Haiti Earthquake Trauma: How to Cope With the Inhumane Humanity

To the Editor: On January 12, 2010, a massive earthquake devastated Haiti, killing about 2.5% (222,000) of the national population, injuring more than 3% (309,000), and causing approximately 7,000 people to have limbs amputated.[1] Two-and-a-half years later during the summer of 2012, following a quantitative assessment,[2–6] our team of researchers conducted a clinical study to document the mental and resilience processes developed by children and adolescents to deal with the traumas and human and material losses related to the earthquake. At first, we received more than 200 requests for psychological help. None of the respondents had ever met a mental health professional or talked about the earthquake before our intervention. Remaining silent about the dramatic events was considered respectful toward the community, avoiding the reminiscence of the suffering and collective memories of the earthquake. However, because of limitations in time and resources, we decided to retain only 24 children and adolescents injured during the earthquake for a clinical evaluation and a brief 6-session therapy. The case presented here demonstrates the difficulties mental health professionals may be confronted with when dealing with the inhumane losses generated by mass traumas.

Case report. The only son of his widowed mother, Kervens (assumed name) was 16 years old at the time of the interview (14 years old at the time of the earthquake). During the earthquake, he lost a hand (cut by a concrete wall that fell on him) and a leg (torn away during a rescue attempt while being rescued from under his house remains). Several days later, US military physicians amputated his other arm, although Kervens recalls he had only minor injuries. In addition to the loss of 3 limbs and the phantom limb pain and other physical injuries resulting from the collapse of his house on him, Kervens also experienced psychological suffering from the trauma associated with waiting for the rescue team, the early passing of his father before the earthquake, the loss of another significant caregiver (his former nanny and second mother), and the consequences of living in a society with no adapted infrastructures. Despite the trauma he had experienced, Kervens did not meet *DSM-IV* criteria for posttraumatic stress disorder or depressive disorder. Rather, he presented high resilience and high social support satisfaction.

Meeting Kervens for the first time, and all the other children with prosthesis and missing limbs, it struck us how powerless we are in changing the living conditions of these young people. Every new encounter is a reflection on our ability and legitimacy in receiving the stories of their misery and providing them with adequate care. What can we do to relieve their suffering?

Lost in our perplexity, reaching out to Kervens at the first interview in the waiting room, we each extended our hand for the usual welcoming handshake. However, in return, Kervens offered the end of his amputated arm. "What a blunder!" we thought to ourselves. Again, this brought skepticism regarding our ability to truly understand and embrace the reality of these children's lives. Once in the consultation room, Kervens said, "I know my situation is difficult, but I do not want your pity." When we inquired how he defined pity and if we had done something that revealed pity, he replied, "I know that you know what I mean. You are smart enough for that and I do not want your pity." To this day, we are almost certain that Kervens saw in our eyes how much we were disappointed to have extended a hand to him.

Throughout the clinical sessions with Kervens, we were astounded by his resilience and ability to cope with his losses. We were constantly reminded of the works of Irvin Yalom suggesting that the therapeutic relationship and process is built over the fragility.[7] It is easy to feel fragile, powerless, and inadequate in a therapeutic relationship such as the one described here. This fragility might stem from the difficulty to understand how these individuals can overcome and integrate their successive losses.

If the theoretical and practical aspects of our professional trainings do not always prepare us to deal with this magnitude of suffering, accepting the fragility and vulnerability of our patients[7] is one way to help them rebuild their lives.[8] If the inhumanity of Kervens and other children's losses affected us to the point of haunting our dreams, their strength to move forward, their resources drawn from such a deep abyss, and their great capacity of resilience undeniably moved us. With these children and adolescents, we learned to understand and accept the fact that the clinician can be disarmed in front of the inhumane humanity. And these clinicians' vulnerability, by itself, does participate in the construction of the therapeutic relationship with the patient.

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Jude Mary Cénat, PhD[a]
cenat.jude-mary@uqam.ca
Daniel Derivois, PhD[b]
Patricia Eid, PhD[c]

[a]Department of Sexology, Université du Québec à Montréal, Montréal, Québec
[b]Department of Psychology, Université Bourgogne Franche-Comté, Dijon, France
[c]Department of Psychology, Education and Physical Education, Notre Dame University–Louaize, Lebanon

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