

MENTAL HEALTH TASK FORCE IN DISASTER: JAFFNA DISTRICT

QUALITATIVE ASSESSMENT OF PSYCHOSOCIAL ISSUES FOLLOWING THE TSUNAMI

Introduction

The tsunami which affected South Asia on 26th December 2004 is now known to have caused over 175,000 deaths worldwide and displaced millions of people from their homes and livelihoods. In the Jaffna District, 1256 people lost their lives, and 1240 are still missing. 48,769 people were displaced as a result of the disaster. As of 19th January 2005, 3758 families were still housed in welfare centres and 6651 families were housed with relatives and friends. In the affected areas family and community structures, which are so vital for psychosocial wellbeing, have been drastically altered by the tsunami.

This document outlines the work carried out by the Mental Health Task Force in Disaster to date, our initial impressions of the psychosocial needs of the community following the disaster, and our initial recommendations about the likely ongoing needs of the community, in the short- and long-term.

Psychological context

Throughout their response to the disaster, the Task Force has attempted to base their decisions on what we know of normal psychology, stressing the need to avoid pathologising natural reactions to trauma. Research suggests that for most people, psychological reactions resolve during the first or second month post-disaster. In the immediate phase, in-depth psychological interventions that push the client to talk about their experience in detail can prove harmful to some, so this approach should be avoided. Instead, dissemination of information about normal psychological reactions, with an emphasis on the expectance of natural recovery can be helpful (WHO, Mental Health in Emergencies, 2003).

Long-term planning will also need to take into account normal psychological processes such as grief. Usually after a severe loss, there is a period of mourning, which can last a year or longer, during which time the person begins to adjust to their loss and rebuild their life, supported by their family, friends, and other social and religious support systems. Although grieving people may at times experience psychological “symptoms” they do not always require help from counselling, psychological or psychiatric professionals. Therefore, even though the present circumstances are very unusual, we should not assume that all those people who have experienced losses will need input from psychological services. Instead, we need assessment and referral procedures which can identify the minority with more severe or abnormal grief reactions, to ensure they receive appropriate help from higher level psychiatric, therapeutic or psychological services.

Similarly, PTSD and depression will only be possible to diagnose after some time has passed, when people with lasting mental health problems become distinguishable from those who will go on to naturally recover. Therapeutic interventions are more likely to be successful if they are carried out after the individual has been able to restore a degree of normalcy to their lives, for example, when they have a semi-permanent residence, and some security about their basic needs. However, given the widespread nature of the disaster, general community psychosocial measures can be implemented with the aim of promoting mental health, particularly amongst children and adolescents.

Qualitative assessment of issues arising after the disaster

- Immediately, a high number of people experienced an acute stress reaction, feeling distraught, dazed and highly emotional. This reaction lasted only a few days, so those affected have now got over this initial reaction.
- There has been a high degree of loss of life: e.g. many family members lost in one family, all families in a community losing family members or close friends. Consequently whole communities are grieving together. One of the main psychological problems identified was grief reaction, some atypical in nature, commonly complicated by guilt, anger and hostility, and suicidal ideation. Psychotic reactions needed medical treatment.
- Those who have not lost family members may have experienced a high degree of property and financial loss. There was one case of suicide due to property loss. The economy has been massively affected by the disaster.
- Usual support systems have been destroyed, as many or all in a community were affected, the individual cannot receive community support. Village structures and organisations were also destroyed, and people were displaced from their familiar surroundings and social context.
- The fact that people were unprepared, and that the scale of devastation from the tsunami was unexpected may have contributed to people's distress, as they would not have been able to use their usual coping mechanisms for times of stress.
- Affected people have to deal with practical stresses: e.g. the registration system, trying to reunite surviving family members, perceived inequities in the distribution of aid, leaving welfare centres and settling in temporary shelters.
- Families have been separated after the disaster between different welfare centres, or were separated at the time of the disaster. Unresolved emotions, hopes and unanswered questions relating to missing relatives, or cases where bodies have not been recovered or identified are common, and may interfere with the natural grieving process.
- There has been less opportunity to carry out the traditional funeral rituals, which may also interfere with the natural grieving process.
- Initially, fear of the sea and nightmares have been commonly reported. A brief survey carried out by VIVO, of 71 children (aged 8 – 15), showed 40% were at risk of developing Post-traumatic Stress Disorder, and many others showed symptoms. For some of these children, symptoms will resolve over the next few months, but a significant minority are likely to need specialist help.
- Mistrust in nature has been reported by many as a consequence of the disaster, expressed as a description of the sea as: "She, who gave everything, also destroyed everything". Fears relating to the future and the return to coastal areas are also common.
- Guilt feelings have been commonly reported, particularly family members questioning themselves about what they could have done differently to save loved ones, particularly in relation to not holding on to children, or having gone elsewhere. Guilty feelings and associated depression were risk factors for suicidal ideation.
- Anger was a common reaction. After a natural disaster, it may be difficult for people to know where to direct their anger, and feeling angry at nature or gods is common. We have also observed anger being turned inwards, so that people blame themselves and feel guilty, or people blame each

