

Tsunami wreaks mental health havoc

Survivors are likely to spend years wrestling with the mental health impact of the Asian tsunami and the earthquake off the Indonesian coast. Aid programmes will quickly reconstruct homes, schools and hospitals, but rebuilding the shattered lives and minds of the people who lost friends, family, homes and their livelihoods will take much longer.

After a huge earthquake on 26 December with its epicentre near the Indonesian island of Sumatra sent walls of water smashing into coasts of Indonesia and neighbouring countries, as many as 280 000 people lost their lives and more than one million people were displaced. Three months later, 1300 people were killed on the Indonesian island of Nias by the aftershocks.

“There are areas where everybody knew someone who has lost everything or who had one or more family members disappeared. The tsunami will be a landmark in the memory of many communities,” said Dr Pau Perez Sales, a consultant for psychosocial and mental health programmes for Médicos del Mundo-España (MdM-E).

Mental health experts now argue that governments in the region should grasp the opportunity not only to address the short-term mental health problems caused by the tsunami but use the influx of funds and assistance to develop mental health systems in the long term.

Based on their experience of large-scale disasters, aid agencies set about preparing for a rise in mental health problems. Disaster relief planners quickly drew up strategies to bolster national-health services to help survivors cope with the aftermath.

The precise demand for mental health services after the tsunami was unknown, but WHO said that the prevalence of mild and moderate common mental disorders in the general population is 10% and that this can increase to 20% after a disaster. Severe mental health problems, such as psychosis or severe depression, typically affect 2–3% of any given population but can increase to 3–4% after a disaster, WHO said.

Aid agencies feared a high burden of mental conditions after the tsunami and earthquakes, said Dr Daya Somasundaram from the Department of Psychiatry at the University of Jaffna, Sri Lanka, who has been training com-

munity workers to provide counselling and other forms of psychosocial support interventions.

“WHO estimated that 50% may have problems and 5–10% have serious problems needing treatment. One [non-WHO] survey found 40% post-traumatic stress disorder (PTSD) in children,” Somasundaram said, referring to people in Sri Lanka. Other data had suggested that the mental health burden in Sri Lanka was even higher.

Altogether at least five million people have been affected in India, Indonesia, Maldives, Myanmar, Thailand, Seychelles and Sri Lanka by the earthquakes and tsunami, and in addition to those who lost their lives or were displaced. As soon as the scale of the disaster became apparent aid agencies, the UN, governments and WHO mobilized relief teams and millions of dollars of aid were shipped and flown to the affected regions.

At first, agencies focused on helping national health authorities deal with vulnerable survivors and organizing the safe burial of the dead. Priority was also given to monitoring risks to health through early warning disease systems and supporting recovery of countries' health systems.

Ministries of health, WHO and other partners quickly did health assessments to determine survivors' most pressing needs. Surveys of the most affected regions categorized peoples' mental health into three groups.

First: survivors with mild psychological distress that resolved within days or weeks. Second: people with moderate or severe psychological distress

that resolved with time or mild chronic distress. Third: people with mental disorders, divided into those with mild and moderate mental disorders and those with severe mental disorders.

Tsunami-affected countries were advised to urgently provide mental health care via general and community-based services. Mental health workers had to deal with grief reactions, depression with suicidal tendencies, PTSD and other conditions.

Bhava Nath Poudyal, a mental health expert with the International Catholic Migration Commission

in Indonesia, said many survivors faced “economic loss, loss of loved ones, need for livelihood — and stress reactions, emotional issues related to loss — some anxiety, especially at night, demoralization and psychosomatic complaints”.

Countries were also advised to provide social and psychological support, such re-opening schools, reuniting families, organizing child-friendly services and fostering economic development

as well as simple psychological interventions, such as training community health workers in basic counseling skills.

One problem that concerned WHO was programmes focusing solely on PTSD, which the agency believes has been wrongly considered to be the biggest mental disorder after a disaster. It warned other agencies not to waste precious time in building PTSD-focused services that might miss survivors with other mental health problems.

Delivering any sort of health care was compromised by the massive

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Reuters/A. Datta

An Indian woman mourning the death of a relative who was killed in the Asian tsunami catastrophe. The photograph was taken in Cuddalore, Tamil Nadu in India, on 28 December 2004. It won first prize in the World Press Photo of the Year competition 2004.

destruction of infrastructure and difficulties of coordinating responses when so many agencies were involved, said Professor Harry Minas, a WHO consultant and Director of the Centre for International Mental Health at the University of Melbourne, Australia.

A more complex problem for Western aid agencies was adapting their clinical and psychological support services to the cultural specifics of the tsunami-affected population. Many interventions required understanding of the socio-cultural context which meant that local mental health professionals had to play a lead role.

“In Sri Lanka, concepts like ‘mental health’ or ‘psychological problems’ are not part of the lexicon of the population. They expressed emotional distress through the body, e.g. headaches or bodily pain,” said Sales, adding that western clinical responses to acute stress disorder, PTSD and similar conditions were probably inadequate.

One solution in Sri Lanka was to ask local social organizations to help provide support to the affected population. “Culturally adequate support seemed to come, in many cases, from

the community”, said Sales. A traumatic event causes a breakdown in basic assumptions around oneself, the world and the role we have in it, said Sales.

Therefore “religion had a decisive role in the cultural processing of traumatic situations ... not necessarily in active practising, but as the cultural matrix from where trauma is understood”, Sales said.

Somasundaram said that in Jaffna “we are encouraging the use of traditional practices like mourning and funeral rituals for the dead and use of traditional relaxation like yoga”.

WHO mental health expert Dr Mark Van Ommeren said it was important to install long-term programmes: “We advised governments against one-off ventures”.

Minas, who has been working in Aceh,

Indonesia, with WHO’s Department of Mental Health and Substance Abuse, and the Indonesian Ministry of Health, said projects had to be sustainable so they could be taken over by local health workers.

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Dr Sales said his agency’s priorities after the tsunami struck were health care in refugee camps focusing on psychosocial issues; community mobilization; health education and nutritional assessment; and rehabilitation of infrastructures, such as hospitals.

“For psychosocial attendance, it seemed clear to MdM-E that a short-term crisis-focused model ... where no mental health facilities were available in most areas of the country seemed inadequate,” Sales said.

For example in Trincomalee in north-eastern Sri Lanka, WHO and national health authorities developed a national mental health plan based on a 12-bed mental health unit in a general hospital and a training programme of community and psychosocial workers for outreach work.

MdM-E suggested a slightly different programme that would make better use of current resources and would be better in the long term: a 12-bed inpatient unit in the general hospital with outpatient consultations, occupational therapy, a full-time psychiatrist and auxiliary personnel.

“We changed an emergency short-term view for a developmental long-term view ... instead of a narrow trauma-focused perspective,” said Sales. ■

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