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Recovery and Beyond: Working with Young Tsunami Victims in Thailand

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The tsunami struck Asia on December 26, 2004 and left a devastating impact. Hundred thousands of people lost their lives across the region. In Thailand 6 provinces along the Andaman coastline in the south was severely hit. The official death toll for Thailand was 5,376, but the real figure was thought to be much larger. Four hundred and ninety fishing villages with an estimated population of 100,000 were affected; 3,689 houses were partially or totally damaged; 2,435 fishing boats were destroyed. The estimated financial damage was more than 200 million US$[12]. Of all 6 provinces, Phang Nga was the most strongly struck. One of the area in Phang Nga called Khao Lak which was one of the best known place for beaches and holiday resorts in the world with excellent location-the beach in the front and the hill at the back, with the hotel rooms in between-was almost completely destroyed. The cruel fact was that the tsunami happened during the highest point of tourism season-just one day after Christmas. Thus, the casualties were not only Thais, but holiday-makers from all over the world.

Immediately after the tsunami, the Department of Mental Health of Thailand and several professional bodies tried to organize mental health services to the affected area. Hundreds of mental health personnel with good intention rushed to the south in the first weeks after the attack. The problem was that Thailand had never experienced such a large scale disaster. Therefore, some people ended up going their not knowing what to do. It was a common experience for psychiatrists or mental health workers to walk around the wrecked area asking questions and trying to interview victims in order to offer psychological help, but soon found out that people were too distressed and no one was in the mood to talk to them. Some of the volunteers then gave up the mental health work and found themselves more useful collecting bodies from the beach. Some almost went from helper role to victim role. There was a story of a group of 3 psychiatrists who went to one island and while they were trying to soothe people down from their distress, then came a panic shout that "Tsunami is coming again!!", so they alarmingly ran up the hill and

got separated from each other for many hours, surrounded by lots of terrified people, before they could reunion with the team.

Disaster recovery can be classified into 6 stages : 1) Heroic ; 2) Tunnel vision ; 3) Honeymoon ; 4) Disillusionment ; 5) Reconstruction/Recovery ; and 6) Enhancement/Post-traumatic growth[9]. During the early phase of recovery, the tsunami victims in Thailand received outpouring of support from people and organizations both in-and outside the country. Governmental officers, NGOs workers, and volunteers flocked the area. Though out of good intention, their activities were sometimes not well-coordinated and therefore the victims did not get the optimal help they needed. Poorly organized distribution of donated clothes and food led to redundancy in some areas, shortage in another.

Then we entered the disillusionment phase when the resources dried up, the volunteers decreased in number because they had something else to do. One or two years later, we found no time to visit them any longer, although this was probably the time they needed us the most because of the emergence of many psychiatric disorders, for example, PTSD, depression, and substance abuse, in the later phase of trauma. It is clear that the work needs to be extended well into the recovery phase. In this article, we will review the work of a team in Phang Nga, with its project now moving beyond the recovery well into the enhancement phase.

The team consists of volunteered psychiatrists from different institutes in Bangkok. We choose to base our work in schools, unsurprisingly as the majority of the team is child psychiatrists who are familiar with school mental health. The traveling distance from Bangkok to Phang Nga is quite far―788 km. The visit to the area has been spacing out from 5 times a year in the first 2 years to 2 times a year from year 3. So far there have been 15 visits. The program is expected to be run for 5 years, as opposed to 2 years as we first planned since we reckon the importance of continuing work. The team has got the funding from the institutes that the members of the team work in, and also from Thai Health Promotion Foundation in the first 2 years. In the later years it has been more difficult to get funding ; another classic example of the disillusionment phase we have discovered ourselves. Fortunately, donated money from a gentleman who really wants to help the children in the affected area has kept the project going. The team is very grateful to him, and therefore always makes sure that the money is very well-spent.

The mission of the team was not quite clear in the first place, but after months and years of learning we have come up with this list. First of all we want to screen mental health problems that children in the area might have as a result of the tsunami. In doing so we need valid instruments, but we had very few, so we need to develop new ones. And when we can identify the cases who need help we hope to provide the right intervention for them. The intervention also has to be developed since we had no experience ever in treating children from such a large scale disaster. We also plan to train teachers and health personnel so they can form a network to take care of the children with us. And in the end we hope that what we learn could give us insight into trauma work through the research.

