Disaster Mental Health

Kumar Ravi Priya
Indian Institute of Technology Kanpur, India

A disaster is said to occur when a hazard (an event or physical condition with potential to cause loss of life, property, or environment) is realized and the losses incurred exceed the ability of the society to cope using its own resources (Coppola, 2007). It is not just the disastrous event, but also its spiralling sociocultural and political consequences that can be traumatizing for the survivors (Abramowitz, 2005; Bracken, Giller, & Summerfield, 1995).

Disasters produce challenges for the mental health of survivors and posttraumatic stress disorder (PTSD) is a widely discussed psychiatric outcome of disaster. However, the World Health Organization (WHO, n.d.) posited, on the basis of the experiences of its trauma care professionals, that only 3–4% of survivors undergo severe psychiatric disorders and psychiatric intervention for the majority of a population and a specific focus on PTSD may not be justified. Furthermore, the cross-cultural validity of PTSD is under scrutiny and is doubted by some international experts; as one of them pointed out, “PTSD is a western notion of some validity when we have a ‘western’ notion of self and agency” (Weiss, Saraceno, Saxena, & van Ommeren, 2003, p. 612). What a sizable number of survivors undergo in the post-disaster context is sociomoral forms of distress or suffering for which community resources rather than psychiatric intervention is relevant (Bracken et al., 1995, Summerfield, 1999; Weiss et al., 2003).

It follows that scientific study of mental health outcomes of disasters constitutes a multidisciplinary domain where, besides a scientific understanding of and intervention for psychiatric disorders, attention also has to be given to sociomoral forms of distress or suffering and community resources for healing (Weiss et al., 2003). This is a multidisciplinary approach consisting not only of psychiatric intervention, but cultural psychological perspectives as well.

Psychiatric Perspective on Disaster Mental Health

For survivors of a disaster who either experienced or witnessed loss and responded to it with fear, helplessness, or horror, the symptoms of PTSD are constituted of: 1) re-experiencing or intrusive distressing recollections of the event (including recurrent distressing dreams of the event); 2) persistent avoidance of thoughts, activities, places or people associated with disaster and numbing of general responsiveness (that was absent before the disaster); 3) persistent symptoms of increased arousal (irritability, difficulty concentrating or falling or staying asleep) or hypervigilance (that was absent before the disaster) (American Psychiatric Association, 2000).

For a diagnosis of PTSD, these symptoms should have caused clinically significant distress or impairment in social or occupational areas of functioning for more than one month. It is also important to note that the disorder is premised on the twin processes of allostatic load and traumatic memory.

McEwen (1998) described allostasis as the condition in which the human body has excessive amounts of neurohormones called cortisols (released in the blood by adrenal glands to alert the organism in response to a stressful situation) due to the inability of the neurophysiological system to shut down the release of cortisols (as the stressful or traumatic situation prevails for a long period of time). The person faces pathophysiologic consequences of this allostatic overload in the form of the symptoms of PTSD. Wilson (2004, p. 19) called
traumatic memory the “hallmark feature of PTSD” because it is assumed to be memory traces of the disastrous event encoded in the brain that break through from the past into the present.

Foa, Keane, and Friedman (2000) provided a comprehensive review of the conceptual frameworks, guidelines for application, and effectiveness of different types of therapies, including cognitive-behavioral therapy, which has proven effective. Hudgins (2002) elaborated on the appropriateness of another type of therapy for PTSD – experiential therapy – that utilizes psychodrama and drawings to help survivors accept and transcend the trauma:

Remember that research on the neurobiology of trauma demonstrated that unprocessed trauma material is stored in the right brain as sensorimotor representations – fragmented images, smells, sensations, nonverbal behavior, and emotional nuances – without cognitive labels. Action methods directly access these places without words, so they can be experienced, expressed, and integrated into new personal narratives of healing. (Hudgins, 2002, p. 26).

As Foa et al. (2000) pointed out, it is the experience and sensitivity of clinicians that help them decide the nature and timing of one or a combination of these therapies.

Cultural Psychological Perspective on Disaster Mental Health

The universal use of and exclusive focus on PTSD has been critiqued for ignoring the cultural variation in survivors’ responses to disasters. Cultural values and resilience affect the appraisal of (and physiological reactions to) such events differently in diverse cultures and this may modulate the prevalence of PTSD (WHO, n.d.). Furthermore, as Summerfield (1999) and Young (1995) pointed out, traumatic memory is based on the Western construct of self that is “constituted through continuities of memory” (Breslau, 2004, p. 116).

The role of culture in affecting disaster mental health is premised on variations in the notions of selfhood in diverse cultures. Also, the post-disaster context in which survivors’ distress or suffering is understood also allows for understanding the impact of spiralling sociopolitical changes (frequently observed after a disaster) on the sufferer’s view of self. Bracken et al. (1995) illustrated how a sociocentric or relational construal of self may give rise to distress or suffering that is sociomoral in nature by citing the case of a woman survivor (in the government’s 1980s counter-insurgency operation in Uganda that accounted for the lives of hundreds of thousands of civilians):

A 28 year old woman who witnessed her husband being killed by the army was unable to bury his body as she was forced to flee the area immediately with her children, for fear that she herself, would be killed. When she was able to return 6 months later his body could not be traced. When she was seen by members of our team some 5 years later she was still haunted by nightmares and feelings of shame because she had not been able to bury her husband according to traditional rites. It was this aspect of her loss that she spoke most about when interviewed and which seemed to cause her most distress. (Bracken et al., 1995, p. 1077)

In another study among six Guinean communities attacked by Sierra Leonean and Liberian RUF forces in 2000–2001, Abramowitz (2005) reported that communities sharing the narratives of natives’ disregard of community rituals and social supports, and the dislocation of local moral worlds, reported higher rates of distress. Clearly, the physical and emotional symptoms of distress in this sociocentric culture were associated with survivors’ collective trauma and non-adherence to local moral values.

WHO (n.d.) also recommends the role of community resources in restoring the mental health of disaster survivors. Abramowitz (2005) reported that communities that were able to preserve among their survivors the culture’s values, support, and rituals showed less distress. This clearly suggests that community resources for mental health may facilitate people’s rebuilding of new enabling meaning and value for their experiences amid disaster.
SEE ALSO: Indigenous Healing Systems; Resilience

References

Abramowitz, S. A. (2005). The poor have become rich, and the rich have become poor: Collective trauma in the Guinean Languette. Social Science and Medicine, 61, 2106–2118.


