

A Case Study: How a Disaster Mental Health Volunteer Provided Spiritually, Culturally, and Historically Sensitive Trauma Training to Teacher-Counselors and Other Mental Health Professionals in Sri Lanka, 4 Weeks After the Tsunami

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This article is a case study describing how one disaster mental health volunteer for an international relief organization developed and then taught a trauma training curriculum 4 weeks after the tsunami hit Sri Lanka. The curriculum was developed specifically to train mental health professionals and teacher-counselors (teachers with 1 year intensive training in foundational counseling). The curriculum was carefully constructed to meet the needs of the tsunami survivors and then revised after meeting with and gathering information from the adults and children in several refuge camps. In addition, the curriculum underwent several revisions after considering civil war effects, as well as cultural and religious values, beliefs, and behaviors practiced in Sri Lanka. Finally, the article focuses on curriculum delivery and the generally positive evaluations of it by participants. [*Brief Treatment and Crisis Intervention* 6:316–325 (2006)]

KEY WORDS: tsunami, Sri Lanka, trauma training, disaster mental health, spiritual sensitivity, cultural sensitivity.

No man is an island, entire of itself; every man is a piece of the continent, a part of the main . . . any man's death diminishes me, because I am involved in mankind, and therefore never send to know for whom the bell tolls; it tolls for thee. (John Donne, 1624/1952, Meditation XVII, p. 441)

On December 26, 2004, one of the world's worst natural disasters occurred, resulting in the death or disappearance of 223,492 people (United Nations Office of the Secretary-General's Special Envoy for Tsunami Recovery, 2005). At 7:58 a.m. (local time) a magnitude

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This article is dedicated to all those affected by the December 2004 South Asian tsunami, which killed over 200,000; left countless orphans, widows, and widowers; and displaced hundreds of thousands. Millions around the world saw the

unbelievable destruction and decided to contribute through monetary donations, assistance, and other means. This article is also dedicated to all those who took time out of their busy schedules to serve as volunteers with one of the many relief organizations, as well as those who stayed at home and picked up the slack, and the employers who so readily gave permission for their workers to be gone.

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9.0 earthquake on the bottom of the Indian Ocean resulted in a tsunami, producing waves of up to 100 feet that hit 11 Indian Ocean countries (Paulson, 2005). The destruction from the tsunami was far ranging, involving vast destruction of property (often whole communities) and extensive loss of life. The death rate by country was as follows: Indonesia 129,775; Sri Lanka 35,322; India 12,405; Thailand 8,212; Somalia 78; Myanmar 61; Maldives 82; Malaysia 69; Tanzania 13; Bangladesh 2; the Seychelles 1; and Kenya 1 (United Nations Office of the Secretary-General's Special Envoy for Tsunami Recovery, 2005). The enormity of the needs of the affected communities was soon realized by government officials of the affected countries, as well as the television-viewing public around the world who watched the most enduring images of the aftermath of the tsunami. Volunteer disaster-relief organizations, lay people, professionals, community groups, professional organizations, etc., from around the world wanted to assist in the relief efforts. These efforts were focusing on meeting basic human needs (water, food, and shelter) and health and mental health needs of survivors of the tsunami-affected areas.

Curriculum Development

Two weeks after the tsunami hit, a local relief organization based in the Northwestern United States was asked if they could provide trauma training in Sri Lanka for local mental health professionals and teacher-counselors (teachers with 1 year intensive training in foundational counseling) on how to assist survivors of the tsunami. One disaster mental health volunteer, with a history of disaster mental health training and experience in providing mental health services after large-scale trauma events and trauma training, was asked to develop the curriculum and later to provide the training in Sri

