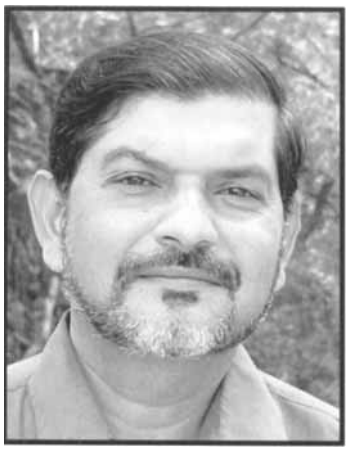
Traumatic bereavement and the Asian tsunami

Perspectives from Tamil Nadu, India



Prathap Tharyan MD MRCPsych
Professor of Psychiatry
Christian Medical College
Vellore
Tamil Nadu
India

WHEN OVER 8,000 PEOPLE were killed along the south eastern coast of India by the tsunami of 26 December 2004, the psychiatry department of the Christian Medical College in Tamil Nadu was asked by the state government to provide counselling and psychosocial support to the worst hit areas. Over the months our teams have learned much first-hand about traumatic bereavement, acute stress reactions and the resilience of people in the face of multiple losses. However, we have been left with many questions about what are appropriate interventions to deal with traumatic grief in the Indian culture.

Below are the poignant words of a young fisherman in a village near Vellankrani in Tamil Nadu two weeks after the devastating tidal wave.

> We have never been afraid of the sea. She is our mother and she feeds us. We have braved many storms and cyclones and we have often been out at sea when the waves were as tall as mountains but we have never been afraid. Our *kattumarams* (the word 'catamaran' comes from the Tamil *kattu* or tie and *maram* or log) are made from logs of wood that will never sink. On occasions when the sea has been very rough we have cut the logs apart and tied ourselves each to a log and come home. But this tsunami was different. To begin with we had never heard of this word before. It came out of nowhere, destroyed everything that we held precious and took away the one thing that sustained us, out trust in the sea. I don't think I will ever be able to go out to sea again.

Overall, the tsunami killed more than 280,000 people, displaced more than one million and affected the lives of around five million more[1]. India was less affected than Indonesia, Thailand or Sri Lanka, but over 2,000 km of the country's eastern coast bore the brunt of nature's fury, unprecedented in living memory. The district of Nagapattinam in Tamil Nadu accounted for more than 6,000 of the 8,000 dead, mostly women, children and the elderly. Over 5,000 people were reported missing and many are still unaccounted for.

EDITOR'S NOTE

In our efforts to find a good scientific basis for our therapies we tend to overestimate the importance of our successes. The successful treatment of post-traumatic stress disorder (PTSD) in the West has resulted in this condition becoming over-diagnosed and its importance exaggerated. Immediately following the Tsunami, Dr Chandri, Regional Mental Health Adviser to the WHO, claimed 'almost all of the people affected by the Tsunami ... will be suffering from some form of psycho-social trauma'. Yet Professor Tharyan, who provided psychiatric services in the tsunami zone in India, has found little evidence of persisting PTSD three months after the disaster. In this paper he considers why this may be and identifies some of the problems that remain. CMP

The Christian Medical College responded immediately to this humanitarian crisis, sending multidisciplinary health-care teams to many parts of Tamil Nadu, the Andamans and Sri Lanka, and members of the psychiatry department to Nagapattinam to work in co-ordination with other governmental and non-governmental agencies there. As the relief effort gives way to reconstruction and rehabilitation, we are aware that we have learned much about trauma and bereavement, the many kinds of losses the tsunami wrought, the compassion of ordinary people from different states and countries, and the ability of simple people to recover from incomprehensible adversity. Yet, there many more questions for which the answers are not immediately available but that are important to document and to consider.

Traumatic grief in the immediate aftermath

The tsunami brought losses of many kinds: apart from loved ones, homes, livelihoods and possessions, the disaster also robbed people of their pride, reducing self-reliant fishermen to living in temporary shelters, dependent on handouts from the government and well-wishers. The loss of trust in a benign, all-providing 'mother', echoed above in the statement of the young fisherman, was perhaps the worst loss of all and reminiscent of the shift in world view that accompanies all forms of bereavement, traumatic or otherwise.

