Response of mental health professionals in Gujarat

We visitedAnand-Kheda(between Baroda and Ahmedabad). Sixty people died in the riots here, and thousands were rendered homeless in approximately 125 villages. Victims have received scant support from the government and voluntary organisations.

Reports are common, of insomnia, startle reactions, fearfulness, intrusive memories and sadness. The commonest coping method has been of prayer. The women and the elderly appear depressed; young males appear very angry. Children are also affected. Spiritual leaders have been largely silent. Victims fear returning to their homes, and the state government's order to close relief camps on the eve of the monssons has aggravated existing stress.

The victims of communal violence in Gujarat have experienced extraordinary physical and psychological trauma. These pains are compounded by government inaction against the perpetrators of violence, and by the lack of support from outside their community.

The experience of a disaster can trigger off intense emotional reactions, sometimes highly individual in nature. Sometimes the reaction is delayed. Sometimes it can lead to considerable disability. Most people may not need professional help, but support from family and friends is critical. Psychological symptoms can persist decades after the traumatic event.

Mental health response to disaster in India

Overall, the mental health response following large-scale trauma in India has been from a psychiatric perspective, ignoring the multiple influences on people's experiences of, and responses to, a disaster. What is needed is a psychosocial perspective viewing victims in their cultural milieu. Further, there has been insufficient documentation of work, very little sharing within the mental health community, and a preoccupation with research without an 'action' component.

There were isolated psychosocial interventions following the 1992-93 riots in Bombay. Such relief was provided for the first time through lay mental health workers, after the Kandla cyclone. Relief after the Orissa cyclone and the Bhuj earthquake also had a mental health component. Voluntary organisations played an important part .

There are many barriers to an adequate psychosocial response to large-scale trauma. The country has only 7,000 mental professionals spread unequally across different states. The field focuses on treating individual patients rather than communities. Mental health professionals are not experienced with negotiating with NGOs, or working with the development model necessary in the context of a disaster. Social work institutes may jump on to the bandwagon to make their presence felt but abandon the field without setting a long-term process in motion. Some NGOs' efforts are dictated by the availability of financial grants, preventing a long-term intervention. Finally, there is a lack of awareness about mental health issues across all target groups.

People working in mental health will also have to reflect on the conflicts between religious identity and professional responsibility. This is a requisite for post-riot counseling, also important during times of peace.

Further, some activists have biases obstructing equitable counseling to all affected people. For example, after the Bhuj earthquake, some activists stopped me from going to homes of a particular community stating that they were rich and required no help. Grief is universal; mental health intervention must reach all hearts.

Mental health professionals in Gujarat

In Gujarat, mental health professionals from Ahmedabad have been working with violence victims in government hospitals and in relief camps. However, the response has been feeble when compared to the Bhuj earthquake. The most important reason for this is the fear and uncertainty of the situation. Second, the sanction of the violence by a large majority has affected mental health professionals as well. They are also restricted by the absence of institutional mechanisms to provide systematic relief.

Gujarat needs a long-term plan for community-based psychosocial intervention using volunteers. The key actors should be disaster workers, primary care workers, teachers, medical professionals and social activists. Training must include some counseling skills, briefing on social issues, team building, and breaking stereotypes. This must be a government-mandated effort with inputs from specialists close to the affected region.

Every riot victim has a right to mental health relief for a reasonable period, provided by the State. Research or assessments must include an action component; victims should not be viewed as a laboratory. Counsellors must plan to work on long-term conflict resolution. They must move to the centre of the disaster zone, not hide in the periphery.

In Gujarat, the mental health fraternity was silent fearing the disruption of 'therapeutic neutrality'. This is actually a denial of professional responsibility. Mental health professionals need not be sloganeers, but they must raise sane voices during difficult times. A small minority has made active efforts and taken stands, but on the whole, silence has transformed the profession's empathy into apathy. This collective silence must be broken with concerted action toward healing and prevention.

Harish Shetty

(Dr H Shetty, Dr S Shah, Dr H Sharma, and Ms P Pushkarna visited the camps. The team was supported by Mr S Desai and Ms A Patel from the Charutar Arogya Mandal. Medical personnel and social workers of the preventive and social medicine department of Pramukhswami Medical College provided critical inputs.)

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