

# Distress, wellbeing and war: qualitative analyses of civilian interviews from north eastern Sri Lanka

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*This paper outlines a methodology for the development of culturally sensitive measures of war problems (including psychological and behavioural problems) and wellbeing for use among refugees affected by the recently concluded civil war in Sri Lanka. These measures were derived from qualitative data collected from individuals living in areas affected by the civil war. The authors utilised a qualitative data analysis methodology, involving both open coding and thematic analysis. Examples of frequently coded nodes and questionnaire items that were developed from them are presented, and next steps (validation of the measures) are discussed.*

**Keywords:** cultural psychiatry, culture, positive psychology, qualitative analysis, scale development, Sri Lanka, trauma, war, wellbeing

## **Introduction**

The war trauma suffered by communities in north eastern Sri Lanka is considerable. In 2006, more than 2500 individuals were killed in the conflict and 200,000 individuals were made to flee their homes due to violence between the Sri Lankan government and the Liberation Tigers of Tamil Eelam (LTTE) (International Crisis Group, 2006). The psychosocial needs of these communities are great; the longstanding effects

of the civil war have resulted in significant adverse changes at the individual, family and the societal levels (Somasundaram, 2007). Thus, developing suitable psychosocial interventions that alleviate the suffering of war affected Sri Lankans is a necessary, if complex, task that involves the consideration of both the individual and the community (Galappatti, 2003). The development of culturally sensitive assessment tools and identification of variables that both encourage and impede wellbeing (in part through our work) will enable policy makers and representatives of nongovernmental organisations (NGOs) to develop psychosocial interventions that better address the needs of the communities.

The first step in the development of any potentially effective intervention should be the development of culturally and psychometrically valid measurement instruments for the purpose of assessing the nature and extent of distress of the community in question. Psychosocial caregivers in Sri Lanka should be able to use this work to tailor interventions that specifically address the community's problems, build on its strengths and compensate for its weaknesses. One implication of this would be that psychosocial interventions to assist individuals could target a particular dimension identified by these measures.

*Cultural psychiatry and the assessment of psychiatric disorders*

Over the last 30 years the field of clinical psychology has identified and systematically studied posttraumatic stress syndrome (PTSD), a posttraumatic syndrome with a specific set of diagnostic criteria that is distinct from other types of psychopathology. The disorder is characterised by the presence of three symptom clusters following an event that is experienced as traumatic: re-experiencing; avoidance; and hyperarousal symptoms. Research thus far demonstrates that PTSD is associated with a variety of problems including physical health problems and alcohol/substance abuse (Keane, Marshall, & Taft, 2006). However, much of the research validating PTSD as a diagnostic category has been carried out in Western, industrialised, developed countries. Thus, how PTSD varies across cultures is currently only vaguely understood. Since cultural differences are tied to variations in the social construction of reality – which is in turn influenced by cultural differences in cognition and the experience and expression of emotion – the perception of what is traumatic experience, as well as the individual and social responses, can conceivably vary greatly (Friedman & Marsella, 1996; von Peter, 2008). A recent meta-analysis of 181 epidemiological studies, including studies in developing countries, reported an unadjusted, weighted prevalence rate of 30,6% for PTSD and 30,8% for depression. However, many methodological problems remain (Steel, Chey, Silove, Marnane, Bryant & vanOmmeren, 2009). In addition, the fact the symptoms associated with the disorder can be identified in every setting does not necessarily mean that PTSD is similar in all settings. It could be that those symptoms are not indicative of distress. Expressions of psychological distress are determined

largely by culture (Kleinman, 1986). What are identified as symptoms of illness, and therefore indicators of distress, in one cultural context may not be applicable in another context. According to Kleinman (1981), to assume otherwise would be to commit the *categorical fallacy*, where *'the reification of a nosological category developed for a particular group. . . is then applied to members of another culture for whom it lacks coherence, and its validity has not been established'* (Kleinman, 1987). It is clear that identifying these local *'idioms of distress'* is necessary if one is to construct valid instruments for the assessment of posttrauma psychological distress, so as to identify those who may need interventions (Keane, Kaloupek, & Weathers, 1996; de Jong, 2002). The study of local idioms of illness (and well-being) in specific communities is an important endeavour, since expressions of illness, or wellbeing, stem from a specific value or belief orientation (Lopez & Guarnaccia, 2000). Understanding the acceptable means of communicating distress and wellbeing in a particular community is essential to develop a culturally competent model of mental health (Osterman & de Jong, 2007). Such a study must use qualitative, epidemiological and (in the case of psychological distress) clinical research methods, to understand how the social world interacts with the individual's physical and psychological processes. In the last decade, researchers have begun to utilise this cultural psychiatry approach to identify local idioms of psychological distress with a view towards to developing assessment of psychopathology and suitable interventions (Miller, Kulkarni, & Kushner, 2006; de Jong, Komproe, VanOmmeren, El Masri, Araya, Khaled, van de Put & Somasundaram, 2001). Consistent with this research model, the authors used qualitative data as the basis of our instruments.

*Positive psychology and the mental health of displaced populations*

During the past decade, the emerging field of positive psychology (Seligman & Csikszentmihalyi, 2000) has supported and stimulated research aimed at redressing the imbalance between psychopathology and disease, relative to human strengths and wellbeing (Linley et al., 2006). This has furthered the field's goal of creating 'a psychology of positive human functioning... that achieves a scientific understanding and effective interventions to build thriving individuals, families and communities' (Seligman, 2002).