Fisherman and catamaran off the coast of Velankani in Nagapattinam district, Tamil Nadu. *Photo by Prathap Tharyan*

It is well recognised that grief is a process with a clearly understood course and components[2]; however, nearly everyone exposed to large scale trauma of the magnitude of the tsunami also undergoes severe emotional and psychological trauma that manifests as acute stress reactions[3]. Virtually everyone we met two weeks after the disaster was unable to sleep at night and reported waking up with images of towering waves crashing down on them and re-living the sensation of being hurtled through the air by the rushing waters. The sound made by the tsunami – a high-pitched whine likened by some to a speed boat and by others to the sound made by a helicopter – mixed with the cries for help of children and loved ones was also re-experienced, filling them with dread. For many these cries signified the restless souls of the dead, buried in mass graves nearby, and they feared to sleep in the villages, preferring the cramped and hot conditions of the shelters[4].

These distressing and disruptive experiences that complicated the grief process were compounded for many by survivor guilt. One young woman we met rued the fact that she let go of both her elderly mother and her sister while fleeing from the advancing torrent; and neither was ever seen again. Another mother of three young children had left strict instructions with the oldest, a girl of eight years, to look after her siblings and not to leave the house until she returned from collecting the daily catch of fish from her fisherman-husband. The tsunami struck while she was away and, though she and her husband survived, her neighbours later told her that her eldest daughter had refused to flee with her siblings when the tsunami struck, in spite of their entreaties. While guilt is not uncommon in many bereaved people, the nature and intensity of the guilt experienced suggested to us that resolution of grief would be all the more difficult.

However, subsequent visits by our teams revealed that these acute stress reactions had largely subsided and, three months after the tsunami, post-traumatic stress disorder (PTSD) does not appear to be a significant mental health problem among adult survivors. While normal grief is apparent among the many who lost loved ones, on the whole the predictions of widespread psychological consequences, including increased suicides, among the survivors[5,6] do not appear to have been substantiated thus far; indeed the public health value of PTSD as a concept, particularly in non-Western, low-income countries, is increasingly being questioned[7].

The reasons for this are not entirely clear, but some answers may be found in the differences between the beliefs and attitudes in Indian and Western cultures towards death and dying, the structure of the social fabric in this part of the world that emphasises collective over individual perspectives, the nature of the grieving process with its overt displays of emotions, and the use of rituals and spiritual practices[8]. The resilience of a hardy people, inured by years of hardship and with expectations of life very different from those in more affluent circumstances, needs to be recognised, rather than focusing on vulnerability as is common in post-disaster scenarios[9,10].

The nature of bereavement in India

Grief is a private matter in most Western societies and the expression of grief is largely subdued and restricted to the funeral parlour and the privacy of one's home or the offices of a bereavement counsellor. This is consistent with the ethos of life in the West, where self-determination and privacy are cherished facts of life, as opposed to traditional practices in south Asian countries, where individual desires are subjugated by the dictates of common affiliations to families, communities, religious traditions, gender, and trans-generational roles. Interest in others' affairs is not seen as an invasion of privacy but rather as a connectedness, interdependence and involvement in the lives of important others. Consequently, grieving is a community affair and expressions of grief and mourning are loud and publicly demonstrated, funeral processions are as tumultuous as wedding processions, and there are well-delineated roles and social customs associated with grieving that are universally observed.

The importance of rituals

The many rituals associated with death and bereavement in traditional Indian culture pertain to ancient notions of pollution and purification that ensure the repose of the departed soul[5]. Our first visit to Nagapattinam coincided with one such ritual or *karyam* where prayers were said by priests for the departed and in most households that had suffered a loss, pictures of loved ones were placed before glowing lamps, incense, flowers and religious offerings. Such rituals allow survivors to confront their grief, bring families and communities together and help punctuate, and eventually set limits to, the process of grieving.

In one of the village we visited, the administration had arranged a community memorial service for the children who lost their lives in the tsunami. Parents planted coconut saplings in memory of each of their lost children and this memorial will stand as a living reminder of the loss the village suffered, as well as a tribute to the compassion of an administration that used a novel method to share in the grief of a traumatised people.

