

Médecins Sans Frontières: mental health care in post-tsunami Aceh Province, a field report

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This article describes a mental health program in the Aceh Province, a conflict area in Indonesia, after the tsunami. The intervention aimed to normalize community life, through activities such as the construction of a volleyball field and the organization of a tournament, as well as organizing talking groups to reinforce solidarity and mutual support. On an individual level, offering counselling services supported normalization. The beneficiaries appreciated the communities based group activities the most. As for individual psychological support, counselling proved to be an unknown approach for the majority of the population, and therefore did not always meet their expectations of a fast, practical resolution to their problems.

Keywords: mental health, tsunami, coping mechanisms, counselling, normalization

Introduction

In Aceh province, the tsunami of December 2004 killed over 128,000 people. Around 35,000 people remain missing to this day and are presumed dead. Of the 4,01 million people of Aceh, at least 50% were directly affected by the tsunami¹.

Prior to the tsunami, the Province lived with a long standing armed conflict between the Indonesian army (TNI) and the Free Aceh Movement (GAM)². The year 2004 became one of the bloodiest years in the 28 years of conflict. Killings, disappearances, rapes, torture and forced displacement were common atrocities. Human Rights Watch (2005)

reported over 2300 casualties between May 2003 and the 25th of December 2004. About 720,000 IDPs (Internally Displaced Persons) were reported to live in government run camps either inside (120,000) or outside (600,000) of Aceh Province. Another 200,000 to 400,000 internally displaced people were living outside this formal camp system (U.S. Committee for Refugees, 2004). Whether living within the government structures, or outside of them, all IDPs were living in appalling conditions beyond the reach of humanitarian aid workers.

In the aftermath of the tsunami, a peace agreement between the Indonesian Government and the GAM was signed on the 15th of August 2005. Demands for self-governance and political representation were accepted, and by mid-2006 new laws for Aceh were finalized.

The Médecins Sans Frontières (MSF) intervention

Set-up of the programmes. On 28th December, the first MSF team arrived with 3,5 metric tons of relief supplies in Aceh's regional capital of Banda Aceh (north western part of Sumatra Island). A medical clinic was set up and assessments and relief operations began. In the days and weeks following, MSF Belgium identified three areas in Aceh that needed ongoing care: Sigli (Pidie District), Lamno (Aceh Jaya District) and Banda Aceh (Banda Aceh and Aceh Besar

District). Mental health care was implemented in: of this intervention mental health care in catastrophes, such as: limb numbness, shortness of breath, sleeping problems. In the first days these symptoms moved all to the counselling mobile clinics. Many health teams suffered from social network reoriented towards basic needs in artificial. We know the tsunami both caused However, in addition the unprecedented resources the tsunami in capacities, or 'the tsunami effect was already a Prosser & For possibility exist psychological distress. Objectives of the initiative of MSF's was 'to help overcome the

District). Mental health programmes were implemented in all three locations. The format of this intervention was based on 15 years of mental health experiences in areas of natural catastrophes, such as Peru, Haiti and Iran.

In the first days of operations, mental health teams moved along side the medical mobile clinics. Many of the clients presenting themselves to the medical consultations suffered from somatic stress symptoms such as: limb numbness, headaches, palpitations, shortness of breath, and stomach aches or sleeping problems. Those presenting with these symptoms were referred by the doctor to the counsellor. After a few weeks, when the mobile clinics ceased to operate, mental health teams started to focus on outreach activities in devastated areas, where many people were still searching the ruins for belongings. When it was discovered that many people within the city received valuable support from family and friends, the focus of the intervention was later reoriented towards IDP camps where the social network was less strong and the living conditions more precarious.

Distinctions between psychosocial and other basic needs in complex emergencies are artificial. We know that the conflict and the tsunami both caused severe traumatic stress. However, in addition, the displacement and the unprecedented damage to both economic resources and social fabric following the tsunami not only degraded resilience capacities, or inhibited coping processes, 'the tsunami exacerbated what for many was already a fragile existence' (de Jong, Prosser & Ford, 2005). Therefore also, the possibility existed to exacerbate pre-existing psychological difficulties or mental illness.

Objectives of the intervention. The general objective of MSF's mental health programmes was 'to help the population of Aceh to overcome the psychological consequences

of the stressful events, including conflict related issues, the tsunami and the resettlement procedure through individual and community based care.'

