Leading Article

The challenge of providing mental health care for children after the tsunami

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Known and the unknown

Research evidence supports that psychological morbidity in children following natural disasters such as earthquakes, flash floods and hurricanes can be high and widespread[1,2,3]. When considering the magnitude of the recent tsunami disaster and the extensive bereavements, losses and injuries suffered by the children, we too can anticipate that large numbers will be similarly affected. In the short period of less than 3 months since the disaster, paediatric and mental health services have seen acute stress reactions in the form of separation anxiety, bedwetting, nightmares, panic attacks and somatic complaints. Although such reactions are universal under similar circumstances, they are transient in the majority and will disappear without any intervention.

However, we do not understand enough about the psychological impact of the tsunami in the medium and long term and the anticipated demand on community and specialized child health services. There are several reasons for this uncertainty. Firstly, mental health research data on child survivors of natural disasters are mostly from industrialized countries. The data from low income countries are mostly related to war situations. It is known that ongoing man made violence is a more virulent cause of psychological trauma than a single isolated technological or natural disaster[4]. Hence, it is difficult for Sri Lanka to identify with data from either of these two situations and apply them in order to understand the outcome of the tsunami. Secondly, the significant variation in the post-disaster reactions shown by children indicates the importance of individual childhood characteristics and environmental factors in their origin[5]. In this context, pre-existing behavioural and emotional problems and parental psychopathology are high risk factors[6]. Developing countries have a relatively high 25-30% prevalence of childhood mental disorders[7]. Hence, it is possible that a high prevalence of long term post disaster mental health problems would be seen. Thirdly, studies on disaster related mental health mainly focus on the prevalence of post traumatic stress disorder (PTSD) and its correlations, with little regard to cultural and ethnic differences in presentation of symptoms in the study populations. More recent publications question the validity of the diagnosis of PTSD in the non-western and traditional cultures and are critical about the assumption of psychological damage following traumatic experiences[8,9]. Taking all these factors into account, the future mental health needs of the child survivors of the tsunami in Sri Lanka is still an unknown quantity to a large extent.

The challenge

The real challenge is to prevent long term mental health problems in children, facilitate the recovery process and promote resilience to withstand future crises. Very low level of mental health resources in the country, especially in terms of trained personnel, is a hindrance but should not be seen as an obstruction to progress. It should be emphasized that physical and social care should take priority over psychological intervention in the early post-disaster stage[4]. The longer term outlook for the children will depend on the resumption of ordinary life within the family and the wider community[10]. Children with persistence of the early stress reactions may need more specialized mental health care. Such children have a better chance of being identified early in primary health care, paediatric services or school setting rather than in the mental health services. Hence, collaboration and networking between these different services for children with capacity building of the relevant professionals and other workers with training input would be important.

Physical and social care

Fulfilling the basic health needs are an essential aspect of preventing adverse mental health consequences following a disaster situation. These needs include clean water, sanitation, food, shelter, prevention of epidemics of communicable diseases and protection from further stress and harm[11]. Ideally, mental health screening should happen at the time as the emergency medical care is offered, soon after the disaster, as children with head injuries and other forms of physical harm are vulnerable to develop mental health problems[12]. Social care involves encouraging normal daily activities, returning to school, organizing child friendly activities, family reunification, and re-establishing cultural and religious activities[13]. Maintaining bereaved children

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within families or extended families and in their own communities have shown positive results in war situations. Social care should also look into preventing family dysfunction, alcoholism, unemployment and ongoing social hardships, which are obvious adversities for children. Working with the legal, voluntary and child protection services are of crucial importance here.

Mental health care

More serious post traumatic mental disturbances that need specialized attention are likely to develop with time in a minority of children. Reluctance to seek mental healthcare due to stigma or rejection of help due to perceived intrusion could leave children with unmet mental health needs[14]. The adolescent age group deserves special mention because of their high suicide rate in Sri Lanka. The mental health interventions should address anxiety, depression, thought problems, aggression, and alcohol abuse of directly affected adolescents and their peer groups[15]. Trauma counselling programmes transposed from the west have been criticized for being culturally inappropriate, pathologising normal responses and jeopardizing local systems of coping. Hence, the direct use of western mental health models should be avoided as far as possible. Psychological intervention should be conducted ideally by the local mental health professionals who are familiar with the cultural attitudes and preferences[8,16].

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