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COMMUNITY, ENVIRONMENT AND DISASTER RISK MANAGEMENT VOLUME 21

RESISTANCE, RESILIENCE, AND RECOVERY FROM DISASTERS: PERSPECTIVES FROM SOUTHEAST ASIA

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INVESTOR IN PEOPLE

ENDORSEMENTS

Crises and catastrophes are on the rise, becoming more the rule than the exception. Thus, a volume devoted to issues of resistance, resilience, and recovery could not be timelier or more important. Hechanova's and Waelde's insightful work should be required reading for leaders, scholars, and community members globally looking for culturally sound and effective evidence-based intervention frameworks.

Kathleen M. Sutcliffe
Bloomberg Distinguished Professor, Johns Hopkins
University and co-author of *Still Not Safe: Patient Safety and the Middle Managing of American Medicine*

Thoughtful and sensitive. The book does not only offer keen ideas about mental health and psychosocial support in times of disaster, it also gives us a deeper appreciation of the concepts of resistance, resilience, and recovery from disasters that is specific to the context that is Southeast Asia. In the midst of the global pandemic we are currently facing, this book gives us valuable insights as to how we can ensue collective resilience among our people in Southeast Asia and move forward in a way that is fit to the context of our new normal. What I appreciate most about the book is that it's giving a space for one of those groups that is often neglected in times of disaster — the disaster responders.

Marshaley J. Baquiano,
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Disasters have profoundly affected the evolution of human cultures through known history, and no region has felt these effects more than Southeast Asia (SEA). This volume provides a concise and unique resource for understanding how stress-resistance in the face of disaster, resilience to its most acute effects, and longer-term adaptive recovery are entwined with the cultural ecologies of those affected. These are perhaps the most fundamentally important distinctions for understanding how we can accurately anticipate and respond effectively to the mental health and psychosocial support needs of communities and organizations across SEA impacted by such catastrophic events. I recommend this book as a practical and scholarly resource for informing culturally sensitive studies and humanitarian interventions in general, and especially in SEA context.

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Disaster Relief Chair, APA Division of
Trauma Psychology

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CONTENTS

III. MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT INTERVENTIONS

IV. CONCLUSION

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LIST OF TABLES

LIST OF FIGURES

PREFACE

As of this writing, more than a quarter of a million people are in evacuation shelters as a result of Taal Volcano in the Philippines, which explosively erupted just days ago (National Disaster Risk Reduction and Management Council, 2020). Since then, the region has experienced more than 900 volcanic earthquakes, raising the prospect of volcanic tsunamis. The Philippine Institute of Volcanology and Seismology (PHIVOLCS) has posted an Alert Level 4 for Taal, meaning that a hazardous eruption is possible within hours to days (PHIVOLCS, 2020). The area is covered in feet of volcanic ash, obliterating homes, livelihoods, and communities.

It is now clear that human-induced climate change affects the likelihood and severity of many types of natural disasters (National Academies of Sciences, Engineering, and Medicine, 2016). The reality of climate change and its relationship to increased risk of natural disasters means that disaster preparedness and response must be a priority, as this elevated risk is associated with increasing vulnerabilities worldwide (Van Aalst, 2006). Much work already documents that climate change and disaster have deleterious effects on mental health, particularly for those who are impoverished and marginalized (Hayes, Blashki, Wiseman, Burke, & Reifels, 2018). Thus, disaster preparedness and response must address mental health and psychosocial support (MHPSS), that is, interventions that can address the range of severity of disaster stress sequelae from normative responses to more severe and lasting psychopathological outcomes. The chapters in this volume document that Southeast Asia is particularly vulnerable to disasters of all kinds, which exact a terrible toll of suffering and destruction.

Three key concepts guide the considerations of disaster mental health presented in this volume: resistance, resilience, and recovery, as described in the Johns Hopkins model. Resistance is a form of psychological immunity to developing manifestations of distress and dysfunction following disasters. Resilience refers to the capacity to effectively rebound from distress and dysfunction that occurs as a result of disaster. Recovery refers to the capacity to restore adaptive functioning following distress, impairment, and dysfunction that occur as a result of a disaster (Kaminsky, McCabe, Langlieb, & Everly, 2007). Addressing these three capacities of resistance, resilience, and recovery requires a solid evidence base to guide effective planning and practice that has been informed by all levels – from the individual to the population – and is grounded in knowledge about applications that are culturally appropriate.

