# "To do no harm," Staff Care, and Ethnomedical Competence: Four Spiritual Care examples of Psychosocial Trauma Recovery after the 2004 Tsunami and 2005 Earthquake in South Asia

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> Indeed there was a near melee of activity from the large number of agencies who rushed to the region, albeit most of them without any previous experience of a country like Sri Lanka, its culture and background problems. Many came specifically to provide mental health assistance to the 'traumatised victims' of the tsunami. But the question is: were such communities seeking mental health and psychosocial assistance framed in this way? The impressions gained from field level discussions are that they were not. They did not want counselling, instead pointing to their shattered homes and livelihoods. The children were observed to be sad, and a few with nightmares, but well functioning and keen to have their schools rebuilt.
>
> (Jayawickrama, 2006)

## INTRODUCTION

How can spiritual care be appropriately and safely integrated into psychosocial trauma recovery work? What constitutes "appropriateness" vis-à-vis the diversity of psycho-, social-, and medical tasks that need to be accomplished in global disaster relief? In order to respond to such questions, this chapter will present a framework involving re-fashioned categories and new terminology in hopes of bringing to life the pitfalls and potential solutions of global trauma work. Such pitfalls and a review of past recommendations will be outlined. Next, four case studies of collaboration from South Asia will be discussed through fieldwork vignettes and interview material. The chapter's synthesis will involve methods and support for applying spiritual care techniques in ways that offer healing in diverse domains of health. "Appropriateness" will be discussed by maintaining that there is a cost-benefit determination that takes into account psychosocial benefits at the lowest cost (including cultural costs) to the disaster-affected society. The chapter will end on its message that collaborations happen best within democratic and symmetric relationships of stakeholders innovating optimal interventions.

From a category standpoint, spiritual care techniques are among the many ethnomedical techniques within the larger domain of **integrative medicine**[1] that -- when blended with the domains of public health and group psychology -- make up integrative psychosocial resilience [IPR, figure 1].

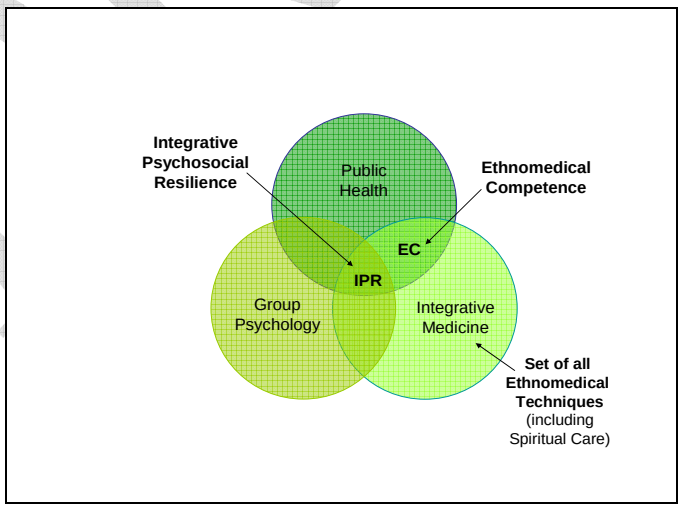


**Figure 1**

[1] Integrative Medicine – set of all empirically efficacious ethnomedical techniques for healing and curing human suffering. Includes spiritual care, traditional medical systems and allopathy (modern biomedicine). Modern psychiatry with its pharmaceutical methods and psychotherapy methods is viewed as one subset of ethnomedical techniques among many others.

IPR brackets our attention on healing the psychosocial wounds of disaster (and excludes other important relief functions such as food, water, sanitation, disease prevention, structural repair, communications, security). The designation "ethnomedical" incorporates the view that all healing practices are configured by the context in which they were created and the context in which they are currently being applied. **Ethnomedical competence** [EC] is the capacity to discern appropriate blends of techniques that meet public health needs for particular situations. Appropriate blends are ones which deliver substantial benefits while doing minimal harm (including minimization of costs). While maintaining an evidence-informed stance on effectiveness and safety, EC views Western and non-Western techniques as equally respected partners.

**Box 1: Cultivating Ethnomedical Competence**

1. Utilize literature review, anthropology and related disciplines in order to arrive at a more accurate view of affected persons, preliminary therapeutic goals and list of possible interventions.
2. With the community, learn about local idioms of distress, negotiate mutually agreeable goals and prepare to exercise maximal flexibility consistent with those goals. Balance cultural power so that all parties collaborate in democratic and symmetrical learning environments. Consider utilizing a consultant with ethnomedical experience to provide perspective and cultural skill sets.
3. Study applicable culturally-embedded, local healing interventions. Ascertain how culturally embedded interventions are (or are not) being utilized.
4. Take a step back to view the entire field of possible interventions (Western, local and non-local/non-Western) and choose a set of interventions on the basis of feasibility, efficacy, "doing no harm," and cost.
5. Work within a plan of integrated services. Expand program monitoring/evaluation terms and outcome studies so that the measured parameters take local signs of distress into account.

Why even bother to create so many categories with new terminology? These categories aspire to take into account the increasing academic critique (Jayawickrama 2006; Shah, 2006; Shah, 2007a; Summerfield, 2005) against the individual-focused pathology-oriented, psychological protocols that are applied by outsiders coming to Asian disasters with the intent of doing good. Many Asian-centric relief authorities prefer *psychosocial* conceptualizations of trauma intervention in order to respect the dynamic relationship between psychological states and social realities – recognizing that strengths and vulnerabilities in either will co-influence the other. Psychosocial programs show "commitment to non-medical approaches and distance from the field of mental health, which is seen as too controlled by physicians and too closely associated with the ills of an overly biopsychiatric approach" (Ommeren, Saxena, & Saraceno, 2005). The blending of integrative medicine, public health, and group psychology into IPR is a framework to mitigate the challenges that are inevitable in doing cross-cultural and transnational psychosocial work.

