



CHAPTER 5: PSYCHOLOGICAL ASPECTS

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Any form of mass burial always has a very negative psychosocial impact at the individual and community level since it is contrary to the very understandable desire that everyone has of giving a worthy farewell to our family members and friends. Another problem resulting from mass burial is that corpses are not identified which increases grief and uncertainty, and complicates the mourning process for the survivors.

INTRODUCTION

Even though the number of the dead and the missing caused by disasters (earthquakes, hurricanes, floods, volcanic eruptions, and events caused by humans) are tending to diminish, thanks to increasingly efficient warning systems and improved disaster preparedness for communities, there are still events that have a very high death toll.

The presence of a great number of dead bodies after a disaster creates uncertainty and fear in the population that can be exacerbated by incorrect information that the bodies present the threat of epidemics. There is also tension and a widespread feeling of grief; the reigning chaos and highly charged emotional climate can result in behaviors that are difficult to control. This type of situation requires appropriate psychosocial interventions for the individual and community.

But mass fatalities do not only result from natural or man-made disasters: they frequently occur in warfare. In the last few decades many countries of Latin America have undergone internal armed conflicts that have been characterized by massive human rights violations. Violence has been used as a means of social control by participating forces and there have been frequent, indiscriminate massacres of civilians, including of women, children, and the elderly. In addition, the majority of these massacres have been the product of processes that involved prior psychological manipulation.

The demands made by communities (or by authorities) for burials to be made in common graves occur almost always because of unfounded rumors and beliefs about the danger of epidemics or decomposition of corpses, or to provide a “rapid solution to problems to avoid more trauma.” However, the family as a social unit will never agree to burying its relatives in that manner or without respecting the prior, obligatory identification of a corpse. In addition, unnecessary haste in carrying out mass burials can result in later disputes and claims, as well as leaving psychosocial impressions that make the recovery process difficult.

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In cases of armed conflict, the recovery of historical memory has been part of the strategy to restore the social fabric. This involves exhuming and delivering the remains to families so that they can carry out their customary mourning rituals, thereby dignifying the victims.

The management and disposal of corpses is a problem with serious psychological implications for the family and the survivors, in addition to other political, socio-cultural, and health considerations. It also involves the issue of human rights, which cannot be overlooked.

SPECIFIC VULNERABILITIES

Vulnerability results from a dynamic process where various factors interact to determine whether or not psychiatric pathology or other emotional and human behavioral problems appear.

Massive fatalities and major material losses in the context of a disaster present a condition of high psychosocial risk. Those providing mental health care should recognize differences in vulnerability, especially as it relates to gender and age, as well as risk to the emergency response team members.

Mass fatalities can have different effects on male and female populations. There is evidence that while the mental health of men is affected more immediately, women suffer for a longer time, and psychological disorders manifest themselves later.

Social and cultural patterns influence the differences in how men and women react: men tend to repress painful emotions, have a difficult time talking about feelings, and when they do, they interpret it as weakness; women tend to communicate more easily, to express their fears, and to seek support and understanding for themselves and their children.

Women are more frequently confined by domestic responsibilities and it is more difficult for them to be integrated into their communities. They can be overcome by feelings of solitude and isolation, and sometimes they have to assume the role of head of household due to the death or disappearance of their husbands or older children. This can lead in the medium- or long-term to depression; moreover, access to health services is often more difficult for them.

In some cultures the elderly are a source of experience and wisdom and have the historical memory of how populations, over time, have confronted critical situations. However, there are also aspects of exclusion: some are isolated, lack support networks, are perceived as a burden, and are not taken into account as active and productive factors in a community. Another psychosocial risk factor exists in that frequently the elderly have suffered losses before, and at this stage of life have more evident health problems and disabilities.

Another vulnerable group includes the children who, following a traumatic event, have less understanding of what has happened and are limited in their ability to com-

municate their feelings. Some children completely deny or show indifference when they learn that they have lost one or more of their family members; the emotional impact is so intense that frequently they do not speak about what they have experienced. Some think that the child has forgotten, but this is not the case; he or she is able to recall and talk about the traumatic experiences they have undergone once their feelings of fear are under control.

The post-traumatic reactions in children should be attended to rapidly. Assuming that children “do not feel” or “do not understand” is a serious error that leaves them exposed to suffering and fear.

GRIEF

It is to be expected that after the death of one or more loved ones, that sadness, suffering, and grief will arise. The grieving period is when a person assimilates what has happened, understands it, overcomes it, and rebuilds his or her life. This is a normal process that should not be hurried or discouraged; nor should it be regarded as an illness.

In our culture, we feel the need to remember our loved ones and to commemorate their life and death as a way of expressing that they “will not be forgotten,” while dealing with one’s own feelings of sadness. The grave, a headstone, a photograph, or flowers in the home are common ways of expressing this. Performing rituals established by one’s culture and community forms an important part of the recovery process for the survivors.

Grief is experienced with a mixture of sadness, anxiety, fear, and anger; in the most critical moments there are extremes of very intense emotional pain and despair. Afterwards, progressive relief comes and concludes with expressions of renewed confidence and hope.