A community based approach allows for people to regain control over their life by stimulating their capacity for self-help, and reinforcing the existing resources and capacity of the natural leaders. Individual consultations allow the interventions to be targeted only not towards victims of the tsunami who have particular difficulties in overcoming the disaster, but also to focus on more chronic psychological disorders, those who believe themselves to be possessed, and victims of conflict.

The implementation of this programme was based mainly on five types of activity: psycho-education, psychosocial activities, talking groups, individual and family counselling, and training. Although the general objectives and methods were similar over all three of the project locations, each developed its own strategy according to their specific context and needs.

Data collection

The data presented in this article is based on a qualitative evaluation study, during which over 400 people were interviewed³. Several tools were developed, among them: the Emotion Expression List (EEL) and the Individual Client Interview (ICI). The EEL was set up to better understand the way emotions are expressed in Aceh culture, as well as the perception people have on some psychological disturbances. A first set of open-ended questions addressed the way people could or could not express their emotions freely. The second part of the EEL presented a list of 10 emotions for which people had to give examples of causing factors, perceived external signs and ways of coping with it.

The last part of the EEL presented 10 common psychological conditions (such as: depression, anxiety, post traumatic stress syndrome, etc.) for which respondents were asked if they know about these conditions, how they would explain them, what could be the causes, and what could be done to help people affected by them. The ICI was also made up of three parts. The first set of questions targeted the background of the client's problem: what were his/her major complaints, how it affected his/her life, what made him/her decide to consult a counselling service.

The second part questioned what the person had already done, prior to counselling, to feel better and where he/she found help. The last part focused on their opinion and evaluation of the counselling provided.

Mental health problems and changes in context

Mental health problems often emerge when stable contexts turn into long-term stressful ones. Drastic changes potentially disrupt the framework of a persons' daily life by altering a persons' beliefs, views and perspectives of the world in such a way that finding a balance again can become a very difficult task. To increase the understanding of recent changes of the life in Aceh, and to shape the context of our intervention, a summary of the impact of the conflict, the tsunami and the displacement will also be given below.

Conflict. Years of instability, characterised by the occurrence of abductions, tortures and killings, resulted in years of constant pressure, stress and anxiety. Confrontations with conflict related stimuli such as soldiers or gunfire provoke trauma related reactions within many respondents even now. A very tangible effect was the restriction in freedom of movement. On the one hand, the military actively restricted the movement of civilians by setting up roadblocks, performing identity

controls and by imposing no-go or black areas to prevent aid workers from entering conflict zones. On the other hand, continuous security threats prevented people from taking unnecessary risks such as walking around at night, going far outside the village, or farming the land (Human Rights Centre, 2005). Men proved especially vulnerable as they were at risk of being suspected of supporting either GAM or TNI. Hindering farming, or other job-related activities, resulted in a significant rise in the levels of unemployment. Consequently, the lack of income caused significant economic and financial problems.

Tsunami. Much more than during the conflict, material problems (lack of: housing, clothing, food or household utensils) were key issues in the aftermath of the tsunami. Especially at a private level, the loss of housing and property and the shortage of food were the most problematic. The massive destruction of public facilities such as roads, bridges, schools and mosques was given fairly little attention. Only the lack of proper health care was pointed out as important. Initially economic problems (income, wages and employment) were less important. However, in addition to the impact of the conflict, many more jobs were lost due to the destruction of fields, shops and infrastructure.

As well as material or financial problems most were unable to handle the overwhelming emotions provoked by the losses incurred as a result of the disaster and showed signs of severe shock. Nearly everyone had to live through a personal grief process. Many displayed acute traumatic stress symptoms such as: intrusive thoughts and memories, heightened anxiety, sleeping disorders or feelings of guilt. Many felt hopeless and feared further disasters. *People said they didn't care about money, they did not want to find a job or money because it might disappear with a new earthquake or tsunami*

...they had no hope, Banda Aceh Displacement. Finding a job and being given to material things did not rise significantly living in the tent of hundreds of organizations for many, but limited to the population in crowded barrack poor living mental problems, sanitation, fr (allegedly) in Secondly, we were still struggling population or nursing grief within the ge this shows how fulfilled, and tions, deal with Thirdly, over NGO work Whereas before NGOs, people unhappy to l ations for the income. Further dents complete aid distribution

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... they had no hope at all' (Dahlia, MSF psychologist, Banda Aceh).

