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A CONCEPTUAL FRAMEWORK FOR UNDERSTANDING THE IMPACT OF DISASTERS

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To have an overall, holistic or what is called BIO-PSYCHOSOCIAL perspective of disasters and their impact, biological, psychological and sociological as well as psychological aspects will be examined. To be comprehensive, the physical destruction should also be considered, but this will be left out in this paper.

When a community of individuals and the environment they live in are given a massive jarring up as a result of a disaster like the recent bushfires, every biological, psychological and sociological system of human functions is strained to the full, and therefore extreme spectra of functioning and malfunctioning may be observed, and with rapid fluctuation over time. The bushfires were a major stress with many upswings. In our everyday clinical work it is the distant ripples of such stresses with which we deal.

It is difficult, perhaps even overwhelming, to try and deal with all aspects of disasters. This may be why different aspects of the experience are inspected by different disciplines according to their interests and abilities to observe events. Biological epidemiologists may note increased mortality and morbidity after disasters, sociologists note social structures. Psychodynamically oriented psychiatrists note deep psychological problems over long periods.

Our experience is based on observations in the first 5 weeks following the bushfires in the Macedon and Mt Macedon regions, a week involvement 5 months later in the Warrnambool area, and continuing interest from Melbourne throughout the period. This paper looks at our findings in the BIOLOGICAL, PSYCHOLOGICAL and SOCIOLOGICAL areas. These three inter-related areas will be treated apart and will then be drawn together again in a tentative attempt to conceptualize the overall experience, in particular to try and see what useful interventions may be applied to help individuals and communities.

BIOLOGICAL ASPECTS

During the fire experience and the next few days, intense psychophysiological (sympathetic and parasympathetic) symptoms were prominent. A mother who believed that she would die saw her baby's head move on her chest from the pounding of her heart. Perc like a rock, muscular tension "as if whipped from head to toe" were described, as well as dropping to the floor as if the web would come out. Fatigue, fainting and "collapsing" were described too. Acute psychosomatic illnesses in the form of anoxia, myocardial infarcts, asthma, epilepsy and premature birth (premature calving in cows) were noted.

Over time psychophysiological and psychosomatic illnesses generally became attenuated, though new illnesses have been cropping up even until now. Current local GP's describe increased attendances to their surgeries and the local hospital
The Australian
Clinical Psychologist | 14 | November 1983

over numbers attending last year, in spite of a decreased population. Minor infections, anxiety-related symptoms, psychophysiological symptoms, sleeping difficulties and marital difficulties, among other things, and tranquillizers are being prescribed. It is felt that many patients come in with physical complaints as a "ticket" to be able to seek emotion support for fire-related stresses.

Mental Aspects

I shall mention 3 aspects - cognitive, psychological defenses, and affects or emotions.

Cognitive - There is a total immersion in the disaster experience. A man doing duty on a road block did not recognize his friend in a passing car. The doctor on duty was not conscious of the concentration of the affected people, there is little left over for stopping long-distance visitors, and minor symptoms of the child who threatened to leave her alone. One could say that this lady used the defenses of SENSATION and SATURATION to avoid the effects of fear, guilt and anger.

In fact one could say that we saw the gamut of psychological defenses being used at different times.

Effects and Emotions - One can similarly say that the gamut of emotions was widely displayed. Especially in the acute phase exists of terror, panic, and on the other hand what was described as "the stunned mullet" syndrome were noted. There was longing for one's near and dear with attempts to save them. Survival activity was intense. The old and lame managed physical effort on e.g. lifting drums of water. The young laughed at circumstances they found impossible. Cross heroine and cross cordwainers were seen. Each of these intense feelings and untypical activities depended on the person's perception at a particular time.

Not all feelings in the disaster were unpleasant. Euphoria and excitement were experienced with the perception that one was overcoming the danger, or that one had indeed survived. Breaking down of individual barriers in families and groups was intense and pleasant. Some observations in disaster only met the need for survival, the authorizes and cohesiveness, and imply from their observations that disasters are good for one.

