Thai Flood Survivors' Perceptions of Their Mental Wellbeing and Psycho- Social Support Services Received

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ABSTRACT

Introduction: Natural disasters result in considerable harm, are often associated with loss of life and property, posing a direct threat to the well-being of a society. Flooding is a common natural disaster occurrence in Thailand, profoundly affecting the lives of those who survive. To date little is known about the mental wellbeing and experience of community support after flood disasters in Thailand.

Aim: To explore the experiences of mental wellbeing and psychosocial support of flood survivors.

Method: Qualitative interpretive design was employed. Informants consisted of 12 survivors who had experienced one particular flood crisis, selected by purposive sampling. The data were collected using in-depth interviews and non-participant observations. All informants were Buddhists. The half of survivors was educated to 14 years of age, ten of the survivors were employed and the remaining survivors were housewives.

Results: Emergent themes were: (i) loneliness and anxiety; (ii) acceptance and optimism; (iii) not sleeping and physical illnesses; (iv) caring for each other and ourselves.

Implications for practice: Future public health disaster planning in Thailand must include targeted psychological preparation of key frontline health workers and the provision of mental health survival kits. Of crucial importance is using Thai meditation techniques, Thai informed psychotherapeutic training coupled with flood related social assistance that draws on village neighbourhood support, for survivors and their families. In Thailand, psychiatric nurses and emergency disaster health care providers need protocols for addressing the specific psychosocial needs of disaster survivors, specifically the potential for loneliness and anxiety.

Keywords: Mental health, Community support, Survivors, Natural disasters, Thailand

INTRODUCTION

Globally there has been reported to be an increase in the rate of mental health disorders after a natural disaster, specifically anxiety, depression, suicide, which can have a long-term psychological and social impact, and include work related stress disorders [1]. Natural disasters result in harm and loss of life or property, and pose a direct threat to the well-being of humans. A natural disaster is a major adverse event resulting from natural processes including floods, volcanic eruptions, earthquakes, tsunamis, and other geologic processes. Moreover, experiencing natural disasters has been associated with posttraumatic stress disorder symptoms including migraines and headache [2]. The disaster of flooding, in particular, has been strongly associated with poor mental health outcomes. The severity of which depends on the extent of the flood, the localized health system response, and affected population's resilience, or ability to recover [3].

The existence of resilience factors (associated with the ability to cope with natural disasters), are linked to a reduction in psychological distress and long term trauma [4].

In Thailand floods have had profound impact on economic and social development of the country, plus the capacity of allied services to provide targeted services people who face floods. The direct effects of flooding include physical injury, chronic illness, loss of family members, loss of property and loss of employment [5]. The psychological effects of a flood include; insecurity, insomnia, irritability, feelings of grief, hopeless, helpless, fear of death, and horror of events. The psychological sequel from such disasters can escalate into posttraumatic stress disorder (PTSD), acute stress disorder (ASD), depression, suicide [6]. For flood disasters, in particular, there has been a reported to be an increase in both suicidal ideation and attempts within the 12 months period post flood. An awareness of the potential for increased suicidality, associated risk factors and the role of formal and informal support services is seen as crucial to the prevention of acute mental health conditions following widespread natural disasters [7].

Thailand has its highest number of “floods only events” in the provinces of Petchaboon Ayutthaya, Bangkok and Songkhla, Trang. In 2014, there was a major flood to Hat Yai Songkhla, resulting in approximately 105 deaths [8].The costs of physical injuries and associated economic losses were estimated to be in excess of 20,000 million baht [9]. High rates of mental health problems were identified; particularly depression and suicide [10]. Flooding is a common natural disaster in Thailand, profoundly affecting the lives of those who survive. To date little is known about the mental wellbeing and experiences of community support after flood disasters in Thailand.

AIM

mental health experiences from survivors of the flood in Hat Yai, Songkhla in Thailand. A secondary aim was to identify psychosocial supports needs regarding mental health care service provision.

METHODS

An exploratory qualitative study design was employed [11,12].

