Assessment of the psychosocial and mental health needs, dysfunction and coping mechanisms of violence affected populations in Bireuen, Aceh

A qualitative study

Bhava Poudyal, MA*, Judith Bass, Theodora Subyantoro, MA*, Abraham Jonathan, BA*, Theresia Erni, LLB*, & Paul Bolton, MBBS*****

Abstract

Qualitative research is important due to the shortage of literature in understanding cultural influences on psychosocial and mental health syndromes and their presentation, especially in developing countries. This qualitative study aims to investigate the psychosocial and mental health needs of populations in Aceh, Indonesia affected by over 30 years of conflict, their dysfunction, and their positive coping mechanisms. Results from this qualitative assessment indicate the presence of depression, anxiety and somatic symptoms. The data provide local terminology and ways in which the local population describes their own distress, which is an important addition to the understanding of the mental health consequences of this conflict. The data has been used to develop appropriate intervention strategies and adapt and validate assessment tools to measure psychological distress, dysfunction and coping mechanisms.

Keywords: violence, qualitative, psychosocial, dysfunction, coping

*) International Catholic Migration Commission (ICMC)
Jakarta
Indonesia
poudyal@icmc.net

**) Department of Mental Health
Johns Hopkins Bloomberg School of Public Health
Maryland
USA
jbass@jhsph.edu

***) Center for Refugee and Disaster Response
Johns Hopkins Bloomberg School of Public Health
Maryland
USA

Introduction

The problems and needs of survivors of violence in Aceh, Indonesia are closely connected with the conflict between The Free Aceh Movement (GAM) and the Indonesian Government that went on for over 30 years. As GAM struggled for independence and the Indonesian government tried to curb it through military operations, the people of Aceh experienced and witnessed significant violence. During the Suharto regime (1967 to 1998), the people of Aceh faced a lot of violence, and were hopeful after the fall of Suharto in 1998 that they would see peace. Unfortunately, the conflict continued, and in 2003, Aceh was put under martial law following the failure of the Cessation of Hostility Agreement (CoHA) that was signed on Dec 9, 2002 by the GAM and the government of Indonesia. This continued the conflict until the devastating tsunami in December 2005. After the tsunami, both the GAM and the Government of Indonesia established a truce, with peace finally realized

in September 2006 when GAM was allowed to be a political party and participate in elections and local and national government.

A study conducted around this time by the International Organization for Migration[1, 2] in high-conflict communities across Aceh found that nearly three-quarters of those assessed reported living through combat, with more than one-quarter reporting having been beaten and nearly forty percent reporting a family member or friend being killed. With this exposure to violence, they also found high rates of depression symptomatology, post-traumatic stress disorder and anxiety.

While this study indicates high rates of mental health problems among the general population, it does not provide us with sufficient information to develop targeted interventions and locally useful assessment tools. To get the necessary information, we used qualitative methods to explore important mental health problems, dysfunction and coping strategies from a local perspective. Data from this type of assessment consist of how local people view their problems in terms of the nature of these problems, their severity, their causes, and how people deal with them. Program implementers can use this information to select problems that match local priorities, and to design and adapt interventions that are likely to be effective in terms of local feasibility and cooperation. The information is also useful in designing indicators and assessment tools to evaluate both the need for, and the impact of, programs and to monitor their implementation.[3, 4] In this report we present the results from our qualitative study that identifies targets for intervention including the salient mental health problems, indicators of functional impairment, and coping strategies that could be enhanced.

In the context of this qualitative study, "violence" refers to all acts of intentionally inflicted physical and/or psychological injury, whether by a person acting on their own initiative or under the direction of another person, and excludes accidental injury. The term "survivors of violence" includes not only those who were injured but also others who have been affected by these acts either by indirect exposure (such as witnessing an act) or by having to live with their consequences (such as family members).

Study purpose

The primary purpose of this qualitative assessment was to understand how local people affected by violence perceive their current psychosocial and mental health problems resulting from these experiences, including the variety, importance and severity of these problems, the nature and terminology used to describe these problems, their perceived causes, and what people do to help themselves when they have these problems. In addition, data were gathered to identify what constitutes the most important aspects of normal daily functioning in order to design locally-appropriate measures of functional impairment. Finally, data were also collected to understand the various coping skills used by the local population to minimize their excessive negative emotions and to deal with daily life stress.