Displacement. Firstly, due to difficulties in finding a job and the lack of capital, the attention given to material and economic problems did rise significantly, especially for the people living in the temporary shelters. The arrival of hundreds of NGOs (nongovernmental organizations) did provide job opportunities for many, but the positive impact remained limited to the younger, educated and urban population in Banda Aceh. In the overcrowded barracks, emphasis was put on the poor living conditions and the environmental problems including lack of: proper sanitation, fresh water, food, privacy and (allegedly) medical care.

Secondly, whereas trauma, fear and grief were still strongly present within the IDP population one year after the tsunami, continuing grief reactions were scarcely noticed within the general population. Once again, this shows how people whose basic needs are fulfilled, and who live under proper conditions, deal with their grieving process better. Thirdly, over the year, the comments on NGO work have become more critical. Whereas before hardly anyone mentioned NGOs, people started to feel reluctant or unhappy to be dependant on aid organizations for the provision of food, shelter or income. Furthermore, a fourth of the respondents complained about the inequality of aid distribution.

Differences of impact on men and women

The loss of jobs was a major problem for a fourth of the interviewees. Men, in particular, seem to have difficulties in dealing with economic and financial changes in their life. The loss of a job was seen especially to have detrimental effects on the emotional well-being of men. Not only does a job provide an

income, equally important, it adds meaning to life and allows men to take power and position within society. Hence, unemployment due to security issues, or the tsunami, leads to feelings of powerlessness. For women, however, a job is mainly regarded as a way of earning money to buy food, without any major social function. The job situation started to improve after the signing of the peace agreements and the implementation by many NGOs of cash for work programmes.

Whereas few respondents thought men were traumatized either by the conflict or the tsunami, many had the tendency to see women as victims. Women were presumed to be less resilient towards stress and more prone towards mental health problems. According to half of the respondents women cannot forget the memory of the people that passed away and are still afraid of conflict or tsunami related stimuli (soldiers, guns, wind, water). But, an interesting side effect of the tsunami seems to be the growing public voice, and role, of the women in the society.

The years of instability also resulted in worry about the future and the wellbeing of the children. Nearly half of the worries of the adults regarding children are related to schooling, including the poor quality of schooling, the increased dropout of students and students being afraid of going to school due to traumatic memories. Regarding the latter, a third of the informants feared that many children are still traumatized by the conflict and/or the tsunami. The loss of one or both parents was considered the main cause of trauma and increased sensitivity.

As the above shows, different stressors were perceived or experienced differently by men and women, and the needs changed over time. The challenge was to comprehend the different needs and demands of the beneficiaries, and to include them in our mental health intervention.

Apart from the psychological care to more chronic cases, the major part of our activities can be summarised as contributing to the normalization process of the daily life of the people in Aceh. Such a normalization process could be found within three different areas:

1. Getting control over emotional reactions,
2. Restructuring daily life, and
3. Reconstruction of the social network.

Focussing on normalization contributed to the fortification of peer support, and the revitalization of existing coping mechanisms.

Normalization of the community life

Due to the importance of community life in Aceh, there is a strong focus in this article on the normalization of community dynamics (Van Ommeren, Saxena, & Saraceno, 2005). To show how a functional community life has an impact on individuals, the social identity and the traditional coping mechanisms in Aceh are explained.

Social identity and social network. The results of the evaluation study clarify how religion asserts the greatest social influence on culture in Aceh. Over one third of the key informants defined their identity as '*strong in culture and religion*'. Culture and religion are, in fact, very closely related in this area and are characterised by politeness and good morality. In line with what was presumed as a result due to prior MSF experience in Indonesia, the people of Aceh attribute strong value to the community life. Indeed, one's identity is strongly linked to the community or social group, which is considered to be the common place for sharing, discussing and giving/receiving support. More important than individual development, or being part of a family, being part of the society was perceived as the primary importance by 57% of the key informants. The level of community participation and the wellbeing of

the family are considered the most important factors influencing the emotional status of the people in Aceh. Considering themselves to be '*very hospitable and open towards people from outside Aceh*', half of the informants clearly marked a difference between 'us' (Acehnese) and 'others'. Differences within the Acehnese communities are not very important. The sharing of a similar cultural background helps to overcome interpersonal or inter-group differences. As many as 96% of the informants claimed an absence of subgroups in the community and 71% of the informants said no distinctions were made between the different ethnic groups in the province. Furthermore, in line with the attitude of respect and morale, feelings of superiority towards poorer, or less educated, people were unacceptable.

