

Ocean waves and roadside spirits: Thai health service providers' post-tsunami psychosocial health

Emma Varley, PhD Assistant Professor, Department of Humanities and Social Sciences, Lahore University of Management Sciences, Pakistan, **Wanrudee Isaranuwatthai, PhD** Postdoctoral Fellow, Social Aetiology of Mental Illness (SAMI) CIHR Training Program, Centre for Addiction and Mental Health, Toronto, Canada, and **Peter C. Coyte, PhD** Professor of Health Economics, Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Canada

A massive earthquake off the west coast of Sumatra in Indonesia triggered a tsunami on 26 December 2004. At least five million people around the world were affected, and the total number of deaths exceeded 280,000. In Thailand, the tsunami struck six southern provinces, where the disaster's immediate impact was catastrophic. Based on ethnographic fieldwork in Phang Nga Province (2007), this paper provides an overview of the disaster's psychosocial consequences for Thai health service providers, the vast majority of whom were bypassed by regional post-tsunami mental health initiatives. The available tsunami literature only briefly attends to health providers' experience of professional 'burn-out', rather than explores the tsunami's wide spectrum of psychosocial effects. This research aims to remedy such oversights through 'critical medical' and 'interpretive phenomenological' analysis of the diverse and culturally-situated ways in which health providers' experienced the tsunami. The paper concludes by arguing for disaster-related psychosocial interventions to involve health providers explicitly.

Keywords: health care providers, psychosocial health, qualitative approach, trauma, tsunami

Introduction

On 26 December 2004, a massive earthquake off the west coast of northern Sumatra in Indonesia triggered a tsunami. At least five million people around the world were affected, and the total number of deaths exceeded 280,000 (WHO, 2005b). In Thailand, the tsunami struck six southern provinces: Phuket, Phang Nga, Krabi, Ranong, Satun, and Trang. Its immediate impact was catastrophic. Approximately 60,000 people in Thailand were directly affected, with 4,224 dead and 1,733 missing in Phang Nga Province alone (Tsunami Souls, 2005). Based on ethnographic fieldwork in southern Thailand (2007), this paper provides an overview of the disaster's psychosocial consequences for health service providers, the vast majority of whom were bypassed by regional post-tsunami mental health initiatives and interventions. Indeed, the available tsunami literature only briefly attends to health providers' experience of

professional ‘burn-out’ (Carballo, Heal and Horbaty, 2006; Ghodse and Galea, 2006), rather than explores the tsunami’s wide spectrum of psychosocial effects. Among tsunami-affected individuals, psychosocial symptoms have been shown to include acute stress, post-traumatic stress disorders, secondary trauma, and functional symptomatology (Chandra, Pandav and Bhugra, 2006; Sumithapala et al., 2006; Vijaykumar et al., 2006). Accordingly, this research aims to remedy such oversights through ‘critical medical’ and ‘interpretive phenomenological’ analysis. But rather than place primacy on clinical assessments or diagnostic criteria, this approach entails examination of the diverse and culturally-situated ways in which health service providers’ subjectively experienced, understood and recovered from the tsunami in Phang Nga Province. The paper concludes by arguing for disaster-related psychosocial interventions to involve health providers explicitly, and to accommodate the affective inter-relationship between socio-religious, organisational contexts and their evolving experience of trauma, loss, resilience and recovery.

Theory and methods

Individuals’ experiences of psychosocial trauma and vulnerability in the aftermath of the Indian Ocean tsunami, and the ways in which such experiences are shaped by issues of age, gender, ethnic, community and religious identity, have been investigated extensively among survivors, aid workers and, to a much more limited degree, health service providers in Sri Lanka and Indonesia (Brown, 2005; Dewaraja, Sato and Ogawa, 2005; Miyazaki, Dewaraja and Kawamura, 2005; Nyman, 2005; Pincock, 2005; Ranawaka and Dewaraja, 2005; Riddez et al., 2005; Cheng, 2006; Dewaraja and Kawamura, 2006; Leiba et al., 2006; Peltz et al., 2006; Yamada et al., 2006; Chan and Huak, 2007; Clark, 2007; Knox, 2007; Wickrama and Kaspar, 2007; Gaillard et al., 2008; Thoresen et al., 2008). Yet, while multiple studies address the psychosocial impacts of the tsunami on ‘everyday citizens’ in Thailand (Krauss, 2005; Chakrabhand, Panyayong and Sirivech, 2006; Visanuyothin et al., 2006; Tang, 2007; Moniruzzaman, 2010), the available literature overlooks the disaster’s psychosocial effects on the health service providers that supplied emergency treatment to survivors.

For the purposes of this paper, ‘psychosocial’ is broadly defined as ‘the influence of social factors on the individuals’ mind and behavior’ (Sumithapala, Siribaddana and Perera, 2006, p. 8). Although the concept has been monopolised historically by clinical biomedicine and bio-psychiatry in particular, the notion of ‘psychosocial health’ was originally intended to incorporate ‘non-medical approaches and [represent] distance from the field of mental health’ (Shah, 2007, p. 55). Hence, this research seeks to merge the concept of ‘psychosocial’ with analysis of the tsunami’s interwoven socio-cultural, spiritual, and professional consequences. Moreover, it builds on studies that attempt to remedy the dearth of ‘precise data on the overall nature and scope of mental health and psychosocial problems in the populations that were affected by the tsunami’ (Carballo, Heal and Hernandez, 2006, p. 396). While the available literature confirms that psychosocial outcomes are influenced by personal,

cultural and social forces (Bhugra and Van Ommeren, 2006, p. 213; see also Alvarado and Mason, 2005, p. 1), tsunami-focused studies rarely examine the specificity of local culture and its correlative effects on survivors' sense of trauma or recovery.

