Jurnal ASPIKOM, Vol. 6, No. 2, July 2021, pp. 265-277
P-ISSN: 2087-0442, E-ISSN: 2548-8309
DOI: http://dx.doi.org/10.24329/aspikom.v6i2.867

Mental Health Communication in Indonesian Natural Disaster Victims Trauma Recovery

Komunikasi Kesehatan Mental Pemulihan Trauma Korban Bencana Alam Indonesia

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Abstract

Trauma healing is a crucial stage in a long tourism sector recovery process after a natural disaster. Post-disaster psychological support is needed to reduce trauma in society, especially for remote communities. However, health services for people affected by health crises due to disaster at the provincial level are inadequate. This study aims to identify mental health communication forms in the trauma recovery process for tsunami victims in Pandeglang, Banten. This research uses the case study method. Approached descriptive-qualitatively, this study describes the practice of mental health communication in the context of trauma healing for natural disaster victims in Indonesian tourist attractions. This study found that mental health communication efforts included psychosocial assistance for children and adults, treatment for people with mental health disorders (ODGJ- orang dengan gangguan jiwa), counseling for victims, home visits, and health services for 26 ODGJs, and home visits for victims without mental disorders.
***Keywords**: Mental health communication; Natural disaster; Tourist attraction; Trauma healing*

Abstrak

Pemulihan trauma merupakan tahap krusial dalam rangkaian panjang proses pemulihan sektor pariwisata setelah diterpa bencana alam. Dukungan psikologis pasca-bencana sangat diperlukan untuk mengurangi tingkat trauma masyarakat, khususnya untuk komunitas terpencil. Namun, layanan kesehatan bagi penduduk terdampak krisis kesehatan akibat bencana di tingkat provinsi belum memadai. Penelitian ini bertujuan untuk mengidentifikasi bentuk komunikasi kesehatan mental dalam proses pemulihan trauma korban bencana alam tsunami di Pandeglang, Banten. Penelitian ini menggunakan metode studi kasus. Didekati secara kualitatif dengan jenis penelitian deskriptif, penelitian ini dapat menggambarkan praktik komunikasi kesehatan mental dalam rangka pemulihan trauma korban bencana alam di daya tarik wisata Indonesia. Hasil penelitian ini menemukan bahwa upaya komunikasi kesehatan mental yang dilakukan di antaranya adalah pendampingan psikososial pada anak dan dewasa, pengobatan bagi orang dengan gangguan jiwa (ODGJ), bimbingan konseling bagi korban, home visit dan pelayanan kesehatan untuk 26 ODGJ, serta home visit untuk korban tanpa gangguan jiwa.
***Kata Kunci**: Bencana alam; Daya tarik wisata; Komunikasi kesehatan mental; Pemulihan trauma*

Article History: *Received December 5, 2020; Revised February 18, 2021; Accepted April 17, 2021*

Introduction

In research entitled "Tourism Image Recovery Strategy Post-Natural Disasters in Indonesia" in 2019, the researcher underlined a statement from the key informant who was the Head of the West Nusa Tenggara (NTB) Provincial Tourism Office, stating that the first thing to do after a natural disaster in the form of earthquake was to solve trauma-related problem (trauma healing). The first trauma healing target is the tourism industry starting from hotels, restaurants up to tourism service businesses, including airlines, because they are afraid to do their business again. The next trauma healing target is for the community in the tourism area to no longer be traumatized. After the trauma healing is complete, the process is continued with recovery on attractions, accessibility, and amenities (3A). Next, when all the accessibility becomes normal, flights start to recover somewhat. International flights are added to Perth, Australia, and so on. Therefore, in restoring the tourism image of NTB province, trauma healing is the first stage to carry out after disaster mitigation is complete (Kurniasari, Haloho, & Christian, 2019).

Trauma healing is crucial in a long series of the recovery process in the tourism sector after a natural disaster (Koentjoro & Andayani, 2016). It starts from trauma recovery for the drivers of the tourism sector itself, such as hotels, airlines, restaurants, tourism service entrepreneurs, and communities around tourist attractions affected by natural disasters (Puspitasarie, Manoby, & Utomo, 2019). Post-disaster psychological support is needed to reduce the trauma of those affected by the disaster, especially those remote communities (Novianty, 2011).

