

Child mental health in the aftermath of the Ditwah cyclone in Sri Lanka

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Background

Child and adolescent mental health was already under considerable strain in Sri Lanka before Cyclone Ditwah; the cyclone and associated flooding are likely to act as powerful multipliers of existing risk, particularly for trauma-related, mood, anxiety, and behavioural disorders in exposed children (1,2). Our review emphasises that the medical response in the aftermath must be explicitly trauma-informed, context-sensitive, and integrated into routine medical care, with regional psychiatrists providing guidance and leadership for early detection, stepped-care intervention, and advocacy.

Ditwah cyclone and flooding in Sri Lanka

Sri Lanka's geographic location in the Indian Ocean and its exposure to both monsoonal systems and cyclones from the Bay of Bengal/Arabian Sea create a high baseline risk of extreme precipitation, storm surges, and riverine flooding, which is now amplified by climate change (3). Cyclone Ditwah, which occurred in late November 2025, produced intense winds, heavy rainfall, landslides, and extensive flooding, resulting in widespread damage to housing, schools, health facilities, transport infrastructure, and agricultural land, and displacing large numbers of families, including a substantial child population.

The Kelani River basin and other low-lying urban areas, already recognised as vulnerable to flood amplification through land-use change and hydrological shifts, are likely to have experienced heavy flooding, disrupting schooling, community networks, and access to healthcare for children. In the context of simultaneous economic stressors and fragile social protection mechanisms, Ditwah's impact is best conceptualised not as an isolated event but as an acute stressor layered onto chronic adversity caused by the armed conflict, Tsunami, Easter Sunday Attack, COVID-19 pandemic, and the economic crisis, with implications for long-term psychological morbidity in the paediatric population (4).

Psychological impact after a natural disaster

The psychological sequelae of natural disasters in children and adolescents encompass a spectrum from acute stress reactions to chronic post-traumatic stress disorder (PTSD), depression, anxiety, complicated grief, and functional impairment (5). Longitudinal data suggest that PTSD symptoms generally decline over the first one to two years post-disaster. Yet, a non-trivial subgroup follows chronic or relapsing trajectories, particularly when ongoing stressors, prior adversity, or lack of support are present (6). Multiple risks and protective factors, including proximity and subjective perception of threat, bereavement and loss, displacement, parental mental health, family violence, social support, and cultural or religious coping practices, shape youth post-disaster psychopathology (7).

Facets of psychological impact on children

Children can feel the impacts of a natural but unexpected disaster in multiple ways. The unexpectedness, the extent of property damage, sudden loss of loved ones and related events can directly affect the children's mental stability. The cues and facts that the children receive by the observation of the behaviour of remaining family members, neighbours, victimised peer group, adults and mass media can cause indirect impacts on the child's mental state, both acute and long-term. Thus, collectively children display a characteristic but developmentally modulated response to mass trauma, with disaster, war, and terrorism research converging on similar risk-resilience pathways across contexts (2).

In the immediate aftermath of a natural disaster, significant societal turbulence occurs, leading to widespread public panic. Acute stress responses arise in both the child and the adults, making the situation worse for the children, making them more vulnerable and helpless due to the lack of stability in their guardians (2).

After acute-onset disasters, internalising, externalising, rumination, and avoidant coping strategies are consistently associated with greater post-traumatic stress symptom severity, highlighting the role of maladaptive coping in maintaining distress (8).

The intermediate phase following a disaster is a crucial period for victims and service providers to adjust, rethink, and resume. During this phase, some children will resolve, adapt to, and accept the new lifestyle, both with and without struggle (5). Some children are slow to adjust depending on the extent of their losses and their individual temperaments. The parenting styles of each parent following individual losses can change on different scales. These acute changes influence the attachment styles and bonding. The deranged family dynamics between remaining family members amidst the bereavements can lead to situations such as accidental parenting (3,4,5,6). Elder/capable siblings take the responsibilities of the dead parents, looking after the younger/sub-capable siblings, is a widespread phenomenon in the Sri Lankan set-up. Parents become hypervigilant of the remaining children in fear of losing them, leading to helicopter parenting and highly expressed emotions, which can adversely affect the children. Vicarious learning of coping styles by observing their immediate environment is inevitable. Managing the immediate environment and encouraging adults to adopt adaptive coping mechanisms rather than maladaptive ones is of heightened importance (5). Emotional and behavioural symptoms in children and adolescents after a natural disaster are shown in Table 1.

