

Sri Lanka's post-Tsunami psychosocial playground: lessons for future psychosocial programming and interventions following disasters

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This paper explores examples of unsolicited, culturally inappropriate and conflict insensitive interventions initiated by both local and international teams to Tsunami-affected populations in Sri Lanka. It also explores the apparently prevalent belief that psychosocial interventions can be delivered as 'relief packages' to those affected, and as part of project-based, rather than process-enabling, interventions. The need for an integrated approach to psychosocial intervention following disasters remains a challenge for humanitarian agencies and local authorities in post-disaster settings. Regulatory mechanisms for non-governmental organisations (NGO's), charitable or individual groups, seeking to 'intervene' in the mental health and psychosocial sphere in the aftermath of disasters, are challenging the complex political, donor, humanitarian and resource-poor gradients. This discussion serves to highlight the significant task of balancing humanitarian compassion with effective psychosocial programming, especially in resource-poor contexts that seem to readily absorb such interventions.

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A carnival of interventions

If you were a person displaced by the 26 December Tsunami that struck Sri Lanka,

and currently live in a transit accommodation centre while awaiting your house to be re-zoned and constructed, then chances are you have been subjected to an array of post-Tsunami 'psychosocial' interventions, from a myriad of groups.

The influx of sympathetic, enthusiastic (and sometimes eccentric) volunteers from foreign lands into the Tsunami relief camps, carrying their own toolboxes of 'psychosocial and trauma recovery' activities, added as much amusement as it did confusion to many of the beneficiaries, local aid workers and authorities involved in recovery and development efforts. Mental health and psychosocial programmes, that usually feature as a small appendage tacked on to the list of health and recovery action plans following a disaster, were given high priority following the Tsunami in Sri Lanka, and across all levels: governmental, non-governmental, United Nations agencies and civil society groups. The high-level political support for mental health service provision both encouraged and stimulated the health and community development sectors. Sri Lanka's President identified psychosocial interventions as 'one of the Government's top priorities' in the post-Tsunami recovery plan (WHO/WPRO, 2005; Daily News, Sri Lanka, 2005). The president even cautioned authorities to be particular about enlisting only qualified

personnel for post-trauma counselling (Daily News, Sri Lanka, 2005).

The word 'psychosocial' and the acronym 'PTSD' (post-traumatic stress disorder) became so widely used, they soon became part of the popular post-Tsunami discourse. Despite longstanding concerns about the appropriateness of applying a psychiatric 'PTSD' label to traumatic reactions, especially for children and adolescents (Perrin, Smith & Yule, 2000), both politicians and news columnists dared not give a speech nor write an article on the recovery efforts without mentioning the potent four-letter acronym.

It was, however, at the Tsunami relief camps that the carnival of interventions truly manifested.

In the Southern district of Galle, a foreign volunteer team dressed in bright yellow t-shirts and matching caps entered a temporary accommodation campsite, which housed over 100 Tsunami-affected families. The team, travelling in a hired bus decorated with bright yellow banners and streamers, looked like a troop from a Brazilian Mardi gras parade. They then proceeded to hastily mobilize the transit camp authorities to round up the children for what they termed 'psychosocial therapy'. Bright-coloured tents were quickly assembled in the camps. The resident children, with a mixture of both amusement and confusion, complied with the instructions from their bemused elders, and were soon shuffled into groups, according to age. The foreign teams then began massaging (using an ointment) the limbs and foreheads of these 'traumatized children', all in the name of 'psychosocial healing and therapy'. In one instance a masseur, who spoke English as a second language, was applying Betadine (an antiseptic) on the face of a young boy who had no apparent cuts or abrasions on his face. When an observer asked the masseur what she doing, the woman replied, 'this boy no English'. The young boy immediately

responded, 'What is your name?' A World Health Organization (WHO) team visiting the camp to conduct an initial assessment witnessed this 'psychosocial' phenomenon and reported it to the relevant district level health authorities.

Although research supporting the effectiveness of drama and art therapy interventions in coping with anxiety and psychosocial trauma are limited (National Center for PTSD USA, 2005), particularly with young children and adolescents (Perrin et al., 2000), these interventions are usually intended to be included as a single component of a long-term, multi-level intervention program (Ehrenreich & McQuaide, 2001; Tribe, 2004). More importantly, such interventions need to be conducted in a manner that is both culturally appropriate, and conflict sensitive.

In Kalmuani in the Eastern province, a foreign group offered sessions that integrated drama and music therapy as a means of 'psychosocial release'. This psychosocial drama 'troupe', conducted a once-only psychosocial workshop with the children and young people of the affected communities (predominantly Muslim), involving expressive Western dance and song, in an area near a mosque. The vehement response by some community leaders and Imams of the local area to government authorities came swiftly.

A headline in one island newspaper many months after the Tsunami read; '17 Japanese experts arrive to undertake psychosocial activities for Tsunami victims', and written somewhere near the end of the article the comment 'bi-lingual interpreters needed urgently'.