The research process and data analysis were guided methodologically and theoretically by critical medical anthropology (CMA) and interpretive phenomenological analysis (IPA). CMA examines how socio-cultural, political and economic forces shape 'health' and 'illness', as well as the ways in which individuals experience micro- and macro-level events through their bodies, health and emotions (see Baer, Singer and Susser, 2003, pp. 42–45). Using this approach, our research explored qualitatively the ways in which the tsunami threw social practices and cultural beliefs, as well as issues of relationality and professional hierarchies, into sharp relief. By relation, IPA focuses explicitly 'on the world that the study participants subjectively experience' (Maggs-Rapport, 2000, p. 221). In ways that are directly relevant to this assessment of the tsunami's psychosocial impacts, IPA typically engages with experiences of personal significance, such as the ways that individuals cope with matters of health, illness, trauma and loss. Our approach, derived from a synthesis of CMA and IPA, facilitated critical ethnographic examination of Thai health service providers' individually-situated, culturally-shaped psychosocial response.¹ Through an analysis of providers' narratives of subjective experience, our research foregrounds the ways that Thai health service providers ascribed meaning to their experience of the tsunami (Biggerstaff and Thompson, 2008, p. 215). In this way, our methodological and analytical stance operates in distinct contrast to clinical assessments of psychosocial response; assessments that are generally characterised by appeals to diagnostic criteria (Shah, 2007, p. 54).

In response to deficits in the available tsunami literature concerning Thailand, our research concentrated on Thai Muang District in Phang Nga Province, where we solicited the accounts of government and private health providers working in and around the district capital of Thai Muang, a small town of some 8,000 residents. Thai Muang's District Hospital and Public Health Offices (PHOs) acted as first-response centres after the tsunami. Phang Nga was the most severely-affected province in Thailand, suffering the highest number of casualties and economic losses (see 2BBangkok.com, 2005). Six months prior to the start of fieldwork, Saowadee Sangtong, a district public health officer at the Thai Muang District Public Health Office, was solicited to act as the study collaborator. In turn, the public health collaborator individually recruited study participants by telephone or in-person. All of the participants approached for the study agreed to be interviewed, even after being provided with the option of decline without penalty. Health providers that had provided frontline emergency treatment and patient support during and immediately after the tsunami were specifically recruited. Participants represented individuals who had experienced both 'primary' and 'secondary traumatisation' following the tsunami (Ehrenreich, 2001, pp. 12–13). Approximately one-half of our research participants had experienced the tsunami firsthand; the remainder had been indirectly affected, such as through their treatment of victims and survivors. Interviews were

conducted with Ministry of Public Health (MoPH) staff, including physicians, dentist, nurses, and public health officers, from a variety of clinical departments at the District (Community) Hospital (Outpatient and Inpatient Departments, and the Emergency Ward), the District Public Health Office, and Sub-district Public Health Offices. After being provided Thai–English language research information and informed consent documents, providers agreed to take part. They were interviewed during their ‘off-duty’ hours at Thai Muang’s District Hospital, District Public Health Office, one rural PHO, and one private clinic.

Where CMA served to orient methodologically interview questions towards the affective influence of culture, religion and the organisational structure on health providers’ psychosocial health, the ‘ideographic case-study approach’ characteristic of IPA entailed the development and analysis of in-depth descriptions from ‘a single case [and] shared themes from up to ten cases’ (Fade, 2004, p. 648). Such an approach requires methodological flexibility and foreknowledge of the research context; ‘set questions or pre-ordained lists of themes are not usually used, as the purpose of the research is to explore the respondents’ perceptions of what is important in relation to the phenomenon in question, rather than to look at what the researcher deems important’ (Fade, 2004, p. 648). Indeed, and in ways that interconnect with the narrative methods employed by medical anthropologists, IPA emphasises ‘the descriptions people give to their cultural world, providing them with the opportunity to describe their experiences in their own terms’ (Maggs-Rapport, 2000, p. 220). Although individual interviews were initiated and guided by researchers’ broad concerns regarding the tsunami’s effects on providers’ psychosocial health, stress was placed on identifying areas of common, thematic experience in interview transcripts. These themes were used to organise data, thereby permitting our analysis to reflect and uphold participants’ interests and worries. Unlike IPA’s traditionally inductive approach, however, our research project’s ultimate objective was not the development of a theoretical model, but rather the production of an in-depth qualitative assessment of health service providers’ ‘psychosocial’ experience of the tsunami.

Using IPA’s case study approach, 12 of the MoPH’s 78 Thai Muang District employees were interviewed; study participants therefore represented 15 per cent of the total workforce. Over one week in August 2007, six health service providers were interviewed at the Thai Muang District Hospital. Supplementary research included interviews with five public health officers employed by the Thai Muang District Hospital, District Public Health Office, one Administrator at Ban Lam Kaen’s Public Health Office, and one of Thai Muang’s three private physicians. In-depth semi-structured and open-ended interviews lasted between one and three hours each; interviews were translated from Thai into English and transcribed in note form. Audio recording, a standard feature of IPA methods, was not used due to health service providers’ concerns about confidentiality and the sensitivity of interview topics. Permission to quote from participants’ narratives was sought from providers at the completion of each interview. Interviews were followed by discussion and critical reflection by research team members (Fade, 2004, p. 648). The structure of this paper follows the

thematic emphasis placed by participants on their recollections of the tsunami and their efforts to adjust to the traumatic memories associated with the disaster. We examine participants' accounts of their encounters with death, loss and environmental destruction and the somatic symptoms associated with fear, depression and anxiety. Finally, we explore health workers' uncertainties about revisiting tsunami-affected sites, which were frequently described as haunted by the ghosts of tsunami victims; and providers' coping strategies. By according ethnographic primacy to providers' narratives, this study stresses the crucial inter-relationship between providers' subjective experiences as witnesses and survivors, and identifies the potential impacts of such experiences on their practice of medicine.

