

Psychological Issues and Social Support

6

Although in most situations there are some facilities for the medical, orthopedic, and long-term rehabilitative care of landmine victims, hardly any exist for their psychosocial needs. The mental health consequences of landmine injury include post-traumatic stress disorder, depression, and anxiety. Individual difficulty in relationships and daily functioning is considerable, and the landmine victim faces social stigmatization, rejection, and unemployment. Training in relatively simple mental health care is recommended for staff working in health facilities. Very often, however, families and communities must function on their own.

Community-based peer support groups offer cost-effective psychological, social and other health benefits, and provide a means to educate local populations about the needs of persons with disabilities and the resources available to help.

Psychosocial support should be community based, and involve social service providers from both the non-formal and formal health and social service sectors in order to provide culturally appropriate support. The families of mine victims play a crucial role in recovery, and should receive education and support to care for injured family members. Survivors who have progressed in their rehabilitation and reintegration into society are well suited to provide peer support. Research on trauma and recovery suggests that empathy and attentiveness expressed by peers have positive therapeutic effects. In post-conflict countries where there are virtually no psychological support services, investment should be made in training and employing competent, locally based social service providers and development workers.

From: Guidelines for the Care and Rehabilitation of Survivors; ICBL Working Group on Victim Assistance, 1999

SOCIAL ASPECTS OF LANDMINE INJURY

A universal question from a badly injured mine victim is, "Will I survive?" The answer depends very much on the assistance which can be obtained.

After first-line management gives a good chance of survival, there are other questions:

"How is my family going to survive?"

"How will my community regard me?" Sometimes those injured are thought to have had a "jinx" — to be affected by witchcraft or sorcery. Or basically unlucky — the gods are against you.

"Will my wife or my children listen to me, obey me?" "What will I look like?" A victim who had worked as a lab assistant and was in a coma for three months, woke and looked at herself in a mirror, then lapsed into a coma again. Some would rather die than look mutilated.



Figure 40. Careful inspection of a stump at the ICRC Orthopaedic Centre, Addis Abeba, Ethiopia. Photo: Max Deneu, courtesy of the International Committee of the Red Cross.

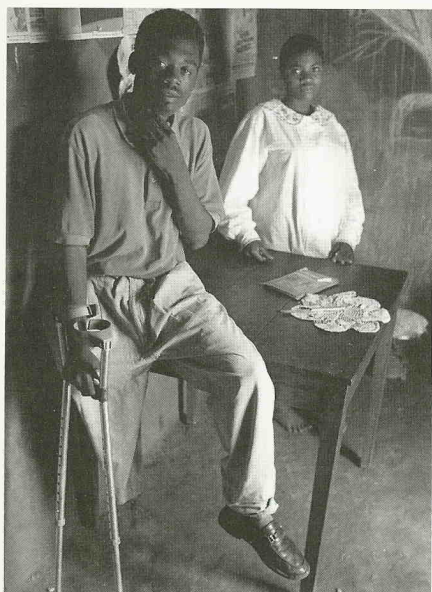


Fig 41. All the family is affected by a mine injury. Luena, Angola.
Photo: Don Doll, S.J., Jesuit Refugee Services.

"On December 13, 1993, a 31-year-old relief worker with the International Rescue Committee in Somalia suffered traumatic amputation of the right foot and blast and shrapnel injuries to both lower legs after his vehicle struck a landmine. The patient underwent emergency surgery in Kenya, where a below-the-knee amputation was performed on the right lower leg. He suffered profound blood loss, requiring 16-17 units of transfused blood. He was evacuated to Switzerland and subsequently to the United States, where he remained hospitalized for 2 months. During 1994-1996, he underwent seven surgical procedures to save his lower left leg. In February 1997, a below-the-knee amputation of his lower left leg was performed. Total medical expenses have exceeded \$300,000. The patient is undergoing rehabilitation."

Journal of the American Medical Association

Because of these factors, many patients and/or their families will refuse to let an amputation be done and will discharge themselves from hospital.

The assistance of the family is very important – they can help monitor compliance with exercises during rehabilitation, for example. Maintain the family as a unit facing this new situation. It is common for those who recover to try to get on with life as it was before. You dream that you are still whole.

National policies do not make good allowance for the disabled. There are stairs and steps; hotels and public buildings are not planned to allow access for the disabled.

Sometimes there can be a progress and development in emotional response, so that instead of remaining worried about how I look, I see that my survival allows me a second chance, a new beginning. Further, after a season of pain from mutilation and surgery, I find a better comfort, and things look better, so that I become kinder. While some may feel cheated of normal life, and remain angry, others will describe their luck — I might have died — I was allowed to survive.

Interviews with persons injured in the past by a mine may raise these issues:

- Effect on the marriage: Has the partner remained or left?
- Effect of the injury on intimacy and sex: How has your wife/husband, your girlfriend/boyfriend reacted when you are close together?