Study location

The interviews for this qualitative study were conducted in three villages in Bireuen district, one of the hardest hit districts in Aceh.[1] These three villages were representative of the region in terms of nature and severity of conflict experiences, social economic status, and size of the villages. All the interviews were conducted in these three villages at people's homes, under trees, or at local mosques.

Methodology

This study draws on methods developed by Bolton and colleagues,[5, 6] that have been applied in other under-resourced and fragile environments. Local interviewers were trained in the use of open-ended, non-leading methods of interviewing in which the respondent is probed for as much information on a topic as they know and are willing to say. Everything the respondent says is recorded verbatim, without summarization, paraphrasing or translation. Respondents were chosen to represent the diversity of the population and for their particular knowledge of the issue being assessed.

The study involved two weeks of training, data collection and analysis. Twelve interviewers, who were native Acehnese language speakers, received training and daily supervision throughout the interview process. Interviewing was done by means of three qualitative methods used sequentially: Free listing, key informant interviews, and focus groups, with all interviewers working in pairs.

Free listing interviews

Seventy-one community members (36 male, 35 female) were interviewed using this first technique. Respondents included those exposed directly to the violence and members of their families, as well as locally respected persons (community leaders and well known local people). Respondents were asked the primary question: "What are some of the problems that people affected by violence in your community face?" Interviewers probed each respondent for as many problems as the respondent could think of. For each problem, interviewers recorded its name and a short description, in the exact words of the respondent in their local language.

At the end of the interview, interviewers reviewed the list for potential mental health or psychosocial problems, defined as problems referring to *thinking*, *feeling* or *relationships*. For each of these problems, they asked the respondent for the names and contact information of local people who are knowledgeable about that problem and/or who people with these problems go to for help. The focus was on identifying key informants who come from the local area (in contrast to professionals such as health care or social workers who work in areas but often come from elsewhere). This contact information, and the problem each "expert" was said to be knowledgeable about, was recorded separately from the interview.

To analyze the free lists, the interviewers condensed all of their lists into a single composite list of all the psychosocial and mental health problems. Two problems (fear and too many thoughts) were selected for further investigation with the key informants (described below) in that they appeared frequently, were interpreted by the interviewers to relate to many of the other problems mentioned, and the project implementers thought they would be able to address those two problems with their counseling program.

Four additional free lists were generated from each respondent, gathering information about the important day-to-day activities and tasks that men and women do to care for themselves, their families, and their communities, and on the coping strategies they use to deal with their problems. This information was sought with the intention of formulating locally appropriate indicators of functioning and coping.

Key informant interviews

A total of 22 key informants (KI) were interviewed using the second interviewing technique. The KIs were identified through the names and contact information provided by the free list respondents described above and

by "snowball sampling" (i.e. referral by one key informant of another key informant). In addition, some of the free list respondents who were identified as clearly knowledgeable were enlisted as key informants. Fourteen (64%) of the KIs were interviewed between 2 to 4 times in order to record as much information from them as possible. Five of the KIs were only interviewed once because upon review of their responses they were deemed to either be unknowledgeable about the problems and/or the population of interest.

Key informants were asked to tell all they knew about each of the two problems fear and thinking too much, with particular reference to the nature of each problem, its causes, effects, what people do to address each problem, and what could be done by others to help. Like with the free list interviews, the study interviewers conducted the analysis of the KI interviews. The interviewers reviewed the text of the interviews to identify all the different signs and symptoms mentioned for each problem area, indicating how many different KIs reported each sign and symptom. Items that the interviewers identified as meaning the same thing (i.e. don't want to talk and quiet) were grouped together. For signs and symptoms that were grouped together as meaning the same thing, the interviewers were asked to come to a consensus as to one of the terms that could be used to capture the overall meaning of the group of terms. The end product were two lists, one each for fear and thinking too much, with all the different signs and symptoms and the frequency with which each was reported.

In addition to the analysis of the signs and symptoms, the interviewers also reviewed the KI interviews to identify local ways that people coped with the problems they had.

