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EDITORIAL

Hitherto, African psychologists were informed and oriented towards Euro-American idea of psychology. There was no attempt to project the distinctiveness of African culture and environment on the perception and orientation of African psychologist/Psychology. Attempt to change this was what necessitated the establishment of African Society for the Psychological Study of Social Issues with the first convention held on 29th May, 1998 at University of Ibadan. The Theme of the Convention was: **THE PSYCHOLOGICAL AND HEALTH EFFECTS OF WAR AND VIOLENCE ON WOMEN AND CHILDREN IN AFRICA.**

Wars and violence seem to be a prominent feature in many parts of Africa. Observation from various troubled spots shows that the direct health effect of war and violence on women and children are deadly diseases, poor food and nutrition, unsafe water and insanitary conditions. The psychological and health effects of war and violence on women and children are traumatic, stressful and delibitating and require urgent national hand international attention.

In this special issue of the African Journal for the Psychological Study of Social Issues (AJPSSI), attempt has been made to put on record, the research and documentation device on the crucial issue of the psychological, social and economic effect on women and children. The various articles put together in this issue are papers presented at the first convention and inauguration of the African Society for the Psychological Study of Social Issues. It is our hope that our effort would motivate African Psychologists and other social scientists to assume the responsibility of advocacy for the rights of women and children in Africa. In addition, we hope that the Organization of African Unity's Conflict Resolution Committee would wake up to its responsibility of preventing war and violence in Africa.

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POST DISASTER PSYCHIATRIC DISORDER: A CASE OF STUDY OF A LIBERIAN REFUGE WOMAN IN NIGERIA

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ABSTRACT

Post-traumatic stress disorder (PTSD) is the latest classification of neurotic disorders emanating from traumatic experiences (DSM III). It has been a focus of empirical interest among contemporary researchers. This interest has grown over the years as a result of concern for adequate intervention to victims of both natural disasters and deliberate human torture.

The present study is a case report of a Liberian refugee woman in Nigeria who was referred for expert management. Efforts were made to systematically draw inference about how the process of trauma could devastatingly dispose an otherwise premorbidly stable individual to a state of psychiatric breakdown.

INTRODUCTION

Post-disaster psychiatric disorder is the emergence of florid psychiatric symptoms as a consequence of a traumatic event such as war, earthquake, flood, and fire disaster.

There is often no history of pre-disaster psychiatric condition among sufferers. Post-disaster psychiatric disorders will include stress disorder, a major (unipolar) depression, a bipolar affective disorder, generalized anxiety disorder and Alcohol abuse/dependence or any other psychiatric conditions that may present.

The emergence of large-scale wars late in the 19th century with their psychological casualities provided an open testing ground for evolving theories of stress response and for developing corresponding treatment ideas. In fact, the development of sophisticated stress-reponse conceptualization can be traced through the theories of combat stress reaction. During the American civil war, before psychiatry developed, combat stress reactions were viewed as wrong ways of thinking or feeling - for example, as cowardice and nostalgia.

The outbreak of World War I (WWI) generated stress theories based on models of the mind. Freud (1955) originally described traumatic response as a memory disturbance or as in inability to forget. He believed that this memory disturbance arose from the inability to physically react at a moment of strong emotion. As Freud's theories of psychopathology evolved, however he moved away from interest in trauma toward research into unconscious fantasies and conflicts.

At the time of WWI, Freud described primarily in terms of internalised conflicts, that is, as the outcome of an unsuccessful struggle between unconscious wishes and the prohibition against expressing those wishes.

In 1919, Ferenczi, Abraham, Simmel, and Jones (1921) studied WWI combat stress reactions and applied then the current theories of Freud about unconscious conflict rather than his original ideas about trauma. As a result of this subtle shift, stress reactions became connotatively associated with psychopathology and lost their earlier ties to cognitive processing problem (i.e. the inability to forget). More specifically, combat stress reactions were named "war neuroses" and were thought to result from conflict within the soldier's ego between unconscious wishes to save his life by escaping the fighting and conscious societal prohibitions against expressing those wishes that stemmed from conscious motives such as ambition, self-esteem, patriotism, the habit of obedience, and others.