Lanka. Based on this request, a curriculum outline was designed and developed to be a practical guide. It was then reviewed and, with minor changes, approved by several Sri Lankan mental health professionals (e.g., other trauma-relief mental health volunteers, clinicians at a mental health center) and other individuals (e.g., representatives of the Northwest relief organization, Sri Lanka's minister of health). The approved curriculum outline included the following topics: (a) curriculum overview—definition and types of trauma; (b) trauma responses—emotional, physical, and cognitive responses; (c) trauma reactions/a continuum of responses—post-traumatic stress (PTS), acute stress disorder, and post-traumatic stress disorder; (d) death and traumatic death—bereavement over the life cycle; (e) threats of suicide; (f) child abuse; (g) substance abuse; (h) factors to consider—personal, predisposing, peridispersing, postdispersing, and preventive; (i) family and community responses; and (j) trauma assessment and interventions.

Cultural values, beliefs, and practices, as well as relevant historical events, had to be taken into account in developing the curriculum, in order to avoid ethnocentrism and to encourage cultural awareness. Ethnocentrism is best described as the assumption that all cultures function similar to one's own, which often means mainstream, dominant culture (Cavaiola & Colford, 2006). Cultural awareness refers to acknowledging and appreciating the different values, beliefs, behaviors, and rituals of a particular culture (Cavaiola & Colford, 2006). Developing a culturally aware curriculum was important because otherwise Sri Lankan teacher-counselors and other mental health professionals might feel skeptical, misunderstood, and untrusting that the trainer and the curriculum would meet their needs (Castro, Pescholdbell, Abeita, & Rodriguez, 1999). Therefore, cultural factors, such as family, community, religious/spiritual beliefs, and practices, and relevant

historical events of Sri Lanka were carefully considered when developing the curriculum.

Gathering information about these cultural factors included reviewing the existing literature, doing online searches, receiving materials from the relief organization, and an informational interview with a local mental health professional who had previously lived in Sri Lanka. This process of information gathering resulted in a better understanding about a variety of cultural factors, including information such as: (a) Sri Lankans typically value family life and find meaning and identity in their roles as fathers, mothers, daughters, sons, etc. (Durvasula & Mylvaganam, 1994); (b) the major ethnic groups in Sri Lanka are Sinhalese (74%), Sri Lankan Tamils (12%), Indian Tamils (who view themselves as separate from Sri Lankan Tamils) (5.5%), Moors (7.1%), Malays (0.4%), Burghers and other people of mixed European and Sri Lankan heritage (0.4%), and a very small percentage of others (Fernando, 2004); (3) it is estimated that approximately 70% of Sri Lankans are Sinhalese Buddhist, approximately 12% are Tamil Hindu, approximately 8%–10% are Roman Catholic and Protestant Christians, and approximately 8% are Muslim (Fernando, 2005); and (d) in the 1980s, linguistic, ethnic, and religious antagonism between the Sinhalese and Sri Lankan Tamils resulted in a civil war, with a cease-fire in effect for several years (which has been broken on several occasions) (Fernando, 2004). The civil war years are associated with violent acts such as torture and death.

Information Gathering and Assessment

Four weeks after the tsunami, the disaster mental health volunteer who had been actively involved in developing the trauma training curriculum traveled with a logistician to Colombo, the capital city. Prior to providing the trauma training, the volunteer wanted to

assure that she had developed a degree of cultural competence as well as a good understanding of survivor's trauma effects so that she could effectively deliver the trauma training. Cultural competence, according to Castro et al. (1999), is "the capacity of a service provider or an organization to understand and work effectively with the cultural beliefs and practices of people from a given ethnic/racial group" (p. 504). Cultural competence and understanding of the survivor's trauma effects were achieved by attending meetings held by the Center for National Operations and consulting with a mental health organization in Colombo, which also organized the training sessions for local mental health professionals. In addition, it involved visiting a government organization, dealing with child-abuse issues, and meeting with officials. Gaining understanding also involved meeting with one of the psychiatrists who was instrumental in coordinating the teacher-counselor trauma training. Through these meetings, information previously gathered through literature reviews was confirmed, helping to clarify the importance of addressing issues such as suicidal ideations (Sri Lanka has one of the top 10 suicide rates in the world; World Health Organization [WHO], 1999), alcoholism (Sri Lanka has a longstanding history of alcoholism; WHO, 1999), and multitrauma events (the civil war, accompanying terrorism/torture, and the tsunami; De Silva, 2002). It further was confirmed that in Sri Lanka, mental health services for those with mental illness are generally limited ("39 psychiatrists for the country and a ratio of one psychiatrist per 500,000 Sri Lankans" with "25 working in the West province"; De Silva, 2002, p. 68) and stigmatized (families are generally the caregivers for those with mental illness; De Silva & De Silva, 2001)).

