An Assessment of the Impact of a Problem-Solving Counseling

For Torture-Affected Adults in Aceh, Indonesia

Conducted by:

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

Introduction

This report describes an assessment of the impact of an intervention on the emotional and behavioral health of adults affected by torture and trauma in Aceh, Indonesia. The assessment, conducted by International Catholic Migration Committee (ICMC) and faculty from the Applied Mental Health Research (AMHR) Group at Johns Hopkins Bloomberg School of Public Health (JHSPH), used a controlled trial design to evaluate the effectiveness of a problem-solving counseling program (PSC) designed by ICMC for the treatment of locally-defined psychosocial and mental health problems among adults affected by the more than 30 year conflict between the Free Aceh Movement (GAM) and the Indonesian Army. A controlled design was used because this was the only method available for assessing the true impact of the intervention.

Purpose of this assessment:

To test the feasibility and effectiveness of a problem-solving counseling therapy for reducing the burden of locally-described mental health problems and improving function among adults affected by torture (and other conflict-related violence) in Aceh, Indonesia.

Methods

Intervention

The intervention followed the principles of non-directive counseling. Counselors were trained by ICMC staff to provide emotional support, and to work with the clients to come up with strategies to manage difficult emotions, and provide problem-solving counseling. The support group intervention consisted of 8 weekly sessions, each run by a pair of counselors. In the first two sessions, the intervention was introduced, expectation discussed, and current problems identified by the participants in the group.. The third through sixth sessions consisted of discussions and sharing individual experiences of these problems. The 7th session was an evaluation of how people were doing since they joined the group and included discussions on positive and negative changes. And finally, the 8th session consisted of looking towards the future. Participants were encouraged to talk about their next plans, and if they wanted to continue meeting with the group on their own and how they would arrange those meetings. At the sixth session, the group was requested to choose one leader who would assist in the facilitation of the 7th and the 8th session and continue the group process after the counselor stopped conducting sessions.

During the assessment period, the participants in the control villages received no specific intervention but were free to access any services or programs that they would have received in the absence of the ICMC intervention, though we were not aware of any other specific psychosocial services available in this area.

Screening of Participants into the Assessment

Screening of participants into the assessment was done using a composite psychosocial screening instrument previously piloted and validated for use with this population. That instrument is comprised of adapted versions of: the Hopkins Symptom Checklist (HSCL) which assesses depression and anxiety, the WHO somatic symptoms scale, a locally derived questionnaire on functional impairment, and standard questions on function taken from the WHO Disability

Assessment Scale (WHO DAS). Questions on general demographic information, as well as information on coping with distress, were also included.

A total of 592 adults from 6 villages were screened for inclusion in the assessment, using the assessment instrument. Eligibility was based on severity of psychosocial symptoms and presence of functional impairment. The total assessment sample eligible for inclusion was N=420, or 71% of the total screened sample. Of these 420, 415 (99%) agreed to participate.

Post-Intervention Assessment
The first part of the post-intervention assessment consisted of a brief qualitative assessment to identify unexpected impacts of the intervention not already reflected in the baseline assessment instrument. Information from this qualitative assessment, along with input from the counselors and supervisors, were used to add questions on salient unexpected impacts to the original baseline instrument.

All assessment participants (intervention and control villages) were then re-interviewed using the expanded version of the original screening instrument. The post-intervention follow-up assessment was conducted over two weeks in January 2008. A total of 375 (90%) of the original 415 were found and re-assessed (200 Intervention; 175 Control).

Results

Sample Characteristics
The demographics of the intervention and control groups at baseline were not significantly different. Most assessment participants were between the ages of 30-69 years, though there were sizable numbers of older adults (70 years and older). Nearly 80% of the sample was married. Severity of mental health problems were similar across the intervention and control groups. Functional impairment levels differed, with controls having significantly higher rates of impairment among both men and women.

Results are presented for the assessment sample defined as 'participating' in the evaluation assessment (n=333). Among the intervention sample, 'participation' is defined as attending at least 2 group counseling sessions and being followed-up. Among the control sample, 'participation' is based on having simply been followed-up.

Impact on Symptoms
There was a similar reduction in total symptom scores (a measure composed of scores on all the symptom questions) among both the intervention and control groups. Therefore, improvement due to the intervention itself was small and not statistically significant. This result did not vary by village or by group except for the groups run by one particular pair of counselors (pair #6): when these groups were removed from the analysis intervention participants improved more than 5 points (9% difference) more on their total problems scale score compared to controls, whereas when this pair's participants are included, the improvement was reduced to less than 2 points (a 3% difference)

In evaluating the impact of the intervention on each of the individual syndrome scales (depression, anxiety and somatic symptoms) *those receiving the intervention improved*

significantly more than the control participants only on the somatic syndrome scale. With the participants associated with counseling pair 6 removed, the difference between the intervention and control participants was 2 points (a 14% difference) (p=.02).

These results did not differ for men compared with women. However older men improved less than younger men while women's age was not associated with amount of change.

Impact on Function
Among men, function improved for both the local function scale and items taken from the WHO DAS scale (results were statistically significant, or are close to statistically significant). Women showed significant improvement on the WHO DAS scale only.

Impact on Coping Skills
We hypothesized that the intervention would increase the use of positive coping strategies that local people had told us were ways people helped themselves to feel better. Among both men and women, there was an increase reported use of coping strategies among intervention participants and a decrease reported use among control participants, with the difference over time reaching statistical significance for the men.

Perceived Usefulness of the counseling group
Group participants were asked at the post-intervention assessment about their use of the counseling group and their perception of the degree to which the group helped them cope with their problems. Most of the participants reported using the group when they felt badly and most of these reported that it made them feel better. This trend was stronger among the male participants than female participants.

Other Impacts
In the post intervention qualitative the most frequently reported benefits included the community being more cohesive, being trusted in the community, not having fights in the family, and being more happy and patient. Many respondents also mentioned that they were now brave enough to say their opinions and were more open to dealing with problems in the family. Questions on these points, as well as those reported by the counselors, were added to the assessment instrument so that comparisons could be made across the intervention and control groups. The group receiving the intervention reported improvement on almost all these items, and greater improvement than among the controls. These improvements indicate that while the intervention may not have had impact on certain specific mental health problems, there does seem to be an important impact on improving social support systems (with respect to both community and family) and general use of coping skills. This may explain some of the functional improvement as well as the perceived utility of the PSC among the intervention group.

Conclusions

1. PSC resulted in little improvement in the mental health problems for which the program was implemented. Significant improvement was limited to somatic symptoms.

PSC was somewhat effective for reducing the burden of somatic symptoms but less effective in reducing the burden of depression and anxiety symptoms, when compared with the changes that were experienced by the controls who did not receive the intervention. The impact of the intervention on mental health symptoms did not appear to vary by gender except for an age-related trend: younger men reported more change across all of the syndrome scales compared with older men. Women exhibited no age-related trend.

2. Function improved more among program participants than controls, and the effect was greater among men.

For the functional impairment outcomes, men appear to have experienced more improvement associated with participation in the intervention compared with women.

3. The quality of service provision varied by provider and affected the impact of PSC
An important finding was the differential outcomes by counseling pair. To understand these results, the ICMC staff reviewed the supervision materials for all of the counseling pairs collected during the intervention. They concluded that the pair whose participants experienced the least amount of change were also the weakest pair in skills of empathy and in exploration and review of changes and challenges among participants. These results reinforce the importance of training and supervision throughout the intervention process.

4. Use of coping strategies increased among program participants compared with controls, with participation in the group itself being an important coping method.

Both men and women showed increases in their use of coping strategies for when they feel bad compared with controls, with participation in the group itself being an important source of coping.

5. While negative symptoms did not tend to improve, and there was limited improvement in measures of function measured at baseline (ie, pre-intervention) the data suggest a substantial improvement in socializing and engagement with others, positive feelings of well being and self esteem, improved ability to work and to cope with problems, and improved relationship with family.

These findings emerged from the questions added to the assessment instrument as a result of the post-intervention qualitative assessment and the interviews with supervisors. They reflect impacts of PSC that were not anticipated prior to the intervention but were reported after its completion. Examples include more community cohesion, being trusted in the community, fewer family fights, being more happy, patient, brave with regard to giving their opinions, and more open to dealing with problems in the family.

The strength of the evidence for these changes is weaker than those for questions that were asked both pre and post intervention (and the results compared). It is possible that respondents did not actually experience the level of change they report in the post intervention assessment. However, on almost all items those who received PSC reported improvement in higher numbers than did the control group, suggesting that the differences are real and linked to the intervention.

6. Lack of economic opportunities is a major problem and viewed as a cause of many of the problems assessed in this study.

One of the biggest problems that the villagers from all 6 assessment villages discussed was the lack of economic opportunities and job prospects. Many of the problems we assessed were thought by local people to be caused by economic problems rather than their experiences of torture and violence, and over the course of the program and the assessment the economic situation did not improve. It may be that the prospects for improving these symptoms using a counseling approach are always going to be limited if the underlying causes are economic and these causes are not addressed.

7. Use of a control design was essential in measuring the true impact of PSC.Without a control group our conclusions would have been very different.

We found substantial reductions in severity for most symptoms among the intervention group. Without a control group this would have led us to conclude that the intervention was quite effective for most of the symptoms we assessed. However, similar changes among the control group made it clear that these changes, while substantial, were not due the intervention. Use of a controlled design proved critical to determining the intervention's true effectiveness.

8. Impact assessments using a control design are, with some training and assistance, feasible for service providers.
With external technical assistance a trained team of field-based NGO staff and research assistants were able to rigorously monitor their intervention and assess its impact. In the present evaluation assessment, outside technical assistance was used to guide all stages of the evaluation assessment, from the needs assessment and instrument development and validation process, through the assessment design and evaluation components. Rather than having the technical support team simply conduct the evaluation, time was spent working with the collaborating NGO staff from ICMC to ensure their understanding and training in all components of the evaluation. *The ICMC staff has been trained in all components of the evaluation, including systematic documentation of the components of the intervention through data management and basic analysis.* Throughout the program implementation and evaluation process, input from the ICMC staff into the process ensured that the results were relevant for their continued programming.

Recommendations

1.The PSC program should be continued but should form part of a wider more holistic initiative to also address economic issues among the population.
Based on the results of this assessment, ICMC is currently piloting several types of combined economic and mental health programs in the control villages, in order to begin to learn about the interaction of these two important components of well-being. Meanwhile, a one day workshop for potential group leaders from the counseling groups is being planned at the time of writing – to give them the skills to continue with the sessions after the counselors not longer lead the groups.

2. Changes should be made in how PSC is implemented. These changes should reflect the assessment findings as well as what has been learned during implementation.

In reviewing the intervention process and assessment results, we have learned much about future adaptations and implementation of the intervention. One specific suggestion is that counselors meet with their clients more regularly outside of the group to get to know more about their lives and their problems better, since our experience is that not all of the participants bring all of their issues to the group. Below are some specific suggestions for improvement in selection of counselors, training and supervision that emerged as results of this assessment:

Improve Selection of Counselors:

- Education background: We have learned again that high school graduates can be trained to provide this type of intervention correctly.
- Commitment: We recommend only hiring people who can prove they have the time to commit to full-time work the program (i.e. not having college or family obligations that will inhibit participation).
- Selection through training: We recommend making a practice of bringing more candidates than required for the initial training, so that we can exclude those who demonstrate poor performance during the training.
- Probation: We can recommend a period of probation of 3 months for the counselor. While this would be ideal, it does pose challenges. Generally local partners or even INGOs, do not 'fire' people after the 3 month probation despite the fact that labour laws allow this. The logic is "with some support, he/she will improve". The moment the person is not fired after 90 days, the person automatically gets into a longer term contract (specified until the end of the project/task). If renewed, or continued twice, the person becomes a permanent staff (subject to funding).
- Establish a system for 'replacement' training: Recognizing that it may be necessary to hire new counselors on an ongoing basis, a system is needed to ensure that this new person receives the appropriate training and supervision prior to engaging in the actual counseling program.

Improve Training and Supervision:

- We suggest that after the initial 5-day basic training immediate supervision is required, and would recommend that the supervisor/trainer stay in the field for a minimum of the first month to provide daily supervision, and mentoring to the counselors as they start going to the field.
- We have seen that the counselors who began their work with this intervention by first providing individual counseling have better skills than counselors who go straight to the structure of the group. We suggest that new counselors first conduct individual counseling for about 2 months to develop their skills in probing, exploring, empathy, and slowly guiding the clients towards coping and problem solving.
- The initial supervision has focused on preparation of the structure of the sessions to help with implementing them in the field. We suggest adding field training exercises that aim at strengthening the micro skills in counseling – i.e. exercises to do observation of behavior, reflections of how they could have done things differently, and probing.

- As part of the ongoing training, we suggest increasing the number of exercises that improve skills for reflection, observation, and probing.
- For sustainability of the groups (on going after counselors terminate the group), we suggest that some training be provided to members of the groups who could act as peer leaders.

3.Once the wider initiative has been implemented, ICMC and RATA should monitor impact using the assessment instruments, to determine whether symptoms and function respond better to this package than to PSC alone.

4. ICMC now has the capacity to conduct impact evaluations using control groups, in order to accurately assess impact. They should continue to use this approach when first implementing new interventions and approaches among new populations.

This assessment has demonstrated the importance of including a control group to assess the impact of mental health interventions. Severity of symptoms and dysfunction tend to vary over time. Persons who seek out interventions (or are screened into them on the basis of severity) tend to do so when they are feeling at their worst and therefore will show an apparent improvement over time, as did the controls in this assessment. The extent of this natural change must be measured and subtracted from the changes among the intervention groups in order to determine an intervention's true impact. Otherwise, assessments will tend to suggest that interventions are effective even when they are not. This is not to argue that a control group should accompany every intervention, but rather that early trials in a new population should do so, so as to confirm genuine local effectiveness. After a controlled assessment has confirmed local effectiveness, future evaluations of impact in the same area should not require a control group comparison.

ACKNOWLEDGEMENTS

Talented and dedicated effort from many collaborators was essential to making this assessment a reality. We are endlessly grateful to all the RATA staff and other colleagues at ICMC who provided the intervention and those who contributed to the overall logistics which made possible both the intervention and the associated research. We would also particularly like to thank USAID Indonesia, and Danuta Lockett from Victims of Torture Fund, who provided the critical institutional and financial support.

INTRODUCTION

This report describes an assessment of the impact of an intervention on the emotional and behavioral health and functioning of adults affected by torture and trauma associated with the more than 30 year conflict between the Free Aceh Movement (GAM) and the Indonesian Army. The assessment was conducted by International Catholic Migration Committee (ICMC) and by faculty from the Applied Mental Health Research Group at Johns Hopkins Bloomberg School of Public Health (JHSPH). A controlled trial design was used to evaluate the effectiveness of a problem-solving counseling program (PSC) for the treatment of locally-defined psychosocial and mental health problems among adults living in Aceh Province, Indonesia. This design was chosen to accurately assess the true impact of the intervention. The assessment was conducted between August 2007 and January 2008 in 6 villages in Bireuen district. These 6 villages were selected because they are part of the service region of RATA, the local collaborating NGO who were trained to provide the intervention services. RATA has a history of providing medical services to torture-affected populations in this region.

This report presents background information on the situation of conflict-affected populations in Aceh, Indonesia, and describes how the assessment was implemented, the nature of the intervention, and the final results. We also discuss the significance of these results for the work of ICMC and humanitarian agencies in general, and provide recommendations for future activities.

This report does not describe in any detail the methods used in the preliminary research that led to the trial (such as the approach used to develop the tools used in the evaluation for assessing mental health and psychosocial problems among this sample of Indonesian adults). These methods have been well described in previous reports and are available from the authors on request.

Purpose of this assessment:
To test the feasibility and effectiveness of a problem-solving counseling therapy for reducing the burden of locally-described mental health problems and improving function among adults affected by torture (and other conflict-related violence) in Aceh, Indonesia.