People in Aceh perceive a strong unity or 'togetherness' amongst themselves, which seems to originate from sharing the same religion which, in turn, equals sharing of the same cultural background. So, by reinforcing the social cohesion, religion also has a social function. It was noted, for example, how sharing the same religion and having lived through the same experiences enhanced the acceptance of the loss of family members and friends. Secondly, the mosque is much more than a mere place for praying, it is also a social node where Muslims gather and where social interactions take place and support can be given. The community feeling is strongly reflected in the community coping mechanisms.

Community coping mechanisms. In the light of all the major life changes over the past decades, it proved somewhat of a surprise that according to most respondents (100% of the participants in focus groups, and 86% of the key informants) the culture, social structure, individual and traditional coping mechanisms did not change significantly. It was said

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that the traditional 'togetherness' was still strong. Two equally important traditional coping mechanisms were found in Aceh: rituals and the practice of religion. In times of difficulties, rituals such as '*kenduri*' and '*peusijuk*' (ritual ceremonies to wish for fortune, or to support the unfortunate) are organized in order for people to offer social support to one another. The communal cooking of the women and meals during such rituals fortifies the social cohesion of both men and women, and offer a space to discuss existing problems and to offer support and advice. However, it was also regularly reported that such traditions are changing in the growing urban context of the town of Banda Aceh. For example, inhabitants of Banda Aceh were found to have a wider social network at their disposal than those from Sigli and Lamno, and the traditional inner-community support is more and more being replaced by inter-family support in Banda Aceh.

Nearly all interviewees saw religion as a functional coping mechanism (95% of the key informants and all participants in focus groups). Religion not only helped in constructing a more or less unified Acehese society, it also provided 'answers' to questions such as why the conflict, or the tsunami, occurred.

According to a third of the informants, the conflict was a trial from God allowing the people to feel remorse over their sins and mistakes, and to build a closer relationship with God. During such a trial, people are confronted with obstacles that they need to overcome in order to improve themselves.

The tsunami, however, was seen as a punishment from God, because of the lack of good religious behaviour, the lack of humility and the increase in violence (during the evaluation study only one respondent referred to a possible influence of tectonic plates). It is widely believed that the failure to alter behaviour following a divine trial (such as the

conflict) results in a punishment (such as the tsunami). However, in the light of an almighty God, it is also believed that even negative events ultimately bear positive outcomes and that punishments should still be considered as opportunities. Whether it is called 'establish a close relationship to God', 'surrendering yourself to Allah' or believing that 'even bad events will eventually lead to positive outcomes', in many ways religion help to accept one's destiny and therefore has, as such, a calming effect on people. Since religious activities such as 'praying' (voluntary) or 'taking *salat*' (the obligatory five prayers a day) are performed individually, it might be wrongly concluded that religion should only be considered as an individual coping mechanism.

Interventions at community level. In IDP camps, temporary shelters and relocation barracks where the social sphere and social network were heavily disrupted, psychosocial activities based on community self-help were initiated. Considering the importance of the community life, emphasizing the rebuilding of social networks and traditional coping mechanisms, including reinforcing existing resources and resource people, proved a solid objective.

Solidarity and peer support among the people living in the barracks was very weak due to the fact that emotional distress combined with a totally new social environment hindered people in creating new contacts within the barracks. Confined to their domestic role, women especially proved to be vulnerable to social isolation.

Group activities (inspired from traditional support encounters, *kenduri* and *peusijuk* rituals) such as embroidery or cooking were put in place for women. They stimulated social contact, allowed free expression of difficulties and provided mutual support while giving women a bit of material support.

Table 1. Impact on daily life according to key and non-key informants in the general population

Conflict		Tsunami		Displacement	
1. Trauma/Fear	32%	1. Material	31%	1. Material	46%
2. Economic	30%	2. Trauma/Fear	22%	2. NGO	17%
3. Restricted life	21%	3. Grief	15%	3. Economical	14%
4. Anxiety related symptoms	16%	4. Anxiety related symptoms	11%	4. Loss of facilities	11%
		5. Economic	9%	5. Grief	9%

Men less frequently faced the problem of social isolation: they were more mobile, spend more time outside the home and gathered frequently in the coffee shops with friends and acquaintances for a coffee, a smoke and long discussions. They suffered more from the lack of employment, income and the loss of their productive role/position. In the town of Lamno, MSF mental health teams consulted male villagers extensively regarding their difficulties. They identified the loss of their daily work as fisherman as having the greatest ongoing impact on their psychological equilibrium, and the community well being. In order to address this situation, a boat-building project was set up in collaboration with the fishermen 'union' and a boat carpenter. The fishermen themselves participated in the design and construction of the boats in a very dynamic way. In Aceh Besar, although concerns were similar, men emphasized the lack of leisure activities and sports in the barracks more. They opted for the construction of a volleyball field and the organization of tournament that could render their static lives in the barracks more dynamic.