The mental health initiative carried out during the natural disaster of the eruption of Mount Merapi in 2010 was a psychological first aid in the form of a workshop for 400 nurses throughout Central Java at the expense of the National Disaster Management Agency. In another disaster, the TNI Psychology Team provided psychological trauma recovery assistance from the Army Psychology Service, the Navy Psychology Service, and the Air Force Psychology Service. They carried out Military Operations Other than War, which aimed to provide psychological trauma recovery assistance for the earthquake victims. Psychological support for mental healing of the earthquake victims in handling Atastrophic Events and Post Traumatic Stress Disorder (Fullerton, Mash, Benevides, Morganstein, & Ursano, 2015) was also presented. The TNI Psychology Team also provided methods and techniques for 50 volunteers at the Kren Lombok Hall, Jalan Tambora 1, Perum Puri Gelang Indah, East Lombok. *Aksi Cepat Tanggap* team provided psychosocial support after the earthquake disaster in Lombok, West Nusa Tenggara. *Aksi Cepat Tanggap* team played a role in deploying volunteers consisting of students by providing medical and psychological assistance through trauma healing to children and elderly parents.

The mental healing psychology activity began with data collection on the victims using the need assessment method and need analysis. This is done to record how many victims are affected by post-earthquake stress and the extent of the victims' trauma. After a need analysis, intervention activities were carried out, which included (1) therapy to reduce post-disaster anxiety levels with various relaxation techniques, (2) treatment to restore the emotional condition of the victims with emotive behavioral therapy, cognitive behavior therapy, and hypnotherapy, (3) various motivation training methods to improve the motivation of the victims, (4) gradual and intensive counseling of the victims.

Previous research within the topic of this study entitled "Public disaster mental/behavioral health communication: Intervention across disaster phases" by J. Brian Houston aims to explain disaster communication intervention activities and their results by placing these activities into a multiphase disaster communication framework covering pre-event (preparedness), event (response), and post-event (recovery). In the literature review section, this research proposed The Disaster Communication Intervention Framework (DCIF) including increasing the preparedness and resilience of communities and individuals, reducing the suffering caused by disasters, health promotion, overcoming health problems, health recovery, and helping organizations to understand what happens during and after disasters, as well as rebuilding (Houston, 2012).

Another research relevant to this study is entitled "Post-disaster health status of train derailment victims with post-traumatic growth" by Danielle Maltais, Anne-Lise Lansard, Mathieu Roy, Melissa Genereux, Genevieve Fortin et al. They observed a train accident that caused explosion and fire in Canada. This disaster took the lives of as many as 47 people and damaged houses and buildings around the accident scene. The study compared the physical and mental health of 624 adults from the affected area after three years of this incident. This study proved that people with high social support level, people with low education levels, and people with lower income were more likely to show post-traumatic growth. Meanwhile, in terms of psychological health, post-traumatic stress symptoms and antidepressants were positively associated with post-traumatic growth. Over time, many people have successfully started the recovery process and learned lessons from this disaster (Maltais et al., 2020).

In contrast to the two previous studies above, this research object is the tsunami disaster in Pandeglang Regency, Banten Province, in December 2018. Pandeglang Regency became a pilot project by implementing a coastal primary health service model (Yusuf, 2019). Therefore, this research question is formulated as "what forms of mental health communication are carried out during the trauma recovery process of tsunami victims in Pandeglang, Banten?". Thus, this study aims to identify mental health communication forms during the trauma recovery process of victims of the tsunami disaster in Pandeglang, Banten.