**BACKGROUND: OBSTACLES AND CHALLENGES**

In order to prevent an overly biopsychiatric approach, IPR is a framework that accommodates the blending of psychosocial interventions. Still, psychosocial interventions can be ill-fitting if local interventions are ignored or Western interventions are not culturally adapted. Epistemologically, it makes a world of difference that widely accepted interventions and protocols are developed largely by those in Western settings, validated through randomized control trials with Anglo-European populations seeking generalizability, and configured by the philosophical underpinnings of modernism, positivism, and logocentrism. Part of the cultural cost to a non-Westernized person who avails herself to a Western intervention is that a survivor must do work (and possibly lose parts of herself) to adopt a self-concept that fits the intervention's terms of reference. Operationally, these interventions are then superimposed (taken "off the shelf") or lightly adapted for use cross-culturally and trans-nationally with the hope that they bring benefit (and they often do) without considering a wider palette of interventions that would better take into account the local population (as possibly bring substantially more benefit). With a view toward mitigating these challenges, warnings from leaders in the field include:

**Box 2: Challenges to Cross-cultural and Trans-national Trauma Interventions**

A. A World Health Organization [WHO] bulletin: "We need to remember that the Western mental health discourse introduces core components of Western culture, including a theory of human nature, a definition of personhood, a sense of time and memory, and a secular source of moral authority. None of this is universal" (Summerfield, 2005).

B. "Off the shelf" intervention materials are difficult to use in diverse settings because they are unknowingly embedded with cultural expectations and unsubstantiated assumptions (Norris & Alegría, 2006; Vega, 1992).

C. "Attempts from outside Aceh to 'train' various community leaders in how they might respond to widespread psychological distress at a community level, using western constructs of community reconstruction and development, may be misguided and will probably be unwelcome." (WHO, 2005)

D. "Standardized instruments are useful for evaluating outcomes in relation to standard psychosocial interventions, but they may not encompass local constructions of mental distress, reasons for seeking traditional healing, or definitions of successful treatment, which may be grounded in spiritual cosmologies" (Patel, Kirkwood, & Weiss, 2005).

E. A Sri Lankan academic, Janaka Jayawickrama (2006), offers this analysis: "…unplanned and uncoordinated humanitarian assistance without a clear vision may create as much distress as the disaster. To categorise affected communities as 'traumatised' and in need of psychological or psychosocial support – and on the basis of assumptions that owe nothing to the voices of the people themselves – is to miss important opportunities to provide humanitarian assistance that will be valued by recipients."

Clearly, spiritual care interventions are vulnerable to the above pitfalls, *especially if the field of spiritual care pursues generalizability and protocol-driven interventions.* If, however, spiritual care aligns itself appropriately with local traditions, evolving practice norms, and holistic healers, it can stimulate highly relevant IPR while minimizing harm. With this in mind, what follows are relevant recommendations from different sources:

**Box 3: Recommendations for Utilizing Religious, Spiritual, and Traditional Views in Disaster**

A. The religious construction of meaning surrounding the disaster may mean that efforts to deal with psychological and social consequences of the disaster in ways that are not consonant with such religious and cultural values and beliefs (e.g. trauma-focused counselling, psychiatric approaches) will be both ineffective and unacceptable. (WHO, 2005)

B. Authors M. Carballo, B. Heal, and M. Hernandez (2005) observed improved resilience in tsunami-affected populations utilizing spiritual grounding and religious leaders. They suggest the following: "Some of those affected by the Tsunami may react poorly to alien approaches …external (as well as internal) groups must always pay careful attention to local cultures, religions and traditional ways of coping with incidents such as the Tsunami."

C. "Traditional healers are culturally and linguistically similar to their clients, share the cosmology of their clients, and generally have a holistic approach to healing especially useful to conflict-affected populations who may suffer a variety of traumatic impacts and symptoms, including emotional, psychological, physical/somatic, social and spiritual ones" (de Jong, 2007).

D. "From a public health perspective traditional healers often have the advantage that they are easily accessible from a cultural and geographic point of view" (de Jong, 2007).

Appropriately applied (i.e. ethnomedically competent) spiritual care and pre-existing rituals re-tooled (or re-traditioned) to fit disaster contexts, therefore, have great IPR scope. As the primary mechanism (under UN resolutions 46/182 and 48/57) for inter-agency coordination of humanitarian assistance, the Inter-Agency Standing Committee (IASC) has laid out important guidelines for psychosocial best practices:

**Box 4:** The Inter-Agency Standing Committee's *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* encourages relief workers to interface with appropriate spiritual practices and local healers. Relevant warnings and recommendations from IASC's Guidelines include:

A. Engaging with local religion or culture often challenges non-local relief workers to consider world views very different from their own. Because some local practices cause harm (for example, in contexts where spirituality and religion are politicised), humanitarian workers should think critically and support local practices and resources only if they fit with international standards of human rights. (IASC Action Sheet 5.3, 2007)

B. Ignoring such healing practices, on the other hand, can prolong distress and potentially cause harm by marginalising helpful cultural ways of coping. In many contexts, working with religious leaders and resources is an essential part of emergency psychosocial support. (IASC Action Sheet 5.3, 2007)

C. Blending therapies in order to arrive at ethnomedically competent integrative psychosocial resilience is encouraged in Action Sheet 5.3 as well: "Accept existing mixed practices (e.g. local and Westernised) where appropriate."