The grieving process implies:

- ◆ Freeing oneself from, or leaving behind the relationship with the deceased person;
- ◆ Adapting to the world under different conditions; and
- ◆ Making the effort to establish new relationships.

The way that loss is confronted and grief is endured is closely linked to the following factors:

- ◆ The personality of the survivor and the strength of his or her defense mechanisms;
- ◆ The relationship with the deceased;
- ◆ The circumstances in which the event occurred; and
- ◆ The social support network (family, friends, and community).

In situations of mass fatalities, several authors have described the survivors' fears and feelings:¹

- ◆ Grief and distress because of the loss of family members and friends which, sometimes, coincides with material losses. There also are more subtle and sometimes intangible losses, such as loss of faith in God, loss of meaning in life, etc.;
- ◆ Practical fears: having to assume new roles that are imposed after the disappearance of a family member (for example, the widowed wife who becomes the head of the household, or the widowed father who must take charge of the children);
- ◆ Recurrent fears that something can occur again or that death will befall other members of the family or community;
- ◆ Personal fear of dying: fear of the unknown or fear of facing God;
- ◆ Feelings of solitude and abandonment: it is common for survivors to feel that family members and friends have abandoned them at a difficult time;
- ◆ Fear of forgetting or being forgotten;
- ◆ Anger toward the deceased which is taken out on family members or close friends;
- ◆ Some measure of guilt for someone's death; sometimes, what takes place after the death of a loved one increases this guilt;
- ◆ Shame following the death of a loved one because of circumstances that surrounded the death of that person (your behavior, humiliation, etc.); or shame about the conditions in which a family is left following the disaster.

The most frequent psychological manifestations associated with grief are:²

- ◆ Very vivid and repetitive reminders of the deceased and of what happened;
- ◆ Nervousness or fear, sadness and weeping;
- ◆ Desire to die;
- ◆ Problems sleeping and poor appetite;
- ◆ Problems with memory and difficulty concentrating;
- ◆ Fatigue, lack of motivation, and difficulties returning to normal level of activity;
- ◆ Tendency toward isolation and solitude;
- ◆ Combination of feelings or emotions such as: self reproach, blaming others, frustration, impotence, anger, feeling overwhelmed, etc.;
- ◆ Neglect of appearance and personal hygiene;

1 James JW, Friedman R, *The Grief Recovery Handbook* (New York: Harper Perennial, 1998); Matsakis A. *Survivor Guilt: A Self-Help Guide* (Oakland: New Harbinger Publications, 1999); Prewitt J, *Ayuda psicosocial en desastres: un modelo para Guatemala* (Guatemala: American Red Cross, 2002); Rodríguez J, *Principios generales para la atención psicosocial en situaciones de desastres* (paper presented at the Congreso Latinoamericano de Psiquiatría—APAL; Guatemala, June 2002).

2 Organización Panamericana de la Salud, *Protección de la salud mental en situaciones de desastres y emergencias* (Washington, D.C.: OPS/OMS, 2002); Rodríguez J, *Psicoterapia: una relación de ayuda* (Guatemala: Empretec, 1999).

- ◆ Physical manifestations such as dizziness, nausea, headache, chest pain, tremors, difficulty breathing, palpitations, dry mouth, and high blood pressure.

THE PROCESS OF UNRESOLVED GRIEF

In all societies there are rituals, norms, and forms of expressing grief that are derived from different conceptions about life and death. In Latin American culture certain rituals have evolved, such as vigil over the corpse for 24 hours, burial, friends accompanying the family, performing religious ceremonies after the burial, and observing anniversaries of the death.

When there are massive fatalities, missing persons, and unidentified corpses, this process is changed and the different facets of grieving cannot be observed. In many cases, the corpse is not recovered, producing a feeling of emptiness, of “frustrated or unresolved grief.”

In catastrophic disaster conditions and in war, grieving entails the need to face many losses and it takes on a broader meaning that applies to the community as well. It implies the rupture of a life’s plan, not only in the family dimension, but in social, economic, and political dimensions as well. It is possible, then, to identify not only the individually experienced grief of people in the family setting, but there is also “collective grief” that implies an emotional atmosphere of suffering and anger that affects the community dynamic. Fears and feelings merge, communication channels are blocked, and the behaviors of the group change. Subsequently, it is necessary to work on the historical memory of the affected group.

When violence is the main cause of a death, it is more difficult to confront the pain and to proceed with normal mourning; the suffering increases and traumatic reminders persist. When massacres have been carried out in public, the impact of the death of loved ones is compounded by having been witness to atrocities. Survivors experience the senselessness of death and a profound sense of injustice, and feel conflicting emotions and reproach for “not having done anything.”

Forced disappearances are an inhumane method frequently used by the forces participating in armed conflicts in our region. In many natural disasters and man-made accidents, disappearances also occur. Although the family is certain that the missing person has died, living with that loss is much more difficult. Ambiguity of thoughts and emotions arise and there is additional concern about how the death occurred and what happened to the corpse.

