Culture and Psychosocial Elements Impacting on Disaster Recovery: Response in Indonesia

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Abstract: Natural disasters are commonplace in the world but the 2004 tsunami created a critical mass of WFOT member countries confronted by the monumental destructive forces of nature. Destroyed were environments and the natural occupations central to the lifestyle of citizens. Working within the WFOT Disaster Preparedness and Recovery Framework, two Indonesia occupational therapists one working in Aceh, Sumatra and the other responding to a major earthquake in south central Java (2006) were confronted by psychosocial and cultural issues which affected their assistance efforts. The unique cultural perspectives of these two distinct Indonesian geographic areas presented some very different and unique challenges. The first author worked with the two therapists to identify the critical phenomena experienced in accommodating psychosocial barriers. The analysis serves to increase knowledge transfer. Highlighted is the important contribution the profession makes to interpreting more sensitively social phenomena and its impact on disaster recovery process.

Key words: psychosocial, disaster response, culture, occupational performance

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Introduction

The tsunami of 2004 was a major wake up call for the world. Even with natural disasters occurring annually around the world, few had the impact that tsunami did in alerting global citizens of their collective vulnerability and interconnectedness. The magnitude of the event’s destruction was highlighted by expansiveness of the geographic footprint of Mother Nature’s violent action.
Four member organizations of the World Federation of Occupational Therapists (WFOT), India, Indonesia, Thailand and Sri Lanka were hit by the monumental forces of nature, which destroyed lives, environments, and disrupted the natural occupations central to the lifestyle of their citizens.

Many citizens of the world live under circumstances of constant “disaster”: natural and man made. They lack the resources and the opportunities to avoid being in harm’s way and their lives are a constant struggle in anticipation of the next assault on their living state. For them, their usual occupational focus is on subsistence and survival. Their occupational performance is seen as extraordinary to many, but in the face of the tsunami and accompanying earthquakes the best of their well honed survival skills were not enough. Occupational therapy, as a profession focusing on individuals interacting with their environment, needs to be proactive in gathering its resources to support the life sustaining activities of all people responding and living in disaster circumstance. Two disaster situations in Indonesia are analyzed by the first author to increase knowledge transfer to other occupational therapists developing disaster preparedness and response plans and to alert them to psychosocial considerations, which can impact on service effectiveness. Furthermore, this discussion highlights a “taken for granted” skill set of occupational therapists relating to cultural sensitivity. Taken together, culture and psychosocial issues influence response strategies and can make the difference in the successful acceptance of assistance from disaster survivors. The paper’s context is the experiences of two Indonesia occupational therapists in greatly different areas of a country made up of over 17,500 islands and 237,000,00 million people (Central Intelligence Agency, 2008). The Indonesian lessons learned by these occupational therapists’ interactions with local residents and their application of strategic adaptation of disaster response program to fit social needs will be shared.

One therapist assisted with the post tsunami recovery work in Aceh, Sumatra through involvement with a well known international non governmental organization (NGO). The second therapist contributed to a regional response to the earthquake disaster in the south of Central Java (Yogyakarta) using students to assist the process. The experiences of both therapists are explored from the unique cultural perspectives of these two distinct Indonesian geographic areas.

**Background**

The World Federation of Occupational Therapist (WFOT) took a leadership role in preparing occupational therapy professionals for disaster response. Following the December 2004 tsunami, the WFOT coordinated a regional environmental scan in April 2005 and later developed and offered a training workshop for therapists from the affected countries (WFOT, 2006). This information can be found elsewhere in the form of reports and documents (WFOT, 2007). Following this initial event sponsored by Direct Relief International (DRI), the WFOT and various other donors including DRI, initiated national training workshops for member organizations in the affected four countries.

The Indonesian Association of Occupational Therapists (IAOT) conducted its National Workshop in Disaster Preparedness & Response (DP & R) in Jakarta April 6–8 2006. There were 40 participants including the authors and it was supported by a coalition of funders: Direct Relief International (Washington DC), the WFOT, the Ministry of Health, Republic of Indonesia, the Indonesian Association of Occupational Therapists and specifically the Surakarta Health Polytechnic.