D. Even when allopathic health services are available, local populations may prefer to turn to local and traditional help for mental and physical health issues. Such help may be cheaper, more accessible, more socially acceptable and less stigmatizing and, in some cases, may be potentially effective. (IASC Action Sheet 6.4, 2007)

E. Before supporting or collaborating with traditional cleansing or healing practices, it is essential to determine what those practices involve and whether they are potentially beneficial, harmful or neutral. (IASC Action Sheet 6.4, 2007)

When attempting to offer sustainable disaster work in South Asia, I have learned the power of engaging experienced non-governmental organizations ("international" iNGOs or "national" NGOs) in mediating collaborations:

1) They often have the trust of the people because staff has taken the time to learn local realities
2) They form a cadre of barefoot counselors providing psychosocial first aid and making referrals
3) They provide feedback on the merits and demerits of outsiders providing services

Indeed, with regard to #3 above -- feedback that [we] outsiders are ethically called upon to solicit -- there have been several NGO communications (Shah, 2006; Jayawickrama, 2006) about wrong-headed interventions brought from the West. Such feedback has also been filtered by World Health Organization officials (Ommeren et al., 2005; Summerfield, 2005).

In order to regulate well-intentioned but inappropriate interventions from iNGOs and NGOs, governments can play significant protective roles. For example, when Tsunami relief efforts by iNGOs and NGOs appeared to be lop-sided in favor of donor stakeholders versus practical needs on the ground, the Government of India took steps which "mandated consulting the affected people in relief efforts, refusing any measures to be permitted which are donor-driven and disturb the way of life of the people" (Prashantham, 2008). A proactive stance for outsiders is to recognize that some degree of "pushback" is inherent to aid relationships (Shah, 2007a) and that pushback can be magnified in cross-cultural encounters. Furthermore, beyond simply anticipating pushback, mechanisms of communication and feedback must be put in place to solicit dissatisfaction from the field as well as HQ/donor commitments to repair and adapt operations so that a program evolves with real-time, real-life concerns.

From a trauma research standpoint, Hobfall (1998) and Draguns (2004) both conclude that a review of past studies suggests the effectiveness of viewing all individuals through the lenses of broader familial, interpersonal, and social

contexts. Going one step further than the *de facto* practice of cultural competence (Shah, 2007a), EC affirms that not only must we take into account multiple contexts to understand the traumatized self-concept, but that once we see the traumatized self-concept through many lenses, it is important to develop IPR (a blend of appropriate techniques from a wide palette to achieve optimal results). Within South Asian populations, spiritual care techniques tend to be prevalent and well-received. In the next section, I will present four cases of blending spiritual care within IPR delivery in South Asian disasters.

**DATA ON COLLABORATIONS**

Tsunami in India (acute phase)

Entering tsunami relief efforts, I [SAS, the author] was facilitated by pre-existing relationships. In this context, "pre-existing" could signify any of the following in varying degrees: confidence, empathy, faith and positive expectations. On the day of the tsunami, December 26, 2004, I contacted a handful of NGOs that knew me, and I let them know what I could offer. Given my capabilities and sense of what I could achieve alone, I was ready to provide consultancy to relief agencies on psychosocial first aid (PFA) and neuropsychoeducation[2] of vicarious trauma and self-care (hereafter "VT/SC education"[3]).

Indicorps, an iNGO located in Ahmedabad, had the most actionable ideas for my involvement. My pre-existing relationship with this iNGO was as an "alongside," meaning that I was a standing resource and consultant for addressing Indicorps staff stress and behavioral health concerns. Indicorps leadership put me in touch with their partners in Chennai, the metropolis from where major NGOs in South India stage their operations. On the subject of anything psychosocial, I was prepared to get responses such as "We cannot stop our acute rescue operations for anything mental health right now." Regarding VT/SC education, I was prepared for, "We cannot see the priority of taking care of unaffected rescue workers when so many affected people need aid." However, after two NGOs heard my description, they stated that they recognized the VT phenomenon in their midst. They had a sense of urgency for which I was unprepared, saying, "We cannot afford not to have such training" and "We have college student volunteers working who have never encountered such tragedy, and they have pained eyes as they work."

On December 30, four days after the tsunami, I arrived in Chennai. Through interviews with fieldwork supervisors, I made an assessment of first responder work exhaustion and current self-care protocols. In one organization, Association for India's Development (AID), college students had arrived by busloads to help clear dead bodies and clean debris. One supervisor was visibly worried that many of the fieldworkers were working without breaks and close to exhaustion because "the devastation was so great and there was too much to do." From what I could gather, aside from AID workers being told that they should rest, there were no formal self-care protocols.

On December 31, I conducted a half-day training for AID fieldwork supervisors and upper management in its Chennai headquarters. The training covered the following:

a. VT/SC education (Bride, 2004; Jayawickrama, 2007; Pearlman & Caringi, in press; Rothschild, 2006; Shah, 2007b; Young, Ford, & Wilson, 2008)
b. Reviewing individuals' currently used relaxation and expressive techniques; inquiring what other techniques would be culturally compatible.
c. Simple mind-body relaxation techniques and leading practice sessions on systematic relaxation (e.g. breathing techniques)
d. Discussion on initiating/maintaining simple SC practices in the field (e.g. buddy system, reminders to breathe for relaxation)

Early in our training, one manager shared with the group how daily morning yoga, even during these days of crisis, was a factor in her resilience. From my point of view, this was an important revelation because it reinforced a link between disaster resilience and a common, non-foreign self-care practice. We explored what it would be like to do yoga postures with the explicit intention of preventing VT. I led a segment in which we practiced Nadi Shuddhi (a yoga practice of alternate nostril breathing) as a method for de-toxifying especially emotional moments. Similarly, I presented other

[2] Classical psychoeducation (teachings to deal with a psychological condition) plus education on the neurobiology of stress/distress/trauma/anxiety/depression. Neuropsychoeducation is taught in the spirit of democratizing health by teaching cognitive mastery and behavioral regulation.