BACKGROUND

Local Situation: Aceh, Indonesia

The site targeted for this project, Bireuen County, was one of the most affected districts in the conflict between the Indonesian military and the Free Aceh Movement (GAM). It was considered a stronghold of GAM and was frequently attacked by the military. GAM had their hide outs in the forests and villages around the forest areas were prime targets for the military. All of the villages participating in this evaluation assessment were highly affected by the conflict. Entire villages experienced torture first hand, or were family members or witnesses of torture and arbitrary killings. A peace treaty was signed between the conflicting partners in August 2005 and since that time there has been peaceful elections and ongoing development, though the area still experiences periodic unrest and challenges to the peace process. August 15,

2007, the Indonesian Independence day was marked by peaceful celebration in Aceh, and the commemoration of the anniversary of the establishment of GAM on December 4, 2007 has made the Acehnese in general perceive that finally peace is there to last. Both these major events happened during the course of the assessment.

Mental Health

Since the late 1980s the mental health of people in low resource environments has become of increasing programmatic interest to non-governmental organizations (NGOs) and other humanitarian organizations. This is particularly true in the case of 'trauma-affected' populations such as those who have experienced torture and trauma, complex humanitarian emergencies (CHEs) and natural disasters. Studies in a variety of cultures suggest that these events can have severe and prolonged effects on mental health and ability to function (e.g, Mollica et al., 2004[1]). For humanitarian reasons, and to assist recovery and development, NGOs have invested substantial resources into interventions designed to improve the mental health of these populations. However, few interventions have been formally evaluated to determine whether or not they are effective.

Most mental health interventions used in CHEs were created and tested in developed countries and western cultures (Bolton & Betancourt, 2004[2]). Apart from pharmaceutical treatments (which are generally not used by NGOs for reasons of cost, adherence, logistics and sustainability), these interventions are mostly derived from an understanding of human nature based on a single culture or group of similar cultures, usually Western. A debate has emerged among field-based practitioners and researchers as to whether these interventions can be assumed to be effective in non-Western cultures. This debate has not been resolved, in part due to a lack of scientific data.

Prior Work

As mental health programming has gained prominence in recent years, faculty at JHSPH (in their role as technical advisors to NGOs) became interested in the gap between the number and variety of mental health programs being offered during CHEs and the lack of local evidence for their effectiveness. Efforts to demonstrate effectiveness were hampered by a lack of accurate assessment methods suitable for use by service providers. Without such methods, there was no way to tell whether interventions used among non-western populations were assisting people, ineffective, or possibly even harmful. Therefore, there was no way to choose between interventions or evidence on which to base improvements, thus preventing progress in this field. To address this issue, JHSPH faculty have collaborated with NGO partners and developed an approach to assessment intended for use in collaboration with service providers working in these settings. This approach uses a combination of qualitative and quantitative methods to better select priority issues for programs to address, to select and adapt appropriate interventions, to accurately quantify need, and to accurately assess the impact of these programs. The use of this approach among the population in Aceh presented in this report began in 2006 with the

[1] Mollica RF, Cardozo BL, Osofsky HJ, Raphael B, Ager A, Salama P.
Mental health in complex emergencies. Lancet. 2004 Dec 4-10;364(9450):2058-67.

[2] Bolton P, Betancourt TS. Mental health in postwar Afghanistan. JAMA. 2004 Aug 4;292(5):626-8.

qualitative assessment described below. The other activities described in this section also form part of this same approach to program assessment.

Prior Qualitative Assessment

In September 2006, ICMC staff, together with the local collaborating NGO RATA, conducted an initial qualitative assessment among torture and conflict-affected adults in Bireuen district in Aceh, Indonesia. This qualitative assessment (QA) was the first phase of the multi-stage needs assessment and monitoring and evaluation process developed by faculty at JHSPH and mentioned in the previous section. The purpose of the QA included:

- Identifying current high priority problems of those affected by violence (survivors and family members);
- Informing interventions to address these problems that are acceptable and feasible, given local environment and culture and the resources of service providers; and
- Informing the development of instruments that can be used in the future to assess baseline level of need, monitor progress of interventions, and assess their impact.

To meet these objectives, the qualitative assessment focused on three areas of interest:

A. To understand how local people affected by violence perceive the current problems resulting from these experiences, in particular:

- The variety of problems currently experienced by survivors of violence
- The perceived importance and severity of these problems
- The nature (in terms of characteristics or symptoms) of these problems
- The local terminology used to describe these problems
- The cause of these problems and what people do when they have them
- The existing resources that could be used to address the problems

B. To understand what constitutes the most important aspects of normal functioning for local people. This refers to the tasks and activities that constitute the roles of men and women in the local population.

C. To understand the various coping skills used by the local population. This refers to the activities or strategies people use locally to deal with their own psychosocial problems including daily life stressors.

Information collected during this qualitative assessment was used to create a locally appropriate assessment instrument to assess A, B, and C, above: The qualitative data was used to select and adapt standard measures of psychosocial problems (the Hopkins Symptom Checklist for anxiety and depression, and the WHO Somatic Scale), to develop separate measures of functional impairment for men and women, and to design an instrument to assess the strategies used locally for coping with the identified psychosocial problems. In addition, sections of the WHO Disability Assessment Schedule were also added to the function assessment scale, to provide a broader measure of function.

Prior Validity and Reliability Testing
Before using the instrument to conduct the trial it first underwent field-based testing of its reliability and validity among torture-affected persons in Aceh. The symptom-based scales show good psychometric properties in this population, suggesting that they are both valid and reliable. Tests of criterion validity found that the symptom scale scores consistently matched the criterion chosen for this assessment: a local community or religious leader's identification along with self-identification of having either the problem of *fear* or *thinking too much*: The respondents identified by both themselves and others as having either of the problems ("cases") showed substantially and significantly higher levels of symptoms than those identified as neither of these problems ("non-cases").

The function scales also showed acceptable validity but performed poorly in the test-retest analysis, particularly the items from the WHO DAS scale and the male-specific functioning scale. The small number of male respondents in the initial study impacted the test-retest results. To further evaluate the test-retest of the scales among men, additional interviews were conducted during this post-intervention assessment, and with the additional data, we were able to confirm that the test-retest reliability of the scales was adequate.

A full description of the validity assessment and results is in the report of that assessment. This is available from the authors of this report.

INTERVENTION

The intervention consisted of a group of activities collectively referred to as the Problem-Solving Counseling (PSC) Program. While PSC focuses on 8 specific group sessions, the preparations for the program, including the community socialization and outreach, and the additional components of group-buddies and home visits are also important and are described below.

PSC follows the principles of non-directive counseling. The counselors were trained to provide emotional support, look at strategies to manage difficult emotions, and to provide problem-solving counseling. The closest reference to the core training material would be "The Skilled Helper" 6th edition – By Egan, G (1998). Pacific Grove, CA:Brookes/Cole.

Socialization/Outreach:

The counselors first informed village leaders about the program and requested their permission to 'socialize about the program' when people gathered together for prayers, or other informal group activities. The socialization consisted of providing information about the results of the qualitative assessment i.e., that there were many people having difficulties with "heavy heart" and "fear" in the village. This was followed by an introduction to the group sessions element of the PSC or "kelompok Peugah Peugah Haba" (talking group) program. The counselors suggested that this talking group could help people cope with their "heavy hearts" better. The villagers were given opportunities to ask questions about the program and its objectives.

An informal socialization followed this formal one, where counselors went and mingled with the communities in coffee shops and conducted home visits to introduce themselves and the program. Through self referrals and referrals from village leaders, teachers, or family members, the counselors listed potential clients. This was following by the baseline screening, informing those who met inclusion criteria about the 'talking group' and fixing schedules; informing those who did not meet inclusion criteria that they would not be joining the groups because it was for people with bigger difficulties of "heavy heart"; and informing these "non-cases" that they could contact the counselors for individual consultation if they felt the need to talk about their problems.

The Support Group:

The support group was formatted into 8 weekly sessions that each lasted between 1-2 hours.

- In the first session, introduction was done, expectations, worries about the group process and what they would contribute as individuals was shared, and ground rules were discussed for how the information presented by the group participants would be kept confidential. The session also including formation of buddy pairs from within the group. The task of the buddies was to check on each other, and visit each other between the sessions.
- The second session consisted of mapping the participants' current problems. The facilitator initiated the session using a body mapping activity to show people the connection between the mind and the body. Then the floor was opened to understand what the problems of the group were. The group decided what they wanted to pick as topics/themes to discuss for later sessions. The most common themes were: sadness, fear, heavy heart, anger, and body pains.
- The third through sixth sessions consisted of discussions and sharing of these problems. Again, the facilitator was non-directive and just facilitated discussions. Typically, people started out by narrating their difficulties. The facilitator guided the discussion to how it was affecting their daily lives, and then shifted to what people were doing to manage with their difficulties before ending the session. Each session started out with an evaluation of what happened during the week, a follow up of action plan of last week and the activities with the buddies. Prayers and religious songs, as suggested by the group participants, were included at the closure of each session. During the sixth session, the group was requested to choose one leader who would assist in the facilitation of the 7^{th} and the 8^{th} session and continue the group process after the care provider stopped conducting sessions.
- The 7^{th} session was an evaluation of how people were doing since they joined the group – discussions of any positive and negative changes felt was conducted.
- The 8^{th} session consisted of looking at the future. People talked about their next plans, and if they wanted to continue meeting with the group on their own and how they would arrange those meetings.

Buddy System:

In addition to the support received from the group process, the intervention also tried to strengthen relationships among members outside of the group setting. The clients were asked to pick a "shahabat" (buddy, or best friend) from within the group. Once buddies were identified, which happened easily, the task of the buddies was explained. The buddies were asked to visit

each other after each group session to check on how they were doing. The buddies were encouraged to meet at least one time within the week before the next session. Each new session began with checking on how the week was, and how people felt with the visits from their buddies. People were allowed to share what they talked about with their buddies if they wanted to. Clients were free to change buddies if they wanted to.

Home Visits:
Though buddies were asked to check on their buddies and bring them to the sessions, in many groups several people would not come to the session on time. The counselors thus encouraged people to come to the sessions by making home visits. Home visits were also made for people who did not attend the session (i.e. were not found by the counselor prior to the session) to check on why they did not come. They were then reminded of the schedule of next group session. Home visits did not include individual counseling activities. In future , home visits might include individual counseling sessions as needed.

Wait-List Controls
During the assessment period, participants in the control villages received no specific intervention but were free to access any available services or programs that they would have received in the absence of the assessment. They were informed at the beginning of the assessment that if they agreed to participate, their villages would be next in line to receive an intervention following the conclusion of the evaluation assessment. The specific intervention strategy to be provided would be determined in part by the results of this evaluation, which would guide whether the counseling program would require change and/or further adaptation.

Mechanism for people with severe disorders:
The counselors were trained to identify people with psychosis as well as anyone who developed suicidal tendencies, and to refer them to health posts or hospital. One person with psychosis was identified during the assessment period. The family was encouraged to take him to the health-post for treatment. During the screening 13 people indicated some degree of suicidal ideation from the questionnaire. A further exploration was done by the counselors to understand the severity of the suicidal ideation. However, it was found that they did not have active suicidal ideation, but it was more of a feeling of “I wish I was dead”. They indicated that actual suicide never crossed their minds, perhaps due to strong religious values that negate suicide.

Intervention Supervision
Counselors worked in pairs and were supervised by ICMC program staff. Each counseling pair met with ICMC supervisors twice a week, once together with all of the other counselors and once just as an individual counseling pair. During the group meetings, they reviewed the topics of the next group session, and did role plays to practice how to implement activities for the next sessions. During the individual meetings the counselors were able to review with the supervisor specific problems and or challenges with their group and discuss solutions and action plans.

ASSESSMENT METHODS

Screening and Recruitment

Screening of participants into the evaluation assessment was done using the composite instrument previously piloted and validated for use with this population. That instrument was comprised of adapted versions of the Hopkins Symptom Checklist (HSCL) for depression and anxiety, the WHO somatic symptoms scale, a locally derived questionnaire on functional impairment, sections from an adapted version of the WHO Disability Assessment Scale (WHO DAS), questions on general demographic information, as well as information on coping with distress.

Recruitment into the evaluation assessment began during the instrument validation assessment (see validation assessment report). Since the validity assessment was conducted in the same villages as the evaluation assessment, and the instrument was found to be valid, all adults screened into the validity assessment were eligible for participation in the evaluation assessment. Once sufficient data was collected for the validation analysis, additional adults were screened from the 6 villages to get sufficient numbers for the evaluation assessment. The goal was to enroll a total sample of 400 adults into the intervention assessment (200 in each assessment arm: control vs. intervention).

The validity assessment data found that those identified as cases by local people had higher problem scores than non-cases. Therefore, to increase the likelihood of finding eligible persons, interviewers identified persons to interview by asking knowledgeable local people (including persons they had already interviewed) to identify additional likely cases.

Eligibility for inclusion in the counseling program was based on severity of psychosocial symptoms and associated functional impairment, as indicated by their symptom severity and function scores on the instrument. The cutoff scores were based on the validity assessment data: we found that the 'cases' were highly symptomatic on the total psychosocial problems scale score, with a mean score on the total symptoms scale (made up of all 44 psychosocial symptom questions in section B of the questionnaire, see Appendix B) of 62 points (sd 24). Since choosing the mean score of the cases as the cut-off would limit inclusion to only half of all cases (the more severe half) we chose, in accordance with standard practice, a cut-off score of one standard deviation below this mean (cutoff = 38 points) in order to include the bulk of persons who would be considered as cases. This score of 38 points gave good discrimination from non-cases, whose mean scale scores were > 10 points less (23.3 points).

We reviewed the interviews of a total of 592 adults (The 179 interviewed during the validity assessment and the additional 413 interviewed subsequently) using this cutoff and the additional criteria of having a > 0 score on the functional impairment scales. 415 adults met the cut-off criteria of having a total psychosocial problems score greater than 38 points as well as some degree of functional impairment. Five additional people were also included because their scale scores were borderline, between 37-37.7 points, and they had significantly high functional impairment scores that we felt they would benefit from the intervention. This gave the total sample eligible for inclusion as N=420, or 71% of the total screened sample.

All of the eligible adults were told to what assessment arm their village was assigned (intervention or wait-control) and asked whether they consented to participate in the trial. 415 (99%) consented to participate.

Post-Intervention Evaluation

Post-Intervention Qualitative Assessment

The first part of the post-intervention assessment consisted of a brief qualitative assessment. This was conducted to identify unexpected impacts of the intervention not already reflected in the baseline assessment instrument. JHSPH faculty guided ICMC and RATA staff in conducting the assessment with a portion of the intervention participants and family members. Those in the control assessment arm were not interviewed. Six interviewers who had been involved with the preliminary qualitative assessment in September 2006 participated in this post-intervention qualitative assessment. They received refresher training from ICMC staff on general qualitative interviewing methods and then specific training on the questions used for this assessment. In order to get a variety of experiences, the RATA counselors were asked to provide names of 5-7 adults per intervention village whom they thought had improved over the course of the intervention period and names of 5-7 adults whom they thought had not improved, or had not improved as much as others. These lists were given to the interviewers with the 'improvement' designation removed so as not to bias the interviews. Those on these lists were invited to participate in this qualitative assessment and for each person an adult family member was also interviewed.

The questions for this qualitative assessment were developed to encourage the respondents to talk about all the changes that have happened in their lives since the intervention program began and all the changes that they think are due to their participation in the program itself. The interviewers were trained to probe into changes that affected the person themselves, their families and their communities, and to ask about both positive and negative changes. The adult family member was asked a similar line of questioning – about the changes in the person who participated, both positive and negative, that affected the multiple domains of their life (self, family and community).

A total of 33 intervention participants (17 identified as having improved a lot and 16 as less improved) were interviewed. The respondents were split evenly by gender (17 male; 16 female). An adult family member for each participant was also interviewed (n=33). The supervisors were also asked to identify unexpected impacts, based on their review of their own weekly supervision reports.