The circumstances that make the grieving process the most difficult to face include:³

- ◆ Disappearances;
- ◆ Inability to recognize corpses;

3 Oficina de Derechos Humanos del Arzobispado (Human Rights Office of the Archdiocese—ODHA), *Guatemala: nunca más*, Report of the Recovery of Historical Memory (REMHI) project (Guatemala: ODHA; 1998); Rodríguez J, Ruiz P, *Recuperando la esperanza* (Guatemala: OPS/OMS, 2001).

- ◆ Collective burials;
- ◆ Massacres; and
- ◆ Situations, in which family members know of the death and are able to carry out a burial, but have many feelings of anger due to the brutality and injustice of the death.

Unresolved grief leads, frequently, to the appearance of psychiatric disorders that require more specialized interventions, as shown in the following cases from Guatemala, Colombia and Peru.

Selection of testimonies compiled in the document *Guatemala: Nunca Más*.⁴

“We saw how they killed the people: the young people; women who were still young girls. So many people were sad: the women for their spouses; people who were poor who could no longer find anything to do for their children. Hence, we are still sad.” Case 2230 (massacre) Jolomhuitz, Huehuetenango, 1981.

“Those who died there, rotted there; no one picked them up, no one buried them because they said that if one of us picks them up or goes to see them, they will kill us in the same place. It was one of them who buried them. I still do not know how they ended up, if some animal or dog ate them; I don’t know...My heart always aches and I think about the violence they endured.” Case 2198, San Pedro Carchá, Alta Verapaz.

“The civilian dead, friends, and enemies, will be buried by military personnel as quickly as possible to avoid the subversive elements using them in their work of agitation and propaganda.” (Counterinsurgency Manual of the Guatemalan Army, page 208.)

“One year we were very sad. We no longer weeded our corn and it died on the mountain. It was hard to get through the year, our heart was no longer happy...It was hard to get back our spirit. Everyone was very sad, our relatives were very sad. One girl was saved; now she is a grown woman and when she remembers, she cries.” Case 553 (massacre), Chiquisis, Alta Verapaz, 1982.

“They were piled in the courtyard of the house; after five or six days the army ordered us to bury the dead. We went and we buried them; but they didn’t go to the cemetery, we just buried them in a place. We found a pit in a ravine where we piled them up and started a fire. It made us sick to do this; we no longer wanted to eat. I saw one who had his chest open; his heart, his lung, everything was outside; another one’s head was twisted backward and his face was in the sun. After two or three months they were removed by their families; they took them to the cemetery but it was not good. They were only liquid and bone; they were just piled in the boxes. They put together about five boxes and we took them to the cemetery, but we got sick. I saw that myself in those times.” Case 1368, Tierra Caliente, Quiché, 1981.

“...in every pit they put thirty, forty people. We couldn’t fit more or we would have to cut them at the knees so that they would fit in the bottom of the pit... and we threw gasoline on them and that flame rose two, three arm

lengths in height. Moans were heard inside the fire; they cried and shouted.” Case 1741 (victimizer), Izabal, 1980-83.

The disaster of Armero (Colombia), 1985⁵

The town of Armero, in the Colombian Andes, was destroyed on 13 November 1985 by a volcanic eruption that caused an avalanche of ash, boiling mud, rocks, and trees. The landslide was almost 2 km wide and reached speeds of 90 km/h. It killed 80 percent of the 30,000 inhabitants of Armero, and left almost 100,000 inhabitants homeless in the surrounding region.

It was impossible to recover the corpses of the dead since the vast majority were dragged a great distance and buried under tons of sand and rubble. This situation prevented traditional ceremonies from being carried out, and many months after the disaster, family members were excited by rumors that the dead had been seen nearby or in far-off places, or wandering like a lost madman. Each of these false reports revived new hopes that were always followed by new disappointments. Two years after the tragedy corpses were found that were able to be identified; this motivated the families to seek the remains of their relatives in order to carry out conventional religious and cultural rites.

In the places where the houses stood, and which could more easily be identified later than in the immediate months after the disaster, headstones were placed with the names of the dead, and relatives now place flowers and say prayers there. They have become symbolic graves where families can conduct memorial activities, albeit belatedly.

A devastating fire in Lima, Peru ⁶

On the night of 29 December 2001 at about 7:15 pm, a major fire broke out in the “Mesa Redonda” shopping district in Lima’s historic downtown, killing approximately 270 people. The fire was caused by improper storage and handling of fireworks.

Many of the bodies were charred which meant that visual recognition by family members was very difficult. Twenty seven psychologists from the Peruvian Society of Emergency and Disaster Psychology, 87 volunteer psychologists, and 60 volunteers from various professions participated in crisis intervention and accompanied family members.

First response was made by the fire department, which worked for more than 14 hours to control the fire; they were affected by the enormous number of people who were calling for help. Squadrons from the municipal civil defense responded, but for the most part young, inexperienced volunteers were providing assistance. Many members of the relief teams were impacted emotionally by the huge number of corpses they had to see and handle, among whom were children clinging to their mothers in a futile attempt at protection.