[3] Vicarious trauma is also known "secondary traumatic stress" in the academic literature. Education on vicarious trauma involving self-care and resilience also aids in the prevention of burnout, which is a related phenomenon of exhaustion occurring as a result of harsh working conditions.

ways to link disaster resilience and common practices, such as "What would it be like to have a peaceful meal (and any preceding prayer) infused with the explicit intention of building resilience vis-à-vis a disaster?" In teaching systematic, intentional relaxation, I suggested that people adopt a regular activity/technique that has resilience as its central purpose. This is in contrast to practices like "vegging" in front of a television or exercising or napping that are passively relaxing for some people.

January 1st, on the request of other voluntary agencies, I was asked to travel to Nagapattinam, the region of India most devastated – in lives lost, witnesses/survivors, and infrastructure destroyed. There I taught PFA to workers from NGOs and promoted PFA at a meeting coordinating government and NGO activities.

In the villages of Nagapattinam, I was asked repeatedly whether I wanted to get groups of survivors together in order to discuss what happened during the tsunami. In my assessment, this was a problematic way to proceed. First, this would resemble a Critical Incident Stress De-briefing (CISD), and although CISD may be beneficial for first responders such as firefighters who have been trained to use CISD after tragedies, the research evidence shows that convening CISD-naïve groups of survivors to discuss a tragedy in the acute phase of horror is likely to be non-beneficial or harmful (Gist & Devilly, 2002; Rose, Bisson, & Wessely, 2006; van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). Second, in the villages to which I would have exposure, survivors were milling about or parts of fluid groups; any group that we wished to repeat the next day would be made up of different people. Thus the stability of the group composition would be compromised, and I as an outsider "swooping in" for a few sessions and "swooping out" may add another layer of disruption, abandonment and "disaster tourism."[4]

On two occasions, when the request came from the victims themselves, I did agree to conduct PFA groups with primarily affected people. We would start with 2-3 people, and then others would drift over in what appeared to be either curiosity or emotional need. In one case we were under a tree and news traveled fast that a "psychological" session was happening. In these sessions, I allowed survivors to ventilate, and I normalized traumatic reactions (survivor's guilt, insomnia, and emotional numbness being among the reactions that people shared openly.)

Finally, traditional time-honored healing practices involving touch, laying on of hands, and energy psychology appeared to be in demand by primary victims. During this project, my use of EC was not robust, and I did not make an assessment of how traditional healers were being utilized in Nagapattinam. Ranjan, a traditional healer, mentor and friend with whom I had been traveling -- after finding no opportunities through me and my PFA training work -- took his own initiative and began providing healing sessions in the same room with volunteer psychiatrists. His services were touted by consumers who found a form of healing that resulted in restfulness and comfort. A line of consumers formed for Ranjan's 10-25 minute healing sessions; and this line continued to grow during the days of his stay in Nagapattinam. As mentioned in another piece (Shah, 2007a), by not partnering with Ranjan from the beginning in more integrative work, I believe I missed an important EC opportunity. Yet, like flowing water's ability to find lower ground and eventually meet up with other bodies of water, the healing of work of Ranjan found its way to the tsunami-affected without much institutional backing.



<u>Tsunami in Sri Lanka (sub-acute phase)</u>

I interviewed Harshada David Wagner (Wagner, 2008), a New York City-based meditation teacher who innovated and implemented psycho-spiritual aid beginning two weeks post-Tsunami. While his Sri Lankan pediatrician wife provided medical aid, HDW worked via Banyan Education (his consulting firm).

The following are excerpts from the interview prefaced with headings describing important psychosocial and spiritual resiliency principles that worked for the disaster setting:

**I. Partnering with local workers to channel, amplify, and adapt interventions. Locals "take the temperature" of the larger community and culturally adapt the work in concentric circles**.

*Arriving January 12th, we developed a 6 week project involving youth and parents in a number of little coastal villages around the town of Akarapattu, in Ampara District on the Eastern coast. It is a mostly Tamil Hindu enclave with some*

[4] Disaster tourism is driven by curiosity and not any relief objective. Swooping in/out has a relief objective, but with a transitory quality. Swooping in/out may bring benefits, but it must be counterbalanced with any harm accrued by disaster victims having to repeat their stories and grieve the loss of a caring presence. As disaster-related phenomenon that well-intentioned people participate in, disaster tourism and swooping in/out have not been adequately discussed in the literature. The ethics (dilemmas, line-drawing, harms, recommendations) of such phenomena require deeper treatment elsewhere.

*parts under LTTE control. When we got to Ampara District, Oxfam-Australia immediately connected us with a team of locals between the ages of 18-24 that became our crew there. These eight team members implemented our ideas, spoke the local language and had interpersonal connections; and they were all tsunami affected themselves. By the end of our work there, we felt that our team members were really the people that we ended up giving the most interventions to. We would debrief together. We would socialize. So I did more explicitly spiritual work with them rather than the larger community.*

*And that was very important because the work happened in concentric circles. First, the local team was enrolled in what we wanted to do. Then as they interfaced with the larger community, they informed us as to the needs, the rhythm of the place, and the vibration of the local people. And then they were responsible for rolling out the interventions.*

**II. Integrating psychological work into a non-foreign spiritual activity.**

*I taught people to meditate. I sat in meditation with people who wanted to do it in community. I would have what you might say were spiritually therapeutic conversations[5] in the process.*

**III. Enlistment in recovery efforts (well-described as a best practice in the disaster literature) with an additional spiritual frame that supported the re-framing of victim-hood into survivor-hood.**

*Then it was healing to do Karma Yoga[6]. Right from the beginning it became very clear that my team experienced healing by being part of our project. Seeing themselves not as victims, but as people who had something to offer. We were very conscious of that, and we would talk about it. As a spiritual practice. We would talk about the psycho-spiritual dynamics of Karma yoga.*