The information from both the qualitative assessment and the supervisors were used to add questions on salient unexpected impacts to the original baseline instrument (see the questions in Section E of the questionnaire, Appendix B). This was done prior to its use to reassess both intervention and control participants (see below: Post-Intervention Quantitative Assessment). These additional questions consisted of:

a) 30 questions gaging to what degree the respondents felt that certain feelings, abilities and their activities had changed in the previous 6 months. All of the questions were asked using a 5-point Likert scale, allowing for respondents to indicate a range of responses from the negative (got a lot worse/did it a lot less often) to the positive (got a lot better/did it a lot more often) over the previous 6 months.

b) A series of 17 life events questions to assess the range of positive and negative life events that may have occurred since the evaluation process began. The purpose of these questions is to more fully understand what was going on in the lives of the assessment participants and how various life events may have influenced the overall impact of the intervention. These data have not yet been analyzed, so results are not presented in this report.

c) A single question about starting an income generating project was added to the end of the instrument in order to provide some indication of the impact of the intervention on economic outcomes.

Exit Interviews of Intervention Facilitators and Supervisors
Concurrent with the post-intervention quantitative assessment (described below) ICMC staff, along with the JHSPH faculty, had a series of discussions with the RATA counselors about their experience with the program and their sense of its impact. This was also an opportunity for them to discuss and suggest improvements in preparation for the implementation in the control villages.

Post-Intervention Quantitative Assessment
Within 4-6 weeks after the completion of the counseling intervention, all assessment participants were re-interviewed using the expanded version of the original screening instrument. The follow-up assessments were conducted by 20 interviewers, 12 of whom had been involved in the baseline screening assessment. None of the follow-up interviewers were involved in the interventions. All received training in general quantitative interviewing methods and specific training in the assessment instrument prior to the follow-up assessment. JHSPH faculty provided technical assistance to the ICMC staff to supervise the follow-up assessment process.

The post-intervention follow-up assessment was conducted over two weeks in January 2008. 375 (90%) of the original 415 were found and re-assessed (200 Intervention; 175 Control). Of the 40 who were not interviewed, 7 refused, 4 had passed away or were too sick to be interviewed, 15 had moved too far away to be contacted or were away for an extended time, 3 were unable to be identified and/or found, and 11 worked out of the village during the day and despite repeated visits were unable to be met and re-interviewed.

Data Analysis
Preliminary Analyses
We assessed the overall severity of each participant's psychosocial problems pre and post intervention by summing the numerical scores for all 44 of the psychosocial symptoms, each item scored on a 4 point scale (0 indicating not having that symptom at all to 3 indicating experiencing that symptom all of the time). Similarly we created three functional impairment scores by summing the responses to the function questions, which were asked on a 5-point scale (0 having no difficulty doing the task to 4 having so much difficult that the task cannot be done). The men's function scale contains 14 items, the women's function scale contains 16 items, and 11 items from the WHO DAS scale (see instrument in Appendix B and specific items in Table 1). Use of coping strategies was assessed by similarly summing individual item scores in the coping section of the instrument. In this section each assessment respondent indicated, using a 4

point scale, how often they utilize each of 9 different coping strategies when they feel badly (0 not at all, 1 rarely, 2 somewhat, 3 often).

Descriptive analyses were conducted on the baseline data to determine if the intervention and control group populations were comparable. Comparisons of pre- and post-intervention levels of psychosocial problems and functional impairment were made to determine the amount of change, by subtracting the post-intervention scores from the scores attained during the original screening interviews (i.e., baseline). Similarly, to assess whether the intervention increased the use of coping strategies, we compared the change in total coping scores of intervention participants to that of controls. The mean changes in scores between the two assessment arms (intervention and control) were compared using analysis of variance (ANOVA) calculations and post-hoc t-tests. Regression analyses were used to evaluate the impact of covariates (e.g. age, village, gender, counseling pair) on the outcomes. The results from the regression analyses were adjusted for potential group effects. This was necessary because people in groups may influence each other and this must be accounted for in the analysis of such clustered data. This is because while the interventions themselves were organized in groups with the intent that peer interactions would be part of the therapeutic process, the analyses are done at the individual participant level rather than the group level. Therefore, to more precisely measure the impact of the interventions on individual change it is necessary to adjust for the influence of the groups.

Factor analysis

Although not part of the original purpose of this assessment, we took the opportunity provided by these data to conduct some additional analyses related to instrument validity. We used factor analysis to explore whether the Western concepts underlying the symptom instruments – anxiety and depression (the HSCL) and somatic complaints (the WHO somatic complaints) - were really appropriate in this population; ie, whether they are conceptually valid. An exploratory factor analysis was conducted with all 44 symptom questions (ie, not including the function or coping questions). The details of the factor analysis and results are described in Appendix C. Briefly, a three-factor model appears to best present the data and the factors are consistent with western constructs of anxiety, depression, and somatic complaints. Hence, these results support the original decision to investigate symptoms using instruments based on these concepts. All analyses presented here are therefore based on the pre-defined depression, anxiety and somatic scales, which will facilitate future comparisons with other research based on the same concepts. For the anxiety and depression problems, the Hopkins Symptom Checklist (HSCL) anxiety and depression subscales are used. For the somatic problems, the WHO Somatic Scale was used. Table 1 below presents the items that make up each scale.

Table 1. Signs and symptoms for the mental health syndrome, functional impairment and coping scales

HSCL Depression Symptoms	HSCL Anxiety Symptoms	WHO Somatic Symptoms	Qualitative Data Only Symptoms**	Male Local Functions	Female Local Functions	WHO DAS Functions	Coping Strategies
▪ no energy*	▪ headache*	▪ headache*	▪ difficult heart	▪ shaving	▪ brushing teeth	▪ standing for long periods of time	▪ praying
▪ blaming yourself	▪ dizziness*	▪ dizziness*	▪ spacing out	▪ brushing teeth	▪ brushing hair	▪ taking care of your household responsibilities	▪ reciting Koran
▪ Crying*	▪ suddenly scared for no reason	▪ pain in chest*	▪ easily angered	▪ brushing hair	▪ putting on make-up	▪ learning a new task, for example, how to get to a new place	▪ Earning money
▪ don't care about family	▪ fearful*	▪ pain in lower back	▪ don't have direction	▪ go to field/ plantation	▪ cooking	▪ how much of a problem did you have in joining in community activities (for example: festivities/religious activity) in the same way as anyone else can	▪ Sitting together to chat
▪ loss of appetite*	▪ nervousness or shakiness	▪ muscles soreness	▪ chaotic thoughts/ confusion	▪ care of animals	▪ cleaning house	▪ are you able to do an activity for 10 minutes	▪ Going (walking) to please ones heart
▪ when sleep, can't sleep well*	▪ heart pounding*	▪ numbness in parts of your body	▪ everything done goes wrong	▪ care of children	▪ getting water	▪ go for a long distance by foot	▪ Discussing
▪ feeling hopeless about the future	▪ trembling*	▪ weakness in your body*	▪ stress	▪ shopping (buy some rice, fish)	▪ go to field/rice paddy	▪ washing your whole body	▪ Listening to advice from wise men
▪ feeling sad*	▪ feeling tense		▪ trauma	▪ community self-help groups	▪ gather fire wood	▪ when put clothes/dress on	▪ Going to find recreation for self
▪ feeling lonely	▪ busy by own self (panic)		▪ can't let the voice out when speak	▪ attend community meeting	▪ washing clothes	▪ when dealing/meeting with people you do not know	▪ Playing soccer or volleyball
▪ thoughts of ending life	▪ can't sit, can't stand* (feeling restless)		▪ hot body	▪ attend parties	▪ community work	▪ maintaining brotherhood with other people	
▪ feeling of being trapped			▪ pale	▪ praying	▪ participating in family welfare program	▪ your daily work	
▪ feeling difficult when having many thoughts			▪ closed breath/ difficulty breathing	▪ reciting Koran	▪ attend parties		
▪ feelings no interest			▪ not wanting to talk	▪ earn money	▪ praying		
▪ difficult to do anything			▪ many thoughts	▪ Go to work	▪ reciting Koran		
▪ feeling of worthlessness					▪ earn money		
					▪ Go to work		

* symptoms from the qualitative data

** symptoms from the qualitative data which are not part of the other scales but are included in the total symptoms scale

RESULTS

Baseline Characteristics

Table 2 presents the distribution of the 420 respondents who were eligible for participation in the assessment. Although there is some variation in the proportion of men and women meeting eligibility criteria, across intervention and control status, the demographic characteristics did not significantly differ. While most were between the ages of 30-69 years, there were sizable numbers of older adults (70 years and older). Nearly 80% of the sample was married, with most of the others being widowed. The mental health symptom scales, which are an indication of the severity of the syndromes, are similar across the intervention and control groups, while the functional impairment levels differ, with the controls having higher rates of impairment among both men and women.

Table 2 also presents information about the sample that is defined as actually 'participating' in the evaluation assessment (n=333). Among the intervention sample, 'participation' is defined as attending at least 2 group counseling sessions and being followed-up. Among the control sample, 'participation' is based on having simply been followed-up. Using this assessment sample, the intervention and control groups did not differ demographically nor by severity of mental health problems. The difference in functional impairment remains, though it is statistically significant only among the females.

Intervention Impact on Mental Health

Table 3 presents the comparison of intervention to control participants for all 3 of the mental health syndrome scales as well as total symptom scores. Based on these analyses, there is a reduction in symptoms in the intervention group, but we also saw a similar reduction in the control group, rendering the improvement due to the intervention itself not statistically significant.

During the exploration of these results, we identified variation in the amount of change across the different intervention groups and villages. To explore this further, we explored the impact of the different counseling pairs on the amount of improvement in their groups. Table 4 presents the number of different groups and the number of participants in those groups, by intervention village and counseling pair. All but one of the counseling pairs provided services to groups in more than one village. The exception is pair 2, which was made up of 1 counselor from pair 5 and one from pair 1 to provide services to a single male group that preferred to meet in the evenings. To explore the impact of different counselors we conducted a counselor sensitivity analysis based on the total symptom change scores. We explored how the results changed when the participants of each counseling pair were systematically removed. Chart 1 presents the comparison of total change scores among intervention and control participants for the total sample and with each counseling pair's participants removed. There was minimal variation in the results for all comparisons except when the participants in pair 6's groups were removed: The intervention participants improved more than 5 points more on their total problems scale score compared to controls, whereas for the other comparisons, the improvement was reduced to less than 2 points. This is an indication that there was a problem with the participants in these groups or, more likely, with the counselors themselves. *Due to this strong variation, all subsequent analyses are presented for the total participant sample and for the total sample minus the participants for counseling pair 6.*

Like Table 3, Table 5 presents the differences in adjusted mean change scores for all 3 of the syndrome scales and for the total symptom scale but with the participants for counseling pair 6 removed. *Based on these analyses, it appears that the intervention participants improved significantly more than the control participants on the somatic syndrome scale.*

Table 6 explores the results further by gender. While there are differences in the amount of improvement by gender, results are similar to those found when the men and women are analyzed together; the intervention participants did not significantly improve to a greater extent than the control participants on any of the scales for either gender group.

Chart 2 presents the results by age and gender. On each chart, the individual points represent the change scores for each of the assessment participants sorted by age, presented separately by gender. Across the scales there is a trend that age is important among the men and less so among the women. For all 4 sets of analyses, older men had lower amounts of improvement compared with younger men, while among women age did not seem to be associated with amount of change.

Intervention Impact on Functioning

To investigate the impact of the intervention on improving functioning, we used two different types of functional impairment scales. The first set of scales was developed specifically for this population based on the prior qualitative research and present locally important activities and tasks for each gender. The other scale is taken from sections of the WHO DAS, a standard scale developed by the WHO to assess disability. Table 7 presents results for the change in functional impairment analyses separately by gender, with the results presented both for the total participation sample as well as for the sample with the counseling pair 6 respondents removed. Among the men, the results are statistically significant, or are close to statistically significant, for both the local function scale and the WHO DAS scale items, indicating that the intervention provided some improvement in functioning. For the women, this trend was only evident for the functions measured using the WHO DAS scale items.

In contrast to the results for the symptom scale, age does not seem to be particularly related to amount of improvement for either scale for men or women (Chart 3). There is a small trend among men for the local function scale, indicating that older men had more improvement in functioning compared with younger men.

Intervention Impact on Coping

Beyond improving mental health well-being and functioning, we also hypothesized that the intervention would positively impact the use of coping strategies that local people had told us were ways people helped themselves to feel better. Nine positive coping strategies (Table 2) were identified and included in the questionnaire to assess change in the use of these strategies over time. Table 8 presents the results of the analysis of use of coping strategies among intervention and control participants, separately by gender. Among both men and women, there was an increase reported use of coping strategies among intervention participants and a decrease reported use among control participants, with the difference over time reaching statistical

significance for the men. For these analyses, the inclusion/exclusion of the participants of counseling pair 6 did not significantly affect the results.

In addition to the general coping strategies assessed at baseline and follow-up, an additional question was added for the intervention participants at follow up about their use of the counseling group and their perception of the degree to which the group helped them cope with their problems. Table 9 presents the results of the analysis of this question, indicating that most of the participants relied on support from the group when they felt badly and most of them reported that when they did so, it made them feel better. This trend was stronger among the male participants than the female participants.

Post-Intervention Qualitative Assessment Results

Among the intervention participants, the most frequently reported benefits of the program included the community being more cohesive, being trusted in the community, not having fights in the family, being more happy and patient. Many also mentioned that they were now brave enough to say their opinions and were more open to dealing with problems in the family. The family members corroborated the respondents' comments and added that the participants often gathered with others more often, had less fear and were often sharing with others.

Results for Additional Questions added to the Assessment Instrumen.

As described in the Methods section, additional questions were added to the assessment instrument based on the findings of the post-intervention qualitative study and interviews with supervisors (see Appendix B, Section E). These questions were designed to assess impacts of the PSC identified as potentially important by those receiving and providing the intervention, impacts which were not already assessed by the instrument.These questions reflect a range of psychosocial and function/activity outcomes that were identified as being associated with participation in the intervention groups. Table 10 present a summary of the results for these questions. The results are presented as the percentages of respondents who gave each response.

Overall, there is a positive trend for an intervention effect for the majority of the items assessed. These items reflect broad categories of increased socializing and engagement with others, positive feelings of well being and self esteem, improved ability to work and to cope with problems, and improved relationship with family, Reviewing the results from Tables 10 and 11, more of the intervention participants reported positive change for each of the outcomes compared with the controls (with the exception of relationships with family where both groups showed similar percentages of respondents reporting improvement). This trend holds true also for the percentages of respondents indicating that things had gotten worse with time, with the intervention participants in general having fewer respondents indicating negative changes.