other, for example criticising the actions of their family members and blaming them for deaths in the family. We have also observed anger being turned or manipulated towards the authorities, for example, people have described problems in aid distribution, or made criticisms of the government.

- There is an elevated incidence of schizophrenia in the Jaffna community (2%). The disaster increased stress on vulnerable individuals, causing people to develop relapse of schizophrenia, exacerbation of symptoms, and making it difficult for people with a diagnosis of schizophrenia to follow their regular treatment routine. Some lost their medical records and medications, and defaulted clinic appointments and treatments. There were concerns that some cases of schizophrenic illness were misidentified as normal reactions to the disaster, and managed only with psychological methods. People with schizophrenia are particularly at risk of suicide, so it is vital that they receive professional psychiatric support.
- We have heard of many rumours relating to the cause of the tsunami, and frequent reports of another tsunami coming were common. These rumours can be seen as people's attempts to make sense of what has happened to them, and in a similar way, some people have developed magical thinking about the disaster, or about ways to keep safe.
- There was a lack of organisation and co-ordination between agencies, which many felt led to aid and psychosocial interventions not reaching all those in need. In particular, the referral process for those experiencing severe psychological reactions was not widely used.
- There were reports of a lack of sensitivity and sympathy in some authorities dealing with tsunami survivors (like principals, government officers etc).
- Initially, few structured activities were available in the welfare centres.
- Many of the affected people have experienced displacement and losses in the past, which might increase their resilience in the present circumstances. However, the present trauma may also bring to the surface memories and emotional reactions related to previous traumatic experiences, thus making it more difficult for individuals to cope.
- There was a high number of widowers (men who lost their wives), many of whom were finding it difficult to cope with young children and babies. Some had taken to alcohol as a way of coping.
- Another vulnerable group identified after the tsunami as having specific needs were adolescents, particularly those having lost a parent. They were seen in the welfare centres as quiet, withdrawn and angry. If specific programmes are not advanced to this vulnerable age group, there is a risk of deviant personality development, such as anti-social personality and exploitation by authorities for their own purposes.

Psychosocial intervention to date: Immediate post-disaster phase

1. Training and co-ordinating workers to visit the welfare centres

The Task Force advised and co-ordinated over 110 individuals from various NGOs, all of whom had previous training in counselling and / or psychosocial skills, and experience working in a psychosocial and counselling context. A short workshop was provided focussing on how these workers could adapt their skills to the immediate post-disaster context. Many psychosocial NGOs sent individuals to the welfare centres, and approximately 30 additional volunteers (workers not attached to a particular NGO) were co-ordinated by the Task Force to visit 7 welfare centres. Monitoring of this work was provided via the usual supervision arrangements of each of the NGOs. The Co-ordinating committee in Vadamaratchi had representation from the Task Force, and oversaw all the psychosocial work going on in the camps.

The aim for immediately sending workers to welfare centres was to provide psychological first aid and support which included:

- Providing an opportunity for people to talk about their experiences, should they wish to do so, with a listener trained to be empathic and non-directive.
- Educating and reassuring people about the normal psychological reactions to trauma, and discouraging labelling of people as having a mental illness. Encouraging the expectation of natural recovery.
- Protecting people from harm, by identifying those people judged to be at risk of committing suicide and referring them on to the multi-disciplinary team and hospital-based psychiatric clinics.
- Encouraging the use of normal coping strategies, where possible.
- Facilitating access to aid required to meet basic needs, by speaking up for people and explaining procedures where appropriate.