The national workshops built on the framework developed for the regional workshop by WFOT’s consultant Kerry Thomas of Australia. This included developing specific project/action proposals for priority areas to be part of the Occupational Therapy National Action Plan such as identifying project activities and considerations for implementation strategies (e.g. resources needs, funding sources, approval, support etc). More specifically it drew on occupational therapy knowledge and thinking processes. The focus was on the profession’s
unique “tool kit” based on occupation within a holistic and environmental approach to evaluation and intervention. A response strategy was formulated to meet the local cultural and social perspectives.

The outcomes of the national workshops were to be integrated with the country’s national disaster preparedness and response strategy. One major objective was to prepare occupational therapists to be leaders and contributing members of disaster response teams. Though able to provide assistance to any disaster situation, the primary consideration for the profession was to ensure that the needs of minority and vulnerable groups particularly persons with disability were being addressed within the general response strategy.

Indonesia is an Island nation and due to internal cultural diversity (34 acknowledged ethnic groups), developing a DP & R nation plan is challenging. As previously noted, the principles from the regional workshop helped shape the planning process and prepare for future responses.

Indonesia offers unique challenges in that it is a country where the tensions of different dialectics must be negotiated along with other cultural differences from secular and traditional, insular and open, transcendence and immanence and most importantly nature and culture (Manzoor, 2003). As the largest Islamic nation in the world, Islam transcends all forms of interaction and forms of “being and doing.” From a secular perspective or if from a more fundamentalist one, there will be an impact on the response of citizens based on their particular culture and the Islamic practices of their indigenous social group (Manzoor, 2003). The history of Indonesia has been characterized by forced national unification (Sarsito, 2006). Indonesia is held together by a set of five principles (Pancasila): a unifying language (Bahsa Indonesian) and a strong “hand”: first that of Sukarno who lead the revolt against the re-establishment of Dutch colonialism and then Suharto up to 1998. Ethnic identity and cultural norms can be stronger than a national identity (Chandra, 2004).

Case Scenario Number One—Sumatra

The first scenario is based in Banda Aceh; the closest land mass to the ocean epi-centre of the earthquake that precipitated the December 2004 tsunami. Entire communities where wiped from the map including their infrastructure and services. The reader needs to be familiar with the special circumstances that enveloped this north western area of the island of Sumatra. A number of situational and cultural considerations existed, which would impact on the usual disaster response strategies and the acceptance of aide by the citizens of the area. But at the time of the emergency these were not major considerations.

Banda Aceh is a very conservative Islamic area. Before the disaster, it was an area of prolonged armed conflict between those embracing these former views and the Jakarta-based Indonesian national government. Thus the immediate response of survivors to relief efforts and ultimately to the recovery process were affected.

In keeping with more traditionalist values, there existed specific gender roles limiting women’s participation in the community, including the restriction of the succession of property titles.

Given the absolute destruction or severe incapacitating damage to large portions of the transport system and other civilian infrastructures and services, the Indonesian army was given the task of disaster response. They were already in the region and had the resources to respond. Military involvement in national disaster responses is a common strategy in many parts of the world. But in this case, the survivors were reluctant to take assistance from soldiers who earlier were seen to be the aggressors during the many years of conflict. With the monumental state of the damage, there was a lack of coordination of response activities across the government and the many NGO that quickly mustered resources to the area. Few health facilities remained in operation to treat survivors. Many members of the region’s health manpower network expected to respond also died There was limited local health manpower to offer health services (Java Reconstruction Fund,
In the long term joblessness in both traditional areas (fishing) and general services would add additional stressors. Also there was a greater focus on the physical recovery of people, things and processes as there was a lack of understanding of psychosocial rehabilitation needs of survivors by rescue teams. The loss of human connections were devastating as extended family networks and generational ties were lost. Social looting took place by people claiming to be survivors. People taking advantage of the relief efforts came from other areas unaffected by the present disaster but suffering from longstanding economic depression. They sought food as well help to obtain living allowances and housing support not formerly available to them. Based on records from the four districts, 126 disabled persons were identified including only one who was disabled before the tsunami.

