-Nazis do, or they need to painfully disassociate from them.

Physical Assault, Domestic Violence; Sexual Violence

In the 1980s millions of people were documented to be victims of violence annually in the U.S. Two million cases of child abuse and neglect were reported annually. 3.3 million children witnessed spouse abuse annually.

Assaults are traumatic. For instance victims of domestic violence suffer not only PTSD, but shattered core beliefs of safety, trust, self-belief, self-judgements and views of a moral universe as well.

In 2002 the World Health Organisation estimated that 73 million boys and 150 million girls under 18 were sexually abused. In the U.S. 11% girls and 4% boys in high schools had been sexually abused. By college, a sixth of college women were victims of rape. Sexual violence, especially of children is especially virulent, as it shatters self-esteem, identity, intimacy, love, creativity, and fulfillment. Worse still, abuse of children leaves them unable to consciously process what happened to them and the reasons for their intense problems. Even if they knew, and complained, children have been often disbelieved and blamed for their problems.

Dying and Bereavement

Everyone needs to face death of oneself and of others. In normal circumstances one traverses the stages of loss- shock, denial, pining, grief, and acceptance.

Traumatic deaths are especially distressing because they are meaningless and purposeless. They are absurd, without morality, honour, point, or rounding out of a poignant story. Such deaths and bereavements are difficult to grieve and accept. They often lead to unresolved grief, depression, and a variety of biopsychosocial dysfunctions.

Summary

Different traumatic situations emphasised different aspects of stress and trauma. Disasters taught us that traumatic situations have pre-impact, impact, post-impact, and recovery phases, though distress could remain over decades. We learned that there are primary and secondary victims, such as

medical personnel. We need to pay attention to different age groups (especially not forget children), and subsequent generations.

Combat psychiatry emphasised reliving and suppression of fight and flight circumstances. Sexual abuse and the Holocaust emphasised the pervasive biopsychosocial and spiritual consequences of trauma over time and generations.

Common themes emerged from different traumatic situations. First, each traumatic situation was initially denied. Next, the victims were blamed. When recognized, physical symptoms were the first to be identified. Mental consequences were denied till they were too obvious to ignore.

Though different situations bore particular badges, for instance combat highlighted PTSD and loss highlighted depression, each traumatic situation contained a parade of a wide variety of symptoms, which could over time gel into one or more physical, psychological, or social dysfunctions.

Traumatic situation could cascade over time, places, and persons. Further, these consequences radiated from instincts to political, ideological and spiritual dimensions. For instance, Hitler blamed Jews for Germany's travails.

The COVID-19 pandemic is another traumatic situation. We will examine its manifestations, and then see what collective wisdom we can glean about them.

Конец ознакомительного фрагмента.