CHAPTER 12

Is PTSD a "Good Enough" Concept for Postconflict Mental Health Care? Reflections on Work in Aceh, Indonesia

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In November 2005, eleven months after a devastating tsunami and barely three months after the signing of the Helsinki accords, which brought to an end nearly two decades of fighting between the Indonesian military and Gerakan Aceh Merdeka (the Free Aceh Movement or GAM), the International Organization for Migration (IOM) in Indonesia invited us to provide consultation concerning mental health strategies in previously high-conflict areas of Aceh (Aspinall 2005, 2009, Reid 2006, Drexler 2008). By February 2006, we were accompanying IOM research teams into villages of three districts of Aceh to conduct a major psychosocial needs assessment, a survey designed to guide IOM in launching postconflict psychosocial or mental health programs, to which we were deeply committed for more than five years.[1]

The survey we helped lead, which included both quantitative and qualitative interviews, produced an outpouring of stories of violence and torture, enacted primarily by the Indonesian military against civilian communities. In one village, interviewers left in such shock that Jesse Grayman, then working for IOM, arranged for the organization to send a mobile mental health team to this village.[2] On February 15, 2006, we joined a group of Acehnese doctors and nurses, including a brave and committed psychiatrist, and a guide who was a former leader of GAM in the area, in a caravan of four-wheel-drive vehicles, marked with the blue and white symbols of IOM, up into the hills of North Aceh. We passed untended rice fields, overgrown pinang (areca nut)

groves, and burned-out remains of houses, schools, and other buildings along the side of the deeply rutted, muddy road, finally stopping in a shabby village center, with a few nearly empty shops where people had begun to gather, expecting our visit. We were greeted with coffee, cigarettes, and small talk, which gradually turned more somber as people began to refer to the events of the conflict. After a short time, we walked to the *meunasah*, an Acehnese village center and prayer house, where we were met by a tall, thin man in his forties, wailing loudly as his friends tried to support him. The doctor preceded him up the stairs to a large, open room, where the two sat down, facing each other, surrounded by a growing crowd of villagers, and opened his clinic. Our scribbled handwritten field notes report the following.

In April 2004, men in black shirts came at 4 A.M. and accused this man of being a spy for GAM. They beat him, bound his hands and legs, tied a plastic bag over his head, suffocated him, hung him on a pole like a goat, beat him many times, smashed his head, and left him for dead. The villagers found him and released him. Since then, he can't sleep, he can't work, he can't take care of his family, and he cries constantly. The doctor took control, grabbed his hands, said a prayer, calmed him, took his blood pressure, and gave him an injection of a sedative. Soon he was sleeping quietly.

Thunder and lightning crashed, accompanying a tropical downpour, as one by one, villagers came forward to tell their stories to the doctor. We sat at the edge, talking with those who had come to talk with the doctor. "How are you?" we asked a man who sat quietly, smiling. His eyes began to water. They came and took everything from his house. The villagers were forced to leave, and when he came back, his house was empty, everything was gone. The chickens were gone, everything was gone. He feels sad, he cries easily, he often sleeps at nine then wakes at twelve, and he has little appetite. He was hit; for a long time he couldn't work. He is now a bit better but still has pain in his body. He looks seriously depressed.

A woman tells her story to the doctor. Her husband was taken in 1990, he was cut open, his heart was taken out. He was killed in front of her and her children. Her child had a gun put at his throat. She has a pain in her heart; she feels sad, easily frightened. She was dragged by the soldiers for two meters, then fell unconscious. She still feels pain in her back. They killed her husband in front of her daughter and her children. Her daughter was covered by a cloth, so she didn't have to see. They cut off his ear and put it in the meunasah. She doesn't know where his head was put. She suddenly makes a joke, and the mood lightens.

A woman approaches the doctor crying, telling how she was tortured, her toenails torn out, beaten. Soldiers kept asking her, where is GAM. She didn't know. Her husband was taken, her house was burned, and still now, she doesn't know where her husband is, though this happened in 2004. He wasn't a GAM member, but he was accused and tortured, as they asked where is GAM, where are the weapons. She was suspected of cooking food for GAM. A second group of soldiers came and asked her, where is the flag of Indonesia? Why don't you report to us? She finally escaped to the forest, where she hid for seven days and nights, afraid she would be beaten again. They came back and burned her motorcycle, saying it belonged to GAM, accused her of cooking rice for the combatants, because she had leftover rice in the house. They commanded her to lie down, then shot a gun near her ear, terrifying her. And so the stories went on, for nearly five hours—until the doctor had had all he could take and asked a man from the local soccer team to massage his shoulders and back. We all relaxed for a bit, then took our leave.

For us, this was the start of a long and deep involvement, in which we took this spontaneous trauma clinic as a model for the development of mental health outreach teams, organized by IOM, staffed by young GP doctors and nurses, mostly Acehnese, and funded by diverse donors, particularly the World Bank. These teams traveled regularly first to twenty-five villages (in the pilot phase of the program), then to another fifty (in phase 2 of the program), where altogether they treated over twenty-one hundred persons identified as having mental health problems, most related specifically to the conflict. We fought to have IOM and the donors support these teams; we worked closely with them, carried out formal evaluations and wrote reports, met with patients to hear stories of suffering and recovery, and have continued to advocate for this model of care, even as donor funds for Aceh have largely disappeared. It is from within this position of advocacy, and as social scientists who conducted a formal evaluation of this program, that we discuss the usefulness of posttraumatic stress disorder (PTSD) as a clinical concept in postconflict mental health work.

Trauma, memory, and PTSD have long been the site of anthropological critique and exploration. From Ian Hacking's (1995) fine work on memory, dissociation, and multiple personality disorder, to Allan Young's (1995) groundbreaking work on the emergence of PTSD in the context of the rehabilitation of veterans of the Vietnam War, from Paul Antze and Michael Lambek's (1996) drawing together of the growing ethnographic writing on trauma and memory, to a strand of writing—represented by that of Arthur

Kleinman and his colleagues—that criticizes PTSD as the medicalization and professionalization of social suffering (Kleinman and Kleinman 1991; Breslau 2004), anthropologists have levied sustained criticism of the psychiatric category PTSD as represented by the American diagnostic and statistical manuals. This critique has been elaborated by ethnographers, psychologists, and psychiatrists in special collections in journals such as *Transcultural Psychiatry* (Zarowsky and Pedersen, "Rethinking Trauma in a Transnational World" [2000]) and *Culture, Medicine and Psychiatry* (Breslau and Guarnaccia, "Cultures of Trauma" [2004]), and in edited books such as Das et al. (2000) and Fassin and Pandolfi (2010). Anthropological analyses of trauma and PTSD have been linked to broader critiques of humanitarian interventions in postconflict settings, particularly those using the rhetoric of trauma, as representing a form of "mobile sovereignty" (Pandolfi 2003, 2008) and the emergence of an "empire of trauma" (Fassin and Rechtman 2009).

