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The influence of culture on disaster mental health and psychosocial support interventions in Southeast Asia

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ABSTRACT
Southeast Asia (SEA), which has borne the brunt of some of the most severe natural disasters in the past decade, has unfortunately, been largely under-represented in the world literature on disaster mental health. This article describes cultural factors that may inform the design and conduct of disaster-related mental health psychosocial support (MHPSS) interventions. Specifically, it discusses cultural nuances in emotional expression, shame, power distance, collectivism, and spiritual beliefs and their implications on providing post-disaster psychosocial interventions. It describes the MHPSS interventions implemented in the region using the Johns Hopkins Perspectives Model of Disaster Mental Health categories of resistance, resilience and recovery. Given the challenges on the delivery of MHPSS, there is a need for evidence-based interventions and to ensure that disaster responders in SEA understand the cultural factors that impact the delivery of MHPSS interventions.

The Southeast Asia (SEA) region, composed of Vietnam, Laos, Cambodia, Thailand, Myanmar, Malaysia, Philippines, East Timor, and Brunei, is geographically prone to various types of natural disasters. Situated along the Pacific Ring of Fire, the region is prone to seismic and volcanic activity leading to earthquakes, tsunamis, and volcanic eruptions (Samphantharak, 2014). From 1981 to 2010, there were a total of 912 disasters in the region, the majority of which were floods (47%) and tropical cyclones (38%). The two countries in this region that experience the most disasters are the Philippines (372) and Indonesia (302). Over the 20-year period, disasters have killed 199,075 people and affected 310,443,666, with Indonesia experiencing the most fatalities (189,150) and the Philippines reporting the most number of affected (124,699,066) (Samphantharak, 2014).

Unfortunately, despite its vulnerability to disasters, the region is largely under-represented in the world literature on disasters and mental health. In this paper, we bring together literature from SEA on the impact of disasters on mental health and the cultural factors that may influence the provision of psychosocial interventions. We also describe the existing mental health psychosocial support (MHPSS) interventions in SEA and discuss implications for research and practice.
Psychological impact of disasters on mental health

Disasters are linked to elevated depression and symptoms of mood disorders such as a sense of loss, helplessness, fatigue, and withdrawal (Bonanno, Brewin, Kaniasty, & La Greca, 2010). A common post-disaster condition is posttraumatic stress disorder (PTSD). The prevalence of PTSD depends on the level of trauma with about 30% of survivors experiencing PTSD symptoms (Bonanno et al., 2010). However, most survivors’ symptoms are transient, and only about 5–10% of survivors develop PTSD (Bonanno et al., 2010). Beyond this, large losses of life may also lead to enduring grief reactions (traumatic or complicated grief) and secondary grief reactions. There is also evidence that disasters exacerbate previous disorders such as substance use disorders and depression (Bonanno et al., 2010).

Studies in SEA report similar outcomes to those found in other parts of the world. A post-Typhoon Haiyan study in the Philippines described the psychological impact of the disaster in terms of five dimensions: somatic (body pains, headache, palpitations), emotional (anxiety, fearfulness, irritability), cognitive (guilt, inability to concentrate, hopelessness), and behavioural (inability to sleep, maladaptive behaviour such as alcohol and drug use) (Hechanova, Ramos, & Waelde, 2015). A study using expressive arts therapy among disaster survivors in the Philippines reported narratives of fear, anxiety, grief, isolation, and guilt (Parr, 2015). Survivors of the Mount Merapi volcanic eruption in Indonesia described “solastalgia” or the loss of a feeling of safety and comfort in their home environment as a consequence of the disaster and the devastation it brought (Warsini, Buettner, Mills, West, & Usher, 2014). Similarly, a study among Thailand survivors of the 2004 tsunami revealed that a significant number of fisher folk voiced their fear of returning to a sea-based livelihood (Rigg, Grundy-Warr, Law, & Tan-Mullins, 2008).