THE EXPERIENCE OF BEING INJURED BY A LANDMINE

Ken Rutherford, a US Aid worker, was blown up by a mine in Somalia in 1993, when he was 31 years old. He was travelling in a vehicle which struck a large line. He remembers the car filling with dust. He saw a foot on the floor and wondered, "is it my foot?? He was dragged out and hit the ground. His mouth filled with blood because he had bitten his tongue. Tourniquets were put on both his legs and they were propped up against a seat. His right leg was hanging off, and his left foot was damaged with the 4th toe gone, in a mess of bloody flesh.

He recalls thinking: "My life is over." (He had been engaged to marry only two months before). Then a new thought – "I am not ready to go yet."

Ken and two other injured persons were lifted into the back of a truck. There was no pain – he was in shock and confused. He kept trying to put his foot back on, and thought it looked weird, wrong. Some survivors describe great emotion affecting them after injury, but he seemed to feel quite calm, asking, "Can you put my foot back on?"

The trip to the hospital was 50km, and took 2-3 hours. During that time he began to feel pain and had to be held down. All three victims were screaming. "People were looking at me; I did not know what I was doing."

Psychological Issues and Social Support

He was transferred to an airstrip and a plane was called. It was hot waiting in the sun, and he was in pain. He was laid down in the plane, which brought a doctor and some blood. He had a pain-killing injection and this made him comatose. His blood pressure was 55mmHg, and he was given two units of blood in the plane during a 2-3 hour trip to Nairobi.

On arrival at the hospital he remembers a doctor being mad at him for moving so much. He was saying, "Don't cut off my legs!" He recalls the staff cutting off his shirt, a present from his fiancée.

When he woke he was told, "Your right leg was cut off to save your life." His surgeon also wished to remove the left foot, and called his parents in the US for permission to do this. His father was a Christian scientist, who said "Keep his legs; God will provide," and refused permission.

Next he was transferred to a specialist unit in Switzerland. He said, "I want to go home (to US)," but he was told — "you wouldn't make it, you must be stabilized first."

His left foot was packed in ice and debrided and he was loaded into a small plane, still with I-V blood running. Morphine was administered every three hours, but pain returned after two hours.

The plane landed at Luxor to refuel, and he was placed under the shade of the wing. He spent five days in Switzerland where surgery was done to try to save his left foot. His girlfriend and his family came to support him there, and accompanied him back to the US. He told his fiancée to leave him, but she stayed with him. In the US, further surgery was performed, his foot grafted, graft removed, a hole left in his foot. He was admitted to an institution which specialised in the preservation of limbs. Nevertheless, he was told, "There is a chance we cannot save your leg." But they kept trying. Six more operations were performed over the next three years. He was living in a wheel chair. His foot was stiffened with a triple arthrodesis. It was a focus of pain. No one said "you would be better off without that foot." He still had the big toe. "I wanted it off; it was making me a cripple."

Finally in 1997, three-and-a-half years after the injury, after much difference of opinion, his left leg was amputated. Then he could be fitted with prosthesis and learn to walk.

Had the leg been removed earlier, he would have been mobile much sooner. But with more delay the decision to take off the leg becomes more difficult.

Ken has many problems still. He needs to remove the legs for a long trip in a plane or a car.



Figure 42. Women near the Luena, Angola, marketplace are often victims of landmines because they must enter the fields to plant crops to grow their food. Photo: Don Doll, S.J., Jesuit Refugee Services.



Figure 43. Moses Thomas, aged 36, lost his leg to a mine in 1985; he lives with his wife and children in a railroad car permanently parked in the train station in Luena, Angola, which is home to many war-displaced people. Photo: Don Doll, S.J., Jesuit Refugee Services.

He married his fiancée and they have three children. He teaches at a university. He feels that he has been given a second chance at life; that people are nicer than he recognised before; the world seems a more positive place.

He has not felt the need for psychological support. Psychologists interviewed him, and he would tell his story, but he felt quite in control, even serene about it. The support of family is of great importance, and contact with other amputees is helpful. They have clubs, and understand each other — like a world which is their own. He is aware that a lot goes through the head of a person with this experience, and it is important to try to show a positive hope for the future.

He is aware that he received extraordinary treatment and had a lot of luck — the chance of getting to an airstrip quickly, the lucky arrival of a plane in time with a doctor and with blood, the opportunity to receive care from a skilled surgeon in Nairobi, to have rehabilitation in the US, a steadfast girlfriend, and supportive parents. His Somali friend, who probably would not have received such attention said that if he had lost a leg, his life would be over.

He has dreams: In one dream he sees his father shot and chases the gunman. He is about to catch him when his legs fall off.

In another dream he is injured in a gully, and is trying to put his foot on, feeling that if he can attach it before help comes, it will be alright. He hears people coming; he gets the foot on, but just as they arrive it falls off again.

EMPLOYMENT AND ECONOMIC INTEGRATION

Assistance programs must work to improve the economic status of the disabled population in mine-affected communities through education, economic development of community infrastructure, and creation of employment opportunities.