As Phang Nga was severely hit by the tsunami and there is no way we could go to every child, the screening procedure is crucial.

We initially try to identify at-risk children by monitoring the children who lost family member, had direct exposure to the tsunami, sustained injury, and had previous history of psychiatric disorders. The Pediatric Symptoms Checklist (PSC) is among the first questionnaire we use for screening, but after a while we find it not very specific to psychiatric conditions most associated with trauma-PTSD and depression-so we later give up. The Thai version of Children Depression Inventory (CDI) has been already available at that time so we include it for depression screening. Problem is how we can screen PTSD as there is no instrument at that point. Luckily, with international contact we find the Children Revised Impact of Event Scale (CRIES) which proves to be a useful instrument in many traumatic events such as war, sinking ship, and road traffic accident[3], and after the systematic, culturally sensitive translation into Thai, we start using CRIES in order to screen PTSD.

All of the cases that we could identify then go through psychosocial intervention, mainly supportive psychotherapy, group therapy, and cognitive behavioral therapy (CBT). There is a problem with some cases that the team thinks it would be more effective if the child receives medication. The prescription process is extremely difficult because the project is school-based and the parents are not around to give consent. It is also hard to monitor the efficacy and the side effects. Therefore, we decide to keep medication treatment to a minimum.

The children who are screened and diagnosed as PTSD has a chance to ventilate their distress and then are supported by psychiatrist in the team. Later, they have group therapy. This is very useful as children can share their traumatic stories. The group process makes it easier for many children to express themselves as they can learn though seeing other children talk. This can also be a self-help group when they learn to support and advise each other various kinds of techniques that can help them cope with traumatic memories. The CBT techniques can also be taught in a group format[10]. The easiest one we teach every traumatized children to help them cope with hyper-arousal symptoms such as startle response or increased autonomic activity, is the breathing exercise. In Buddhist country like Thailand it is not very difficult to understand as children can compare this concept to meditation. We also teach them the muscle relaxation. The techniques need to be modified to a shorter and more fun version to facilitate the children's understanding, for example, to stiffen your body like a robot and let it loose like a floppy doll to learn about the feeling of tension and relaxation.

The children who have the abstraction to understand the concept of thinking would also be taught to deal with the intrusive thought which could be very negative, for example, some might think all the time that tsunami is going to happen again soon. We need to teach them the very basic concept of cognitive therapy which is THOUGHT leads to EMOTION. You have a negative thought so you feel bad. But if you can modify your thought and see it from a different viewpoint, preferably in a more positive way, you can feel better. For example:

"Tsunami is going to happen again soon"→ feeling scared

How about if we change the thought to:

"Tsunami can happen, maybe, but now my school is not near the beach, and we have the alarm system on a high pole with loud speaker,

and we have practiced the evacuation. And it's likely from scientists' opinion that tsunami may never happen again for a hundred years"

How do you feel when you replace the old thought with this coping thought?

One of the most disturbing features of PTSD is the intrusive images or flashbacks. We then teach imagery technique to the children to help them cope. We ask them to project the image onto the screen and think it is just like a TV screen showing pictures from a DVD player. Then we teach them to act like they have remote control to manipulate the image: to move it forward and backward, to freeze it with PAUSE button, or to make it disappear by pressing STOP button. The key thing is now they know that they can control the image, not the image controlling them. Another technique to deal with the intrusive images is dual tapping. The children are asked to bring up distur bing image in their mind while doing hand cross-tapping on shoulders or knees. This proves to be very effective as children report that disturbing image would become blurred or faded away.

