Photo: Annie Spratt/Unsplash

Lessons learned

A systemic family psychotherapist analyses lived experiences in natural disasters.
By Prathiba Subramaniam

Introduction

The days of 18 March 2006 and 7 February 2009 will always linger in my professional memory, as they evoke in me the emotional vulnerabilities I faced, both as a resident and as a practitioner, with two natural disasters – Cyclone Larry in the Atherton Tablelands and Black Saturday in West Gippsland.

In 2006, I learned the complexity that arises from disasters being classified as traumatic events and the absence of sound research for evidence-based practice in mental health interventions during first response. In 2009, I learned the benefits of using the lens of post-traumatic stress disorder (PTSD) symptoms in first-response mental health treatment for children, families and the community.

This article is my attempt to share some of my learnings as a child and family therapist and to be an indirect support to my fellow counsellors and psychotherapists who are keen to aid the survivors of the 2020 bushfires.

During my first week of relocation to West Gippsland Hospital as a community mental health worker, I found myself facing another natural disaster. On the afternoon of Friday 9 January 2009, I saw an eerie orange colour fill the skies from my temporary accommodation at the nurses' quarters. My phone started ringing. My new manager, Linda, was calling me. She told me in a rushed and distressed tone, "Prathiba, Churchill area has been affected by the bushfires, and Labertouche area. There are lots of children, families at the shelter, quite stressed – as you can understand. Council have called us seeking any sort of help. I know you have just arrived; can you offer disaster relief?" (continued page 42)

PTSD theories into first response mental treatment

PTSD theories have been titrating their way into child and adult mental health over the last decade to help us understand how the brain, body and hormones respond to 'emotional' shocks, and the impacts over time. Levine (2010) articulates well about the activation of the fight/flight/freeze/flop energy during a shock experience and the importance for this response to be resolved during the experience. If left unresolved, then the nervous energy remains trapped and, over time, causes more symptoms of physiological pain.

As a disaster relief worker during the first six to eight months of the Black Saturday bushfires, I found enough evidence of such 'locked' nervous energy from listening and witnessing children's, adults' and families' stories. And I started to move away from talk-based therapy to more PTSD-informed interventions of sensory-motor therapy, such as visualisation and body-based expressive therapy, which was far more rewarding.

Theory into practice

In one of the evacuation centres, I was asked to assist a woman, who appeared to be in shock and was sitting in silence. As I sat with her, I softly enquired if she was okay. All she could say was, "My horses – I left the paddock open for them."

I noticed that, in her telling, her body was rigid and her eyes were glazed, and I felt she was talking to me from her paddock. I started to join in with her and began to enquire what she was seeing, smelling, hearing and feeling as she stood there.

During this experience, I felt with her the strong connection she had with her horses and encouraged her, if she could, to use her voice or a movement to indicate the horses to notice her. She started to use her voice, and started to yell "run". Once she used her voice, she also started adding sounds and movement – clapping her hands and waving them.

After some time, she slowed down and I checked with her if she could see her horses listen to her warnings. She closed her eyes, slowly and deliberately inhaling and exhaling, and then she opened her eyes – which I noticed now had some sparkle in them. "Yes, I know they listened to me. They are smart, they will be safe."

About the author

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Children and families

For children and families in disaster relief, mental health impacts can come from exposure to cumulative stress on a daily basis, changes in routine (school, after school and weekend), changes in physical environment (living in camper vans or shared house), and changes in roles and functioning (eating, sleeping, leisure and new responsibilities).

Where I was working at that time, mental health interventions for children were invested on an individual level, when from what I was witnessing, the work was required on a family or systemic level. I felt let down with individual intervention models for children, which do help them feel good during the session, but don't fit in post-disaster relief. In a child's words, "What's the point of feeling good in my session when stress is a big part of our 'real' lives now?"

How best can I help the child along with his/her family experience – to support and provide relief for each other without inducing further stress? I found myself using the framework of systemic family therapy, and dyadic psychotherapy, particularly using the PACE model – playfulness, acceptance, curiosity and empathy (Hughes, 2007).

Children became great ambassadors within the family and community sessions to voice stories of bravery, compassion and love witnessed during the first response. I found, working as a team with other mental health workers, we could map out individual resilience in families through many practical ways, such as a family newsletter, with each member taking a turn to a share story. And these stories were connected to the wider community to act as witnesses to congratulate and, at times, to advocate for further support and needs. Tuning into the collective pain helped parents to feel less burdened from the weight of being strong for their children. They could tune into each other, and their children could contribute to helping their parents by retaining their childhood qualities – such as playfulness.

In conclusion, I use the words of Dr Rob Gordon (2016), who I believe has developed stronger awareness among mental health practitioners for disaster recovery treatment.

"Recovery is a complex and poorly understood process full of challenges and adjustments. What's important is to provide people with an opportunity to talk about what actually happened to them and the impact that was, rather than going into their emotional experience, their background history and all other things we would deal within a clinical context. Many do recover well and gain meaning from the experience. They make creative changes. However, the potential consequences involve life-changing events." ■

References

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