The psychosocial fallout of the 2004 tsunami

Thai Muang operated as the central treatment point for thousands of tsunami victims not only from Thai Muang District, but also from neighbouring Khao Lak (Takuapa District), where washed out highways prevented thousands of victims from reaching Khao Lak's clinics or Takuapa's District Hospital. Within six hours of the disaster, the Government of Thailand deployed emergency rescue teams and mobile mental health units (World Health Organization, 2005a; Visanuyothin et al., 2006). Such assistance, however, did not reach Thai Muang for several days due to the destruction of arterial roads and modes of transport. In the immediate aftermath of the tsunami, health service providers working in Thai Muang District's rural and urban PHOs encountered innumerable logistical barriers to emergency service provision and disaster response. Owing to limited supplies and absent electricity, as well as the unreliability or unavailability of telephone services, rural PHOs were forced to shift hundreds of patients to Thai Muang's District Hospital. Over the first three days of service provision, approximately 750 patients were treated at this 75-bed hospital.² Following the tsunami, there was a rapid shift in the nature of local clinical services. Volunteers and informal public-private health sector alliances were critical to maintaining uninterrupted service provision. At clinical locations throughout Thai Muang District, volunteers and private physicians helped to triage the injured, create lists of 'missing persons', and identify the dead. The magnitude of patients and dead, however, quickly overwhelmed Thai Muang's formal health service centres, resulting in the ad hoc establishment of emergency treatment and morgue facilities in nearby Buddhist temples.

During the night after the tsunami, clinic staff and community volunteers moved necessary resources and health equipment to temples located on higher ground or further away from the water. For instance, triage centres were set up at the Buddhist temple in Lam Kaen, a small hamlet located midway between Thai Muang Town and Khao Lak's now-decimated beach resorts. The temple served as the central treatment facility for several affected areas. Using generators and fuel supplied by Thailand's Navy, whose nearby base had been flooded, the temple became the refuge of thousands of people seeking food, medical treatment, and security. Thousands more

arrived to search for the bodies of lost relatives and friends, which had been stored at a makeshift morgue adjacent to the temple. One senior nurse estimated that, in the first few months after the tsunami, more than 10,000 people came to the temple complex for medical treatment or to search for those still 'missing'.³ By the evening of 26 December, a medical examiner had arrived from Bangkok, accompanied by a team of specialists, to take tissue, hair and dental samples in order to identify the dead. Despite a lack of prior training, local MoPH staff members were recruited to assist with the handling and identification of bodies. Within a week, the temple also functioned as the site for mass cremations.

Thai resort employees and Asian and European tourists from Khao Lak's devastated hotels comprised the bulk of patients at the Thai Muang District Hospital, situated a short drive from the Lam Kaen temple. The majority of victims required urgent treatment for lacerations, deep tissue injuries, and respiratory and septic infections. Without sufficient training in tsunami-related emergency medicine, health providers cleaned wounds and sutured them shut, leading to high rates of bacterial infection, morbidity and mortality due to retained foreign objects, such as sand (Johnson and Travis, 2005; Kespechara et al., 2005). Although several physicians spoke English, most foreign victims were non-English speakers, resulting in staff having to communicate, often with severely injured or traumatised patients, using improvised 'sign language'. One nurse recalled that treating children proved to be especially problematic, not merely because of language difficulties but also because of many children's intense fear in the absence of their parents. Providers also recounted donating money and clothing or making available their homes and vehicles to Thai and foreign tsunami victims. Since many providers were local to Thai Muang District and had long-term relationships with patients from surrounding communities, the social and emotional dynamics associated with emergency service provision were depicted as being particularly acute. Providers described struggling to manage their concerns about missing family members while treating the injured. One nurse recalled her fear that she would encounter neighbours or relatives among the critically injured patients, or the decomposing bodies stored at impromptu morgues. And for the public health officers who were recruited to search through Khao Lak's ruined hotels for bodies, the tsunami-ravaged landscape served to exacerbate their feeling of devastation:

On the fourth day, someone asked me to go to the affected areas. I went in [to Khao Lak] for the first time and saw the damage. Before people had been saying it was a 'big wave' or 'water'. . . . These were neutral terms. I saw that [the tsunami] had completely destroyed hotels and nothing was left. I realised that if anyone was there, they were probably all dead. . . . The team with the [pathologist] from Bangkok had gone in three or four days after and there were still a lot of people helping and in charge of [body] identification. . . . There was still a lot of confusion, tractors, diggers, big trucks. People were still searching for bodies and if they found it they put up a red flag. I didn't go down to the beach, but I could see . . . the hotels were now all gone. There was still too much debris. I went on the back of a truck on the way and [saw] truck after truck, all with organisation logos on the side, full of bodies.⁴

More painfully, the search for survivors and bodies along Khao Lak's shoreline reminded providers that family members working at local hotels were unlikely to have survived. Such difficulties posed significant challenges for providers' maintenance of the boundary between their professional demeanour and personal anxiety and fear. One nurse tearfully described having lost a sister to the tsunami:

My younger sister was working at a hotel near the beach. We couldn't find her at first. There was a lot of confusion and we hadn't seen our sister in a while. . . . She drowned and they found her body six days later. I couldn't go and look for her because I was working at the [PHO] but other family went and looked. At that time, I didn't even have enough time to focus on my sister, or to cry, because there was no time. After six days of looking . . . they found her. The roof on the bungalow where she was working had collapsed on her body. People had heard moaning . . . but by the time they dug there she was dead. . . . [Maybe] she could have been alive before?⁵

