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Trauma Healing Intervention Following Flash Flood Disaster in Tanah Datar Regency, West Sumatra: A Psychosocial Community Service Approach

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Abstract

Natural disasters inflict not only physical destruction but also profound psychological trauma on affected communities. The May 2024 flash flood in Tanah Datar Regency, West Sumatra, Indonesia, caused widespread casualties, property loss, and displacement, leaving survivors—particularly children, adolescents, and elderly persons—with acute and potentially chronic trauma responses including post-traumatic stress disorder (PTSD), severe anxiety, sleep disturbances, and social withdrawal. This community service program reports a structured, multi-modal trauma healing intervention implemented on 27 August 2024, at the Tanah Datar disaster post, reaching more than 100 affected residents. The program employed a participatory psychosocial approach integrating child-friendly expressive arts activities (drawing, storytelling, and play), small-group reflective sessions for adolescents and adults, religiously and culturally grounded healing practices aligned with local Minangkabau traditions, and a psychosocial first aid training component for local community volunteers. Evaluation through facilitator observation, structured questionnaires, and brief qualitative interviews demonstrated significant improvements in emotional expression, reduction of trauma symptoms, restoration of social engagement, and enhanced community psychological resilience. Local volunteers and community leaders who received foundational trauma healing training demonstrated readiness to continue psychosocial accompaniment independently, strengthening the program's sustainability. These findings substantiate the effectiveness of culturally embedded, community-integrated psychosocial interventions in post-disaster trauma recovery and provide a replicable model for disaster mental health programming in Indonesia and comparable contexts.

Keywords: *trauma healing;mental health; psychosocial intervention; post-traumatic stress; community resilience*

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1. Introduction

Natural disasters represent among the most severe acute stressors that human communities encounter, generating simultaneous losses across physical, social, economic, and psychological domains (Norris et al., 2002). The psychological sequelae of disaster are well-documented and can be profound and enduring: survivors frequently experience acute stress responses, grief reactions, post-traumatic stress disorder (PTSD), major depressive disorder, generalized anxiety, and complicated bereavement (Galea et al., 2005). These consequences are not uniformly distributed across populations; children, elderly persons, individuals with pre-existing mental health conditions, and those who experience direct bereavement or property loss are disproportionately vulnerable to severe and persistent psychological impairment (Ferrario et al., 2004)

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Indonesia, situated within the Pacific Ring of Fire and exposed to the dynamics of the Asian monsoon system, is among the world's most disaster-prone nations. Flash floods, in particular, are recurrent and devastating hazards in the Sumatra highland region, where steep topography, deforestation, and intense seasonal rainfall create conditions for rapid-onset, high-intensity inundation events (BNPB, 2024). In May 2024, Tanah Datar Regency in West Sumatra experienced a catastrophic flash flood (banjir bandang) that caused substantial loss of life, destroyed hundreds of homes, and displaced thousands of residents. The suddenness and intensity of the disaster severely limited the community's capacity for preparatory coping, amplifying traumatic impact (Brewin et al., 2000).

Despite the critical importance of psychological recovery in comprehensive disaster response, mental health and psychosocial support (MHPSS) remain systematically underemphasized relative to physical and material relief operations in Indonesian disaster management practice (Departemen Kesehatan Republik Indonesia, 2019). The national disaster management authority (BNPB) and the Ministry of Health have issued guidelines for psychosocial support in disaster contexts; however, implementation is frequently delayed, underfunded, and insufficiently tailored to local cultural contexts (Kementerian Sosial Republik Indonesia, 2020). This gap is particularly consequential in West Sumatra, where the Minangkabau cultural system—with its distinctive matrilineal social structure, Islamic religious practice, and communal healing traditions—offers both resources and particularities that effective MHPSS programming must engage (Naim, 1979).

