

# Central System of Psychosocial Support to the Czech Victims Affected by the Tsunami in Southeast Asia

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## Abbreviations:

DNA = deoxyribonucleic acid  
MoD = Ministry of Defence (Czech Republic)  
MoI = Ministry of the Interior (Czech Republic)  
PTSD = post-traumatic stress disorder

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## Abstract

The Tsunami disaster affected several countries in Southeast Asia in December 2004 and killed or affected many tourists, most of them from Europe. Eight Czech citizens died, and about 500 Czechs were seriously mentally traumatized. The psychosocial needs of tourists included: (1) protection; (2) treatment; (3) safety; (4) relief; (5) psychological first aid; (6) connecting with family members; (7) transportation home; (8) information about possible mental reactions to trauma; (9) information about the normality of their reaction; (10) procedural and environmental orientation; (11) reinforcement of personal competencies; and (12) psycho-trauma therapy.

The Ministry of Foreign Affairs of the Czech Republic was in charge of general emergency management. General coordination of psychosocial support was coordinated under the Ministry of Interior of the Czech Republic, which is connected to the Central Crisis Staff of the Czech Government. The major cooperative partners were: the Ministry of Foreign Affairs, the Ministry of Defence, the Ministry of Health, Czech Airlines, psychosocial intervention teams of the Czech Republic, and the Czech Association of Clinical Psychologists.

The main goals of relief workers were: (1) to bring back home the maximum number of Czech citizens; (2) to provide relevant information to the maximum number of affected Czech citizens; (3) to provide relevant information to rescue workers and professionals; and (4) to prepare working psychosocial support regional network.

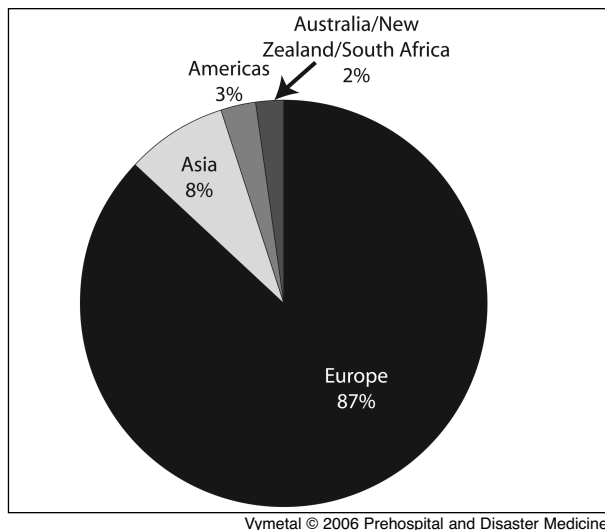
Major activities of the Ministry of Interior (psychology section) included: (1) establishing a psychological helpline; (2) running a team of psychological assistance (assistance in the Czech airports, psychological monitoring of tourists, crisis intervention, psychological first aid, assistance in the collection of DNA material from relatives); (3) drafting and distributing specific information materials (brochures, leaflets, address lists, printed and electronic instructions); (4) communicating via the media and advertising; and (5) providing analysis and research studies.

Central coordination of psychosocial support has been found as successful in the first phase after the disaster. The plans must be built for preferable cooperation in the psychosocial field in the Czech Republic. Better collaborates with journalists must exist in order to reduce secondary psycho-trauma. There is a need for intensive international cooperation in the psychosocial field and to build the network at the global level.

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## Introduction

The Czech Republic is located in Central Europe, has 14 regions, and a total population of 10 million. Recently, the country experienced various disasters (e.g., extensive floods in 2002 affecting 75,000 people; traffic crashes with many casualties; tornadoes). Since then, a psychosocial support system has been developed for emergency situations. Currently, the Czech Republic has a system of post-traumatic intervention care within the Ministry of the Interior (MoI), intended primarily for police officers and firefighters. The system is comprised of approximately 120 trained professionals specializing in critical



**Figure 1**—Distribution of the number of tourists who died in the Tsunami

incident stress management and crisis intervention. Each region has one team that either can work independently or with other teams in case of a local disaster. This central system could be used in disasters involving Czech inhabitants—as occurred after the Tsunami. The advantage of central coordination is a direct link to the Central Crisis Staff of the Czech government. Many non-governmental organizations (NGOs) may be involved in psychosocial support as well. In fact, an entire network of psychosocial support currently is being developed and improved in the Czech Republic.

The country also has a representative in the Task Force on Crisis and Disaster Psychology (under the European Federation of Psychologists Association), which has these main aims: (1) to define the standards and levels of necessary education; (2) to create a European Network of psychosocial support; and (3) to present a report to the European Council.