The domination of the 'medical model' has emphasised the diagnosis of psychiatric disorders over the fact that refugees are normal individuals with strengths and resources that have been caught in abnormal situations. In refugee mental health research this has led to at least two serious limitations in our understanding of their wellbeing. For one, some researchers have argued that this research paradigm obscures the fact that most refugees do not show evidence of a diagnosable psychiatric disorder, and even those that do, nevertheless function effectively (Summerfield, 2005; Miller et al., 2006). There is little insight on how most refugees continue to function adaptively in the wake of extreme situations, and which resources and strengths facilitate such functioning. This is mainly due to the focus on concepts of loss, separation, stress and trauma, all of which emphasise what is lacking for refugees to experience wellbeing. This limitation contributes in no small way to the second issue: most disorder focused interventions designed to alleviate psychological distress and promote psychological wellbeing ignore the many wellsprings of wellbeing that refugees may rely on to maintain an adequate level of psychological functioning. Far from being irrelevant,

therefore, it would seem that positive psychology has the potential to make a serious and important contribution to the research on displaced populations. As Ryff and Singer (2002) have pointed out, positive human functioning is most remarkable when seen in contexts of significant life challenge and adversity (Stein, Seedat, Iverson & Wessely, 2007). The capacity to both prevail in the face of challenge and to experience personal growth as a result of such challenges has received increased attention following the advent of positive psychology (Bonnano, 2004).

With regard to wellbeing, a consistent finding in the literature is that the characteristics and resources valued by societies also correlate with happiness (Lyubomirsky, King, & Diener, 2005). This means that conceptions of wellness can vary by culture, as culture is potentially a major force constructing individuals' understanding of happiness and consequently their subjective experience of it (Lu & Gilmour, 2004). Understanding how these individuals conceptualise happiness and wellbeing, and which resources they associate with wellbeing, could have very important consequences for understanding the coping mechanisms individuals use in times of war and conflict. Resources such as self-esteem, optimism, personal control and a sense of meaning have all been shown to act as a buffer against stressful life events (Taylor, Kemeny, Reed, Bower & Gruenewald, 2000). Additionally, while people can adapt relatively well to isolated incidents of trauma, adapting to a long term situation involving significant resource loss (Hobfoll, Johnson, Ennis & Jackson, 2003) may be much harder. However, the same factors that serve to bolster these individuals' wellbeing (material goods, social relationships or personal resources) may also serve a protective role in preserving their subjective

quality of life in the face of adverse life conditions. Identifying the resources and strengths at work in uplifting these individuals' wellbeing and resiliency would enhance the ability of psychosocial caregivers to create effective interventions. In this context, the development of a culture-sensitive wellbeing measure that identifies and measures these resources is an important project (Fernando, 2008).

## Methods

The authors used qualitative data collected through the Social Policy Analysis and Research Centre (SPARC) at the University of Colombo, Sri Lanka, in collaboration with the Asia Foundation under the 'Reducing the Effects and Incidence of Torture' (RESIST Programme) as the basis of our instruments. The RESIST Programme, under the guidance of Dr. Jon Hubbard, Research Director for the Center for Victims of

Torture (Minneapolis, MN), gathered this qualitative data on local concepts of wellbeing, coping mechanisms and war related distress by having trained interviewers go up individuals on the street and ask if they had time to answer a few questions. These data were collected in areas affected by war in northern and eastern Sri Lanka in 2006.

*The interviews* The qualitative dataset consists of 604 copies of the *Adult War Problems Interview (AWPI)* and 622 copies of the *Adult Competencies Interview (ACI)* (both are semi-structured interviews developed by RESIST), collected from individuals living in the war affected north and east Sri Lanka, during 2006. Tamil language data was collected from five districts,<sup>1</sup> and both genders were equally represented in the sample. Many of the participants were between the age of 21 and 45 (see table below).<sup>2</sup>

### *Breakdown by district*

	Batticaloa	Jaffna	Mannar	Trincomalee	Vavuniya
AWPI	20	263	109	7	205
ACI	12	179	143	14	274

### *Breakdown by gender*

	Male	Female	N/A
AWPI	370	209	25
ACI	317	292	13

### *Breakdown by age*

	21–30	31–45	46–60	61–75	76–99	N/A
AWPI	232	244	85	19	0	24
ACI	267	224	96	23	2	10

In the *Adult War Problems* semi-structured interview, interviewers asked participants 18 years or older to think of two people (one male and one female) they knew who have had problems due to the war, and to list their top four problems. The interviewer wrote down their answers, which consisted of a single phrase for each problem. They were also asked to identify the main problem for each of these same individuals. They were next asked why they thought some people were negatively affected by the war, whereas

others were not. The interviewers wrote down up to four responses to this question; each response consisted of a sentence or two. Lastly, participants were asked what could be done to help those who are suffering. Again, the interviewers wrote down up to four responses, with each response consisting of a sentence or two. As each questionnaire had information on two individuals (one male and one female), we had AWPI data from 604 men and women (1208 responses in total).

Adult War Problems Interview

**ADULT INTERVIEW**

**Date:** \_\_\_\_\_

**Interviewer:** \_\_\_\_\_

**Community:** \_\_\_\_\_

**Ethnicity:** \_\_\_\_\_

**Age of person you are interviewing:** \_\_\_\_\_

**Sex of person you are interviewing:** Male \_\_\_\_ / Female \_\_\_\_

**I. Beginning Question:**

‘People are exposed to many terrible things during a war. Some people are changed or have serious problems because of their war experiences. It would be very helpful for us to know the kinds of problems people are having. Think of an adult that you know who has been changed or is having problems because of the war, but don’t tell me who it is. It does not have to be the adult who has been the most seriously affected but a person who has problems because of their war experiences. Then I’m going to ask you a few questions about this person’

‘Are you thinking of a woman or a man?’      **Circle one:**      Woman      Man

‘How old is this person?’      **Enter age:**      \_\_\_\_\_

‘What kind of problems is this person having because of their war experiences?’ (4 responses)

‘Of all these, which do you think is most important?’      **Enter Number:**      \_\_\_\_\_

**II. Second Person:**

‘Now I’d like you to think of one more adult that has been changed or has problems because of their war experiences, and again don’t tell me who it is. This time think of a man/woman (ask the opposite sex from their first example.) Then I’m going to ask you a few questions about this person.’