RESULTS TABLES

Table 2: Baseline demographics and scale scores for evaluation sample

	Eligible for Participation			Actual Participants*		
	Intervention Sample (N=214)	**Control Sample (N=206)**	**p-value[1]**	**Intervention Sample (N=158)**	**Control Sample (N=175)**	**p-value[1]**
Sex						
Male, N (%)	107 (50)	85 (41)		71 (45)	70 (40)	
Female, N (%)	107 (50)	121 (59)	.07	87 (55)	105 (60)	.36
Age						
Less than 30 years, N (%)	17 (8)	14 (7)		10 (6)	12 (7)	
30-49 years, N (%)	91 (42)	97 (47)		70 (44)	81 (46)	
50-69 years, N (%)	79 (37)	77 (37)		56 (35)	67 (38)	
70 or more years, N (%)	27 (13)	18 (9)	.54	22 (14)	15 (9)	.49
Marital Status						
Single, N (%)	10 (5)	6 (3)		4 (3)	5 (3)	
Married, N (%)	170 (79)	161 (78)		126 (80)	136 (78)	
Widow/Widower, N (%)	32 (15)	39 (19)		26 (16)	34 (19)	
Divorced, N (%)	2 (1)	0	.29	2 (1)	0	.44
Mental Health Symptoms Scales						
HSCL Depression scale, Mean (SD)	17.4 (8.1)	17.9 (6.5)	.46	17.6 (8.1)	18.0 (6.6)	.63
HSCL Anxiety scale, Mean (SD)	17.8 (6.5)	17.0 (5.9)	.23	18.1 (6.2)	17.1 (5.8)	.13
WHO Somatic scale, Mean (SD)	15.4 (4.1)	15.5 (3.7)	.78	15.6 (4.0)	15.4 (3.8)	.68
Total symptoms[2], Mean (SD)	65.9 (20.5)	65.3 (17.8)	.78	66.2 (20.1)	65.7 (18.1)	.78
Functional Impairment Scales						
Local functions, male (14 items), Mean (SD)	10.5 (8.6)	13.7 (10.4)	.02	11.9 (9.5)	13.7 (10.8)	.29
Local functions, female (16 items), Mean (SD)	11.5 (10.6)	14.9 (9.7)	.01	11.6 (9.8)	15.1 (10.0)	.02
WHO DAS items (11 items), Mean (SD)	10.0 (7.0)	12.0 (6.7)	.003	10.3 (7.0)	12.1 (6.8)	.02

* Participants defined as being followed up and for intervention participants, attending at least 2 group sessions

Table 3: Overall change in scale scores comparing intervention to control participants*

HSCL Depression Scale *(possible range: 0-45)*	**Intervention (N=158)**	**Control (N=175)**
Baseline score, mean (sd)	17.6 (8.1)	18.0 (6.6)
Follow-up score, mean (sd)	13.9 (9.0)	14.6 (7.4)
Amount of change, %	3.7 points (21%)	3.4 points (19%)
Difference between intervention and control groups in adjusted mean score change (95% CI)**	0.4 (-2.3 – 3.0) p=.77	
HSCL Anxiety Scale *(possible range: 0-30)*		
Baseline score, mean (sd)	18.1 (6.2)	17.1 (5.8)
Follow-up score, mean (sd)	14.0 (8.2)	13.8 (7.0)
Amount of change, %	4.1 points (23%)	3.3 points (19%)
Difference between intervention and control groups in adjusted mean score change (95% CI)**	-0.1 (-2.6 – 2.3) p=.91	
WHO Somatic Scale *(possible range: 0-21)*		
Baseline score, mean (sd)	15.6 (4.0)	15.4 (3.8)
Follow-up score, mean (sd)	12.7 (5.3)	13.9 (4.8)
Amount of change, %	2.9 points (19%)	1.5 points (10%)
Difference between intervention and control groups in adjusted mean score change (95% CI)**	1.2 (-0.5 – 2.8) p=.15	
Total Symptoms Scale *(possible range: 0-132)*		
Baseline score, mean (sd)	66.2 (20.1)	65.7 (18.1)
Follow-up score, mean (sd)	51.6 (27.0)	53.3 (22.2)
Amount of change, %	14.6 points (22%)	12.4 points (19%)
Difference between intervention and control groups in adjusted mean score change (95% CI)**	1.4 (-6.6 – 9.5) p=.72	

* Assessment participants defined as being followed up and for intervention participants, attending at least 2 group sessions

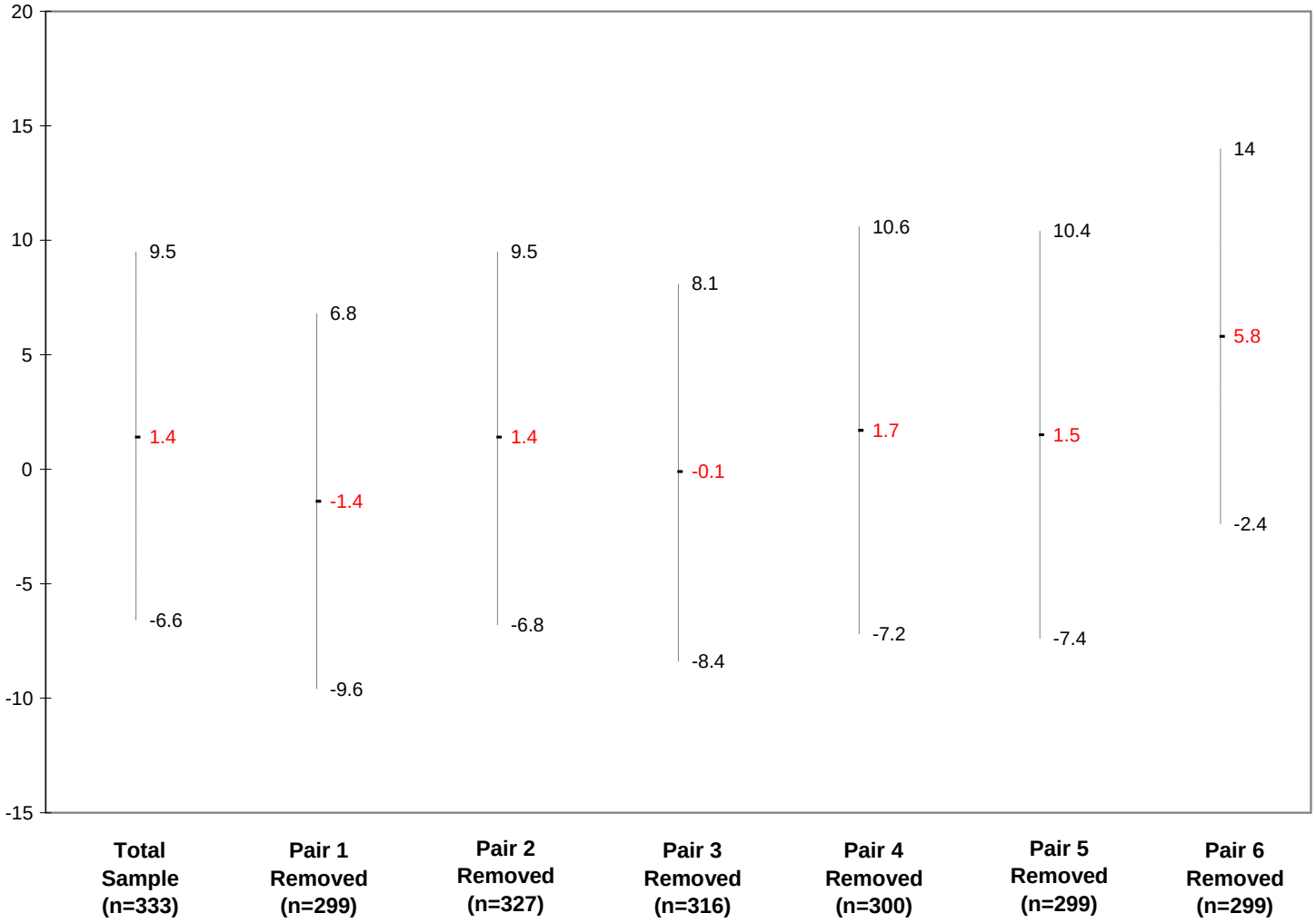
****** adjusted for baseline symptom score, sex, age and group clustering

Table 4: Number of groups (total participants) by village for each counseling pair

	Intervention Villages		
Counseling Pair	**BR**	**BG**	**AB**
Team 1	4 (26)	1 (8)	
Team 2*			1 (6)
Team 3	1 (9)		1 (8)
Team 4	1 (7)	2 (18)	1 (8)
Team 5	1 (8)		4 (26)
Team 6		4 (30)	1 (4)

* Note: team 2 was made up of one counselor from pair 5 and one from pair 1 and provided counseling to a single male group that met in the evenings

Chart 1: Counselor sensitivity analysis: comparison of total symptom change scores by individual counseling pairs removed*



* Data presented as estimates of change in total symptom score comparing intervention with control participants and 95% confidence interval, controlling for age, sex and clustering by counseling group

Table 5: Differences in Adjusted Mean Score Change and Percentage mean score change* (ie, amount of change for intervention groups minus amount of change for control groups) for Mental Health Scales

	All participants (n=333)	**Counseling Pair 6 removed (n=299)**
HSCL Depression Scale	0.4 (-2.3 – 3.0) 2% difference p=.77	1.7 (-1.1 – 4.4) 7% difference p=.21
HSCL Anxiety Scale	-0.1 (-2.6 – 2.3) 4% difference p=.91	1.3 (-1.0 – 3.6) 11.5% difference p=.25
WHO Somatic Scale	1.2 (-0.5 – 2.8) 9% difference p=.15	2.1 (0.4 – 3.7) 14% difference p=.02
Total Symptoms Scale	1.4 (-6.6 – 9.5) 3% difference p=.72	5.8 (-2.4 – 14.1) 9% difference p=.16

* adjusted for baseline symptom score, sex, age and group clustering

Table 6: Changes in symptoms by gender

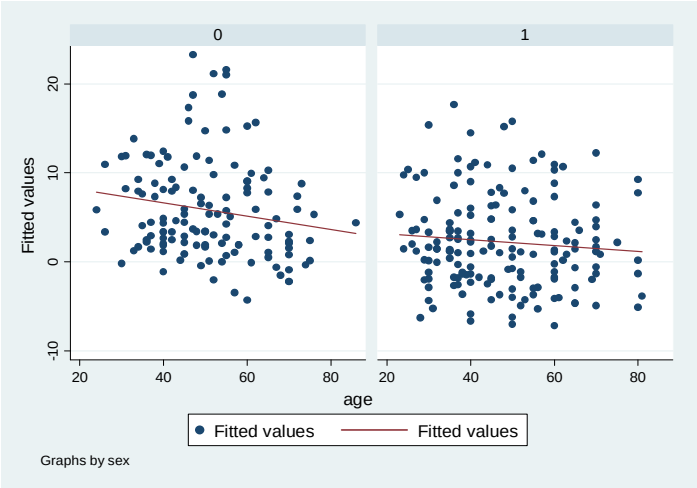
	Females		Males	
HSCL Depression Scale *(possible range: 0-45)*	**Intervention (N=87)**	**Control (N=105)**	**Intervention (N=71)**	**Control (N=70)**
Baseline score, mean (sd)	18.9 (8.2)	18.6 (6.5)	16.1 (7.8)	17.2 (6.8)
Follow-up score, mean (sd)	17.1 (9.6)	16.4 (7.6)	9.9 (6.4)	11.9 (6.1)
Amount of change, %	1.8 points (10%)	2.2 points (12%)	6.2 points (39%)	5.3 points (31%)
Difference between intervention and control groups in adjusted mean score change (95% CI)**	-0.7 (-4.3 – 3.0) p=.70		1.7 (-1.2 – 4.6) p=.23	
Difference in adjusted mean score change (95% CI)** Counseling pair 6 removed	1.2 (-2.8 – 5.2) p=.52		2.2 (-0.8 – 5.3) p=.13	
HSCL Anxiety Scale *(possible range: 0-30)*				
Baseline score, mean (sd)	18.3 (6.3)	17.7 (5.9)	17.9 (6.1)	16.2 (5.6)
Follow-up score, mean (sd)	16.1 (8.2)	15.5 (6.7)	11.5 (7.5)	11.3 (6.8)
Amount of change, %	2.2 points (12%)	2.2 points (12%)	6.4 points (36%)	4.9 points (30%)
Difference between intervention and control groups in adjusted mean score change (95% CI)**	-0.4 (-4.4 – 3.5) p=.81		0.3 (-3.0 – 3.5) p=.86	
Difference in adjusted mean score change (95% CI)** Counseling pair 6 removed	1.8 (-2.0 – 5.5) p=.31		0.7 (-2.8 – 4.1) p=.68	
WHO Somatic Scale *(possible range: 0-21)*				
Baseline score, mean (sd)	15.4 (3.9)	15.2 (4.1)	15.8 (4.0)	15.8 (3.3)
Follow-up score, mean (sd)	13.9 (5.3)	14.5 (4.7)	11.3 (5.7)	13.1 (4.8)
Amount of change, %	1.5 points (10%)	0.7 points (5%)	4.5 points (28%)	2.7 points (17%)
Difference between intervention and control groups in adjusted mean score change (95% CI)**	0.70 (-1.4 – 2.8) p=.49		1.8 (-0.5 – 4.1) p=.12	
Difference in adjusted mean score change (95% CI)** Counseling pair 6 removed	2.0 (-0.1 – 4.1) p=.06		2.1 (-0.4 – 4.6) p=.09	
Total Symptoms Scale *(possible range: 0-132)*				
Baseline score, mean (sd)	67.4 (21.0)	66.4 (18.2)	64.9 (19.1)	64.5 (18.1)
Follow-up score, mean (sd)	59.5 (28.1)	59.5 (28.1)	42.0 (22.2)	45.5 (21.0)
Amount of change, %	7.9 points (12%)	6.9 points (10%)	22.9 points (35%)	19 points (29%)
Difference between intervention and control groups in adjusted mean score change (95% CI)**	-0.51 (-11.0 – 10.0) p=.92		3.9 (-7.3 – 15.2) p=.46	
Difference in adjusted mean score change (95% CI)** Counseling pair 6 removed	5.8 (-5.0 – 16.6) p=.26		5.7 (-6.2 – 17.5) p=.32	

* Assessment participants defined as being followed up and for intervention participants, attending at least 2 group sessions

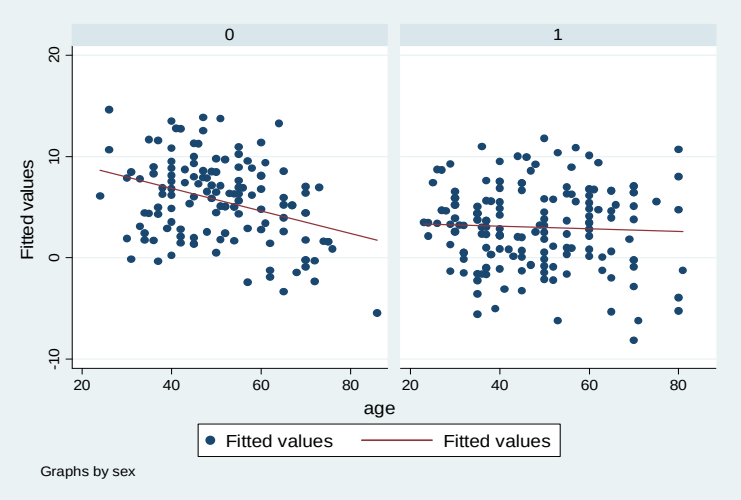
** adjusted for baseline symptom score, age and group clustering. Due to the significant variation by counseling pair, all results are presented with the total participant sample and the total sample minus the participants for counseling pair 6.

Chart 2: Change in symptom scale scores among assessment participants by age, separately by sex (left-male, right- female)*

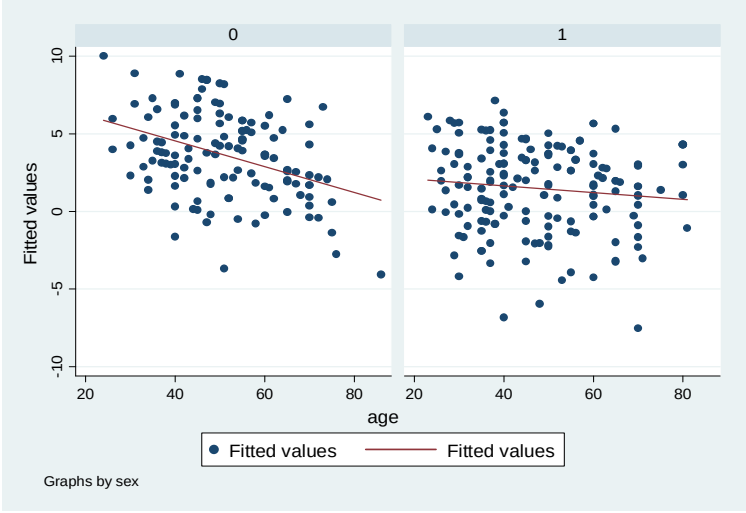
Depression Scale



Anxiety Scale



Somatic Scale



Total Symptom Scale

* Data points represent amount of change for each respondent, the line represents the average change at each age. Results adjusted for baseline syndrome score, intervention/control status, age, sex, clustering by group, and counseling pair 6 removed.