In WWII, combat exhaustion replaced the term war neurosis. This

nomenclature maintained allegiance to Freud's idea that psychological reasons relating to wishes to flee combat situations were at the root of most stress reactions. This trend continued, till 1952, when the first edition of the Diagnostic and Statistical Manual (DSM-I) of the American Psychiatric Association changed the name to gross stress reactions. In 1968, this term was replaced in DSM-II by transient situational disturbances. In 1980, in the wake of the Vietnam war, DSM-II introduced the new term "post traumatic stress disorder".

Current psychological trends in the theory of trauma arises from the search for a model of trauma that could account for a stress reaction in the absence of pre-existing psychiatric pathology. Horowitz (1986) based on decades of field studies and empirical research developed an information-processing model of a normal stress response.

Reminiscent of early Freudian theory, Horowitz posited that a stress reaction was the mind's way of trying to grasp, organise, process, and integrate overwhelming stimuli. To do so, the mind alternated between compulsive repetitions of aspects of the memory and periods of denial or withdrawal from the memory. Compulsive repetitions typically involved intrusive thoughts (nightmares, dreams) emotions (flashbacks of feelings related to the original event), behaviour (unexplainable recurring gestures, compulsive verbalizations of the event, or physiological symptoms (sweating, tremors and palpitations). During the normal course of attempting to process a stressful event with periods of denial. Denial could be an attempt to ward off any ideas, emotions, or feeling related to the event.

Horowitz also found that most people with normal stress reactions typically struggle with universal themes after a stressful event. These themes include, fear of repetition, fear of merger with victims, shame and rage over vulnerability, rage at those exempted, guilt or share over aggressivek impulses, guilt or shame over surviving, and sadness over losses.

In Horowitz expression, once normal stress responses had been

delineated, traumatic reactions could be differentiated from pre-existing psychopathology. In addition, normal stress responses could be differentiated from pathological ones, and the progression from a normal to a pathological stress response could be determined.

Meanwhile, developments in post-Freudian psychoanalytic theory has added to information-processing theory, thus enriching the picture of the internal world of trauma victims.

The discipline of Ego psychology has expanded our understanding of breakdowns in egos functioning that can occur under the impact of trauma.

The object relations theory, particularly work that explored self-representations, object-representations, and the splintering, splitting off, and projection that occur has provided invaluable conceptual tools for entering the intricate three dimensional inner world of trauma victims, (Jacobson, 1971; Kernberg, 1980; Ogden, 1986). Self psychology, with its elaboration of the development and importance of cohesiveness and continuity of self, has given view phenomenological meaning to the dread that is stimulated by the impart of trauma.

The work of Brown and Fromm (1986) have proposed the concept of simple versus complicated PTSD. According to this model, the more chronic and repetitive the trauma is (as opposed to a brief or circumscribed event), the younger the person is at the time of the trauma, and the more atrocious the trauma is (i.e. human violence perpetrated on another human), the more one will see a "complicated post-traumatic stress reaction". In contrast, the more limited and circumscribed the traumatic event is, the older the person is (particularly in terms of having already developed a stable sense of identity and internal cohesion), and the less human-initiated the violence or atrocity is, the more likely the chance for a "simple" post-traumatic stress reaction.

A "simple" post-traumatic stress reaction can be normal or pathological (going by Horowitz's model). Symptoms will generally

be time-limited; resolution will sometimes occur merely with the help of a supportive environment at the time of crisis; and treatment, if needed (i.e. with pathological responses) is usually brief and symptom-focused, with the goal of getting the patient "back on tract" in terms of working through the trauma.