The volunteer went to several refugee camps in Galle, in the Southern portion of Sri Lanka, as well as to Batticaloa on the East Coast, to better

understand the effect of the tsunami on survivors. Therefore, after permission was obtained with the help of some translators, adult survivors at several of these camps were interviewed, and children were asked to participate in a drawing activity. The adult interviews were conducted in small group format and revealed that the complexity of the trauma event was far reaching and had an effect in the following matters: loss and grief issues (lives, property, community, and livelihood); displacement (refuge camps and repeated moves, lack of family and community support, and cramped living environments); multi-trauma events (interplay between the tsunami trauma effects and preexisting civil war terrorism/torture trauma); emotional, physical, and cognitive effects (symptoms of PTSD, substance abuse, somatic disturbances, trauma-related cognitive disturbances, mood disturbances, anger, and potential danger to self and others); and fear (of another tsunami will hit them). In addition, in many camps, survivors reported that they were affected by a lack of resources (e.g., water, food, shelter, clothing) for meeting even basic needs.

Based on existing literature (Gaensbauer & Siegel, 1995; Terr, 1988), it is believed that for children to demonstrate their memories and emotional reactions after a traumatic event, it is often helpful to use a communication vehicle that is not dependent on language, such as drawing, behavioral reenactments. Drawing was chosen as a tool for the children to communicate their experience of the tsunami. After the children had drawn their pictures, they were asked to walk to where the disaster mental health volunteer and translator sat, and to talk about their picture and then leave it with them. As the drawings were done in group settings, this process was used in order to avoid having children retraumatized by listening repeatedly to other children's traumatic experiences. This process was repeated with the second drawing;

however, the theme was a happy memory. The children were encouraged to keep the second drawing. Over 100 children in various refugee camps, ranging in age from 5 to 14 years, participated. The drawings of the tsunami consistently showed houses, people, trees, and often a bicycle and the family dog, covered by water. There were a few exceptions, such as soldiers shooting in the air to warn others, a boy rescuing his brother. Children's descriptions of their tsunami drawings focused overwhelmingly on the loss of family members, sometimes including their whole family, friends, neighbors, and belongings. Not one child cried during this process. The translators explained that this was appropriate and expected behavior and that crying would be unacceptable and should not be encouraged in front of peers. The second drawings overwhelmingly focused on birthday parties and other family/community celebrations. All but five children were eager to give the tsunami drawings to the translator, whereas all but seven children were eager to hold on to the happy time drawings.

The information gathering and assessment was used to again assess the curriculum previously developed, resulting in the curriculum being expanded in the areas of suicide, substance abuse, and child abuse. Additionally, more focus was put on trauma grief and loss in children and adolescents.

Trauma Training

The training of the mental health professionals occurred in Colombo, and participants were primarily mental health professionals, as well as one physician (who wanted to become a psychiatrist), two pastors, and one volunteer. All understood English and all except one spoke English, the training was done in English, using the revised curriculum. The training was conducted over several days and involved lecture,

discussion, and role-play. Several participants had been working with torture victims and were interested in learning more about multiple-trauma effects. The other topic of great interest was how to do suicide assessments, so a suicide assessment protocol was presented and was practiced through role-play. Throughout the training, participants were encouraged to ask questions and if information presented did not fit their culture, customs, rituals, values, and belief systems, to let the trainer know.