Anthropological critiques such as these are embedded in broader intellectual debates about the use of the concept of trauma to promote humanitarian governance and in more specific studies of the cross-cultural validity of the concept of PTSD. On the one hand, critiques of "psycho-social interventions" as a "new form of international therapeutic governance" (Pupavac 2001:358; see also Pupavac 2002, 2004, 2012) are part of a larger critical discussion of liberal humanitarianism and responses to complex emergencies, and even broader critical analyses of those theories of economic development that see violence as emerging in settings of poverty, weak states, and underdevelopment and as requiring liberal development aid and the reconstruction of societies as its remedy (Duffield 2001, 2002, 2009, 2012). These incorporate many of the anthropological criticisms of the medicalization and professionalization of suffering in settings of violence and the pathologization of whole populations (Pupavac 2001; Summerfield 2004). A group of human rights activists and psychiatrists involved in humanitarian work for victims of war and torture argue—and here we quote from a 1999 article by Derek Summerfield—that "for the vast majority of survivors posttraumatic stress is a pseudocondition, a reframing of the understandable suffering of war as a technical problem to which short-term technical solutions like counseling are applicable. These concepts aggrandize the Western agencies and their 'experts' who from afar define the condition and bring the cure. There is no evidence that war-affected populations are seeking these imported approaches, which appear to ignore their own traditions, meaning systems, and active priorities" (1999:1449; see also Summerfield 2000, 2001, 2004, 2008).

For Summerfield, the extension of notions of trauma and PTSD to non-Western societies represents forms of psychological imperialism that "risk an unwitting perpetuation of the colonial status of the non-Western mind" (2000:422).

The issue of the cross-cultural validity of the PTSD construct has been submitted to extensive empirical research over the past decade (see Introduction and Chapter 1 of this volume). The best review of this work was undertaken by Hinton and Lewis-Fernández (2011) in the context of debates over the criteria of PTSD in the DSM-5. They conclude that "substantial evidence of cross-cultural validity of PTSD was found," but that issues concerning symptom complexes critical to diagnosis, including the cross-cultural salience of avoidance/numbing symptoms, the importance of local cultural interpretations as shaping symptomatology, the place of somatic symptoms (cf. Hinton et al. [2012]), and the overlap or comorbidity of PTSD, anxiety disorders, and depressive disorders (Hinton et al. 2011; cf. Hinton and Lewis-Fernández 2011) require further empirical research. The research cited by Hinton and Lewis-Fernández, which focuses on symptoms rather than the ontological status of the PTSD construct, is clear. Insofar as the claims that the PTSD construct is limited to Western societies are stated in falsifiable terms rather than purely ideological terms, such claims are not borne out by cross-cultural research. Symptom clusters described by DSM-5 for PTSD are found around the globe.

In this chapter, we do not focus on the broader issues of humanitarian governance and psychosocial interventions for PTSD.[3] We also do not focus narrowly on symptom criteria or the more specific claims about the invention of PTSD in a particular social and historical context or its ontological status across cultures. Instead, we address the issue of the utility of the PTSD concept in clinical or public mental health work in Aceh, and by extension in other postconflict settings.

In this chapter, we propose to elaborate three rather simple claims, which respond to those made by Summerfield (1999:1449), quoted above. First, we provide empirical data suggesting that in the context of postconflict societies with extraordinarily limited mental health resources, "posttraumatic stress" (in Summerfield's terms) is far from a "pseudocondition." To the contrary, what we refer to as "the remainders of violence" in Aceh constitute an extraordinary public health challenge, and critiques such as those by Summerfield serve inadvertently to legitimize the withdrawal of support for the development of mental health services in settings of great need. Second, we

argue that while many of the debates about diagnostic criteria and their universality are of little relevance for the development of public mental health care, phenomena that look quite like those described by the technical medical and psychological literature and by current diagnostic systems as PTSD are quite common in the context of clinical work in Aceh. We will suggest that while the focus on criteria over prototypes and the effort to understand psychiatric disorders, particularly PTSD, as "discrete and heterogeneous" conditions (see B. Good 1992) limit the value of the concept, PTSD remains an important clinical concept and target of public mental health interventions. Third, we will describe what findings from our work in the field tell us about the question of whether, in Summerfield's terms, "war-affected populations are seeking these imported approaches," and whether medical and public health interventions for posttraumatic disorders provide benefit to those who are treated.

The research component of the program described in this chapter was not intended to determine whether the specific diagnostic criteria in the DSM-IV are valid for Aceh and Acehnese culture. The research was not basic research, designed to investigate questions critical to PTSD studies, including those about the relationship between symptom measures and diagnostic instruments. Our discussion of whether PTSD is a "good enough" concept refers instead to the question of whether the PTSD construct is a useful concept for identifying persons with mental health problems and organizing their care, particularly in postconflict societies that have suffered widespread violence and in which mental health services are being developed.

Background: The Psychosocial Needs Assessment (PNA) and the Direct Health and Psychosocial Assistance Programs (DHPAP)

Data for this chapter are drawn from the authors' five years of collaboration with IOM Indonesia in Aceh.[4] Beginning in November 2005, IOM conducted a psychosocial needs assessment in three districts, with support from the Canadian government. In February 2006, teams from IOM and Syiah Kuala University carried out a survey, based on a random, stratified survey of 596 adults (seventeen years old or older) in thirty villages in high-conflict subdistricts in three districts along the north coast of Aceh, which had among the longest and most intensive conflict and violence against citizens in all of

Aceh.[5] Research focused on measuring levels of experienced traumatic events (past and current) associated with the conflict; on symptoms of depression, anxiety, and PTSD; on experiences of head trauma (associated with beatings or suffocation); on help-seeking activities; and on local priorities for psychosocial services.[6] Only symptom checklists, not diagnostic instruments, were used in what was intended to be a very rapid needs assessment aimed at guiding IOM's psychosocial and mental health programs. In addition to the quantitative survey, qualitative interviews were conducted with village leaders and randomly selected adults in each village in the study. Data were analyzed in March 2006, and a final IOM report (the Psychosocial Needs Assessment, phase 1 or PNA1) was released in September 2006 (B. Good et al. 2006). Given the magnitude of violence and associated psychological distress documented by PNA1, IOM and the World Bank supported extension of the survey to seventy-five additional villages in eleven additional districts throughout Aceh. This second survey was conducted primarily in July 2006 (ten districts were surveyed in July, one in November 2006), and a total of 1,376 additional adults were interviewed. A second IOM report (PNA2) was released in June 2007 (M. Good et al. 2007). The report grouped districts into six regions representing different geographical and cultural areas of Aceh, which also had differing histories of conflict and violence.