On the first day of work (31 December) at the central morgue, they still were not sure how to conduct the visual recognition of the remains and expect-

5 Desjarlais R. et al., *World Mental Health: Problems and Priorities in Low-income Countries* (New York: Oxford University Press, 1995); Programa de Cooperación Internacional en Salud Mental “Simón Bolívar”, *Desastres, consecuencias psicosociales. La experiencia latinoamericana* (Serie de Monografías Clínicas No. 2. Illinois (U.S.): Centro de la Familia Hispánica; 1989).

6 Valero S., *El afronte de la muerte* (Lima, 2002; unpublished).

ed a slow process since each of the bodies was to undergo autopsy. This resulted in confusion for family members who waited in line for hours to see the bodies. As bodies continued to arrive, they were piled in a courtyard next to the autopsy room, and people had to return to stand in line time and again. The system using photographs of the victims was not very helpful since the faces were disfigured.

Under these very frustrating circumstances rumors began to circulate among family members. It was said that they were removing body organs to sell, that bodies were being hidden so they could be used by medicine students, and that they were going to burn the remains, which would make later DNA identification impossible. All of the rumors and frustration caused many people to become verbally abusive and to make indiscriminate threats and protests.

Another difficulty was that once a body had been visually identified, families had to wait many hours for bureaucratic transactions to be completed before they were allowed to take the body.

Psychosocial intervention in the morgue was divided into two major groups. Outside of the morgue, psychologists approached groups of 6 to 8 people at a time to give them accurate and up-to-date information. At the same time, they coordinated with the Archdiocese of Lima so that Catholic priests would be present.

Groups of 20 (up to three family members per missing person) were allowed inside the morgue, where they were given instructions, were told about the condition of the bodies, and given directions about where to go. A psychologist or volunteer was assigned to accompany them. On the second day, and under increasing pressure, they allowed entry into the area of the morgue where there were unrecognizable bodies. People were able to positively identify some of these bodies. Inside the morgue a medical station was set up where, when necessary, family members were approached by the crisis intervention team.

A tent was set up by an office of the Ministerial Council of the President, which was responsible for offering funeral services free of charge.

Bodies that could not be identified were sent to a pavilion in the El Angel Cemetery of Lima. This relieved the fears of many family members who thought the remains would be incinerated or placed in a common grave. This action made it possible for many families to grieve more effectively, with the consolation of having a place where they could put a bouquet of flowers or say a prayer.

PSYCHIATRIC DISORDERS AMONG SURVIVORS

In light of a very significant and shocking emotional situation—the death of loved ones—certain feelings and reactions are common; grief usually implies a high level of anguish and unhappiness in people. Moreover, the recollection of what has happened always will be part of the life of the victims and will never be erased from their

memory. But it has been demonstrated that only some subjects experience more serious or lasting problems that could be described as psychopathology.

Some psychological manifestations are the understandable response to traumatic experiences, but they can also be indicators that one is presenting a pathological condition (particularly in conditions of unresolved grief). Psychological assessment should be made in the context of the events, determining whether they can be interpreted as “normal or expected” responses or, on the contrary, identified as psychopathologic manifestations that require a professional approach.

Some criteria for determining whether an emotional expression is becoming symptomatic are:

- ◆ Prolongation;
- ◆ Intense suffering;
- ◆ Associated complications (for example, suicidal behavior); and
- ◆ Significant affects on the social and routine functioning of the individual.

The most common immediate psychological disorders in survivors are episodes of depression and acute, transitory stress reactions. The risk that these disorders will appear increases in accordance with the nature of the loss and other vulnerability factors. Following disasters, increased violent behavior has been observed, as well as excessive alcohol consumption.

Among the delayed effects there are reports of pathological grief expressed as depression, adaptation disorders, manifestations of post-traumatic stress, abuse of alcohol or other substances, and psychosomatic disorders. In wars and long-lasting conflicts, the patterns of suffering are manifested as sadness, generalized fear, and physical expressions of anxiety; such symptoms frequently become serious and long-lasting.

Complicated grief can lead to a depressive disorder⁷ that is characterized by extreme sadness, loss of interest and enjoyment in things, reduced levels of activity, and exaggerated fatigue. Other symptoms include reduced attention span and concentration, loss of self-confidence, feelings of inferiority, guilt feelings, negative prospects about the future, suicidal thoughts or acts, sleep disorders, and loss of appetite.

Adaptation disorders are characterized by a state of personal discomfort, emotional disorders that affect one’s social life, and difficulty in adjusting to the fundamental changes that the loss represents.

Post-traumatic stress is a delayed or deferred type of disorder that appears as a consequence of exceptionally threatening or catastrophic events; it starts after the trauma with a latent period that lasts from a few weeks for up to six months. Often, only a few of the following post-traumatic stress symptoms are exhibited:⁸

7 *Clasificación Internacional de las Enfermedades (CIE-10). Trastornos mentales y del comportamiento. Descripciones clínicas y pautas para el diagnóstico*. 10th revision. [ICD-10, *International Classification of Diseases*; World Health Organization (Madrid: Mediator, 1992)].