Focus groups

To further explore functioning among the local population, one focus group was convened. During the focus group, the participants were provided with a summary of the results of the task lists from the earlier free list interviews. The participants, consisting of 5 male and 5 female KIs, were asked to confirm if these were the activities and tasks that men and women regularly do across all three domains (care of self, family, community) and if there were other important activities not listed. To complete the discussion, the group was asked to identify the most important tasks for each gender, understanding that all of the identified tasks were activities that both men and women do regularly.

Results

This qualitative assessment was completed in two weeks in September 2006. Table 1 presents the mental health problems mentioned by at least 10% of the free list sample (n=71). The problem of fear was the most mentioned problem (44 respondents) followed by heart pounding, heavy heart, shaking and trembling and thinking too much. Reviewing the results, the interviewers thought that the problems of heart pounding, shaking and trembling were all encompassed within the problem of fear, with fear being the emotion and the other three being the symptoms that accompany fear, which is consistent to the cluster of symptoms of anxiety in the Western model. Heavy heart was encompassed within thinking too much by the interviewers, and the study team also thought this might be the theme for Depression from the Western model. Therefore, the in-depth key informant interviews focused on the primary problems of fear and thinking too much.

For the analysis of the KI data separate

Table 1. *Mental health and psychosocial problems identified from the free listing interviews (71 respondents).**

Problem Description	Frequency
Fear/afraid	44
Heart pounding	31
Heartache/Heavy heart	15
Shaking, trembling	14
Too many thoughts/ thinking too much	12
Body pain/stiffness	10
Anger/feelings of revenge/resentful	9
Worried, anxious, stressed	8
Chest pain (broken chest)	8
Sad	8
Trauma	8
Remember the loss	7

*) Problems mentioned by 10% or more of the respondents are presented.

Table 2. *Signs and symptoms of "fear" and "thinking too much" from the KI interviews (22 respondents)**

Symptoms	Frequency "thinking too much"	Frequency "fear"
Body is sick/body pain	12	11
Weak body/no energy	12	10
Heart pounding	5	15
Not calm/can't sit still/ restless	8	
Spacing out	15	4
Loss appetite/forget to eat	8	4
Easily get angry	9	3
Can't sleep/sleep difficulties	6	5
Shaking	1	10
Unhappy/sad	8	2
Broken hearted/heavy heart	2	7
Isolation	7	0
Quiet	4	3
Fever/body feel cold/body feel hot	2	6
Remembering the loss	2	6
Feels like everything done is wrong (guilt)	3	1

*) Symptoms mentioned by two or more of the KIs are presented.

lists were generated for each problem: fear and thinking too much (Table 2). Review of the KI interviews indicated significant overlap and that each primary problem often showed up as a symptom within the description of the other problem. The overlap in symptoms can be seen clearly except for "isolation" which is only seen for the problem of "thinking too much".

Table 3 provides information on what the KIs indicated that the survivors of violence and their families do to help themselves when they experience distress. The identified strategies ranged from things the individual does by him/herself (i.e. go for a walk) to things he or she does with others (i.e. have discussions with friends or family). We did not ask the KIs to identify which of the coping strategies they considered "positive" or "negative." Thus, the strategies need to be evaluated by program staff for what they would consider to be coping strategies that could be promoted, or leveraged, in an intervention strategy.

Table 4 presents a summary of the daily tasks and functions, separated by gender, generated from the free lists and identified as important in the focus group discussion. These items will be used to develop an assessment of functional impairment that would measure an individual's inability to carry out the specified tasks and activities.

Discussion

For assessment of mental health and psychosocial problems in non-Western environments, it is typical for programs and researchers to translate standard Western assessment tools and conduct screening.[2] Field practitioners often express concerns over such methodology. The author's own experience (BP) includes a situation when survivors of torture and violence answered that they always have recurrent memories of the traumatic event when screened through a translated Harvard Trauma Questionnaire,[7] but on further probing, the recurrent memories were actually of loss of cattle and property, and not the recurrent memory of

