

# Responding to the psychosocial impact of the Tsunami in a war zone: experiences from northern Sri Lanka

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*Three days after the Tsunami hit the war-torn Jaffna district in northern Sri Lanka, a mental health task force was formed. The approach of this task force, comprising a cooperative initiative between 18 humanitarian agencies, is described in this field report.*

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## Before the Tsunami

The December 26, 2004 earthquake off the west coast of northern Sumatra triggered a disastrous Tsunami hitting the Asian region. Sri Lanka, 1000 miles west of the epicentre, was directly in the path of the Tsunami. The Eastern and Southern region were among the worst affected areas, however, it is less known that the population in the North was also badly affected.

Before this natural disaster hit Sri Lanka, the populations especially in the North and East were already facing considerable problems due to a man-made disaster: two decades of civil conflict. A survey carried out in the North (Somasundaram, 2001) showed a high incidence of major mental health problems in the community, in particular depression, anxiety disorder and Post Traumatic Stress Disorder (PTSD). Other wide spread problems present were alcoholism, domestic violence and child abuse. The number of children referred for psychiatric help is also increasing, as awareness and recognition of behavioural disorders in children is growing.

Due to the armed conflict, many traditional psychosocial support systems were destroyed and available health services badly impaired. In order to deal with the psychosocial problems among the population in the North, community based psychosocial services have been organised since the 1980's in various towns, initiated by responsible citizens. In addition to these local NGO (Non-Governmental Organisation) activities there are some hospital-based psychiatric facilities available through the government, with some psychiatrists, medical officers and nurses trained in mental health. Since 2002, a hospital based multi disciplinary team of counsellors, social workers, relaxation therapists and an occupational therapist is working in one of the districts.

## After the Tsunami

About 80.000 people in northern Sri Lanka have been directly affected by the Tsunami, which is about 10% of the total population of the area. Only rough estimations can be made of the number of people who are indirectly suffering from the impact of the Tsunami. Many people living outside the area directly hit are affected emotionally, financially, and/or socially. They are difficult to target by aid organisations and can often only be identified when they enter locally existing services.

The North is partly in the hands of the Sri Lankan Army (SLA) and partly under control of the Liberation Tamil Tigers of

Eelam (LTTE), which also influenced the help that could be delivered to the various areas. In the aftermath of the armed conflict, a considerable part of the Northern coastline is still a high security zone, which means that this coast is mined and fenced off with barbed wire. During the Tsunami, this barbed wire became hell for the many people who were caught in it. Women with children, who had to put their children down to untangle themselves, saw their children being washed away. Also due to the Tsunami, land mines came to the surface, which created great fear. Immediately after the disaster, people did not dare enter certain areas to give first aid to the affected people because of these mines.

Most of the people in the North affected by the Tsunami were fishermen and their families, and in general were still in a resettling process after earlier displacements due to the armed conflict. Most of them had suffered loss of life and property before the Tsunami, but not to the extent caused by it. In many families, there were multiple deaths, the majority being women and children.

In the first month after the Tsunami a qualitative assessment of psychosocial needs following the disaster was carried out (Danvers, Somasundaram, Sivayokan, & Sivashankar, 2005). The following psychosocial impacts were identified.

On the *individual level*, the consequences included: acute stress reactions (feeling distraught, dazed and highly emotional) lasting a few days, anxiety (fear of sea, nightmares, mistrust of nature), and grief reactions, some atypical in nature, but commonly complicated by guilt, anger and suicidal thoughts<sup>1</sup>. The fact that people were unprepared, and that the scale of devastation from the Tsunami was enormous may have contributed to people's distress, as they would not have been able to use their usual coping mechanisms for times of stress.

A survey carried out in February 2005 by Schauer, Ruf, Catani, Onyut, Gotthardt, Schauer, Rockstroh, Elbert & Neuner (2005) aimed at identifying children at risk of developing PTSD, found rates in the North (45%) were more than double the rates found in the South (18%). Risk factors were identified as: earlier war experience, domestic violence and the severity of Tsunami experience.

At the *level of the family*, the consequences included: disruption of the normal grieving process (in many cases bodies have not been recovered or identified, or there was no opportunity to carry out the traditional funeral rituals), and a high degree of property and financial loss, which has severely affected the economy. As most affected people were fishermen and lost their equipment, whole families therefore lost their only source of income.

At the *community level*, the most striking consequence was the massive displacement of people and thus destruction of the usual community support systems. Individuals were left without community support. Perceived inequities in the distribution of aid created a lot of unrest and sometimes uproar in the initial weeks after the Tsunami, but as soon as the co-ordination improved, these types of problems disappeared. Due to earlier experiences of displacement and loss some of the affected people in the North appeared to be more resilient and proactive than elsewhere in the country.

Looking at the *society* as a whole, vulnerable groups identified after the Tsunami were: children who lost their parents, adolescents, widowers with small children and psychiatric (schizophrenic) patients.

### **Present situation**

At this stage, few people still live in tents as most have moved to semi-permanent shelters in transit camps. Unfortunately, many of the

semi-permanent shelters have proven not to withstand the heavy rainfall in the second half of 2005, so recently many people had to look for other shelter. The difference with this situation to earlier displacements due to the armed conflict is that then it was often impossible to return to the home place because of danger. This time, however, with the fear of another Tsunami slowly subsiding, people have been eager to go back to their own areas and pick up their lives.