8 Organización Panamericana de la Salud, *op cit.*; Rodríguez J. (2002), *op cit.*; ICD-10, *op cit.*

- ◆ *Re-experiencing the trauma*: recurrent and intrusive memories, nightmares, and flashbacks;
- ◆ *Avoidance of stimuli associated with the trauma*: efforts to avoid conversations, situations, places, or people that remind the person of the event;
- ◆ *Dissociation*: sensations of numbing or unreality, dazed as if in a dream; inability to remember important aspects of the trauma;
- ◆ *Decreased ability to respond to the outside world*: inability to feel emotions, feeling of detachment from others;
- ◆ *Increased activity*: hypervigilance, irritability, or attacks of anger;
- ◆ *Significant anxiety*: occasionally extreme outbursts of fear or panic;
- ◆ *Depression*: frequent suicidal ideation;
- ◆ *Insomnia*;
- ◆ *Vegetative symptoms*;
- ◆ *Alcohol or drug consumption can be an aggravating factor*.

There have also been reports of an increase in the number of suicides in periods after massive fatalities as a consequence of natural disasters or war crimes (for example, in Guatemala and Armero, Colombia).⁹

Suicidal behavior

Reports suggest that in recent years there has been a significant increase in the number of suicides in areas where massacres took place. Although there are no exact studies, and other factors can be an influence, an analysis of death records from the city of Rabinal (Guatemala) showed an evident increase of death by suicide which had been very rare in most indigenous cultures prior to the 1980s.¹⁰

Among the most significant delayed effects noted as a result of the Armero disaster (Colombia) was the high number of suicides occurring among survivors in the first year after the tragedy. It is possible that the figures were even higher than reported, since suicide tends to be concealed or disguised as accidental death [H. Santacruz and J. Lozano cited in “Desastres, consecuencias psicosociales.”]¹¹

Effects of Hurricane Mitch on mental health of the Honduran adult population¹²

Hurricane Mitch ravaged Central America beginning on 25 October 1998. Honduras suffered the worst effects of this natural disaster.

9 Oficina de Derechos Humanos del Arzobispado, Guatemala, *op cit.*; Programa de Cooperación Internacional en Salud Mental “Simón Bolívar”. *Desastres, consecuencias psicosociales. La experiencia latinoamericana* (Serie de Monografías Clínicas No. 2, Illinois: Centro de la Familia Hispánica; 1989).

10 Oficina de Derechos Humanos del Arzobispado, Guatemala, *op cit.*

11 Rodríguez J. (2002), *op cit.*

12 Rodríguez J, Bergonzoli G, Levav I. “Violencia política y salud mental en Guatemala” (*Acta Psiquiátrica y Psicológica de América Latina* 2002;48:43-4).

The Pan American Health Organization (PAHO/WHO) and the Honduran government estimated that more than 1.5 million people were affected, 5,657 died, another 8,058 were missing, and 12,272 were injured. Some 285,000 were made homeless and had to seek housing in one of the 1,375 temporary shelters established. However, there has been little information about the effects of the disaster on the mental health of the population.

The impact of a disaster on mental health is the result of several factors that need to be considered, such as the death and disappearance of family members, neighbors, and friends. Research has demonstrated that disaster can give rise to grief, post-traumatic stress, and other psychiatric disorders, a combination of these reactions, or no problems. Other disorders, such as violent behavior, may present as well. This can evolve toward chronic disorders or to resolution of the acute reaction. Change in conditions, biological and psychological predisposition, occupation and socio-demographic factors, cultural elements, the quality of relationship with the deceased, the nature of the intervention, confirmation of death versus presumed death, and social support causes results to vary.

The mental health of the Honduran population will require continuous surveillance in order to determine the long-term impacts of Hurricane Mitch. Recovery can be prevented by secondary stress factors, including exposure to violence. Individuals subject to secondary stress can be more vulnerable and have higher indices of post-traumatic stress, greater depression, disability, and psychological discomfort. It is necessary to identify the individuals at risk and factors that can mediate that risk, so that services and appropriate interventions can be implemented.

NOTIFICATION OF DISAPPEARANCE OR DEATH, AND VISUAL RECOGNITION OF CORPSES

Notification of death can take place in the home, in a health center, in a morgue, or in another setting. It is a critical moment and is difficult to handle since it can result in strong reactions. Following are some recommendations for providing notification:

- ◆ Compile as much information as possible about the deceased and the event before making the notification;
- ◆ Obtain information about the people who are going to be notified;
- ◆ Make sure that the most appropriate adult family member is the first to receive the news;
- ◆ Make the notification in a direct and personal manner. Where possible, two people should make the notification;
- ◆ Observe common rules of courtesy and respect;
- ◆ Do not take personal objects of the deceased to the interview;

- ◆ Invite family members to be seated. The people making the notification should do the same;
- ◆ Observe the surroundings carefully in order to prevent any hazards, and be prepared to attend to children or others;
- ◆ The message should be direct and simple. Most people will realize from the setting that something terrible has happened, and their agony or anxiety should not be prolonged. Those receiving the news should not be left with any doubt or be given false hopes about the situation;
- ◆ Be prepared to present evidence and answer questions;
- ◆ Help the family members to notify others, if the family so requests;
- ◆ Listen and serve the immediate needs of the family members, as well as reminding them of their rights.