Sri Lankan adolescents

Adolescents in Sri Lanka possess an inherent resilience, having been exposed to numerous crises over the last decade (4). However, the physical and psychological challenges, including self-identity crises, are common in all teenagers worldwide. In a disaster situation, the impacts can vary depending on the developing personality type, cognitive development, available support system and other factors (4). Many teenagers, seen by the authors as mental health clinicians, were affected but survived by Ditwah showed significant distress over resuming education to prepare themselves for upcoming major examinations. They are at high risk of developing adolescent depression, which may manifest as overeating, oversleeping, withdrawn behaviours and irritability, other than the typical features of depression. Adolescents with impulsive traits and poor parental support can develop substance misuse as a maladaptive coping strategy (5,6,7).

Living in temporary accommodations

For adolescents, having been dependent on others for basic needs, limited privacy and broken mentality could lead them to have withdrawn behaviours within the temporary safe centres. Children adjust to less privileged new living circumstances with the help and attention provided by the adults around them. Connecting with peer victims at temporary living settings helps children and adolescents ventilate and adjust better (5). Play can be encouraged as an effective therapy during this post-catastrophic reconstructive phase in children. It helps them cope with the problematic situation until they are resettled in new, permanent residences (5).

Table 1. Emotional and behavioural symptoms in children and adolescents after a natural disaster

Age Group	Key emotional and behavioural Symptoms
Preschool (0-5)	Regressive behaviours: Bedwetting, thumb-sucking, difficulty speaking. Separation anxiety: Fear of being alone or clinging to caregivers. Sleep disturbances: Nightmares or fear of the dark. Re-enactment: Playing out the disaster with toys.
Primary School Age (6-12)	Somatic complaints: Headaches or stomach aches with no physical cause. Irritability: Outbursts of anger, fighting, or withdrawal from friends. Academic decline: Difficulty concentrating or refusing to go to school. Preoccupation: Repeatedly talking about the event or exaggerated safety concerns.
Adolescents (13-18)	Risk-taking: Increased substance use or reckless behaviour. Emotional volatility: Extreme mood swings or emotional numbing. Identity shifts: Feeling hopeless about the future or questioning beliefs. Interpersonal conflict: Increased "acting out" against authority figures or parents.

Emotional and physical safety

Ditwah was not just affecting one part of the country. Its devastating effects spread across the country over the course of days. Telecommunication interruption led to increased anxiety as people could not connect with loved ones, leading to emotional uncertainty. Children were left with unknown persons in insecure environments for a few days. Physical and sexual abuse is a potential threat that cannot be underestimated in such circumstances.

Longitudinal studies following disaster-exposed youth identify distinct symptom trajectories: resilient, recovery, and chronic or relapsing PTSD phenotypes, with trauma severity and prior trauma exposure predicting the less favourable courses (9). This is highly significant for the Sri Lankan population, who have experienced multiple psycho-social, natural, and conflict-related stressors in the preceding decades (2). Importantly, children's outcomes reflect not only direct trauma load but also the burden of daily stressors (poverty, educational disruption, family conflict), which can mediate or exceed the impact of discrete events on mental health, a finding repeatedly demonstrated in disaster-affected Sri Lankan adolescents.

The Sri Lankan experience

Sri Lankan data following the 2004 Indian Ocean tsunami demonstrated high early rates of PTSD and other trauma symptoms among children in severely affected coastal districts, with risk linked to female gender, loss of family members, and complete property loss (10). Follow-up work up to 13 years later indicates substantial symptomatic improvement for many, yet persistent PTSD and depression in a subset and complex interactions with ongoing daily stressors and social support, underscoring the need for long-term monitoring rather than a purely acute relief model (11). Sri Lankan studies also highlight culturally specific coping-religious rituals, familial collectivism, and community participation, which can moderate the relationship between trauma exposure and psychological well-being (1,12).

Northern and Eastern Sri Lanka provide a unique context of combined exposure to protracted civil war and the tsunami, with research documenting very high trauma loads and associated internalising and externalising problems in children, and a powerful link between family violence and child PTSD and functional impairment (13). Broader reviews of child and youth mental health in post-war Sri Lanka indicate that conflict, displacement, and socioeconomic stressors continue to exert significant effects, and describe emerging but still limited child and adolescent mental health services (4). Empirical data specifically on children after the Easter Sunday attacks

are limited in the indexed literature. Still, global evidence on terrorism-related mass trauma in youth suggests similar symptom patterns to natural disasters, with heightened salience of threat, mistrust, and community polarisation (14,15).