**IV. Cultural concept (for Hindus, a guest is equal to a deity) re-tooled for recovery.**

*The other major intervention, well if you had to give it a name you might call it dhrishti[7]. These people coming to the clinics see themselves as victims, as everything they had being taken away from them. We wanted to reinforce that we all have a lot of value inside of us even if so much physical had been taken away. I taught our teams, medical especially, to treat everyone as gods and goddesses. They would not be treated as villagers are in Sri Lanka when they came to the clinic. I taught the team to give villagers an honored seat, and to treat them with the respect reserved for deities. Villagers really noticed this love and reverence, and they responded.*

**V. Symbolically compatible, ethnically homogenous and non-evangelical environments.**

*Also, Anu, my wife, is a Hindu doctor in an area of mostly Hindu villagers surrounded by Christian doctors supported by missionary organizations, almost militantly evangelical. Our medical clinic had Hindu deities hanging on the door and a brown faced doctor. Villagers felt more religiously comfortable.*

**VI. Rituals or ordinary practices re-tooled for recovery.**

*In play therapy, dancing was a huge thing. What we found worked with the kids to raise their energy and spirits was Sri Lankan pop music, which they adore. We would pull up with a van rigged with big speakers, and kids would flock to that van. And that dancing is what they would always do, so they took to it so naturally. We often danced with them. Even if we didn't dance, we were holding the space there, just like with play therapy and satsang. From my point-of-view, it was one of the most freeing things that they did.*

*In Sri Lanka, it is traditional for parents to watch, and not join in with, kids playing. As we did play therapy, dancing, and sports, select parents would be nearby watching. The parents would tell us that "it makes such a difference to hear the sounds of kids playing." So then we would purposely set up our Happiness Clinic in proximity to despairing adults to have the highest impact.*

<u>Earthquake in Pakistan (sub-acute phase)</u>

[5] "Satsang," (being together in the presence of truth) the practice of spiritual practitioners discussing their experiences/struggles/joys with their teacher in a group so that the listeners benefit from the exchange as well.
[6] Karma yoga can be thought of the practice of serving others without any expectation of benefits for oneself.
[7] Dhristi is a special way of seeing that allows the seer to perceive the divinity in the seen entity.

Two months after the earthquake, I [SAS, the author] led a team of psychotherapists to teach PFA, EC and VT/SC education to nearly two hundred relief workers in Islamabad, Mansehra, and Muzaffarabad. Through the coordination of an educational NGO, Idara-e-Taleem-o-Agahi, these trainings brought together national staff workers from governmental agencies (Government of Pakistan), NGOs (ITA, Rozan), iNGOs (World Vision, Save the Children), and UNICEF.

Before arrival in Pakistan, I asked Khalida Sheikh, our team's Pakistani-British psychotherapist, what Muslims may do spiritually to bring comfort in times of tragedy. She replied that a Muslim may repeat silently the *Darood Sharif* (or, *Durood Shareef*), a spiritual formula well known to orthodox Muslims linking a person to Allah and inducing peace. Furthermore, she informed me of a mystical practice using imagery and meditation called *Muraqba*.

We adapted and piloted a 12 minute script of vocal instructions (Sheikh & Shah, 2005). Our pilot subject found the script agreeable and suggested some word changes for superior results. Our trainees and their beneficiaries were predominantly Muslim; still, we inquired whether a relaxation technique using Darood Sharif and Muraqba would be welcome. Even though the individuals had varying degrees of religiosity and types of spiritual practice, everyone agreed to try the Noor Meditation.

**Box 5: "Noor" Muraqba Meditation**

a) Two minutes of progressive relaxation coordinated with inhalation and exhalation

b) Two minutes of reciting a spiritual formula such as *Darood Sharif*; or a repeating a phrase like "Allah Hoo" coordinated with inhalation and exhalation

c) Five minutes of Muraqba guided imagery involving *Noor* (Divine Light) making its way over each portion of the body and then gently interpenetrating muscles, organs, and "spirit." *Noor* is a prevalent positive symbol in Islamic mythology. Participants are told that this Divine Light is healing and that contact with it gives a sense of peace and deep comfort.

Throughout the PFA, EC and VT/SC education modules, we attempted to work the boundary across different care provision traditions -- bringing in useful Western views while leveraging and respecting local customs.

Those who gave verbal feedback expressed that being in touch with one's own spirituality was itself a therapeutic tool in their inner healing. The following are other subjective feedback transcribed from evaluation forms:

- *"I get very tired easily and feel mentally fatigued. Today's sessions have made me realise that to become an effective caregiver, I need to take care of my own mental psychological and emotional needs. I found learning breathing techniques and muraqba exercises very useful."*
- *"I wish that these sessions were offered soon after the Earthquake to all the relief workers"*
- *"The skills I learned today I will pass them on to other people in the community who suffered a great deal due to the Earthquake."*
- *"Relaxation exercises should be produced on C.D. and computer so everyone could learn how to relax."*
- *"The session on alternative healing methods was very useful. The discussions we had and the exercises we shared were very simple and beneficial."*

Finally, I inquired about traditional healing practices or local healers that might be of use to the relief efforts. The NGO and iNGO staff were unaware of accessible practices or healers. When my queries were met with a lack of interest or inquisitiveness, I decided not to pursue this line of inquiry.

<u>Tsunami in Sri Lanka (Chronic, in between, phase)</u>

Harshada David Wagner was invited by a development NGO, Foundation of Goodness (FG), in Seenigama to return one year after the Tsunami to build resiliency within a mixed group of Sinhala Buddhist workers – most were first responders to the Tsunami, some were new FG members. Wagner invited me [SAS, the author] to teach Laughter Yoga during the day-long training in which he would teach meditation, physical activities and group reflection. While Laughter Yoga was unknown to FG, methods of yoga were not foreign. My hope was to provide an intervention that

would be consistent with the recommendation that culturally based rituals and traditions can be re-tooled as the basis for innovative interventions (Norris, 2006).

