Bali 12 months on...

Providing for continuing care and recovery

BACKGROUND Traumatic events such as the bombings in Bali may cause many people to develop post-traumatic stress, traumatic grief, anxiety or depression.
OBJECTIVE This article outlines the requirements of recovery, indications of its progress and the role of general practitioners in preventive care, support and referral.
DISCUSSION Research indicates that more than half of those involved in traumatic events can expect to recover without developing a disorder. However, even optimal recovery from tragedy is a protracted and arduous task that severely taxes physical, emotional and social health. The consequences of this may show as degraded health in the second year following a tragedy.

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It is almost a year since the Bali bombings. Many affected by this tragedy are re-establishing their lives. However, the effects of tragedy are complex and protracted and it may take several years for implications to fully manifest and be integrated. Recovery is a gradual process involving rhythms of distress and stabilisation with a unique timetable for each person. Those involved need to understand what to expect of themselves and to have realistic expectations. General practitioners are in a unique position to support recovery by helping patients understand the recovery process and place concurrent health needs in that context.

Events such as the Bali tragedy affect four main classes of people:

- those present
- the bereaved
- family members of the affected or those indirectly connected to it, and
- the general community.

Terrorist events have an impact beyond those immediately present or indirectly affected.[1,2] While post-traumatic stress responses are common, most people will not develop post-traumatic stress disorder (PTSD) for any length of time. Rates of PTSD of 10–20% can be expected for many disasters,[3] rising to 35% for events such as Bali.[4] However, other conditions may follow including depression, anxiety disorders, social phobia and substance abuse.[5,6] Such problems elevate the proportion with diagnosable disorders to approximately 45%.[4]

Those bereaved in such circumstances may develop traumatic grief characterised by repeated, intrusive, distressing separation anxiety, indications of being traumatised by the loss, and impairment of social, occupational or other aspects of life.[7] The fact that more than half of those involved in any disaster do not present with a disorder is evidence of the effectiveness of social networks, personal coping capacities and other resources assisting the victim's recovery.[8]

Bali

Eighty-eight Australians died in the bombings in Bali, but there is no definitive list of all who were there and who may be affected. Commonwealth and state governments have provided financial, medical and other assistance with counselling provided by 'victims of crime' services in each state. Some 200 people have utilised this program in Victoria alone, where a series of public information evenings have also been held, and community based support groups conducted by trained disaster mental health personnel have been established to facilitate contact between affected people.

Calls to information lines indicate many people experienced post-traumatic stress, depression, anxiety states and traumatic grief responses themselves, or were concerned about survivors refusing assistance.

Longer term recovery

Optimum recovery

Optimum recovery from grief or tragedy is by gradual alleviation of distress over time. In spite of fluctuations, nontraumatic responses are characterised by progressive adaptation to the new circumstances involving loss, injury or emotional distress. The 55% of those who do not develop disorders understand their needs, and know the psychological and social structures of their lives have remained intact, providing the framework for working through the experience; consequently they are not technically 'traumatised'.

Problem responses

However, post-traumatic responses do not conform to this pattern; the meaning or intensity of the experience violates fundamental assumptions, expectations or values about vital aspects of life[9,10] and damages the bio-psycho-social framework that provides the structure for integrating tragic experiences. If this structure fails to occur adequately, the victim becomes 'stuck' in the trauma.[11] The degree to which this occurs depends on the intensity of traumatic stimuli, extent of exposure and presence of prior vulnerability such as mental health problems, traumatic experiences or loss.[5]

One group of symptoms indicates psychological integration failing to occur (eg. persisting heightened arousal, intrusive re-experiencing of the event); another indicates the stress caused by the unsuccessful process impacting on other aspects of life (eg. numbness, dissociation, mental preoccupation, tension, sleeplessness, fatigue, irritability). Although post-traumatic responses develop quickly,[5] many people utilise short term strategies to manage reactions and cope with symptoms, including:

- putting the event out of their mind
- engaging in other activity
- losing themselves in work
- concentrating on other things, or
- throwing themselves into recovery activities.

Some people sustain this, but persisting stress exhausts others, their resources wane. Avoided experiences are unable to be fended off and begin to intrude as: unexpected nightmares, unpredictable episodes of emotion, being reminded of the event by other experiences, preoccupation with the event or transferring feelings onto other issues. This group may develop symptoms at various times during the first year after the event or later.

Another group has post-traumatic symptoms all along, but seek help when their tolerance has reduced because of the exhaustion from the effort of 'holding it all together'. A third group presents with chronic stress conditions from the effort of avoiding memories and show stress related physical complaints, aggravation of pre-existing health problems, depression, anxiety or substance abuse.

Social consequences

Sometimes victims who are integrating their experiences become increasingly out of step with their social environment because of changes in values, priorities and philosophy of life, whereas friends and family soon return to normal. Communication gaps develop as the victim feels less able to participate in everyday activities, is not understood or is expected to 'be over it by now'. This degrades social support, often leading to deteriorating physical, emotional or mental health.

Family members may present concerns about their loved one's social withdrawal, unhappiness, inability to do everyday tasks, loss of interests, irritability or other changed behaviour.