Academically, this research can help develop mental health communication studies, especially regarding trauma recovery for victims of natural disasters in Indonesian tourist attractions. Factually, the Indonesian tourism sector's enormous potential not supported by stable natural conditions (Kurniasari, 2017). Indonesian geographic location, which is in the ring of fire, makes this country vulnerable to natural disasters. Besides, scientific research on trauma healing for victims of natural disasters in the Indonesian tourism sector has not been widely carried out. In practical terms, this research can be used as a guide for mental health practitioners who treat victims of natural disasters at the recovery stage of their trauma. Besides, this research can also be helpful for anyone who needs mental health communication techniques within the realm of health.

Method

This study applies the constructivist paradigm with a qualitative approach. The case study method is used in this research in which the researcher carefully investigates a program, event, activity, process, or group of individuals. Cases are limited by time and action, and researchers collect complete information using various data collection

procedures based on predetermined times (Creswell, 2012). This research belongs to the descriptive type because it intends to describe mental health communication patterns applied in the trauma recovery process for natural disaster victims, particularly Indonesian tourist attractions. The object of this research is the victims of the tsunami disaster in Pandeglang, Banten. The data collected in this study are primary and secondary data. Preliminary data in this study were obtained from open interviews with House of Representatives commission nine and psychiatrists. They deal with the mental health problems of the victims of Pandeglang tsunami in Banten province. Meanwhile, this study's secondary data came from previous studies from scientific journals and other related literature. A comprehensive analysis is brought to meet the needs of this study from the combination of secondary data and primary data.

The data analysis technique in this study was carried out by coding, which is a process that involves labeling or indexing all data using the code listed in the researcher's codebook. Coding allows researchers to use code to search for data to identify all text segments where a particular code is mentioned so that analysis can be focused on that segment (Hennink, Hutter, & Bailey, 2011). In this study, open coding, axial coding, and selective coding were carried out. Through this analysis, the researchers found a clear pattern. Thus, researchers can achieve this study's objectives to determine mental health communication in the trauma recovery process of the tsunami victims in Pandeglang, Banten. This study used triangulation of data sources to compare or double-check the degree of confidence of the information obtained from different data sources.

Results and Discussion

Mental Health Identification

Natural disasters are public health emergency. The word "disaster" appears from the comment "bad star." Astrologically, once some stars were not appropriately positioned. It was an indication that something terrible was going to happen. Disaster is defined as a nasty encounter between humans, nature, and technology or human-made (Lestari & Rinasti, 2020). A disaster can have a severe impact that is felt not only by individuals but also by the area's entire population. Disasters are very likely to paralyze essential life support services in the affected areas. This means that it requires a unique response for individuals who suffer from disasters and takes steps to serve all society members in the respective areas. Natural disasters, when experienced suddenly, can also pose psychological consequences for the victims. These psychological impacts develop along with the passage of time and the post-disaster social context.

Natural disasters consist of six phases. The first one is a pre-disaster stage (Mahardika & Setianingsih, 2018). There is an early warning system (Suwaryo, Sarwono, & Yuwono, 2020), for example, an earthquake followed by a tsunami. The second phase is called the impact phase, in which an emotional impact reaction appears even though there are specific reactions as well, depending on the type of disaster. This phase might pose threats in the form of dangerous psychological impacts ranging from shock to panic, starting with confusion, disbelief, and followed by a focus, in the beginning, to defend yourself and protect your family. This impact phase is the shortest phase of the six stages of disaster (Aryanata & Utami, 2019). Phase three is the heroic phase which is characterized by high activity with low productivity, emerging sense of altruism, and enthusiastic communal behavior. In this phase, there can be chaos. This third phase quickly progresses to the fourth phase (Aryanata & Utami, 2019). Called as

the honeymoon phase (Handayani, 2018), it is marked by dramatic emotional changes.

In this phase, the disaster assistance period begins to occur, immunity attachments are formed, and optimism arises, indicating things will return to normal shortly. Here, there is an opportunity for the organization/provider to build and foster a report card with survivors, both individually and in groups, which ultimately leads to a relationship with stakeholders. This phase lasts for several weeks (Rimayati, 2019). The fifth stage is the disillusionment in which communities and individuals realize the limitations of disaster support, optimism gradually becomes discouragement, stress continues, adverse reactions begin, physical complaints start to appear, substance use increases, gap between need and availability of support causes feeling of neglect, and communities are starting to emerge. Broadly returning to business as usual can last for months, even years (Wijaya, Andarini, & Setyoadi, 2015). The last one is the reconstruction phase, in which a feeling of recovery begins. Individuals and communities start to rebuild lives, and people start to adapt but still mourn for losses. This phase can last for years (Wicaksono & Pangestuti, 2019).

