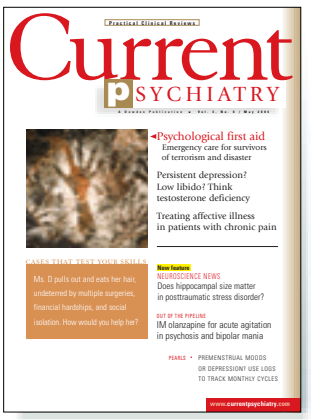
Current PSYCHIATRY

Letters

FLIGHT, THEN FIGHT



"Psychological first aid: emergency care for terrorism and disaster survivors" (CURRENT PSYCHIATRY, May 2004, p. 12-23) touches on flight, fight, and fright as human reactions to disaster.

Since the Sept. 11, 2001 terrorist attacks, medical professionals have become much more interested in the immediate adverse effects of extreme acute stress and humans' instinctual response to disaster. "Fight or flight," a widely used catchphrase, has influenced the understanding and expectations of clinicians and patients for decades.

"Fight or flight," however, does not reflect the many advances in understanding acute response to stress that have occurred since the phrase was coined in 1929.[1] Indeed, as we note in two soon-to-be-published articles,[2,3] the phrase is no longer accurate.

Gray described the correct sequence of universal hardwired responses to extreme stress caused by a life-threatening situation.[4] Ethologists working with nonhuman primates have clearly established that sequence.

In all mammalian species studied, the urge to flee is the first normative fear response. If fleeing is not an option, the impulse to fight follows. Male and female mammals have demonstrated this response sequence. The belief that man's first instinct is to fight is probably a misconception.

Thus, "flight or fight" is the proper order of responses. Recognizing this order may help us more effectively treat acute stress in emergency and other clinical settings. Understanding these responses as instinct might also help us ameliorate the guilt that plagues many military veterans who wonder why they fled rather than put up a fight.

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1. Cannon WB. *Bodily changes in pain, hunger, fear and rage: An account of recent research into the function of emotional excitement (2nd ed)*.New York: Appleton-Century-Crofts, 1929.
2. Bracha HS. Freeze-flight-fight-fright-faint: Adaptationist perspective on the acute stress response spectrum. *CNS Spectrums* 2004. In press.
3. Bracha HS, Williams AE, Ralston TC, et al. "Fight or flight": Does this 75 year-old term need updating? *Psychosomatics* 2004. In press.
4. Gray JA. *The psychology of fear and stress (2nd ed)*. New York: Cambridge University Press, 1988.

'GUIDELINES' VS. 'RULES'

The Texas Medication Algorithms (CURRENT PSYCHIATRY, February 2004, p. 22-40) have been most useful to our practice.

When the algorithms arrived in 2000, our peer reviewer (not a physician) tried to classify them under "treatment rules." We had some difficulty getting everyone to understand that these are "guidelines," which encourage individual patient decisions, rather than "rules," which mandate treatment based on "cookbook recipes."

With this understanding, though, the algorithms have been beneficial and we look forward to the revisions.

Y. Scott Moore, MD
Lincoln, NE

Letters

DOSING OMEGA-3 FATTY ACIDS

Dr. Martinez' and Dr. Marangell's review on use of omega-3 fatty acids (CURRENT PSYCHIATRY, January 2004, p. 25-52) was excellent.

Please clarify how these agents have been dosed. More specifically, when a study specifies a milligram dose amount of eicosapentaenoic acid (EPA) and/or docosahexaenoic acid (DHA), does that include only the "active" ingredient or the total milligrams of the capsule? In a commercial preparation, for example, a 2-gram fish oil capsule might contain 360 mg of EPA.

Robert L. Murdock, MD
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Dr. Martinez responds

The studies that Dr. Lauren Marangell and I reviewed reported the total daily amount of either EPA or DHA (or both, if combination treatment was being studied) that a study participant would receive.

For example, in studies investigating 2 grams/d of EPA versus placebo, the treatment group received 2 grams/d total of EPA, with no DHA in the study compound. If the study drug contained 200 mg of EPA per capsule, patents would take 10 capsules per day.

Also, only studies looking at combination EPA/DHA treatment used study medications that contained both fatty acids. Again, these studies specified the total daily dosages of both the EPA and DHA portions.

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NMS: SPELLING IT OUT

I read with interest Dr. Stanley Caroff's excellent article on neuroleptic malignant syndrome (CURRENT PSYCHIATRY, December 2003, p. 36-42).

As an instructor of psychiatry residents and clinical staff, I have utilized an acronym that helps raise the index of suspicion for NMS. Coming from the northland, it isn't difficult for me to correlate shaking and stiffness with "FARGO:"

Fever
Autonomic dysregulation
Rigidity
Granulocytosis
Orientation changes

Andrew McLean, MD
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ON SELF-MUTILATION

Dr. Timothy Fong's article on self-mutilation (CURRENT PSYCHIATRY, February 2003, p. 15-23) was practical and on target.

As a professional counselor who frequently deals with such behaviors, these data were appreciated. The article also reinforced observations I have seen in the therapeutic setting.

Randy Tungate, M.MFT
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Coming next month in
CURRENT PSYCHIATRY

Antidepressants in bipolar disorder:
Which ones and for how long?

Assessing suicide risk:
Questions you need to ask

Recovery from schizophrenia:
Fact or fiction?

To comment on an article in this issue of CURRENT PSYCHIATRY, send letters to **pete.kelly@dowdenhealth.com**