Trauma healing, understood as a structured set of psychosocial interventions designed to reduce trauma symptoms, restore emotional stability, and rebuild community resilience, has emerged as a critical component of the post-disaster recovery framework (Hobfoll et al., 2007). Evidence-based approaches to disaster trauma healing integrate psychological first aid (PFA), cognitive-behavioral techniques, expressive arts therapies, group support modalities, and culturally adapted healing practices (Inter-Agency Standing Committee, 2007). For children, play-based and creative expressive methods have demonstrated particular efficacy in facilitating trauma processing in developmentally appropriate ways (Malchiodi, 2011). For adults and community groups, collective sharing, narrative processing, religious practice, and the restoration of social roles and routines are central to recovery (Norris et al., 2008).

This article presents a structured trauma healing community service program implemented by Universitas Prima Nusantara Bukittinggi at the Tanah Datar disaster post on 27 August 2024. The program reached over 100 disaster survivors across age groups and employed a culturally responsive, multi-modal psychosocial intervention framework. The article reports the program's theoretical grounding, methodology, outcomes, and implications for post-disaster mental health policy and practice in Indonesia.

2. Literature Review

2.1. Psychological Impact of Natural Disasters

The psychological impact of natural disasters is multidimensional, spanning acute trauma responses, sub-acute adjustment difficulties, and chronic mental health disorders (Neria et al., 2008). The DSM-5 diagnostic criteria for PTSD—encompassing intrusive re-experiencing, avoidance, negative cognitions and mood alterations, and hyperarousal—are commonly met by disaster survivors at clinically significant rates, with meta-analytic estimates suggesting PTSD prevalence of 30–40% among directly affected

populations in the first year following major disasters (Benedek et al., 2007). Beyond PTSD, depression and complicated grief represent highly prevalent co-occurring conditions, with bi-directional relationships between depressive symptoms and functional impairment in disaster-affected communities (Bonanno et al., 2010).

Children constitute a particularly vulnerable population in disaster contexts. The developmental impact of disaster-related trauma on children can include regression in developmental achievements, school refusal, attachment disruptions, somatic complaints, and elevated risk for long-term emotional and behavioral problems if left unaddressed (Vernberg et al., 1996). Longitudinal studies following natural disasters in Southeast Asian settings, including the 2004 Indian Ocean tsunami and the 2010 Wasior flood in Papua, Indonesia, have documented persistent psychological sequelae in child survivors extending up to five years post-event, underscoring the need for timely and sustained psychological intervention (Marlina & Sari, 2022).

Elderly persons face compounded vulnerability due to the interaction of disaster-related stressors with age-related reductions in physiological and psychological resilience, loss of established social support networks, and reduced capacity to rebuild material losses. For this group, interventions emphasizing social reconnection, spiritual meaning-making, and intergenerational support have demonstrated benefit (Ferrario et al., 2004).

2.2. Psychosocial First Aid and Trauma Healing Frameworks

Psychological first aid (PFA), as endorsed by the World Health Organization, the Sphere Project, and IASC guidelines, provides the foundational framework for disaster mental health response (World Health Organization et al., 2011). PFA is built on five core principles articulated by Hobfoll et al. (Hobfoll et al., 2007): promoting a sense of safety, calming, a sense of self- and community efficacy, connectedness, and hope. These principles translate into concrete program activities including safe space provision, supportive listening, practical assistance, facilitation of social connection, and information-sharing about available resources.

Trauma-focused cognitive behavioral therapy (TF-CBT) and its adaptations for group delivery represent the most extensively evidence-based psychological treatment modality for disaster-related PTSD across developmental groups (Cohen et al., 2017). However, the resource requirements for individual TF-CBT delivery are prohibitive in mass-casualty disaster contexts with large affected populations and limited trained mental health professionals. This has driven the development and evaluation of group-based, task-shifted, and culturally adapted psychosocial interventions that can be implemented by non-specialist facilitators under appropriate supervision (van Ginneken et al., 2013).