Recovery Process

In terms of loss of livelihood, psychological or psychosocial interventions only contribute a low percentage. However, most of the recovery process can be done by providing social assistance or economic support to the community to empower themselves. Human spiritual needs can also strengthen when waiting for certainty in the middle of a disaster situation (Sutarno, 2019).

After a disaster, it is found that people and mental health care providers who suffer from physical damage are not able to handle victims properly. Health care facilities cannot be easily put in use if the whole system is in chaos. Moreover, people are more focused on rebuilding their lives so as not to notice their stress or mental symptoms. When a disaster occurs, widespread suffering affects entire families and communities, residential areas are damaged, and routine life is disrupted, the psychological reaction of the troubled individual will increase.

When an area experiences a natural disaster, there are various psychological effects on the majority of the population. Thus, it is highly necessary to provide mental health services and care at the local level under the provincial government leadership, community health centers, or welfare and mental health centers. The general reaction to the tsunami disaster in Pandeglang was shocked which then developed into various psychological problems which could differ from one victim to another. This psychological problem appears in three aspects, namely, thinking (cognitive), feeling (affection), and behavior (psychomotor). For example, the thought that God is punishing, having difficulty concentrating, feelings of sadness, anger, or survivor guilt (usually happens to mothers who survive but their young children are not saved), and unclear pacing. In general, these reactions are negative such as negative emotions, negative thoughts, behaviors with negative connotations such as dangerous and threatening, but this fact does not rule out positive reactions.

The psychological reaction of the disaster victim is very personal. Victims with the heaviest psychological burden will recover more slowly. Each person's recovery will proceed according to their respective abilities. No definite time can be given to describe how long a person will recover. Often, post-disaster socio-psychological conditions are felt to be much heavier than when experiencing the disaster itself. The psychological aspect of the victim is closely related to various types of loss, including loss of belongings, loss of loved ones, loss of social matters, loss of activity, and loss of

family ties.

Handling mental health problems within the context of trauma recovery for victims arising from natural disasters consists of (1) availability of post-disaster mental health care needs at a local level, (2) understanding post-disaster psychological reactions, and (3) developing post-disaster mentality at a local level.

Availability of Post-Disaster Mental Health Care Needs at Local Level

As an unwanted event, disaster ensues a hefty psychological burden. Family members die or someone suffers from loss of home and property. Moreover, events after a disaster can cause enormous life changes and uncertainty about the future. This causes stress in everyday life. Moreover, those prone to disasters, including the elderly, infants, the sick or injured, and persons with disabilities, may experience great difficulties coping with life after a disaster and suffer more severe stress. In particular, disruption to medical care after a disaster-related mental and physical disorders can negatively affect the patient's mental health. Then, during a disaster, it is possible for a person to witness death or to personally feel the physical effect of a disaster resulting in shock, which is permanently imprinted on his mind.

Handling the psychological aspects of disaster victims is a unique process for each individual and community. The methods for facilitating recovery are highly adapted to the characteristics of the individual and community, including the culture of the community. Every individual has their own way of recovering. Social support serves as a significant factor facilitating and accelerating the recovery process of disaster victims' psychological aspects. Social support may come in various forms, such as attention and assistance from the surrounding environment, especially that of the immediate environment such as family.