Participants were actively engaged throughout the training, sharing their own experiences of working with trauma survivors (torture) and asking many questions about the emotional, cognitive, and biological impact of trauma. The importance of understanding the culture and different religious practices in Sri Lanka became evident when talking about grief and loss issues. There also was great interest in learning about trauma assessment and treatment techniques.

An informal assessment of the trauma training occurred each day, led by the disaster mental health volunteer and the coordinator of the training. Participants reported to both that the training was valuable and that the format allowed for good discussions and exploration of a good balance of lecture, discussion, and practice.

Training was also offered on the East Coast in Batticaloa, and involved teacher-counselors and teacher-counselors in training. All participants spoke Tamil, and only a few understood and spoke English; so the training was conducted with a translator. It took place over several days and differed from the training in Colombo. Although participants seemed eager to learn and actively took notes, there was less discussion among participants and the trainer. Also, the area of most interest for these participants was the cognitive and biological effects of trauma just as in Colombo; however, there was less interest in the emotional effects of

trauma, suicidal ideations, substance abuse, and multitrauma events. There was more interest in learning therapeutic techniques and a desire to find out how to engage schoolchildren in these activities without singling out any of the children, as there was fear about the stigmatization of mental health care. Several techniques were practiced hands on by participants, and others were discussed and slightly adjusted. After the training was completed, the psychiatrist (who was instrumental in coordinating the training) asked participants to assess the training and provide feedback. The participants were very positive about the information provided, but stated that another relief organization had provided them with training about the emotional effects of trauma and taught them foundational terminology (e.g., trauma, crisis); however, they found the cognitive and biological effects very valuable and especially relevant to them as teacher-counselors. They also reported that the techniques were very helpful and requested to have opportunities to practice their skills and then ask questions and to get more advanced training in the future. There was discussion about the translator returning and getting together with the group in the near future. The disaster mental health volunteer was asked to return in several months to provide supervision of the teacher-counselors as they worked with the children in different camps and also to provide more advanced trauma training.

When comparing the trauma training in Colombo with that in Batticaloa, there was an obvious difference in the level of active engagement by participants, as well as regarding interest in specific topics. There are several hypotheses as to the reason for these differences. The need to use a translator might have created enough of a different atmosphere that it influenced the way participants engaged with the disaster mental health volunteer. In addition, several of the participants in Batticaloa

had been affected by the tsunami, both in the loss of property and community, as well as loved ones. After careful assessment of these participants, it was determined that they should be part of the trauma training, as they could benefit from it both professionally and personally. It was also determined that there was a cultural/religious difference between participants, according to the location of the training. Also, according to self-reports, no participants in Colombo had directly witnessed or were directly affected by the tsunami. In addition, unlike in Batticaloa, participants in Colombo self-reported a long history of working with trauma survivors (torture and childhood sexual abuse). Finally, a cease-fire in the civil war occurred the night prior to the training, and there was a funeral for a Tiger Tamil official, which resulted in the closing of the city (stores were closed, bus service was discontinued, and roads were blockaded by the military and there was more police and military presence throughout the city), and this may have impacted the training.

Summary

This case study is intended to serve as an example of how one disaster mental health volunteer was asked by a relief organization to develop and deliver a trauma training curriculum after the 2004 tsunami in Sri Lanka. The author has emphasized the importance of developing a curriculum that is not only comprehensive but also considers relevant historical events as well as culture and religiosity/spirituality, which should be taken into account whenever developing and delivering trauma training curriculum, as it will help diminish skepticism, mistrust, and misunderstanding by locals. As seen in this case study, reading up on relevant historical events, as well as cultural and religious values, beliefs, and practices, although

important, was not enough for designing a historically, culturally, and religiously/spiritually aware trauma curriculum. Although meeting with local organizations and a psychiatrist in Sri Lanka was valuable, most valuable were the meetings at the refugee camps with the adult survivors, as well as drawing and talking with child survivors about their pictures. The training was different in Colombo and Batticaloa, with the main difference being the level of active engagement by participants during the training, as well as interest in specific topics.