Expressive arts therapies—encompassing art-making, music, movement, drama, and narrative approaches—have accumulated a substantial evidence base for trauma recovery across diverse populations, including disaster survivors (Schouten et al., 2015). These modalities enable trauma processing through nonverbal and symbolic channels that are less cognitively and emotionally demanding than direct verbal recounting of traumatic experiences, making them particularly valuable for children and for individuals from cultural backgrounds in which direct emotional disclosure is socially

discouraged (Summerfield, 1999). In the Indonesian context, creative and play-based trauma healing modalities have been incorporated into nationally endorsed post-disaster psychosocial response guidelines (Kementerian Sosial Republik Indonesia, 2020).

2.3. Cultural Dimensions of Disaster Trauma Healing in West Sumatra

The cultural context of West Sumatra's Minangkabau society provides both resources and considerations for disaster trauma healing programming. The Minangkabau social system is organized around matrilineal clan (suku) structures, communal decision-making, and strong traditions of gotong royong (mutual assistance) and adat (customary law and practice) (Naim, 1979). These social structures, when functioning, provide natural support networks and community solidarity mechanisms that can be mobilized in disaster recovery. However, the severity of the Tanah Datar flash flood disrupted many of these networks through bereavement, displacement, and infrastructure destruction, amplifying isolation and helplessness among survivors.

Islamic religious practice, which is near-universal among Minangkabau communities, provides culturally meaningful frameworks for meaning-making, acceptance, and community solidarity in the face of catastrophic loss (Aflakseir & Coleman, 2011). Religious activities including collective prayer (doa bersama), Quranic recitation, religious lectures (tausiyah), and reference to Islamic theological frameworks for understanding and accepting suffering have been documented as significant coping resources for Muslim disaster survivors in Indonesia and elsewhere (Nugroho, 2020). Integration of these practices within psychosocial programming enhances cultural acceptability, reach, and therapeutic effectiveness.

Putri and Wijaya (Putri & Wijaya, 2021) documented that community-based healing approaches grounded in local cultural values—including collective ritual, elder leadership, and the use of culturally familiar metaphors for recovery—were more readily accepted and produced more sustained positive outcomes in West Sumatran disaster-affected communities compared with externally imported clinical models. This evidence strongly supports the culturally embedded design of trauma healing programs in the West Sumatra context.

2.4. Community Resilience and Psychosocial Capacity Building

Beyond symptom reduction in individual survivors, contemporary disaster mental health frameworks emphasize the importance of building community resilience—the collective capacity of a community to absorb disaster impacts, maintain essential functions, and recover and adapt through difficult conditions (Pfefferbaum et al., 2015). Psychosocial capacity building, achieved through training local volunteers, community leaders, teachers, and health workers in foundational trauma support skills, is a critical strategy for extending program reach, ensuring sustainability, and empowering communities to manage future adversities more effectively (Irwanto, 2018).

The Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings recommend a layered intervention pyramid, with community-level social

supports forming the broad base, focused non-specialist supports at the intermediate level, and specialized clinical services at the apex (Inter-Agency Standing Committee, 2015). The trauma healing program reported here was designed in alignment with this framework, positioning community capacity building as a core program objective alongside direct psychosocial support to survivors.

3. Methodology

3.1. Program Context and Setting

The program was implemented in direct response to the May 2024 flash flood disaster in Tanah Datar Regency, West Sumatra, Indonesia—one of the most severe natural disasters to affect the region in recent decades, causing loss of life, extensive property destruction, and mass displacement. The intervention was conducted on Tuesday, 27 August 2024, approximately three months post-disaster, a period that corresponds to the sub-acute recovery phase in which immediate physical survival needs are largely addressed but psychological needs remain acute and largely unmet.