A study of mental health consequences of disaster in Asia revealed high proportion of persons with PTSD symptoms immediately after a disaster (8.6–57.3%). However, these symptoms were lower nine months to a year from the disaster (2.3–32%) and drop (1.2–7.6%) two years after (Udomratn, 2008). Although authors warned about the methodological limitations of small and biased samples (Bonanno et al., 2010), another explanation for the relatively high rates immediately post-disaster is context. In developing countries, the effects of disasters are exacerbated by the lack of mental health resources, poor disaster preparedness, social and educational disruption, and enduring poverty (Dawson et al., 2014). In the Philippines, for example, millions of survivors remained without adequate shelter months after typhoon Haiyan (Hechanova, Ramos, et al., 2015). Not surprisingly, a study in Thailand after the 2004 tsunami showed that 12% of displaced survivors had PTSD symptoms but only 7% of non-displaced survivors were symptomatic (van Griensven et al., 2006).

In addition to contextual influences, there may be some cultural nuances to disasters and their impact. Engelbrecht and Jobson (2016) suggest that in collectivist cultures, trauma is also often experienced interdependently because people are primarily concerned about their family and group rather than themselves. In such cultures, secondary outcomes of trauma survivors are evident in feelings of self-blame, guilt, and shame when a loved one experiences trauma (Engelbrecht & Jobson, 2016). This is validated in a post-Haiyan study in the Philippines that reports that survivors expressed guilt and helpless about not being able to help their neighbours and friends. There was also a sense of
Southeast Asian cultures and implications for MHPSS

International guidelines on provision of MHPSS in emergency settings advocate the use of culturally appropriate interventions (Interagency Standing Committee [IASC], 2007). In particular, Schnyder et al. (2016) suggested the importance of understanding nuances in social emotions, cognitions, and behaviours in addition to possible barriers such as social distance and rejection. They also advocated the need to analyse the appropriate frame for psychotherapy and determine whether treatment should target individuals, families or communities (Schnyder et al., 2016). Unfortunately, there is little specific guidance about what cultural differences might exist, even broadly, between Western cultures where most MHPSS interventions are developed and the disaster-prone countries and communities of SEA. It is also important to note the cultures in this region are not homogenous and that there is tremendous variability within and between countries. However, studies do confirm cultural differences among Southeast Asian countries relative to Western countries and these should be taken into account when delivering MHPSS. In the next section, we present some salient features of SEA cultures and their impact on MHPSS interventions.

Emotional expression

There is robust evidence that negative emotions and appraisals, thought suppression and rumination, and avoidance behaviours predict PTSD following traumatic stress exposure (Dunmore, Clark, & Ehlers, 2001). Thus, a critical factor in delivering psychosocial support in SEA is understanding cultural variations in emotional expression and beliefs. Southeast Asian culture is strongly influenced by Chinese culture (Yan, 2008). A traditional Chinese cultural belief is that illness is caused by excessive, undisciplined, or unbalanced emotions (Haque, 2010). Some Chinese survivors believe that talking about painful issues can stir up painful feelings. Hence, rather than talking about their experience, some survivors cope by comforting others, keeping busy, and volunteering to help others. Intervention methods that may be most effective in this context are those that are compatible with these cultural coping preferences. Projective methods such as art and theater activities that facilitate emotional expression may also be useful (Dueck & Byron, 2012).

Shame

In addition to emotional expression, it is important to note the cultural salience of shame. Studies show that Asians, in general, are reluctant to seek the help of professional therapists (Matsuoka, Breaux, & Ryujin, 1997) because of a number of reasons: (a) they do not wish to tarnish their dignity or damage the reputation of their family, (b) they are concerned that seeing mental health professional means they are crazy, and (c) they are generally hesitant to open up to strangers (Hechanova, Tuliao, Teh, Alinan, & Acosta, 2013). Rather, there appears to be a preference to seek help from family and friends (Hechanova et al., 2013) or local healers (Haque, 2010). One implication of the salience of shame is the...
need to work with and build capability among community health workers, leaders, and healers who are the natural counselors for survivors. Another implication is that Western interventions that focus on individual maladjustment or stress reactions may not be as relevant as interventions that promote social support and interdependent coping efforts (Hechanova, Ramos, et al., 2015).