Second person's sex:      **Circle one:**      Woman      Man

'How old is this person?'      **Enter age:**      \_\_\_\_\_

'What kind of problems is this person having because of their war experiences?' (4 responses)

'Of all these, which do you think is most important?'      **Enter Number:**      \_\_\_\_\_

**III.      Reasons for Problems:**

'Why do you think some people still have problems from the war while others don't?' (4 responses)

'Of all these, which do you think is more important?'      **Enter Number:**      \_\_\_\_\_

**IV.      Ways of Promoting Healing:**

'I now have one last question on this topic. What can be done to help people recover from their war related problems' (4 responses)

'Of all these, which do you think is more important?'      **Enter Number:**      \_\_\_\_\_

**Thank you for your help!**

In the ACI semi-structured interview, participants aged 18 years or older were asked to think of two people they knew who are doing well, and to list the top four attributes of doing well in life. These data consisted of a single phrase for each attribute. They were also asked to identify the main attribute for each of the same individuals. They were next asked why they

thought some people were doing well, whereas others were not, and why that may be the case. The interviewers wrote down up to four responses to this question, with each response consisting of a sentence or two. As each interview had data from one male and one female, interview data from 622 men and women (1244 in total) was collected.

Adult Competencies Interview

**ADULT INTERVIEW**

**Date:** \_\_\_\_\_

**Interviewer:** \_\_\_\_\_

**Community:** \_\_\_\_\_

**Ethnicity:** \_\_\_\_\_

**Age of person you are interviewing:** \_\_\_\_\_

**Sex of the person you are interviewing:**      **Woman**      **Man**      (circle one)

**V. Beginning Question:**

'It would be very helpful for us to know how you can tell a person's life is going well. Think of an adult that you know is doing well, but don't tell me who it is. The person doesn't have to be the best person you know, but someone that is doing satisfactorily. Then I'm going to ask you a few questions about this person'

'Are you thinking of a woman or a man?' **Circle one:** Woman Man

'How old is this person?' **Enter age:** \_\_\_\_\_

'In what ways is this person doing well?' (4 responses)

'Of all these, which do you think is most important?' **Enter Number:** \_\_\_\_\_

**VI. Second Person:**

'Now I'd like you to think of one more adult that is doing well, and again don't tell me who it is. This time think of a man/woman (ask the opposite sex from their first example.) Then I'm going to ask you a few questions about this person.'

Second person's sex: **Circle one:** Woman Man

'How old is this person?' **Enter age:** \_\_\_\_\_

'In what ways is this person doing well?' (4 responses)

'Of all these, which do you think is most important?' **Enter Number:** \_\_\_\_\_

**VII. Reasons for Competence:**

'I now have one last question on this topic. Why do you think some people do well in life while others don't?' (4 responses)

'Of all these, which do you think is more important?' **Enter Number:** \_\_\_\_\_

*Interviewing procedure* Sixty staff members of the Family Rehabilitation Centre (FRC) and Shanthiham, both non profit organisations that provide psychosocial services, conducted the interviews. Two workshops conducted in Vavuniya and Colombo in June 2006 were organised to train interviewers in administering the AWPI and ACI. Dr. Jon Hubbard supervised these sessions. Detailed instructions regarding the interviewing process were provided, including a discussion of ethical considerations of interviewing, understanding and adjusting to local norms, techniques for recording interviews and for handling sensitive information. The importance of getting specific, detailed answers to questions posed,

and the necessity of verbatim recording was stressed. Training emphasised building rapport, promoting a sense of confidentiality, and active listening techniques. It was also stressed that interviewing should be done in a way that all adult age categories, different communities, and both sexes were represented (The Asia Foundation, 2006). It should also be noted that the workshops were designed as a two-way information sharing process, and all the participants interacted with each other. Participants were paired and practiced interviewing, with one person playing the role of interviewer, the other playing the role of the interviewee. After one round, the roles were reversed. Following each practice session, participants

discussed ways to improve the quality of the interviews. After three practice sessions on the ACI and AWPI, a pair of interviewers performed the interviewing process in front of other participants for critique. Strategies for improving the interviews were analysed, and factors such as facial expressions, showing empathy, noncommittal approach to the responses, and time management during interviewing were considered. All participants were asked for consent before each interview (The Asia Foundation, 2006)<sup>3</sup>.

*Data analysis* These data were coded utilising the NVivo coding software (QSR International, 2006), and involved the analysis of two separate translations (Tamil and English) of the AWPI and ACI data. The first step was to utilise the open coding method (Strauss, 1987; Berg, 2006) with a view towards systematically identifying and possibly extracting the main themes/topics/issues. To this end, the authors counted words, themes, items, concepts and semantics. Strauss (1987) has outlined four basic guidelines for conducting open coding, which the authors followed:

- 1) Ask the data a specific and consistent set of questions
- 2) Analyse the data minutely
- 3) Frequently interrupt the coding to write a theoretical note
- 4) Never assume the analytic relevance of any traditional variable such as age, sex, social class, and so on, until the data have shown it to be relevant

Following Berg (2006) in open coding, the authors carefully and minutely examined the data line-by-line and word-by-word to determine tentative concepts and categories that fit. These concepts and categories were based on common themes and experiences related to psychological distress and well-

being. These were drawn solely from the database, with minimum influence of prior conceptions of trauma and wellbeing (Guarnaccia, Rivera, Franco & Neighbors, 1996, for a similar method).