As is often the case during catastrophic times, people also resolved conflicts during this time of need. Conflicts between the Aceh Independence Movement and Indonesian Army were reduced and finally an agreement to end the war was signed. Members of the movement went to villages and cities from their camps to look for their families. The central government established a Board of Tsunami Recovery and Reconstruction and began building infrastructures in unaffected areas in all of the Aceh province. But the magnitude of physical devastation and state of survivors was alarming.

The World Health Organization expected that the psychological state of survivors would reflect an increase in certain psychiatric disorders such as depression, anxiety, and sleep disorders (WHO, 2005) but there were few available services to respond to mental health needs. Aid workers attempted to provide psychosocial support indirectly through empowering women, children, families and the communities in order to restore their resilience capacity. Even the public press reported psychosocial issues.

Adding to the acute trauma of the tsunami was the pre-existing context of the environment and the results of a culture of suppression due to central government policies. The area is mountainous and travel is difficult. Earthquakes are frequent. As a conflict zone there is fear of both the Rebels and the Army. A constant fear exists about outsiders and sensitivity to new persons (Non governmental organizations (NGOs), local & international) who have different religious backgrounds. This state of lack of trust made it difficult to take assistance especially from the Army who controlled supplies and were issuing coffee and food. Few would leave their home go to distribution centres. Poverty and malnutrition were already common.

One Indonesian occupational therapist was recruited by Handicapped International to assist with the rehabilitation and recovery phase. He provided physical rehabilitation services in six primary healthcare facilities (remote areas), worked on capacity building and developing livelihood support such as pre-vocational training. He used occupation related to recovery needs as interventions and dealt with psychosocial issues he found coexisting with physical phenomena.

The social experiences associated with disasters focus on losses of family connections, networking opportunities and changes in the performance of traditions and habits.

Examples of social Losses are:

- Withdrawal for social contacts
- Disruption of support networks
- Family deaths: immediate & extended
- Friends, coworkers & neighbors gone
- Gathering at Mosque, coffee house, market, well, etc. is no longer possible

These losses and disruptions in social habits created problems for survivors in their new roles as widows and widowers and as persons with disability. The role changes impacted on intimacy needs, ability to earn a living and to access support. The occupational therapists in Aceh dealt with some of these issues by running group therapy sessions for survivors through an NGO; raising community awareness regarding disability to refocus attention in helping others during recovery. Occupation was central to the interventions such as encouraging home modifications to decrease the barrier for disabled person. The occupational therapist also worked to
support public health needs through education to take steps to prevent outbreaks of polio. He did skills training and hygiene education (animals out of houses) to increase effective health promoting habits for all while focusing on enabling the quality of life of persons with disability.

When asked how he did his job he noted using environmental and holistic approaches in finding persons with disability and providing them with services. He worked with families, religious leaders, local authorities, traditional Healers, anyone available to assist and participate in the recovery process. He used local/natural resources (designed splint from palm tree) as supplies were limited. Working through local NGOs, he went door to door, sent out fliers and contacted his own network of Javanese to promote awareness and encourage contact.

He travelled long distances for many hours on poor roads for short visits and professional sessions. Though he stayed in a larger centre, there were feelings of isolation due to the lack of possibilities to communicate with other professional’s and his own family. He had to use satellite communications and was able to return to Java every two months, which he paid for himself. Consequently, high stress levels ensued. As a team leader, he also had the support of two physical therapists with whom he debriefed. Eventually after a year he returned home, where he practices in a large oncology facility. The contract in Banda Aceh was a challenging personal and professional experience.

Case Scenario Number Two—Java

Approximately one month after the Jakarta Disaster Preparedness and Response Workshop in April 2006 an earthquake hit the heavily populated Yogyakarta district in Central Java. This is an area known for volcanoes and tremors. The occupational therapy faculty of the Surakarta Health Polytechnic (SHP) occupational therapy program were able to contribute to relief efforts in a timely manner, in part due to their participation in the aforementioned Disaster Preparedness & Response workshop. The faculty joined others in first responding to the needs of victims and those visibly suffering from trauma. The faculty then organized a team, which included students who worked to assist the emergency teams to look after trauma victims. In a parallel effort, the team focused on identifying and assisting persons with disabilities. As an aside, Surkarta where the Surakarta Health Polytechnic (SHP) is located, is approximately 60 kilometres north of Yogyakarta but was not greatly affected by the shock waves.