**Power distance**

A number of SEA countries such as Indonesia, Philippines, Malaysia, and Thailand are classified as high power distance countries which means it is accepted and expected that power is distributed unequally (Hofstede, 2003). Concepts of power distance can affect the therapist–client relationship. For example, studies show that Asians may expect therapists to be directive and give advice and when they do not, may be perceived as incompetent or indifferent (Haque, 2010). There are those who suggest that Western-style counseling may not be a good match for tradition Thai populations, especially in rural areas (Tuicomepee, Romano, & Pokaeo, 2012).

**Collectivism**

Asian cultures have been described as predominantly collectivistic where individuals are interdependent with kin, community, and society (Hofstede, 2003). Paton et al. (2008) argued that in the Asian context, community and institutional factors influence disaster preparedness. Their study in Indonesia found that greater collective efficacy (or the degree of community cooperation and assistance involved in disaster preparation) predicted individuals’ intention to seek information about and prepare for a disaster (Sagala, Okada, & Paton, 2009).

Healing in collectivist cultures is a function of the resilience of both the individual and his/her reference group (Haque, 2010). When asked to reflect on their strengths, Filipino survivors tended to cite external sources of strength (faith in God, family, friends) rather than internal or personal attributes (Hechanova, Waelde, et al., 2015). A study of Filipino workers’ motivation reinforces this, revealing that in contrast to Maslow’s hierarchy of needs that highlights the value of self-actualisation, the primary motivation of Filipinos appears to be actualisation of their family members (Ilagan, Hechanova, Co, & Pleyto, 2014). Dueck and Byron (2012) suggested that in collectivist cultures, strengthening reference groups should be incorporated into the intervention strategy. Group-based interventions provide a good venue for healing among Filipino disaster survivors, because social support is highly valued among participants (Hechanova, Ramos, et al., 2015). Engelbrecht and Jobson (2016) also posited that group therapies are effective in collectivist cultures because they increase empowerment and reduce psychological shame, alienation, isolation, passivity, and helplessness.

**Spirituality, coping, and mental health**

Another important component of culture is spirituality. Spirituality can influence mental health of survivors by shaping their attributions. Religious beliefs shape attributions about disaster and illness in two ways, by giving religious significance to hardships and
providing a juxtaposition of hardships with a higher order good (Aten, O’Grady, Milstein, Boan, & Schruba, 2014). However, as the following section will reveal, spirituality also shapes how people cope. In addition, membership in religious groups facilitates both social and instrumental support.

There is a wide diversity of faiths being practiced across the SEA region. Countries such as Malaysia and Indonesia are home to both Muslims and Hindus. Hinduism may shape mental health because of its influence on the attributions of survivors. A traditional Hindu belief is that an individual’s mental health depends on a person’s actions (karma). Maladjustment is attributed to the neglect of one’s duties toward God and behaviours such as cruelty to others, lust, and extortion. Illnesses are treated using traditional healing practices like prayers, purification, the use of herbal plants and other forms of Ayurveda traditional medicine (Haque, 2010). Yoga and meditation that help achieve a tranquil state of mind are integral parts of Hinduism and have been used to treat clinical conditions such as anxiety, substance abuse, insomnia, and pain (Haque, 2010).

Islam is also practiced in other SEA countries. In Islam, pure thoughts and deeds bring people closer to God and keep them mentally healthy. Traditional Muslim practices use various folk and traditional practices to overcome psychological distress in life (Haque, 2010). A study of highly traumatised Muslim refugees revealed that private prayer was their most common form of coping (Ai, Tice, Huang, & Ishisaka, 2005).

However, Dawson et al. (2014) also suggested not all spiritually related cognitions may be helpful. Their study found that the belief that honoring Allah will preclude harmful events from occurring is positively correlated with severity of PTSD symptoms (Dawson et al., 2014). They suggested that this appraisal may heighten a sense of threat and vulnerability because it introduces an element beyond survivors’ control.

Muslims’ belief in predestination may also be a deterrent to seeking mental health care. The interplay of gender and religion is also an important consideration – men see male counselors and female see female counselors. However, a male chaplain may offer pastoral care to a Muslim woman but in the presence of a patient’s male relative (Kirkwood, 2002).