Done by self	Done with others
Pray	Recite Koran with others
Work	Discussions with family/friends
Find recreation	Kenduri (cook for others during ceremonies)
Sit at home not going anywhere	Play football and volley ball
Do more fasting (religious)	Listen to lectures by religious leader
Go to look for money	Avoid fights and arguments with others
Go for a walk	Get involved in community work
Vow (make promises to God about making amends if he granted the wish)	

Table 3. *Coping strategies identified during the Key Informant interviews (22 respondents).*

Table 4. *Female and Male Task and Activity List.*

Female tasks and activities	Male tasks and activities
Take shower	Earn money
Put on make up	Eat rice
Iron clothes	Pray
Eat rice, meals	Sport (volleyball, football)
Sit around for relaxation, chat with others	Take a bath
Pray	Help clean up the house/fixing the house
Cook	Go to the market to shop (buy rice, fish)
Prepare the children to go to school	Shave
Wash clothes	Religious art (recite traditional poetry in Arabic language)
Work	Recite Koran
Take care of self (wear clothes, comb hair, take a nap, cutting nails)	Community work
Wash dishes	Community meeting
Fetch water	Go to kenduri (ritual/ceremony meals)
Look for woods	Music art (related with prayer and religion)
Educate children	Brush teeth
Kenduri/cooking for people having ceremony or ritual	Brush hair
Clean up the house	Visit people who experience calamity
Take care of children	
Earn money	
Take care of elderly	
Participate in Family Welfare Program (making cakes, sewing traditional fan)	
Learn/recite Koran regularly	
Community work (clean up mosque)	
Visit people who experience calamity	

the torture or violence they experienced, as purported by the question. Another example is the issue of asking about nightmares. Our experience is that people respond positively to the question on nightmare when they might have a dream that culturally signifies bad luck (i.e., dreaming of your tooth falling out). When further probed, they might not be distressed by the dream, but are worrying constantly about other things, like how to send their child to school. This raises the challenge of the assessment tool's validity in the local context, which cannot be assessed without understanding the local language, expressions of distress and what is considered problematic.

These challenges emphasize the importance of understanding what is distressing to the targeted population first.[8] Understanding local idioms of distress is a valuable way to gain a more in-depth understanding of local mental health symptomatology. For example, in this study conducted all in Acehnese, we identified several expressions of distress like "Ule Mekerlep", which literally translated means 'cockroaches running around in your head' and "Jantoeng ie meu en", which literally translated as "heart is playing." When the Acehnese interviewers were asked to describe what these idioms meant, the former was described as meaning having "too many thoughts" and the latter as being restless.

Beyond just generating local idioms of distress, the study also gathered signs and symptoms that define the mental health problems experienced by the local population. The study results showed a lot of general psychological symptomatology but did not generate any evidence that these problems are grouped together within individuals as a specific syndrome or set of syndromes. The study team was open to finding symptomatology of Post Traumatic Stress Disorder (PTSD) or Major Depressive Disorders as might be expected from the literature on post-conflict populations.[9, 10] However, if we use the Western clinical model, then comorbidity of anxiety and depression symptoms, together with somatic presentations of distress, appears to be the most appropriate way to define the mental health problems faced by this population. This finding is also consistent with published literaturewhere anxiety and depression are the most common mental health problems with people exposed to extreme stressors.[11] Besides the mental health problems, economic problems and general health problems also stood out as an important problem in the community.

Promoting positive coping mechanisms for people exposed to extreme stressors is a recommended intervention strategy.[12] It is assumed that all populations have their own ways to deal with distress, informed by cultural, economic, and environmental influences. The study team investigated the coping mechanisms of the targeted population to understand what people do to cope to reduce their levels of distress in their context. Among the strategies that were important to this population included a variety of religious practices (praying, reciting Koran, fasting, making vows) as well as activities that promote interaction with others (playing sports, community work). Identifying what the local population already does, both positive and negative strategies, is important for ensuring interventions fit within the local context and build upon strategies that are already used locally.

In recent years, the focus of researchers and field practitioners has shifted beyond only focusing on symptomatology to including assessing dysfunction as well. Standard tools, like the WHO-DAS II[13] exist. However, upon exploration with the local experts, it was found that some items like "standing for long periods of time" and

"walking a long distance" were vague and very subjective, depending on the local context. Additionally the tool does not address the different roles and tasks of men and women within the local context. With the assumption that local tasks and roles may vary from culture to culture, the research team relied on local people to identify the important specific tasks that an adult man and woman needs to do to care for themselves, their family, and participate in their community. Using this locally specific information allowed us to develop tools to measure functioning that get at the important things local people need to do, rather than a more general measure of impairment.