Sampling and Recruitment

The principal investigator a PhD prepared registered nurse selected flood survivors names from the hospital register of a major public hospital in the province which the study site was located, using the following inclusion criteria:

- Above the age of 18 years.
- Diagnosis of “at risk” depression scores form Q depressive questionnaire
- Live permanently in Hat Yai, Songkhla
- Having an experienced by the 2014 flood

The purposive sampling criteria employed were that of; having experienced being in the flood, an “at risk” diagnosis of depression drawn from scores on the Q Thailand National Depressive Questionnaire (http://www.dmh.go.th). This self-report Q Depressive Questionnaires is a nationally mandated tool developed by the Thai Department of Mental Health (http://www.dmh.go.th). The 1 or 2 Q is a standard mental health assessment tool used widely in Thailand. The 2 Q contained 2 questions as follows: 1) In two weeks, including today, have you felt “depressed” or “hopeless” or “discouraged”. 2) In the two weeks. Including today, do you feel “tired”.

- If the answer is “no” to both question, the person is considered not a depressed.

If the answer is If the question is “yes” to one or both of the two (any symptoms in question 1 and 2) refers to being "at risk". A total of 15 survivors were approached by way of a mobile phone call, with 12 agreeing to be interviewed. A total 3 refused for reason such as get sick, and too busy.

ETHICS

Ethics was granted by the research committee for morality at the Prince of Songkla University No.0521.1.05/0282 and permission was subsequentially received to access the study site hospital register for recruitment purposes. The survivors had the right to refuse furthers questions, withdraw from the study if they wished and were ensured that all data would be handled anonymously and confidentially. The signed witnessed confidentiality agreements were obtained at the beginning of the data collection process.

APPROACH

A semi structured interview guide was developed from the literature reviewed. Content validity of the interview guide was performed by three experts who were namely ;an expert psychiatric nurse, a psychologist and a lecturer who had each been involved with psychiatric and mental health nursing education for more than 10 years. Minor modifications were subsequently made to the interview schedule.

After getting written ethics permission, the researcher invited participants, the date, time, and place were arranged according to each person's availability. The primary researcher introduced herself and explained the purpose of the research, the collection data requirements and the period of the time of research process.

Once informed consent was obtained, semi structured interviews were conducted following the interview guide. Most of the interviews were carried out in a private room at the district health office.

DATA COLLECTION

Rapport was established prior to the interview by asking the participants non-direct warm-up questions. The interviewers were conducted over a 7 week period with duration between of between 45-60 min. An audit trail was kept of changes to the interview guide as a result of analysis, and decisions made in the process of the individual interviews, also nonverbal gestures such as crying or smiling were further noted to provide contextual data. Concurrent analysis was employed to develop on going and in-depth questions. When each new set of interview data had been analyses and no new themes emerged, the research team considered that saturation had been reached. Recruitment subsequently ceased upon theoretical saturation being achieved [13].

ANALYSIS

Transcriptions were read and compared with the audio tapes to ensure that all content from the interviews had been correctly transcribed. A sub set of transcripts were then translated to English and then back translated. The back translated versions were then matched with the original Thai versions to ensure the accuracy of the translations, word modifications made accordingly.

All collected interview data was transcribed, then line coded into themes and sub-themes by reading and reading of transcripts. This process looked for patterns of meaning and issues of potential interest. Emerging categories were then expanded as data from each participant interview was added. Data from individual informants were compared and contrasted to identify unique and common experiences.

RIGOR

To uphold conformability all the interviewer by first author conducted all interviews solely [14]. A single objective view was reached through research team member meeting to agree on emergent themes through checking for any discrepancies. To achieve dependability an audit trail of field work decision making was kept. Triangulation with the interview data and the audit trail non-verbal notes was used to ensure data consistency and trustworthiness and included collecting data notes on non-verbal behavior and investigator memos [15].

FINDINGS

Participants

All survivors were Buddhists. The half of survivors were educated to completing high school, 7 the survivors were employed and 5 were housewives. The ages ranged from 35-55 years, with a mean of 44.79. There were 8 women, and 4 men, and 10 married, 1 divorced, and 1 single.

The major emergent themes were: (i) loneliness and anxiety; (ii) acceptance and optimism; (iii) not sleeping and physical illnesses; (iv) caring for each other and ourselves.

Loneliness and Anxiety

Some survivors testified to feeling very isolated from others after the flood. Survivors expressed that they were stressed, lonely and anxious, as seen in the following:

"I was worried because I was alone. I cried because I am in very dark place and I was scared" (S1).

"I also worried but sometimes didn't want to cry. But I was alone so I cried first. Let's think how scared to be alone. What if there were dangerous thing like snake and so on. We couldn't ask anyone to help" (S3).