Laughter Yoga involves three major components that I have adapted for use in disaster resiliency for workers:

a. Instructions to laugh in various ways (e.g. milkshake, cell phone, lion, electric) so that the physiological act of laughing, through a neurological feedback loop, induces a psychological state of wellbeing and joy
b. Interactive group activities that stimulate further laughter through being socially contagious; some interactions ask that people act out social "values" (e.g. handshake, shyness, appreciation)
c. Breathing activities from yoga traditions. In addition to the other deep breathing techniques taught during a Laughter Yoga session, laughter itself spontaneously induces breathing in a way that lengthens the exhalation. Prolonging exhalation engages the vagus nerve and parasympathetic nervous system enough to reduce heart rate and bring about a subjective feeling of calm (Hobfoll et al., 2007; Sakakibara & Hayano, 1996; van Dixhoorn, 1998).

Our sessions of Laughter Yoga were loud, enthusiastic, and sometimes challenging. Laughter activities appeared to reinforce playfulness and interconnectedness in a novel way that was linked to yoga traditions.

**SYNTHESIS**

**Box 6: Integrative Psychosocial Resilience -- Seven Project Steps**

1. **Inventory of team capacities and determining optimal scope of work**
2. **Communicate with networks; Build collaborations; Delineate scope of work**
3. **On-site assessment; Development of ethnomedically competent services; Exit strategy determination**
4. **Service provision**
5. **Monitoring/Outcomes measurement; Monitoring team for burnout/vicarious trauma**
6. **Returning to and refining Steps 1, 2, 3, 4, 5 as appropriate**
7. **Closing work processes; Exit**

Of note, the four IPR cases described in this chapter do not represent ideal applications of the above seven project steps. While subjective evaluations were collected, objective or pre-/post- outcomes measurements were lacking. This is a major gap in monitoring and evaluation, and projects should strive to close this gap not only to ensure the quality of its services for immediate beneficiaries, but also because reliable objective data can provide a guide (with evidence-based recommendations and warnings) to the field of psychosocial relief work.

With varying degrees of success, the above four IPR cases strove for EC. However, in order to make key EC processes more transparent, the following section describes EC rationale correlated to the IPR cases:

**Box 7: EC-IPR Case Correlations**

A. As an American physician, I remained more inclined to in have contact (educational or therapeutic) with relief workers rather than primary victims for the following reasons:
1. The emotional vulnerability/susceptibility of workers is frequently less than that of primarily affected victims. Even if I was working in one of the South Asian languages I speak fluently, I believe I am always prone to teach something culturally inappropriate; and workers are in a better position to say "Stop, this is not working." Such a structural power gradient is due to at least two factors: class differences (in which poorer, disenfranchised beneficiaries are likely to affirm whatever is being offered to them without contradicting the speaker), and voluntary agency work culture (in which staff are exposed to or thrive upon a culture of debate and resistance).
2. Workers can determine what parts of my education/therapies are applicable to primary victims. Workers thus act as an additional tier of cultural adaptation -- adding to EC. This process is displayed in the feedback from the Pakistani trainee who said, *"…skills I learned today I will pass them on to other people in the community who suffered a great deal due to the Earthquake."* Conversely, a worker can protect primary victims from any interventions that might clash with the cultural context.

B. When my queries for local healers or traditional healing practices were met with a lack of interest or inquisitiveness, I decided not to pursue this line of inquiry in acute or sub-acute phases. While not inappropriate to ask in any phase, a more aggressive pursuit should be deferred for chronic or in between phases. Action Sheet 6.4 of the IASC guidelines advises: "Information may not be immediately volunteered when people fear disapproval from outsiders or consider the practices to be secret or accessible only to those sanctioned by the community."

C. While I have intuited that it is inappropriate to use Laughter Yoga with disaster survivors or with workers in the acute/subacute phases, it has been well-received when I do it for disaster worker capacity building or burnout prevention in chronic or in between phases.

D. In the Pakistani case, we proceeded to make compressed digital [mp3] recordings of the "Noor" Muraqba Meditation so that workers could email it to each other.

E. Evangelism, as hinted upon in the Sri Lankan case, should be checked in disaster zones. Action Sheet 6.4 of the IASC Guidelines addresses this in the following way: "International and national 'outsiders' should take a non-judgmental, respectful approach that emphasises interest in understanding local religious and spiritual beliefs and potential cooperation with the local way of working. Emergencies should never be used to promote outsiders' religious or spiritual beliefs." Thus, *spiritual care practitioners have an opportunity to build institutional trust and integrity* with heterodox and religiously-other communities by checking any quid pro quo interaction that could come off as "relief in exchange for conversion."

F. In the Indian case of conducting PFA groups out in the open, the physical boundaries of the group should have been enforced in order to prevent adverse exposure of unwitting listeners (cf. CISD articles by Gist & Devilly, 2002; Rose, Bisson, & Wessely, 2006; van Emmerik et al., 2002).

In the midst of multiple lists of multiple recommendations, it is crucial to remember that our goal is empowering individuals for a sense of control over their lives and fostering resiliency, which includes helping individuals to enhance functioning and helping communities to identify and mobilize their natural resources (Hobfoll et al., 2007; Norris & Alegría, 2006; Solomon, 2003).