Notification of death should always be done individually (case by case). Giving information of this nature to a group should be avoided. Where necessary, several teams or pairs should divide up the work.

If the person is missing, it should be reported as such. This initiates a process of anticipatory grief, but also helps if those missing are subsequently confirmed to be dead.

It is important to explain the circumstances surrounding a case when it is likely that the death or whereabouts of the missing person cannot be confirmed in the short term (or, perhaps, never).

If there are doubts about the identity of corpses, the type of investigations that will be conducted should be explained. To avoid conjecture, it should be made clear that no reliable information can be provided until the investigation has concluded.

An important problem to deal with in cases of mass fatalities is visual recognition of the corpses. Various participants are involved in this very complex process, including: family members, authorities, morgue workers, medical and psychological assistance teams, as well as the mass media.

The people (at times, adolescents) who are forced to face the difficult task of identifying dead bodies are exposed to a very traumatic situation. Family members who are going to identify the remains of their loved ones can manifest this trauma through expressions of despair, frustration, and, occasionally, protest or disagreement with the procedures being used, etc. This can escalate if the bodies are decomposing or are mutilated or burned, as occurs in fires or aviation accidents.

If bodies are not located or cannot be recognized, it should be expected that a variety of rumors will spread. These should be countered by timely and accurate information. Family members should be allowed to view all the bodies, regardless of their condition, since the relatives will do everything possible to identify their loved ones. If this is not allowed, protest and even violence might result.

Medical and mental health services should be as close as possible to the place where body identification is carried out to provide physical and emotional assistance to family members.

Usually, family members ask to see the body as soon as possible, or they might be requested to view the body in order to identify it. Following are recommendations about treatment of the family in this type of situation:

- ◆ The relatives should decide among themselves who will see the corpse;
- ◆ Do not allow family members to enter the viewing area unaccompanied. It is preferable for skilled personnel to escort them and provide some emotional support;
- ◆ Offer privacy and respect so that the family can say goodbye, including allowing them to touch the body;
- ◆ Respect any type of reaction that the family members might have at that moment;
- ◆ If the body is altered or mutilated, the family should receive a clear explanation about its condition before viewing the body;
- ◆ If photographs are used, describe them before showing them to relatives. The photograph system can be effective in situations with a limited number of corpses, but when there are numerous bodies it can cause confusion, or create a situation in which two or three families believe that they recognize the same body;
- ◆ It is almost always necessary to transport family members to the location of the corpse, and to ensure their return after viewing the body;
- ◆ Provide comfortable conditions and guarantee compassionate treatment at the site where the bodies are viewed.

PSYCHOSOCIAL CARE FOR SURVIVORS

Frequently we are confronted with a very discouraging scene, with numerous human and material losses in a situation of insecurity and anguish. The relatives of the missing are tormented by uncertainty about what actually took place. When victims have been buried in common graves or cremated without being duly identified, a situation of prolonged pain and uncertainty is created among the family members.

From the outset, it is necessary to use crisis intervention techniques for the survivors. Following are some recommended actions:¹³

- ◆ Treat them as active survivors and not as passive victims;
- ◆ Assist them and show concern about their physical safety and the health;
- ◆ Ensure that they have shelter, food, clothing, and a place to sleep;
- ◆ Provide emotional support and a sense of connection to other people;
- ◆ Ensure private and confidential communications;
- ◆ Encourage them to “vent” or tell their story and express their feelings;
- ◆ The person providing psychological assistance should be able to listen responsibly, carefully, and patiently. Members of the response teams should

13 Organización Panamericana de la Salud, *op cit.*; Rodríguez J. *Psicoterapia: una relación de ayuda* (Guatemala: Empretec; 1999).

explore their own conceptions and concerns about death and should not impose their views on the people they are helping;

- ◆ Do not use a medical manner when providing assistance, and do not necessarily treat the victims as patients;
- ◆ Rather than giving advice, allow survivors to reflect on what has happened and how to face the future. Advice given should refer, instead, to practical issues and available channels of assistance;
- ◆ Provide as much information as possible, and listen to doubts and problems to help find solutions;
- ◆ Encourage survivors to return to their daily routines as soon as possible;
- ◆ Prevent the interference of the media or other groups;
- ◆ Spiritual or religious support is usually a valuable way to calm family members.

An important element in handling grief is to expedite mortuary transactions and to obtain free or affordable funerals for low-income people. The delay in delivery of the corpses and uncertainty about how payment can be made for funeral services increases anguish and suffering for the families of victims. Frequently the authorities do not place importance on the issue of funeral services, especially in the midst of the chaos created by a disaster. However, funerals do have great significance for families, and the inability to have access to these services can be the motive for protests and collective unrest.