"Flooding causes more anxiety but I felt warmed my heart with its neighbours as the home side took care and sharing food" (S9).

It can be seen that the loneliness and anxiety of the disaster sufferers needed to be acknowledged and form a part of immediate psycho-social support requirements, alongside physiological interventions.

Acceptance and Optimism

Informants, while reporting tension and anxiety, about the flood also testified to coming to accept it, sharing the experience with neighbours and friends and turning to religious books for solace to boost their feeling of acceptance and optimistic about their futures, as follows:

It's good to have family members living together, talking to each other, read religion's book, find activities to do with family, neighbours and government (S2).

"I wasn't worried because before the flood the government warned and reminded us and the village health volunteers have phone call for each person. We managed our stuff, and told our neighbour. When the flood came we just enjoyed. But when it was done we started worried because it was big cleaning and we were lazy" (S1).

"I wasn't worried because I faced the flood many times. When the flood occurred, I smiled because I've already prepared everything. All the stuff I moved to the second floor. Actually, I was not worried because I accepted it if will be flood then will be flood and I just get ready for it" (S8).

"When I was on the roof of the flood. Then I saw something floating in the water sometimes feel giggle, and I had never seen and felt good" (S2).

A Thai sense of acceptance and preparation, plus strong community networks appeared to keep the survivors content. There was also a sense of resignation as the flood event became incorporated into their lives, which appeared to decrease the internal conflict posed from unexpected events.

Not Sleeping and Physical Illness

Initially, after the flood, all survivors said they remembered not sleeping. Some people reported that they had also had diseases, headaches and heart palpitations.

"My uncle get to leptospirosis. I am scared of disease" (S1).

"I want to have some medicines immediately when I knew the water was higher" (S3).

"After the flood, I borrowed any money from my neighbours and I always borrow. My debt is highly money. So, I think it made me have hypertension" (S5).

"I have a headache when I talk about my debt to my friend because I was so stressed I think" (S4).

"When the flood came I've got Leptospirosis and had to take medicine for many days" (S6).

The manifestation of flood related physical illnesses effected each family differently depended on their stage in the life course Moreover, survivors noted that it was difficult to be control some of the pandemic diseases caused by sceptic waste such as leptospirosis or bites and diseases spread from poisonous insects .

Caring for Each Other and Ourselves

The theme of "taking care of each other" to enable these informants to overcome their distress form the crisis, and a necessary sacrifice and act of kindness. These altruistic acts manifest positive thoughts which stimulated increased community neighbourhood support. These informants wanted to provide the best possible care for their neighbourhoods and support their communities, caring for themselves first through prayer and staying calm.

"Pray and go to the temple can help. My neighbour was praying every night for the flood not getting higher" (S4).

"I wasn't worried because before the flood the government warned and reminded us and the village health volunteers have phone call for each person. We managed our stuff, and told our neighbour. When the flood came we just enjoyed. But when it was done we started worried because it was big cleaning and we were lazy"(S5).

"The flood come I smile. Because I prepare everything already. I've moved all stuffs to the second floor. Not to worry. But have to accept it (S3).

"Being calm is to sit still and look at the flood. Do nothing. If we're not being calm we'll be worry so much" (S6).

"Before the flood we have to come after training about how to face to the flood" (S2).

The strength of the people in the villages and community was seen as important especially to foster the atmosphere of mutual help in times of crisis:

"We talked to each other on the roof. Funny" (S4).

"Our responsibility is to warn them. After we receive the news from the head. Then we tell our neighbour. After that it's depend on them" (S2).

"In this area, we are not selfish. We stayed on the roof and singing. It's not quiet" (S1).

"Some of the volunteers has a plan and write it down how to face with flood" (S3).

Caring for one another during disasters such as floods was viewed as a cultural expectation. This was seen "talking across the roof tops" to neighbours and central to building the resilience in the community. Collective sharing and common experience was seen to decrease conflict in times of crisis and as an act of compassion that provided generalized mutual support to one another. .

These aspects of community support and early preparedness was seen by the informants to reduce the need to wait for the limited help offered from government services:

"We managed our stuff, and told our neighbours. When the flood came we just enjoyed. But when it was done we started to worry because it was big cleaning and we were lazy" (S1).