The PNA project found extraordinarily high levels of violence enacted against civilian populations in the villages of rural Aceh. Levels of reported traumatic events were directly associated with levels of symptoms of depression, anxiety, and PTSD, and both were extremely high in this population. The PNA research also found that villagers seldom considered seeking mental health care from the public primary care clinics (*puskesmas*). The primary care system is most commonly associated with maternal and child health care; clinics are often difficult to reach from the more isolated villages; and villagers recalled that during the conflict the military maintained surveillance of the primary care centers. Indeed, the Indonesian military routinely monitored the clinics to catch wounded combatants seeking care and sometimes used the clinics or posts next to these clinics as their bases of operation.

Based on findings of this research, IOM agreed to develop a pilot program that used mental health outreach teams to go into remote, previously high-conflict villages with the explicit mission of providing mental health care and rebuilding the links between these villages and the primary care centers. The IOM mobile mental health teams consisted of general practitioners (GPs) and

nurses, working directly for IOM, who were given training and supervision by an Acehnese psychiatrist from Syiah Kuala University and by psychiatrists from the University of Indonesia in Jakarta. Team members worked closely with the local Community Mental Health Nurses (CMHN), who accompanied them into the villages, and village cadre, trained as part of an ongoing World Health Organization project, to take services directly into communities. The IOM teams and local CMHN conducted active case finding in the villages, identified persons with diagnosable mental illnesses, and provided a combination of medications, psychological counseling, and psychosocial group support. Between November 2006 and August 2007, this Direct Health and Psychosocial Assistance Program Pilot Phase (DHPAP Pilot)[7] provided direct mental health care to 581 individuals in twenty-five villages in the district of Bireuen. After eight months, full responsibility for persons still requiring treatment was transferred to local primary care centers. The project was evaluated by external evaluators, who strongly supported the project and verified the quality of care being provided by these teams of nonpsychiatrists. The program developed particularly close working relationships with staff in the district health office and the primary health care centers.

Beginning in November 2007, IOM extended this program to fifty new villages, twenty-five in Bireuen and twenty-five in the neighboring district of Aceh Utara.[8] The DHPAP Extension project provided care to 1,556 persons with significant mental health problems. In addition, IOM livelihood teams provided supportive livelihood training and material (valued at approximately US$300 per client) to 200 of those being treated for mental health problems, with the goal of evaluating the added mental health benefits that would accrue from linking clinical care and vocational support.

The Harvard team was responsible for designing and implementing a formal evaluation of this project. The first 1,137 patients treated were entered into a longitudinal study aimed at evaluating the reduction of symptoms and improvement in social and vocational functioning as a result of the care provided. Patients were interviewed at three times: T1 when entering treatment (February–August 2008); T2 when full responsibility for patient care was transferred to the local primary care clinics (March 2009); and T3 (August–September 2009), six months after the delivery of the livelihood intervention and just a few months before the end of the project. In addition to the quantitative survey questionnaires, qualitative interviews of a small sample of patients were conducted at several times during the course of the program.[9]

Data from the PNA research and the two intervention projects allow us to address the issues raised in the introduction.

Is PTSD a Pseudocondition in Aceh? Trauma-Related Mental Health Disorders as a Public Health Challenge

Mental health problems pose an extremely important public health challenge in low-income societies; this challenge increases very significantly in settings suffering natural disasters or armed conflict. A WHO model estimates that "severe disorders" (psychoses, severe depression, severe disabling anxiety disorders) have a 2–3 percent twelve-month prevalence in a normal population, which increases to 3–4 percent in "disaster" settings, and that mild to moderate disorders, diagnosable conditions deserving mental health services, have a 10 percent twelve-month prevalence, which increases to 20 percent in "disaster" settings, reducing to 15 percent with natural recovery (World Health Organization 2005).

Our PNA research documented extraordinary levels of violence enacted against civilian populations throughout Aceh, particularly in four of the six regions we compared, and these were directly and significantly correlated with extremely high levels of psychological symptoms (B. Good et al. 2006, M. Good et al. 2007). For example, in the two North Coast districts in which IOM later carried out the DHPAP interventions (Bireuen and Aceh Utara), 85 percent and 87 percent of the adult population (respectively) reported experiencing combat or gun fights; 49 percent and 53 percent reported being beaten; 25 percent in each district reported being tortured; 3 percent and 8 percent reported a spouse killed, and 4 percent and 9 percent reported having a child killed. In Bireuen, 68 percent of young men between ages seventeen and twenty-nine reported head trauma—being beaten to the head, strangled, or suffocated (often as part of interrogation). Although rates of physical violence directed at men were higher than those directed against women, women also experienced extremely high levels of direct physical assaults, as well as assaults against their kin and their homes. For example, 20 percent of women (compared with 56 percent of men) reported being beaten, 14 percent (compared with 36 percent) reported being attacked by a knife or gun, and 11 percent (vs. 25 percent) reported being tortured. Violence against civilians—both men and women—was thus extremely widespread in these settings.

It was not surprising, therefore, that the psychosocial needs assessment documented high rates of psychological symptoms. The study used standard scales for depression and anxiety (the Brief Symptom Inventory, or BSI) and for PTSD symptoms (the Harvard Trauma Questionnaire, or HTQ), carefully translated using local idioms, and asked questions about local idioms of distress and trauma-related experiences, including specifically dreams and nightmares (see B. Good et al. 2006 for a description of the instrument developed for the survey). Findings of the PNA research concerning levels of mental health symptoms can be summarized as follows.

First, both PNA1 and PNA2 documented extraordinarily high levels of psychological distress, indicating a significant public health issue. The levels of symptoms were related both to the level of conflict in the region surveyed and to the time in which the survey was carried out. The PNA1 survey, conducted in February 2006, reported some of the highest rates of psychological symptoms in the postconflict literature. For example, using the cutoff score of a mean of 2.5 on a 1–4 scale for the Harvard Trauma Questionnaire, as recommended by Mollica et al. (2004), 51 percent of respondents in Bireuen and 45 percent in Aceh Utara were rated symptomatic for PTSD.