In other parts of SEA such as Thailand, Vietnam, Cambodia, and Lao where Buddhism is common, there can be great emphasis on increasing conscious awareness and the power of the mind. A Buddhist belief is that emotion, while innate, can also be regulated by the circulation of ch’i (air) and determined by one’s food and drink. Indigenous healing practices in Buddhist cultures include acupuncture, qigong, and herbal medicine (Haque, 2010). A post-tsunami study of Buddhist children reported that religious practices such as meditation, reciting the five precepts of Buddhism, and reading Buddhist stories were common forms of coping and a source of resilience (Fernando, Miller, & Berger, 2010).

Another Buddhist belief relevant to disasters is the importance of blessing and cremating the dead. Without these rituals, people believe that spirits may not rest. After the 2004 tsunami in Thailand that killed more than 4000 people, there was much anxiety over tsunami victims whose bodies were never found and buried properly. To honor the dead and placate the spirits of unburied, spirit houses (miniature wooden house with clay figurines that represent deceased ancestors) were built and villagers offered fresh fruit, flowers, and water daily to distract spirits from entering nearby homes (Varley, Isaranuwatchai, & Coyte, 2012).
A vast majority of Filipinos belong to Catholic or other Christian denominations. Although disaster exposure can lead to questioning God and believing that a disaster is punishment from God (Hechanova, Ramos, et al., 2015), seeking spiritual support is also a common coping mechanism among disaster survivors in the Philippines (Hechanova, Ramos, et al., 2015). Nakonz and Shik (2009) suggested that religion influences Filipino’s ability to survive difficult circumstances in three ways. The first is through the reappraisal or redefinition of the problem. For example, Christians believe that God “never gives you a problem you cannot manage” and hardships are seen as spiritual opportunities. The second way is through seeking divine intervention. Praying to God to intervene in difficult situations is an important coping strategy and is reinforced by the belief that “God helps those who help themselves”. Another coping mechanism is surrendering their hardship to God and praying for the patience and wisdom to deal with the situation (Nakonz & Shik, 2009). Beyond these individual coping efforts, Church masses, prayer groups, ministries, and religious communities provide a common form of social networks among Filipinos and are important social resources. Support from religious groups can also be instrumental whether in the form of exchange of advice or mobilising funds to help out members in financial distress (Nakonz & Shik, 2009).

The benefits of religious participation have also been observed in other SEA countries. A post-tsunami study in Thailand observed that Muslim fishing communities appeared to be more cohesive and had better access to support than mixed-faith communities (Rigg et al., 2008). In Myanmar, which is 90% Buddhist, most of the country’s 400,000 monks are deeply involved in social life as bringers of relief and solace to those who need it most, thus providing a rich spiritual resource for communities (Seekins, 2009).

**MHPSS interventions in SEA**

There are a plethora of MHPSS interventions and a useful framework to view these interventions is using the Johns Hopkins Perspectives Model of Disaster Mental Health that suggests three clusters: resistance, resilience, and recovery. Resistance describes the ability of individuals/communities to prevent distress, impairment, or dysfunction. Mechanisms that may enable resistance are disaster preparation, group cohesion, positive cognitions, self-efficacy, and hardiness. Resilience describes the ability of individuals or communities to rapidly and effectively rebound from perturbations. Some interventions that build resilience are Psychological First Aid (PFA), stress management, adaptive coping skills interventions, pastoral interventions, and others. Recovery describes the ability of individuals to return to adaptive functioning in the wake of clinical distress, impairment, or dysfunction through psychotherapeutic interventions (Kaminsky, McCabe, Langlieb, & Everly, 2007). We use these three clusters in reviewing the MHPSS interventions in SEA.

**Resistance interventions**

**Public disaster preparedness interventions**

A widespread belief is that providing public information about hazards and how to mitigate their consequences will motivate people to prepare for disasters. An innovative disaster intervention is the International Tsunami Museum that opened in Thailand two years ago.
after the 2004 tsunami. The exhibits showcase the 2004 Indian Ocean tsunami and provide information about tsunami warning systems and evacuation procedures. The museum draws teachers, students, and other visitors each year and has increased visitors’ knowledge of disasters and appropriate responses and decreased their fears (Sattler, Assananangkornchai, Moller, Kesavatana-Dohrs, & Graham, 2014). An educational video presenting the same content was distributed in far-flung areas and achieved the same educational goals of improving knowledge of disasters and response (Sattler et al., 2014).