The criteria for referral to a specialist (psychologist or medical psychiatrist) are limited and specific, including:

- ◆ Persistent or aggravated symptoms that have not been relieved using initial measures;
- ◆ Major difficulties in family, work, or social life;
- ◆ Risk of complications, especially suicide;
- ◆ Coexistent problems such as alcoholism or other addictions;
- ◆ Major depression, psychosis, and post-traumatic stress disorder which are serious psychiatric conditions that require specialized care.

The use of medications should be restricted to the strictly necessary and only prescribed by physicians. Indiscriminate or prolonged use of psychotherapeutic medications is not recommended. Some, such as tranquilizers, have important side effects and can be addictive.

The vast majority of cases can and should be treated on an outpatient basis, in one's family and community environment. Hospitalization usually is not necessary. Routine, daily life is where psychosocial recovery of people after traumatic events takes place.

Recommendations for assisting children who have survived a traumatic event include:

- ◆ Use a strategy of flexible, rather than professionalized, psychosocial recovery;

- ◆ Regard the school, the community, and the family as fundamental therapeutic spaces. Teachers, community members, women's groups, and youth groups can be facilitators in work with minors;
- ◆ Strengthen the training, care, and motivation of personnel who work with children;
- ◆ Techniques using group recreation are essential tools for the psychosocial recovery of children. They should be combined with recreation and sport;
- ◆ Encourage a return to normal life, including school, as soon as possible;
- ◆ Take advantage of widely accepted traditions with regard to the care and treatment of affected minors.

PSYCHOSOCIAL CARE FOR FIRST RESPONSE TEAMS

An especially vulnerable group includes members of the first emergency response teams who are responsible for handling corpses or human remains; many are young volunteers or military personnel. Also vulnerable are those responsible for conducting autopsies; they feel overwhelmed and over-extended with the work load when mass fatality situations occur. In general, the wide range of workers who in one way or another intervene in this kind of situation should not be forgotten.

Not all professionals and volunteers are suitable for these tasks; their suitability depends on a variety of factors such as age, personality, previous experience, beliefs about death, etc. They should be well informed about the tasks they will be asked to do. We should avoid having persons under age 21 participate in handling dead bodies.

There are certain factors that increase the probability that an emergency response worker will suffer psychological disorders:

- ◆ The conditions in which the corpses are found (advanced stage of decomposition, mutilated, charred, etc.) or when only fragments of bodies can be recovered;
- ◆ Prolonged exposure to very traumatic experiences;
- ◆ Ethical conflicts;
- ◆ Simultaneous exposure to other traumas or recent stressful situations;
- ◆ Unfavorable living conditions;
- ◆ A lenient selection process for professional staff.

It is likely that the members of the emergency response teams will experience some difficulties when returning to their daily lives after the emergency tasks are completed. These problems should not necessarily be regarded as symptomatic of illness, and require, above all, family and social companionship and support.

The concept of universal vulnerability¹⁴ holds that there is no type of training or prior preparation for a person working with seriously injured and dead victims that can completely eliminate the possibility that he or she will be affected by post-traumatic stress or other psychological disorders. If major symptoms of psychopathology do appear, the cases should be referred for specialized treatment.

Following are some general recommendations for the care of members of emergency response teams:

- ◆ Consider the characteristics and the specific behavior patterns of the team. Generally, they feel satisfied about what they have accomplished and develop an altruistic spirit;
- ◆ Keeping the team active is positive: it relieves stress and strengthens self-esteem;
- ◆ Promote work rotation and fixed working hours. Team members who handle dead bodies for a certain period of time should be reassigned to other, less difficult tasks;
- ◆ Encourage team members to take care of themselves physically and to rest periodically;
- ◆ Listen conscientiously;
- ◆ Guarantee confidentiality and the ethical handling of personal situations and those of the organization;
- ◆ Redefine the crisis as a potential for growth;
- ◆ Enlist the family's help in sensitizing processes;
- ◆ Reduce stress-causing factors and assess underlying emotional conditions prior to and during the emergency;
- ◆ Create opportunities and space for reflection, catharsis, and integration of the experience. Recognize that someone's anger is not personal, but an expression of frustration, guilt, or worry;
- ◆ Encourage the team to express mutual support, solidarity, recognition, and esteem;
- ◆ When possible, the team involved in the handling and identification of the corpses should attend group counseling sessions at the end of the working day, and a week after the completion of operations.

Recommendations for personnel who have worked in the handling of corpses, after they return to normalcy and reintegrate into daily life are:

- ◆ Return to your routine as soon as possible;
- ◆ Do physical exercises and relaxation exercises;
- ◆ Seek contact with nature;
- ◆ Get enough rest and sleep;
- ◆ Eat balanced and regular meals;

14 Organización Panamericana de la Salud, *op cit.*

- ◆ Do not try to lessen the suffering by using alcohol or drugs;
- ◆ Seek company and speak with other people;
- ◆ Participate in family and social activities;
- ◆ Observe and analyze your own feelings and thoughts;
- ◆ Reflect on what you have experienced and its meaning in life.

THE IMPORTANCE OF TRUTHFUL, APPROPRIATE, AND TIMELY INFORMATION

The availability of information that is truthful, transparent, appropriate, and timely is vital for the emotional restraint of family members and the general population. This should be provided at various levels:

- ◆ Provided directly to an individual;
- ◆ Provided directly to a group and the community; and
- ◆ Provided through the communications media.