The enormity of the disaster left patients and providers alike struggling to cope with sensorial and emotional memories. Among reported anxiety 'triggers' was the sound of ocean waves, the feeling of 'sand in the body [that] couldn't be taken out',⁶ or being overwhelmed by a sense of intense vulnerability when driving on the ocean-side highways once strewn with bloated corpses. Some providers recounted not merely remembering but actually seeing such scenes anew each time they drove along these routes. Although most foreign patients had been referred elsewhere within the first month after the tsunami, health providers faced the ongoing challenge of treating not only the physical injuries and ailments of local patients, but also their emotional distress, which persisted well beyond the disaster. As part of the recovery process, a number of public health officers were recruited to work in local communities with visiting national and international, governmental and non-governmental mental health outreach teams. As most health providers' prior medical training had not included mental health or psychosocial support, staff members were trained briefly in diagnosing and treating common complaints, such as depression (see Pengjuntr, 2005, pp. 1–2). Providers asserted that such training enabled them to care more adequately for community members once outreach teams left Phang Nga. Providers also claimed, however, that the MoPH's follow-up training and post-tsunami workshops had supplied only cursory diagnostic overviews and therapeutic guidance concerning post-traumatic stress disorder (PTSD).⁷ As a result, providers were forced to 'improvise' frequently with severely distressed patients, while staying attuned to the differences between trauma-related somatic complaints and verifiable physiological and psychiatric conditions.⁸ Many providers described their early efforts to relieve patients' suffering as a creative synthesis of Buddhist beliefs and clinical biomedicine:

I advised [victims] that everything is karma. Everything is temporary and an illusion. I [prescribed] medication only when a patient was ready for it. This required . . . [that] their mind had to be calm. We used Lorazepam, 0.5 to 1.0 mg; Phloxadin 50 mg for appetite; Trancine, an anti-depressant [and] beta-blockers for heart patients. . . . I told them to avoid

caffeine. If there was a lack of sleep, then to have warm milk and put one teaspoon of sugar in it before sleep. If symptoms persist, we [sent] them to a psychiatric specialist in another province, Surat Thani.⁹

For health providers, such outreach posed additional complications and stresses:

At the beginning, the staff knew not to ask [victims] ‘trigger questions’, or to raise memories of peoples’ losses. I brought other outreach organisations to victims’ houses, and officers came from other mental health units. . . . Everyday these organisations would go to the same houses and ask similar questions. Victims were working hard to accept the situation, and find a peaceful place for their memories, but some got angry and lost their temper and asked these outreach workers, ‘Why do you ask us the same questions, over and over again?’. . . . I tried to talk to those involved after a few [such] times, saying, ‘These people are frightened already and don’t want to answer’. Or, ‘Leave this house alone’. Sometimes they listened, sometimes they didn’t.¹⁰

By circumventing ‘inappropriate’ mental health interventions and psychosocial surveys, providers claimed that they had simultaneously aided survivors and enhanced their own sense of professional and social worth. At a deeper level, however, it is apparent that providers’ protection of vulnerable individuals mirrored their own search for ‘relief’ and ‘recovery’, or, the avoidance of problematic stimuli and memories. Providers’ experience of ‘psychosocial distress’—which we define as individuals’ socially- and culturally-shaped physical, mental, or emotional experience of an event—was exacerbated by the absence of the provision of mental health, psychosocial or counselling mechanisms specifically for health providers, many of whom counted their patients’ emotional disquiets as also being their own.¹¹ One senior public health officer’s efforts to support tsunami victims paralleled his daily struggles to comfort and guide the hundreds of community health volunteers who worked under the direction of Thai Muang District PHOs. Because three volunteers had died in the tsunami, his efforts were directed at enhancing surviving volunteers’ sense of physical and emotional security:

Some were having a hard time and we were thinking of how to help them. . . . I would try to find the cause, for instance, if there was a loss or dead relative. . . . Sometimes [they] saw their dead relatives. The worst part was the condition of the body, its position. . . . We didn’t talk about the past and tried to give hope and reasons for motivation in the future. We offered help for their needs, like drinking water. We worked in teams and stayed together. We noticed during meetings or visits that some people looked okay, but were a little sad. But if locals came to talk to them and they didn’t know the volunteer had suffered a loss, the volunteer would get upset and not want to talk. . . . For [volunteers], the closer they were to a loss, the harder and longer it took. For others, after a few months, they started to get better. We had tight, supportive relationship and . . . involved the upset person more with work.¹²

As part of their attempts to make sense of feeling ‘overwhelmed’, ‘distressed’, and ‘traumatised’ by their experiences during and after the tsunami, many providers argued that their training had not equipped them, personally or professionally, to deal with death on such a momentous scale. As one public health officer noted, ‘I have never, never seen so many bodies before’.¹³ Given the nature of their jobs, multiple health providers were exposed to exponentially more horrific scenes than their patients. Staff who had worked at the Lam Kaen temple morgue appeared to struggle the most with problematic or intrusive memories. For example, the position that decomposing bodies had taken—with limbs raising and extending as they swelled in the heat—was described as illustrating the ‘shock’ experienced by victims when they died:

There were hundreds of bodies under the sun, all bloated. We cremated the Thai people first. [In local culture] we normally wait three days before cremating them, but under these circumstances, with unclaimed bodies, we couldn't. We couldn't identify them by looking anymore [so] we took samples of their clothing and jewellery. We took photos and built up a ‘case’ for each body. We put up a poster-board with photographs. . . . When the body was put at the outer area of the temple, they put the bodies [on] plastic tarps but they were uncovered. Most bodies were in a ‘shock’ position. The body couldn't be posed [for traditional burial wrapping]. . . . I felt a lot of stress, very much, as did a few of my colleagues who helped with the ID [identification] process. We . . . wore many masks [yet] the smell was awful. There was a health officer if we needed a break, and we would take turns. My clothes smelled of dead bodies and I would put them in the washroom [at night], but then it would smell in there too and I didn't want to use that room. I could still smell the bodies later, even after it was all over with. If I close my eyes now, I can see the bodies. Although the smell went away, when I see pictures I can smell them again. I remember one body in particular. The eyes were coming out, it was so bloated. It was a man in a ‘shock’ position. I want to forget it, but I can't.¹⁴