The program was implemented at the designated disaster response post (posko bencana) in Tanah Datar, coordinated with the local sub-district administration (Camat), community leaders (tokoh adat and tokoh agama), and village governance structures. Institutional authorization was granted by the Research and Community Service Institute (LP2M) of Universitas Prima Nusantara Bukittinggi (Letter No. 162/UPNB.SP/8.NA/II/2024). The program team comprised one licensed psychologist (Dahlia Susanti, M.Psi., Psikolog) as program director and clinical supervisor, and two trained student facilitators (Sri Wahyuni and Suci Amanah Putri).

3.1 *Participant Population*

The program reached more than 100 disaster-affected residents across four population segments: (1) children aged 5–12 years; (2) adolescents and young adults aged 13–25 years; (3) adults and elderly persons (>25 years); and (4) community volunteers and local leaders identified as potential psychosocial support agents. Participants were recruited through community leader referral and open invitation at the disaster post. No formal exclusion criteria were applied, consistent with the community service and public health nature of the program. Participants presenting with apparent acute psychiatric crisis were referred to the local community health center (Puskesmas) for clinical evaluation.

Intervention Design and Components

3.2 The program was structured across five sequentially delivered intervention components, differentiated by participant age group and therapeutic objective: Component 1 — Trauma Healing for Children (Usia 5–12 tahun / Ages 5–12): Child participants engaged in structured play sessions, guided drawing and expressive art-making, collaborative storytelling, and group singing activities. These modalities were selected on the basis of their documented efficacy in enabling non-verbal trauma processing, restoring positive affect, re-establishing a sense of safety and normalcy, and rebuilding peer social connection in child disaster survivors [11, 16]. Facilitators were trained to observe for signs of acute distress and to respond with developmentally appropriate, non-directive supportive engagement.

Component 2 — Reflective Group Sessions for Adolescents (Usia 13–25 tahun / Ages 13–25): Small-group discussions facilitated by trained student facilitators provided adolescent participants with structured opportunities for emotional expression, peer normalization of trauma responses, and psychoeducation about common psychological reactions to disaster. Reflective journaling and peer sharing exercises were employed to encourage introspection and articulation of personal coping strategies.

Component 3 — Psychosocial Support Groups for Adults and Elderly (Usia >25 tahun / Ages >25): Adult and elderly participants received supportive group listening sessions in which they were invited to share experiences, express emotions, and receive empathic validation from group members and facilitators. This format aligns with narrative exposure principles and the communal storytelling traditions of Minangkabau culture. Religious and cultural healing practices—including collective dua (supplication), tausiyah (Islamic spiritual guidance), and culturally familiar symbolic recovery narratives—were integrated to enhance cultural congruence and therapeutic depth.

Component 4 — Cultural and Spiritual Healing Activities: Across age groups, culturally grounded collective healing rituals were incorporated, including structured group prayer, guided mindfulness breathing, and brief adat-informed community solidarity affirmations led by invited local religious and customary leaders. These activities served both direct therapeutic functions (fostering calm, meaning-making, and hope) and community cohesion functions (reinforcing solidarity and shared identity in the face of collective loss).

Component 5 — Local Volunteer and Community Leader Training (Pelatihan Pendamping Lokal): A dedicated training session was delivered to community volunteers, teachers, and local leaders, covering: (a) recognition of normal and pathological stress responses in disaster survivors; (b) foundational principles of psychological first aid; (c) child-friendly and culturally appropriate active listening techniques; and (d) referral pathways for survivors requiring clinical mental health intervention. Participants received simplified written reference materials supporting ongoing practice.

3.3 *Evaluation Design*

Program evaluation employed a concurrent mixed-methods design. Quantitative data were gathered through a brief structured questionnaire assessing emotional state, trauma symptom frequency, and perceived social support, administered before and after participation. Qualitative data were collected through: (1) systematic facilitator observation using a structured observation protocol; (2) brief semi-structured individual and small-group interviews with a purposively selected sub-sample of participants and community leaders at program conclusion; and (3) written reflective notes from facilitators following each session. Descriptive analysis was applied to quantitative data, and thematic analysis was employed for qualitative data to identify patterns across observation, interview, and reflection sources.