The primary health care workers (e.g. Public Health Inspectors, Midwives etc.) were given an awareness raising programme and asked to look into psychosocial issues as well as their normal work.

2. Providing information to the media

The Task Force has co-ordinated articles and interviews in the local papers on the following topics:

The work of the Task Force, psychosocial work carried out in the affected areas, how to help yourself psychologically, understanding how the tsunami occurred, listening to affected people, risks of developing PTSD and depression and how to contact services if needed, requests for support for affected people and using traditional methods of psychosocial support.

Aims:

- To educate and reassure people about the normal psychological reactions to trauma, and to discourage labelling of people as having a mental illness. To encourage the expectation of natural recovery.
- To encourage newspapers to report in a way that does not needlessly increase the distress of the public.

3. Writing and disseminating leaflets

The Task Force has produced two publications, the first, a booklet designed for workers, and the second, a pamphlet designed for those affected by the disaster. The aim was again to educate about the normal reactions to trauma and reduce labelling of people as having mental illnesses.

4. Developing a referral system for those with severe difficulties

The Task Force developed a 3 tier referral structure: Field workers can refer to the Multi-disciplinary Team at Base Hospital Point Pedro, General Hospital Jaffna and District Hospital Tellipallai, and the MDT can refer to the Psychiatrists. (Please see appendix 1).

5. Developing links with Killinochi and Mullativu

The Task Force has offered to liaise with psychosocial workers in Killinochi and Mullativu, and in the first week after the disaster, sent a team of workers to Mullativu to offer crisis intervention. A representative of the Task Force attended the weekly co-ordinating meeting in Killinochi at UNICEF, and set up an ongoing programme at Marathenkerny area with a clinic at the local hospital.

Recommendations

Immediate (0 – 4 weeks post-disaster; this is now past)

Social interventions should focus on meeting basic needs, re-uniting families, providing opportunities for structured and normal activities, and supporting usual coping mechanisms. Structured activities for children (such as games and schooling) should be organised.

For most people, psychological interventions should be limited to supportive listening, with the aim of educating the public about normal reactions to trauma, and emphasising the likelihood of natural recovery. Any worker offering this type of intervention should be regularly supervised by an experienced colleague, trained to offer guidance in intervention and to take account of the psychological impact on the worker. Regular, in-depth counselling or psychotherapy should be avoided. Vulnerable individuals can experience severe reactions after a trauma, so people at risk of self-harm or suicide should be referred to the psychiatric clinics, particularly those expressing serious suicidal intent, or experiencing a psychotic episode.

Short-term (e.g. 1 – 6 months post-disaster)

During this period, many people will begin to naturally recover from their psychological reactions to the trauma. People who have lost relatives will still be grieving, and energies may be focussed on the practical issues of rebuilding lives. Many may experience continuing psychological problems, and a minority may develop serious problems like pathological grief, PTSD and depression. Fear of returning to the sea, lack of motivation to re-start life activities and suicidal ideas will have to be dealt with. WHO has estimated that 30-50% of those directly affected will have psychosocial problems who will benefit from help and support, whilst 5 – 10% will develop severe problems needing specific intervention and treatment.

Suggested activities for this period include:

1. Education and awareness-raising

WHO suggests a need to educate the public about the difference between normal distress and mental illness, so that those experiencing continued difficulties can access appropriate support. Those working in the welfare centres or affected villages could be offered a short training programme, and similar programmes could be made available for the public, as well as by providing information through the media. Authorities such as educational and government officers should be sensitised to the effects of the disaster, and given advice about how to deal with the survivors in a kind and sympathetic way.

2. Needs assessment to determine the developing long-term consequences of the disaster

Local services should carry out a needs assessment of the likely long-term psychological impact of the disaster. In particular, research from other natural disasters can tell us about mental health problems following the disaster.

3. Promote access to existing services and begin longer-term counselling and therapy for those in need

Information should be given to all about how and when to access professional services. A self-referral system to psychiatric clinics and the Multi-disciplinary team could be implemented. Longer-term support should begin, taking into account for each individual degree of stability and normalcy in their lives. Individuals should have access to specialist interventions where needed, using the three tier referral system (see appendix 1). Two such referral units have been set up at Base Hospital Point Pedro and Marathenkern hospital. Tertiary referral of severe cases needing medical treatment can be referred to Teaching Hospital Jaffna and District Hospital Tellipallai.