During those activities, group discussions were often initiated among the participants, which led to the spreading of valuable information that reinforced our psycho-education objectives. Furthermore, close supervision of those group activities also helped us in the

identifying those individuals in need of more individual support.

Within community based psychosocial projects, value is put equally on the process as on the outcome. Therefore, a participatory approach with the beneficiaries was applied to define what to do and how to do it. For each community project, beneficiaries had to identify their priorities and participate in the definition of the activities to carry out. MSF provided for framework and means. This direct involvement of the beneficiaries into the aid process was a key element in the recovery process as it helped them to regain some control over their daily lives and wellbeing.

Those activities not only provided distraction and social interaction, they also helped structure time and create social cohesion amongst the IDPs. Regarding the latter, in the low stimuli environment of the camps, our activities quickly became 'the talk of the day'. Participants talked about it with their families, who in turn talked about it with their friends, and so on. Therefore, social interactions and messages passed beyond the confines of the activity itself.

Although the danger existed that mostly extrovert or outgoing people would be reached, feedback revealed how the positive effect of the activities was not limited to participants only, indeed a strong increase in social networks and relationships in

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Table 2 Impact on daily life according to focus group discussions with IDPs

Conflict		Tsunami		Displacement	
1. Trauma/Fear	48%	1. Material	23%	1. Material	36%
2. Economic	30%	2. Trauma/Fear	22%	2. Economic	17%
3. Anxiety related symptoms	10%	3. Grief	15%	3. Trauma/Fear	14%
4. Restricted life	4%	4. Few facilities	7%	4. Anxiety related symptoms	11%
5. Lack of aid	3%	5. Anxiety related symptoms	7%	5. Loss of facilities	9%

general was noted. For example, during *Idul Fitri*, the most important Muslim holiday, many people preferred to celebrate within the camp structure, rather than going out to visit friends.

Following the improvement of the social support network, many IDPs were willing to start working on a more regular basis. Thereby, mental health programmes should be able to search for partners organizing income-generating activities. However in Aceh, the demands and the logistical difficulties were so high, that other NGOs could not easily nor quickly implement such activities. The resulting unequal distribution of wages for work activities, for example, leads to a lot of frustration.

Normalization at the individual level

Emotions and mental health. At first glance people seem extroverted and free in expressing their emotions. During the research, hardly anyone reported social restrictions regarding talking about 'negative events or difficulties' which is considered to be a part of the culture (85% of the key informants). 'Sharing thoughts and feelings' was even spontaneously linked to emotional relief and reduction of trauma related complaints (by 66% of the key informants and 76% of the respondents to the Emotional Expression List). Only a minority avoids talking about

negative events because 'it only brings back memories'.

However, it was found that the perception of this absence of social restrictions must, in fact, be balanced. Asked whether one is free to talk about everything that happens, or if some stories or feelings cannot be shown or told, over half of the respondents acknowledged existing limitations. In half of the cases, embarrassment or shame hinders talking about personal 'secrets', such as family problems, personal failure or very private feelings. As stated above, a strong normative character exists within the Achenese culture. Social codes on emotional expression should be interpreted as 'all can be discussed, as long as the content and process are not considered taboo or improper'.

Showing 'positive emotions' such as joy, happiness is well accepted and positively perceived by all respondents. The perception of 'negative emotions', however, depends on the level of the intensity of the emotions. Internalised 'negative' emotions such as sadness and shame are more accepted and less negatively perceived than externalised emotions because they are less visible. Indeed, more overt and visible emotions such as anxiety, fear and especially anger (which is by far the strongest and most visible emotion) are far less tolerated and are perceived very negatively. According to the Achenese interpretation of Islam, it is allowed to feel angry, to be upset, to cry or to mourn. However, these emotions cannot be expressed in extreme

ways because it suggests disrespect towards God's plans or towards one's position in society. Regarding the latter, one is obliged to accept the hierarchical position in the family and not to disagree or question a superior. A wife for example cannot disagree with her husband, just as children are obliged to obey the parents.