Following this, the authors engaged in *thematic analysis* (also known as *axial coding*) of the data. Thematic analysis is a dynamic process where a master scheme is developed to organise the data under major themes and subthemes. This analysis involves the interaction of two processes: specification of the content characteristics (basic content elements) being examined and application of explicit rules for identifying and recording these characteristics. When coding the ACI data, the number of entries in each category was counted to allow for the demonstration of magnitude. This is important, because it would allow the possibility of examining the number of items in each category, which in turn would help to identify which concepts and categories were most salient in the data. The AWPI data was not coded using this methodology as the authors wanted to include all psychological and behavioural problems irrespective of their base rates in the general population.

To get a sense of the type of data used, some examples from the two interviews are below:

*Results: Penn/RESIST/Peradeniya (PRP) War Problems Questionnaire*

Open coding of the AWPI data revealed three preliminary groups of concepts: traumatic events, war-related general problems, and war related psychological and behavioural problems.

Thematic analysis of the qualitative data pointed towards the existence of the same three distinct clusters, but also with distinct subclusters:

### **Examples from the AWPI**

*Question asked: What kind of problems is this person having because of their war experiences—four responses for one man and one woman they knew*

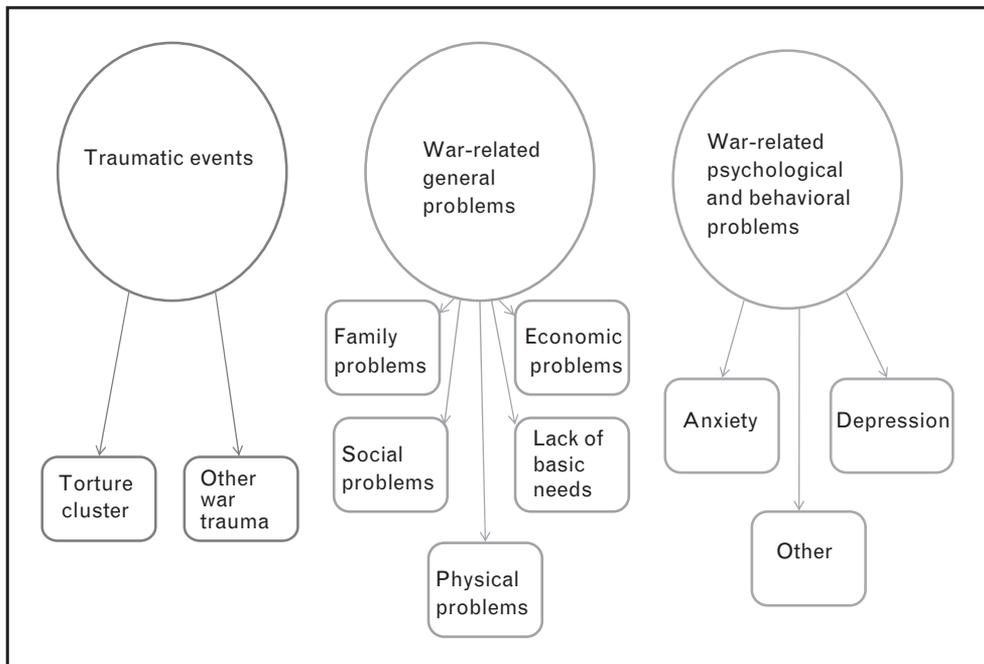
Batticaloa	<p><i>Man:</i> Lost leg due to land mine, so unmarried; loss of father, so worries; unable to travel</p> <p><i>Woman:</i> Unable to walk because back bone is damaged, so need others help for all activities; unable to do any job; unable to travel desirable places</p>
Jaffna	<p><i>Man:</i> Cheated; displaced from own village; no money; question about children's future</p> <p><i>Woman:</i> Lack of income from husband; lack of educational facilities for children; repression of children; frustration</p>
Mannar	<p><i>Man:</i> Refugee life; no interest to find job, because getting help from nongovernmental organisation; unable to go to particular places; unauthorised relationship</p> <p><i>Woman:</i> No employment opportunities; lack of security; loss of relatives; affected state of mind</p>
Trincomalee	<p><i>Man:</i> Loss of eyes; dependant on his wife; fear; unable to see anything in world</p> <p><i>Woman:</i> Broken leg through army torture, so unable to walk; cannot escape natural disaster like tsunami</p>
Vavuniya	<p><i>Man:</i> Lost of agricultural lands; poor economic condition; doesn't have courage to live alone; fear of others</p> <p><i>Woman:</i> Lives alone; difficulties interacting with others; blocks in self effort; lack of economic facilities</p>

### **Examples from the ACI**

*Question asked: In what ways is this person doing well—four responses for one man and one woman they knew*

Batticaloa	<p><i>Man:</i> Can fulfil daily requirements because he is moderately rich man; he interacts with others good in good manner in any problem; good family background, parents are good; he believes in God and prays regularly</p> <p><i>Woman:</i> Head of family, fulfils husbands' role, children's requirements; she maintains good relationship with relatives and others; she doesn't care other's mistakes; believes in God, and prays with family regularly</p>
Jaffna	<p><i>Man:</i> Financial status; children are living at London; happiness in life; doing actively</p>