In contrast, a "complicated" post-traumatic stress response is always pathological. Symptoms, which can be irreversible, typically involve permanent structural changes, both neurological and psychological. With complicated post-traumatic stress response, resolution may never occur despite the best treatment efforts. Recovery is possible only with a long-term treatment program focused on the repair of self and ego structures via internalization of aspects of the treater and the treating environment.

Another recent synthesis of several theoretical strains is that of Parson (1984), who combined various aspects of psychoanalytic thinking (including object relations theories, ego psychology, an self psychology) with neurological findings and information-processing models to weave a comprehensive and complicated model of trauma's effects on internal psychic structure.

Person affirms that "certain psycho-toxic events can shatter onging psychic structures". He spoke of the fragmentation of self-representations and other-representations, ego splitting, and identity disruption as resulting from exposure to chronic repetitive trauma. Person beliefs that these symptoms may lead to misdiagnoses of psychosis or schizophrenia in some people suffering from post-traumatic stress disorder (PTSI).

He noted that such people are not "border-line" or "schizophrenic" in the traditional sense because their premorbid character structure has developed to a healthier degree than is typically seen on borderline or schizophrenic patients.

SOCIOLOGICAL PERSPECTIVES

In Freud's time, sociological and environmental supports were rarely considered part of the diagnostic picture. However, many clinicians

now recognise the influence of contrasting environmental support systems on the severity and irreversibility of the stress response. A cohesive environmental support group, either during or after the traumatic event, can affect the degree of pathology of the stress response.

CASE REPORT

F.K. is a 25 years old Liberian refugee patient, referred from the Oru-Ijebu, Ogun State, Liberian Refugee Camp, by the protection officer of the National Commission for refugees at the presidency.

First presentation at Aro hospital was on the 9th of January 1995 with a four day history or aggressive behaviour, restlessness, violence and destruction of properties, high irritability, poor sleep, irrational talk and heaviness of the head. Patient was said to be apprently well until about two weeks from the day of presentation when she was noticed to be talking to herself, laughing to self, talks excessively, fights people for no obvious reason, picks up quarrel with everybody, she sleeps poorly and sometimes does not sleep at all. She however eats well but sings and often dances along.

PAST MEDICAL HISTORY

There is no known past medical history. Patient birth was claimed to be uneventful. She had been on antileprosy medication at the camp but stopped due to the pregnancy she had. Patient delivered a baby few days into admission.

FAMILY SUPPORT

Patient is the third child of four siblings. The first child is a male, seond child is a female and the last child a female. Father was said to have died 11 years ago after an unspecified operation. Mother is alive, a 55 years old trader. Her whereabout is however unknown. Other sisters and brothers were said to be living in another camp in Ghana. There is a denial of mental illness in the family.

PERSONAL HISTORY

Patient personal life revealed a person that is literate, she read up to class eleven in Liberian High School, an equivalent of the senior

secondary school 2 in Nigeria. She could not finish her education before the war broke out.

During the war in Liberia, patient used to sell meat and roasted yam in one of the markets in Monrovia and also to ECOMOG soldiers in their camp. At the tempest of the war, patient reported to have lost her wares to some unscrupulous being. She took refuge at the ECOMOG camp where she reported to have suffered severe stress and assault. She went without food for several days, drank only tea for survival. She was sexually molested which resulted in her getting pregnant. She delivered a baby whose father she can not identify. The baby eventually died due to malnutrition. She suffered rape on two occasions in the hands of the ECOMOG soldiers. She had a temporary relief in the hands of a Nigerian Hausa ECOMOG soldier who brought her to Nigeria on the promise of marriage. Prior to her coming to Nigeria, she had stayed with this man for almost a year.

On getting to Nigeria with this soldier, patient claimed to have had a turn of events as her beloved husband turned out to be an alcoholic. She suffered severe molestation and physical assault from this man on several occasions. This eventually made her to run for cover. On her flight for freedom she unfortunately met another Yoruba man in Lagos, a driver by profession who promised to take her back to Liberia. She lived with this driver in Epe for several months as a housewife. It was in his house she picked up the habits of smoking Indian hemp, cigarette and alcohol. The driver introduced all these to her.