When the children have all the skills, we then encourage them to do the exposure task. It is a basic concept for all fears that the only way to overcome the fear is to face it. We teach them to rate the fear using the analogy of thermometer when zero is no fear, and 100 is the maximum fear. And we introduce the concept of fear hierarchy, compared it to climbing the ladder. You start from the lower level, before moving up, and up. In the case of tsunami, the children are afraid of the sea and would consequently avoid going there. The top of the ladder is going to swim in the sea, but you need to probably start from walking hundred meters away from the sea, then walking on the beach, then walking in the water, then taking a dip and, finally, swimming. The children can imagine doing it first before doing in vivo exposure. During the exposure task we encourage the children to use the breathing and relaxation skills, together with the cognitive skills we have thought. There is one thing we observe when we bring them to the beach to do the in vivo exposure task, in that it is very common for Thai children to pray to someone they respect (Lord Buddha, previous kings, prominent historic figures, spirit house, etc.) to draw strength before going into exposure. This makes a lot of cultural sense to our work because although we teach them various kinds of strategies to cope with fear, the most effective is the way we do not teach, that is, praying to the superpower. We later consider adding the spiritual aspect to our CBT.

Until this stage we quite know how to screen the children in need of help and we know how to help them. But they cannot get better just by our flying from Bangkok to visit them every 3-6 months. We have learnt that one of the most crucial things to succeed is to empower the community. With that when we are away the teachers and the parents can cope, and consequently the children can learn the coping model from the adults. Therefore, we do the training. So far there have been more than 10 trainings for the teachers and health personnel. Apart from the knowledge and attitude that they gain, now the network of help and support has been set. We also allow residents to join the trip. To date more than 60 residents in child psychiatry, general psychiatry, and pediatrics have rotated to the area and learnt a lot from what they see. In terms of clinical experience, this should be the best setting to gain insight about PSTD as hundreds of cases are identified. What the residents can

only read from textbook and think it is quite rare is now very common in front of their own eyes. And with supervision from the staffs in the team they can practice some very useful skills to help traumatized children such as supportive psychotherapy, CBT, and group therapy. The residents can also learn how in the real life we can make sense of the concept of community and school mental health. The fact that school mental health is not just the extended OPD leads us to understand the importance of setting up and reaching out to the network. The concept of prevention-secondary and tertiary in this case-is now not difficult to grasp as we learn from such a concrete example like this.

Now with screening and treatment plan we have at least 5 psychiatrists going back and forth from Bangkok to take care of children in the area every 3-6months. We have teachers who are trained to detect and help the young victims of tsunami. The network with the hospitals and health personnel in the area has also been set. But it seems the continuity of our work is still a bit lacking. What do we need more? What is the missing link? Our answer is the people who will do the same work as us when we are away. With donated money we decide to hire 6 psychologists and 2 nurses to work full-time in the area. They can help monitoring some cases that need more attention.

Before the tsunami, we knew virtually nothing how to handle the psychological consequences of the large scale disaster. We have learnt a great deal afterwards and with that we want to organize our knowledge we have gained through the research. So far we have published scientific articles on the prevalence and symptoms description of psychiatric disorders after the tsunami[1,5~8,11], the development of screening test[2], and preliminary study of the intervention with CBT[4]. We are also collecting and analyzing the data regarding the applicability of cognitive model of PTSD in children and the randomized controlled trial of CBT for children who have this disorder, as well as the study concerning resiliency as a protective factor for PTSD.

Now we are proud to say we have moved beyond the recovery into the enhancement phase. It is amazing to see new school buildings much better than before the tsunami. We now have psychological-minded teachers and school psychologists. The latter ones could be seen as luxurious because most of the schools in Thailand still do not afford it. We have better prepared mental health system to cope with future disasters. We do not want any more disasters, definitely, but if it is going to happen again we believe we are now in the better position to cope.

There is one lovely little story from the trip to the area in the later years. During the group discussion we ask group members to share what helps them recover. One girl who once had PTSD and is now free of the symptoms says she is feeling much better these days. The critical incidence is when she saw the news of the cyclone Nargis in Burma and thought those people suffered much more than her and they received much less help from outside. So she decided to donate her belongings (some of them she received from the donation after the tsunami) to help out with the cyclone victims and felt tremendously fantastic.

One touching picture drawn by one of the child victims can sum it all up nicely. It shows a spiral figure starting from outside at number 1 which reads "Happy day". Then came the

tsunami at number 4 with difficult time follows. Help comes in from all sorts in later numbers. At number 13 "The sea is clean" and 14 "Happiness returns". The best of all is number 15 which reads "Tsunami makes us stronger", and at the center depicting the map of Thailand with bold letters "We can live together by giving and sharing".

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