

One world spirit

The Indian Ocean tsunami was the greatest natural disaster of our times. And it hit primarily two resource-poor countries – Sri Lanka and Indonesia – both already saddled with problems of conflict.

Clearly, the first thing was to rescue survivors, bury the dead, clear debris, provide basic housing and prevent disease. The international response with both resources and personnel in this respect was tremendous. But then the question arose as to what would be the most appropriate 'help' in the face of the immense mental suffering that was evident. As a result of the world having to contend during the past 20 years with a number of large-scale disasters – usually 'man-made' ones in places without a great deal of access to mental health services – there has been debate in psychiatric and psychological circles about best practice in such emergencies. Very recently, the World Health Organisation (WHO) outlined the basic tenets of a consensus that had emerged on this topic.¹

Acute emergency phase

The main need at this stage, it says, is to facilitate social networks, while ensuring 'a reliable flow of information' and enabling people to get back to normal activities as far as possible. It is important to create space for community activities – including cultural and religious events – and allow people to participate in familiar grieving rituals; for example, involving priests and other spiritual practitioners. Children without carers have to be looked after and protected from exploitation and any unnecessary exposure to having to talk about their experiences. And every effort has to be made to reunite families and help people to contact relatives.

The WHO document plays down attempts at individual interventions at this stage, warning in particular against rushing in with trauma-focused counselling. The reasons for this advice are clear in the body of the document. Techniques subsumed within the term 'trauma-focused counselling' have been developed in North America and Western Europe in association with the concept 'post-traumatic stress disorder' (PTSD). First, the usefulness of this concept to people whose cultural roots are in Asia and Africa has been contested – a controversy that is not yet settled. Second, there has emerged a consensus among

many people who have worked in emergency situations that, as the WHO puts it, 'interventions that are most often implemented to reduce traumatic stress – one-off psychological debriefing (organized by international and local organizations) and benzodiazepine medication (prescribed by local physicians) – have little evidence of effectiveness, and indiscriminate application can be harmful'.

So, what WHO suggests is that the acute stress of individuals is best managed without medication but with 'psychological first aid' – mainly non-intrusive emotional support, covering basic physical needs, protection from further harm and the organisation of social support networks.

Post emergency phase

After the first few weeks, the social interventions in the acute emergency phase need to continue, but help should now be directed also to 'disaster-inflicted poverty', together with the promotion of 'community-based self-help support groups to brainstorm solutions that are future-orientated and the generation of mutual emotional support'. In this phase, mental health specialists have a role in assisting and supervising (from a psychological angle) general health care staff, and in planning and developing longer-term mental health systems. All this should be done in collaboration with (what may be available of) the sources of help and support that the local communities normally turn to, such as faith healers.

The overall aim now is to provide meaning to life for people who are bereft and an opportunity for communities to get together, plan for the future and rehabilitate themselves (with help). WHO advise that if and when general ongoing mental health care is available, then trauma-focused counselling may be planned as a part of general mental health services or as a part of the school health system.

I am not sure to what extent WHO guidelines are being followed in the countries affected by the tsunami. In Sri Lanka, it is reported that some foreign teams, although well-meaning, are tending to rush in to do their own thing – sometimes based on trauma counselling learned in very different cultural settings – disregarding indigenous cultural norms and religious sensitivities. Although the government may have appointed a team called the

'psychosocial desk', led by a community-minded psychiatrist, to try to co-ordinate psychosocial care, its ability to regulate what foreign agencies do depends very much on the willingness of those agencies to seek guidance.

There are over 100 foreign non-governmental organisations doing 'psychosocial' work in Sri Lanka since the tsunami struck. Many of these new agencies appear to have little understanding of local customs and grieving rituals. Worse still, some groups are known to impose religious ideologies; for example, encouraging people to join in Christian prayers in an area where the majority are Muslims. Controlling all of this is an enormous headache for government agencies.

Although in the short and medium term, Indonesia and Sri Lanka certainly need the practical and personal help given in such abundance by the international community, it must be remembered that ultimately, the communities in these countries must be the architects of their own psychosocial recovery. A well-known psychiatrist who works with refugees in Australia comments: 'Solutions imposed in a hurry from the outside are never durable. Rushing in and out with quick-fix approaches can do more harm than good and can leave a residue of resentment and unfulfilled promises.'²



The tsunami disaster has left Indonesia and Sri Lanka with enormous problems of social reconstruction. Over the next months and years, they are sure to see longer-term psychological/mental health problems emerge that can be traced to the trauma of this tsunami. Experience tells us that these will almost certainly affect only a small minority of people. Since we have no way of predicting who these people will be, targeted interventions to prevent long-term psychological effects of 'trauma' are not possible.

A theme that runs through the WHO guidance is the uncertainty around the question of using Western-style 'talking therapies' to help people who have been traumatised. While accepting that if someone wants to talk about their experiences it is important to listen and support with compassion, persuading people who have been traumatised to 'talk about' their experiences because 'it is good for them' may merely undermine individual resilience in coping with trauma.

There are a number of reasons for suggesting this. First, unlike in many Western countries, where people in trouble

tend to look to 'experts' for psychological support, the sources of support for many people in non-Western settings tend to be around spiritual and religious systems, and with other people in the community – including, of course, people who have come from other places showing concern and compassion.

Second, in non-Western cultural settings, preservation of mental health is not often seen as being about the relief of 'symptoms' and treatment of 'illness'. It is rather a matter of relating to other people ('togetherness', one may call it), contemplation and spiritual sustenance. So bringing in therapists diagnosing symptoms and medicalising distress, depression and anxiety may just add to a person's problems by stigmatising their distress and reducing their capacity to come to terms with it in a culturally appropriate way.

Finally, there are questions generally about the advisability of pressing people into 'sharing their feelings', as many counsellors and psychotherapist may do – especially in cultural settings where it is felt as intrusive when 'outsiders' ask personal questions. The dogma on which we base much of our (Western) psychological interventions is that

talking about disturbing feelings prevents them causing mental health problems in the future. What is being realised now is that many people who have been exposed to traumatic experiences wish to get on with their lives, pushing their (traumatic) memories away, and only feel secure enough to talk about them many months or even years later. Indeed, it is possible that reliving traumatic memories may merely perpetuate distress, preventing people from making the overall adjustments in their lives that are needed.

The Indian Ocean tsunami has shaken us all to consider our common humanity as belonging to one race and one place – this small and vulnerable planet. Yet, the public reaction to the tsunami emergency also serves to highlight the discrepancies in wealth and health in the world today. While acknowledging the one world spirit that has generated such compassion towards the people affected by the tsunami, we need to consider that there are (as it were) ongoing tsunamis – for instance, the HIV/AIDS and starvation emergencies. We need our one world spirit to carry on.

1. Van Ommeren, M., Saxena, S. and Saraceno, B. (2005) 'Mental and social health during and after acute emergencies: Emerging consensus', *Bulletin of the World Health Organisation*, 83(1): 71–7.
2. Silove, D. and Zwi, A. B. (2005) 'Translating compassion into psychosocial aid after the tsunami', *Lancet* 365: 269–70.