The cumulative effect of her past traumatic experience precipitated by the effect of multiple drug abuse made her to develop her first mental breakdown in the house of this driver. She was consequently thrown out under an unimginable harsh condition. She roamed about the street of Lagos for several days begging for food and shelter and at times sexually abused. She fortunately met by chance a Liberian woman on the street of Lagos who helped her to the refugee camp in Oru-Ijebu. At the camp she adjusted to life and married a ca mp mate, a 37-year-old Liberian tinker. They both have a baby

boy just before her present admission.

PREMORBID PERSONALITY

Patient was said to be gentle, easy going and respectful.

MENTAL STATE EXAMINATION

This showed a young lady, average height, dark complexion dressed in a blouse with wrapper and bathroom slippers. She was obviously pregnant and filthy. She was quiet up to a stage when she decided to walk away from the assessement room. There was however no abnormal motor activity. Her speech was spontaneous, coherent and rational, her mood was irritable and her affect appropriate. Both her dream and form of though processes were normal and logical.

Her content of thought was however characterised with idea of reference. There was thought broadcast, thought withdrawal but no thought insertion. There were no abnormal perceptions of any kind.

Her cognitive function revealed a well oriented to time, place and person. Both her remote and recent memory was intact. Her concentration and attention was not tested, and her general knowledge was said to be fair. She had a partial insight into her problems. Physical examination could not be done on her due to uncooperative attitude at the time of examination.

DIAGNOSTIC IMPRESSION

Based on the above history, a post disaster psychiatric condition of affective disorder (mania) was made on the patient.

PSYCHOMETRIC EVALUATIONS

Four available psychometric evaluations that tap general mental ability, memory impairment, personality traits and mood disorder were made on the patient. These were done to diagnostic purposes and also for determining patient's rehabilitation status. The evaluative instruments used includes:

Raven's standard progressive matrices (the non verbal) version

Eysenck personality questionnaire (EPQ).

Beck's depression inventory.
Weschler memory scale.

TEST BEHAVIOUR/ADMINISTRATION

Patient test of general mental ability revealed a borderline mental ability individual. She has a Raven IQ of 77 (based on normalized T scores of Nigerian University subjects). On the Eysenck Personality Questionnaire (EPQ) which measures three key dimension of personality (neuroticism, psychoticism and extroversion) patient's profile revealed a highlyl neurotic individual with a high predisposition to psychotism. Her EPQ profile further revealed an extroverted individual.

Patient was found to be severely depressed based on her high raw scores on the Beck's Depression Inventory. The test for memory impairments as measured by the Weschler Memory. Scale showed that patient was good on subscale that measures personal and current information, orientation and mental control. Her logical memory was however poor. Her performace on the digit span was of average, this particular aspect would have revealed the presence of an organic brain damage. Patient performance on subscales on visual reproduction and Association Learning was of average.

An overall memory quotient of 80 was made on patient (based on Normalized T scores of a Nigerian Population.

DISCUSSION

In summary, a post disaster Psychiatric condition of young Liberian woman who developed an affective disorder (manic illness) after an episode of war without a prior evidence of mental illness or subnormality has been presented. Consistent with previous work (Smith, North, McCoool and Shea; 1990, Fernstein; 1989, Mollica, Wyshak and Lavalle; 1987, and with study that shares the same environment with the present report, Adamson, Ekpo, Makanjuola, Orija and Agomoh; 1994). This case report has shown the impact and importance of severe environmental stress on the breakdown of mental illness.

Some of the disaster stressors that have been shown to contribute significantly to the development of post disaster psychiatric state include exposure to personal threat or death, or loss of a home or communities among others. The patient F.K., lost her home and experience a familiar disintegration.