	<p><i>Woman:</i> Be in home as a queen; workers for home work; has lots of properties; kind in family</p>
Mannar <sup>4</sup>	<p><i>Man:</i> Educational knowledge; working in an organisation; earning for society welfare; familiar with all people</p> <p><i>Woman:</i> Care to society improvement; working in an organisation; not involving any problems</p>
Trincomalee	<p><i>Man:</i> Industrious person (help to poor people); active with skills; social service (rehabilitation work for affected person); kindly behaved to others</p> <p><i>Woman:</i> Knowledgable (BA graduate in Sri Lanka University); brilliant (graduate teacher, has own land, other needed properties); hard worker (teacher, educating children well and earned lots of money); good speaking skills (help to improve life)</p>
Vavuniya <sup>5</sup>	<p><i>Man:</i> Kindly behaved with family and society; trust in job; unity, kind, respect, support of family; understanding others mind and work for it (help to others)</p> <p><i>Woman:</i> Ability to finish anything if thought living according to society; has style for him (dresses well for men); well behaved with society as a woman</p>



Examples of items from each of the clusters/subclusters are listed below.

*Traumatic events:*

- *Torture cluster (nine items):* Electrocutation in detention; rape
- *Other War Trauma (13 items):* Being caught in a landmine; injured in air bombing/bomb blast/raid/attack

*War related general problems:*

- *Family problems (20 items):* Maltreatment by children; disruption of marriage plans
- *Economic problems (10 items):* Loss of land/home; Lack of employment opportunities
- *Social Problems (26 items):* Lack of documents; Being shunned by society due to time spent in prison
- *Lack of Basic Needs (9 items):* Lack of food; Sanitation problems
- *Physical Problems (19 items):* Shrapnel in body; Back problems

*War related psychological and behavioural problems:*

- *Anxiety (20 items):* High inner fear/*fearsituation in mind?*; avoiding going outside the house due to fear

- *Depression (22 items):* Unsteady mind due to loss of my loved ones; disappointed in life
- *Other symptoms (16 items):* Use of alcohol to forget painful memories; feeling unable to pass even one day

With regards to psychological and behavioural problems, prototypical symptoms of anxiety and depression were identified (e.g., feelings of guilt, problems concentrating, being easily scared) as well as a number of idioms of distress (e.g., *'heart pain,' 'broken mind,' 'extreme fear,'* and *'being in a panic situation'*).

*Results: PRP Competencies Scale*

With regards to the ACI data, initial coding revealed three preliminary groups of concepts: *Relationship with family and community, religious and social involvement, and personal growth.* While a range of concepts were noted in the data, examples of more frequently cited attributes of doing well were *'having good/well motivation'* (having positive thoughts to fulfil goals), *'being of good morality,' 'showing benevolence to others,' 'having unity of family,'* and *'being a good member of the community'*. As an illustrative example, the following represents the most salient concepts or nodes present in the data from three districts severely affected by the war, Mannar, Jaffna, and Vavuniya:

Most coded nodes		
Mannar	Jaffna	Vavuniya
Education: 48	Religion: 89	Religion: 52
Religion: 43	Has employment: 70	Family support: 44
Helps others: 43	Educated: 58	Property: 27
Faces challenges: 33	Family unity: 48	Luxury items: 10
Has employment: 26	Family support: 46	Tolerability: 9
Sufficient economy: 22	Faces challenges: 38	Relative abroad: 9
Motivated: 22	Kind to others: 44	

Most coded nodes		
Mannar	Jaffna	Vavuniya
Ability to accept anything: 21	Faces challenges: 38	
Good character: 21	Ability to accept anything: 37	
Social service: 18	Good habits: 34	
Family support: 14	Property: 33	
Family unity: 19	Educating children: 30	
Family responsibilities: 10	Care of children: 20	

In coding these data, exhaustive lists of nodes for each province were drawn up and compared with each other. Further thematic analysis of the qualitative data pointed towards the existence of five distinct and more narrow clusters: *thinking the right thoughts, family responsibilities, religion, fulfilling family needs, and achievement/education*. These clusters accounted for most of the nodes coded and provided a more specific categorisation of the data than the three broad clusters outlined earlier in the analysis:

here is the salience of concepts such as education, religious practices and beliefs, and pro social behaviour. It seems that individuals may invoke achievement (education) and relating to others (pro social behaviour) as defining features of wellbeing, and that religious beliefs may both serve as a marker of wellness and a robust coping mechanism. Furthermore, thinking the right thoughts may be an indicator of resilience. Analysing the data using these coding procedures provided a culture-specific view of

**Categorisation of some frequently occurring nodes into clusters**

Thinking the right thoughts	Family responsibilities	Religion	Fulfilling family needs	Achievement/education	No clear category
Responsibility	Children’s needs	Having a religious personality	Adequate income	Status	Children abroad
Having ‘good well-motivation’	Taking care of family	Fulfilling religious obligations	Saving	Education for children	
Self-confidence	Marriage for children	Involved in social service	Having assets	Good family background	

Given that one goal of this analysis was to construct a culturally specific model of psychological wellbeing, what is of interest

psychological wellbeing among war affected Sri Lankans. The PRP Competencies Scale incorporates many of the idiomatic

expressions of this view. Each cluster was represented with items such as the following:

- *Right thoughts*: I am well motivated to accomplish my daily life tasks
- *Needs*: I can successfully fulfil my family's needs
- *Family*: There is a strong sense of harmony in my family
- *Religion*: I fulfil my religious responsibilities; I have strong religious faith
- *Education*: I place a great emphasis on education
- *Pro social attitudes*: I have the respect of my community

With regards to the specific lessons that the qualitative data offer, many of the factors associated with wellbeing point towards the importance of communal activities, including religious practices, family and social obligations, as important idioms of wellbeing. This agrees with previous assessments that highlight the importance of the community in fostering mental health (Somasundaram, 2007; Galappati, 2003). While the question of whether such resources are in fact indicative of improved wellbeing and functioning are empirical questions that the authors intend to test. The qualitative data points tentatively towards the importance of group and societal level interventions that improve the quality of social life, as well as develop individual interventions that help foster improved social interactions.