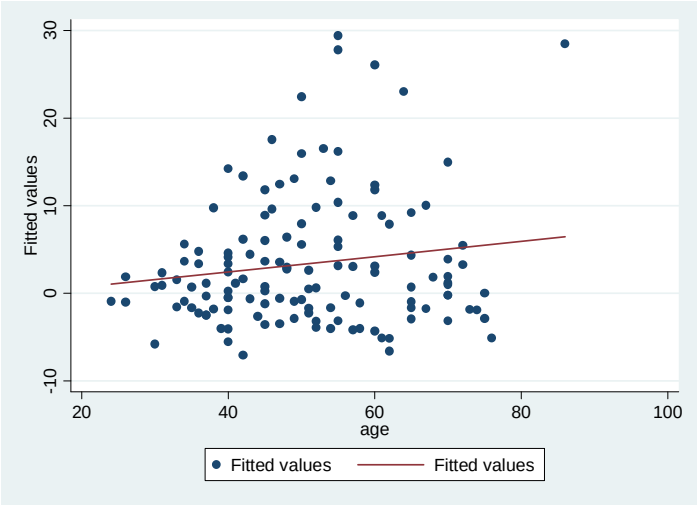
Table 7: Change in Functional Impairment among participants

Local Function Scale, Male *(possible range: 0-56)*	**Intervention**	**Control**
Baseline score, mean (sd)	11.9 (9.5)	13.7 (10.8)
Follow-up score, mean (sd)	8.0 (6.2)	11.3 (8.1)
Amount of change, %	3.9 points (33%)	2.4 points (18%)
Difference between intervention and control groups in adjusted mean score change (95% CI)*	2.8 (-0.2 – 5.9) p=.07	
Difference in adjusted mean score change (95% CI) counseling pair 6 removed*	3.1 (-0.1 – 6.3) p=.06	
WHO DAS items, Male *(possible range: 0-44)*		
Baseline score, mean (sd)	10.0 (7.7)	11.7 (7.5)
Follow-up score, mean (sd)	7.0 (4.9)	10.0 (5.9)
Amount of change, %	3 points (30%)	1.7 points (15%)
Difference between intervention and control groups in adjusted mean score change (95% CI)*	2.4 (-0.1 – 5.0) p=.06	
Difference in adjusted mean score change (95% CI) counseling pair 6 removed*	2.7 (0.1 – 5.3) p=.04	
Local Function Scale, Female *(possible range: 0-64)*		
Baseline score, mean (sd)	11.6 (9.8)	15.1 (10.0)
Follow-up score, mean (sd)	13.0 (10.5)	14.6 (8.1)
Amount of change, %	-1.4 points (-12%)	0.5 points (3%)
Difference between intervention and control groups in adjusted mean score change (95% CI)*	1.1 (-2.3 – 4.6) p=.48	
Difference in adjusted mean score change (95% CI) counseling pair 6 removed*	2.5 (-1.5 – 6.5) p=.20	
WHO DAS items, Female *(possible range: 0-44)*		
Baseline score, mean (sd)	10.6 (6.5)	12.3 (6.3)
Follow-up score, mean (sd)	9.8 (6.2)	12.3 (5.7)
Amount of change, %	8 points (8%)	0 points (0%)
Difference between intervention and control groups in adjusted mean score change (95% CI)*	2.3 (0.4 – 4.3) p=.02	
Difference in adjusted mean score change (95% CI) counseling pair 6 removed*	3.6 (1.8 – 5.4) p=.001	

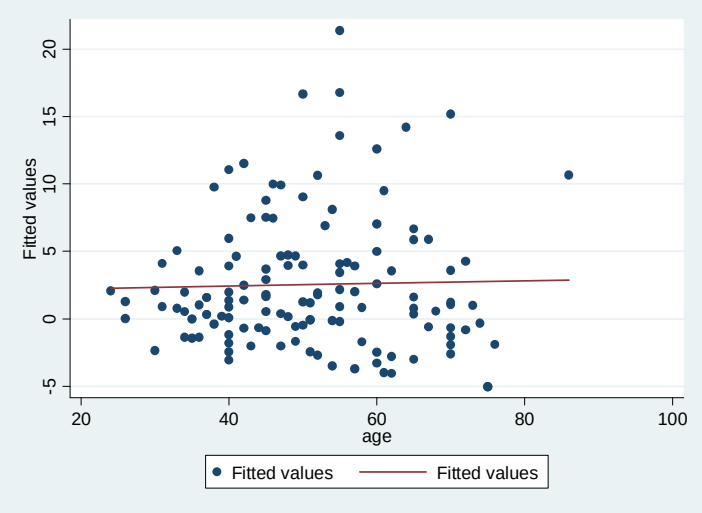
***** adjusted for baseline function score, sex, age and group clustering. Due to the significant variation by counseling pair, all results are presented with the total participant sample and the total sample minus the participants for counseling pair 6.

Chart 3: Change in function scale scores among assessment participants by age, separately by sex*

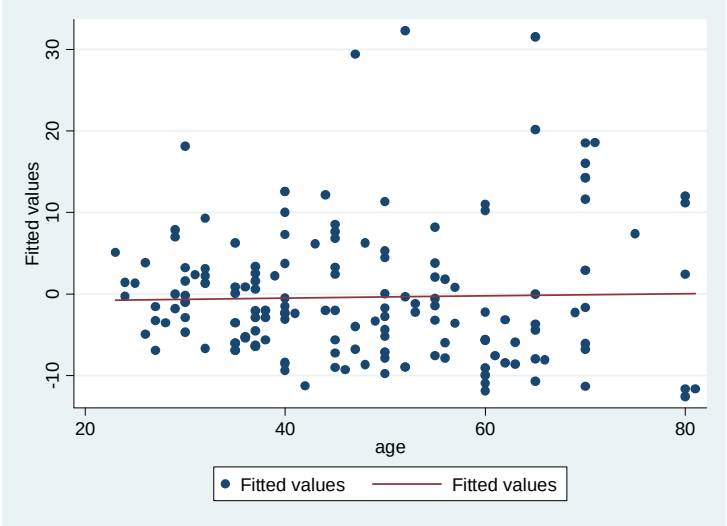
Male: Local function scale



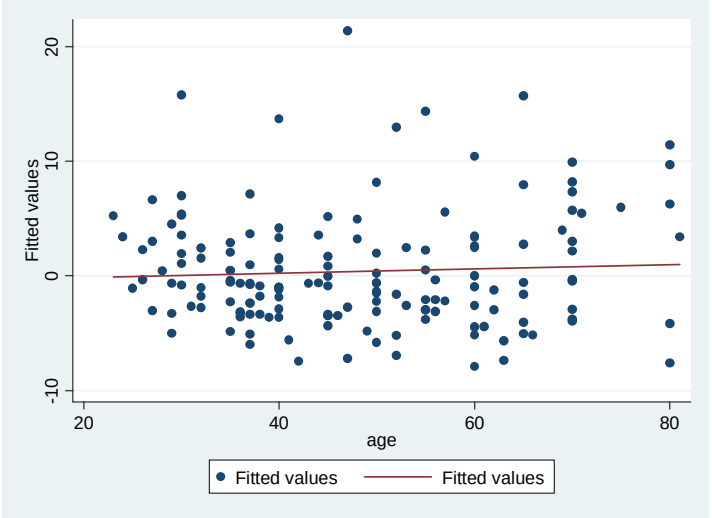
WHO DAS scale



Female: Local function scale



WHO DAS scale



* Data points represent amount of change for each respondent, the line represents the average change at each age. Results adjusted for baseline function score, intervention/control status, age, clustering by group, and counseling pair 6 removed.

Table 8: Change in Usage of Coping Strategies*

	Females		Males	
Coping Scale *(possible range: 0-27)*	**Intervention (N=83)**	**Control (N=103)**	**Intervention (N=69)**	**Control (N=68)**
Baseline score, mean (sd)	13.7 (4.4)	14.1 (4.5)	16.9 (5.4)	17.3 (5.0)
Follow-up score, mean (sd)	14.7 (4.2)	12.8 (4.7)	17.7 (4.3)	15.1 (4.3)
Amount of change**, %	1.0 points (-7%)	-1.3 points (9%)	0.8 points (5%)	-2.2 points (13%)
Difference between intervention and control groups in adjusted mean score change (95% CI)***	2.2 (-0.1 – 4.5) p=.06		2.7 (0.7 – 4.8) p=.01	
Difference in adjusted mean score change (95% CI)*** Counseling pair 6 removed	1.3 (-0.9 – 3.6) p=.22		2.8 (0.7 – 4.8) p=.01	

* 10 respondents (6 female, 4 male) have missing baseline data and are not included in this analysis.

** The hypothesis is that the intervention will improve usage of coping strategy, so the change scores are based on follow-up – baseline scores.

*** Regression analyses adjusted for baseline coping score, age, and clustering by group. Due to the significant variation by counseling pair, all results are presented with the total participant sample and the total sample minus the participants for counseling pair 6.

Table 9: Reporting on use of intervention and perceived effectiveness by intervention participants (questions d10a and d10b)

	How often do you use this when you feel badly				**By participating, how did it make you feel***		
	Not at All	**Rarely**	**Somewhat**	**Often**	**Made it worse**	**Stayed it same**	**Made it better**
Females (n=87)	1 (1%)**	2 (2%)	11 (13%)	73 (84%)	15 (17%)	28 (33%)	43 (50%)
Males (n=71)	0	8 (11%)	6 (9%)	57 (80%)	1 (1%)	9 (13%)	61 (76%)

* Because of the small number of respondents who gave the extreme responses – 'made it a lot worse' and 'made it a lot better' - categories were collapsed from 5 to 3 categories. Responses 'made it a little worse' and 'made it a lot worse' were combined and responses 'made it a little better' and 'made it a lot better' were combined.

** This respondent was not asked about how their participation made them feel because they indicated they didn't use the intervention to cope with their problems.

Table 10. Percent reporting change over the previous 6 months*

	Intervention (n=158)			Controls (n=175)		
	Better	Same	Worse	Better	Same	Worse
Abilities						
To accept problems	47	46	7	26	51	23
To deal with problems	48	44	8	33	49	19
To share problems	56	35	9	25	64	11
To be open if family has problems	55	37	8	34	57	9
To work	31	33	36	21	39	40
To control anger	49	44	8	34	51	15
To be patient	61	37	2	50	40	10
Relationships:						
With family	48	52	0	48	49	3
Feelings:						
Motivation	46	46	8	25	54	21
Courage	26	59	15	15	67	18
Mind's calmness	47	41	12	31	45	24
Cohesion in the community	51	47	2	32	64	4
	More often	Same	Less often	More often	Same	Less Often
Activities						
Going to community activities	48	37	15	36	33	31
Sociable with neighbors	49	44	7	35	55	10
Having discussions	57	35	8	41	40	19
Being open and talkative	47	39	14	28	54	18
Sharing	37	48	15	33	43	23
Visiting/gathering with others	52	39	9	41	37	22
Positive Feelings:						
There are people who care about you	41	50	9	38	44	18
Feeling respected	35	60	5	30	59	11
Feeling appreciated	37	58	5	32	58	10
Feeling friendly	48	51	1	37	61	3
Laughing	43	53	4	32	53	15
Feeling happy	39	54	7	22	54	24
Feeling close with others	48	49	3	37	51	12
Negative Feelings:						
Feeling suspicious	4	36	60	9	39	52
Thinking about bad things	9	22	69	13	32	54
Family						
Having fights in the family	12	42	46	6	45	49

* Because of the small number of respondents who gave extreme responses, response categories were collapsed from 5 to 3 categories. Responses made it a little worse and made it a lot worse were combined and responses made it a little better and made it a lot better were combined. Responses doing it a lot less often and a little less often were combined and responses doing it a lot more often and a little more often were combined.

CONCLUSIONS

1. PSC resulted in little improvement in the mental health problems for which the program was implemented. Significant improvement was limited to somatic symptoms.

PSC was somewhat effective for reducing the burden of somatic symptoms but less effective in reducing the burden of depression and anxiety symptoms, when compared with the changes that were experienced by the controls who did not receive the intervention. The impact of the intervention on mental health symptoms did not appear to vary by gender except for an age-related trend: younger men reported more change across all of the syndrome scales compared with older men. Women exhibited no age-related trend.

2. Function improved more among program participants than controls, and the effect was greater among men.

For the functional impairment outcomes, men appear to have experienced more improvement associated with participation in the intervention compared with women.

3. The quality of service provision varied by provider and affected the impact of PSC
An important finding was the differential outcomes by counseling pair. To understand these results, the ICMC staff reviewed the supervision materials for all of the counseling pairs collected during the intervention. They concluded that the pair whose participants experienced the least amount of change were also the weakest pair in skills of empathy and in exploration and review of changes and challenges among participants. These results reinforce the importance of training and supervision throughout the intervention process.

4. Use of coping strategies increased among program participants compared with controls, with participation in the group itself being an important coping method.

Both men and women showed increases in their use of coping strategies for when they feel bad compared with controls, with participation in the group itself being an important source of coping.

5. While negative symptoms did not tend to improve, and there was limited improvement in measures of function measured at baseline (ie, pre-intervention) the data suggest a substantial improvement in socializing and engagement with others, positive feelings of well being and self esteem, improved ability to work and to cope with problems, and improved relationship with family.

These findings emerged from the questions added to the assessment instrument as a result of the post-intervention qualitative assessment and the interviews with supervisors. They reflect impacts of PSC that were not anticipated prior to the intervention but were reported after its completion. Examples include more community cohesion, being trusted in the community, fewer family fights, being more happy, patient, brave with regard to giving their opinions, and more open to dealing with problems in the family.

The strength of the evidence for these changes is weaker than those for questions that were asked both pre and post intervention (and the results compared). It is possible that respondents did not actually experience the level of change they report in the post intervention assessment. However, on almost all items those who received PSC reported improvement in higher numbers than did the control group, suggesting that the differences are real and linked to the intervention.

6. Lack of economic opportunities is a major problem and viewed as a cause of many of the problems assessed in this study.

One of the biggest problems that the villagers from all 6 assessment villages discussed was the lack of economic opportunities and job prospects. Many of the problems we assessed were thought by local people to be caused by economic problems rather than their experiences of torture and violence, and over the course of the program and the assessment the economic situation did not improve. It may be that the prospects for improving these symptoms using a counseling approach are always going to be limited if the underlying causes are economic and these causes are not addressed.

7. Use of a control design was essential in measuring the true impact of PSC.Without a control group our conclusions would have been very different.

We found substantial reductions in severity for most symptoms among the intervention group. Without a control group this would have led us to conclude that the intervention was quite effective for most of the symptoms we assessed. However, similar changes among the control group made it clear that these changes, while substantial, were not due the intervention. Use of a controlled design proved critical to determining the intervention's true effectiveness.

8. Impact assessments using a control design are, with some training and assistance, feasible for service providers.
With external technical assistance a trained team of field-based NGO staff and research assistants were able to rigorously monitor their intervention and assess its impact. In the present evaluation assessment, outside technical assistance was used to guide all stages of the evaluation assessment, from the needs assessment and instrument development and validation process, through the assessment design and evaluation components. Rather than having the technical support team simply conduct the evaluation, time was spent working with the collaborating NGO staff from ICMC to ensure their understanding and training in all components of the evaluation. *The ICMC staff has been trained in all components of the evaluation, including systematic documentation of the components of the intervention through data management and basic analysis.* Throughout the program implementation and evaluation process, input from the ICMC staff into the process ensured that the results were relevant for their continued programming.

RECOMMENDATIONS

1.The PSC program should be continued but should form part of a wider more holistic initiative to also address economic issues among the population.

Based on the results of this assessment, ICMC is currently piloting several types of combined economic and mental health programs in the control villages, in order to begin to learn about the interaction of these two important components of well-being. Meanwhile, a one day workshop for potential group leaders from the counseling groups is being planned at the time of writing – to give them the skills to continue with the sessions after the counselors not longer lead the groups.