**Community-based disaster preparedness**

Community-based disaster preparedness programmes have emerged as means to strengthen coping and adaptive capacities at the local level. The community-based disaster preparedness initiatives of the National Red Cross consist of four key areas: technical information dissemination and training, risk and vulnerability awareness, local knowledge and resources, and mobilisation (Allen, 2006). Technical information dissemination and training is offered to those who lead disaster mitigation and resource mobilisation efforts. Risk and vulnerability awareness is conducted among a wider group of community participants to empower the community to address its own vulnerabilities and promote cooperation for disaster-related initiatives. Parallel to these efforts are activities that aim to harness local knowledge and identify resources that can be mobilised in times of disasters. Finally, the mobilisation of community members involves setting up community structures and planning. A community disaster risk reduction and management council is organised to map out early warning systems, evacuation plans, capacity building, and other initiatives. The strength of community-based disaster preparedness is that it empowers locals by supporting them to become self-reliant (Allen, 2006). Unfortunately, there has been no systematic evaluation on the impact of these initiatives.

**School-based disaster preparedness**

There has also been a rise in the involvement of children in disaster preparedness through school-based programmes. One such programme by Plan International in the Philippines involves students in risk mapping, risk communication, and community action such as restoring mangroves. The author suggests that children not only have the capacity to enact autonomous risk management practices but may also be risk communicators and create behavioural change in other people in their communities (Tanner, 2010). Unfortunately, no systematic evaluation of school-based disaster preparedness interventions has been conducted.

**Resilience interventions**

**Media programmes**

International guidelines for mental health and psychosocial support in emergency situations advocate the use of media to help people cope immediately after a disaster (IASC, 2007). In Thailand, relief organisations sponsored radio programmes that discussed mental health issues and ways of coping (Sattler et al., 2014). Unfortunately, the impacts of these programmes have not been studied.
**Psychological First Aid**

Given evidence that forcing individuals to relive traumatic events has harmful effects, critical stress debriefing has since been discontinued and PFA has become the recommended first psychosocial response immediately post-disaster (IASC, 2007). PFA consists of nine core actions: contact and engagement, safety and comfort, stabilisation, information gathering, current needs and concerns, practical assistance, connection with social supports, information on coping, and linkage with services (Forbes et al., 2011; Vernberg et al., 2008). There is evidence supporting the use of adapted PFA in the Philippines after Typhoon Haiyan in promoting coping self-efficacy (Hechanova, Ramos, et al., 2015). Another study that examined the experiences of responders using PFA affirmed its value in reducing distress and promoting safety, calm and self-efficacy. Disaster responders highlighted the usefulness of cultural adaptations of PFA, including integration with local counseling models, the introduction of mindfulness and meditation techniques, and group-based approaches (Landoy, Hechanova, & Kintanar, 2015).

**Resilience skills interventions**

There is robust evidence on the effectiveness of psycho-education on posttraumatic stress reactions and interventions that hone adaptive coping skills (Schnyder et al., 2016). Post-typoon Haiyan, the Psychological Association of the Philippines developed a resilience intervention based on the needs, vulnerabilities and protective factors of Filipino survivors of supertyphoon Haiyan. The intervention was named *Katatagan*, a Filipino concept that closely approximates the construct of resilience. The intervention consists of six modules: finding and cultivating strengths, managing physical reactions, managing thoughts and emotions, positive activities, seeking solutions and social support, and moving forward. Founded on cognitive-behavioural theory principles, modules used indigenous symbols and imagery. Although there was no module that specifically focused on spirituality, beginning and ending the session with a prayer became a norm. Because music is very much part of the Philippine culture, it was often incorporated at the end of modules (Hechanova, Ramos, et al., 2015). The intervention was pilot-tested and results showed that, after the six-week programme, participants reported significant decreases in posttraumatic stress symptoms, anxiety, and depressive symptoms compared to a control group (Hechanova, Ramos, et al., 2015). Another longitudinal study reported increased in coping self-efficacy of survivors six months after participation in *Katatagan* (Hechanova, Waelde, & Ramos, 2016).

