Introduction: Spirituality and Catastrophe

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In this issue, the focus of the Southern Medical Journal's Spirituality/Medicine Interface Project is on what physicians need to know about spirituality and mass catastrophe. As used here, spirituality involves religious beliefs, practices, and traditions, but also more broadly includes a search for the sacred, ultimate truth, or ultimate reality. Spirituality is closely related to but distinct from concepts such as meaning and purpose in life, connectedness to others, and sense of peacefulness to which spiritual strivings may eventually lead but are not part of the definition itself. Mass catastrophes include natural disasters (eg, hurricanes) and acts of human terrorism (eg, bombings) that affect entire communities; these contrast with personal catastrophes (eg, murder, infidelity, torture, disfigurement). Catastrophe as discussed here will be limited to disaster on a community-wide scale.

The purpose of these articles is to prepare physicians to address the unique emotional, social, and spiritual needs of survivors and of their families, of rescue workers, and of the treating physicians themselves. Besides generally preparing physicians to meet the medical and psychological needs of survivors, this issue will help to increase awareness of the spiritual needs of these potential patients, to learn how to sensitively identify those needs, and to determine when and whom to refer. The role that religion and spirituality play in helping survivors cope with the trauma of disasters is often quite significant. The ultimate result, we hope, will be a nation that is more resilient during times of catastrophe.

Relevance to Physicians

Disasters result in almost $1 billion per week in property damage and injuries each year in the United States. This figure does not include catastrophes like Hurricane Katrina (August 29, 2005), which resulted in 1,836 deaths and 705 persons still missing, or the September 11, 2001, terrorist attacks which claimed nearly 3,000 lives. These disasters, however, pale in comparison to events that occur abroad, such as the December 26, 2004, earthquake off of the west coast of Sumatra and the resulting tsunami that killed 150,000 people, left 25,000 missing, and displaced over 1,000,000 people in Asia and Africa. These deaths, of course, are only a tiny fraction of the number of traumatized people who sought medical and psychiatric attention afterwards. Such catastrophes overwhelm emergency and healthcare systems; government services cannot possibly meet all the physical, psychological, social, and spiritual needs of affected persons. Communities must search for resources from within.

Americans utilize their own spiritual beliefs to a surprising degree in dealing with catastrophe, and faith-based organizations have played a crucial role in helping survivors. A national survey of the U.S. population by the Research and Development (RAND) corporation less than one week after the September 11th terrorist attacks found that 9 of 10 Americans turned to religion to cope with these events. Similarly, a national poll of the U.S. population by the Red Cross after September 11th discovered that 60% indicated that they would rather seek help from a spiritual caregiver than from either a physician (45%) or from a mental health professional (40%). That survey was prompted by clinical observations from Red Cross workers after September 11th that disaster victims and family members often pushed past clinical psychologists to talk with people wearing collars. This should not be too surprising in a nation where nearly 90% of the population believes in God or a higher power, 90% pray, two-thirds are members of religious organizations, and nearly half attend religious services weekly or almost weekly.

Religious organizations contribute in many ways to a tradition that is centuries old. Almost every religious organization in the U.S. has a disaster relief arm that is immediately mobilized whenever catastrophe occurs. In small communities, clergy often coordinate disaster relief efforts due to their longstanding leadership roles in those communities. Because they are located in every community, religious organizations have the ability to raise and administer resources much faster than government agencies and, through modern means such as the Internet, can raise funds for such efforts almost immediately. During the first few days after Hurricane Katrina, for example, religious organizations were in the field...
actively providing assistance well before FEMA and other government agencies had mounted a response.11,12 Both before and immediately afterward, religious organizations provided emergency shelters for the displaced. Religious communities from all over the nation donated money, paper goods, clothing, food, and school supplies, as well as sending volunteers to help Katrina survivors. To this day, religious groups of varying faiths continue to feed, clothe, and house survivors displaced by the hurricane, adopting families and helping to rebuild obliterated homes.16