This study explored the psychosocial and mental health symptoms and problems, indicators of functioning, and coping strategies and did not investigate the domains of economic problems and general health problems that were also mentioned as major problems by the community. Understanding how the economic situation and general health issues impact mental health and how mental health problems impact economic and general health issues is an important issue for future research.

Conclusions

Based on the study results the community perceived psychosocial and mental health problems as major problems, along with general health and economic problems. The psychosocial and mental health problems for this population fell within the domains of anxiety and depression problems combined with somatic presentations of distress. These general results are similar to those found in a psychosocial needs study conducted by International Organization for Migration,[1] yet this study adds the local description and expression of these problems rather than relying on the Western models defined by the standard instruments used in the IOM study. In addition to symptomatology, this study also adds the dimensions of functionality, and local coping mechanisms.

The importance given to the mental health problems identified by people in the community led the researchers to develop a community-based psychosocial counseling program that was implemented by locally based NGO staff trained and supervised by ICMC. The local idioms of distress and the important signs and symptoms were used to adapt standard Western tools, making them more appropriate to the local population than basic translation methods would have done. These assessment tools were then used to screen people into the psychosocial program and evaluate its impact. The validated mental health assessment tools and measures of dysfunction and coping are available from authors by request.

Acknowledgements: Special thanks go to several people for making this assessment possible. Thanks to Melinda Hutapea, for the amazing administrative and logistical support she provided. Thanks to the RATA staff and the interviewers who worked tirelessly not only as interviewers but who also assisted with any and all issues that came up throughout the study. Finally, thanks to the Victims of Torture Fund at USAID/DC for their continuing support and encouragement of this project.

References

1. Psychosocial needs assessment of communities affected by the conflict in the districts of Pidie, Bireuen and Aceh Utara. International Organization for Migration, 2006. www.iom.or.id/publications.jsp?lang=eng&pbgroup=ind
2. Psychosocial needs assessment of communities in 14 conflict-affected districts in Aceh. International Organization for Migration, 2007 www.iom.or.id/publications/pdf/17_PNA2eng07-e.pdf (January 25, 2009).
3. Bass JK, Ryder RW, Lammers MC et al. Postpartum depression in Kinshasa, Democratic Republic of Congo: validation of a concept using

a mixed-methods cross-cultural approach. Trop Med Int Health 2008;13:1534-42.
4. Bolton P, Bass J, Betancourt T et al. Interventions for depression symptoms among adolescent survivors of war and displacement in Northern Uganda: a randomized controlled trial. JAMA 2007;298:519-27.
5. Bolton P, Tang AM. An alternative approach to cross-cultural function assessment. Soc Psychiatry Psychiatr Epidemiol 2002;37:537-43.
6. Murray L, Haworth A, Semrau K et al. Violence and abuse among HIV infected women and their children in Zambia: a qualitative study. J Nerv Ment Dis 2006;194: 610-5.
7. Mollica RF, Caspi-Yavin Y, Bollini P et al. The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. J Nerv Ment Dis 1992;180:111-6.
8. Bass J, Bolton P, Murray L. Invited comment: do not forget culture when studying mental health. Lancet 2007;370:918-9.
9. de Jong JTVM, Kompre IH, Van Ommeren M et al. Lifetime events and posttraumatic stress disorder in 4 postconflict settings. JAMA 2001;286:555-62.
10. Lopes-Cardozo B, Bilukha OO, Gotway CC et al. Mental health, social functioning, and disability in postwar Afghanistan. JAMA 2004;292:575-84.
11. de Jong JTVM, Komproe IH, Van Ommeren M. Common mental disorders in post-conflict settings. Lancet 2003;361:2128-30.
12. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. 2007. www.humanitarianinfo.org/iasc/contents/products
13. The World Health Organization Disability Assessment Schedule Phase II Field Trial Instrument. Geneva, Switzerland: The World Health Organization, 1999.