The chapters in this volume address ways to enhance resistance, resilience, and recovery using leadership models and MHPSS interventions that are developed and implemented using a whole community approach that is grounded in and guided by cultural considerations. Because much work about disaster planning

and recovery is based on work done in Western cultures, in the first chapter, we address cultural considerations for MHPSS in Southeast Asia. Part II addresses leadership and organizational models for MPHSS. The powerful role of different forms of education to reduce disaster vulnerabilities is reviewed in Chapter 2 authored by Roman Hoffmann and Daniela Blecha. In Chapter 3, Mendiola Teng-Calleja, Pinky Rose Sabile, and Angelique Pearl Virtue Villasanta review ways to structure workplace organization to enhance employee and organizational resilience in the face of disasters. In Chapter 4, Elirozz Carlie Labaria, Avegale Acosta, and Charlotte Kendra Gotangco explain how the disaster planning process, including prevention, mitigation, and preparedness efforts, can be integrated with mental health efforts.

Part III of this volume reviews different forms of MHPSS support interventions as they have been applied in Southeast Asian countries. In Chapter 5, Jason O. Manaois, Chantal Ellis S. Tabo-Corpuz, and Andrew G. Heise review psychological first aid and its application in SEA. The next two chapters address specific disaster intervention approaches, namely, mindfulness and art therapy. In Chapter 6, Adriana Panting, Andrew G. Heise, Ma. Regina M. Hechanova, and Lynn C. Waelde review the rationale, cultural adaptations, and evidence base for integrating mindfulness and meditation into MHPSS. In Chapter 7, J. Sedfrey S. Santiago discusses art therapy as a way to allow expression of disaster stress experiences and provide a pathway to financial support for disaster survivors, using the Banglos fisherfolk as an illustration. Disaster responders bear heavy stress exposure burdens. In Chapter 8, Johnrev Guilaran and Hong An Nguyen describe MHPSS interventions for disaster responders themselves. The last chapter of Section II, Chapter 9, authored by Grant J. Rich and Skultip (Jill) Sirikantraporn, addresses posttraumatic growth as an outcome of disaster exposure. In the final chapter in Section IV, Chapter 10, we summarize the challenges and prospects for promoting resistance, resilience, and recovery in SEA.

The chapters in this volume address both the vulnerabilities and protective factors in SEA, highlighting the extent to which geography, poverty, and lack of resources, capability, and evidence-based disaster interventions make SEA populations more vulnerable to disasters and their negative outcomes. On the other hand, the strong sense of family, community, and spirituality appear to be protective factors. The chapters also highlight gaps in MHPSS responses and the need for rigor in examining the impact of interventions.

The idea for this volume developed from our collaboration to develop disaster MHPSS programs for the Philippines following Typhoon Haiyan. We are grateful to our collaborators in that initial effort from Ateneo de Manila University, the Psychological Association of the Philippines, and University of the Philippines Visayas Tacloban College. The funding for the original project that brought us all together was provided by Ateneo de Manila University and Palo Alto University. We also wish to acknowledge the Rockefeller Foundation Bellagio Center Residency Program that funded the initial conceptualization of this book project. We thank Alicia N. Torres for providing editorial assistance in the preparation of this book.

In a region that is constantly challenged by disasters, we hope to highlight how important it is to understand cultures and the possible ways in which the world can learn from Southeast Asia. We hope to encourage further research and translation into disaster mental health practice.

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January, 2020

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PART I

INTRODUCTION

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CHAPTER 1

CULTURAL IMPLICATIONS FOR THE PROVISION OF DISASTER MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN SOUTHEAST ASIA

Ma. Regina M. Hechanova, Lynn C. Waelde and Alicia N. Torres

ABSTRACT

Southeast Asia (SEA) is a region highly susceptible to earthquakes, volcanic eruptions, and tsunamis, though the region has been underrepresented in disaster mental health research. This chapter addresses risk factors for SEA, including its disaster-prone location, the psychological toll of frequent disasters, and stigma and shame and lack of psychoeducation about psychological help-seeking. Collectivism, strong family ties, and religious faith are among SEA's resilience factors. Culture should be heavily accounted for in mental health and psychosocial support (MHPSS), considering the wide array of cultural differences in spirituality, affect and expression, power distance, and gender and masculinity in SEA. Because culture affects treatment satisfaction, treatment engagement, and treatment outcomes, future research should explore how aspects of SEA culture impact accessibility and engagement in MHPSS.