While rates were still high in the PNA2 study, conducted in July 2006, psychological symptoms were significantly lower than in PNA1, even in regions that reported levels of traumatic events similar to those the PNA1 region. Levels of mental health problems were highest in the three regions with the highest levels of traumatic violence experienced. Levels of psychological symptoms were, however, lower in even the highest conflict areas in the July survey (PNA2) than in the February survey. For example, the East Coast region, surveyed in July, had high levels of violence (as measured by the traumatic events scale) comparable to those in North Coast communities surveyed in February, but levels of psychological symptoms were much lower. A rating of "symptomatic for PTSD" (with the mean of 2.5 or higher on the HTQ) was achieved by 8 percent of the total survey population in the East Coast region, as compared with the 34 percent rate for all three PNA1 North Coast districts in PNA1. Extremely high levels of depressive symptoms and anxiety symptoms were also reported in all regions, but again PNA2 scores were lower than PNA1 scores, even in regions such as the Southwest Coast and the East Coast, where traumatic events were similar to those in the PNA1 North Coast region.

Our analyses suggest that the reduction in symptoms from February to July 2006 was due to the advance of the peace process (M. Good et al. 2007).

In February 2006, only six months after the signing of the Helsinki Memorandum of Understanding (MOU), villagers were still extremely anxious that the peace agreement would not last, and many of the perpetrators of military violence had not yet left the region. Our measure of "current stressors" was quite high in February. By July 2006, a kind of euphoria had begun to set in, as the peace process had gone forward without a single breach, and all of the imported Indonesian troops involved in the conflict had left the region. Our measure of current stressors had declined by this time, suggesting that decline in levels of overall symptoms was related to the peace process moving forward, particularly the gradual evacuation of the Indonesian troops involved in the counterinsurgency war, rather than to regional differences and rates of violence.

Second, levels of psychological symptoms were almost equivalent for men and women in both the PNA1 and PNA2 surveys. Given that most population surveys find significantly higher rates of mood disorders among women than men, we interpret these findings to mean that men had particularly high levels of psychological distress and mental health problems, related to higher levels of traumatic violence experienced.

Third, odds analyses indicated that level of traumatic violence experienced by an individual was an extremely high predictor of level of psychological symptoms (demonstrating a clear dose effect [Mollica et al. 2004]). For example, in PNA1, odds ratios for PTSD symptoms being above the cutoff level increased from 1.00 to 4.87, 14.00, and 40.77, as number of past traumatic experiences reported increased from zero to three (assigned an odds ratio of 1.00), to four to seven, eight to ten, or eleven or more events reported. It should also be noted that level of current stressors was also a high predictor of psychological symptoms. PNA2 also found highly significant dose effects of traumatic events on psychological symptoms, but both psychological symptoms and odds ratios were lower in PNA2.

Given the decline in symptoms from February to July 2006, does this suggest that indeed the levels of symptoms reported were simply expected or normal reactions to violence rather than actual mental disorders? In part, yes. Symptom checklists can measure overall levels of distress in an individual or community at a particular time. They are not diagnostic instruments and are not designed to describe the number of persons who are suffering a mental disorder or should be provided mental health services. Such instruments do not, for example, have duration criteria—indicating how long a person has been experiencing such symptoms or where they are in what might be

considered a normal recovery process—and reported symptoms of depression, anxiety, and PTSD using such instruments are closely interrelated, indicating overall distress rather than distinct disorders. However, it is our interpretation that the levels of traumatic violence experienced, and levels of closely associated mental health symptoms, are important indicators of the magnitude of the public health challenge. While making no claims to the percent of the population with diagnosable mental illness or those who would benefit from treatment, these data suggested a very significant need for providing quality mental health care in postconflict regions of Aceh.

The community response to newly available clinical mental health services provided a different indicator of the magnitude of the public health challenge. The DHPAP mobile mental health project, launched in February 2008 (two and a half years after the MOU and end of violence), treated approximately 6 percent of the total population of the fifty villages in which the project was conducted—or approximately 11 percent of the adult population. These are clinical data—the number of persons who actually sought care when available in their village, not population-based data. Our interpretation of these data is that whereas the Acehnese are remarkably resilient, and the great majority of people recovered from the distress associated with the violence, a very significant number of people did not recover but developed longer lasting, psychiatrically relevant mental disorders. These represented cases in which symptoms or disorders were clinically significant and not self-remitting and are the disorders that constitute the larger public mental health challenge.

The PNA surveys were not undertaken as pure research but as genuine assessments of the need for services. From a public health point of view, the findings were important. Aceh had suffered not only a devastating tsunami, killing approximately 160,000 persons living along the coast, but civilian communities in the hills had also suffered through an extremely violent conflict—in some regions for nearly twenty years, in other regions for the past five years. In the high-conflict areas, despite the enormous resilience of the population, there were extremely high rates of symptoms of depression, anxiety, and PTSD. For a significant portion of the population—greater than the 11 percent of adults actually treated by the mobile mental health teams—these conditions produced longer-lasting mental disorders. This was, however, a setting in which only four psychiatrists served a population of more than four million people at the time of the tsunami. In a vast province requiring at least a twelve-hour bus ride from the southern borders of

the province to the capital, Banda Aceh, in the north, only one psychiatric hospital, four fully trained psychiatrists, and very few psychiatric nurses or clinical psychologists were available to provide care.[10]

Our point in describing the situation in these public health terms is to indicate our view that trauma-related conditions, including depression, anxiety disorders, and PTSD, should be understood and responded to as public mental health problems. The great challenge in postconflict settings with such limited resources is not to treat "trauma" per se or focus narrowly on PTSD, but to develop mental health services that can provide sustainable care for the wide range of mental health problems—organic problems related to head trauma, acute and chronic psychoses, and depression and anxiety disorders, including panic disorder and PTSD—that are certain to be present as remainders of violence in settings of postconflict.

Is PTSD a Culturally Valid Concept in Postconflict Aceh?

But what of the specific PTSD construct, and the claim that it is a pseudocondition better considered the understandable suffering of war? Our data here are of two kinds. First, we have quantitative data, both from the PNA research and the formal evaluation of phase 2 of the DHPAP program that provided clinical services to members of these communities. Second, we are anthropologists. We carried out interviews with families and village leaders in these communities, as well as with the clinicians who were providing care. We accompanied the medical teams as observers at times, and in particular in November 2008 we and our colleagues interviewed a small number group of patients who had been in treatment for six to nine months, asking about their experiences of care and their symptoms before treatment and at the time of the interview. It was in this context that a local phenomenology of trauma-related illness and PTSD emerged.