Individual coping mechanisms. Many respondents mentioned that '*being part of the society*' and '*getting engaged in physical or social activities*' as two of the most essential points for a person's emotional wellbeing. This shows the importance of the community or social sphere within individual coping mechanisms. Still, many people tend to isolate themselves with their worries in order to avoid shame or embarrassment. Significant differences exist between men and women when it comes to exhibiting or handling emotional problems. Men are looked on as leaders of the family and the community, and are therefore expected to be in control. Losing control by succumbing to stress or frustration would be seen as a proof of an inability to function as a leader. '*It is considered to be their role to be strong, if they would share their emotions, others might laugh and say they are weak*' (Adah, MSF psychologist, Banda Aceh). Women, on the other hand, are considered to be more extroverted, do not hide their feelings and even '*tend to get carried away by their feelings*'. During mental health activities, women were indeed more willing and able to focus on their emotions than men. However, even for women, discussions in a group context about family, relationship problems, or personal failure was considered improper, especially in the villages.

When people feel the need to talk about their personal problems, most turn to a friend (80% of the respondents to the Emotional Expression List), to family members (56%) or to other community members (40%).

Corresponding with this, prior to attending a counselling service, three quarters of the interviewed clients shared his or her complaints with family members (63% of the respondents to the Individual Client Interview) and/or with a close friend (47%). In order to avoid losing respect, men preferred to talk to men and women to women. Depending on the nature of the problems one will address oneself towards friends or family. The stronger and more intense the emotions, the more people turn towards friends. Fear of judgement or gossip often prevents the sharing of deep emotions within the family. Hardly anyone would vent emotional problems with community or religious leaders.

However, when asking who can offer 'support', nearly half of the respondents pointed towards religious leaders such as the *Teungku* (teacher for Islamic study), the *Ustaz* (teacher of reciting Al Qur'an), the *Iman* or the head of the *Ulama* (association of Iman) (41% of the key informants). Second in importance are members of the family (34% of the key informants). A third receive support from friends as well (34% of the key informants). Equally important are community leaders and public figures such as *Kepala Desa* and *Pak Geuchik* (heads of village), teachers and members of the council of elders (31% of the key informants). Other community members such as neighbours or colleagues didn't seem to be that important. The role of mental health professionals was also acknowledged (by 17% the key informants). The concept of 'giving support' is related to giving advice. In terms of getting support, be it for practical or emotional problems, many people in Aceh are orientated towards fast and practical problem solving solutions. Just like aspirin offers quick relief for headaches, people expect advice to procure them with fast working solutions to

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overcome their worries. When it comes to practical solutions, religious leaders are the most trustworthy because they are considered knowledgeable persons.

Interventions at individual level. Our most visible interventions to support individuals were those activities related to psycho-education. As most people had not experienced such a large scale disaster before, with its correlated emotional reactions, they also did not have a prior understanding of stress reactions (mental health knowledge and services were almost nonexistent in Aceh). Therefore, it proved necessary to inform people about the common reactions after traumatic events. In total, three different topics were discussed: self-control and preparedness to aftershocks, stress and traumatic reactions, and changes in the family dynamic, including children's reactions. Different channels were used to diffuse such information: radio programmes were broadcast, leaflets were distributed, and a music CD was recorded and distributed. The most interactive, however, were the psycho-education sessions that were held in most locations where mental health programmes were operational or initiated (included mobile clinic, outreach and barracks). To enhance participation, such sessions were frequently organized in cooperation with camps leaders or religious leaders. Since information on the phenomenon of tsunami and earthquakes, and tips on what to do in case of another event occurring, were prerequisites to regain control over one's life, those topics were discussed during the first session. Furthermore, the high demand for such information made participants very active and it also proved a valuable step in the building of a trusting relationship. In the following sessions, stress and traumatic reactions were discussed, focussing on normalization of those reactions, identifying available resources and coping mechanisms for self-help. Relaxation

and breathing exercises to deal with stress reactions were also proposed.

Psycho-education also proved very effective to convey information on the availability of individual counselling. One third of our clients came for counselling after participating in an information session. Other clients were identified and referred by MSF teams during psychosocial and medical activities (17%), by community members (14%) or by medical staff from the health centres (10%). Many clients actively shared their worries with a resource person, and tried different things prior to counselling.