2. Changes should be made in how PSC is implemented. These changes should reflect the assessment findings as well as what has been learned during implementation.

In reviewing the intervention process and assessment results, we have learned much about future adaptations and implementation of the intervention. One specific suggestion is that counselors meet with their clients more regularly outside of the group to get to know more about their lives and their problems better, since our experience is that not all of the participants bring all of their issues to the group. Below are some specific suggestions for improvement in selection of counselors, training and supervision that emerged as results of this assessment:

<u>Improve Selection of Counselors:</u>

- Education background: We have learned again that high school graduates can be trained to provide this type of intervention correctly.
- Commitment: We recommend only hiring people who can prove they have the time to commit to full-time work the program (i.e. not having college or family obligations that will inhibit participation).
- Selection through training: We recommend making a practice of bringing more candidates than required for the initial training, so that we can exclude those who demonstrate poor performance during the training.
- Probation: We can recommend a period of probation of 3 months for the counselor. While this would be ideal, it does pose challenges. Generally local partners or even INGOs, do not 'fire' people after the 3 month probation despite the fact that labour laws allow this. The logic is "with some support, he/she will improve". The moment the person is not fired after 90 days, the person automatically gets into a longer term contract (specified until the end of the project/task). If renewed, or continued twice, the person becomes a permanent staff (subject to funding).
- Establish a system for 'replacement' training: Recognizing that it may be necessary to hire new counselors on an ongoing basis, a system is needed to ensure that this new person receives the appropriate training and supervision prior to engaging in the actual counseling program.

<u>Improve Training and Supervision:</u>

- We suggest that after the initial 5-day basic training immediate supervision is required, and would recommend that the supervisor/trainer stay in the field for a minimum of the first month to provide daily supervision, and mentoring to the counselors as they start going to the field.
- We have seen that the counselors who began their work with this intervention by first providing individual counseling have better skills than counselors who go straight to the

structure of the group. We suggest that new counselors first conduct individual counseling for about 2 months to develop their skills in probing, exploring, empathy, and slowly guiding the clients towards coping and problem solving.

- The initial supervision has focused on preparation of the structure of the sessions to help with implementing them in the field. We suggest adding field training exercises that aim at strengthening the micro skills in counseling – i.e. exercises to do observation of behavior, reflections of how they could have done things differently, and probing.
- As part of the ongoing training, we suggest increasing the number of exercises that improve skills for reflection, observation, and probing.
- For sustainability of the groups (on going after counselors terminate the group), we suggest that some training be provided to members of the groups who could act as peer leaders.

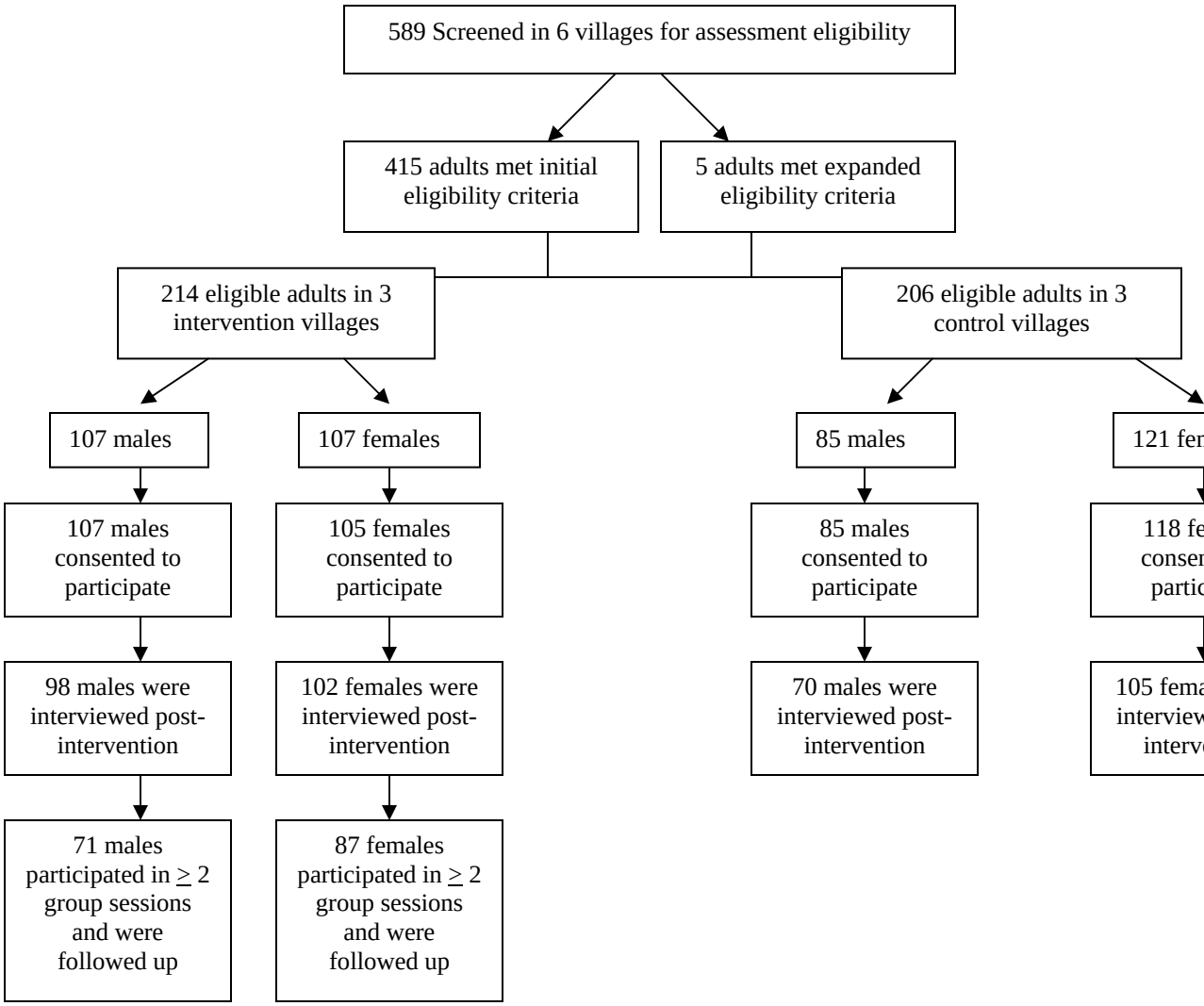
3.Once the wider initiative has been implemented, ICMC and RATA should monitor impact using the assessment instruments, to determine whether symptoms and function respond better to this package than to PSC alone.

4. ICMC now has the capacity to conduct impact evaluations using control groups, in order to accurately assess impact. They should continue to use this approach when first implementing new interventions and approaches among new populations.

This assessment has demonstrated the importance of including a control group to assess the impact of mental health interventions. Severity of symptoms and dysfunction tend to vary over time. Persons who seek out interventions (or are screened into them on the basis of severity) tend to do so when they are feeling at their worst and therefore will show an apparent improvement over time, as did the controls in this assessment. The extent of this natural change must be measured and subtracted from the changes among the intervention groups in order to determine an intervention's true impact. Otherwise, assessments will tend to suggest that interventions are effective even when they are not. This is not to argue that a control group should accompany every intervention, but rather that early trials in a new population should do so, so as to confirm genuine local effectiveness. After a controlled assessment has confirmed local effectiveness, future evaluations of impact in the same area should not require a control group comparison.

APPENDICES

Appendix A: Flow-Chart of Participants in the Evaluation Assessment



Respondent ID# _____

Appendix B: The Assessment Instrument
SURVEY OF ADULTS IN ACEH – PROGRAM FOLLOW-UP

INSTRUKSI

Assalamualaikum nan loeng……... loeng kerja bak Rata dan kamoe nak teumanyeng pertanyaan tentang masalah yang geu alami lee ureng-ureng. Kamoe na di sinoe semenjak nam buleun yang ulikeot dan selama nyoe kamoe meuputuri organisasi kamoe dan kegiatan kegiatan yang kamoe pubuut sama-sama ngen warga gampong nyoe.
Hello, my name is _____. I work for RATA and we are asking people about problems that some people have. We were here about 6 months ago and during that time we introduced our organization and presented some of the work that we are going to be doing with people in your village.

Urou nyoe dan 10 uroe ukeue, kamoe neuk peugah haba ngen ureng-ureng gampong nyoe yang kaleuh kamoe peugah-peugah haba yang ka ulikeot tentang masalah-masalah yang mungken geu alami lee ureng-ureng. Untuk neujaweb pertanyaan nyoe perle watee sekitar 40 menet, pu droneh na wate jino?
Today, and for the next 10 days, we are talking with people that we spoke with last time about problems that some people might have. To go through all of the questions will take about 40 minutes, do you have the time right now?

Menyo responden geu jaweb hana, loen ucap terima kasih dan tanya bak ureng nyan pu keuh jeut ta teumanyeong bak wate lain. Tapi mese responden geu jaweb jet loen lanjut ke penjelasan laen:
If the respondent answers no, thank them and ask them if you can re-schedule. If the respondent answers yes, then explain the following:

UNTUK DESA KONTROL: Slama 10 uroe nyoe, kamoe nak teumanyeng bak ureng rayek bak gampong nyoe. Bak akhe10 uroe nyan, kamoe akan jak lom bak tiep ureng untuk peugah-haba yang lebeh lee tentang program kamoe d an pelayana puu yang kamoe jet bantu.kamoe hana bie bantuan dana/peng dan barang-barang laen keu ureng gampong nyoe
FOR CONTROL VILLAGES: During these 10 days we will be asking many of the adults in your village these questions. At the end of the 10 days, we will return to each one of you to talk more about our program and what services we can provide to you. We are not providing financial services and will not be able to provide money or other goods to any of the people in your village.

UNTUK DESA INTERVENSI: Selama 10 hari ini kami akan menanyakan pertanyaan-pertanyaan berikut pada orang-orang dewasa di desa Anda. Kami tidak menyediakan pelayanan finansial dan tidak akan dapat menyediakan uang atau barang pada siapapun di desa Anda.
FOR INTERVENTION VILLAGES: During these 10 days we will be asking many of the adults in your village these questions. We are not providing financial services and will not be able to provide money or other goods to any of the people in your village.

Catatan untuk interviewer:
Ta tanyeng pu wawancara nyoe jet dua the manteng(droneh ngen loeng),mese na yang temanyeng paken,tapejelas bahwa nyoe prosedur yang penteng sebab .menyoe lee ureng akan lee jawaban entek dan wawancara akan susah.
Ask that the interview be conducted in private. If this is questioned by anyone, explain that this is an important part of our procedure, and that we have found that some people give different answers when there are other people present.

Desa village:
Nama responden name of respondent:
Jenis kelamin gender:
Usia age:
Status Kawin marital status: Sidrow single Kawen married Meucree widow Balee divorced
Lokasi location:

Respondent ID# _____

Bagian A : Pertanyaan mengenai tingkat keberfungsian Assessment of Function

Nyoe loen baca saboh daftar dan kegiatan.nyoe adalah tugas dan kegiatan penteng bagi ureng agam/ineng untuk gee pebut,yang gee pegah lee ureng-ureng sekitar daerah nyoe.untuk setiap kegiatan atawa loen nak tanyeng bak droneeh padub naa susah droe neeh pebut kegiatan nyanapabila ta baneing ngen ureng laen yang sama uemuu ,sama jenis kelamin.lheh nyan droneeh entek nepegah ba loen pu hana susah that, bacut,biasa manteng,susah bacut atawa hanjet nee peebut mee bacut

I am going to read a list of tasks and activities. These are tasks and activities that other people around here told us were important for men/women (refer to sex of the respondent) to be able to do. For each task I am going to ask you how much more difficulty you are having doing it compared with WHAT YOU THINK OTHERS WHO ARE ABOUT YOUR SAME AGE AND SEX NORMALLY DO. You should tell me whether you are having no more difficulty, a little more, a moderate amount more, or a lot more, or you often cannot do that task.

Untuk mangat nee ingat lon na saboh kertah yang na gamba, tiep gamba nyan mewakili kesulitan yang bea-beda.neupeulemah bak ureng responden kertah gamba yang nupejelas *tingkat kesulitan yang beda-beda,neu tunyok bak saboh gamba lage ureng dro neh jelaskan.*

To make it easier to remember I have a card here with pictures. Each picture represents a different amount of difficulty. Show the respondent the card illustrating levels of difficulty. Point to each picture as you describe it.

Gamba pon nyan sidroe ureng yang hana susah di banding ngen lee ureng agam/inoeng yang selanyee. Gamba kedua neupeulemah urenh yang na susah bacut,ganba keulhee neupeulemah ureng yang na susah lebeh lee bacut, gamba yang ke peet neupeulemah ureng yang na susah cukop lee, gamba terakher neupeulemah ureng yang sering that hanjeet lee pubuut sapu.untuk saboh kegiatan/buut long lake bak ureng droneh neu peutunyok gamba yang theh yang menjelaskan beurapa susah droneh neupeubuut kegiatan nyan,dibandeng ngon ureng laen yang seulayee dan jenis kelamin yang sama.

The first picture shows someone who has no more difficulty than most other men/women of your age. The second picture shows someone who has a little more difficulty. The third picture shows someone who is having a moderate amount more difficulty. The fourth picture shows someone who is having a lot more difficulty and the last shows someone who is having so much difficulty they often cannot do the task. For each task or duty, I will ask you to point to the picture which shows how much difficulty you are having in doing that task, compared with what you think others who are about your same age and sex normally do.

Respondent ID# _____

Jino.loen kheen kegiatan/tugasnyan,dan tiep abeh saboh, neuci peugah*: dalam dua minggu terakhir nyoe, pukeuh droneh hana ne alami susah, susah bacut, lebeh susah/payah,brat that susah atawa hanjet sama sekali, sehingga that sering hana nee peebut lee kegiatan-kegiatan nyan.* tapeulemah gamba yang droneh jelaskan,lheh nyan catet jawaban ngen neuboh tana bak kotak yang kana di sampeng kegiatan /tugas bak table di miyub nyan.Now say each task, and after each one say: In the past two weeks are you having no more difficulty, a little more, a moderate amount more, a lot more, or are having so much difficulty that you often cannot do the task? pointing to each picture as you say it. Record the response by marking the appropriate box next to the activity or task in the table below.