**Family-based interventions**

A family-based intervention using expressive arts therapy was implemented for Haiyan survivors in the Philippines (Parr, 2015). Participants were grouped by developmental stage and given art materials and toys that served as tools to talk about themselves, their experiences, and their memories of their experience of Typhoon Yolanda. After the individual activities, participants were grouped according to family units and asked to reflect on their experiences as a family through a family collage. These were presented and processed with the entire group. The activity ended by asking participants to share their reflections as a community (Parr, 2015). Unfortunately, there was no evaluation on the impact of this intervention.
School-based interventions
There is growing evidence that school-based psychological interventions can be an effective tool for supporting student survivors (Rolfsness & Idsoe, 2011). A study in Yogkakarta, Indonesia implemented an intervention programme for teachers composed of two components: psycho-education about the impact of disasters on adults and coping exercises such as relaxation and deep breathing. The second day provided psycho-education about the impact of disasters on children and strategies to support child survivors. The last day focused on understanding and dealing with students’ misbehaviour and inattention. Pre-test and six-week post-test surveys showed a significant drop in teachers’ posttraumatic stress and depression symptoms (Rolfsness & Idsoe, 2011). However, the study did not examine the effects of the programme on the children.

Interventions for providers
A neglected topic in disaster response is attention to those who provide the mental health interventions to survivors. A study after a tsunami in Thailand highlighted how providers struggled to treat the injured while dealing with their own concerns about missing family members and coping with their own experiences of death and devastation. Health providers reported being overwhelmed by physical and sensory memories, chronic backaches, insomnia, heart palpitations, depression, and loss of appetite (Varley et al., 2012). To help responders, the Thai Health ministry sponsored meditation workshops, herbal infusions at hospital sauna, provided dietary supplements, and massages (Varley et al., 2012). However, there was no evaluation of these interventions.

A study in the Philippines described the development and implementation of a group-based and mindfulness-informed PFA intervention for use with government workers who were also survivors of Typhoon Haiyan. The PFA session consisted of mindfulness exercises, small group sharing, psycho-education about stress reactions, and other coping strategies. To promote community efficacy and connectedness, a small group activity helped identify survivors’ needs and brainstorm solutions. The identified needs and solutions were presented to the government workers’ managers for follow-up. The intervention ended with a plenary activity where survivors sang, prayed, and exchanged words of support. Pre and post-evaluations of the intervention revealed that the intervention significantly increased participants’ coping self-efficacy (Hechanova, Ramos, et al., 2015).

A longitudinal study examined training expectancies and utilisation of a manualised mindfulness meditation and mantra programme for counselors and psychologists in the Philippines following Typhoon Haiyan. Across the eight weeks of the study, the number of minutes of mindfulness and mantra practice increased. At the eight-week follow-up, greater minutes of total practice was associated with significantly lower depression severity. The results showed that participants perceived the training as credible and useful for both disaster work and self-care (Waelde, Hechanova, Ramos, Macia, & Moschetto, submitted for publication).

Recovery interventions
There is robust evidence of the usefulness and effectiveness of psychotherapies for trauma survivors such as cognitive-behavioural therapy, exposure therapy, cognitive processing, and eye movement desensitisation and reprocessing (Schnyder et al., 2016).
Unfortunately, a common challenge reported across SEA is the lack of mental health professionals to provide specialised services for survivors who need clinical care (Hechanova, Ramos, et al., 2015; Prasetiyawan, Viora, Maramis, & Keliat, 2006). It is thus not surprising that there are few studies of psychotherapeutic interventions for survivors in SEA. One study reported the use of group-based brief cognitive behaviour therapy with tsunami child survivors with PTSD (Pityaratstian et al., 2015). Their randomised controlled trial found that children who received the intervention had significant improvements in PTSD symptoms compared to those in the waitlist control group.