The Islamic and socio-cultural context of Central Java is thought to be different from the pre-tsunami Banda Aceh. Although Java too is primarily Islamic, its religious practice and cultural roots are in old animistic origins and its integration of old religious mysticism is mixed with the practices of modern day Islam. These old beliefs predate Islam and Hinduism and speak to the spirits and or Gods of the natural world.

Java’s culture is also based on a hierarchical society (Chandra, 2004). Individuals respond to authority but leaders are held responsible through “wahyu”: disasters and events can be attributed to a lack of integrity and living according to Javanese spiritual traditions. This belief is still held by some and complimentary to the Islamic view of nature (Adcock, 2006).

Fewer of the social and interpersonal barriers of Aceh: paranoia, fear and suspicion of strangers existed. Survivors accepted the first wave of assistance as it came from other Javanese and thus they were able to help each other. The occupational therapy students participated in distributing food to survivors in response to the basic needs for survival and support.

Thousands of survivors lost their homes and businesses. Restoring shelters was very important to address immediately, because extended families frequently lived together in compounds made up of several buildings. After helping the critically injured, the work began to find and assist people with disability.

Given the closeness of the earthquake to Surakarta many students had their own transport and being familiar with the area was a major advantage in making personal contact with survivors. Some had family and friends in the area unlike the Aceh region, where the relief workers were “foreigners”. The “OT” Team assisted with
the set up of a disaster relief post in a village hall and then after a debriefing, the students began home visits in search of persons with disabilities (PWD). Within the disaster relief post they served in access of 50 to 60 clients everyday. Home visits gave the opportunity to problem solve first hand and provide consultations directly in the social context of the problem. The destruction though not as environmentally catastrophic as Banda Aceh still disrupted livelihoods, social patterns and daily habits. Working, tending the home, going to school were stopped as the physical structures were destroyed and all effort and free hands went to creating emergency shelters and re-establishing physical order.

As the schools were destroyed, classes were held outside. It was easy in this social gathering of young peers for the OT to offer play therapy sessions for the children as a means to relate their experiences and fears. Though the literature on adults is mixed on the benefits of debriefing (Raphel, 2003) the children settled with the normalizing activities of familiar games. Social gatherings were instigated for the adults. Many of the adult survivors were taken to the Orthopaedic Hospital in Surakarta as there was a lack of treatment space in Kalten one of the major quake sites. This put additional stress on the family unit.

The family is a primary social group; the moving of the injured to another city meant that a relative had to go with the patient to provide care and meals. This is customary in the region. As a result some “helpers” were lost to the area but this also gave some peace to the family members left behind who had to deal with the physical recovery process and the construction of temporary tent shelters.

Students assisted with the record keeping on persons with disabilities. Use of their “expert” knowledge helped to provide relief to local health care practitioners. By teaming up with local NGOs, the students facilitated access and distribution of materials such as medicines, blankets and some building supplies. With the shared cultural values and habits of the local residents, there was a compatible mix of values and concerns of helpers and those helped.

The challenges in Central Java were less about culture and more about the disruptions to social institutions. There was an initial lack of coordination in the disaster relief strategies. Government emergency response with the services they controlled was delayed and or lacking in some areas but not to the degree found in Aceh and for some different reasons:

- Unequal local services and distribution of relief
- Bureaucratic system of oversight delayed action
- Legal aspect of those who could provide assistance (Certified/competency)
- Suspiciousness on the part of some survivors about non Javanese relief workers
- Environment was inaccessible due to mountainous terrain

The citizens were quick in starting to restore their lives by cleaning debris and engaging in trade through their micro industries where possible. International aid helped restore destroyed structures, homes and service facilities (Java Reconstruction Fund, 2007).