Child mental health services in Sri Lanka

Child and adolescent mental health services (CAMHS) in Sri Lanka have undergone incremental development since the end of the civil war, but remain markedly under-resourced relative to need. The first cohort of board-certified child and adolescent psychiatrists began practice only in 2016, and specialist services are concentrated in a few urban centres, with significant gaps in rural and estate sectors and limited multidisciplinary teams, community outreach, and inpatient capacity (16). The retention of specialists has been difficult due to the higher income and facilities provided by countries such as the United Kingdom and Australia, leading to a massive brain drain of psychiatrists (17). The scarcity of multidisciplinary teams, such as child counsellors and community workers who are specially trained to deal with children and adolescents, is a significant challenge in these post-catastrophic situations. It creates a massive vacuum in monitoring, surveillance strategies and service provision, leading to avoidable adverse outcomes.

Overcoming challenges in managing affected children In the Ditwah aftermath, managing child mental health problems is complicated by the confluence of high caseloads, limited specialist availability, and disrupted infrastructure, which make conventional clinic-based psychiatric care impractical as a primary strategy. As shown in Table 1, children commonly present to non-psychiatric settings with somatic complaints or behavioural difficulties, and without explicit enquiry about exposure and symptoms, trauma-related disorders are frequently missed (5).

Disaster contexts introduce additional diagnostic challenges, as acute stress responses, grief, and adaptation must be distinguished from emerging disorders, while also considering the role of chronic adversities and ongoing daily stressors in symptom maintenance. At a systems level, weak referral pathways exist between schools, primary care, and specialist services; a lack of validated, culturally adapted screening tools; and limited training in child mental health and evidence-based psychosocial interventions for non-mental health professionals hinder the provision of timely, effective care (2,4).

National-level strategies to reopen schools in affected areas help children and adolescents cope with their distress, engage with peers, and resume their lives amid

the crisis. Teachers can be utilised as resource persons to identify children who need special attention (14). The behaviours such as disengagement and withdrawal, regression, attentional deficits, self-harm attempts, poor self-care, suicidality, deteriorating performance and irritability can be observed by the teachers and counsellors (14). They can be referred to specialised care facilities in hospitals. Social workers in public administration and public health care workers can be incorporated into surveillance to identify high-risk children.

Recommendations

For non-psychiatrist doctors, especially primary care doctors, a pragmatic, stepped-care, trauma-informed approach is warranted in the post-Ditwah period, adapting global evidence to local realities. International literature supports brief, structured psychosocial interventions, school-based and group-based cognitive-behavioural programmes, narrative exposure, and classroom interventions as effective in reducing PTSD and, to a lesser extent, depressive and anxiety symptoms in disaster-exposed youth; these can be implemented or facilitated by trained non-specialists with appropriate supervision (14,18,19). Key practice points for non-psychiatrists are shown in Table 2.

Conclusion

The Ditwah cyclone and resulting floods are likely to precipitate a substantial but heterogeneous burden of mental health problems among Sri Lankan children, interacting with pre-existing adversities and service limitations. Experience from the tsunami, war, and other crises in Sri Lanka, combined with the global disaster mental health literature, indicates that outcomes can be significantly improved by early identification, culturally attuned psychosocial support, and targeted interventions for high-risk youth, even in low-resource settings.

Given the scarcity of child and adolescent psychiatrists, primary care medical doctors will inevitably be the backbone of the mental health response for affected children after Ditwah. They must therefore adopt trauma-informed, developmentally sensitive, and evidence-informed practices as part of routine clinical care. Strengthening training, integrating school and community-based psychosocial programmes with the formal health system, and addressing social determinants alongside clinical care are essential to mitigating the long-term mental health consequences of this and future disasters on Sri Lanka's children.

Table 2. Recommendations to manage psychological distress in children and adolescents

Category	Key Actions
Identification	Routinely screen children from affected areas for exposure and symptoms. Use appropriate age checklists for high-risk groups and those with prior trauma.
Psychoeducation	Explain common reactions to children and caregivers as normal responses to abnormal events. Encourage routines, school attendance, and culturally/religiously supportive practices.
Interventions	Implement school-based group programs that incorporate relaxation, drawing, and narrative techniques. Role-plays and school drama may improve emotional expression and help-seeking.
Family Care	Screen parents for distress/PTSD, as this impacts child recovery. Address ongoing adversities like family violence, housing, and food security alongside psychological care.
Referral Path	Use a stepped-care model: manage mild-to-moderate cases in primary care. Refer severe cases with significant functional decline to specialist regional psychiatric services.

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Declaration of interests

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