#### Situation after the 2004 Tsunami

More than 230,000 (Reuters) victims from several nations were missing as a result of the Tsunami disaster. Approximately one-third of these persons formed a group of missing people in the first weeks after the catastrophe. Nearly 2,500 dead victims were tourists. As many as 2,200 Europeans died or were presumed dead (Figure 1). The most affected countries in the world (dead and presumed dead) were: Germany (658), Sweden (608), Great Britain (247), Finland (189), Switzerland (121), Japan (93), Italy (54), France (51), Denmark (47) and Netherlands (37) (Figures 2 and 3). The most affected country by number of deaths per million population was Sweden (68) and Finland (36), followed by Norway, Switzerland, Denmark, Germany, Singapore, Great Britain, Hong Kong and the Netherlands (Figure 4 and Table 1). (The stated figures were taken in February 2005 and they have been used for illustrative reasons.) For each deceased person, at up to 10 relatives and friends were counted as persons possibly needing help coping with the trauma.

Approximately 7,000 Czech tourists were in Asia at the time of the Tsunami, including about 800 Czechs in the

affected areas in Southeast Asia. More than 300 Czech citizens still were missing on the third day after the Earthquake and Tsunami. Three weeks after the Tsunami, 11 people still were missing, and one body was identified. Currently, all eight dead citizens have been identified.

An estimated 500 Czechs were traumatized mentally by this event. These people tried to protect their children, observed the cruelty of the deaths of other people around them, tried to help the injured, and/or tried to find relatives and/or friends in morgues.

#### Needs Assessments

Those needing help after the Tsunami included: (1) injured and non-injured tourists who tried to survive or observed the aftermath of the Earthquake and Tsunami; (2) the bereaved, families of missing persons, and families of traumatized tourists; (3) the professionals in the field (embassy and airline employees, travel agency staff, rescue personnel); and (4) the professionals in the Czech Republic (including mental health professionals). Although a comparative analysis of the organization of psychosocial help in European countries has not yet been completed, general data are presented in Figure 1.

The specific, psychosocial needs of tourists included: (1) protection, treatment, safety, and relief; (2) psychological first aid; (3) connecting families via telephone, e-mail, and standard messaging services; (4) transportation back home; (5) information about possible mental reactions to trauma; (6) information about the normality of these mental reactions; (7) procedural and environmental orientation; (8) reinforcement of personal competencies; and (9) psycho-trauma therapy.

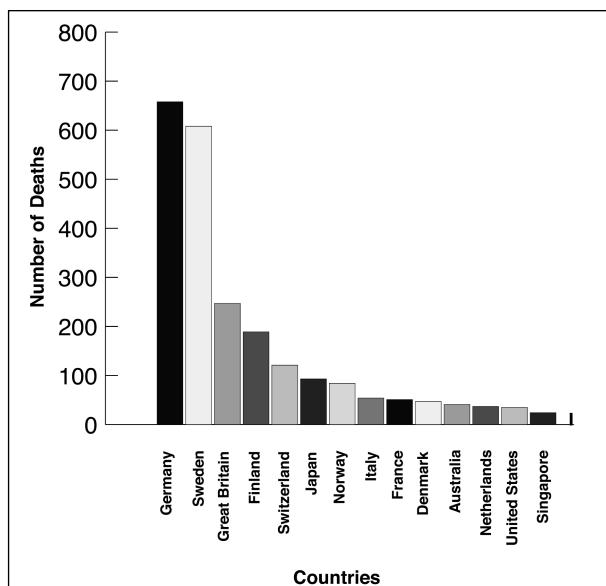
People with a history of psycho-trauma, injured tourists, children, the elderly, people who spend a lot of time at home, lonely people, and the bereaved, were especially vulnerable to the development of post-traumatic stress disorder (PTSD).

Most Czech tourists were celebrities, backpackers, and/or in the upper-middle-class (mainly students and internationally mixed couples). They primarily consisted of young people and people of working age, and were spread throughout the affected area.

#### Central System of Psychosocial Support

The Ministry of Foreign Affairs of the Czech Republic was in charge of general emergency management. General coordination of psychosocial support was provided by the MoI of the Czech Republic, which was connected to the Central Crisis Staff of the Czech government.