**How Occupational Therapists Helped**

In this second disaster case scenario, the occupational therapists (OT) and the OT students played multiple roles in the disaster response phase and later in the recovery. The disaster relief worker role was one shared with other emergency response providers as was the health services providers but some aspects of the roles were unique. With their ecological perspective of the person and their environment, the OT was a an interpreter of the barriers related to cultural norms for external relief workers, a therapist and clinician in detecting high levels of stress and anxiety states and physical rehabilitation and a community member sharing the disaster experience with friends and family. The OT professional was a “filter of behaviour” but this role required additional sensitivity of local conditions and expressions of religious and social practices. As community members sharing the cultural values it was easier to be accepted and they had less adjustment as a response worker in entering the community.
The knowledge and skills of the professional occupational therapist in dealing with psychosocial phenomena was of great assistance in dealing with the burden of loss felt by the family compounded by the cultural expressions of roles.

Some of these issues were experienced as: (1) Responsibility for family cohesion and the burden of financial losses, (2) Wife or husband unable to earn money or work because must stay with partner (survivor in bed or in a wheelchair), (3) Physical & emotional burden of taking care of survivors, (4) Social burden of helping others, (5) Feeling isolated (unable to go visit around), and (6) No answers to needs through networking.

Sexuality was a major concern for many. Therapists helped persons explore reasons why sex no longer was satisfying or providing pleasure. Clients talked about:

- Lack of privacy generally
- Anger & denial of interruptions in sexual performance
- Being ignored by spouse
- Bed (emergency cots) were too small for sexual activity
- Private space and time was not available to engage sexual activities

For persons with disability there were different needs and issues. Some existed before the earthquake and others were a direct result of the changes in health status following the earthquake:

- Afraid to engage sexual activity because of injuries
- Husband/wife thinking of exchanging partner
- Taking a longer time to engage sexual activity
- Sexual organ must be cleaned and clean water limited.
- Interruptions in require bladder/bowel management
- Divorced and no sexual partner
- Love affair/cheating perceived thus disrupting thinking and sexual expressions
- No sexual desire because hygiene is bad (pressure sore, bladder/ bowel incontinent) or trauma
- Couple unaware of alternative sexual activities (oral sex, petting, etc)

Many of the items above could be addressed by education. The occupational therapists were able to bring up intimacy roles because of their specific education and shared cultural values. These factors made it easier to connect to people and speak of these very personal needs. In some cases their age (young students speaking to older people) was a barrier due to hierarchical structure of society. If the student felt there was an issue from the initial interaction, they would get a more senior person to assist.

**Conclusions**

These two cases from the same country highlight our need to base our practice soundly on theory and context, because of the uncertainties that emerge as people’s lives unfold. Moreover, local cultural expressions and social phenomena colour interactions, perceptions and responses. Theory provides a tool on which to base evaluations and services so that interventions can be more culturally sensitive.

The ecological approach of occupational therapy provides a framework to systematically analyze the persons’ action and reaction in relation to the various aspects and forces of their environment. The focus of everyone’s activities are therefore broader than the immediate desired output as it is then becomes the outcome of cultural and social exchanges and interactions. The world is becoming increasingly diverse and all health practitioners are being challenged to understand illness and trauma experiences from multiple perspectives. Failing to do so will further increase the disparities in service provision noted between ethnic groups (Srivastava, 2008).

Occupational therapists are underutilized by the health system for addressing psychosocial phenomena and occupational therapists themselves tend to deal more easily with physical states. Reports to the World Federation of Occupational Therapists (WFOT) indicate a continued decline in occupational therapists indentifying with psychosocial or mental health practice in some countries (Brintnell, Haglund, Larsson & Piergrossi, 2005). This latter behaviour
pattern perpetuates the lack of awareness by other health professionals and policy makers of the utility of the occupational therapy professional in situations where both physical and psychological injuries interact with changes in social structure and supports. This is also a description of the aftermath of disaster states.

Focusing on the physical to the almost exclusion of psychological and social issues also contradicts our own statements about being holistic in our practice. Nor does it support our claims of integrating a mind, body and spirit perspective in our approach to occupational performance and behavioural issues.

References


