“To array a man’s will against his sickness is the supreme art of medicine”
— Henry Ward Beecher

Tsunami

The Mental Health Challenge in SriLanka from working within the disaster area

Tsunami is a Japanese word that translates as ‘harbour wave’, generally called tidal wave, though the term is a misnomer as it has nothing to do with tides. A tsunami is not a single wave but a series of waves that can travel across the ocean at speeds of more than 800km/hr; while in shallow waters near the coast it gets slower and water mass raises up to 50m. As recently witnessed the destruction caused by a tsunami can be immense. Catastrophes generally challenge the human capacity to transcend shock and loss and grief. A disaster of this scale can bring about lasting psychological sequelae. While shock, panic, bafflement are often the first reactions, followed by numbness, and/or agitation, followed still later by post traumatic symptoms of nightmares and flashbacks, hyperarousal, insomnia, avoidance and depression. These latter symptoms can last for years.

It was Michael Rutter, in the Isle of Wright study, who clearly established that resilience in adversity is a major capacity of human beings. The World Health Organization recommends ‘psychological’ first aid (1) – a mix of empathy, support, counselling and provision of basic physical needs – that can be done by volunteers with just a little training. It is the long term issues where things become more complex. As the victims of this catastrophe try to re-establish the pattern of their lives, this, together with inert psychological vulnerability that many might be carrying will need additional benefits of mental health interventions, that might help restore symptom recovery but importantly also enable the much needed functional recovery.

The two worst affected areas – the South and the East – were visited by the author and time was spent with the mental health professionals at their request to assist them in their enormous selfless task.

Context

The mental health problems include (a) those found in normal times (b) plus a substantial increase due to the adverse effects of the disaster (c) plus the adverse effects of the conflict in the north and east. The burden of these problems is both on the mental health and general health care system, as many distressed people present with somatic complaints to the general health system.

It has been estimated that due to the combined effects of the earlier conflict and the recent disaster, the majority of the population in the north and east of Sri Lanka have been displaced (3). Some are now returning to their homes. The required mental health efforts will centre not only on immediate relief, but also on building capacities and enhancing resilience and coping.

Epidemiology

Earlier epidemiological surveys in Sri Lanka have shown high levels of psychiatric morbidity even before the Tsunami; with 25% prevalence of major depression; 14% PTSD, and a suicide rate high on world standards especially among displaced persons as in Vavaniya. In the context of the recent Tsunami the most prevalent disorders are major depression, generalised anxiety, somatization disorder and post traumatic stress disorder. The most vulnerable groups are women, children and those who are unable to receive treatment. Early experience raises doubts about the appropriateness and effectiveness of mental health concepts in resource poor countries with political conflict and disasters. For instance the concept of PTSD seems valid in the USA where it is prevalent in war veterans (7) and disabling (8). Some observers, however, sees PTSD as a pseudo condition with no relevance in non-western traditional societies, and consider it a medicalisation. of normal distress (9,10).

Our Perspective

From the early evidence as studied by our team, and in congruence with the local professionals of the area, there seems to be a low prevalence of PTSD as might be experienced in similar situations in the West. An interesting finding that has emerged in the eastern affected area has been the increased presentation of people with somatic complaints, with people presenting to the physician, cardiologist and even surgeons to diagnose stress relate conditions. The lack of mental health resources together with the very limited psychological perspective of the people contributes to stress and distress presenting as physical complaints.

There has been, however, an influx of well-intended NGOs offering trauma focussed interventions to people affected by the disaster in these resource poor areas. The interventions include debriefing and benzodiazepines and are built around a model of ‘post-traumatic’. However, there is little evidence for the effectiveness of theses intervention and their indiscriminate application can be harmful (11,12,13). The approach of promoting PTSD case finding and trauma focussed treatment (14) in the absence of a system wide public health approach that considers pre-existing human and community resources,
By Dr Russell D’Souza
Senior Lecturer, Department of Psychiatry, University of Melbourne, has just returned from Sri Lanka.

social interventions and care for people with pre-existing mental disorders might not be appropriate.