## **Discussion**

The data collected through the RESIST Programme offered a valuable opportunity for the development of instruments to assess the mental health of war affected populations in Sri Lanka. The qualitative methodology utilised in this project was both

efficient and relatively inexpensive. Given the somewhat volatile nature of many parts of the north east during the time of data collection, a more in-depth ethnographic approach may have not been feasible. Nevertheless, the authors acknowledge the value of methodologies that incorporate interviews testing deeper questions regarding cultural descriptions. The *Key Informant* approach (Betancourt, Speelman, Onyango & Bolton, 2009) is one such method that could have successfully complemented the methodology used.

It should also be noted that these data were collected through the FRC and Shanthiham, which provide psychosocial programming to many regions where the data collection took place. Therefore, it is possible that participants were biased by the fact that they were being asked questions about trauma, distress and wellbeing by representatives of a local non profit organisation, as they have an incentive to report more negative symptoms than they may actually have (Hoening, 2004). While this should be acknowledged as a possibility, it should also be noted that the interviewers sampled from a wide range of inhabitants in the villages that were assessed, and also received training on appropriate conduct while interviewing participants.

The development of a single psychological distress and wellbeing measure for the whole of the northern and eastern provinces from these data raises the question of whether it is possible to speak of a single Tamil culture in these areas. While the authors believe that many of the nodes used to develop items for the measures represent typical responses from participants across the two provinces (especially given that much of the data were collected from the two northern districts of Jaffna and Vavuniya) we remain open to the

possibility that different resources and psychological symptoms may be more prevalent in different regions of the north east. Utilising cluster analysis on the questionnaire data in the next stage of this project may shed further light on this question.<sup>6</sup>

On a similar note, the authors also acknowledge that the convenience sample approach utilised for data collection did not assess variations of responses based on factors such as socioeconomic class and religion. It may well be that interesting and important variations in 'cultural beliefs' would have become apparent were more attention paid to such distinctions. That said, the high number of responses from the Jaffna and Vavuniya districts suggests that much of the data were collected from Hindu Tamil participants.

In addition, given the relatively young age of the participants, it may be that the data collected may not provide the type of cultural knowledge that an older population could provide (Rozin, 2003). While the data that form the basis of the two measures are the result of a 'broad' understanding of culture, using an older demographic could have provided more insight into the cultural practices of the communities assessed. It should be noted, however, that questions on age, income, ethnicity and religion have been included in the next series of studies (detailed below) with a view towards capturing these more nuanced 'cultural' variations in our follow-up studies.<sup>7</sup>

In some respects, this project mirrors the work of Fernando (2008), who has developed a culturally sensitive psychological distress scale for Sinhalese populations affected by the tsunami of December 2004 (Miller & Fernando, 2008). Her work is important and has contributed significantly to current understandings of the needs of tsunami affected populations. That said, as Bolton & Tang (2002) have pointed out, it is

important to have a grounded understanding of the idioms of distress and well-being among specific populations, and it is quite likely that the idioms identified in the AWPI and the ACI differ from data collected among the Sinhala population in the south of the country.

The next step is to pilot test the preliminary questionnaires with a small population of war affected Sri Lankans. This will be done with a view towards subjecting the items in these questions to an exploratory factor analysis, in order to study the latent variables underlying the scale, and to evaluate the psychometric properties (e.g., reliability) of the instrument.

With regards to the *PRP War Problems Questionnaire*, there are plans to administer this new measure, along with the *World Health Organization Disability Assessment Schedule II* (WHODAS; Janca, Kastrup, Katschnig, Lopez-Ibor Jr., Mezzich & Sartorius, 1996), a physical functioning scale based on World Health Organization (WHO) criteria. This scale includes self-reports of socioeconomic activity, levels of physical energy, and perceived health status, so it can be determined whether the new measure sensitively predict scores on these outcome scales. Furthermore, the *Posttraumatic Stress Symptom Scale- Self-Report* (PSS-SR; Foa, Cashman, Jaycox & Perry, 1997), a measure of PTSD symptoms, will be administered so the degree of overlap between PTSD symptoms and the more indigenous symptoms measured by the newly developed *Penn/RESIST/Peradeniya War Problems Questionnaire* can be measured. Similarly, two depression measures—the *Beck Depression Inventory* (BDI; Beck, Ward, Mendelson & Erbaugh, 1961) and the *Centre for Epidemiological Studies – Depression* (CES-D; Radloff, 1977) scale will both be administered so as to examine the degree of overlap between depressive symptoms, as measured

by these two standard measurements, and those measured by the war problems questionnaire.