Management of Post-disaster Psychological Reaction

Various psychological reactions experienced one to two months after a disaster, including negative reactions, are normal reactions considering that a person experiences so much loss in a very short time. Depression, panic attacks, motivation loss, insomnia, loss of appetite, fate mourning, irritability experience, lack of ability to concentrate, poor memory, and fainting are some examples of misfortune that those disaster victims might encounter. Usually, the condition is temporary, and the healing is natural. It is also possible that from the post-disaster community, there are resilient individuals so that they can remain optimal after experiencing a disaster. However, after the disaster, their psychological reactions can develop into Post Traumatic Stress Disorder (PTSD) which is marked by three things, namely re-experiencing, avoidance, and hyper-arousal. This disorder can occur at least six months after the incident. In the long term, some people's symptoms will become acute, triggering other psychological disorders such as the chronic low ability to concentrate. The healing process will take longer depending on the extent and duration of the symptoms.

As part of mental health care activities, information on the types of psychological reactions that occur during a disaster and how to respond to them should be made available to benefit local communities, particularly concerning PTSD. Some aspects that need to be considered are (1) post-disaster psychological changes affect more than half of the affected population, and most of their reactions are normal, (2) PTSD can only be diagnosed at least one month after symptoms appear, (3) when PTSD is diagnosed, most people can be cured, and natural healing can be facilitated by avoiding secondary shock and obtaining adequate personal support. It is necessary to build a network of people in

the neighborhood who can help, (4) phycological debriefing conducted immediately after a disaster cannot prevent PTSD, (5) around 10-20% of people who have had severe experiences show long-term PTSD symptoms. If these do not go away naturally, a specialist should always be available for consultation.

Flashback-focused PTSD is a reaction commonly existing among survivors, but a diagnosis of the disorder can only be made as early as one month after the disaster. Symptoms tend to be unstable during the initial period making psychiatric diagnosis difficult. Therefore, survivors' difficulties during the initial period are generally considered to be a stress reaction. While allowing time for natural healing, it is better to focus on providing specific information and assistance to deal with problems related to practical uncertainty and treating serious symptoms such as insomnia and anxiety by administering medication or consultation. However, during the natural healing process, an initial stress reaction, anxiety, or carelessness can lead to unexpected accidents or secondary events. Thus, it is necessary to build public awareness from the beginning by providing information and education about psychological changes and opportunities for healing.

Considering that the psychological impact of disaster is massive, with a large number of people suffering from it. In contrast, the number of mental health professionals, clinical psychologists, and psychiatrists is limited. Efforts should be urgently made to increase the layperson's capacity to become a bridge between mental health professionals and society at large. In this case, for example, teachers, community leaders, religious leaders, artists, journalists, and general volunteers can be empowered to assist the recovery process through interventions with psychological implications. This effort is carried out by laypeople who are trained and equipped with PFA, namely the ability for early detection to make referrals to professionals. Teachers, volunteers, journalists, and religious leaders can provide peace when communicating with victims. Professionals, both clinical psychologists and psychiatrists, can intervene with counseling or psychotherapy according to the professional competence of those referred.

PFA is first-line psychosocial support after a crisis or disaster occurs (Susanto, Yurisma, & Martono, 2019). In various countries, PFA has been put into disaster preparedness and response stage. Indonesia is prone to natural disasters, and the Ministry of Health is aware of regionalization in disaster-prone areas. However, this awareness contributes nothing if the people facing the natural disaster are gripped with helplessness. The eruption of Mount Merapi in 2010 was recorded as the most significant volcanic natural disaster since the 1870s, claiming 353 lives and displacing 350,000 other people (Suarjana, Christiawan, & Nugraha, 2020).

Commission 9 of the Indonesian Parliament proposed the PFA pilot project in collaboration with experts and the Ministry of Health. PFA training was provided for 200 community mental health nurses from five mental hospitals in Central Java to help victims of the volcanic eruption of Mount Merapi in 2010. Unfortunately, the Ministry of Health's budget for the emergency phase was insufficient. Fortunately, the National Disaster Management Agency approved a proposal for the PFA. This training aimed to equip nurses with standard competencies and qualifications in Inter-Agency Standing Committee (IASC) guidelines on mental health and psychosocial support emergencies (Salasa, Murni, & Emaliyawati, 2017).