Keywords: Mental health and psychosocial support; Southeast Asia; culturally adapted interventions; trauma; disaster mental health; culture

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The Southeast Asia (SEA) region consists of two geographic regions. Mainland SEA consists of Myanmar, Thailand, Malaysia, Laos, Cambodia, and Viet Nam. Maritime SEA consists of Indonesia, Brunei, Singapore, East Timor, Christmas Island and Cocos Island. It is considered as one of the most disaster-prone regions in the world (United Nations International Strategy for Disaster Reduction (UNISDR), 2010) because it lies along the Pacific Ring of Fire.

Despite its vulnerability, the region is underrepresented in terms of disaster mental health research. In this chapter, we summarize the literature about the impact of disasters, risk factors, and vulnerabilities in SEA. We also describe various aspects of SEA culture that may shape the provision of mental health and psychosocial support (MHPSS) in the region. Culture is a set of behavioral norms and cognitions representative of people from a definable population that are different from members of other populations (Lehman, Chiu, & Schaller, 2004). There is a growing need for cultural adaptations of MHPSS interventions, because most approaches were developed in Western, individualistic cultures with uncertain application in SEA. Culture can impact treatment satisfaction, engagement in treatment, and treatment outcomes (Constantine, 2002), making cultural considerations for MHPSS a vital concern.

The SEA region is located between two great oceans – the Pacific Ocean and the Indian Ocean and in the intersection of geologic plate creating earthquakes, volcanic eruptions, and tsunamis. Not surprisingly, countries in SEA have a history of disasters including typhoons, floods, tsunamis, volcanic eruptions, earthquakes, landslides, epidemics, and droughts (UNISDR, 2010). Between 1981 and 2010, the region experienced as many 912 disasters such as floods (47%) and tropical cyclones (38%) (Hechanova & Waelde, 2017). During this period, disasters have killed 199,075 and affected 310,443,666 survivors in the region (Samphantharak, 2014).

PSYCHOLOGICAL IMPACT OF DISASTERS IN SEA

There is an extensive literature demonstrating that disasters' survivors experience depressive symptoms and related symptoms of mood disorders including fatigue, loss, helplessness, withdrawal, and enduring grief reactions. In addition, the experience of trauma exacerbates previous disorders such as substance use disorders and depression (Bonanno, Brewin, Kaniasty, & La Greca, 2010). Studies in SEA have reported similar symptoms among disaster survivors. For example, a post-Typhoon Haiyan study in the Philippines described somatic, emotional, cognitive, and behavioral symptoms similar to that reported by disaster survivors in other parts of the world (Hechanova, Ramos, & Waelde, 2015). Beyond these deleterious outcomes, survivors of the Mount Merapi volcanic eruption in Indonesia (Warsini, Buettner, Mills, West, & Usher, 2014) and the survivors of the 2004 tsunami in Thailand (Rigg, Grundy-Warr, Law, & Tan-Mullins, 2008) described a sense of *solastalgia* or the loss of a feeling of safety and comfort because of the devastation of their environment.

Around the world, studies suggest that about 30% of disaster survivors experience transient PTSD symptoms but only about 5%–10% of survivors develop full-blown PTSD (Bonanno et al., 2010). Although there is a lack of epidemiological studies in SEA from which to draw conclusions, initial reports from Asia report a higher proportion (8.6%–57.3%) of survivors with PTSD symptoms immediately after a disaster. However, in the medium term, by nine months to a year after the disaster, this proportion decreases to 2.3%–32%, and two years after the disaster, it deceases to 1.2%–7.6% (Udomratn, 2008). Although the relatively higher prevalence may be because of small and biased samples (Bonanno et al., 2010), the percentage of those who are at risk for PTSD may also be due to the lack of mental health resources, poor disaster preparedness, social and educational disruption, and enduring poverty (Dawson et al., 2014). For example, a study in the Philippines after Typhoon Haiyan reported that millions of survivors were displaced and did not have adequate shelter for months (Hechanova, Ramos, et al., 2015). A study in Thailand showed that among displaced survivors of the 2004 tsunami, 12% had PTSD symptoms as compared to 7% of non-displaced survivors (van Griensven et al., 2006).