Academic and fieldwork support for IPR approaches as outlined above are increasing. Examples include Transcultural Psychosocial Organization's methodology as described by Eisenbruch, de Jong, and van de Put (2004) integrating "as far as possible traditional, local, and Western healing methods." Compared to medically-oriented programs, open-minded spiritual care programs may have more liberty or comfort or more access in applying ethnomedical techniques such as breathing relaxation, spiritual formulae, or "self-dialogue through the repetition of a word or verse" (de Jong, 2002). In one of the most authoritative reviews of what empirically helps in mass trauma, Hobfoll et al. (2007) cited multiple articles in the literature giving support to diverse ethnomedical techniques; for example: "Yoga also calms individuals and lowers their anxiety when facing traumatic circumstances, while muscle relaxation and mindfulness treatments that help people gain control over their anxiety are being applied that draw from Asian culture and meditation."

**CONCLUSION**

Two questions came at the beginning of this chapter. How can spiritual care be appropriately and safely integrated into psychosocial trauma recovery work? The Seven Project Steps (Box 6), four IPR cases in South Asia and the overall IPR framework are responses to this first question. What constitutes "appropriateness" vis-à-vis the diversity of psycho-, social-, and medical tasks that need to be accomplished in disaster relief? Box numbers 1, 2, 3, 4 and 7 are responses to this second question.

Among the ethnomedical components of integrative medicine, spiritual care is no less valid than modern psychiatry – it only needs to be deployed in a way that ensures EC. While spiritual care practitioners may find it more natural to draw from local culture and idiom, this is not true *a priori.* Mental health practitioners who work within the psychosocial model are increasingly looking to local culture for clues and strengths for appropriate blends. And often, spiritual care

and mental health are housed in the same practitioner or program. Such integration frequently gives rise to important hybrids of practice that will be exceedingly relevant to EC and IPR.

There are both good indicators and unclear signs regarding spiritual care and re-tooling religious traditions. In Sri Lanka, in conjunction with an NGO named Sarvodaya, a US-based colleague (Logan, 2008) evaluated subjective outcomes among a group of women who had participated in "Psycho-Spiritual Healing Project," which included therapeutic play, physical activity, group discussion, experientials, and meditation. The consensus was that meditation had been "the most useful and most calming." In the Pakistani and Indian cases above, I solicited feedback from trainees and most people gave the trainings glowing reviews. From a scientific evidence point-of-view, post-hoc analysis of such feedback will not go very far. In my cases, even with great urging, no one provided negative feedback -- a skew that may be a function of the goodwill created between trainers and trainees.

The "appropriateness" question may be solved by a complicated cost-benefit calculation that recognizes intangibles and involves diverse stakeholders. Experience shows that an overly biopsychiatric approach predicated on generalizability misses important cultural specificity and angers some stakeholders. Experience also shows that psychosocial interventions with multiple therapeutic mechanisms given by well-meaning cultural relativists tend to produce positive feedback and no scientifically convincing measurements of effectiveness. Improving our knowledge on both sides of this equation is crucial. Collaborations with disaster-affected stakeholders and disinterested researchers together will advance our field of work. Gradual approximations with EC will help to unpack the many layers of complexities involved with people's trauma and the interventions that we develop to support recovery.

In closing, I want to express my gratitude to the people of South Asia for their willingness to teach me expanded notions of psychosocial resilience. Reading into this chapter's opening excerpt from Jayawickrama, there may be situations in which 'traumatised victims' want neither mental health interventions nor spiritual care interventions. Some people may simply want restoration of tangible conditions (livelihood, schools) so that they can control their destinies and address their inner lives in collaboration with the people of their choice.

For those people, however, who are open to global exchanges of a psychosocial nature, I will propose we work according to one last guideline: Planetarity.[8] While not congruent with our current notions of globalization, the flattening of the Earth, or being green, my usage of planetarity is an ethical call for how different people/nations relate to one another, and when necessary, help one another in times of crisis. With regard to psychosocial trauma, Planetarity stimulates opportunities for democratic and symmetric relationships of stakeholders innovating optimal interventions. New species of interventions -- ones that no one can imagine just yet – may arise in response to such calls as long as we have open minds, non-domineering work processes and curious spirits.

**BIBLIOGRAPHY**

Bride, B. (2004). The impact of providing psychosocial services to traumatized populations. *Trauma and crisis: An international journal,* 7, 29-46.

Carballo, M., Heal, B., & Hernandez, M. (2005). Psychosocial aspects of the tsunami. *Journal of the Royal Society of Medicine,* 98: 396-399.

de Jong, J.T.V.M. (2002). Public mental health, traumatic stress and human rights violations in low-income countries: a culturally appropriate model in times of conflict, disaster and peace. In Trauma, War and Violence: Public Mental Health in Sociocultural Context, ed. J.T.V.M. de Jong. New York: Plenum-Kluwer.

de Jong (2007). Nongovernmental organizations and the role of the mental health professional. In R.J. Ursano, C.S. Fullerton, L. Weisaeth, B. Raphael (Eds.) Textbook of Disaster Psychiatry (pp. 206-224). Cambridge, UK: Cambridge Univ. Press.

Draguns, J. G. (2004). From speculation through description toward investigation: A prospective glimpse at cultural research in psychotherapy. In U. Gielen, J. Fish, & J. Draguns (Eds.), *Handbook of Culture, Therapy, and Healing* (pp. 369-387). Mahwah, NJ: Lawrence Erlbaum.

[8] From Gayatri Chakravorty Spivak: a sociohistorical call for people to be ethically responsible for each other.

Eisenbruch, M, de Jong, J.T.V.M., and van de Put, W. (2004). Bringing Order Out of Chaos: A Culturally Competent Approach to Managing the Problems of Refugees and Victims of Organized Violence. *J of Traumatic Stress,* 17:2, pp. 123–131.

Gist, R., Devilly, G .J. (2002) Post-trauma debriefing: the road too frequently travelled. *The Lancet.* 360:9335, 741-742.