There are also reports of the use of individual counseling, group-based counseling, and other forms of providing psychosocial support (Carandang, 1996; Ladrido-Ignacio & Perlas, 1995) and pastoral counseling for disaster survivors (Aten et al., 2014), although none reported evaluations of effectiveness. Although there are anecdotal reports of the use of culturally nuanced interventions such as art and drama, there is little empirical evaluation.

One response to the dearth of mental health professionals is the use of mobile teams or empowering community health workers to deliver mental health services. In Thailand, immediately after the Indian Ocean tsunami, the Department of Mental Health established a Mental Health Recovery Center in Khao Lak and provided mental health services via mobile teams (Sattler et al., 2014). Similarly, in Indonesia, health workers (general practitioners and nurses) in community health centres managed and treated mental disorders including providing psychotropic drugs post-disaster (Setiawan & Viora, 2006). Nurses were provided special training to enable them to deliver psychiatric nursing care for patients and doctors were given a refresher course in primary care psychiatry to treat community patients (Prasetiyawan et al., 2006).

**Conclusions and recommendations**

The sparse literature about MHPSS shows that the science of disaster response is in its infancy in SEA. However, this review affirms the importance of sensitivity to local context and culture. It also highlights the importance of providing interdisciplinary and cultural training to local responders and mental health professionals to build their capacity to work in diverse environments. Given the dearth of mental health professionals in the region, the delivery of MHPSS appears to be primarily in the hands of community helpers such as teachers, health professionals, and emergency personnel. The salience of spirituality in SEA also suggests that collaborating with faith-based professionals may also be critical in providing MHPSS. Aten et al. (2014) argued that spiritual leaders are often “gatekeepers” in their communities and are willing to identify community needs and gaps in services and refer members to professionals with whom they have an established relationship.

Given the need for a public health approach in disaster response, the World Health Organization (2016) has recognised the importance of manualised psychological interventions that can be delivered by lay health workers. A promising intervention that might be considered for adaptation in the region is the Problem Management Plus programme (WHO, 2016). Composed of five sessions that focus on basic stress management strategies, problem solving, behavioural activities and strengthening social support networks, it has been tested in low-income settings such as Pakistan and has been found to reduce anxiety.
and depressive symptoms (Rahman et al., 2016). As more of these interventions are developed, there is a need to systematically train and coach community helpers to deliver them. This requires the need to re-orient the role of mental health professionals to go beyond being direct providers of service to becoming trainers and coaches of community facilitators.

Although the emergence of standardised interventions is a positive development, it is also important to note that these still need to be contextually and culturally nuanced. Hence, rather than just funding the delivery of standardised mental health interventions, there is a need to be more flexible and ensure interventions are culturally appropriate. As a positive example, after Medicins sans Frontieres achieved its funding needs for tsunami relief, they began to solicit unrestricted donations to provide contextually sensitive care to survivors (Bauman, Ayalew, & Paul, 2007).

However, beyond just providing funding, it is crucial to remember that the development or adaptation of interventions requires competencies in design and evaluation. Unfortunately, despite the growing number of published articles about disaster interventions in SEA, most are case studies, qualitative studies, or one sample studies with pre–post measures without randomised controlled trial designs or assessments (Seyle, Widyatmoko, & Silver, 2013). Hence, more robust designs are needed to establish the efficacy of MHPSS interventions. At the same time, only a few studies have described the process of design or adaptation of the interventions to ensure cultural relevance and sensitivity. The lack of culturally sensitive and evidence-based interventions should challenge mental health professionals with local knowledge to contribute to both practice and science by developing, documenting, and evaluating interventions. Concomitantly, there is clearly a need to strengthen the capability of local mental health professionals to design and evaluate interventions in their own communities.

In conclusion, this paper described how context and culture shape disaster mental health in SEA. We highlighted common vulnerabilities, protective factors, and cultural nuances that need to be considered in the delivery of MHPSS in the region. However, it is important to note that although there are common cultural values and traditions, SEA is not singular culture and there are many variations within cultures and individuals within the region. Future studies may seek to deepen understanding of disaster attitudes and practices within the countries in this region.

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