Communal living is a cherished facet of the African cultural, therefore destruction of such communes tends to be devastating.

Also of importance is the human-made nature of the disaster and the younger age group of the victims studied. Young age and human-made disasters have both been associated with higher and more chronic post disaster psychiatric disorder. These various factors could partly explain the high level and extent of the dysfunction obtained in this patient. Coupled with all these is the chronicity of the war stressor itself as the patient had been exposed to the war for a minimum period of 3 months before her emigration to Nigeria. The up-rooting influence of her emigration thereafter to a foreign and unknown terrain on her psychological well being could have added to the level of the Psychopathology obtained and her eventual breakdown. Personal styles of coping and the social support available to a victim of war could mitigate the potential of vulnerability. The coping styles and the level of available social support the patient acquired was not ego strengthened enough thus increasing her vulnerability to Psychopathology.

In conclusion, it is clear that disaster had many consequences for mental and physical health and that there is a responsibility for government and health care providers to ensure a thorough and systematic understanding of these issues and the appropriate provision of health care.

It is very easy to see the problems of victims as being solved by "aid", Welfare or support. All of these are important. However the specific and critical issue of health especially mental health must be understood and addressed if the consequences of disaster are not to have a long-term and destructive impact on the community. Mental health issues should be assessed and addressed at every level in

disaster planning and management.

REFERENCES

Adamson, T.A. Ekpo, M.A., Makanjuola, J.D., Orija, B.D. & Agomoh, (1994). Emotional Disorders and Post-Traumatic Stress Disorder in Liberian Refugees arriving in Nigeria. Manuscript submitted for Publication.

Brown, D.P., & Fromm, E. (1986). Hypnaotherapy and Hypo-Analysis, Hillsdale, NJ: Eribawm.

Ferenczi, S., Abraham, K., Simmel, E. and Jones, E. (1989). Psycho-analysis and War Neuroses in M.J. Peebles: Post-Traumatic Stress Disorder. Bulletin of the Menninger Clinic, 53, 274 - 286.

Fernstein, A. (1989). Post-Traumatic Stress Disorder: A Descriptive study supporting DSM-III-R Criteria. American Journal of Psychiatry, 148, 665 - 666.

Freud, S. (1955). Memorandum on the electrical treatment of War neurotics in MJ Peebles, (1989). Post-Traumatic Stress Disorder. Bulletin of the Menninger Clinic, 53, 274 - 86.

Horowitz, M.J. (1986). Stress Response Syndromes (2nd Ed.). Jaconson, E. (1971). Depression: Comparative of Normal Neurotic and Psychotic Conditions. New York: International Universities Press.

Kernberg, O.F. (1980). Object relations theory and psychoanalytic technique. International World and External Reality (pp. 155 - 179). New York: Aronson.

Mollica, R.F., Wyshak, G. and Lavalle J. (1987). The Psychological Impact of War Trauma and Torture on Southeast Asian Refugees American Journal of Psychiatry, 144, 1567 - 1572.

Ogden, T. (1986). The Matrix of the Mind: Object-relations and the Psychoanalytic Dialogue. Northvale, NJ. Avoson. Parson, E.R. (1984). The reparation of the self: Clinical and Theoretical dimensions in the treatment of Vietnam combat veterans. Journal of Contemporary Psychotherapy, 14, 4 - 56.

Peeble, M.J. (1989). Post-Traumatic Stress Disorder. A Historical Perspective on Diagnosis and Treatment. Bulletin of the Menninger Clinic, 53, 274 - 286.

Raphael, B. (1985). Mental and Physical Health Consequences of Disasters. The Medical Journal of Australia, 143, 180 - 181.

Smith, E.M., North, C.S. McColl, R.E. and Shea, J.M. (1990). Acute post disaster psychiatric disorders: Identification of Persons at Risk. American Journal of Psychiatry, 147, 202 - 206.