Religion, Spirituality and Demoralization
Another recognisable issue is the place of religion, spirituality and rituals in enhancing resilience, coping and rebuilding through acceptance and finding meaning even in the suffering and loss. It was indeed of significance when a woman who had lost her family and all her possessions told me “I have lost every thing I had and now I have only my God”. This is at a time when in the west people in their comfortable abodes, in the face of the Tsunami, are debating the existence of a God. From the interviews of these disaster victims we established that rather than rocking their faith, this set back has bolstered their belief. If our experience in the affected areas is mirrored elsewhere, it illustrates the universal importance of faith in the world.

Thus in these resource poor areas, the collaboration of medical and mental health professionals with appropriate traditional resources such as religious leaders and pastors is seen as an important and necessary engagement to provide care, meaning and community support. The management of this disaster will need to be tailored to the varying needs of each of the regions and respond to the different phases and include acute emergency, post traumatic contingency planning, collaborations, integration of primary health care, access to services, training and supervision and monitoring indicators. (15)

To address the situation of massive need and limited professional resources, innovative approaches need to be considered. These range from training alternative professionals, use of community resources such as teachers, faith healers, clergy and volunteers to empower the population. In the use of culturally acceptable forms of coping, some strategies and interventions that have been used successfully in other disaster situations have been considered. One such approach called ‘focussing’ was used in Afghanistan and involves focussing on painful thoughts and feelings but requires no explicit disclosure of information and no ethical dilemmas of possible self-disclosure. It is found that interventions are better to avoid disease terms and to reflect community-oriented approaches. Interventions might be considered in different levels (18). First is the need to increase resilience of populations. All affected people must be given increased knowledge and skills on the handling of stressful life situations by accepting healthy life styles. Second, as there is evidence of a correlation between a mother’s distress and that of the child (19,20,21), the whole family should become the focus of effective support. Third, traditional methods of support and community solidarity should be encouraged. With the massive loss of life and large-scale displacement that has taken place the rebuilding of community support is in reality a way of promoting mental health. The media can be an important positive influence in spreading the mental health promotion message to the general population. Mental health skills of caring for the population could be integrated with the general services, through teachers in the education system and volunteers. Finally, in all the efforts to rebuild, there is a temptation to just implement short-term measures to alleviate such suffering. This must be accompanied with a long-term plan to rebuild essential mental health services at the primary, secondary and tertiary levels thus ensuring the approach of “building capability” that we have suggested in the first place. This will mean not only empowerment of the people but a population that will be positively prepared for future disasters and emergencies.

Conclusion
Past experience indicates that survivors of disasters experience high levels of psychiatric problems that necessitate mental health promotion to address their needs. It is found that interventions are better to avoid disease terms and to reflect community-oriented approaches. Interventions might be considered in different levels (18). First is the need to increase resilience of populations. All affected people must be given increased knowledge and skills on the handling of stressful life situations by accepting healthy life styles. Second, as there is evidence of a correlation between a mother’s distress and that of the child (19,20,21), the whole family should become the focus of effective support. Third, traditional methods of support and community solidarity should be encouraged. With the massive loss of life and large-scale displacement that has taken place the rebuilding of community support is in reality a way of promoting mental health. The media can be an important positive influence in spreading the mental health promotion message to the general population. Mental health skills of caring for the population could be integrated with the general services, through teachers in the education system and volunteers. Finally, in all the efforts to rebuild, there is a temptation to just implement short-term measures to alleviate such suffering. This must be accompanied with a long-term plan to rebuild essential mental health services at the primary, secondary and tertiary levels thus ensuring the approach of “building capability” that we have suggested in the first place. This will mean not only empowerment of the people but a population that will be positively prepared for future disasters and emergencies.

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