Even at the time of the fieldwork for this study (2007), providers described themselves as still being deeply perturbed by their emotional disquiets and traumatic memories, as well as by those endured by former and current patients, friends, family, and neighbours. The majority of participants discussed having struggled to manage feelings of deep regret and guilt at not having saved more victims in the first few days after the tsunami. As one nurse noted, ‘[o]n the day of the tsunami, we could hear people screaming for help, but we couldn't help . . . it haunts me even now’.¹⁵ In ways that are reminiscent of PTSD, many providers described being inundated by physical and sensorial memories, as well as depression, chronic backaches, insomnia, health palpitations, and loss of appetite. More unexpectedly, our research also uncovered how the disaster's emotional fallout reverberated through health providers' accounts of the spectral forces they believed haunted local roadways at night.

Ghost stories operated as prominent cultural and religious markers of the psychosocial toll emanating from widespread death and destruction. On this point, the

proliferation of ghost stories throughout Phang Nga following the tsunami have been characterised as ‘cultural factor[s]’ by which survivors could ‘express mass trauma’ (Barton, 2005). As elements of post-tsunami psychosocial experience, providers’ firsthand experiences of the ‘spirits’ of lost friends or relatives were reflective of, and alleviated by, Buddhist doctrine and spiritual belief systems:

People talked about ghosts, especially in the beginning . . . or, people [could] smell the one they lost. Then, people go to the temple and give donations in [the victim’s] name. It happened with me with my sister’s ‘smell’ – it only happened in the first few weeks, and I could smell her body decomposing. I would feel so badly and it reminded me of her, but I was really busy. It still reminded me to go to the temple.¹⁶

When a public health nurse was asked if she had experienced any residual ‘tension’, problematic memories, or fear associated with local clinical or temple spaces post disaster, she said: ‘I feel different about the temple, and I had to pass it this morning on the way to the hospital, and all the images came back again. . . . I can [fall] asleep easily, but sometimes as I fall asleep the images appear in my head.’¹⁷ Even two years after the disaster, a number of providers admitted still to feeling deeply hesitant about visiting tsunami-affected sites. Not only did this impact on the ability of health providers to move easily between clinical facilities, but also ‘ghost stories’—when combined with providers’ anxiety about potential future floods—presented unexpected challenges for provider-assistant patient transport:

People in Khao Lak say they see the ghosts of victims but aren’t overly scared. Two or three months afterward, the road wasn’t properly constructed again and there were no lights. If I needed to go along the road to the community hospital, I would always have my driver avoid the [affected] roads and take an alternate route. I wasn’t sure if the people we saw on the road were real or ghosts, imagined or not. I was very afraid. In ‘affected’ areas it was more scary, but the hospital sites weren’t a problem.¹⁸

I’m afraid of ghosts, especially on the road to Khao Lak. Many people talk about seeing bodies on the road, and [discuss] hitchhikers who turn out to be ghosts. I haven’t seen them, but I can easily imagine them. I don’t want to go there, or that way, alone.¹⁹

A few months ago, we sent a patient to Dehguobah and passed Khao Lak. It was stormy weather and we were watching the waves and prepared to turn away if we had to. . . . There was a flood recently on the way to Phuket, and when things like this happen, we worry and have, like, ‘flashbacks’.²⁰

The spiritual and symbolic implications of tsunami ‘ghost stories’ did not go unnoticed by national and international media (Shea, 2005). With the exception of our research, however, health service providers’ beliefs in, and navigation of, such experiences have been addressed insufficiently by the tsunami literature. The widespread appearance of tsunami victims’ ‘ghosts’ throughout Phang Nga was explained as the result of cultural and religious notions of ‘improper’ deaths. As a prominent

Thai psychologist noted, 'Thai people believe that when people die, a relative has to cremate them or bless them. If this is not done or the body is not found, people believe the person will appear over and over again to show them where they are' (ABC, 2005). Evidence of the local preoccupation with the tsunami's spiritual fallout is demonstrated, in part, by traditional 'spirit houses', comprising a miniaturised traditional-style Thai wooden house, replete with clay figurines that represent deceased ancestors. The house is placed atop wooden or concrete posts that are between two and six feet in height. Spirit houses typically are found at the entrance to family properties or businesses. During our research in 2007, spirit houses were also in evidence at local clinics, PHOs, and the Thai Muang District Hospital, as well as at Khao Lak's newly rebuilt resorts. Spirit houses allow individuals not only to honour their ancestors, but also to placate the restless, roaming spirits of tsunami victims that are said to move among or haunt living survivors (Broman, 1999). Within traditional belief systems, such spirits are especially likely to haunt sites and 'spaces' associated with untimely deaths or 'bad' events (Van Esterik, 1978). Daily offerings of fresh fruit, flowers, and water are placed at the entrance to spirit houses to distract spirits, for example, from entering nearby homes. Several providers stated that, given their ability to mediate loss or to ameliorate the spiritual 'risks' associated with tsunami-affected areas, spirit houses had become important mechanisms of recovery, recognition of personal loss, and cosmological protection. In contrast to the 'ghost stories' narrated by a number of public health officers, senior-level MoPH staff and hospital administrators appeared to be invested in dismissing the veracity of 'spectral' accounts. They were careful, though, not to insult directly the beliefs of staff members who professed to having had supernatural experiences or were fearful of particular areas, such as the roads leading to Khao Lak.²¹

