THE INVISIBLE FACE OF DISASTER

The psychological impact of disaster remains long after the physical reconstruction of an area is completed. The challenge for disaster assistance professionals lies in understanding the true nature of disaster-related psychiatric disorders, finding both immediate and long-term programs to help those who are suffering. BY ITZHAK LEVAV

Newspapers recount emotional stories about the devastating effects of disasters. Television does likewise, though more graphically, showing us horrible views of mutilated bodies, children clinging to their parents, adults searching for shelter, destroyed houses, debris-filled roadways and collapsed bridges.

What the mass media seldom report is the additional and long-lasting psychological toll disasters inevitably leave in their wake. This is a very real, very costly impact, and there are abundant scientific data to support its existence. It has the potential to disrupt the lives of otherwise healthy survivors and to further endanger those who are wounded or sick. It pervades disaster sites long after the physical reconstruction has been completed, and it may even lie dormant for a time only to emerge later in wholly unexpected and devastating ways.

The challenge for disaster assistance professionals lies in understanding the true nature of disaster-related psychiatric disorders and disability, separating them from the purely physical ramifications of assistance programs, and finding both immediate and long-term programs to help those who are suffering.

Let us reflect on the nature of traumatic events. Fundamentally, they embody intense fear, constitute a major threat to the integrity of life and body, and bring with them considerable losses, not only in terms of property but in people's personal sense of security and hopes for the future. This constellation of factors constitutes the framework within which disaster-linked reactions express themselves.

Although the nature of these reactions is mental and not physical, they can be measured and reliably diagnosed, just as physical damages are. Based on a study by the Pan American Health Organization/World Health Organization and the Ministry of Health in Tegucigalpa, Honduras following Hurricane Mitch, it is possible to estimate that between 400,000 and

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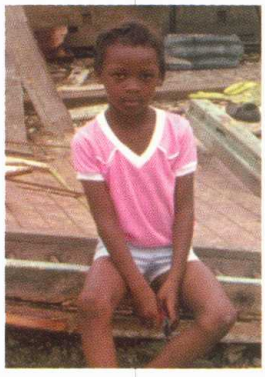
600,000 adults throughout the country were emotionally affected by the disaster. Post-Traumatic Stress Syndrome and Major Depressive Disorder are two of the most commonly identified reactions that afflict disaster victims. The Honduras study showed precisely those reactions in the aftermath of Hurricane Mitch. Adults living in neighborhoods that were hit heavily by the storm had higher levels of psychiatric disorders. For instance, women from areas that were not severely damaged suffered major depressive disorders at a rate of 14.6 percent, whereas those who lived in areas exposed to the most destruction suffered at a rate of 26.2 percent. The proportions for men were 9.8 percent in low-risk areas and 15.8 percent in areas that suffered most. The figures for Post-Traumatic Stress Syndrome followed similar patterns.

The study also showed a rise in the abuse of alcohol among the men of Tegucigalpa. It is well known that individuals may attempt to reduce their mental anguish by turning to alcohol, since it is the most universal and readily available method of self-medication.

The researchers also found that the distribution of post-traumatic disorders was far from random. There was a direct connection between the rates at which the disorders appeared and the status of the neighborhoods, a proxy for social class. Rates were highest among the residents in shelters, all of whom came from neighborhoods with lower status, where the residents had endured the greatest stress.

Honduras is a country with markedly adverse economic, social and health situations. When the hurricane struck, more than half of its population lived at or below the poverty line; following the disaster, statistics showed that an additional 17 percent of the inhabitants had plummeted into poverty. Thus, the effects of the disaster were compounded by the situation on the ground.



When poverty levels are combined with what is known about the distribution of psychological trauma, there is a clearer pattern for aid workers to follow when dealing with psychological damage control. In other words, efforts to extricate people from poverty would need to take their probable mental status into account. That mental status could well constitute a factor that could weigh down those attempts.

Fortunately, much can be done to alleviate the trauma that people experience as a result of disasters. Obviously, nothing can replace programs that assist people in reconstructing their communities and their nation. Housing, food and work are essential. But equally important is work on reorganizing communities, building support systems, fostering positive leadership and promoting a sense of solidarity. The appropriate psychological intervention and psychotropic medication for individuals, as well as counseling for groups, families and individuals, are all needed if mental health and quality of life are to be restored.

Mental health experts have many roles to play in disaster assistance, but one of the most important is to help fashion public policies. For instance, should children be separated from parents to provide them with safer conditions while the emergency lasts? Studies going back as far as World War II have shown that such a policy is wrong, despite the apparently humane motivation behind it. Should schools be closed? Mental health experts would recommend against it.

The experts can also assist decision-makers to cope with their own trauma. In one instance, a very perceptive mayor of a town in Nicaragua told me how affected she was by the whole thing yet, because of her duties, she felt that she could not leave her post. She longed to talk with someone who could understand her situation and offer help. Moreover, she wanted help for her excellent and committed technical team members, who had worked hard and efficiently during the emergency but who were now fighting with each other in the aftermath.

Helping people, whether they are in positions of authority or poverty-stricken victims, involves a wide range of outreach programs. Depending on their degree and complexity, they will undoubtedly increase the burden on service providers. What is clear is that there is no alternative but to make the effort. The psychological effects of trauma cannot be erased by simply turning away. National authorities and donors need to ensure that the psychological cries for help from those who are caught up in disasters are heard by informed ears.

When television cameras and newspaper reporters tell the story of destroyed buildings and gutted roads, there are very few arguments about the need to reconstruct the physical world and repair the structural damage. Less visible to the casual viewer—but arguably more important to the recovery of the afflicted nation—is the reconstruction of people. That is, after all, the overriding reason for any intervention.

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