An extremely common initial presentation of distress, reflected in our interviews, in clinical interactions, and in the medical records, would begin with a simple statement, *jantung berdebar debar*, my heart pounds.[11] Those diagnosed as suffering a psychiatric disorder would often go on: *Saya sering takut*, I am often afraid. *Teringat*, I have memories that come unbidden to me. *Tidak bisa tidur dengan enak*, I can't sleep well at night; *ada mimpi buruk*, I have nightmares or bad dreams, wake up feeling frightened, and cannot sleep again. *Gelisah*, I often feel restless, anxious, worried. My body feels

weak, *lemah*; I lack spirit or energy, *semangat*, so that I am unable to go off to work in the rice paddies or the gardens. In some cases, these symptoms were presented as such—as symptoms—to the physicians or a member of the medical team, with narrative content emerging after several meetings with the clinicians, when a close enough relationship was established to recount horrifying memories, such as those described in the beginning of this chapter. In other cases, the narratives came first, with symptoms essentially describing the embodied response to the events that had occurred. Physicians would then inquire further to determine more specific diagnoses.

In this setting, depression, PTSD, or an anxiety disorder, including panic disorder, seldom appeared as discrete, heterogeneous conditions, as represented in diagnostic manuals. Although this mental health outreach program was conducted two and a half years after the violence had stopped, it was carried out in communities that had suffered years of violence, and any disorder—even schizophrenia or a major depression resulting from the death of a child or spouse in a manner unrelated to the conflict—was caught up in memories of the violence. These had been years of extreme fear and anxiety, of experiences of loss as well as terror. Symptoms of depression, anxiety, intrusive traumatic memories, and sleep disturbances, as well as disabling bodily symptoms, were present in varying degrees in nearly all of the cases treated by the IOM teams. These had also been years of remarkable resilience and a commitment to resistance and struggle, on the part of men, women, and even children (M. Good 2015; M. Good and B. Good 2013). For most, symptoms faded—or were reduced in frequency and severity—after the violence ended, as communities gained confidence that the peace process would hold. Our clinical data, however, indicate that a smaller group of persons developed or maintained more severe, long-lasting symptoms. For many such persons, these conditions were extremely debilitating, reducing their ability to work, to function in the household, or to participate fully in the community.

Despite the ubiquity of symptoms, many of those treated by the IOM teams presented fairly classic clinical pictures of major depressions, generalized anxiety disorder, panic attacks, and somatoform disorders, as well as PTSD. Many presented with relatively high levels of somatic or bodily complaints—pain, stomach problems, heart sensations, loss of energy. Many presented with symptoms indicating mixed depression and anxiety, PTSD with depression or other anxiety disorders (including panic disorder), or one of these disorders with mixed psychotic symptoms. In the case of PTSD, the

symptoms of intense, intrusive memories are clearly marked by the Indonesian term "*teringat*," "to remember" in the sense of memories coming unbidden, in contrast with the term "*mengingat*," to remember in the sense of an active remembering process. In some cases, individuals described intrusive memories as being linked to acute episodes of extreme fear or anxiety, with symptoms meeting criteria for panic attacks, as well as to nightmares in which these events were vividly reexperienced.

The boundary between acute remembering, often with intense anxiety, and reexperiencing of the kind popularly described as "flashbacks" is often unclear in Aceh. Patients being treated would describe acute, intrusive remembering of terrible events they had witnessed directly, things that had been done to them, or in some cases events they had only heard about when a family member was tortured or killed. Some would describe seeing such events being played out as though on a video—in some cases, even if they had not seen the events directly. Many would describe becoming anxious in specific places in their villages or their homes where terrible events had happened, or in some cases having extremely acute memories be triggered when they were in such settings. And many described avoiding going out in crowds or trying to avoid the places where these events had occurred.

Equally striking was the fact that many people who initially were treated would, at some point early in their care, tell stories of what they had witnessed or experienced as though they had occurred very recently. (Clinicians, as well as researchers, were trained not to request people to retell the stories of their most traumatizing events, given the evidence of the potential harm associated with debriefing. Many persons would, however, talk about what had happened to them at some point in the treatment process or during interviews.) We recall cases in which stories were told to us, or to clinicians (who retold the stories to us), as though they had occurred in the past days, weeks or months, but we or the clinicians would later learn that the events had happened years before, in some especially memorable cases up to sixteen years earlier. Although Indonesian language does not neatly distinguish present and past tense, these stories were told as though in the present, as recent occurrences that were cause for current, ongoing anxiety.

The item on the Harvard Trauma Questionnaire, "feeling as though the event is happening again," is rated as happening "never" by only 22 percent of the patient sample—by only 12 percent of those given a clinical diagnosis of PTSD, but also only 27 percent of those who were not given a PTSD diagnosis. The description of nightmares is often quite similar, suggesting that

nightmares are akin to such intrusive memories or flashbacks occurring during sleep rather than waking hours (Grayman et al. 2009; Hinton 2009; Hinton et al. 2009, 2013).

We analyzed the symptom checklist data—of the Harvard Trauma Questionnaire (HTQ)—using the algorithm developed by Mollica et al. (1999, 2004) to determine whether individuals suffered constellations of symptoms consistent with a DSM diagnosis of PTSD. We are quite aware that these were not diagnostic interviews, and no data are available to assess duration criteria. However, this method allows analysis of the copresence in an individual of symptoms that meet criterion B (reexperiencing symptoms), criterion C (avoidance and numbing), and criterion D (arousal symptoms). Following Mollica's method (which counts a symptom as present if it is rated either as 3 or 4 on a 4-point scale), 52 percent of individuals surveyed in Bireuen in PNA1 and 51 percent in Aceh Utara (but only 14 percent of those who were surveyed in Pidie, a neighboring district also surveyed in PNA1) met these criteria for a diagnosis of PTSD. If we increased the severity level of the symptom to a 4, in order to count it as present, the percent of persons meeting these criteria dropped to 26 percent, 25 percent, and 3 percent in Bireuen, Aceh Utara, and Pidie, respectively. In the intervention program we evaluated (DHPAP Extension), the clinicians gave a clinical diagnosis of PTSD to 33 percent of the 1,137 patients in our study at time 1, when initially entering treatment. This would constitute about 3–4 percent of all adults in these villages.