4. Results and Discussion

4.1 *Reach and Participant Engagement*

4.2 The program successfully engaged more than 100 disaster-affected residents across all four targeted population segments. Children represented the largest single group, consistent with the demographic profile of the most affected nagari communities in Tanah Datar. Participant attendance was sustained across program components, with high levels of active engagement observed throughout, indicating program acceptability and cultural appropriateness. The involvement of local community leaders and religious figures in facilitating cultural and spiritual healing components was identified by facilitators as a key factor in community receptiveness and trust-building, consistent with evidence that

community endorsement significantly enhances participation in disaster mental health programs (van Ginneken et al., 2013).

Outcomes for Children

4.3 Prior to program participation, child participants demonstrated clear signs of post-disaster psychological distress. Facilitated observations documented behaviors consistent with trauma responses including hypervigilance, startled reactions to ambient sounds, emotional withdrawal, flat affect, reluctance to engage in play, and episodic crying without apparent precipitant. These presentations are characteristic of acute trauma responses in school-aged children following sudden-onset disaster (Vernberg et al., 1996).

Following participation in the Trauma Healing for Kids component, substantial behavioral changes were evident. Children showed increased spontaneity in play, expressive vocalization and laughter, willingness to engage with unfamiliar facilitators and peers, and reduction in hypervigilance behaviors. Drawings produced during expressive art activities demonstrated thematic progression across sessions, with initial disaster-related imagery giving way in later sessions to representations of homes, families, and future activities—a pattern documented in expressive arts therapy literature as indicative of beginning trauma processing and forward-orientation (Schouten et al., 2015). These gains are consistent with evidence that even brief, structured play-based psychosocial interventions can produce measurable reductions in post-disaster distress in children when delivered with fidelity and cultural sensitivity (Malchiodi, 2011).

Outcomes for Adolescents and Adults

Adolescent and adult participants demonstrated different but equally meaningful pre-intervention presentations. Many adult participants presented with signs of emotional suppression, social isolation, and helplessness—commonly observed in individuals in the middle recovery period following major personal loss (Bonanno et al., 2010). Several participants noted that the program represented their first opportunity to speak openly about their psychological experiences since the disaster, as the immediate post-disaster period had been entirely consumed by practical survival and recovery demands.

Participation in reflective group sessions and psychosocial support groups produced observable shifts in emotional expression and social engagement. Participants progressively demonstrated greater comfort in sharing personal experiences, increased peer emotional support behaviors, and expressions of relief, hope, and community solidarity. Consistent with theoretical frameworks emphasizing the primacy of social reconnection in disaster recovery (Pfefferbaum et al., 2015), group-based sharing appeared to perform multiple therapeutic functions simultaneously: normalization of individual trauma responses, reduction of shame and isolation, provision of mutual emotional validation, and reinforcement of collective identity and resilience.

The integration of religious and cultural healing practices was particularly salient for adult and elderly participants. Collective prayer sessions were observed to generate visible calming responses across participants, and tausiyah content addressing Islamic frameworks for understanding and accepting adversity (ujian, rezeki, tawakal) provided meaning-making frameworks that participants described as deeply helpful. This aligns with literature documenting the protective and restorative functions of religious coping among Indonesian Muslim disaster survivors

Community Capacity Building Outcomes

4.4 The local volunteer and community leader training component produced demonstrable knowledge gains among participants regarding trauma recognition and psychosocial first aid principles. Post-

training assessments indicated that trained volunteers could correctly identify common trauma response presentations, articulate the core principles of supportive listening and safe referral, and demonstrate foundational child-friendly engagement techniques. Community leaders expressed both capability and motivation to continue psychosocial support activities within their respective community contexts.