In addition to the classical symptoms of trauma, there appear to be some cultural nuances of trauma in SEA. Tuliao's (2014) review of the Philippine literature concluded that Filipinos do not differentiate between physical and mental disorders. He cited a study by Shakman (1969) that described how survivors seek out indigenous and folk healers because of disturbed behavior and somatic complaints that appear to have no medical causes. The somatization of illness may not be unique to the Philippines, however, because different cultural groups somaticize psychological symptoms (Chhim, 2013). There is also evidence of some trauma-related symptoms that appear to be culturally specific. In Cambodia, the term *baksbat* (broken courage) is used to describe posttrauma symptoms including feeling fearful, mute and deaf, and lacking trust in others (Chhim, 2013).

MENTAL HEALTH PROFESSIONALS

Fortunately, countries in SEA have increasingly instituted disaster risk reduction and management (DRRM) and mental health policies and programs. Indonesia, Myanmar, and Thailand included MHPSS in their disaster preparedness programs (Ito, Setoya, & Suzuki, 2012). A barrier to the delivery of MHPSS is the lack of mental health resources to provide the needed services. Countries in SEA (Lao, Cambodia, Myanmar, Indonesia, Viet Nam, and the Philippines) have the lowest number of psychiatrists in Asia (Ito et al., 2012). Fortunately, a protective factor is the active role of non-governmental organizations (NGOs) and universities in providing psychosocial rehabilitation services in the community. Some countries such as Indonesia have begun to embed community mental health in their nursing training programs (Ito et al., 2012).

In addition, although there may be dearth of formal mental health care providers, a protective factor in the region is the existence of traditional healers.

Many Cambodians seek help from herbalists (*Kru Khmer*). In Indonesia, up to 80% of people consult traditional healers before they consult a medical professional. Traditional healers are also popular in East Timor and Viet Nam. Many Filipino, especially in rural areas, consult *arbolario*s (herbal doctors) who use prayers, herbs, and medicinal plants to heal afflictions (Araneta, 1993). Some also seek help from *manghihilots* who provide *magnetic healing* using prayers and massages similar to acupressure or reflexology (Araneta, 1993; Tan, 2008). Thus, it is important to disaster responders to work with and build capability of local healers (Ito et al., 2012).

STIGMA AND SHAME

Even where mental health programs exist, an important risk factor is whether survivors will actually avail of them. Two important cultural barriers to the provision of postdisaster support is the presence of stigma attached to persons with mental illness and the cultural value of shame. There is much evidence that Asians, in general, are reluctant to seek help from mental health professionals (Hechanova & Waelde, 2017; Matsuoka, Breaux, & Ryujin, 1997; Tuliao, 2014). The reasons are varied. Some are reluctant to open up to people they do not know (Hechanova, Tuliao, Teh, Alianan, & Acosta, 2013). There are also those who simply do not want to burden others (Hechanova & Waelde, 2017). Others are ashamed because seeing mental health professional may mean they are crazy and they do not want to tarnish their dignity or damage their family's reputation (Hechanova & Waelde, 2017). The desire not to lose face is evident in findings that internalized stigma is negatively correlated to the intent to seek professional help (Tuliao, 2014).

THE ROLE OF FAMILY

Given the presence of stigma and shame, survivors in SEA generally prefer seeking help from family and friends (Hechanova et al., 2013) or local healers (Haque, 2010). Fortunately, family relationships are usually protective factors in SEA because families play an essential role in the patients' mental health treatment (Ito et al., 2012).

However, a risk factor is that the lack of knowledge and negative attitudes toward mental illness may prevent people from seeking care (Ito et al., 2012). Thus, it is important for disaster responders to work with survivors' natural counselors – families, community health workers, leaders, religious workers, and healers (Ito et al., 2012; Seekins, 2009; Udomratn, 2008).

COLLECTIVISM

Countries in SEA are described as collectivist and in such cultures, people's identities are interdependent and tied to that of their families, community, and

society (Hofstede, 2003). However, collectivism may be a risk factor because even those who are not directly affected may have feelings of self-blame, guilt, and shame when their kin experience trauma (Engelbrecht & Jobson, 2016). A study of Haiyan survivors in the Philippines reported that many expressed feeling guilt and helplessness because they were not able to help their neighbors and friends (Parr, 2015). Alternatively, just as collectivism may influence the impact of disasters, it may also mitigate their impact. Paton et al. (2008) argued that community and institutional factors may influence disaster preparedness in Asia. A study in Indonesia found that the amount of community cooperation influenced the extent to which community members sought information about and prepared for a disaster (Sagala, Okada, & Paton, 2009).