These early feelings became attenuated with the receding danger, and were replaced with restitutive type feelings like shame at the indignities and helplessness, regrets, anger and guilt. Guilt in the 2 cases quoted, these affects try to restitute past events and relationships, and self-identity.

For instance we noted the intense GUILT on the part of those whose houses survived toward those whose houses burnt. The guilt was felt toward the person who had "good fortune" to have their house survive and the one who had "bad fortune" was felt upon themselves.

This man showed the common defenses of DENIAL of his losses. The EXECUTIVE WORK (HARD WORK) and IMMEDIATE REBIRTH FANTASIES (many people planted and watered immediately after the fire) manifested a sense of omnipotence, of overcoming, here and now. A NUMERATION or REPRESSION OF FEELINGS was also noted and the COMPELLING SOCIALIZATION was used to help the repression.

Case 4: A 46 year old women was seen some weeks after the fire complaining of severe palpitations and very vivid dreams of killing her children. Following the fires she put a "blanket" on all her emotions, and at the time of the interview she appeared to cope well. What she needed was to be consulted was to GUIFF for want of US to leave the fire-shelter with her family and she were congregated through the use of

GRBFE AT LGBS seemed to come into play and was heavily defended against. It seemed to be a process that crying would weaken them in their endeavours to rebuild. The fire and it was "useless to get emotional". Perhaps human vulnerability is difficult to acknowledge. Yet in suppressing grief, people seemed blocked from being fully human.
The Australian
Clinical Psychologist - 15 - November 1983

and they tended to develop mental health problems or "Problems of living".

With time, COGNITIONS, DEFENCES and EFFECTS progressed or settled to as many variable degrees and combinations as there were people.

SOCIAL ASPECTS

In spite of a long, hot, dry summer, warnings were only partially heeded. Pyros were present as to why Macedon would not burn, even after a short bushfire two weeks before the major fire. As the smoke and fire burned, mentally disturbed, it became more personally threatening. From community effort, the concern moved to the loss of one's family. This was passionate, except on occasions when need was inevitably separated, when individuals viewed themselves above all others concerned. Fire, attempted in a last resort, and because there was only one escape road, there was panic in car accidents, and in this case selfishness was not uncommon.

Once survival was assured for the community, it exhibited high levels of CORROBORANESS and EMOTIONAL EXPOSURE of OLDEN TIMES, reactions in communities under threat. Yet outsiders and their problems were needed. They were accepted, but ambivalently.

This was not only due to the cross and often insensitive giving by the bureaucracy, but also because the crisis underscored the recipients' needs and destitution. Even the warrant granting which one case was at long last among work, not plied to give, only excessive, being a personal failure, rather than relief, for many, anger for lack of adequate preparation and care was placed and displaced on seaplanes, the bureaucracy and their offerings. Greed and envy for not getting enough or others getting more was not uncommon.

Our own team was part of the helping community itself. It was, sociologically speaking, an emergent team, i.e. spontaneously formed, it dealt with the bureaucratic or professional team. Our involvement dealt with sensitivity with recipients' preference. We were one outside service who were not receive complaints, but rather received appreciation for what we offered.

Currently the community is slowly rebuilding. Wounds are left like those who left the area not to come back. Much bush is dead. The Caravans still live in by virtue of their cold. There are marital strains. There are fights in schools, promiscuity and delinquency unlike this time last year. Violence and community have disappeared. But there is still more increased cohesiveness was there. There is a strong sense ahead.

A special word may be said about CHILDREN.

Everything said thus far applies to children too. However, they often take their cues from their parents, e.g. to allow themselves to cry rather than not. They can be asible in drawing, playing, and their distress was expressed more behaviourally, e.g. clinging, fighting, etc.

Case 3: An 8 year old boy became uncharacteristically aggressive

to his mother, who punished him for his added demand on her after their home was burned out. Talking to the child in front of the mother, it became clear that he was angry with her for destroying (or allowing to be destroyed, which is the same) his pet and toys. When this became clear, mother and child could once again exchange emotions, to the benefit of both. The symptom cleared.