The authorities and community leaders should be prepared to provide information directly either to individual or groups, as well as to respond to questions and be ready to find answers to these questions.

The communications media have a dual nature: on one hand they are profit-driven enterprises, and on the other, they have an enormous social responsibility for the public service they provide. Information on disasters and large numbers of fatalities is often exploited as newsworthy, emphasizing the unknown and extraordinary and even manipulating certain morbid interests of the public. However, ethical and sensitive reporting about these events should be insisted on, with the objective of providing truthful, responsible, and useful information.

There are mass fatality situations in which the family members first learn about what has happened through the media. In these cases it can be expected that there will be large masses of people struggling to obtain information or to be taken as soon as possible to the site of the events.

A frequent problem is the number of people who go to morgues, hospitals, or other places in search of relatives, where admission is limited to individuals or small groups. This creates problems of congestion and disorganization. Solutions for this kind of situation should be found that are adequate, humane, and respectful to these people.

When, for various reasons, public safety personnel are not available, the work of considerable numbers of health care or relief workers must be dedicated to crowd control. In most cases the crowds are not aggressive, but because of their sheer numbers it is necessary to organize them into groups so that they can be given necessary information. It is essential to inform the public that the risk of epidemic outbreaks from dead bodies is minimal. This risk is nonexistent when bodies are buried by landslides or collapsed buildings.

For these communication tasks it is important to seek the timely support of neighbors and community organizations that have, in addition to human talent, extensive knowledge about the population and its customs.

ROLE OF THE AUTHORITIES

The role of governmental authorities, as well as of community leaders and non-governmental organizations, is very important. It is the responsibility of the health sector to advise authorities about technical and human aspects related to managing massive fatalities (social, legal, human rights, health, and psychological concerns). They can perform an important function in informing as well as monitoring the response the most affected people.

The decisions made by the authorities define, in many cases, the behavior to be followed in management of mass fatalities and in addressing the population that is living in a very complex emotional atmosphere. Hurried and inappropriate decisions can cause major and lasting damage, as well as complicating later processes of psychosocial care and rehabilitation of the population.

Regardless of the power of the authorities responsible for managing the emergency and of the epidemiological justifications used to hasten the disposal of the human remains, measures should be adopted that respect and consider the customs of the population, avoiding situations such as mass burial in common graves or mass cremations. Such measures usually are prohibited by law and violate the provisions of fundamental human rights.

It is advisable for authorities and public institutions to have spokespersons who are specifically responsible for managing information, and who can support the emotional restraint of the population. It is advisable to have regularly scheduled briefings, and to make use of official bulletins, avoiding any ambiguity in content.

CONCLUSIONS

Coping with an emergency in which there are a large number of fatalities is not only the problem of the health sector: other actors such as government institutions, NGOs, local authorities, and the community itself are involved. The most immediate general measures that help to create a climate of order and emotional calm include following:

- ◆ Ensure a correct and orderly response on the part of the authorities;
- ◆ Provide truthful and timely information;
- ◆ Encourage inter-institutional cooperation and community participation;
- ◆ Guarantee basic health service and prioritize psychosocial care for survivors;

- ◆ Provide priority care to the most vulnerable groups, taking into account gender and age differences;
- ◆ Anticipate an increased number of people with manifestations of unresolved grief or psychiatric disorders, and facilitate adequate care for them;
- ◆ Ensure the careful and ethical handling of corpses by emergency response teams;
- ◆ Establish a clear, orderly, and individualized approach to giving notification of deaths and disappearances;
- ◆ Avoid mass burials or burial in common graves. Support the identification and registration of corpses, as well as delivery of corpses to family members so that the desires and the customs of the families are respected.

Traumatic experiences as well as losses and grief necessarily take on different forms of expression according to the culture. The predominant concepts about life and death and performing funeral rites for loved ones are important for the process of acceptance and understanding of what has occurred.

Delayed effects from disaster situations with large numbers of fatalities should be taken into account, with a view to designing appropriate intervention strategies for their prevention and effective control. However, the most frequent institutional response is based on individual psychiatric care, and serves only a small number of the affected population.

In situations where massacres have taken place, the need for medium- and long-term measures to repair the social fabric should be emphasized. These measures include:

- ◆ Restitution (material and indemnity);
- ◆ Humanitarian assistance and respect of human rights of the survivors;
- ◆ Recovery of the collective memory and dignity of the victims;
- ◆ Exhumations that can contribute to explaining the events and assist the grieving process of the family and community;
- ◆ Active role of different actors (state and civil society);
- ◆ Promotion of peaceful coexistence;
- ◆ Social and political changes that contribute to general well-being and strengthened peace and democracy.

Many countries of our region have been affected historically by multiple traumatic events such as armed conflicts and natural disasters, in a context of substantial socioeconomic misfortune. The human and material losses have been enormous; we are obliged to assist with the psychosocial recovery of these populations in the framework of comprehensive health services, and this obligation should be recognized in policies of the State.

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