Associated physical problems

The stress on a victim's physical, mental and social life in coming to terms with tragedy cannot be underestimated. Like bereavement, the first year is difficult, but often in the second year after the event they begin to feel despondent and suffer degraded health. The mobilisation of physical and emotional reserves to deal with an emergency and adapt to changes recedes when the 'emergency' is over. This exhaustion is associated with diminished sense of needs and victims may neglect their welfare, develop unhealthy lifestyles, increase their use of tobacco or alcohol, eat poorly, exercise less (or excessively) and neglect recreation. If they have health crises, recovery is often slow and complicated. Individuals suffering from PTSD may not present with psychological symptoms at all, but rather with physical (somatic) symptoms.[12]

Strategies for GPs

Education

Education about post-traumatic responses and recovery is a pre-condition for identifying needs, providing self care and understanding the role of professional assistance. Information about what to expect, advice on managing symptoms, adjusting normal demands

Table 1. Resources for Bali victims

Commonwealth government assistance for medical, travel, funeral expenses and income support assistance	**www.baliassist.gov.au**	Centrelink: Phone 13 61 25
Australian Red Cross Bali Appeal	**www.redcross.org.au**	Phone 1800 999 411
Referrals to counselling services and further information on recovery programs		
Tasmania	lynn.young@dchs.tas.gov.au	Phone 03 6336 5551
Queensland	David.Shellshear@families.qld.gov.au	Phone 07 3224 2194
New South Wales	peter.olney@community.nsw.gov.au	Phone 02 9683 2388
South Australia	Frittum.Julie@saugov.sa.gov.au	Phone 08 8226 6667
Western Australia	taniac@fcs.wa.gov.au	Phone 08 9350 7250
Northern Territory	paul.maher@nt.gov.au	Phone 08 8922 7268
ACT	Rob.Baker@act.gov.au	Phone 02 62071487
Victoria	Terri.Elliott@dhs.vic.gov.au	Phone 1800 634 245
Counselling and health advice telephone counselling services		
Care-ring 136 169	**www.care-ring.org.au**	
Lifeline 131 114		
Parentline 132 289		
Kids Helpline 1800 551 800		
Grief education and support services		
National Association for Loss and Grief	**www.nalagvic.org.au**	Phone 03 9351 0358
Bereavement Counselling Service	**www.grief.org.au**	Phone 03 9817 7266
Grief Line		Phone 03 9596 7799
Patient information and fact sheets	**www.dhs.vic.gv.au/emergency**	
Bali support	**www.balisupport.com**	

to needs, preventive health care and supportive social relationships all support recovery.

Making the link

Patients presenting for health care or psychological complaints associated with traumatic experiences often do not link their problem with the trauma. They may not understand that:

- protracted arousal depletes health
- extensive emotional and social changes result from trauma, and
- anxiety and depression are caused by changed assumptions and values undermining the validity of pre-trauma life.

People assume if they are not conscious of the trauma, it is not the problem. However, the link is often via an intervening factor such as changed meaning, social relations, priorities, or emotional attitudes. It is important to investigate the relationship between the trauma and the problem.

In patients presenting with somatic complaints, the role of the GP is to avoid excessive medical investigation and intervention and to provide the patient with a framework for understanding that their physical distress is a reflection of psychological distress.

Support

The importance of an accepting a GP who is inter-

ested in the whole person cannot be overestimated during the isolating recovery period. General practitioners can encourage patients to talk about their experiences since they are often reluctant to burden their social network with their memories or emotions. This helps them to identify their needs more clearly.

Preventive health care

Regular preventive health care is vital for those affected by traumatic events, beginning as soon as possible, and continuing past the vulnerable first anniversary. General practitioners can assist by regularly monitoring the victim's health, identifying problems as they develop, and taking preventive approaches.

When to refer

While there is progress in security, accepting what has happened and adapting to a new life, recovery is proceeding. Reactions suggesting recovery may not be proceeding and vulnerability to PTSD or other disorders are:

- post-traumatic symptoms appearing
- persistence of symptoms
- development of stress conditions
- depression, anxiety, substance abuse or other conditions
- relationship crisis or breakdown
- inability to work, study or fulfill responsibilities, and
- detachment, loss of meaning or value in life.

Since trauma interacts with pre-existing problems, its role in the development of any significant physical mental or social health problem in the two years following the tragedy should be considered. Early referral and assessment may prevent impaired health, and deterioration in personal life, relationships or work.

Where to refer

Most people affected by disasters were previously average people managing their lives who would never have utilised mental health services. Victims need to understand the reason for referral and not feel they are developing a 'traditional' mental illness (most will recover readily). They need information about trauma, and need to know that the symptoms they are experiencing are normal for anyone involved in trauma and that they can do much to help themselves. Resources for victims of the Bali tragedy are listed in Table 1.

Conclusion

A range of mental heath practitioners may treat general stress symptoms, anxiety and depression, but serious post-traumatic stress requires specialist treatment. General counselling provides emotional support, but is ineffective for post-traumatic symptoms.[11] The clinician needs to understand the consequences of trauma, educate the patient, provide a safe environment for confronting traumatic memories, and be able to deal with their consequences. (See the article 'Post-traumatic stress disorder' by Simon Howard page 683 this issue).

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