Hobfoll, S. (1998). Stress, culture, and community: The psychology and philosophy of stress. New York: Plenum Press.

Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R.A., Brymer, M. J., Friedman, M. J., et al. (2007). Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence. *Psychiatry*. 70:4, 283-315.

Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

Jayawickrama, J. (2006, Winter). Taking People for a Ride: The Sri Lankan Example of Tsunami Affected Communities and Experience of Mental Health Interventions. In D. Khoosal, D. Summerfield (Eds.) *Bulletin of Transcultural Special Interest Group of Royal College of Psychiatrists, London* (pp. 2-10). Available at http://www.rcpsych.ac.uk/college/specialinterestgroups/transculturalpsychiatry.aspx.

Jayawickrama, J. (2007). *Concepts of Care: A Workbook for Community Practitioners.* Disaster and Development Centre in Collaboration with UN Refugee Agency (UNCR), Geneva.

Logan, G. (Personal communication, July 6, 2008)

Patel, V., Kirkwood, B., Weiss, H. et al. (2005). Chronic fatigue in developing countries: a population survey of women in India. British Medical Journal. 330, 1190–1193.

Prashantham, B.J. (2008). Asian Indians: Cultural Considerations for Disaster Workers. In A.J. Marsella, J.L. Johnson, P. Watson, J. Gryczynski (Eds.) *Ethnocultural Perspectives on Disaster and Trauma* (pp. 175-207). New York, NY: Springer Science.

Norris, F. H., & Alegría, M. (2006) Promoting Disaster Recovery in Ethnic-Minority Individuals and Communities. In E.C. Richie, P.J. Watson, & M.J. Friedman (Eds.) *Interventions Following Mass Violence and Disasters: Strategies for Mental Health Practice* (pp. 319-342). New York: Guilford Press.

Ommeren, M. van, Saxena, S., & Saraceno B. (2005). Mental and social health during and after acute emergencies: emerging consensus? *Bulletin of the World Health Organization.* 83(1):71.

Pearlman, L. A., & Caringi, J. (in press). Vicarious Traumatization and Complex Trauma. In C.A. Courtois & J.D. Ford (Eds.) *Complex traumatic stress disorders: An evidence-based clinician's guide.* New York: Guilford Press.

Rose, S., Bisson, J., Wessely, S. (2006) Does brief psychological debriefing help manage psychological distress after trauma and prevent post traumatic stress disorder? *The Cochrane Database of Systematic Reviews: Evidence Update.* Effective Health Care Alliance Programme.

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma.* New York: W.W. Norton.

Sakakibara, M., Hayano, J. (1996). Effect of Slowed Respiration on Cardiac Parasympathetic Response to Threat. *Psychosomatic Medicine.* 58, 32-37.

Shah, S.A. (2006). Resistance to Cross-cultural Psychosocial Efforts in Disaster and Trauma: Recommendations for Ethnomedical Competence. *The Australasian Journal of Disaster and Trauma Studies,* 2006-2. Retrieved July 7, 2008 from http://trauma.massey.ac.nz/issues/2006-2/shah.htm.

Shah, S.A. (2007a). Ethnomedical Best Practices for International Psychosocial Efforts in Disaster and Trauma. *Cross-Cultural Assessment of Psychological Trauma and PTSD.* Eds. E. Tang and J. Wilson (p. 51-64). New York: Springer Verlag. http://www.springerlink.com/content/w153865n576l7455/.

Shah, S.A. (2007b). Secondary Traumatic Stress: Prevalence for Humanitarian Aid Workers. *Traumatology*. Vol 13, No 1, March 2007, p. 59-70.

Sheikh, K., & Shah, S. A. (2005). *Muraqba Noor Meditation.* Developed through personal correspondence.

Solomon, S. (2003). Introduction. In B.L. Green, M.J. Friedman, J.T.V.M. de Jong, S.D. Solomon, T.M. Keane, J.A. Fairbank, et al. (Eds.). *Trauma interventions in war and peace: Prevention, practice, and policy* (pp.3-16). New York: Kluwer/Plenum Press.

Spivak, G. C. (2003). *Death of A Discipline*. New York: Columbia Univ. Press.

Summerfield, D. (2005). What exactly is emergency or disaster "mental health"? *Bulletin of the World Health Organization.* 83(1).

van Dixhoorn, J. (1998). Cardiorespiratory effects of breathing and relaxation instruction in myocardial infarction patients. *Biological Psychology, 49:1-2, 123-135*.

van Emmerik, A. P. A, Kamphuis, J. H., Hulsbosch, A. M., Emmelkamp, P. M. G. (2002). Single session debriefing after psychological trauma: a meta-analysis. *The Lancet.* 360:9335, 766-771.

Vega, W. (1992). Theoretical and pragmatic implications of cultural diversity for community research. *American Journal of Community Psychology*, 20, 375-392.

Wagner, D.H. (Interview by author, March 5, 2008)

Wilson, J.P. (2008). Culture, Trauma, and the Treatment of Post-Traumatic Syndromes: A Global Perspective. In A.J. Marsella, J.L. Johnson, P. Watson, J. Gryczynski (Eds.) *Ethnocultural Perspectives on Disaster and Trauma* (pp. 351-375). New York, NY: Springer Science.

World Health Organization (2005). *WHO Recommendations for Mental Health in Aceh, Department of Mental Health and Substance Abuse.* World Health Organization: Geneva, Switzerland (Report by B. Saraceno, H, Minas, & S. Indradjaya).

Young, B.H., Ford, J.D., & Wilson, P. (2008). Disaster Rescue and Response Workers. In A.J. Marsella, J.L. Johnson, P. Watson, J. Gryczynski (Eds.) *Ethnocultural Perspectives on Disaster and Trauma* (pp. 395-398). New York, NY: Springer Science.



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