The economic status of survivors depends largely upon the political stability and economic situation of the communities in which they live. Employment opportunities, income-generating and micro-enterprise projects, literacy and vocational training, apprenticeship, and job referrals contribute to the self-reliance of survivors and community development. Economic rehabilitation programs for survivors should be designed using the same principles of good development work. Post-conflict economic reconstruction in mine-affected communities should include rehabilitation of the health and social service systems.

ICBL: Guidelines for the Care and Rehabilitation of Survivors 1999

REPORTING THE CONSEQUENCES OF LANDMINES TO THE COMMUNITY AND NATIONAL AGENCIES

Global agencies (International Committee of the Red Cross and World Health Organisation) are seeking regular reporting from affected countries which will give information not only about where anti-personnel and other mines are laid, but also how well the health facilities are able to cope with the needs of victims and how community well-being is affected.

“Additional studies focusing on disability from landmines are also needed because little is known about survivors of landmine injuries after they are discharged from medical care. There are numerous data gaps in the knowledge about disabled survivors, including how victims' families are affected, what psychosocial needs they may have, whether they are using their prosthesis, what services they require, to what extent they may return to participation, and to what extent the qualities of their lives may be improved. Without these data, it is difficult to determine the most effective use of limited resources.

Studies that examine other consequences of landmines are also needed. For example, what impact does living in close proximity to landmines have on immunization and nutritional status in nearby communities, on people's access to water, and on a community's economy? These indirect consequences may have as great an effect on public health as the direct consequences of landmines on individuals, families, and communities.”

How to Get Involved

To get more involved in the campaign against landmines and to order more copies of this book, contact:

Kenya Association of Physicians and Medical Workers for Social Responsibility
PO Box 19954, Nairobi, Kenya; Tel: 254-2-714-757/724-543, Fax: 254-2-724-590;
Contact: Paul Saoko at psaoko@healthnet.or.ke or Dr. Walter Odhiambo at wodhis@healthnet.or.ke

Ugandan Association of Medical Workers for Health and Environmental Concerns
PO Box 7072, Kampala, Uganda; Tel: 256-41-531-350, Fax: 256-41-245-597
Contact: Dr. Eddie Mworosi at mworosi@imul.com

Zambia Healthworkers for Social Responsibility
c/o Dept. of Medicine, School of Medicine, PO Box 50110, Lusaka, Zambia;
Tel: 260-1-253954, Fax: 260-1-250-753
Contact: Dr. Robert E. Mtonga at bobmtonga@hotmail.com

LANDMINE INJURY — PATIENT REFERRAL RECORD (Sample)

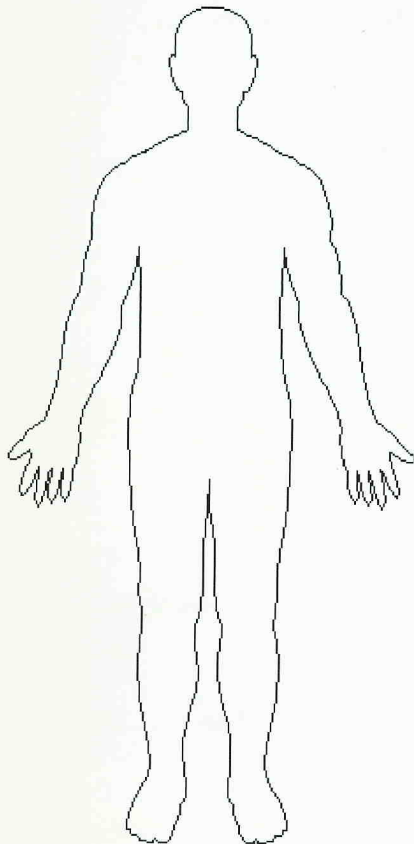
Names..... Age Sex

Marital Status: Married Single Divorced Widowed

Address.....
.....

Occupation/Profession..... Pregnant Yes/No

Date of Injury..... Time of injury.....



Where Injured (Please circle best answer):

Footpath Farm Field Wild Bush Home

Public Place, e.g., School Yard, etc.

Other (Specify).....

HEALTH UNIT (Name)

Date of arrival Time of arrival

Means of transport to health unit: Foot Vehicle Bicycle Other
(Specify).....

Admission Findings:

BP Pulse Temp.

Mucous Membranes Conscious Level Respiratory rate

INJURIES — mark your findings on the simple diagram.

Lower Limb Injury (Please circle):

Left: Below Knee Above Knee

Right: Below Knee Above Knee

Other Injuries

Other limb Abdomen Chest Face

Perineum Neck Scalp Skull Back

Other (Specify).....

Haemorrhage Control — Pressure Dressing..... Tourniquet.....

Other (Specify).....

If Tourniquet — state level above injury line 2-5cm..... >5cm.....

Time tourniquet applied

Time tourniquet last loosened

Splint applied Yes..... No.....

Resuscitation with I-V Fluids No..... Yes

When started.....

No. of litres since.....

Medication: Penicillin..... Tetanus toxoid..... Other (specify).....

I-M I-V

Analgesia Drug and dose Time of last dose

Condition at referral: Poor..... Fair..... Good.....

A V P U P

Referral by: Name (print)

Position:

Signed:

Date: Time: