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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 BIOPSYCHOSOCIAL perspective of disasters and their impact, biological 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 shaking 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 major upheavals. 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 2 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 teased apart and will then be drawn together again in a tentative attempt to conceptualise 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 heave on her chest from the pounding of her heart. Fear like a rock, muscular tension "as if whipped from head to toe" were described, as well as dragging in the uterus as if the womb would come out. Fatigue, fainting and "collapsing" were described too. Acute psychosomatic illness in the form of anginas, myocardial infarcts, asthmas, 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 till now. Currently the local GPs describe increased attendances to their surgeries and the local hospital

over numbers attending last year, in spite of a decreased population. Minor infections, anxiety related symptoms, psychophysiological symptoms, sleeping difficulties and marital difficulties seem to account for the increases. More minor tranquilisers are being prescribed. It is felt that many patients come in with physical complaints as a "ticket" to be able to seek emotional support for fire-related stresses.

MENTAL ASPECTS

I shall mentioned 3 aspects - cognitive, psychological defences, 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. While the experience pervades the attention and concentration of the affected people, there is little left over for shopping lists, official forms or recognizing friends.

Distortions in time, space, person, memory and concentration occur, with the fire taking up the central reference point. For instance, there was constant thinking and talking about the disaster.

Defences - It may be time now to give some clinical samples to give you a feel of how people coped and felt.

Case 1: A 45 year old man was seen with severe chest pain a week after the fires. He had lost all his possessions and a wonderful big garden. He nearly died trying to save his house. He also lost his nursery. After the fire he shipped in masses of plants, worked nearly continuously, and was appreciated by the community as a great morale-booster. From the outside he was cheerful and an exemplary coper. His chest pains were immediately preceded by his elderly neighbours telling him how he should have saved his house with buckets of water, the way they saved their house. He was suffused with anger to the neighbours which he held back with great difficulty. It was particularly galling that he had to depend on them for his basic necessities like water, toilet, etc. His continuous activity and massive fantasies of immediate replanting were defences against feelings of loss, grief and fury for what happened to him. Some of this fury was displaced on his insensitive neighbours. He could tell that his chest pain would ease if he could only cry, but each time he came close he felt impelled to become active or cheer someone up.

This man showed the common defences of DENIAL of his losses. The EXCESSIVE WORK (a very common defence) and IMMEDIATE REBIRTH FANTASIES (many people planted and watered immediately after the fire) manifested a sense of OMNIPOTENCE, of overcoming the fire here and now. A NUMBING or REPRESSION OF FEELINGS was also noted and COMPULSIVE SOCIALIZATION was used to help the repression.

Case 2: A 46 year old woman was seen some weeks after the fires complaining of severe palpitations and very vivid dreams of killing her children. Following the fires she put a "blanket" on all her emotions, with a marked change in her personality. However to an outsider she appeared to cope well. What she needed to repress was GUILT for wanting to leave the fire-shelter where her family and she were congregated through the use of

palpitations and chest pains, and ANGER with her children who did not physically surround her as she wished them to during the fire. Her symptoms started when she felt that one of her children might want to leave home, and she again had to repress her anger with a child who threatened to leave her alone. One could say that this lady used the defences of REPRESSION and SOMATIZATION to avoid the effects of fear, guilt and anger.

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

Affects and Emotions - One can similarly say that the gamut of emotions was widely displayed. Especially in the acute phase extremes 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, e.g. lifting drums of water, which under normal circumstances they found impossible. Gross heroism and gross cowardice were seen. Each of these intense feelings and associated 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 observers of disasters only note the fight for survival, the euphoria and cohesiveness, and imply from their observations that disasters are good for one.

These early feelings become attenuated with the receding danger, and are replaced with restitutive type feelings like shame at the indignities and helplessness, regrets, anger and guilt, as noted 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 instrumental in providing shelter for the have-nots. Guilt was generally felt towards those whom one could protect ("should" protect) and was appeased through protection. ANGER on the other hand was felt to those who should have protected one or what was valuable to one; it was appeased by a sense of being protected. The lady in the shelter described felt guilt and anger according to whether she perceived herself as a failing protecting mother, or an unprotected, abandoned child.

Not saving a person or a pet, or even allowing one's charges like children to experience danger gave rise later to guilt as one went over the event. This guilt was often at the core of blocks to grieving. There was a HIERARCHY OF PROTECTIVENESS maintained by GUILT and ANGER, as mentioned. Parents protected children, who protected pets and teddy bears.

GRIEF AT LOSS seemed to come late and was heavily defended against. It seemed to many that crying would weaken them in their endeavours to rebuild, that it was "useless to get emotional". Perhaps human vulnerability is difficult to acknowledge. Yet in suppressing grief, people seemed blocked from being fully human,

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

With time, COGNITIONS, DEFENCES and AFFECTS 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. Myths were present as to why Macedon would not burn, even after a minor bushfire two weeks before the major fire. As the actual fire burned, fighting it became more socially self-centred as it became more personally threatening. From community effort, the concern moved to saving one's family. This was paramount, except on occasions when members were inevitably separated, when individuals saved themselves above all other concerns. FLIGHT was attempted as a last resort, and because there was only one escape route there was panic, motor car accidents, and in this case selfishness was not uncommon.

Once survival was assured for the community, it exhibited high morale, COHESIVENESS and EMOTIONAL EXCLUSION OF OUTSIDERS, common reactions in communities under threat. Yet outsiders and their provisions were needed. They were accepted, but ambivalently. This was not only due to the crass and often insensitive giving by the bureaucracy, but also because the givers underscored the recipients' needs and destitution. Even the warmest giving which on one level was so much a threat, for seeing oneself destitute, pitied, or needy, brought one's losses home to one and melted the defences around one's grief. Rather than grieve, for many much anger for lack of adequate protection and care was placed and displaced on scapegoats, the bureaucracy and their offerings. Greed and envy for not getting enough or others getting more was noted.

Our own team was part of the helping community from outside. It was, sociologically speaking, an emergent team, i.e. spontaneously formed to deal with the crisis, as against a bureaucratic or statutory team. Our involvement dealt with sensitivity with recipients' ambivalence. We were one outside service which did 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 lived in by victims are cold. There are marital strains. There are fights in schools, promiscuity and delinquency unlike this time last year. Strains and rifts in the community have reappeared. But there is still some increased cohesiveness too. There is a long struggle ahead still.

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 or not. They express themselves more in drawing and 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 house was burnt 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.

CONCEPTUALIZATIONS

1. Biopsychosocial. It can help to 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. Stresses tend to sensitise to further stresses, merge, aggregate and find common threads, like with the man whose loss of home and garden was compounded by his lost family or 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 straight after the fire, hiring planes to take him all over Victoria, and a woman, a prior schizophrenic, became distressed because she believed that she caused the fires.

5. Imprinting. The disaster was imprinted 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 actions afterwards may be maladaptive.

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 reminiscent of solutions of a neurosis. Here the neurosis may be postulated to be acute, and treatment must be adapted to the situation.

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

INTERVENTIONS

1. Biopsychosocial. In each case all three areas of human functioning must be considered. One should know and recognize psychophysiological symptoms as cognitive, emotional and defensive reactions and one should also be able to advise about the latest rumours, 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 obsessional 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.