There is also robust evidence that social support cultivates psychological resilience postdisasters (Sasaki et al., 2019). Those in collectivist cultures may have an advantage because they derive their resilience from themselves and their support groups (Haque, 2010). A study among Filipino disaster survivors supported this idea. When asked to reflect on the sources of their strengths, survivors cited the faith in God, family, friends rather than personal characteristics or resources (Hechanova, Waelde, et al., 2015). In addition, social support may actually buffer and increase resistance to the negative effects of a disaster. A study by Sasaki et al. (2019) reported that participants who had emotional and instrumental support prior to a disaster were less likely to report depressive symptoms after a disaster compared to those who did not have support.

One implication of these findings is that interventions that promote social support and interdependent coping efforts may be more important in SEA than interventions that focus only on individual resilience (Hechanova, Ramos, et al., 2015). This idea is corroborated by a study that found that a sense of community promotes the adaptive coping behaviors of first responders (Agbayani, Villaflor, Villaret, & Hechanova, 2019). The authors explained that the sense of community contributed to responders' feeling they are not alone and emboldens them to connect with one another.

All these points suggest the importance of strengthening intact social groups as part of postdisaster interventions. Indeed, studies in the Philippines suggest that group-based interventions are effective in collectivist cultures because they promote healing and empowerment, reduce feelings of shame, decrease alienation and isolation, and discourage passivity and helplessness (Hechanova, Ramos, et al., 2015).

CULTURAL FACTORS THAT MAY INFLUENCE THE DELIVERY OF MHPSS IN SEA

Beyond the vulnerabilities and protective factors, culture can shape how people respond to MHPSS. The Interagency Standing Committee (IASC, 2007) guidelines on the provision of MHPSS in emergency settings emphasize the importance of cultural sensitivity among disaster responders. Beyond understanding the context and language, responders need to understand nuances in

social emotions, cognitions, and behaviors to effectively respond to survivors in SEA (Schnyder et al., 2016). Although there is great variability within and between countries in SEA, these nuances in Southeast Asian countries make them different from Western countries and should be considered when providing MHPSS.

SPIRITUALITY

Spirituality shapes attributions about disaster, gives religious significance to hardships and shapes how people cope (Aten, O'Grady, Milstein, Boan, & Schruba, 2014). Religion may also serve as recovery capital because membership in religious groups facilitates both social and instrumental support. There is a diversity of faiths practiced in SEA. Countries such as Malaysia and Indonesia are home to Hinduism which teaches that an individual's mental health depends on a person's actions (karma). Hindus believe that neglecting one's duties toward God and negative behaviors such as cruelty to others, lust, and extortion lead to illnesses. Afflictions are treated using traditional healing practices like prayers, purification, the use of herbal plants, and traditional medicine, yoga and meditation (Haque, 2010).

Buddhism is widely practiced in Thailand, Viet Nam, Cambodia, and Lao and teaches that emotions can also be regulated by the circulation of ch'i (air) and determined by one's food and drink. Buddhist healing approaches typically include acupuncture, qigong, and herbal medicine (Haque, 2010), meditation, reciting the five precepts of Buddhism, and reading Buddhist stories (Fernando, Miller, & Berger, 2010). The blessing and cremation of the dead is also important among Buddhist who believe that spirits may not rest without these rituals. After the 2004 tsunami in Thailand that killed more than 4,000 people, villagers built spirit houses and offered fresh fruit, flowers, and water daily to put spirits to rest (Varley, Isaranuwatchai, & Coyte, 2012).

Islam is also practiced in a number of 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 and private prayer are most common form of coping (Ai, Tice, Huang, & Ishisaka, 2005).

Ninety percent of Filipinos belong to Catholic or other Christian denominations. Nakonz and Shik (2009) suggested that Christianity helps Filipinos survive difficult circumstances in three ways. First, hardships are seen as spiritual opportunities to become closer to God or that there is a reason for whatever hardship one is experiencing (i.e., "God never gives you a problem you cannot manage"). Christians seek divine intervention, surrender their hardships to God, and pray for the patience and wisdom to deal with difficulty (Nakonz & Shik, 2009). Tuliao (2014) reported that some Filipino practices prior to Spanish colonization remain. These include the belief that physical and psychological disorders are caused by malevolent spirits and the use of Ayurvedic and Chinese traditional medicine (Lagaya, 2005).