With regards to the *PRP Competencies Scale*, there are plans to pair the instrument with measures of wellbeing, including the *Life Satisfaction Scale* (LSS), a widely used and psychometrically sound measure of life satisfaction (Diener, Emmons, Larsen & Griffin, 1985), and the *Subjective Happiness Scale* (SHS; Lyubormirsky et al., 2005) so that the degree of overlap between life satisfaction and happiness, as measured by the LSS and SHS, and the potentially more indigenous markers of 'wellness' measured by the wellbeing questionnaire can be examined. Two measures of resilience and posttraumatic growth: a shortened version of the *Posttraumatic Growth Inventory* (PTGI; Tedeschi & Calhoun, 1996), and the *Changes in Outlook Questionnaire* (CiOQ; Joseph, Williams, & Yule, 1993), which measures successful adaptation to adverse life events will also be included.<sup>8</sup>

In order to ensure the systematic translation into Tamil of these measures, the translators used a *translation monitoring form* to record the translation, lexical back translation and evaluation of *each item* of these measures. This method enables translators to systematically identify irrelevant, incomprehensible, unacceptable and incomplete translation (van Ommeren Sharma, Thapa, Makaju, Prasain, Bhattarai & de Jong, 1999). The authors supervised the translation process and these sessions were invaluable in identifying limitations in the design and presentation of the measures, as well as ambiguities in the translations (Jayawickreme, Jayawickreme, Goonasekera & Foa, in prep).

## **Conclusion**

To summarise, this research programme attempts to combine insights from clinical

psychology and positive psychology to achieve a more precise understanding of the predictors of wellbeing among refugee populations in Sri Lanka. The project to create a locally valid measurement of psychological distress and wellbeing for use in Sri Lanka populations affected by war contributes to the conflict management tools available to psychosocial agencies in Sri Lanka and increases their conflict management capacity. The authors hope that populations directly suffering from the effects of the civil war will benefit from this project in the long term. As stated earlier, the authors believe that the results of our project will offer important and valuable insight into how specific communities who have, and continue to endure, adverse experiences conceptualise and express psychological distress and wellbeing. The findings will then be able to inform psychosocial interventions in these communities.

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## References

- Beck, A. T., Ward, C. H., Mendelson, M., & Erbaugh, J. (1961). An Inventory for Measuring Depression. *Archives of General Psychiatry, 4*, 561-571.
- Berg, B.L. (2006). *Qualitative research methods for the social sciences*. New York: Allyn & Bacon.
- Betancourt, T. S., Speelman, L., Onyango, G., & Bolton, P. (2009). A qualitative study of mental health problems among children displaced by war in northern Uganda. *Transcultural Psychiatry, 46*(2), 238-256.
- Bolton, P. & Tang, A. M. (2002). An alternative approach to cross-cultural function assessment. *Social Psychiatry and Psychiatric Epidemiology, 37*, 537-543.
- Bonnano, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely adverse events? *American Psychologist, 59*, 20-28.
- de Jong, J. T. V. M. (2002). Public mental health, traumatic stress and human rights violations in low-income countries. In J. T. V. M. de Jong (Ed.), *Trauma, war, and violence: Public mental health in socio-cultural context* (pp. 1-91). New York: Kluwer Academic/Plenum.
- de Jong, Komproe, I. H., Van Ommeren, M., El Masri, M., Araya, M., Khaled, N., van de Put, W., & Somasundaram, D. (2001). Lifetime events and posttraumatic stress disorder in 4 postconflict settings. *Journal of the American Medical Association, 286*, 555-562.
- Diener, E. Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment, 49*, 71-75.
- Fernando, G. (2008). Assessing Mental Health and Psychosocial Status in Communities Exposed to Traumatic Events: Sri Lanka as an Example. *American Journal of Orthopsychiatry, 78*(2), 229-239.
- Foa, E. B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment, 9*, 445-451.
- Friedman, M. J. & Marsella, A. J. (1996). Posttraumatic stress disorder: An overview of the concept. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (1996). *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 11-32). Washington, DC: American Psychological Association.
- Galappatti, A. (2003). What is a psychosocial intervention? Mapping the field in Sri Lanka. *Intervention, 1*(2), 3-17.
- Guarnaccia, P. J., Rivera, M., Franco, F., & Neighbors, C. (1996). The experience of ataques de nervios: towards an anthropology of emotions in Puerto Rico. *Culture, Medicine & Psychiatry, 20*, 342-367.
- Hoeing, W. (2004). Self-image and the well-being of refugees in Rhino Camp, Uganda. *New Issues in Refugee Research, 103*.
- Hobfoll, S. E., Johnson, R. J., Ennis, N., & Jackson, A. P. (2003). Resource loss, resource

- gain, and emotional outcomes among inner city women. *Journal of Social and Personality Psychology*, 84(3), 632-643.
- International Crisis Group (2006). *Sri Lanka: The failure of the peace process*. (Asia report No. 124).
- Jayawickreme, N., Jayawickreme, E., Goonasekera, M. & Foa, E.B. (in preparation). *Focus Grouping Measures of Depression, PTSD & Well-Being: Some Issues for Practitioners*.
- Janca, A. Kastrup, M., Katschnig, H., Lopez-Ibor, J. J., Jr., Mezzich, J. E., & Sartorius, N. (1996). *The World Health Organization Short Disability Assessment Schedule (WHODAS-S): a tool for the assessment of difficulties in selected areas of functioning of patients with mental disorders*. *Social Psychiatry and Psychiatric Epidemiology*, 31, 349-354.
- Joseph, S. Williams, R., & Yule, W. (1993). Changes in outlook following disaster: the preliminary development of a measure to assess positive and negative responses. *Journal of Traumatic Stress*, 6, 271-279.
- Keane, T. M., Kaloupek, D. G., & Weathers, F.W. (1996). Ethnocultural considerations in the assessment of PTSD. In A. J. Marsella, M. J. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 183-205). Washington, DC: American Psychological Association.
- Keane, T. M., Marshall, A. D., & Taft, C.T. (2006). Posttraumatic stress disorder: Etiology, epidemiology, and treatment outcome. *Annual Review of Clinical Psychology*, 2, 161-197.
- Kleinman, A. (1981). *Patients and healers in the context of culture: An exploration of the borderlines between anthropology, medicine and psychiatry*. Berkeley, CA: University of California Press.
- Kleinman, A. (1986). *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books.
- Kleinman, A. (1987). Anthropology and psychiatry: The role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, 151, 447-454.
- Lazarus, R. S. (1993). From psychological stress to the emotions: A history of changing outlooks. *Annual Review of Psychology*, 44, 1-22.
- Linley, P. A., Joseph, S., Harrington, S., & Wood, A. M. (2006). Positive psychology: past, present, and (possible) future. *Journal of Positive Psychology*, 1, 3-16.
- Lopez, S. R. & Guarnaccia, P.J.J. (2000). Cultural psychopathology: uncovering the social world of mental illness. *Annual Review of Psychology*, 51, 571-598.
- Lu, L. & Gilmour, R. (2004). Culture and conceptions of happiness: individual oriented and social oriented SWB. *Journal of Happiness Studies*, 5, 269-291.
- Lyubomirsky, S. & Lepper, H. S. (1999). A measure of subjective happiness: preliminary reliability and construct validity. *Social Indicators Research*, 46, 137.
- Lyubomirsky, S. King, L., & Diener, E. (2005). The benefits of frequent positive affect: does happiness lead to success? *Psychological Bulletin*, 131(6), 803-855.
- Miller, K. E. & Fernando, G. (2008). Epidemiological assessment in emergency settings;