Besides, mobile mental health services were also carried out to schools during the Mount Kelud eruption natural disaster. Here, psychosocial support and assistance were

provided to school students. Mental health security was also carried out by (1) promoting mental health, (2) making Indonesian people adapted to lifestyle changes due to climate change such as global warming, and (3) assisting Indonesian people who live in the ring of fire locations to accept the reality, to avoid denial, and to be spry (Prihatin, 2019).

Based on this experience, national disaster management authorities could consider setting up a team that can travel to the affected areas to direct local first-aid workers in PFA when a disaster strike. This pilot project is deemed necessary and continues to be implemented by the Ministry of Health to date. In general, the world is in crisis. However, apart from catastrophic events, psychological and mental distress can occur everywhere, whether at work, in supermarkets, at home, at school, in various means of transportation, in public spaces, and in hospitals.

Psychological and mental health first aid is a skill that can save human life (Anika, Yusuf, & Tristiana, 2019). PFA can also be included in training for workers who deal with trauma victims as part of their daily work such as firefighters, police officers, health staff in hospital emergency units, community mental health nurses, psychologists, and social workers or humanitarian aid workers (Halimah & Widuri, 2012). During a PFA disaster, mental health assistance needs to be done as a significant effort and primarily to provide psychosocial service to survivors. Trained non-professionals can also perform PFA techniques. The problem so far is limited psychosocial assistance that has been provided only by professionals in the mental health sector.

PFA in natural disasters and non-natural disasters have similarities, including (1) survivors show a series of physical, emotional, and cognitive symptoms, (2) emotions with other stress reactions increase such as stiff bodies due to not moving much, continually watching, (3) someone who is affected or exposed is not in a position to think and act rationally when a disaster occurs (SP, 2005). Even front liners, doctors, and nurses are not in a sufficiently rational position to think because they are burdened with patients' safety and theirs (Huriani, Sepriani, & Sumarsih, 2018).

Some of the PFA measures evaluated are (1) danger to oneself and others, (2) disorientation of time, place, and people because disasters are unpredictable and authentic, resulting in no structured schedule, (3) direct threats due to catastrophe, (3) threats to life due to disasters, (4) physical injuries, (5) delayed evacuation during the catastrophe, (6) loss of family members, (7) history of mental disorders and substance abuse, and (8) limitations with telemedicine.

Post-disaster Mental Health Care Development at Local Level

In providing post-disaster mental health care services at local level, appropriate strategies should be selected respective to the existing situation. Efforts are needed to increase efficiency over time by keeping in mind the factors that cause stress in society, the symptoms that appear, and the differences from one condition to another. Post-disaster mental health care activities at the local level consist of a series of general assistance programs designed to improve entire communities' mental health and reduce group mental trauma. Besides, there are also activities for prevention, early detection, and mental disorder treatment, specifically the availability of information related to disasters and psychological education for the general public carried out by volunteers and mental health nurses who go to the disaster area. Furthermore, practical assistance for disaster recovery, including screening of mentally challenged individuals, encouraging people to come for consultations, and referral to specialists, can help to

improve the mental health of the community.

In the case of the tsunami disaster in Pandeglang Regency, Banten Province, a series of mental health problems was found in the society during the Commission 9 DPR RI (House of Representatives) working visit. The problems are including anxiety, sleep disorder, loss of family, property, and work, and relapses from drug withdrawal of those people with mental disorders (Fauzi, 2020).

Table 1. Mental Health Management and Its Follow Up for Tsunami Victims in Pandeglang (source: open-ended interview)

No.	Mental Health Management for Pandeglang Tsunami Victims	Follow Up
1	Psychosocial assistance for children and adults	Post-tsunami monitoring by the mental health division of Labuan Community Outreach Team
2	Treatment for people with mental disorders	Providing health services for refugees with mental disorders
3	Post-tsunami counseling guidance for victims	Monitoring of people with mental disorders affected by the tsunami
4	Home visit to people with mental illnesses who were affected by the tsunami	Post-tsunami refugee monitoring by providing health services to people with mental disorders
5	Providing health services for 26 people with mental disorders	Providing health services for people with mental disorders
6	Performing trauma healing on children and adults	Giving health education to people with mental illnesses following a predetermined schedule every month

Activities carried out to overcome mental disorders of tsunami victims in Pandeglang Regency, Banten Province were psychosocial assistance for children and adults, treatment for people with mental disorders, post-tsunami counseling for victims, home visits to ODGJ affected by the tsunami, providing health services for 26 people with mental illnesses, home visit to victims without mental disorders affected by the tsunami, and conducting trauma healing on children and adults (Widyastuti, Widha, & Aulia, 2019).