The data presented here cannot provide conclusive evidence for the existence of PTSD—as defined by DSM or ICD criteria—in Aceh. This was not a study of the validity of the PTSD construct in Aceh, seeking answers to the questions raised by Hinton and Lewis-Fernández (2011) in their important review of empirical evidence for cross-culturally validity. The research focused on supporting the public health work, which was the mission of IOM. The data do, however, suggest that trauma-related mental health problems that strongly resemble PTSD present a very significant public health challenge in a setting that has suffered widespread violence and has extremely limited mental health resources. Clinicians on the IOM teams attempted to identify persons who met DSM criteria for PTSD, either as a primary diagnosis or more commonly comorbid with another diagnosis, and found the diagnosis a useful guide for treating patients in these villages.

Describing PTSD as a pseudocondition or a natural response to the ravages of violence misses a critical dimension of PTSD—that it is a condition

that persists beyond the expected natural recovery from violence in those settings where the violence has ceased. Such a description tends to devalue the level of persistent suffering and disability experienced by many in postconflict communities and may lead international donors and policy makers to give inadequate attention to the profound mental health needs of such populations.

It is important to add that while classic symptoms of PTSD were present in this population in Aceh, an accurate clinical description requires a notion of complex trauma (see Introduction and Chapter 1 of this volume for a fuller discussion of complex trauma).[12] PTSD as a response to a single, traumatizing event that occurs in the life of someone otherwise secure is profoundly inadequate for understanding persons with prolonged experiences of war or prolonged childhood abuse, which is why there is often such a sharp disjunction between clinical experience in postconflict settings and PTSD treatment protocols. It is also important to note that a focus on PTSD as a discrete and heterogenous condition is often inaccurate and unhelpful in clinical practice. Panic attacks, associated with intrusive memories or flashbacks, are commonly present for those who meet criteria for PTSD in this population, and comorbidity of PTSD, depression, and anxiety disorders, particularly generalized anxiety disorder, may very well be more the norm than the exception (B. Good and Hinton 2009). None of this suggests, however, that PTSD is a pseudocondition. What our work does suggest is that a clinical perspective, joined with a public health perspective, is far more critical to responding to the needs of war-affected populations than narrowly biological or diagnostic perspectives that focus on ever more refined diagnostic criteria rather than on developing interventions that have public health utility in low-resource settings. The challenge of providing mental health care with extremely limited resources for populations profoundly affected by violence remains, unfortunately, marginal for the vast number of researchers in trauma studies, as indicated by research dollars and journal publications.

PTSD: Is There Evidence That War-Affected Populations Seek Western Treatments?

So what about the broad set of claims about trauma treatment as an imposition of treatment forms irrelevant to local cultures, which jeopardize local coping strategies (e.g. Pupavac 2001), or Summerfield's claim that PTSD as a

concept serves primarily to "aggrandize the Western agencies and their 'experts' who from afar define the condition and bring the cure," and that "there is no evidence that war-affected populations are seeking these imported approaches, which appear to ignore their own traditions, meaning systems, and active priorities" (1999:1449)?

When IOM began providing outreach mental health services in villages in Aceh that had suffered through the conflict, there was little evidence about what traumatic disorders looked like in this setting, whether people considered these to be conditions that would respond to medical treatment, and whether relatively standard medical treatments—including the use of antidepressant medications, counseling, and psychosocial interventions—would be considered appropriate or would be effective. Some local NGOs worked with torture victims during the course of the violence, despite political repression, and continued this work postconflict. However, the question of the cultural fit of providing diverse forms of mental health care in rural communities was largely unanswered.

The pilot intervention, using outreach teams to provide medical care for persons with diagnosable mental health problems in these high-conflict villages, was inspired in part by the success of the initial visit of the IOM team to a particularly severely impacted village, described in the introduction to this chapter. That initial experience of bringing a mental health team in IOM vehicles to the village suggested that even during the early postconflict period, marked by continued fear of the military, people were anxious to gather and talk with a doctor about illnesses they associated with conflict-related experiences, that they were prepared to tell their stories and describe their symptoms to a medical team, and that they were anxious to find medications that would help relieve their symptoms (M. Good 2010). The DHPAP Pilot project, the nine-month pilot program in twenty-five villages aimed at developing a model of care, built on these impressions. The IOM medical team—consisting of three doctors, three nurses, all Indonesian and all but one of whom were Acehnese—were able to develop methods for case finding; they learned to use village health volunteers (*kader*), conducted general medical clinics in the villages to screen for persons with mental health problems, and made home visits, during which new cases were often referred. Clinically, the teams gained experience, learned to make clinical evaluations in these village contexts, learned that people would seek medical treatment and would take medications when they were provided, and had the clinical experience of watching many of those they treated recover. The DHPAP Pilot program

provided strong evidence that Acehnese villagers who suffered trauma-related mental health problems would indeed seek and make use of treatment, and that the IOM outreach model was a viable means of providing services. What was absent from the pilot study was any strong empirical evidence for the effectiveness of the treatment.

The DHPAP Extension project included an empirical evaluation component, designed to study the effectiveness of these outreach teams when extended to fifty new villages—to determine levels of symptoms and social functioning when persons entered into treatment, to compare levels at times 1, 2, and 3 to learn whether symptoms were reduced and social and vocational functioning improved over the course of treatment, and to learn how those treated evaluated their own response to treatment. The sample consisted of the first 1,137 patients who were treated in the program and agreed to participate in the study. The research was able to follow 1,063 of these patients through to time 3, with only a 6.5 percent loss to follow-up. Unlike the PNA sample, with nearly equivalent numbers of men and women (in the random, population-based sample), the clinical sample consisted of 68 percent women and 32 percent men.

All patients were given an initial clinical diagnosis. When the treating physicians considered it appropriate, medications were provided. Villages were visited on a monthly basis, more often during the initial phase of case finding. Counseling and home visits were part of the usual clinical practice. Support groups were organized in some of the villages, and additional livelihood or vocational support was provided to 200 of the patients. Table 12.1 describes the clinical diagnoses registered by the IOM team for this sample of treated patients at time 1. Generalized anxiety disorder, PTSD, and mixed depression and anxiety made up 90 percent of the treated sample. Of the 1,063 patients who remained in the sample until time 3, 47 percent were given an antidepressant medication, 44 percent were given an antianxiety medication, and only 3 percent were given an antipsychotic medication. Forty percent of the sample used medications for three months or less, and 74 percent of the sample used medications for six months or less. So were the treatments effective? Here we provide four small pieces of data, from a much larger data set, that may be useful to respond to those who question the whole enterprise.