Spiritual traditions and practices

Spiritual beliefs and practices are widespread in Indian culture and, though the fishermen of costal Tamil Nadu are not marked by particular religious practices that demarcate them from other communities, there is a widespread belief in the immutable soul or *atman*. There is also a common subscription to evil spirits, sorcery, the

evil eye and other notions of spiritualism, existing in easy harmony with more modern notions of natural causation, concepts borrowed from the ancient ayurvedic tradition, and the western medical model of infectious diseases.

For many, the tsunami was seen as an act of nature, for others it was an act of a displeased god. Whatever their views on the cause, the near universal belief in the karmic cycle of birth and rebirth (where the *atman* returns to find abode in another, hopefully more pious or respected, life-form) could prevent some of the fears and concerns of those who believe in reward or retribution after death. However, I am unaware of any comparative study of the effects of these contrasting beliefs on the process of mourning, though empirical evidence indicates that even in Western societies, people who profess stronger spiritual beliefs seem to resolve their grief more rapidly and completely than do those with no spiritual beliefs[11].

Resillience in the face of uncommon adversity

At the weekly meetings of media and health care in Nagapattinam, the administrator in charge of the post-tsunami relief effort took pains to emphasise that the reports of disastrous psychological consequences were wrong and disrespectful of the resilience of the fishing community of Tamil Nadu. She cautioned mental health professionals to avoid medicalising the normal responses to abnormal situations, and particularly counselled against the use of medication and the overuse of psychiatrists, as opposed to trained community volunteers, to befriend the survivors.

At the time these assertions appeared fuelled by ignorance of psychological matters; more ominously they suggested low prioritisation and allocation of resources for mental health interventions and support teams. It will be important to have a systematic survey six months or more after the tsunami to detect those whose recovery from grief has been slow or complicated, so that we can intervene to prevent long-term mental and physical health impairments and behaviours[12]. But, at least thus far, the administrator's statements appear prophetic.

In Nagapattinam, as in other parts of Tamil Nadu, importance was given to helping children to normalise their lives and one of the priorities of the government was to reopen schools. The majority of children appear to have recovered from their ordeal and this was apparent from school reports and the smiles on the faces of the children we spoke to. However, emerging data from formal surveys undertaken by colleagues suggest that a significant number of children in shelters and in orphanages have high scores on measures of psychological disturbance (Impact of Event Scale) and many continue to draw pictures of the tsunami. Whether these predict longer term morbidity is as yet uncertain and efforts are underway to train teachers and community volunteers to help these children.

The factors that contribute to resilience in the face of adversity are less well studied than those that contribute to increasing the risk for complicated grief states and PTSD. This resilience does not seem restricted to hardy fishermen from Tamil Nadu but was also noted following the coal waste tip tragedy in the Welsh village of Aberfan in 1966 where, in spite of little formal intervention, there were no dire consequences and even affected children appear to have resumed their normal lives and remain well[12].

Thus it appears that resilience in the face of trauma is more common than is believed and the capacity for normal functioning without professional intervention is underestimated[10]. This confirms the conclusions from empirical research that indicate that counselling and other interventions do not necessarily benefit, nor are they indicated for, all bereaved people but should be reserved for those individuals at high risk[14].

Identifying those at high risk

Our team has been working in collaboration with the National Institute for Mental Health and Neurosciences at Bangalore which was designated by the Indian government to coordinate the response. The scale of the disaster was such that with the limited resources available, there was little chance of (and as discussed above, little to recommend) providing psychosocial support to everyone. Thus our overall goals have been to identify those most affected and therefore most vulnerable to psychological distress and morbidity and provide them with immediate psychosocial support; to identify and train community-level volunteers to provide these services in the long term; and to strengthen existing health services to include provision of psychosocial care for those who need it.

Within the first month a list was prepared of those at potentially high risk and sent to all public health centres. The list included

- those with multiple deaths in the family
- those who lost a spouse
- those who lost a child under the age of 20 years
- those who lost their homes
- those whose loved ones were reported as missing
- those with multiple losses (eg home and family member)
- those with previous mental disorder
- those showing symptoms of excessive grief, post-traumatic stress or substance dependence

Information on who would be potentially vulnerable was obtained from the government records of compensation claims, primary health centre nurses, community volunteers, and by asking residents of villages about anyone showing symptoms of excessive distress.