"The point is we help ourselves before flood occur, and also help friends, When flood we stay in the roof. Cannot help much. But after flood we help we help ourselves then we help our friends. After the flood we work hard. We go to check on many things" (S7).

"I think we have to prepare and it's very important. If we prepare well, our stuffs will not get risk so much. And we will not be serious or worry if the flood comes because it natural thing" (S3).

"We don't have certain plan like everyone think that the flood is coming so we have to look after ourselves first" (S1).

"Well, we have to take care of ourselves first. We don't have any plans that we write down in papers. But we do have plans in our mind" (S6).

DISCUSSION

These results yield first time findings, specific to the experiences of mental health needs and psychosocial supports post flooding in Thailand. The informants testified that while experienced stress, anxiety and sleeplessness when facing the flood disaster, they also reported drawing on community support, prayer and self-care strategies. This is in keeping with Benter [16], who noted the psychological impacts of floods had many cultural manifestations. The participants indicated that the most of the survivors engaged in self-help and cared for other people, as both a religious and cultural imperative exchanged among the people who worship together.

The theme of acceptance and optimist indicate a central Thai characteristic focus on community and religion rather than on individual needs in a crisis [17]. In Thailand, the vast majority of the population (94.6%) are Buddhist [18], with accords with the religion of our informants. Religious settings support the exchange of social, emotional, information, and spiritual assistance among people who worship together. Religious congregations often provide care for fellow members who are ill, through conversations, consultation, encouragement and help relating to modifying or adapting lifestyle changes such as healthy diet and exercise [19]. Importantly, in Thailand, Buddhism generationally is embedded with the ethos of charity. On each Buddhist Holy day the monks support prayer in order to prevent and provide protection against crisis, illness or possible death. Flooding is viewed as a misfortune for Thai people thus central to this belief prayer, religious books and good deeds for neighbours can promote merit and well-being as well as helping with avoiding future misfortune [19].

These flood survivors reported not sleeping and having physical illnesses. If these emergent issues were not addressed directly post the disaster, anxiety can overwhelm and lead to serious, depression, confusion violence against others, or suicidal behavior [20]. According to Aguilera [21], complex psychosocial tensions increase after natural disasters, however our informants sought ways to help each other and themselves to manage their potential for psychological and physical stress. The construction of the shared social identity seen in this cohort of flood survivors indicated a sense of togetherness after a crises which has been documented as informing a collective resilience Kaniasty and Norris, drawing on personality theory unpack a community sense of connectedness during and after a disaster trauma when shared personalities inform collective responses for both survivors and victims

The emergence of community strength and networks was an important finding as it meant the community could find ways to solve arising problems, from which these flood survivors were able to draw solace The central role of religion and

spirituality in buffering mental health illness in Thailand suggest more official recognition needs to be paid to the role of religion as a mental health support mechanism. The use of religious solace was seen to enable understanding, empathy and compassion for these survivors. A link between mental health services, the use of religious practices had overlapping goals to promote individual and community resilience, growth, and well-being [22] is paramount. Flooding meant that people in these communities tried to help each other means to have a harmonious approach to community concerns and reduce dependency on government agencies.

IMPLICATIONS FOR PRACTICE

This analysis provides first time baseline data for Thai health care providers to develop a more targeted psychological model, that draws upon the theory of personality behaviors in a crisis for while enhancing Thai community and religious values to support survivors and their families after natural disasters. Developing these strategies will prevent further individual and community mental health crises in Thailand.

Future public health disaster planning in Thailand must include targeted psychological preparation that aligns with community cultural beliefs by key frontline health workers. This can be achieved, in part, by core allied health undergraduate programs on these religious and community beliefs and values. The provision of mental health survival bags containing Thai meditation technique instructions and alerts for the risk for depression is critical. Educating health professional especially front line and mental health nurses on the importance of an emphatic feedback on the experience of natural disasters for victims and their families is further recommended. Furthermore, education on the construction of collective social identities for health professionals is need to understand human response in a flood disaster. Such education and service provision would enable both survivors and their families to n draw out the unique aspects of their responses, and to maximize collective response through community support. Acknowledge of personality behavior during a crisis would also enable better preparedness from which national disaster responses for other crisis situations would have applicability. Thailand, psychiatric nurses and emergency disaster health care providers need protocols for addressing the specific psychosocial needs of disaster survivors, in terms of potential for loneliness, anxiety and sleeplessness.

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