Dealing with extended grief or traumatic reactions is part of a very private sphere and people are often reluctant to talk about it. As stated previously, men are rarely willing to talk about emotional difficulties and, even if women are more open to it, they mainly receive direct practical advice, without having the possibility to express themselves about the way an experience or event was felt or lived.

Psychological counselling proved therefore to be an unknown approach for the people of Aceh. During the individual client interviews, a majority of the clients testified to not knowing what to expect from counselling (62%). Those who said they had knowledge of counselling prior to the first session, either expected talking or 'answering the questions you get' (23%), 'getting advice' (8%) or 'talking in order to regain spirit' (7%). Yet, most clients did comprehend the aim and objectives of counselling. The decision to go for counselling support was primarily motivated by a wish to solve existing problems (whether practical or emotional), or to at least be able to freely talk about them (66%). What were new were not so much the aim of counselling, but more the way in which a counsellor operates. Therefore, it was essential during the

first session to spent sufficient time to properly explain the process of counselling.

Our mental health workers were psychologists from Jakarta who were mainly experienced in testing and human resources selection. Our training had been aimed at making them acquainted with a problem solving approach, in which clients are stimulated to use both their individual resources and the available supportive mechanisms in the community. It turned out that, although they appreciated the relationship with the counsellor, his care and his listening capacities, many clients were unhappy with this approach. The complaints of the clients concerned the nature of some questions challenging their usual point of view or addressing emotional reactions, the lack of medication, and the fact that instant solutions were lacking.

Reflective questions in which we stimulated clients to reconsider statements such as: *'I will never be happy again'* or *'I will always remain the same'* or *'my life is over now'*, with the idea of helping the client to consider possible alternatives towards their problems, were not always well received. In retrospect, one could say that such interventions were inadequate. Statements like *'I will never be happy again'* indicate that the client has overwhelming feelings of despair, and therefore not yet open to looking for solutions to their problems. In such a situation, the counsellor should restrict himself to showing empathy and recognizing the legitimacy of these feelings, for example by saying: *'I understand that you feel desperate right now, you have every reason to feel this way'* (Van der Veer, 2003). For young, inexperienced counsellors it often is difficult to cope with strong feelings of despair and helplessness.

Clients found it equally difficult to answer questions aimed at projecting oneself into the future, such as: *'how could things be different*

for you' or *'what would you have done if'*. Clients preferred to stick to more pragmatic topics, such as: where, who, when and what questions and answers. This may be related to the fact that people with limited education may simply not be used to hypothetical/deductive abstract thinking (Kohlberg & Gilligan, 1972).

However, this approach did work better with those clients whose main complaints were related to the conflict, and who had been struggling with their burdens for many years. Counsellors were usually put on the same level as community leaders, hence more than anything else, people expected to receive practical advice to rapidly solve their difficulties.

The less formal the counselling was conducted, the more comfortable our clients felt. Home visits, for example, were viewed very positively, perhaps because it was considered more as a courtesy visit and less an official appointment with the psychologist.

In general, neither national counsellors nor clients experienced problems of cultural gaps, even if they had to communicate through translators. This was surprising as Aceh province has its own dialect and they didn't always share the same religion, which we know is an important element in the life of the beneficiaries. Respect of cultural differences was a major strength of the team.

Those people that did state that outsiders could not help them with their problems because of a lack of understanding of the local context were in the end most often referred to our expatriate psychologists. Especially in the conflict areas, clients would often prefer to be counselled by expatriate psychologists because they assumed it would guarantee better confidentiality and political neutrality. However, another type of gap existed. In the case of a few counsellors, there was initially some display of superiority attitudes towards

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the beneficiaries: capital versus province, urban versus rural, educated versus non-educated, were some of the differences highlighted. This matter was addressed during the training and the supervisions, and as each of the counsellors was willing and attentive to become a good professional, capable of empathy, respect and non-judgement, it did not remain an issue.

Conclusions

The implementation of a mental health programme in a situation where the population's prime concerns are material and financial in nature is a difficult task, requiring flexibility, patience and creativity. The people of Aceh strongly relate mental health to material, financial and social wellbeing. Because of its social elements, activities aimed at the community were most appreciated by our beneficiaries. It was said to be helping in restructuring life, giving life back into one's own hands and preventing depressive thinking. Still, people often preferred to participate in wages for work programmes, as it directly responded to their basic needs.