Sebelum setiap item, katakan pada orang tersebut '*dalam 2 minggu nyoe, padum lee susah yang droneh rasa wate …..'Before each item, say to the person 'In the last two weeks, how much difficulty have you had with…"*

Laki-Laki male	**dalam dua minggu terakhir nyoe,** Tingkat kesulitan dalam menyelesaikan tugas atau kegiatan In the last two weeks, amount of difficulty doing each activity **Hana bacut susah No difficulty**	**Susah susah a little difficulty**	**Lebeh susah A moderate amount**	**Brat that sekali A lot of difficulty**	**Hanjet sama ngen loeng So much, cannot do it**	**Hana sesuai susah not relevant for me**
A01 Cuko janggoet shaving (Q)	0	1	2	3	4	9
A02 Sikat igo brushing teeth (Q)	0	1	2	3	4	9
A03 Suegot oek brushing hair (Q)	0	1	2	3	4	9
A04 jak u gle/jak u lampoh go to field/plantation (Q)	0	1	2	3	4	9
A05 Peulara binatang care of animals (Q)	0	1	2	3	4	9
A06 Tahire aneuk care of children (Q)	0	1	2	3	4	9
A07 Jak u kuede untuk belanja (bloe breuh, ungkot) shopping (buy some rice, fish) (Q)	0	1	2	3	4	9
A08 Ikut gotong royong community self-help groups (Q)	0	1	2	3	4	9
A09 Ikut musyawarah/rapat gampong attend community meeting (Q)	0	1	2	3	4	9
A10 Jak bak khanduri attend parties (Q)	0	1	2	3	4	9
A11 takziah/ sembahyang praying (Q)	0	1	2	3	4	9
A12 Jak bak beut reciting Koran (Q)	0	1	2	3	4	9
A13 Jak mita peng earn money	0	1	2	3	4	9
A14 Jak bak kerja Go to work	0	1	2	3	4	9

Respondent ID# _____

Sebelum setiap item, katakan pada orang tersebut '*dalam 2 minggu nyoe, padum lee susah yang droneh rasa wate …..*' *Before each item, say to the person 'In the last two weeks, how much difficulty have you had with…"*

Perempuan female	**dalam dua minggu terakhir nyoe,** Tingkat kesulitan dalam menyelesaikan tugas atau kegiatan In the last two weeks, amount of difficulty doing each activity **Hana bacut susah No difficulty**	**Susah susah a little difficulty**	**Lebeh susah A moderate amount**	**Brat that sekali A lot of difficulty**	**Hanjet sama ngen loeng So much, cannot do it**	**Hana sesuai susah not relevant for me**
A15 Sikat igo brushing teeth (Q)	0	1	2	3	4	9
A16 Suegot oek brushing hair (Q)	0	1	2	3	4	9
A17 Bouh bedak putting on make-up (Q)	0	1	2	3	4	9
A18 Magun cooking (Q)	0	1	2	3	4	9
A19 Peugleh rumoh cleaning house (Q)	0	1	2	3	4	9
A20 Tajak cok ie getting water (Q)	0	1	2	3	4	9
A21 Jak uglee/ublang go to field/rice paddy (Q)	0	1	2	3	4	9
A22 Yak cok kayee gather fire wood (Q)	0	1	2	3	4	9
A23 Seumerah washing clothes (Q)	0	1	2	3	4	9
A24 Ikut gotong royong community work (Q)	0	1	2	3	4	9
A25 Ikut kegiatan PKK participating in family welfare program (Q)	0	1	2	3	4	9
A26 Jak bak khanduri attend parties (Q)	0	1	2	3	4	9
A27 Takziah/ Sembahyang praying (Q)	0	1	2	3	4	9
A28 Jak bak beut reciting Koran (Q)	0	1	2	3	4	9
A29 Jak mita peng earn money	0	1	2	3	4	9
A30 Jak bak kerja Go to work	0	1	2	3	4	9

Respondent ID# _____

Sebelum setiap item, katakan pada orang tersebut *'dalam 2 minggu nyoe, padum lee susah yang droneh rasa wate …..' Before each item, say to the person 'In the last two weeks, how much difficulty have you had with…"*

Laki-Laki dan Perempuan male and female	**dalam dua minggu terakhir nyoe,** Tingkat kesulitan dalam menyelesaikan tugas atau kegiatan In the last two weeks, amount of difficulty doing each activity **Hana bacut susah No difficulty So much, cannot do it**	**Susah susah a little difficulty**	**Lebeh susah A moderate amount**	**Brat that sekali A lot of difficulty**	**Hanjet sama ngen loeng not relevant for me**	**Hana sesuai susah**
A31. Teudeong treup standing for long periods of time	0	1	2	3	4	9
A32. Ta uroh rumah tangga taking care of your household responsibilities	0	1	2	3	4	9
A33. Meuruno hal-hal baroe, contoh : pakiban cara tajak bak saboh tempat yang baroe learning a new task, for example, how to get to a new place	0	1	2	3	4	9
A34. ne ikot kegiatan-kegiatan dalam masyarakat (contoh:kanduri/kegiatan keagamaan) dalam cara yang sama lage ureng laen jet ikot joining in community activities (for example: festivities/religious activity) in the same way as anyone else can	0	1	2	3	4	9
A36. nepuebut saboh buut selama 10 minet doing an activity for 10 minutes	0	1	2	3	4	9
A37. Jak jiouh ngen tapak going for a long distance by foot	0	1	2	3	4	9
A38. Manoe washing your whole body (Q)	0	1	2	3	4	9
A39. Wate souk baje when put clothes/dress on	0	1	2	3	4	9

Respondent ID# _____

Sebelum setiap item, katakan pada orang tersebut '*dalam 2 minggu nyoe, padum lee susah yang droneh rasa wate …..*'*Before each item, say to the person 'In the last two weeks, how much difficulty have you had with…"*

Laki-Laki dan Perempuan male and female	**dalam dua minggu terakhir nyoe,** Tingkat kesulitan dalam menyelesaikan tugas atau kegiatan In the last two weeks, amount of difficulty doing each activity **Hana bacut No difficulty** **Susah susah a little difficulty** **Lebeh susah A moderate amount** **Brat that sekali A lot of difficulty** **Hanjet sama ngen loeng So much, cannot do it** **Hana sesuai susah not relevant for me**					
A40. Wate ne hadapi/meuteume ureng yang hana meuturi dealing/meeting with people you do not know	0	1	2	3	4	9
A41. Tajalein hubungan saudara ngen ureng laen maintaining brotherhood with other people	0	1	2	3	4	9
A42. Pu neu pubut droeneuh si uro-uro doing your daily work	0	1	2	3	4	9

	Hana meu bacut pih Not at all	**bacut** a little bit	**lebeh** a moderate amount	**Brat that** a lot	**Brat that that** so much (more than a lot)
A35. Padum rayeuk masalah kesehatan mempengaruhi perasaan droeneuh how much does your health problems influence your feeling?	0	1	2	3	4
A43. Tentang hai-hai yang kaleh tapegah bunoe, padum lee kesulitan-kesulitan buno meuganggu udeep droeneuh? From things that we had discussed before, how much have they been disturbing your life?	0	1	2	3	4

A44. Beu mandum dalam 30 uro akher nyoe, padum uro susah nyan trouk? _____/30 (uro)
In the past 30 days, for how many days were these difficulties present?

A45. Dalam 30 uro terakher nyoe, padum uro droneuh hanjet nee peebut lee kegiatan si uro-uro atawa kerja? _____/30 (uro)
In the past 30 days, how many days that you were totally unable to carry out your daily activities or work?

A46. Dalam 30 uroe ulekot nyoe,padum uroe droneh hanjet lee neu pubuut buut se ure-uroe atawa kerja droneh secara punoeh ? (hana sii uroe jumat) _____/30 (uro)
In the past 30 days, how many days you cannot do your daily activities or work /atau kerja fully in a day not including going to prayer on Fridays tidak termasuk pergi sholat pada hari jumat?

Respondent ID# _____

Bagian B- Psychosocial Assessment Instrument

Nyoe loen baca naa padit boh pertanyaan.untuk mandum pertanyaan, loen neek tanyeng padum na nee rasa hal-hal lage pertanyaan nyoe wate dua minggu ulikot termasok uro nyoe.
I am going to read you a list of statements. For each one I am going to ask you how much you have felt like that IN THE LAST TWO WEEKS, including today.

Sebut tiep-tiep pertanyaan. Dan tiep pertanyan ta tanyeng padub na sereng responen meurasa kegiatan nyan ,dalam dua mimggu akhe nyoe,ulang katagori jawaban lheh tiep pertanyaan dan bah responen yang suot.Catat jawaban dari responen ngen ta lingkari angka dalam yang na disampeng pertanyaan tentang gejala di minyup nyoe. ***Say each statement, and after each one ask how often the respondent has felt like that in the last 2 weeks. Repeat the categories after each statement and let the respondent choose one. Record the response by circling the appropriate box next to the symptom.***
Sebelum setiap item dibacakan , katakanlah pada responden *'dalam 2 minggu nyoe, padum geu na meurasa...'*
Before each item, say to the person "In the last two weeks, how often did you feel …"

Symptoms	**Hana meu bacut pih** Not at all	**Jareung** Rarely	**Kadang-kadang** Sometimes	**Sereng** Often
B01. Saket ulee headache (S1/A8/Q1)	0	1	2	3
B02. Mumang dizziness (S2/A3/Q2)	0	1	2	3
B03. Saket lam dada pain in chest (S3/Q3)	0	1	2	3
B04. Saket bak rhueng pain in lower back (S4)	0	1	2	3
B05. Saket lam tuleeng soreness of muscles (S5)	0	1	2	3
B06. Keubeeh bak badan numbness in parts of your body (S6)	0	1	2	3
B07. Badan rasa leumeh weakness in your body (S7/Q4)	0	1	2	3
B08. Troek yee hana meupu seubab suddenly scared for no reason (A1)	0	1	2	3
B09. Yee fearful (A2/Q5)	0	1	2	3
B10. Gugop dan meukhet-khet nervousness or shakiness (A4/Q6)	0	1	2	3
B11. Dada meu dup-dup heart pounding (A5/Q7)	0	1	2	3
B12. Meukheot-kheot trembling (A6)	0	1	2	3
B13. Meurasa kaku feeling tense (A7)	0	1	2	3
B14. Gabouk meu kedroe busy by own self (panic) (A9)	0	1	2	3

Respondent ID# _____

Sebelum setiap item dibacakan , katakanlah pada responden *'dalam 2 minggu nyoe, padum geu na meurasa...'Before each item, say to the person "In the last two weeks, how often did you feel …"*

Symptoms	**Hana meu bacut pih** Not at all	**Jareung** Rarely	**Kadang-kadang** Sometimes	**Sereng** Often
B15. Taduk ken tajak ken can't sit, can't stand (feeling restless) (A10/Q8)	0	1	2	3
B16. Hana tenaga no energy (D1/Q9)	0	1	2	3
B17. Tapeu salah droe kedroe blaming yourself (D2)	0	1	2	3
B18. Kliek crying (D3/Q10)	0	1	2	3
B19. Hana peremeun keluarga don't care about family (D4)	0	1	2	3
B20. Bue han ek tapajoh loss of appetite (D5/Q11)	0	1	2	3
B21. Wate taeh han tigeut when sleep, can't sleep well (D6/Q12)	0	1	2	3
B22. Ka putoh asa keu masa ukeu feeling hopeless about the future (D7)	0	1	2	3
B23. Meurasa sedih feeling sad (D8/Q13)	0	1	2	3
B24. Meurasa sidroe feeling lonely (D9)	0	1	2	3
B25. Dak meuejet tapoh droe teuh thoughts of ending your life (D10)	0	1	2	3
B26. Merasa han leupah sahoe feeling of being trapped (D11)	0	1	2	3
B27. Susah that wate lee pikiran feeling difficult when having many thoughts (D12)	0	1	2	3
B28. Meurasa hana lee minat feelings no interest (D13)	0	1	2	3
B29. Meurasa payah bak pu but-but difficult to do anything (D14)	0	1	2	3
B30. Meurasa hana harga/han yuumlee feeling of worthlessness (D15)	0	1	2	3
B31. Susah hate difficult heart (Q14)	0	1	2	3
B32. Teutahe-tahe spacing out (Q15)	0	1	2	3
B33. Bagah beungeh easily angered (Q16)	0	1	2	3
B34. Hana meuhojak don't have direction (Q17)	0	1	2	3

Respondent ID# _____

Sebelum setiap item dibacakan , katakanlah pada responden'*dalam 2 minggu nyoe, padum geu na meurasa...'*
Before each item, say to the person "In the last two weeks, how often did you feel …"

Symptoms	**Hana meu bacut pih** Not at all	**Jareung** Rarely	**Kadang-kadang** Sometimes	**Sereng** Often
B35. Meurawe pikiran chaotic thoughts/confusion (Q18)	0	1	2	3
B36. Mandum salah pu yang tapuebut everything done goes wrong (Q19)	0	1	2	3
B37. Stres stress (Q20)	0	1	2	3
B38. Trauma trauma (Q21)	0	1	2	3
B39. Han itubit su ate tapeugah haba can't let the voice out when speak (Q22)	0	1	2	3
B40. Badan su um hot body (Q23)	0	1	2	3
B41. Pucat pale (Q24)	0	1	2	3
B42. Nafah sige saho closed breath/difficulty breathing (Q25)	0	1	2	3
B43. Peugah haba hanale not wanting to talk (Q26)	0	1	2	3
B44. Lee pikiran many thoughts (Q27)	0	1	2	3

Bagian D – Coping (cara mengatasi)

Untuk pertanyaan D01a – D09a (kolom phone)
Ureng-ureng di daerah nyoe na geupeugah tentang mandum kegiatan yang geupubuut untuk geu Bantu ureng nyan agak lebeh get. Jino akan loen baca na tiep-tiep kegiatan nyan dan untuk tiep-tiep kegiatan nyan akan loen tanyeng padum na sering droneh peubuut kegiatan nyan untuk neu Bantu droneh wate teungeh susah. Untuk pertanyaan D01a – D09a (kolom pertama): *For Questions D01a-D09a (first columns): People have told of many different activities people sometimes do to help themselves feel better. I am going to read some of these activities and for each one I am going to ask you how often you do this activity to help yourself when you feel bad.*

Untuk pertanyaan D01b – D09b (kolom phone)
Nyoe Loeng baca kegiatan/buut yang droneh peubuut watee droneh meurasa hana mangat/susah. Untuk tiep-tiep kegiatan nyan , tulong neu bithee bak loeng pikiban pu kegiatan nyan jet mebantu droneh: metamah susah, lebeh susah bacut,hana beda,bacut lebeh get, lebeh brat get.
After all of section A go to Questions D01b-D09b (second columns): I am going to go through the activities that you said you sometimes do when you feel bad. For each one, please tell me how it made you feel: A lot worse, a little worse, no difference, a little better, a lot better.

A. Cara mengatasi	**Hana meu bacut pih** Not at all	**Jareung** ***Rarely***	**Kadang-kadang** Somewhat	**Sereng** Often	*B. Seberapa banyak itu membantu*	**Metamah susah** A lot worse	**Lebeh susah bacut** A little worse	**Hana beda** No difference	**Bacut lebeh get** A little better	**Lebeh brat get** A lot better	**N/A**
D01a. Ta sembahyang/medoa Pray	0	1	2	3	D01b. Ta sembahyang/medoa Pray	1	2	3	4	5	9
D02a. Jak beut Recite Koran	0	1	2	3	D02b. Jak beut Recite Koran	1	2	3	4	5	9
D03a. Ta mita peng Earn money	0	1	2	3	D03b. Ta mita peng Earn money	1	2	3	4	5	9
D04a. Geu duk rame-rame peugah haba Sitting together to chat	0	1	2	3	D04b. Geu duk rame-rame peugah haba Sitting together to chat	1	2	3	4	5	9
D05a. Geuba geu jak peusenang hate Go (walk) to please own heart	0	1	2	3	D05b. Geuba geu jak peusenang hate Go (walk) to please own heart	1	2	3	4	5	9

A. Cara Menghadapi	**Hana meu bacut pih** Not at all	**Jareung** ***Rarely***	**Kadang-kadang** Somewhat	**Sereng** Often	*B. Seberapa banyak itu membantu*	**Metamah susah** A lot worse	**Lebeh susah bacut** A little worse	**Hana beda** No difference	**Bacut lebeh get** A little better	**Lebeh brat get** A lot better	**N/A**
D06a. Musyawarah Discussion	0	1	2	3	D06b. Musyawarah Discussion	1	2	3	4	5	9
D07a. Ta dingo nasehat ureung careong Listen to the advice from wise men	0	1	2	3	D07b. Ta dingo nasehat ureung careong Listen to the advice from wise men	1	2	3	4	5	9
D08a. Geu jak gak hibur droe Go to find recreation for own self	0	1	2	3	D08b. Geu jak gak hibur droe Go to find recreation for own self	1	2	3	4	5	9
D09a. Maen bola kaki ngen voli Play soccer or volley	0	1	2	3	D09b. Maen bola kaki ngen voli Play soccer or volley	1	2	3	4	5	9
FOR INTERVENTION VILLAGES					FOR INTERVENTION VILLAGES						
D10a. Ikoet dalam kelompok RATA Participating in RATA groups	0	1	2	3	D10a. Ikoet dalam kelompok RATA Participating in RATA groups	1	2	3	4	5	9

Section E. Additional Questions for Follow-Up
Bagian E. Pertanyaan Tambahan untuk Tindak Lanjut