4. Ensure quality of psychological interventions given.

It is important that psychological interventions are of a high standard. Any increase in counselling resources will have to occur over a long period of time, as counselling training is a long process, requiring months, if not years. WHO states that short one-week to two-week (or less) skills training without thorough follow-up supervision is not advised. The Task Force will therefore advocate careful planning rather than quick solutions to the potential increase in demand placed on existing services. It is expected that until new counsellors are trained, existing services will be under increased strain over the next year.

Rather than focussing on training new counsellors and psychosocial workers, it is important to mobilise existing resources and facilitate networking between already trained workers. Existing workers include

the hospital based Multi-disciplinary Team, Psychosocial Trainers (Shanthiham), Counsellors (Shanthiham, Ahavoli, Wholistic Health Centre, Family Resource Centre), Teacher Counsellors & Befrienders (GTZ – Becare), Psychosocial Advocates (UNICEF), Samurdhi Workers and Graduates (previously trained Psychosocial Trainers who left Shanthiham for government appointments). The primary health care staff, particularly Family Health Workers, should be mobilised and given training on psychosocial issues, so they can contribute to this work with ongoing support from mental health professionals.

5. Community work

In view of the widespread nature of the disaster, psychosocial work in the emerging communities should be organised, to ensure and encourage positive psychosocial functioning (e.g. cultural and religious rituals, organisation of community centres, yoga, structured play activities and schooling for children). These activities would be designed to prevent later mental health problems, encourage a return to normalcy, and promote mental health. A programme to involve adolescents in organised group activities, responsibilities and vocational training will be needed.

6. Extra training on specialist topics

Those workers expected to do in-depth counselling at the secondary and tertiary levels (and in particular, the Multi-disciplinary team, who see people with more severe mental health problems) may require short, top-up training on specific topics, such as grief, therapeutic approaches for PTSD, play therapy, and relaxation techniques and yoga. Logistical support for such programmes would have to be funded.

7. Co-ordinated planning and networking

Communication and co-operation between organisations should continue to be encouraged, in order to plan training and psychosocial services and avoid areas of overlap in services, or gaps in service provision. Networking (both within and outside of the psychosocial field) will enable organisations to be aware of the variety of services on offer, and organisations should be encouraged to refer to one another if they do not provide a particular service themselves.

8. Awareness of the needs of special groups, and a wholistic approach to care

Certain special groups emerged as a result of the disaster, for example, widowers (males who have lost their wives) and orphans. These groups may have particular needs that should be identified and planned for. Group meetings of men to reduce alcohol use, and other social activities should be started. In all cases, a wholistic approach should be taken in planning psychosocial services. Services should aim to take into account a person's family, community and cultural context, as well as their other needs (e.g. practical, financial etc), rather than solely focussing on psychosocial issues.

Long-term (more than 6 months post-disaster)

We expect the majority to gradually and naturally recover from their traumatic experience. However, there will be a minority who experience continuing mental health problems, such as depression, complicated grief reactions, alcohol abuse and Post Traumatic Stress Disorder. This minority will require highly specialised interventions from a team of experienced mental health practitioners.

In the long-term, it is desirable that any mental health needs arising from the disaster should be addressed by accessing the usually available and developed mental health services (e.g. referrals to the psychiatric clinics and multi-disciplinary team, input from the NGO counselling associations), rather than setting up separate services for disaster survivors. Services should be accessed through traditional resources at the community level.

A community level approach of empowering local resources like Family Health Workers, Village Leaders and Government and NGO workers to handle the majority of psychosocial problems will be the most effective way to address the massive mental health consequences of the disaster. Community level workers would need to be able to identify the more severe cases for referral, and so would require training

in basic mental health, as recommended by WHO. The manual “Mental Health in the Tamil Community” could be used for this.

We stress that the psychosocial component should be taken into account in all rehabilitation, resettlement and development programmes. An integrated, wholistic approach that includes psychosocial and mental wellbeing will enhance the recovery process. Following the needs assessment described above, decisions will need to be made about how existing services need to be expanded to cope with an increase in demand, and how existing services will link with rehabilitation and reconstruction efforts. If new counsellors and psychosocial workers are to be trained, their long-term sustainability will need to be addressed, and staffing and equipment costs in the long-term must be funded, as well as the short-term costs of the training programmes.

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