Training volunteers in trauma and bereavement counselling

Workshops on trauma counselling for NGO volunteers have been well-attended and focused on the process of normal grief and acute stress reactions, differentiating normal from pathological responses, assessing suicidal risk, and providing emotional first aid - a combination of active listening, empathetic sharing of feelings, as well as problem solving and providing practical solutions. Further workshops will be required shortly to train volunteers to detect complicated grief reactions and provide practical, behaviourally-oriented strategies to help those affected.

Bereavement counselling services
Visiting experts have observed that formal bereavement services do not exist in the affected areas and indeed this holds for most of the country. In India, familial ties and community support are more widely used than formal bereavement support services. There has been little need felt to provide such support, though the increase in palliative care units attached to, or operating in, hospitals attests to the growing recognition that even Indian families need support when dealing with illness in their loved ones.

Social problems

However, while the majority may have at least some support from their families, there remain many made vulnerable by multiple deaths or, more significantly, by the status of widowhood. A distressing memory of our initial trip was the observation of a young widow having to ritually cut her *thali* (a sacred amulet signifying marriage) and remove her *bindhi* (the dot-shaped, coloured symbol worn on the foreheads of married women); the ritual symbolised her fall from grace and loss of the security and status of a married woman. On the heels of this came a statement from her brother-in-law that she was no longer welcome in their home. While bereavement support services might help her grief to some extent, the lack of adequate social support is more than likely to limit any real chance of recovery and resolution of grief.

Many of the fishermen, currently unemployed and lacking the means to resume their livelihood, are consuming excess amounts of alcohol. It is difficult to differentiate between demoralisation ensuing from their predicament, and sub-clinical depression or complicated grief. Only sustained follow-up and speedy restoration of their means of livelihood will resolve this issue.

Evidence-based interventions and the tsunami

The tsunami served as an opportunity for organisations, such as the Cochrane Collaboration, to compile comprehensive lists of interventions for the aftermath of natural disasters and to disseminate concise evidence summaries of these interventions, backed by good quality systematic reviews of randomised controlled trials. (For further details see http://www.cochrane.org/docs/asiancrisis.htm#response [accessed 01.06.05]). We used one relevant review[16] to dissuade the use of single-session debriefing[15].

However, there continue to be many gaps in our knowledge about the efficacy of interventions following traumatic bereavement. Pragmatic, randomised, controlled trials of such interventions that are culturally appropriate and acceptable to Indians are urgently needed, as are systematic, observational studies of the natural course and outcome of those identified as vulnerable to complicated grief. ●

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EVENTS IN 2005

7th international conference on the social context of death, dying and disposal. 15-18 Sept. Bath, UK. Plenary speakers: Robert Kastenbaum, Tony Walter, Nigel Hartley. Contact Glennys Howard: tel 01225 386952; http://ddd7@bath.ac.uk

Bereavement Research Forum. Symposium. 16 November. London. Presenters: Liz Rolls, Ann Grinyer. Contact Angie Couchman: 01241 47576; a.r.couchman@bham.ac.uk

Trauma and loss. Guernsey Bereavement Symposium. 23 Sept. St Peter Port, Guernsey. Speakers include Rose Dixon, Peter Saunders. To apply: tel 01481 730996; gsybereavement@cwgsy.net

Family grief. 11th Annual international bereavement and loss conference. 8 Sept. Manchester, UK. Speakers include Marilyn Relf, Gordon Riches. Apply to MABF: tel 0161 371 8860; www.mabf.org.uk

The many ages of grief. Annual conference, Cruse NW region. 17 Sept. Chorley, Lancs, UK. Keynote speaker, Colin Murray Parkes. Contact Gwyneth Johnson: tel 01204 395034; crusenorthwest@tiscali.co.uk

Challenges in palliative care and bereavement: the impact of good practice. 2nd national conference. 1, 2 Nov. Bury, Lancs, UK. Apply to Mary Kinsella, 0161 778 3381; www.pat.nhs.uk/palliativecare