It is important to acknowledge that this case study should not be used as a model for developing and presenting a trauma training curriculum in another location. It was developed to be country specific and specifically designed to deal with the aftereffects of a catastrophic natural disaster. The curriculum would need to be adjusted for the country affected and the nature of the disaster or trauma (natural [e.g., tornado, earthquake, tsunami] or human made [e.g., war, terrorism]). In addition, it is important to consider whether the training is for mental health professionals with or without traumatology knowledge or non-mental health professionals. Equally important is to determine, preferably before the training starts, if participants have been directly affected, as this might change the content and delivery of the curriculum. Finally, the curriculum should be adapted according to what training has previously been provided and when the training occurred. An evaluation of the training should be conducted. In this case example, the participants identified the importance of the disaster mental health volunteer showing cultural proficiency, and most importantly, willingness to ask questions as well as adjust the curriculum to participants' needs and questions. In addition, it seemed very important to the participants that the volunteer had spent time in the refugee camps and gained firsthand understanding of the devastation and aftereffects of the tsunami.

Discussion

More research is needed in this area, not only through case studies but also with empirical research. This is especially important as more trauma-relief organizations are being asked to respond to international disasters, not only to provide crisis counseling directly but also to train locals and equip them with the necessary skills. Therefore it must be asked, what is appropriate trauma training? Who should deliver it? Should there be standard training protocols to be used by staff and volunteers of trauma-relief organizations. If so, who should be involved in developing these training protocols? Is standardization a way to avoid duplicating services by different organizations and, more importantly, assuring consistent quality? Does a standardized curriculum allow for flexibility in acknowledging and incorporating the different values, beliefs, and behaviors practiced in different countries? Should (disaster) mental health volunteers or staff of relief organizations have a certain amount of trauma training and clinical experience as well as cultural competence, or better yet, cultural proficiency, before providing the training? Much remains to be determined.

Appendix: Tsunami Crisis Response Curriculum

The goal is to link western notions of trauma counseling with Sri Lanka's cultural, religious and historical customs, values, and beliefs.

1. Curriculum overview—definition and types of trauma

A. Overview

- A brief overview of the content of the workshop will be provided. The goal is to provide information about:
 1. trauma

2. trauma responses and reactions
3. grief and loss
4. safety issues
5. 5 factors to remember
6. trauma assessment and interventions

B. Foundational terms and definitions

- Disaster (human made and natural)
- Trauma
- Traumatic event'

2. Trauma responses—emotional, physical, and cognitive

A. Emotional signs and symptoms

- Fear
- Inability to feel safe
- Sadness, grief, and depression
- Guilt
- Anger, irritability
- Numbness, lack of feelings
- Inability to enjoy anything
- Loss of trust and self-esteem
- Emotional distance from others
- Intense or extreme feelings
- Feeling chronically empty
- Blunted, then extreme feelings

B. Physical signs and symptoms

- Nervous energy
- Fatigue
- Jitters
- Weakness
- Dizziness
- Muscle tensions
- Fainting
- Chest pain
- Upset stomach
- Nausea
- Vomiting
- Thirst
- Rapid heart rate
- Elevated blood pressure
- Chills
- Lack of energy

- Teeth grinding
- Difficulty breathing
- Profuse sweating
- Visual difficulties
- Muscle tremors
- Grinding of teeth
- Shock symptoms

C. Cognitive signs and symptoms

- Changes in the way people think about (a) oneself, (b) the world, and (c) others
- Heightened awareness of surroundings (hypervigilance)
- Less aware of disconnectedness with self
- Difficulty concentrating
- Poor attention/memory problems
- Difficulty making decisions
- Intrusive images and dissociation
- Nightmares
- Night terrors
- Poor abstract thinking
- Blaming someone
- Intrusive images
- Suspicious
- Hypervigilance
- Uncertainty
- Confusion

3. Trauma reactions/a continuum of responses

- PTS
- Acute stress disorder
- Post-traumatic stress disorder (PTSD) (acute PTSD, chronic PTSD, and PTSD with delayed onset)

4. Death and traumatic death—bereavement over the life cycle

- The 3- to 5-year-old child is egocentric, which complicates the mourning process, because children that young believe that the world revolves around them.