Some recent social development that has been observed in the camps is the reforming of relationships: the number of both remarriages and early marriages has increased. After remarriage, children from a former marriage are often left in the care of relatives. From earlier experiences in Internally Displaced Persons (IDP) camps it is known that often these camp marriages are not often sustainable and frequently end with the wife abandoned and left with the children. These might be problems that will be increasingly seen over the next few years.

Illegal brewing of alcoholic beverages (*kassipu*) is also common in many camps and the amount of alcohol that is used is considerable, which certainly contributes to a rise of secondary problems.

Another source of tension in some camps is that Tsunami-IDPs live together with war-IDPs and it creates envy and a feeling of inequality when some organisations only give aid to those people affected by the Tsunami.

### **Psychosocial interventions in response to Tsunami**

*Immediate interventions (0 – 4 weeks after the disaster):* In the first four weeks after the Tsunami there was an influx of organisations, consultants and individuals who felt the need to help for humanitarian reasons. Both local and international organisations showed a

great deal of interest in psychosocial activities, even when they had no expertise in the field. This sometimes resulted in poor interventions. Many consultants and individuals also offered training in psychosocial issues. Although it was undoubtedly well meant, the question should be raised as to how effective this has been. Many new and inexperienced people were given brief training about similar subjects by a variety of people and there was no real coordination about what was being taught. With so many newcomers in the psychosocial field there was a need for co-ordination and guidelines.

Three days after the Tsunami, the Mental Health Task Force in Disaster (MHTF) was formed by 18 different organisations providing humanitarian services in the Jaffna district. The purpose was to coordinate and direct mental health and psychosocial activities. Initially the MHTF met on a daily basis, but in time, the frequency of the meetings became less following need.

In June 2005, the MHTF has handed over their activities to the local government at district level. In the LTTE controlled area in the North, a separate coordinating body was formed with a similar purpose.

The core activity of the MHTF had been providing and coordinating psychological first aid by mobilizing and upgrading existing resources to visit the welfare centres. Short training sessions were provided for counselors, psychosocial workers and all those with some experience in this field. Information was given about how to adapt their listening and counselling skills to a crisis intervention situation. Workers were strictly advised to provide supportive listening only for those who were ready to talk, and to never force anyone to speak about their experiences.

Another important activity was to give information to the public about normal reactions to trauma, emphasising the likelihood of

natural recovery. Information was provided to the media about different stress-related issues, and a pamphlet was printed for the people affected by the disaster, as well as a booklet for workers in the community.

*Short term interventions (1–6 months after the disaster):* Before the Tsunami, community level workers such as family health workers, traditional healers, village leaders, teachers, and government and NGO workers had already been trained by various local NGOs in basic mental health and psychosocial skills. In order to enable these people to handle the majority of psychosocial problems after the Tsunami themselves, and to identify the more severe cases for referral, a short refresher course was given by the Mental Health Task Force.

In addition, a large number of local and international organisations with projects in the Tsunami affected areas were provided with psychosocial training for their fieldworkers. Training was also given at community level to core groups of community members. Presently, more capacity building of community psychosocial services (training of community support officers) is going on in all affected areas in the whole country with the help of the World Health Organization.

Playgroups for children were started, relaxation techniques taught, expressive activities and counselling services were also offered. For both psychosocial trainers and counsellors, clinical supervision and additional training on specific topics was provided.

As some affected areas in the North were not well covered initially by the various psychosocial organisations and psychiatric services, the psychiatrists in the North have developed an outreach program in which they now provide psychiatric clinics on a regular basis to the hospitals in these areas.

*Long term interventions (> 6 months after the disaster):* The expectation is that the majority

of the affected people will gradually and naturally recover from their traumatic experiences. However, there will be a minority who experience continuing mental health problems requiring specialised help. Any mental health needs that arise from the disaster should be preferably addressed by existing mental health services, rather than setting up separate services for Tsunami survivors. Existing services will have to expand to cope with the expected increase in demand.

It is important that the psychosocial component should be taken into account in all rehabilitation, resettlement and development programmes. A holistic approach that includes psychosocial and mental well-being will enhance the recovery process.

## **Conclusion**

The framework used by the Mental Health Task Force in Disaster for dealing with psychosocial issues following a large-scale natural disaster such as the Tsunami, has proven to cover most aspects. Problems perceived were mainly related to logistics and the specific political situation.

Providing psychological first aid in the more remote areas was hardly possible because of lack of (finances for) transport. Human resources to provide adequate supervision and advice on self-care for workers in the field was also limited and not always used to maximum effect.

The overload of offers of foreign help might have been more effectively streamlined; as most consultants only stayed for a couple of days and needed a translator, they added to the workload of the local psychosocial organisations.

In the first months after the disaster, local NGOs were able to rise above personal interests and disagreements, and formed a united front. The challenge is to maintain this unity

and use it as a basis for longer term cooperation and planning.

Although some lessons can be learned, psychosocial help in the North after the Tsunami has been well organised and coordinated compared to other affected areas in Sri Lanka.

It is obvious that the Tsunami has put mental health and psychosocial issues high on the agenda, and from a public health perspective, a window of opportunity has been created.

The challenge is to use this opportunity to improve the existing mental health services in Sri Lanka, especially in the North and the East where, due to years of armed conflict, the incidence of mental health problems was already high before the Tsunami.

## References

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<sup>1</sup> Many survivors just after the Tsunami wished to be dead, but the actual number of suicides and suicide attempts has not been any higher than normal.

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