The follow-up efforts carried out were (1) monitoring during the post-tsunami recovery process by the PKM Labuan Mental Health team, (2) providing health services to refugees with mental disorders, (3) monitoring people with mental disorders affected by the tsunami, (4) monitoring post-tsunami IDPs by providing health services for people with mental illnesses, (5) providing health services to people with mental disorders, and (6) providing health education to ODGJ according to a predetermined schedule every month.

All these efforts were made for the tsunami victims in Pandeglang during their recovery process to live their daily lives as before and ensure that they were empowered to revive the coastal tourism sector in their area. Undeniably, a synergy from various parties such as medical personnel, social workers, community service teams from universities, CSR teams from companies, and the government is needed. This way, the

mental health of the people affected by the disaster can be overcome. This is not impossible to complete if this effort serves as a pilot project for trauma recovery of other natural disaster victims that hit coastal areas in particular and different regions in general.

Conclusion

During the tsunami in Pandeglang Regency, common mental health conditions that afflict the victims include (1) anxiety, (2) depression, (3) psychological trauma and avoidance symptoms, (4) adjustment disorders such as hopelessness because they cannot work or study. Normally, efforts that can be made in handling mental health include (1) promotional efforts, (2) preventive efforts, (3) rehabilitative efforts, and (4) curative efforts.

Health facilities other than those in the health sector and community-based service facilities are (1) psychologist practice, (2) social worker practice, (3) social care center, (4) social welfare center, (5) social rehabilitation center, and (6) social protection houses. Professional training and other related activities are needed to improve the skills of officers who deal with victims with mental trauma during a disaster. Not only for psychologists and public service centers, but civil servants who are also health professionals also need to be encouraged to take the training. This way, they can be better prepared to combine administrative and clinical expertise in formulating mental health care policies at the local level in a disaster.

The recovery of trauma to victims of natural disasters in Pandeglang Regency, Banten Province, which is also a tourist destination in Indonesia, requires many parties, psychologists and social service providers, particularly social workers, to work together. Many social workers must be mobilized for the health line and crisis intervention team. It is better if the coastal primary health service model starts from Pandeglang Regency itself.

Currently, after the occurrence of large-scale natural disasters, attention to psychological aspects and mental health is more adequate than before. There are various efforts to increase local capacity to be able to do simple, practical things, but quite helpful and have an impact on psychological recovery. Inter-sector coordination and collaboration have been initiated in handling the psychological aspects of disaster victims. Referral systems have also started running in several post-disaster areas. The handling of psychological aspects of disaster victims is not short but is a relatively long process, so it is necessary to ensure its sustainability in the community. Psychological recovery becomes a complex process if adequate social conditions do not support it.

Practically, this research suggests central and local governments optimize recovery efforts for victims of natural disasters, especially from mental health, because they experience psychological trauma, mainly if a natural disaster occurs at a tourist attraction. Those victims who earn their living from the tourist attraction sector might have a negative economic impact. If the tourism sector can recover immediately, various other industries can revive the economy in areas affected by natural disasters.

Academically, this research suggests a more comprehensive method for future researchers, such as a survey method for survivors and medical personnel who have handled natural disaster victims with trauma. The focus group discussion method can also be done by presenting various elements such as representatives of the health office, representatives of the Regional Disaster Management Agency, and related communities. Structured or in-depth interviews can also be conducted to obtain in-depth data so that

the research results are more holistic.

Acknowledgements

The authors would like to express their highest gratitude to Institut Teknologi dan Bisnis Kalbis for funding this research.

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