- The child 6–12 years old is of school age. Children at this stage learn basic skills, but attach their cultural values to it.
- The adolescent 13–19 years old often deals with self-esteem and identity issues more than the school-age child. They want to differentiate (be oppositional to the parents), yet be the same as their peers.
- The adult 20–40 years old can be devastated by the death of a loved one (children, spouse, parents, extended family, and friends).
- The adult 40–60 years old, similar to the young adult, can be devastated by the death of a loved one.
- The elderly adult more than 60 years of age typically has acquired relationships, memories, cognition, material things, accomplishments, and spiritual realizations, but also losses.

5. Threat of suicide

A. Assessing client safety includes asking about:

- Living situation
- Personal history, level of function, and resiliency
- Immediate physical needs—food, shelter, and financial maintenance
- Environmental crisis
- Grief and loss issues
- Multiple-trauma background
- Interpersonal relationships and support/resources, self-destructive behavior such as substance abuse, and sexual acting out and suicidal ideation (and means of completing plans)
- Cultural and religious values and beliefs

- Things to do and not to do
 - Safety assessment, crisis counseling, and resources
6. Threat of child abuse
- A. Assessing the child's situation includes asking about:
- Living situation
 - Caregiving situation
 - Loss of one or both parents
 - Previous abuse history
 - Cultural and religious values and beliefs
 - How to contact the authorities and access counseling
7. Threat of substance abuse
- A. Assessing the person for present and past behaviors and asking about:
- Personal history of substance use or abuse
 - Present living situation
 - Environmental crises
 - Grief and loss issues
 - Multiple-trauma background
 - Self-destructive behavior
 - Interpersonal relationship and support/resources
 - Accessibility of substances
 - Cultural and religious values and beliefs
 - Resources to access
 - History gathering, assessment, and intervention strategies
8. Five factors to consider—personal, predisposing, peridisposing, postdisposing, and preventive factors
- A. Personal factors
- Age
 - Gender
 - Cultural values and beliefs
 - Spiritual beliefs and values
 - Physical well-being
 - Psychological well-being
- Relational history
 - Family
 - Living environment
 - Community
- B. Predisposing factors
- Personality disorders
 - Poor coping abilities and strategies
 - Difficulty learning from previous experiences
 - Low self-esteem
 - Unstable work history as well as lack of finances
 - Chemical dependency
 - Legal problems
 - Chronic mental health issues (e.g., obsessive compulsive disorders, anxiety disorders, paranoia, PTSD, depression)
 - Past and/or present legal problems
 - Impulsivity
 - All or nothing thinking
- C. Peridisposing factors
- Proximity to and duration of exposure to the traumatic event
 - Perceived threat to safety of self and others, including possible injury or loss of life
 - Extreme fear, helplessness, and horror
 - Dissociation and subjective tsunami interpretation
- D. Postdisposing factors
- involves but not limited to the level of:
- Family support
 - Friends' support
 - Other support received
 - Early available and accessible resources
 - Educational material, such as information about normal reactions after a natural disaster

E. Preventive factors

- Resiliency factors
- Stress Buffers

9. Family and community responses

- Parent responses
- Child responses
- Community support/resources (past and present)

10. Trauma assessment and intervention

Assessment

- Assessment interview
- A quick trauma checklist
- Sentence completion
- Parent and teacher feedback

B. Intervention

- 1:1 crisis counseling
- Drawing exercises
- Writing exercises and journaling
- Stories and metaphors
- Rituals
- Family exercises

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