Tables 12.2 and 12.3 provide an overview of the levels of symptoms (divided for women and men) for the PNA2 sample, and the DHPAP patients at time 1, when patients entered treatment, at time 2, which marked the end of the formal IOM treatment, and at time 3, a follow-up five months after time

Table 12.1. Diagnosis of Patients at Time 1 by Gender

	Men		*Women*		*Total*	
Diagnoses	*% of patient sample suffering disorder*	*Total patient sample N = 370*	*% of patient sample suffering disorder*	*Total patient sample N = 752*	*% of patient sample suffering disorder*	*Total patient sample N = 1,122*
General anxiety disorder	41%	150	44%	327	43%	477
Mixed depression and anxiety	12%	45	17%	127	15%	172
Depression	4%	15	7%	50	6%	65
Insomnia	4%	15	3%	19	3%	34
Somatoform disorder	10%	37	12%	87	11%	124
PTSD	40%	147	29%	218	33%	365
Psychotic disorders	4%	13	1%	11	2%	24

2 (a total of twelve to eighteen months). The tables indicate percentage of persons in each category who were at or above two cutoff levels for the symptom checklists used: a recommended cutoff level for indicating caseness in international research, and a higher cutoff level we used to identify the more severe cases. The tables reveal two primary findings. First, the clinical sample at time 1 has symptom levels far higher than the normal population distribution in the PNA2 study. Although this would be expected, it indicates that those who sought and decided to make use of medical care, given the case-finding methods employed by IOM, were persons who continued to have extremely high levels of symptoms more than two and a half years after the end of the conflict. Second, the tables demonstrate what the entire outcome study found: levels of psychological symptoms declined dramatically from time of entry into the treatment to the end of the DHPAP outreach activities and continued to drop for the next five months (during which a small percentage continued to receive care from the public primary care clinics). This was true equally for persons diagnosed by the clinical team with anxiety, depression, or PTSD.

Table 12.4 provides data from one of several general questions we asked each respondent at time 3 as the program was ending, concerning their own evaluation (on a 7-point scale) of the change in their symptoms or functioning since they began treatment with the IOM teams. Over 80 percent reported that their symptoms were better, and over 45 percent indicated improvement at the 6 or 7 level on the 7-point scale. Whether measured objectively, using symptom checklists adapted for local cultural conditions, or self-evaluation of whether they had gotten worse or better, the study demonstrated dramatic changes from the beginning to end of treatment, changes that continued into the follow-up period.

We also used a number of measures to try to determine improvement in social functioning, particularly in ability to work. Early in the study we found many people who complained that they were simply not able, not strong enough, or did not feel well enough to work. In this region of Aceh, this usually meant not being able to go to the rice fields or into the forested garden areas to cultivate and harvest a variety of agricultural crops. However, many also engaged in small enterprises—running a coffee shop, baking small cakes and selling them in the market, doing significant handicrafts for cash sales. Of all of the scales and questions we used to evaluate social functioning, a simple set of questions about how many hours a week they could work was most telling. At the beginning of the study (time 1), we asked each individual to

Table 12.2. Symptom Measures for Patients at Times 1, 2, and 3, Compared with PNA2: Women

Symptom Levels	*PNA 2 N=1,376*	*Time 1 N=752*	*Time 2 N=730*	*Time 3 N=719*
Mean anxiety score "symptomatic" (≥1.75)	46%	90%	69%	60%
Mean anxiety score "high symptomatic" (≥3.0)	10%	45%	25%	12%
Mean depression score "symptomatic" (≥1.75)	40%	76%	57%	43%
Mean depression score "high symptomatic" (≥3.0)	5%	13%	6%	3%
Mean PTSD score "symptomatic" (≥2.5)	12%	28%	15%	8%
Mean PTSD score "high symptomatic" (≥3.0)	4%	7%	3%	1%

Table 12.3. Symptom Measures for Patients at Times 1, 2, and 3, Compared with PNA2: Men

Symptom Levels	*PNA 2 N=1,376*	*Time 1 N=370*	*Time 2 N=353*	*Time 3 N=340*
Mean anxiety score "symptomatic" (≥1.75)	33%	89%	59%	43%
Mean anxiety score "high symptomatic" (≥3.0)	8%	39%	18%	8%
Mean depression score "symptomatic" (≥1.75)	31%	68%	49%	28%
Mean depression score "high symptomatic" (≥3.0)	3%	9%	3%	4%
Mean PTSD score "symptomatic" (≥2.5)	8%	22%	13%	7%
Mean PTSD score "high symptomatic" (≥3.0)	3%	7%	3%	2%

indicate how many hours of work he or she usually did before becoming sick, and how many could be done when they became sick (with this mental health problem). The whole sample, including men and women, young and old, reported a mean of twenty-eight hours that they estimated they worked before the illness. (Recall, this was during the conflict, when the military would not allow most villagers to go to their fields.) They reported that

Table 12.4. Response at Time 3 to Question: Since you received treatment by IOM, have your mental health symptoms (from stress or trauma) become worse, stayed the same, or gotten better?

	Percent	*N = 1,063*	*% worse, same, better*
Much worse	0%	0	1%
Somewhat worse	0.3%	3	
A little worse	0.8%	9	
The same	16%	167	16%
A little better	37%	388	83%
Better	38%	406	
Much better	9%	90	
Total	100%	1,063	100%

when they were ill, their ability to work declined to a mean of ten hours per week. When asked at time 3, at the end of the twelve-to-eighteen-month follow-up, how many hours per week they were able to work, this treatment sample reported a mean of forty-one hours per week! This and other measures indicated a dramatic recovery of ability to work associated with the mental health intervention.

This study did not have a control group. It was a prospective observational study, not an experimental study. We know that the peace process continued to unfold during this time, that social and economic conditions continued to improve along with security. However, this study began enrolling patients only in February 2008, two and a half years after the August 15, 2005, peace agreement, and approximately two years after most of the military forces began leaving the region. This program identified persons who had not recovered up until that time. It is our interpretation that the medical intervention played a critical role in the recovery of many of those treated by the combined IOM and Ministry of Health teams.

Our qualitative interviews and observations of cases supported this interpretation. It is quite remarkable to hear persons with trauma experiences describing terrible events that happened in the quite distant past—in some cases more than fifteen years earlier—as though they occurred in the past week. It is also remarkable—and gratifying—to watch recovery processes, as individuals who had previously discussed such terrible events with an extreme sense of present temporality begin to discuss these same events as genuinely part of the past. In brief meetings in July 2010 with persons we had

interviewed in 2008 as part of the qualitative evaluation, many made clear not only that the symptoms they described were now very much in the past, but that they had no interest in discussing with us the terrible events during the conflict that they had worked through early in their treatment and in some cases had discussed with us in detail in earlier interviews. We were thus able to observe individuals who had clearly been disabled, unable to leave their houses to work, return to full activity.