- recommendations for enhancing a potentially useful tool. *Intervention*, 6(3), 255-260.
- Miller, K. E., Kulkarni, M., & Kushner, H. (2006). Beyond trauma-focused psychiatric epidemiology: bridging research and practice with war-affected populations. *American Journal of Orthopsychiatry*, 76, 409-422.
- Miller, K. E. & Rasco, L. M. (2004). *The mental health of refugees: ecological approaches to healing and adaptation*. Mahwah, NJ: Lawrence Erlbaums.
- Osterman, J. E., & de Jong, J. T. V. M. (2007). Cultural issues and trauma. In Friedman, M. J., Keane, T. M., & Resick, P. A. (Eds.), *Handbook of PTSD: Science and Practice* (425-446). New York: Guilford.
- QSR International (2002). *Using NVivo in qualitative research*. Melbourne: QSR International.
- Radloff, L. S. (1977). The CES-D Scale. *Applied Psychological Measurement*, 1, 385-401.
- Rozin, P. (2003). Five potential principles for understanding cultural differences in relation to individual differences. *Journal of Research in Personality*, 37, 273-283.
- Ryff, C. D., & Singer, B. H. (2002). Flourishing under fire: resilience as a prototype of challenged thriving. In C. L. M. Keyes & J. Haidt (Eds.). (2002). *Flourishing: positive psychology and the life well-lived*. Washington, D.C.: American Psychological Association.
- Seligman, M. E. P. & Csikszentmihalyi, M. (2000). Positive psychology: an introduction. *American Psychologist*, 55, 1-20.
- Seligman, M. E. P. (2002). Positive psychology, positive prevention, and positive therapy. In Snyder, C. R. and Lopez, S. (eds). *Handbook of positive psychology*. Oxford: Oxford University Press.
- Somasundaram, D. (2007). Collective trauma in northern Sri Lanka: a qualitative psychosocial-ecological study. *International Journal of Mental Health Systems*, 1(5), 1-27.
- Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *Journal of the American Medical Association*, 302(5), 537-549.
- Strauss, A. L. (1987). *Qualitative analysis for social scientists*. Cambridge: Cambridge University Press.
- Stein, D. J., Seedat, S., Iversen, A., & Wessely, S. (2007). Post-traumatic stress disorder: medicine and politics. *The Lancet*, 369, 139-142.
- Summerfield, D. (2005). What exactly is emergency or disaster 'mental health'? *Bulletin of the World Health Organization*, 83, 76-77.
- Taylor, S. E., Kemeny, M. E., Reed, G. M., Bower, J. E., & Gruenewald, T. L. (2000). Psychological resources, positive illusions and health. *American Psychologist*, 55(1), 99-109.
- Tedeschi, R. G. & Calhoun, L. G. (1995). *Trauma and transformation.: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage.
- Tedeschi, R. G. & Calhoun, L. G. (1996). The post-traumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9, 455-471.

Tedeschi, R. G., Park, C. L., & Calhoun, L. G. (1998). *Posttraumatic Growth: Positive changes in the aftermath of crisis*. Hillsdale, N.J.: Lawrence Erlbaum Associates.

The Asia Foundation (2006). *Capacity building in monitoring and evaluation*. Colombo: The Asia Foundation/RESIST.

van Ommeren, M. Sharma, B., Thapa, S., Makaju, R., Prasain, D., Bhattarai, R., & de Jong, (1999). Preparing instruments for transcultural research: use of the translation monitoring form with Nepali-Speaking Bhutanese Refugees. *Transcultural Psychiatry*, 36, 285-301.

von Peter, S. (2008). The Experience of 'Mental Trauma' and its Transcultural Application. *Transcultural Psychiatry*, 45(4), 639-651.

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<sup>3</sup> More information on the training process can be found in "Capacity building in monitoring and evaluation", The Asia Foundation/ RESIST, June 2006.

<sup>4</sup> With the exception of the ACI example from Mannar and Vavuniya, these randomly selected examples come from male respondents.

<sup>5</sup> See previous endnote.

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<sup>7</sup> Thanks to an anonymous reviewer for this point.

<sup>8</sup> As of May 2009, the first stage of data collection has already been completed.

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