Despite the important roles that personal faith and religious organizations play in helping people cope with disasters, emergency management services have made little effort to integrate faith-based communities into the formal disaster preparedness and response system. Moreover, although the American Red Cross is officially responsible for meeting these needs, the service is limited and can be provided only during the period immediately following disasters, thus leaving the onus to local religious groups. Because of the largely uncoordinated nature of religious activities in the past, conflict between religious groups and the Red Cross, EMS workers, and mental health agencies have occurred, resulting in turf battles and a poor distribution of resources. Although national organizations have arisen to try to help coordinate the activities of religious and other volunteer groups, integrating these activities remains a problem. Moreover, the religious responses of survivors is not always positive or predictable, as in the case of the Sego Mine disaster where religion and faith, initially acting as a crutch, became divisive as those affected expressed anger, resentment, and deep bitterness. There will invariably be religious responses in the face of disaster, but the nature of the responses will depend on many factors and circumstances.

Contents of Special Issue

The contents of this issue are divided into four sections. The leadoff section focuses on the disaster response system in the US and the physician's role in it. The first article briefly describes the major components of the formal disaster response system at the federal, state, and local levels, and provides a general background on the organizations that are active during disaster response. The second article, by Neil Nusbaum, chair of the Department of Medicine at the University of Illinois College of Medicine, discusses factors that physicians need to consider in providing medical care during widespread catastrophes; he emphasizes the importance of physician flexibility in coping with unanticipated medical needs as a result of stress. Next, in a physician's perspective, Tom Gavagan, vice chair for community health of the Department of Family and Community Medicine at Baylor College of Medicine, and his colleague, Eric Noji, provide their perspective on what physicians need to know when responding to disaster based on their experiences at the Houston Astrodome. Then, Sekar Kasi, Subhasis Bhadra, and Allen Dyer present their experiences in serving in India in the aftermath of the December 26, 2004, tsunami. The final article in this section addresses more specifically what physicians should do to address the spiritual needs of disaster victims as part of overall care.

The second section focuses on the psychological and spiritual needs of disaster survivors, their families, and EMS personnel, and on the spiritual needs of physicians. The first article examines the psychological needs of disaster survivors and discusses the long-term psychological consequences that may result (eg, PTSD, depression). In the next two articles, disaster expert Francis Gunn writes from his perspective as a Catholic priest and as a trained mental health professional who worked in New York City with survivors during the September 11th terrorist attacks. In the final article of this section, family physician Walter Larimore and colleagues address the psychological, social, and spiritual needs of physicians during disasters, and what physicians can do to cope with their own stress.

The third section examines the role of faith communities during disasters. In the first article, Martin Feldbush describes what clergy and counselors do to meet the psychological, social, and spiritual needs of disaster victims. In the second article, Kevin Massey, a director at Lutheran Disaster Response, discusses the role of faith communities in responding to disasters and explores efforts among religious groups to coordinate their disaster response.

The fourth section explores religious coping on the individual level. First, Bowling Green psychologists Kelly Trevino and Ken Pargament review research on the use of religion during natural disasters and acts of terrorism and describe how individuals use positive and negative forms of religious coping when facing catastrophe. Three articles then present a Jewish, a Muslim, and a Buddhist perspective on coping with disaster. David Polluck, executive director of the Jewish Community Relations Council of New York, discusses challenges of living in a country plagued by terrorism/war (ie, Israel), describes how Jews respond to terrorist attacks, and provides resources to help physicians caring for Jewish patients affected by disaster. Next, Abdul Basit, director of the Islamic Society of North America's Center for Health and Human Services, describes the Islamic perspective on coping with catastrophe and therapy for trauma-related disorders. Finally, the Venerable Kong Chhean, a psychologist and Buddhist monk, describes Buddhist health traditions which physicians should know about when treating Buddhist patients.

The section is concluded by a case discussion describing a couple that survive a disaster and the role that the religious community played in their recovery, and a Selected Annotated Bibliography of research studies and resource references on spirituality and disasters.

References


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11. Johnson B. Churches open doors to Katrina evacuees in Alabama.


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