CONCEPTUALIZATION

1. Psychosocial. It can help in tease out some of the interweaving complexities of a situation by considering the biological, psychological and social aspects in any one case. Similarly, by considering this framework, one is unlikely to forget major aspects in a case.

2. Other stresses. Stress tend to sensitise to further STRESSFUL, aggresive and common threads, like with the men whose loss of home and garden was compounded by his lost family in the woman whose fire experience was being compounded by her child wanting to leave home.

3. Latent period. It often takes quite some time for people to seek help, if they ever do.

4. Overt psychiatric problems were relatively few, though there was probably a slight increase in incidence in the community. For example, a man became hypomanic after the fire, hiring planes to take him all over Victoria, and a woman, a prior schizophrenic, became disoriented because she believed that she caused the fires.

5. Improving. The disaster was sealed on people's minds. Cognitions, affects and defences set around the experience. The experience may be assimilated or "papered over" to varying degrees. Affects, defences and cognitions found in disasters all have survival value in the disaster situation, but their excessive acting afterwards may be pathological.

6. Grief and mourning. Eventually losses have to be mourned, affects worked through. These include depression, anxiety and guilt.

7. Neurosis. Working through a traumatic situation, and the emotions and defences pertaining to it is a win-win of solutions of a neurosis. Here the neurosis may be precipitated to be acute, and treatment must be adapted to the situation.

8. Social. Society gives or takes material goods, emotional support and welfare. There is a complex interplay between the individual and society.

INTERVENTIONS

1. Psychosocial. In each case, all three areas of human functioning must be considered. One should know and recognize psycophysiological symptoms as cognitive, emotional and symptoms and one should also be able to advise about the latent reasons, help fill out forms, know people's rights, etc.
2. Other stresses. One should be able to place the significance of the disaster in context with other vulnerabilities and strengths in individuals or families.

3. Latent period. Because of delays and intense defences, the approach to populations has to be of an outreach and comprehensive type.

4. Cognitions, Defences and Affects. Widespread diffusion of information through newspaper advertisements and pamphlets on the normal mental reactions in disasters achieved much relief for people who believed that they were undergoing unique mental instabilities and breakdowns. Warnings were issued about accidents and future possible problems. Closer contact with individuals, families and groups, exploring perspectives on the disaster, defences and effects facilitated reconstitution of strengths, grieving and healing.

There are opportunities for effective early intervention, for example, abreaction at the site of a burnt-out home or where a pet was last seen.

Case 4: An obsessionnal accountant lost his house, office and 10 years of files in the fire. We met him and his de facto 5 days after the fire and talked about the advantages of allowing oneself the feelings of grief, anger, etc. He mentioned how the fire meant that their de facto relationship was now out in the open and the double standards practised vis a vis the in-laws were now untenable.

A confrontation ensued with the in-laws with much discharge of anger. This facilitated a rise in self-esteem and also strong mourning reactions for losses. Within two weeks this couple had utilised the bureaucracy efficiently and to the full and were in the process of building their own communal home. They led the field in their recovery.

5. Social. In each case the supporting or eroding aspects of the family, group and environment must be inspected and treated in their own right.

QUESTIONS

It must be asked whether such interventions really have effect over time. Controlled studies with individuals and fire affected communities where little as against some intervention occurred would be invaluable.

CONCLUSIONS

It is suggested that the biopsychosocial view of disasters is a useful construct in conceptualizing and intervening in disasters. It is a useful discipline to overcome narrow outlooks while it allows some ordering of a mass of overwhelming data.

It will be seen that similar conceptualization is appropriate to other personal disaster situations. What we have to be aware of is the intense involvement (countertransference, if you like) therapists have to weather in such situations. Not only must there be extreme sensitivity in a situation of intensity and without the usual therapeutic props. The distress of the affected person easily becomes one's own. We share the disaster and we identify easily. We could be burnt out (or flooded out, or hit by a car) tomorrow. We need to be at some ease with our own vulnerabilities and losses to be able to help disaster victims in all the aspects in which they need help.