It is not possible to determine exactly what accounted for the recovery. Our PNA1 data indicated a wide variety of local, cultural, and religious strategies individuals used to try to "overcome bad experiences related to the conflict" (B. Good et al. 2006:46–49). Nearly all of those who reported having such bad experiences reported using prayer to overcome them; high numbers (56 percent and 37 percent in Bireuen and Aceh Utara) reported talking with friends and family members as a strategy; an almost equal number reported consulting a religious specialist or seeking medical help; and the other most common strategy reported was "trying to forget about the experience." Community rituals (*peusijeuk*) were held for returning combatants or political prisoners in many villages (39 percent of respondents in Bireuen reported participating in such a ritual, 17 percent in Aceh Utara). Mental health problems were treated by attending prayer groups (*pengajian*), and the religious description of surrendering to God (*pasrah*) with sincerity (*ikhlas*) was often referred to (though this seems to have been more difficult to achieve in the context of the conflict than of the tsunami—cf. Samuels 2012:133–46).

The IOM project was not, in reality, what Summerfield (1999:1449) described as "imported approaches, which appear to ignore their own traditions, meaning systems, and active priorities." There is no evidence that medical care "jeopardizes local coping strategies," as suggested by Pupavac (2001:358). These were Acehnese doctors and nurses, coming to listen to the complaints and stories of Acehnese villagers, themselves participating in the same religious traditions, who came providing medications they said would be helpful. Some had themselves experienced similar traumatic violence. Providing such medical care, making visits to homes and listening sensitively to what people have suffered, and organizing support groups is not an imported Western model of care. Indeed, medications are highly valued and given local meanings. For persons with PTSD, nearly all of whom had severe sleep disruption, the use of fairly sedating antidepressant medications (such as amitriptyline, which is the only such medication available in the public primary health care centers), may have been effective in helping persons to

sleep.[13] All the antidepressants used in the DHPAP Extension project (including SSRIs) may have had some effect in reducing the panic attacks associated with intrusive memories.

Although the medications were apparently useful, and the treatment followed evidence-based practice guidelines (Friedman et al. 2009), we cannot say that the medications themselves were the source of efficacy. It may have been a continued relationship with a small team of doctors and nurses that was particularly significant in enabling many individuals to recover. And the fact of recognition by teams of Acehnese doctors and nurses supported by an international NGO (or in this case an IGO or intergovernmental organization) was also important to these villagers. What we do know is that a large majority of persons treated in this project improved significantly—in terms of symptoms and social functioning, and in their own rating of their mental health—over the course of the treatment. We judge this to mean that the treatment program was highly effective.

Conclusion

We have given only a small hint of what our data suggest. And we have not focused exclusively on PTSD. Indeed, our work argues strongly against a narrow focus on trauma and trauma treatment. Describing immediate psychological responses to disaster or violence as PTSD misses entirely the core of the disorder—the inability to work through trauma in a way that places it in the past, the failure to recover (Shalev 2007). It also argues against narrow debates about symptoms and symptom criteria, to the neglect of a larger public health perspective. On the other hand, our work suggests that PTSD is far from a pseudocondition. It is for many an extremely debilitating condition—a disorder of being unable to put in the past what one desperately wishes to put in the past. And more than this, the care provided by the remarkable young Indonesian doctors and nurses working on the outreach teams makes evident that PTSD, like other trauma-related illnesses, is a treatable condition, that nonpsychiatrist physicians and medical teams can be trained to give high-quality mental health care, and that issues of public commitment and implementation of service models should occupy public health specialists and humanitarian agencies, as well as anthropologists, as much as other aspects of postconflict work. Identifying who can benefit from what kinds of treatments and developing service models that can actually deliver such

treatments is of far greater importance than ontological debates about whether PTSD is a real or pseudo condition.

Notes

1. For analyses of this work, see M. Good et al. 2010; M. Good 2010; B. Good 2012; M. Good and B. Good 2013; and B. Good et al. 2015.

2. This description of our initial visit to this village is drawn, in part, from B. Good (2012:529–30).

3. See B. Good et al. (2015) for a discussion of the issue of humanitarian governance. The diagnosis and treatment of trauma-related conditions is only one part of the broader critique of humanitarianism.

4. Authors Byron Good and Mary-Jo Good began as consultants to IOM in 2005, guiding the design of the project. They then continued their collaboration based on a subcontract from IOM Indonesia to Harvard Medical School, initiated in 2006. They took primary responsibility for designing the PNA surveys, analyzing the data (with the assistance of Matthew Lakoma), and writing the PNA1 and PNA2 reports, along with their collaborator and then doctoral student Jesse Grayman, who coordinated the research in the field. All three of us continued to work closely with IOM to develop and evaluate an intervention program to respond to the needs identified in the PNA. The Goods were primarily responsible for evaluations of both the pilot and extension phases of the DHPAP mental health outreach project, described in this chapter.

5. See B. Good et al. (2006) for a full description of methodology of the survey. Sampling was designed to develop a representative sample of adults, households, and villages in high-conflict subdistricts of three districts of North Aceh.

6. See B. Good et al. (2006) and M. Good et al. (2007) for description of the instruments used for the PNA research, including translation and adaptation of widely used instruments and the development of elements of the questionnaire specifically for this survey. The core instruments included a measure of conflict-related experiences, and symptom checklists for depression and anxiety (based on the Hopkins Symptom Checklist 25) and PTSD (the Harvard Trauma Questionnaire), following Mollica et al. (2004).

7. The DHPAP Pilot phase was supported by funds from the Norwegian government to IOM.

8. The DHPAP Extension phase was supported by a World Bank contract with IOM, with funds from DFID, the UK's Department for International Development.

9. Analyses presented here are drawn from B. Good and M. Good (2010).

10. We sometimes remind people that if Aceh were a state in Australia, one would expect there to be 420 psychiatrists, just to indicate the challenge of building systematic mental health care in a setting of so few mental health resources.

11. This analysis reports symptoms in Bahasa Indonesia, or Indonesian language. Local villages in our region spoke primarily Acehnese. The Indonesian terms, here, are translations of Acehnese and the terms used when Acehnese spoke Indonesian.

12. The term "complex trauma" was introduced as early as 1992 by Judith Herman (1992) but continues to carry diverse meanings in the literature. See the Introduction and Chapter 1 this volume, for discussion.

13. The DHPAP Pilot study used only medications identified as essential drugs and available (at least in theory) in the primary health care system. The only antidepressant used was amitriptyline. Following advice of consultants, the DHPAP Extension project added sertraline and fluoxetine to the IOM team's formulary.

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