Many agencies cooperated in providing psychosocial support to Czech victims. To collect information, the Consular Department of Ministry of Foreign Affairs established 10 phone crisis lines in the Czech Republic for the families of missing people. They also worked with tourists in Czech embassies in Asia. Individual agents worked with the bereaved and relatives of missing persons. They helped with practical tasks and distributed leaflets and brochures with psychological information. The Ministry of Defence (MoD) sent a military aircraft to transport Czech tourists from inaccessible, affected areas, and retrieved one dead body from Thailand. The MoD sent one army psychologist

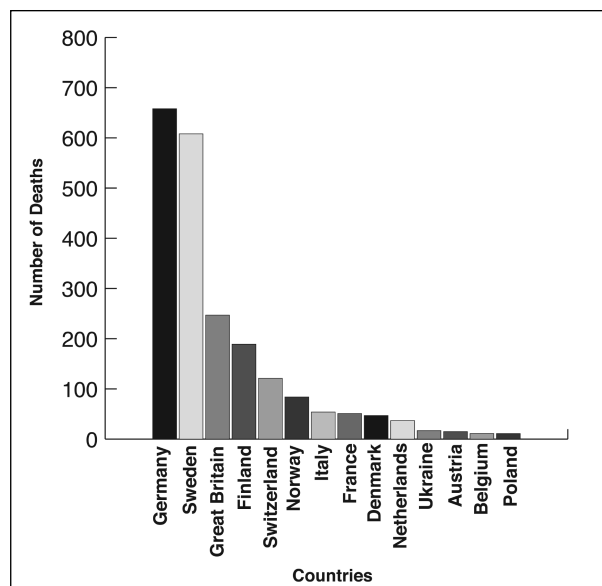


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Figure 2—Distribution of world deaths

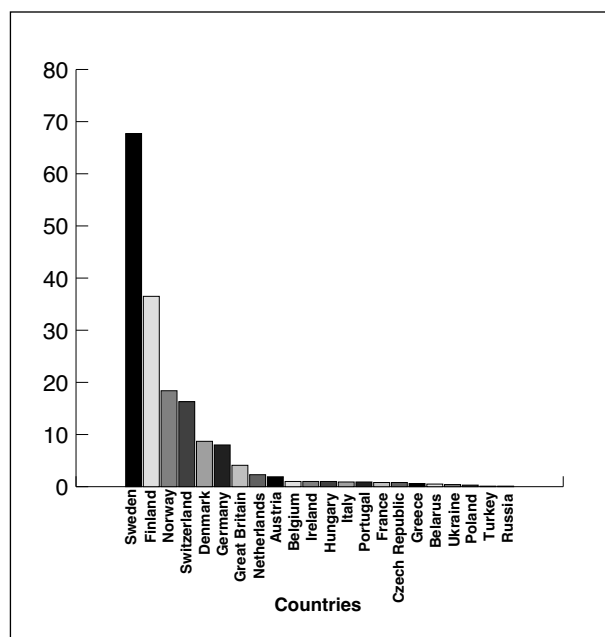
to support the tourists, educate the crew in psychological matters, and work with journalists. The MoD provided suitable places at the Prague airport for psychological intervention. The Ministry of Health sent doctors and a clinical psychologist to Colombo, Sri Lanka, to provide treatment and psychological first aid to Czech tourists. In the Czech Republic, the Ministry of Health set up a short-term information hotline to provide information on hygiene and epidemiological counseling. Czech Airlines dispatched nine special flights for the Prague-Colombo-Prague trip. The company transported 1,350 people from affected areas (approximately 300 were Czechs). They distributed psychological information to tourists on the airplanes, and in the Prague airport. Czech psychosocial intervention teams of the Czech Republic also provide direct contact information for trained psychosocial support professionals (provided by the Czech Association of Clinical Psychologists).

The MoI also provided many other important psychosocial services. A psychological help line was established on 27 December 2004, the second day after the event. It provided counselling, information, and crisis intervention to surviving tourists, relatives, the bereaved, and experts involved in relief work. The help line remained in operation for three months. Ninety percent of all contacts were related to the Tsunami. There were 150 calls in the first month. Of these calls, 60% were serious (e.g., crisis intervention to the tourists, post-traumatic reactions, massive anxiety/fears). A psychological assistance team assisted at airports, monitored the psychological health of tourists, performed crisis intervention and psychological first aid, and assisted in the collection of deoxyribonucleic acid (DNA) material from relatives. The MoI drafted and distributed electronic and printed brochures, leaflets, address lists, and instructions containing: (1) information about mental reactions to the disaster, and the normality of these symptoms; (2) options for help; (3) an address list of psychosocial ser-



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Figure 3—Distribution of deaths of Europeans



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Figure 4—Deaths per million inhabitants (Europe)

vices in the Czech Republic; and (4) the telephone number to the MoI psychological help line. Essential information of various mechanisms to obtain psychosocial support was provided to the public via the media and advertising. Professional authorities from European countries and professionals in the Czech Republic completed questionnaires about the psychosocial system and the use of psychosocial support.