The need for co-ordination and regulation

These anecdotes, however amusing, expose a serious need for better co-ordination,

monitoring and regulation of agencies. There must be an assurance of sustainable and ethical practices in interventions, and emphasizing the importance of conflict sensitivity and cultural appropriateness for post-disaster psychosocial interventions.

Balancing a firm degree of regulation by the relevant administrators (at both the central and peripheral levels), with the flood of compassionate humanitarian enthusiasm in its urgency to 'act' quickly and visibly, poses a precarious challenge, especially in resource-poor and post-conflict contexts that readily absorb such aid. The complex diplomatic, political and donor-driven dimensions of integrating humanitarian aid and intervention, both within the sensitivities of local systems and across the different components of the international response has also been well documented (WHO/PAHO, 1999; International Meeting on Good Humanitarian Donorship, 2003; Charny, 2004; De Torrenté, 2004).

At the field level, Tsunami camp administrators and primary health care workers, more familiar with 'hardware' interventions such as logistics of donor relief items, disease surveillance or latrine construction, readily allowed unrestricted access by groups wanting to intervene with the label 'psychosocial'. These interventions often included 'counseling sessions' for survivors of the disaster by poorly trained non-governmental organization (NGO) staff and volunteers, despite the limited evidence to support the effectiveness of immediate post-disaster critical incident stress debriefing (Gray, Maguen & Litz, 2004).

A young person in Jaffna district, situated in the northern conflict-affected region of Sri Lanka, was visited continuously by a revolving group of foreign and local 'counsellors' from various psychosocial teams. They all asked her to vocalize her traumatic experiences, as she appeared to be

withdrawn and solitary. She explained later that she was more 'traumatized' by people wanting to ask questions about her loss than about the loss itself, and that her perceived inability to express her views when asked these questions, added to her feelings of guilt and shame.

The impact of such measures within the Sri Lankan context has also been described (Galappatti, 2005; van Rooyen & Leaning, 2005; Komesaroff & Sundram, 2006). The scarcity of adequate psychiatric and psychological services in the war-battered north-eastern provinces of Sri Lanka also contributed to this lack of awareness occurring at the periphery. However, as Galappatti (2005) elucidates, the hard-learned lessons and good examples from pre-Tsunami conflict-related psychosocial programming, seemed to have been overlooked in the process of current planning efforts.

These experiences serve to highlight the significant task of limiting the unsolicited and potentially inappropriate iatrogenic interventions initiated by either local or international humanitarian agencies to vulnerable populations. There seems to be a mistaken belief that psychosocial interventions can be delivered as 'relief packages' to those affected in much the same way as hygiene kits are distributed to those displaced.

Guidelines and recommendations

Silove & Zwi (2005) highlight nine guiding principles for cultural competence in mental health programmes following major disasters, and in translating 'compassion into psychosocial aid'. A mental health policy framework and accompanying guidelines on such mechanisms will also assist well-meaning international groups/donors to improve, maximize and navigate their interventions

on the ground. The Sri Lankan Ministry of Health, in collaboration with WHO and other key stakeholders are currently formulating a comprehensive National Mental Health Policy (WHO/Sri Lanka, 2005). The importance of psychosocial interventions working as ongoing 'process'-driven goals, rather than 'project'-driven products, is now becoming more clearly articulated.

Regulatory mechanisms for NGO's, charitable or individual groups seeking to 'intervene' in the mental health sphere following disasters, become challenging across the complex political, humanitarian and resource-poor gradients. Within the Sri Lankan context, a practical recommendation may be to have the Deputy Provincial Director of Health Services (DPDHS), who serves as the main focal point for the provision of public health services within each district, establish a psychosocial co-ordination desk for activities. Indeed, the establishment of integrated approaches to psychosocial interventions catalysed in some Tsunami-ravaged districts in the island due to the dynamic leadership of some experienced community development and mental health workers. For instance, in Batticaloa district on Sri Lanka's east coast,

a 'Psychosocial Working Group' formed as a basis for developing 'pluralistic interventions' that encompass both community development and mental health approaches to service provision (Galappatti, 2003; van Rooyen & Leaning, 2005).

Aside from targeted psychosocial interventions, perhaps one of the greatest healing forces is derived from the efforts aimed at returning to, or recreating the sense of, 'normalcy' in life. This is especially true for children and adolescent survivors of a disaster living for extended periods in shelters or refugee camps (Ehrenreich & McQuaide, 2001; Arntson & Knudsen, 2004; Duncan & Arntson, 2004)

'I just want things to be like what they were before', said the reticent girl in Jaffna who was subjected to the barrage of counselling questions. 'I want school to start, to go to temple and play with my friends... This is what I want'. Let us learn from her wisdom, and from the collective wisdom gained from what was Sri Lanka's post-Tsunami psychosocial playground.

A 'psychosocial intervention' involving children and young people at a Tsunami transit camp, Jaffna district, January 2005. (Photo by author)



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