While health providers spoke eloquently about the emotional trials experienced by patients, family, and friends, or recounted their experiences of ghostly encounters and spiritual vulnerability, it was with noticeable reluctance that they described themselves as having been 'victimised' by the disaster. They suggested that formal efforts to seek recognition of personal loss, or treatment for distress or emotional instability, could lead to stigmatisation by colleagues and supervisors. Their sense of uncertainty was compounded by strict hierarchies of professional seniority and social rank. Such issues were widely cited as key reasons why many felt unable to disclose their struggles to co-workers or their superiors. Some senior health providers, however, strove to help fellow and junior staff members with their experiences of anxiety, unrest or depression. As one senior physician pointed out:

In Thai tradition, with psychological disorders [people] don't easily share these details. They are too shy or embarrassed. And [staff] from other clinics are too shy to come here and share. If they come and talk to the doctor, who will help, they can continue to work. But they might . . . [take] an easier job with no 'concerns', like preparing supplies or gauze. [Senior staff] keep them away from dealing with patients. Two or three [staff] from this hospital did this until they felt better. . . . The hospital held private meetings with senior staff to discuss such cases.²²

Health providers' silence in relation to their psychosocial health risks misinterpretation by the various diagnostic schemas and mental health intervention strategies that are applied to tsunami survivors. For example, the World Health Organization (WHO) has generated numerous training manuals and advisory texts as part of its provision of 'psychosocial care to communities affected by the disaster' (Von Peter, 2009, p. 13). These provide the criteria by which 'relief- and rescue-workers, volunteers, teachers and health-care workers' typically gauged 'normal coping mechanisms from negative ones' (Ibid, p. 15) and seek to interpret survivors' ability or inability to share, narrate and work through cathartically their memories. Within such diagnostic frameworks, many of which are poorly equipped to identify and counter the 'silencing effects' associated with culture, religion, and even organisations, providers' apparent inattention to their own experiences, memories and psychosocial well-being may be misconstrued as 'denial' and 'emotional suppression' (WHO, 2005a, p. 23; see also Von Peter, 2009, p. 16). We argue instead that concepts of professional 'altruism' and clinical 'detachment' appear to have posed the most significant obstacles to providers' self-assessment as 'victims'. Following Von Peter's analysis of 'mental trauma' and its conceptual application to tsunami-affected communities, we also suggest that health providers may have been burdened by 'tainted memories' (Langer, 1991, p. 125, in Von Peter, 2009, p. 16), whereby 'memories can be "trapped by a moral design" . . . thus inhibiting survivors' abilities to remember situations in which they would have been morally obliged to help and save others' (Langer, 1991, p. 125, in Von Peter, 2009, p. 16).

Modes of psychosocial recovery

In addition to the beneficial effects of spirit houses, or senior health providers' strategic support of their emotionally affected colleagues, providers cited a wide array of other, 'effective' post-tsunami coping strategies and psychosocial recovery mechanisms. To cope with chronic anxiety, for instance, several public health officers confirmed that they had self-prescribed the same anti-anxiety medications that were routinely prescribed post-tsunami to 'ordinary' victims (Carballo, Heal and Hernandez, 2006, p. 396). Although such medications are controlled substances, in accordance with MoPH regulations, clinic staff had undeniably easier access to these drugs than their patients. Although the long-term implications of self-medication are unclear, such usage patterns suggest that, in the absence of formal psychosocial support for health service providers, pharmaceuticals may have facilitated recovery, professional functioning, and employment security. In particular, providers' asserted that these medications allowed them to cope quietly without alerting colleagues or supervisors to their emotional complaints. Unlike 'everyday' patients, however, health providers took prescription medications without receiving the counselling normally offered to individuals diagnosed with depression or PTSD.

Health providers also discussed their efforts to assist tsunami survivors as valuable 'distractions' and coping mechanisms. One senior nurse suffering from Systemic Lupus

Erythematosus (SLE) stated that her participation in outreach activities had enabled her recovery from an illness episode: 'After trying to help patients, especially the mental health patients, my own health actually improved. . . . Before, and even more now, I believed that if you do something good, something good happens in return'.²³ Others felt that the structure, continuity and sense of community associated with their jobs supported their efforts to process remaining 'tensions', or to replace painful memories of hospital spaces with positive acts of altruism and patient support. Post-tsunami visits to local clinical facilities by senior MoPH staff were also said to have assisted in the healing process, in that they signified that 'upper level staff were interested in us, concerned for us'.²⁴ By relation, several providers discussed how return visits by foreign tsunami survivors had served as important opportunities for recovery.

Annual tsunami memorial events and official recognition of health providers' contributions by high level staff, and the King in particular, were described as being especially empowering and 'healing'. Others affirmed that official attention to their experience and performance during the tsunami was critical to their emotional recovery. Following the tsunami, the MoPH invited nominations for official recognition of public health officers' heroism and dedication to service. Over the course of three successive calls, the Director of the District Public Health Office nominated all of her officers, but found her efforts unexpectedly thwarted, in that all initial awardees were 'high-ranked [health] officers'.²⁵ It was not until the third call for nominations that local staff received recognition. Conversely, not everyone sought to have their efforts honoured by the MoPH or the King. As one nurse commented, '[i]t [was] my everyday job and I don't expect special recognition. I was happy I could help, and because I couldn't speak English I learned new ways to communicate'.²⁶ A senior clinic administrator reflected on how her contributions to patient welfare had afforded her unique healing benefits:

I believe things couldn't have gone better, because I gave all I could. In general, bad things can't be repaired, [but] to a certain point I was proud I helped people from here and all around the world. I didn't ask their names or for money. First, I gave treatment. . . . It's a bittersweet feeling. Such a sad time, but also so . . . positive and community-oriented. I didn't just help my country, I helped the world.²⁷