Untuk tiep-tiep kejadian udep droneh jino, tolong sebutkan pue keh kejadian nyan terjadi dalam 6 bulen akhe-akhe nyoe. (*setelah membaca masing-masing pertanyaan, pewawancara menyebutkan 'nyoe atau hana.' – jika pertanyaan menyangkut anggota keluarga dekat, tolong tanyakan apa hubungan antara anggota keluarga tersebut dengan responden.)*
For each of the following life events, please say whether it has happened IN THE LAST 6 MONTHS. (after reading each one, the interviewer says 'ye or no.'- if the question is about a close family member, please ask what relation this family member is to the respondent)

Kejadian-kejadian dalam udep droeneuh *Life Events*	**Na** **Yes** **(1)**	**Hana** **No** **(0)**	**Hana lon teupu** **Don't Know** **(2)**	
E01. Mulai neu mengeon lebeh toe *Started up a more close friendship*				
E02. Droneh ka mekeuluarga Got married yourself				
E03. Saudara yang toe droneh ka mekeuluarga Had a close family member get married				**Hubungan** ***Relation:***
E04. Droneh kana sinyak Had a baby yourself (man or woman)				
E05. Saudara droneh yang toe pue kana sinyak Had a close family member have a baby				**Hubungan** ***Relation:***
E06. Droneh kamepisah atau mecree ngen pasangan Got separated or divorced				
E07. Saudara droneh yang toe na geu alami pisah atau mecree Had a close family member separated or divorce				**Hubungan** ***Relation:***
E08. Droneh na ne alami saket brat that Been seriously ill				
E09. Ngen teo droneh na geu alami sakit/kecelakaan brat that Had a seriously ill/injured close friend				
E10. Saudara droneh yang toe na geu alami saket/kecelakaan brat that Had a seriously ill/injured close family member				**Hubungan** ***Relation:***
E11. Ngen toe droneh na yang meninggai Had a close friend die				
E12. Saudara droneh yang toe na yang meninggai Had a close family member die				**Hubungan** ***Relation:***
E13. Droneh na neu alami kekerasan lam bentuk beurangkaban Experienced any kind of violence to self				
E14. Ngen toe droneh na ne alami kekerasan Had a close friend experience violence to self				
E15. Saudara droneh yang toe na geu alami kekerasan Had a close family member experience violence to self				**Hubungan** ***Relation:***
E16. Saudara droneh yang toe na geu minah u desa laen				**Hubungan**

untuk alasan dumpu jeut Had a close family member move out of the village for any reason				***Relation:***
E17. Ne alami gagal panen/pertanian Had a failure in the harvest/farming				

Untuk tiep pertanyaan nyoe, neutulong sebutkan pu keuh na perubahan wate 6 bulen akhe nyoe dibandingkan segolom 6 bulen uleuekoet (setelah membaca masing-masing pertanyaan, pewawancara menyebutkan 'brat that hana geot, baceut lebeh hana geot, lage soet, baceut lebeh geot, atawa brat lebeh geot) For each of the following, please say whether it has changed OVER THE LAST 6 MONTHS, compared before the last 6 months. (after reading each item, the interviewer says 'has this got a lot worse, got a little worse, stayed the same, got a little better, or got a lot better in the last 6 months.')

Changes Perubahan Perubahan	Brat that hana geot *Got a lot Worse* (1)	Baceut lebeh hana geot *Got a little Worse* (2)	Lage soet *Stayed* the Same (3)	Beceut lebeh geot *Got a little Better* (4)	Brat lebeh geot *Got a lot Better* (5)	Tidak tahu *Don't Know* (9)
E18. Na Sanggop droneh neteurimong masalah *Your ability to accept problems*						
E19. Sanggop droneh ne atasi masalah *Your ability to deal with problems*						
E20. Sanggop droneh peugah masalah/Beuhe mengeluarkan pendapat *Your ability to share problems/have courage to say the opinion out*						
E21. Sanggop droneh untuk neubuka bila na masalah lam keluarga droneh *Your ability to be open if there's problem in family*						
E22. Sanggop droneh neu kerja *Your ability to work*						
E23. Sanggop droneh pegadeoh bengeh *Your ability to control anger*						
E24. Mampu droneh untuk neusaba *Your ability to be patient*						
E25. Hubungan droneh ngen keluarga *Your relationship with family*						
E26. Semangat droneh *Your motivation*						
E27. Beuhee droneh *Your courage*						
E28. Tenang pikiran droneh *Your mind's calmness*						
E29. Kompak lam masyarakat *Cohesion in the community*						

Pu na sereng droneh neu pubuut kegiatan nyan selama 6 bulen nyoe dibandingkan segolom 6 bulen uleuekoet. (setelah membacakan masing-masing pertanyaan, pewawancara menyebutkan 'pu drone ne pu but brat that jareung, bacut lebeh jareung, lage soet, bacut lebeh sereng atawa brat that sereng, sejak 6 bulen akhe nyoe' For each of the following activities, please say how often you are doing the activity in THE LAST 6 MONTHS, compared before the last 6 months. (after reading each item, the interviewer says 'have you done this a lot less often, a little less often, the same amount, a little more often or a lot more often, since 6 months ago.'

	Brat that jareung *A lot Less often* (1)	Baceut lebeh jareung *A little Less often* (2)	Lage soet *Stayed the Same* (3)	Baceut lebeh sereng *A little More Often* (4)	Brat that sereng *A lot More Often* (5)	Tidak tahu *Don't Know* (9)
E30. Ne jak bak acara/kegiatan masyarakat *Going to community activity*						
E31. Peugah-peugah haba ngen tetangga *Being sociable with neighbors*						
E32. Tuka pikiran *Having discussion*						
E33. Terbuka dan lee peugah haba *Being open and talkative*						
E34. Merasa na ureng-ureng yang bie perhatian ke droneh *Feeling that there are people who care about you*						
E35. Neupike tentang hai yang broek *Thinking about bad things/problems*						
E36. Ne pu but but seuro-uro *Doing daily activities*						
E37. Na meurasa dihormati *Feeling respected*						
E38. Na meurasa dihargai *Feeling appreciated*						
E39. Na karu karu lam keluarga *Having fights/disputes in family*						
E40. Na Bercerita *Sharing*						
E41. Na neu khem *Laughing*						
E42. Na seunang *Feeling happy*						
E43. Na meurasa curiga *Feeling suspicious*						
E44. Na meurasa akrab/toe ngen ureng laen *Feeling cohesiveness/closer with others*						
E45. Peuramah *Feeling friendly*						
E46. Kunjong Mengunjong/meukumpul ngen ureng laen *Visiting each others/gathering with others*						
E47 Neumita perawatan kesehatan dari puskesmas atau rumoh saket *Getting healthcare from a clinic or hospital*						

E48. Untuk pertanyaan terakhe, kamoe neuk teumanyoeng bak droneh, pu droneh ka neumulai usaha atau kegiatan ekonomi droneh dalam 6 bulen akhe nyoe?
As a final question, we would like to ask you if you have started any new economic projects or activities in the last 6 months?

Na	*Hana*
Yes (1)	*No (0)*

Meunyo na, neu tulong jelaskan:
If yes, please describe:

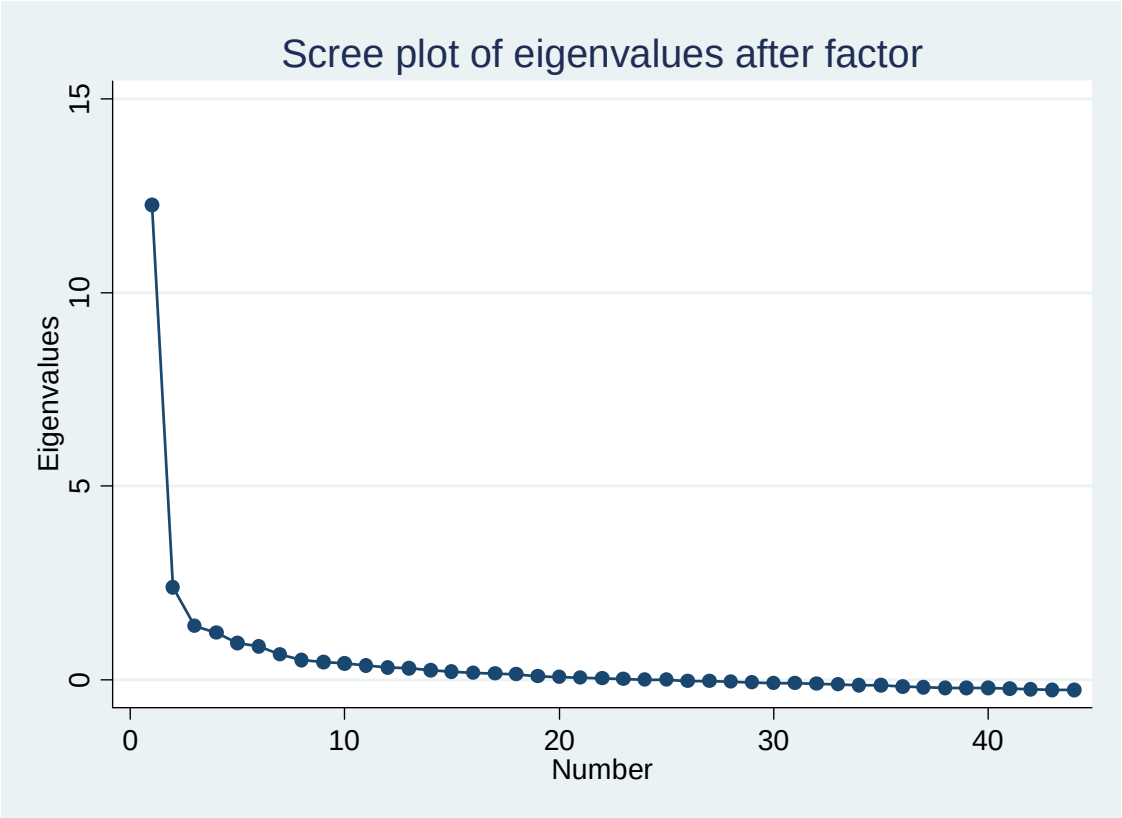
Appendix C: Factor Analysis

We used factor analysis to explore whether the Western concepts underlying the symptom instruments – anxiety and depression (the HSCL) and somatic complaints (the WHO somatic complaints) were really appropriate in this population; to explore whether they are conceptually valid. An exploratory factor analysis was conducted with all 44 symptom questions (ie, not including the function or coping questions). All of the respondents screened at baseline were included in the factor analysis, representing the diversity of symptom severity levels, rather than only those who met criteria for inclusion in the assessment, which is a less diverse sample. A principal factors analysis was conducted to investigate the underlying latent variables that are explained by the correlation between the different symptom responses. This method will allow us to both explore the 'validity' of the underlying constructs (i.e. are we identifying different syndromes) as well informing the development of scales that are appropriate for the local population. Once the analysis is conducted, the resulting factors need to be 'rotated' in order to enhance their interpretability. A promax rotation was used which allows for the factors to be correlated with one another, a common assumption when investigating mental health problems that often co-occur.

The most important step of an exploratory factor analysis is to determine the appropriate number of factors to extract and explore. There are many different criteria that can be used to determine the appropriate number of factors, we relied on the following three: 1) scree plot – where the selection of factors is done at the point before the line begins to flatten out (before the elbow); 2) eigenvalues greater than 1.0; and 3) the point at which the number of factors explains at least 75% of the cumulative variance among the variables. Below is a copy of the scree plot and results from the primary analysis process.

Using the three criteria, three different factor models are suggested. Based on the scree plot, a 2-factor model is appropriate. Based on eigenvalues > 1, a 4-factor model is recommended. And based on the cumulative variance explained, a 3-factor model is suggested. When the results suggest different models, it is standard to explore them all and rely on the prevailing literature and knowledge of the local situation to inform which specific model to go forward with. The results of a factor analysis include loadings for each item on each factor. To investigate the different factors, we used a standard of 0.40 as a cut-off for identifying which items load on which factors. Below is a table with the results of the three different factor analyses. The color coding for the factors is to allow for easier investigation across the three models.

Scree Plot:



Principal Factor Analysis

Factor analysis/correlation — Number of obs = 582
Method: principal factors — Retained factors = 24
Rotation: (unrotated) — Number of params = 780

Factor	Eigenvalue	Difference	Proportion	Cumulative
Factor1	12.26311	9.87148	0.6051	0.6051
Factor2	2.39163	1.00541	0.1180	0.7231
Factor3	1.38622	0.17123	0.0684	0.7915
Factor4	1.21498	0.27641	0.0600	0.8515
Factor5	0.93857	0.08193	0.0463	0.8978

The multiple factor models are presented in Table 12 below. In the two-factor model, the data suggest one factor consisting predominantly of symptoms of anxiety and somatic (i.e. physical) expression of distress (pink) and a second factor consisting of symptoms more oriented towards

depression-like problems (yellow). In the three-factor model, the single anxiety and somatic symptom factor from the previous model is divided into two factors, with a more distinct anxiety factor being presented (blue). The final, four-factor model, further sub-divides the anxiety factor into two sub-factors (blue and purple) with only a few symptoms each. In reviewing these three models, the three-factor model appears to best present the data and these factors are consistent with underlying constructs of anxiety, depression, and somatic complaints. Hence, these results support the original decision to investigate symptoms using instruments based on Western concepts of anxiety, somatic, and depression-like problems in this population. All analyses presented here are therefore based on the pre-defined scales to allow for future comparisons with other research. For the anxiety and depression problems, the Hopkins Symptom Checklist (HSCL) anxiety and depression subscales are used. For the somatic problems, the WHO Somatic Scale was used. Table 1, in the report, presents the symptoms that make up the different scales. For the standard scales, items that were directly translated from the qualitative research are noted. Symptoms that were not part of any of the scales but were identified as important from the qualitative research are included under the 'Qualitative Data' only heading, and the data for these items are included in the total symptom scale scores.

Table 12: Factor Analysis Results for 3 different Models

	2 factor model		3 factor model			4 factor model			
	1	2	1	2	3	1	2	3	4
B01. headache	.58		.47			.47			
B02. dizziness	.65		.56			.56			
B03. pain in chest	.59		.46			.45			
B04. pain in lower back	.61		.64			.63			
B05. soreness of muscles	.52		.64			.64			
B06. numbness in parts of your body	.58		.56			.56			
B07. weakness in your body	.63		.59			.59			
B08. suddenly scared for no reason	.64				.82			.78	
B09. fearful	.65				.84			.81	
B10. nervousness or shakiness	.67				.61			.63	
B11. heart pounding	.65							.45	
B12. trembling	.71				.51			.55	
B13. feeling tense	.41								
B14. busy by own self (panic)					.49				
B15. can't sit, can't stand (feeling restless)					.46				.42
B16. no energy	.53		.50			.50			
B17. blaming yourself		.47		.47			.42		
B18. crying									
B19.don't care about family				.40					
B20.loss of appetite	.42		.55			.56			
B21.when sleep, can't sleep well			.43			.44			
B22.feeling hopeless about the future		.59		.59			.55		
B23.feeling sad									
B24. feeling lonely		.57		.59			.56		
B25. thoughts of ending your life		.45		.47			.45		
B26. feeling of being trapped		.56		.58			.59		
B27. feeling difficult having many thoughts									.70
B28. feelings no interest		.72		.72			.70		
B29. difficult to do anything				.42		.42			
B30. feeling of worthlessness		.80		.80			.78		
B31. difficult heart					.42				.63
B32. spacing out		.47		.43					
B33. easily angered									
B34. don't have direction		.63		.62			.57		
B35. chaotic thoughts/confusion		.44			.47				.76
B36. everything done goes wrong		.53		.50					
B37. stress		.48		.42			.41		
B38. trauma					.59			.49	
B39. can't let the voice out when speak		.53		.48			.53		
B40. hot body	.53		.49			.49			
B41. pale									
B42. closed breath/difficulty breathing									
B43. not wanting to talk		.62		.59			.65		
B44. many thoughts					.51				.74