The formation of an informal local psychosocial support network—comprising trained volunteers, community leaders, teachers, and religious figures—at program conclusion represents a critical sustainability infrastructure. This network provides ongoing peer support to community members, extends the reach of psychosocial support beyond the formal program period, and constitutes a local early warning system for identifying individuals requiring escalation to professional mental health services. Building such networks is identified by IASC guidelines (Inter-Agency Standing Committee, 2015) and national disaster mental health frameworks (Departemen Kesehatan Republik Indonesia, 2019) as essential for translating short-term program impacts into durable community resilience.

4.5 *Theoretical and Practical Implications*

The program's outcomes offer several theoretically and practically significant insights. First, they demonstrate that culturally grounded, multi-modal trauma healing interventions can be effectively implemented by trained community psychologists and student facilitators in resource-constrained post-disaster settings, without requiring specialist clinical infrastructure. This supports the task-shifting model of MHPSS provision as a viable strategy for scaling mental health responses to large-scale disasters in Indonesia (van Ginneken et al., 2013).

Second, the integration of Minangkabau cultural elements—Islamic spiritual practices, communal ritual, and culturally congruent healing metaphors—did not merely serve as contextual window-dressing but appeared to function as active therapeutic ingredients, enhancing program credibility, reducing resistance, deepening emotional processing, and strengthening community cohesion. This finding corroborates cross-cultural mental health evidence indicating that cultural responsiveness is not supplementary but central to intervention effectiveness

Third, the child-focused expressive arts component produced particularly marked and rapid improvements relative to other age groups, consistent with developmental psychology evidence that children are capable of significant post-traumatic recovery when provided with appropriate supportive environments and expressive opportunities (Malchiodi, 2011). This underscores the priority that should be accorded to child-targeted trauma healing in comprehensive post-disaster mental health responses.

Fourth, the documented gap between the timing of acute disaster impact (May 2024) and the delivery of structured psychosocial support (August 2024—three months later) highlights a systemic weakness in disaster mental health response infrastructure in Indonesia. International guidelines recommend commencement of psychological first aid within 72 hours of disaster onset (World Health Organization et al., 2011). The three-month delay observed in this case, while enabling a more structured program design, also meant that many survivors had been without formal psychosocial support during the critical acute and early sub-acute phases. Institutional investment in pre-positioned, rapidly deployable MHPSS teams is a policy priority indicated by this finding.

5. Conclusion

This community service trauma healing program demonstrated the feasibility, cultural acceptability, and effectiveness of a structured psychosocial intervention for flash flood disaster survivors in Tanah Datar Regency, West Sumatra, Indonesia. Reaching over 100 affected residents across four population groups, the program achieved its core objectives of reducing acute trauma symptoms, restoring emotional expression and social engagement, and building local psychosocial support capacity. Child participants showed notable recovery in social engagement and positive affect following expressive arts activities. Adolescent and adult participants reported significant relief, emotional validation, and renewed community solidarity following group reflective sessions and culturally integrated healing practices. Local volunteers and community leaders demonstrated readiness to sustain psychosocial support activities independently following foundational training.

The program's effectiveness was materially enhanced by its cultural responsiveness—specifically, the integration of Islamic spiritual practices, Minangkabau communal healing traditions, and community leader facilitation—which ensured local legitimacy, participation, and deep engagement with program content. This reinforces the principle that effective disaster MHPSS programming in Indonesian contexts must be designed from the outset as culturally embedded rather than culturally adapted from external frameworks.

The findings have direct implications for disaster mental health policy and practice in Indonesia. First, systematic MHPSS capacity building should be integrated into pre-disaster preparedness planning at the provincial and district levels, enabling faster deployment of culturally competent psychosocial interventions following future disasters. Second, the training of local community volunteers in foundational trauma support skills should be regularized as a component of community disaster preparedness programs. Third, higher education institutions, particularly those with psychology and social work programs, should formalize rapid-response community service protocols for deployment in post-disaster contexts. Further research incorporating longitudinal follow-up, randomized or quasi-experimental designs, and validated outcome measures is recommended to build the evidence base for this program model.

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