With the exception of one senior-level health service provider, participants agreed that, since the tsunami, staff relations and inter-clinic alliances had improved. As the head of one department noted, 'I know that if bad things happen, we'll come together and work'.²⁸ However, the 'silences' surrounding providers' psychosocial well-being, and delayed recognition of their contributions, meant that not every participant viewed the professional aspect of their post-tsunami experience so positively:

The people in the government [paid] attention to the victims, but there was no attention to health officers and their losses. They assume that the financial reimbursement is enough. They assume because we are professionals we can handle our emotions. The [government] should observe [our] performance after the tsunami to look for indications of emotions, especially when it's hard to discuss [this] openly.²⁹

In other ways, providers chronicled how psychosocial relief was obtained through prayers for unidentified victims at their cremation, by attending patients' funerals, by offering devotions at prominent Buddhist temples, or by visiting traditional healers. One District Public Health Office employee confirmed that Buddhist practices were 'very important' for providers' early post-tsunami recovery:

Every time we drove past the temple, we could smell the bodies and see the smoke from the cremations, but we remembered 'sangvej' and [felt] 'sangvej'. . . . From Buddhism, there is the concept of 'sangvej', [whereby] we are sad but eventually accept the truth that death is a part of life's cycle.³⁰

Participants' employment as MoPH staff afforded additional therapeutic benefits. Staff members were able to attend ministry-run Thai meditation workshops, use herbal infusion at the hospital's sauna, eat specially prepared dietary supplements, and receive hospital-provided traditional massage. One public health officer suggested that 'distressed' health officers' families should take them on 'meditative trips' that could be modelled on the government-sponsored Buddhist meditation retreats organised for 'everyday' survivors.³¹ Health service providers' cultural- and faith-based coping strategies testify to the 'capacity of individuals and organizations to discern, utilize, and preserve culturally-embedded . . . [and] effective health practices' (Shah, 2006, p. 1)—an approach otherwise defined as 'ethnomedical competence'.

Complicating the recovery process for health providers, as well as for tsunami survivors around the world, was the fact that participants' had limited opportunities to 'avoid the stimuli associated with the tsunami' (Bhugra and Van Ommeren, 2006, p. 213). Providers' descriptions of their unresolved fears reflected their inability to access easily psychosocial support as much as they demonstrated the enormity of the disasters' impact on residents throughout Phang Nga.

Discussion and conclusions

Following on from the works of anthropologist Eric C. Jones, who commented that 'disaster research agendas' "typically only allow for peripheral consideration of who is affected and who is not" (Jones, 2006, p. 18), our research examined Thai health service providers' culturally-mediated or 'psychosocial' experience of tsunami-related trauma, loss, fear, and resilience. Critical medical anthropology and interpretive phenomenological analysis permit insights into the ways in which health service providers' post-tsunami psychosocial well-being and vulnerability were alternately ameliorated or exacerbated by cultural, religious, and organisational factors. Our research found, for example, that treatment opportunities for health service providers in southern Thailand frequently are limited by institutional factors. Providers' accounts confirmed that the absence of post-tsunami support services, as well as organisational culture and notions of professionalism, have compounded their psychosocial vulnerability. Cultural- and religious-based coping practices, many of which

occurred in non-clinical settings, became essential modes of recourse for health service providers, who were less likely to seek treatment from psychosocial services or interventions.

Indeed, although ‘in the course of the humanitarian response to the tsunami . . . more resources were allocated to psychosocial themes than at any other time in the history of humanitarian relief’ (Carballo, Heal and Horbaty, 2006, p. 217), Phang Nga’s health providers have been bypassed comprehensively with regard to psychosocial inquiry, interventions, and outreach. This may have played a crucial role in ensuring that their psychosocial experiences and outstanding needs remain largely unaddressed and unresolved. Notwithstanding the apparent effectiveness of informal coping strategies, providers’ struggles with intrusive memories, persistent somatic complaints, anxiety, depression, and fear of tsunami-affected spaces suggest powerfully that, two years after the tsunami, our participants could be among the minority of survivors still experiencing forms of PTSD (Vijaykumar et al., 2006, p. 228). During the initial post-tsunami emergency period, researchers noted acute stress disorder as being among the disaster’s most widely observed psychosocial impacts (Carballo, Heal and Hernandez, 2006; Carballo, Heal and Horbaty, 2006; Ghodse and Galea, 2006; Vijaykumar et al., 2006, p. 226;). Characterised by ‘emotional numbing, depersonalization, derealisation, re-experiencing of the traumatic event, acute anxiety and increase[d] arousal’, acute stress disorder generally occurs within a month of a traumatic event, with symptoms resolving between a few days or weeks, ‘depending on the nature of the support available’ (Vijaykumar et al., 2006, pp. 225–226). However, the hallmark features of PTSD, which should be experienced for a minimum duration of one month (Vijaykumar et al., 2006, p. 226), include ‘re-experiencing symptoms, avoidance and numbing, symptoms of increased arousal and significant distress or impairment of functioning’ (American Psychiatric Association, 2004, in Vijaykumar et al., 2006, p. 226). The degree of difference between post-tsunami acute stress disorder and PTSD is, therefore, diagnostically marked by intensity and duration.