**Procedure**

A coordinating team of mental health experts was composed of five psychologists from the MoI (two were leaders), 14 regional coordinators (fire-rescue psychologists),

and 140 specialists in psychosocial support by regions (including trained, non-professionals).

The main goals of the coordinating team were to: (1) bring home the maximum number of Czech citizens; (2) provide relevant information to the majority of affected Czech citizens; (3) provide relevant information to rescue workers and professionals; and (4) prepare a regions psychosocial support network.

Central coordination, free services, psychological monitoring at the airports, psychological assistance in the collection of DNA material, the flexibility and creativity of the psychosocial team, the highly motivated workers and enthusiastic professionals, and the principle of solidarity and reciprocity all seemed to work well in the post-Tsunami efforts.

Many difficulties also were encountered during the disaster responses, including: (1) unclear levels of competencies; (2) insufficient care for the mental well-being of the professionals (no debriefings); and (3) a lack of model plans for this type of situation. Specific problems included: (1) failure to obtain a database of affected people (no complete database of tourists existed); (2) upon landing at the airports, some Czech tourists were not protected from journalists, which could have contributed to secondary psycho-trauma; (3) psychological support was not provided in Czech hospitals; (4) few psychotherapists focused on long-term therapy with PTSD clients; and (5) the top state management personnel took over personal responsibility for coordination.

#### *Lessons learned from the Tsunami experience: Egypt bombing*

The Egyptian sea resort Sharm El Sheikh was the target of a series of three bomb attacks on 23 July 2005. It was the cruelest terrorist attack aimed at tourists in Egypt. A total of 88 people were killed, and at least 200 were injured. Of the victims, nine foreigners were killed and 32 were injured.

There were 1500–2000 Czech tourists in affected area. One Czech died, and one was seriously injured. Several Czechs were injured slightly, but did not receive medical treatment.

Nearly 200 Czechs were seriously mentally traumatized. One hundred sixty-four Czechs and 12 Slovaks were flown home by Czech Airlines. A total of 919 Czech citizens returned home as soon as soon as they were able.

The source of mental traumatism associated with this event was the imminent health threat perceived immediately after the bombings. These included: (1) damaged bodies; (2) body parts; (3) the cries of the injured victims; (4) the sight of the burned bodies; (5) amputations; (6) blast injury; (7) foul odors; (8) panic; (9) chaos; and (10) the collapse of the communication infrastructure. In the Czech Republic, relatives feared for their loved ones. The strict security precautions after the attack and the influence of the local media along with the pressure of Czech media in the deeply impacted the bereaves.

The psychosocial requirements of traumatized tourists were to: (1) be safe; (2) have structured information; (3) re-orient themselves; (4) be in touch with relatives and close friends in the Czech Republic; (5) return back home quickly; (6) ensure the normality their reactions and thought; (7) rest; and (8) receive follow-up care (in a few cases).

The main aim of the Psychological Service of MoI was to provide early information about possible immediate and later

Country	Deaths per million inhabitants
Sweden	67.66
Finland	36.25
Norway	18.36
Switzerland	16.24
Denmark	8.68
Germany	7.98
Singapore	5.51
Great Britain	4.10
Hong Kong	2.94
Netherlands	2.27
Australia	2.06
Austria	1.83
New Zealand	1.50
Israel	1.13
Belgium	1.06
Ireland	1.00
Hungary	1.00
Italy	0.93
Portugal	0.86
France	0.84
Czech Republic	0.78
Japan	0.73
Canada	0.62
Greece	0.56
Belorussia	0.48
South Korea	0.41
Ukraine	0.36
South Africa	0.35
Poland	0.28
Philippines	0.17
USA	0.12
Turkey	0.09
Russia	0.07
China	0.01

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**Table 1**—Deaths per million inhabitants (world)

reactions of those affected by trauma, and to provide contacts for professional follow-up care, further psychological first aid, and crisis intervention. With the cooperation of Czech Airlines, 1,095 travellers received psychological information.

The Psychology Service of the MoI was in charge of the central coordination of psychosocial help. Psychologists from the MoI, fire-rescue forces, and police departments worked together. All experts involved were trained and qualified.

Thus, experiences gained after the Tsunami assisted in the management of the victims of the Sharm El Sheikh bombing.

The first week after the event was the most intensive. A psychological help line was available three weeks after the event. A total of 18 people provided psychosocial support, nine of them were in the field.

### **Conclusion**

Central coordination was provided from one place during the first month of the crises. The model's mechanism should encourage cooperation, which should contribute to improving psychosocial support. Stress management processes are needed for all professionals. There must be better collaboration with journalists in order to reduce the possibilities for producing secondary psycho-trauma. There is a need for international cooperation in the psychosocial field, including building European and global networks.