Rather than importing western technical approaches, MSF mental health interventions in emergencies want to focus on reinforcing prior existing coping and support mechanisms of the individuals and communities where we work. It is mainly a matter of finding common grounds between context, culture, and background of psychologists and counsellors, beneficiary's point of view, and programme objectives. As discussed earlier, direct involvement of the beneficiaries in the aid process was a key element in the recovery process as it helped them to regain some control over their daily lives and wellbeing. Working with community leaders and adjusting our intervention according to the position that was given to the counsellors by the beneficiaries also proved to be useful.

This adaptation to the local culture is a requirement for the expatriate mental health officer. It is also necessary for national psychologists. Most of them had received a western-like psychology curriculum at university; they were not experienced in clinical work, and not familiar with the local context and culture. In that sense, they needed basic training on client centred approaches, and to develop their abilities to integrate the client's environment and beliefs into their work, with no preconceived objectives. In order to develop their know how, they also needed regular clinical supervision meetings and cases discussions. Both were implemented throughout the whole duration of the project.

Despite those efforts, it seems that the individual counselling approach remained too distant from what people expected as a solution to tackle their difficulties and problems.

The first session of the counselling process was, in general, well appreciated and procured some relief with the expression it allowed, but it seems that once *'what they wanted to say had been said'*, the follow up sessions were, for some, considered as less valuable.

Is it that we didn't adapt the counselling approach enough to the practical problems of the beneficiaries, or that the idea itself of recovery as a process did not correspond to their own vision?

Considering the precarious economic and material situation in which they lived, which obviously has an impact on their recovery process, as social health and mental health are linked, we should not neglect this aspect in our programmes. We should pay more attention to the socio-economic needs of the survivors in the first phase of an emergency. This would alleviate basic survival concerns and, in turn, could have an impact on their freedom to express more personal/intimate concerns.

¹ Banda Aceh was destroyed by up to 50%, and on the west coast, including Aceh Jaya, many villages were totally wiped out, and some villages lost up to 70% of their population. Pidie district on the east coast was the least affected, in terms of loss of life and livelihood, but has always been at the epicentre of the conflict.

In total over 11.500 homes were destroyed and another 30.000 seriously damaged. Over 500.000 people were displaced and from April 05 onwards. People moved into poorly constructed temporary living camps (TLC). By October 2005 over 64.000 people were still living in tents, 290.000 with host families and 60.000 TLC's (Humanitarian Information Centre, Banda Aceh).

²When the Republic of Indonesia proclaimed its independence, the Province of Aceh was integrated into this new country. The plundering of the natural resources by the Javanese based government and the presence of a highly violent military spurred a demand for independence. This demand was shaped by the rise of the Free Aceh Movement in 1976. In 1989, president Suharto launched a counter insurgency which would become famed for its brutality. Human rights abuses and military sweeping campaigns continued for over 10 years (Human Rights Watch, 2003).

By 2003, a first peace agreement failed and Aceh was put under martial law. The civilian government was suspended and a new massive counter-insurgency operation was initiated against the GAM. Over 30.000 soldiers opposed an estimated 5000 GAM fighters (Human Rights Watch, 2003).

³ The qualitative evaluation study: 'MSF mental health care in post-tsunami Aceh Province' was carried out one year after the Tsunami in the three locations where MSF worked.

It is part of an effort to gain knowledge on the efficiency of MSF programmes and to enhance the quality of our work. For this study, five different tools have been developed, focussing selectively on the cultural perception of emotions, mental

health and counselling; on traditional coping mechanisms and social cohesion; on life changes occurred after the tsunami, conflict and displacement; on feedback on the (I)NGO aid interventions, and on the general culture and context. Over 400 people were interviewed. In addition, analysis was made of individual client files and programme databases.

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Obituary

Erika Stern

It is with great sadness that we announce the death of Erika Stern, a valued member of the International Editorial Advisory Panel of *Intervention*. An eminent organisational consultant, psychodynamic counsellor, psychotherapist and supervisor, Erika Stern played a central role in Group Relations Nederland as a Founding Member, past Board Member, past Chairperson and Conference Director. Her recent work at the Utrecht School of Governance

included: heading both the post-graduate Diploma in Counselling- and Coaching-in-Context, and the Masters of Psychodynamic Counselling. Her international outlook led to vibrant collaborations and active engagement with colleagues and civic leaders, well beyond the borders of the Netherlands. She leaves her colleagues around the globe a considerable legacy, and her contributions and spirit will endure within the practice of many others.