Our research found, though, that bio-psychiatric and psychosocial diagnostic criteria were of nominal importance to health service providers as they navigated a wide array of tsunami-related traumatic memories, losses, and persistent feelings of anxiety, fear, and depression. Even with providers professionally immersed within, and practising medicine using biomedical classificatory schemes and therapeutic regimes, clinical and diagnostic tools were of limited use when narrating their experience of the tsunami. Although providers’ subjective accounts of the tsunami and its aftermath may, at times, be suggestive of biomedical symptomologies, further research is required to assess the clinical relevance of these concepts for health service providers. Until then, the application of these diagnostic criteria to Thai health service providers’ accounts would be inappropriate and premature. By explicating the socio-cultural, spiritual, and relational dimensions underlying Thai health providers’ experience of the tsunami, our work instead reinforces the need for post-disaster psychosocial interventions to incorporate more fully a social determinants of

health approach. To identify and resolve effectively the widest spectrum of psychosocial effects, post-disaster interventions must move beyond biomedical therapeutic regimes and incorporate culturally-embedded and -shaped notions of subjective experience. This entails individual- and site-specific appraisals of local experience and the meanings that affected individuals ascribe to traumatic events. The insights ideally gained from such an approach would complement therapists' understandings of patient-centred, culturally-shaped notions of psychosocial efficacy and resolution. As Thai health service providers' narratives attest, 'cultures define distress, pathways into care . . . [and] influence the appropriateness of clinical care' (Bhugra and Van Ommeren, 2006, p. 213).

A qualitative inquiry into the affective inter-relationship between psychosocial well-being and culture has the potential not only to improve disaster theorising, but also to enhance community- and clinic-based initiatives. By attending to subjective experience, interpretive phenomenological analysis affords critical insights into the ways that individuals and communities utilise 'natural healing processes' (Ehrenreich, 2001, p. 43), many of which operate beyond the scope of formal psychosocial interventions. Future outreach efforts should assess the scope and usefulness of culturally-defined healing practices, and ensure psychosocial services meet the identified needs of specific patient populations. Such psychosocial training and outreach should actively incorporate cultural and religious practices that are supportive of resilience and recovery. Moreover, we call for post-disaster psychosocial assessment and outreach activities to include explicitly health service providers. Interventions should be as attentive to the impacts of disasters for those providing emergency and follow-up medical treatment, as they are to the needs of 'everyday' survivors. This recommendation is especially pertinent considering the ways in which health providers' recovery can, in positive and negative ways, affect health service provision. Ultimately, future psychosocial outreach should attend diligently to providers' use of local cultural, religious, relational, and professional coping strategies, and explore how questions of rank and status may prevent them from asking for help as required.

Acknowledgements

This research was supported by a one-year Canadian Institutes of Health Research (CIHR) Interdisciplinary Capacity Enhancement (ICE) Grant that was awarded to co-investigator Emma Varley and co-applicant Peter Coyte through the auspices of the former's doctoral fellowship in health care, technology and place (University of Toronto). We wish to extend our sincere thanks to the public health officers, administrators and support staff in Thai Muang, Phang Nga Province (Thailand). Without their cooperation, support and guidance, this study would not have been possible. We want also to acknowledge the assistance provided by the Isaranuwatthai family and Monir Moniruzzaman (University of Toronto).

Correspondence

Emma Varley, Assistant Professor (Anthropology), Department of Humanities and Social Sciences, Lahore University of Management Sciences (LUMS), Opposite Sector 'U', D.H.A. Cantt. 54792, Lahore, Pakistan.

E-mail: emma_varley2002@yahoo.ca; emma.varley@lums.edu.pk

Endnotes

- ¹ Our research capitalises on areas of convergence between the ethnographic and interpretive phenomenological approaches. Where ethnographic methods solicit providers' individual views, shared cultural values and the 'meanings' they ascribed to their psychosocial experience of the tsunami, IPA permits the identification and analysis of such 'meanings' as they are embedded in participants' narratives.
- ² Thai Muang District Hospital, 22 August 2007.
- ³ Thai Muang Public Health Office, 23 August 2007.
- ⁴ Thai Muang Public Health Office, 24 August 2007.
- ⁵ Thai Muang Public Health Office, 23 August 2007.
- ⁶ Thai Muang District Hospital, 22 August 2007.
- ⁷ PTSD can be defined as 'a response, sometimes delayed, to an overwhelming event or events, which takes the form of repeated, intrusive hallucinations, dreams, thoughts or behaviours stemming from the event, along with numbing that may have begun during or after the experience, and possible increased arousal to (and avoidance of) stimuli recalling the event' (Caruth, 1995, p. 4).
- ⁸ Thai Muang District Hospital, 23 August 2007.
- ⁹ Thai Muang Clinic, 21 August 2007.
- ¹⁰ Thai Muang Public Health Office, 23 August 2007.
- ¹¹ Indeed, providers contested the available literature that asserts that issues of 'secondary trauma' and 'self-care for helpers' were included in post-tsunami training activities in southern Thailand (see Pengjuntr, 2005b, p. 6).
- ¹² Thai Muang Public Health Office, 24 August 2007.
- ¹³ Thai Muang Public Health Office, 23 August 2007.
- ¹⁴ Thai Muang District Hospital, 21 August 2007.
- ¹⁵ Thai Muang District Hospital, 21 August 2007.
- ¹⁶ Thai Muang Public Health Office, 23 August 2007.
- ¹⁷ Thai Muang District Hospital, 21 August 2007.
- ¹⁸ Thai Muang District Hospital: 23 August 2007.
- ¹⁹ Thai Muang District Hospital, 21 August 2007.
- ²⁰ Thai Muang District Hospital: 23 August 2007.
- ²¹ Thai Muang Public Health Office, 24 August 2007.
- ²² Thai Muang District Hospital, 22 August 2007.
- ²³ Thai Muang District Hospital, 22 August 2007.
- ²⁴ Thai Muang District Hospital, 23 August 2007.
- ²⁵ Thai Muang Public Health Office, 24 August 2007.
- ²⁶ Thai Muang Public Health Office, 23 August 2007.
- ²⁷ Lam Kaen Public Health Office, 20 August 2007.
- ²⁸ Thai Muang District Hospital, 23 August 2007.
- ²⁹ Thai Muang Public Health Office, 23 August 2007.
- ³⁰ Thai Muang Public Health Office, 24 August 2007.
- ³¹ Thai Muang Public Health Office, 24 August 2007.

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